SAN BERNARDINO COUNTY

Behavioral Health

Artwork by Tracy Hutchinson

Mental Health Services Act

Annual Update for Fiscal Year 2022 - 2023

DRAFT

Message from the Director

Welcome

On behalf of the Department of Behavioral Health (DBH) staff, community partners, providers, and stakeholders, we thank you for taking the time to review the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2022-23.

Since 2005, the implementation of MHSA has allowed the Department to focus on developing a robust system of community-informed behavioral health services that focus on the equity and inclusion of all diverse stakeholders in the development, implementation, and evaluation of services across DBH's entire continuum of care.

In addition to MHSA Three-Year Plan for Fiscal Years 2020-21 through 2022-23, the Annual Update Plan provides the Department the opportunity to highlight the achievements of DBH and contracted partner programs during the previous fiscal year (FY 2020-21), demonstrate how community input has shaped DBH programing and implementation, and provide updates, or changes, to existing MHSA programs.

DBH engages in the continuous evaluation of programs and fiscal projections to ensure services are always accessible within the continuum of care. In light of the ongoing COVID-19 pandemic, DBH never closed, remaining open to provide essential services to consumers throughout the County, and serving over 52,000 community members from the beginning of the pandemic in March 2020 through June 2021. To ensure the safety of those we serve and staff, immediate adjustments and evaluations were made to support service delivery.

For specific information regarding San Bernardino County's DBH initial response to COVID-19, please refer to the MHSA Update to Fiscal Year 2020-21 Plan: Response to COVID-19 at: https://wp.sbcounty.gov/dbh/programs/mhsa/ Subsequent Annual Update Plans now demonstrate the long-lasting impacts of COVID-19.

Thank you for the ongoing support and dedication to the programs and services we provide, as well as the community we serve, by 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.

See you on our journey towards optimal health and wellness!

Sincerely,

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

Mensaje de la Directora

Bienvenido

En nombre del personal del Departamento de Salud Mental (DBH por sus siglas en inglés), socios comunitarios, proveedores y partes interesadas, le agradecemos que haya tomado el tiempo para revisar la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para el Año Fiscal 2022-23.

Desde el 2005, la implementación de MHSA ha permitido al Departamento enfocarse en desarrollar un sistema robusto de servicios de salud mental informados por la comunidad que se centran en la equidad y la inclusión de todas las diversas partes interesadas en el desarrollo, implementación y evaluación de servicios en todo el continuo de atención de DBH.

Además del Plan de tres años de la MHSA para los Años Fiscales 2020-21 a 2022-23, el Plan de Actualización Anual ofrece al Departamento la oportunidad de destacar los logros de DBH y los programas de socios contratados durante el año fiscal anterior (FY 2020-21), demostrar cómo la contribución de la comunidad ha dado forma a la programación e implementación de DBH, Y proporcionar actualizaciones, o cambios, a los programas de MHSA existentes.

DBH participa en la evaluación continua de programas y proyecciones fiscales para asegurar que los servicios sean siempre accesibles dentro del continuo de atención. A la luz de la actual pandemia de COVID-19, DBH nunca cerró, permaneciendo abierto para proporcionar servicios esenciales a los consumidores en todo el Condado, y sirviendo a más de 52,000 miembros de la comunidad desde el comienzo de la pandemia en marzo del 2020 hasta junio del 2021. Para garantizar la seguridad de los que servimos y del personal, se realizaron ajustes y evaluaciones inmediatas para apoyar la prestación de servicios.

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Para obtener información específica sobre la respuesta inicial de DBH al COVID-19, consulte la Actualización del Plan de la MHSA del Año Fiscal 2020-21: "Response to COVID-19" al: https://wp.sbcounty.gov/dbh/programs/mhsa/ Los planes de actualización anual posteriores ahora demuestran los impactos duraderos de COVID-19

Gracias por el apoyo continuo y la dedicación a los programas y servicios que brindamos, así como a la comunidad a la que servimos, al tomarse el tiempo para revisar y proporcionar comentarios sobre este plan. La Administración de la Ley de Servicios de Salud Mental de DBH espera recibir su opinión en: DBH-MHSA@dbh.sbcounty.gov

¡Nos vemos en nuestro viaje hacia una salud y un bienestar óptimo!

Atentamente,

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

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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: Michelle Dusick
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	County Auditor-Controller / City Financial Officer
Name: Georgina Yoshioka, DSW, MBA, LCSW	Name: Michelle Dusick
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 E. Vanderbilt Way San Bernardino, CA 92415	

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

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

_____ _____
Local Mental Health Director (PRINT) Signature Date

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

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

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

Community Program Planning

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 include web-conference style meetings and in-person meetings for consumers and family members. Meetings are available for remote communities and translation services are made available for both in person and web-conference meetings.

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

- Behavioral Health Commission (BHC): 12 annual meetings held monthly
- District Advisory Committee meetings: Five quarterly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 12 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate culturally specific subcommittee/coalitions: 15 monthly meetings
- Transitional Age Youth (TAY) Advisory Boards
- MHSA Executive Committee meetings
- Room and Board Advisory Coalition
- System-wide Program Outcomes Committee (SPOC)

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

Additional regular stakeholder engagement and education meetings include:

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

Stakeholder attendance is recorded through meeting sign-in sheets and stakeholder feedback surveys and 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 & Inclusion (formerly OCCES) which reports to the DBH Director, a Cultural Competency Advisory Committee, and 14 monthly cultural subcommittees and coalitions. The 14th cultural subcommittee, Suicide Prevention Awareness Subcommittee (SPAS), was recently approved in June 2020 and held its first meeting in July 2020. The SPAS was developed out of a statewide learning collaborative to discuss strategies for increasing community participation in planning local suicide prevention efforts. SPAS aims to strengthen and build existing statewide suicide prevent efforts, create local awareness of suicide risk factors, supports, and resources, and to inform and support local education areas in suicide prevention efforts.

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 as part of an aligned reporting structure 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. Conversely, MHSA Administration staff participate in each of the Culturally specific sub-committees. 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 Office, Community Outreach and Education division, DBH's four TAY centers, DBH's nine consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA programs and activities.

Consumer engagement occurs through regularly scheduled Community Program Planning 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.

MHSA Annual Update: Community Program Planning Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Annual Update included meetings hosted in multiple venues and available to each region of the County, monolingual Spanish sessions hosted in collaboration with the Consulate of Mexico in San Bernardino, and Family Resource Centers.

A total of 42 scheduled meetings were held throughout San Bernardino County.

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

The MHSA Administrative Manager and Component Leads, in conjunction with the OEI and Public Relations and Outreach (PRO), have responsibility for coordination and management of the Community Program Planning (CPP) process. This process was built upon existing stakeholder engagement components, mechanisms, 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, the majority of meetings were held virtually to ensure safety for the stakeholders and presenters, while offering in-person options at regional Clubhouses.

MHSA Annual Update CPP Demographics

Age

0% 0-15
3% 16-25
75% 26-59
13% 60+

Language

72% English
11% Spanish
1% Other

Gender Identity

18% Male
61% Female
1% Transgender
<1% Gender Nonbinary

Race/Ethnicity

14% African-American/Black
19% Caucasian/White
3% American Indian or Alaskan Native
3% Declined to State
3% Asian/Pacific Islander
29% Latinx/Hispanic
6% More than One Race

N=524 **NOTE: Not every participant responded to the survey. Not every respondent answered every question. For some questions, respondents selected more than one response.**

Community Program Planning

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

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

As listed in the schedule, special sessions of the Behavioral Health Commission's District Advisory Committee (DAC), along with other meetings, were conducted in each geographic region of the county. This schedule ensured representation and participation in each region of San Bernardino County. To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OEI provided stakeholder engagement meetings for the MHSA Annual Update for each of their 14 Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers, Clubhouses, and other community agencies such as the Kiwanis Club of Greater San Bernardino, Department of Aging and Adult Services Senior Affairs Commission, and National Alliance on Mental Illness (NAMI) of San Bernardino. Additionally, the PEI Provider meeting held 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 Annual Update and proposed program changes, as well as obtain feedback and recommendations for system improvement.

To ensure that stakeholders could fully benefit from the community meetings, OEI staff arranged for Spanish, American Sign Language, Vietnamese, or any other language interpretation, upon request, at each meeting.

MHSA Annual Update CPP Demographics

Region

15% Central Valley
14% Desert/Mountain
22% East Valley
19% West Valley
29% Other/Declined to State

Groups Represented

<1% Law Enforcement
2% Education/Students
8% Social or Human Service Program/Agency
<1% Healthcare – Behavioral/ Mental Health
14% Nonprofit Organization
41% Family Member or Loved One
2% Retired/Unemployed
35% Federal, State, County, or City Government
6% Self-Employed
10% Community-Based Organizations
31% Consumer of Mental Health Services
5% Consumer of Substance Use Disorder Services

N=524 **NOTE: Not every participant responded to the survey. Not every respondent answered every question. For some questions, respondents selected more than one response.**

Community Program Planning

In order to increase opportunities for participation across the county, the department hosted additional online sessions on February 1, 2022, from 11:00 a.m. to 12:00 p.m. and January 27, 2022, from 5:00 to 6:00 p.m. These sessions provided additional opportunities to individuals to participate via computer, smart phones, and other technological devices who were unable to attend one of the regularly scheduled meetings.

At the end of the presentation, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concluded, participants were advised about additional opportunities to review the posted draft of the MHSA Annual Update 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: http://wp.sbcounty.gov/dbh/wpcontent/uploads/2016/08/COM0947.pdf.

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 17, 2022. 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 MHSA Administrative Manager to ensure additional opportunities to stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the MHSA Annual Update 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 **673** stakeholders attended this year's Community Program Planning (CPP) stakeholder sessions and DBH received **524** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions. Of the those who completed a survey, **72%** were either satisfied or very satisfied with the CPP meeting and its goals.

Stakeholder Comments

"Very educational."

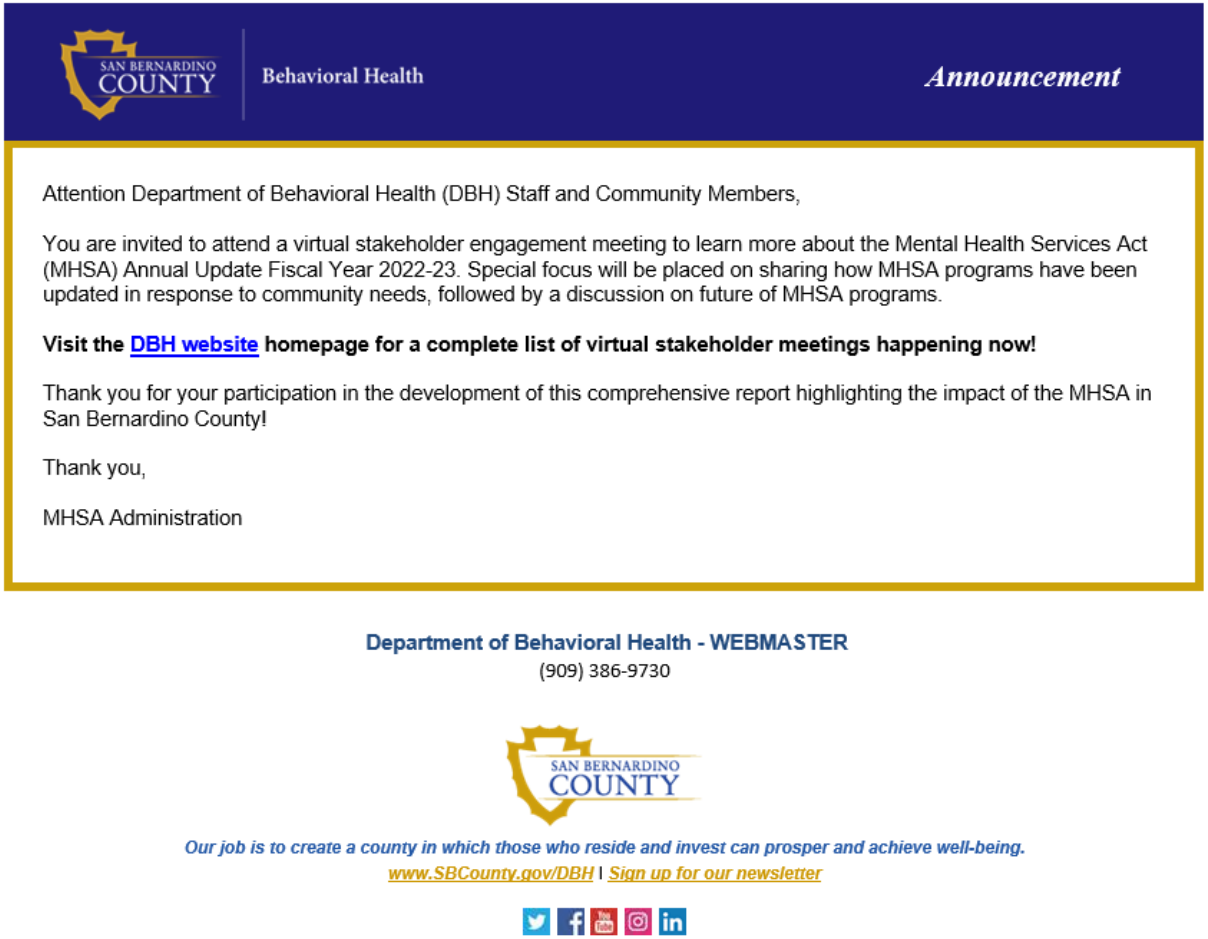
"Thank you so much for making the time to present."

"Everything was presented well, and thoroughly explained."

"I appreciate the additional insight into the process of developing the annual plan through the ongoing stakeholder meetings."

Community Program Planning

The following pages provide the flyers distributed to the community to promote the MHSA Annual Update Community Program Planning (CPP) process.



SAN BERNARDINO COUNTY | Behavioral Health — *Announcement*

Attention Department of Behavioral Health (DBH) Staff and Community Members,

You are invited to attend a virtual stakeholder engagement meeting to learn more about the Mental Health Services Act (MHSA) Annual Update Fiscal Year 2022-23. Special focus will be placed on sharing how MHSA programs have been updated in response to community needs, followed by a discussion on future of MHSA programs.

Visit the DBH website homepage for a complete list of virtual stakeholder meetings happening now!

Thank you for your participation in the development of this comprehensive report highlighting the impact of the MHSA in San Bernardino County!

Thank you,

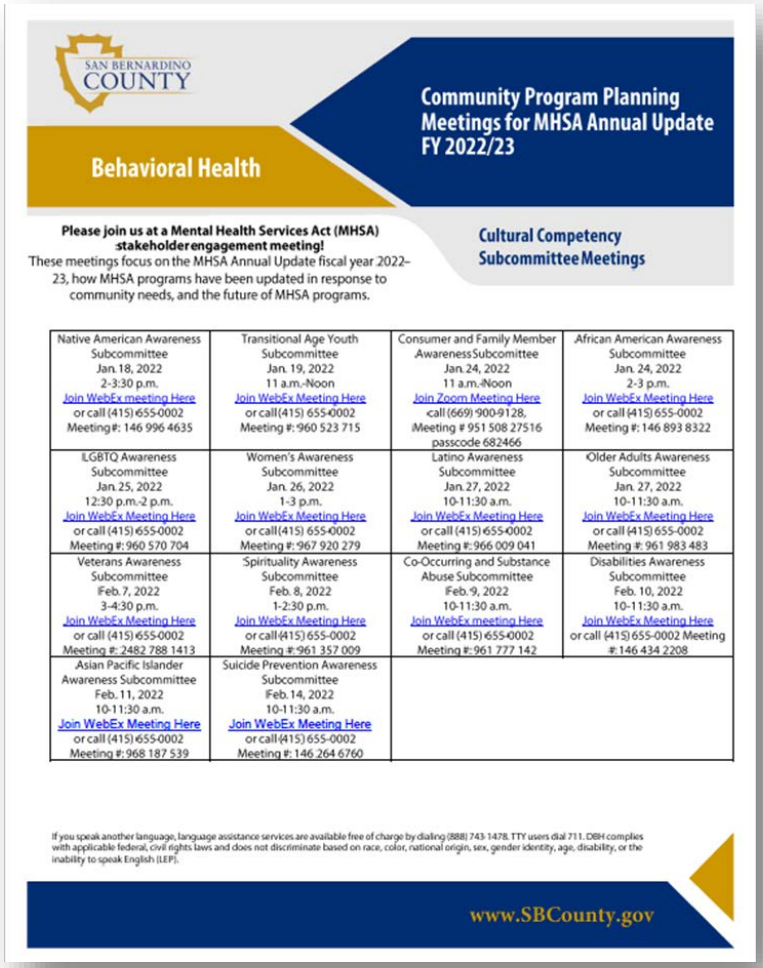
MHSA Administration

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

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

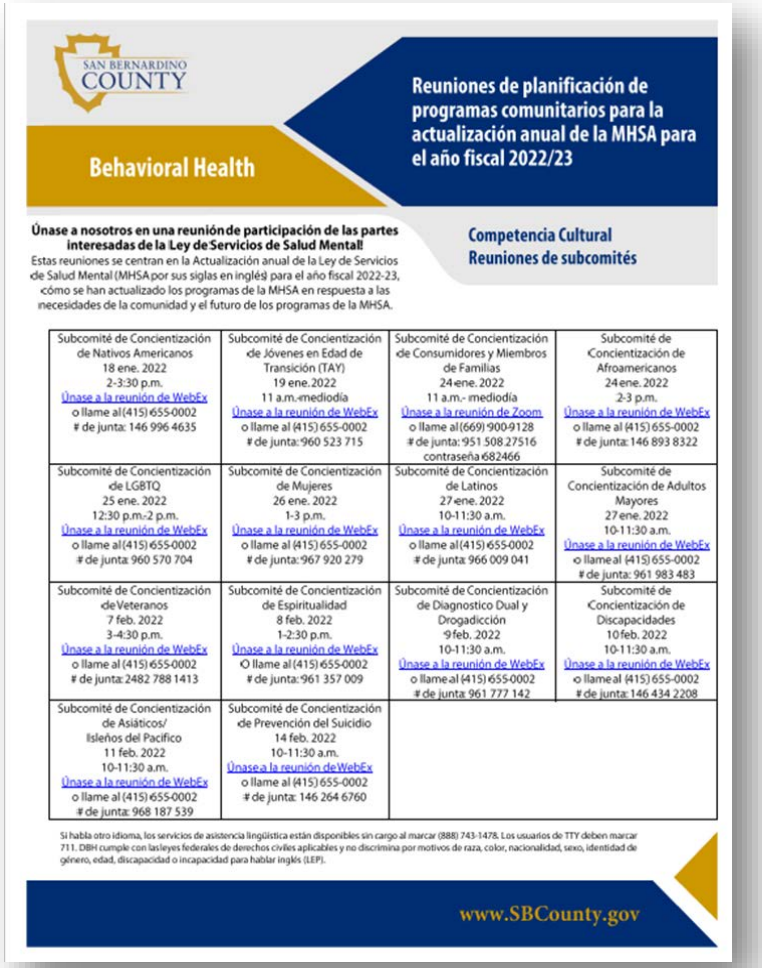
Cultural Competency Subcommittee Meetings

Native American Awareness Subcommittee Jan. 18, 2022 2-3:30 p.m. Join WebEx meeting Here or call (415) 655-0002 Meeting #: 146 996 4635	Transitional Age Youth Subcommittee Jan. 19, 2022 11 a.m.-Noon Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 960 523 715	Consumer and Family Member Awareness Subcommittee Jan. 24, 2022 11 a.m.-Noon Join Zoom Meeting Here call (669) 900-9128, Meeting # 951 508 27516 passcode 682466	African American Awareness Subcommittee Jan. 24, 2022 2-3 p.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 146 893 8322
LGBTQ Awareness Subcommittee Jan. 25, 2022 12:30 p.m.-2 p.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 960 570 704	Women's Awareness Subcommittee Jan. 26, 2022 1-3 p.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 967 920 279	Latino Awareness Subcommittee Jan. 27, 2022 10-11:30 a.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 966 009 041	Older Adults Awareness Subcommittee Jan. 27, 2022 10-11:30 a.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 961 983 483
Veterans Awareness Subcommittee Feb. 7, 2022 3-4:30 p.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 2482 788 1413	Spirituality Awareness Subcommittee Feb. 8, 2022 1-2:30 p.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 961 357 009	Co-Occurring and Substance Abuse Subcommittee Feb. 9, 2022 10-11:30 a.m. Join WebEx meeting Here or call (415) 655-0002 Meeting #: 961 777 142	Disabilities Awareness Subcommittee Feb. 10, 2022 10-11:30 a.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 146 434 2208
Asian Pacific Islander Awareness Subcommittee Feb. 11, 2022 10-11:30 a.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 968 187 539	Suicide Prevention Awareness Subcommittee Feb. 14, 2022 10-11:30 a.m. Join WebEx Meeting Here or call (415) 655-0002 Meeting #: 146 264 6760		

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).

www.SBCounty.gov

English Version



SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA para el año fiscal 2022/23

Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental!
Estas reuniones se centran en la Actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para el año fiscal 2022-23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Competencia Cultural Reuniones de subcomités

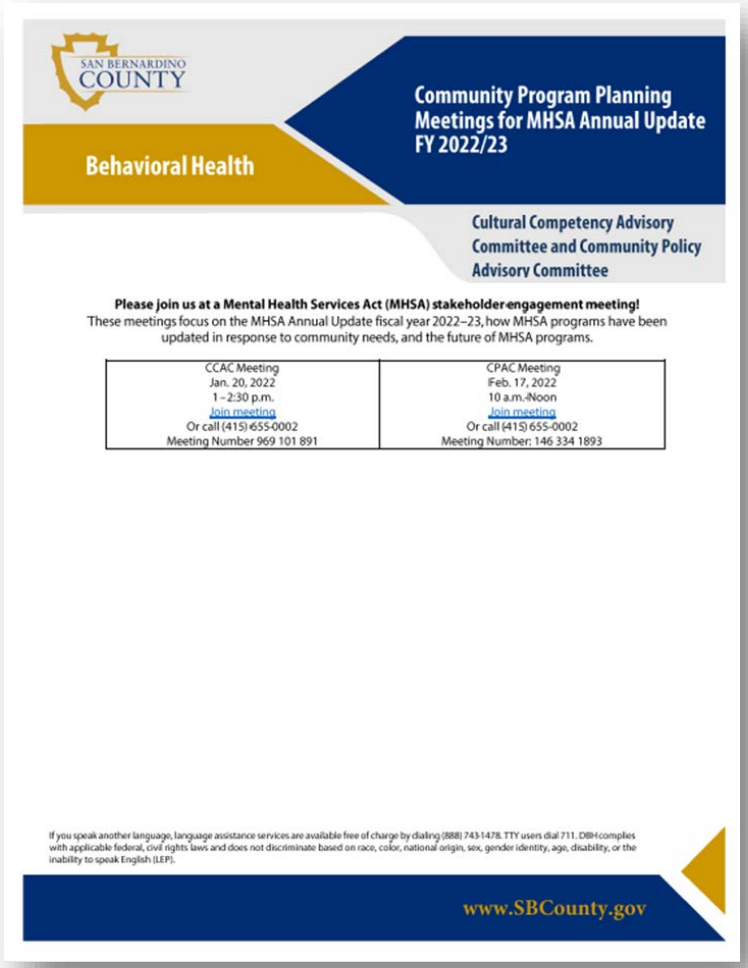
Subcomité de Concientización de Nativos Americanos 18 ene. 2022 2-3:30 p.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 146 996 4635	Subcomité de Concientización de Jóvenes en Edad de Transición (TAY) 19 ene. 2022 11 a.m.-mediodía Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 960 523 715	Subcomité de Concientización de Consumidores y Miembros de Familias 24 ene. 2022 11 a.m.- mediodía Únase a la reunión de Zoom o llame al (669) 900-9128 # de junta: 951 508 27516 contraseña 682466	Subcomité de Concientización de Afroamericanos 24 ene. 2022 2-3 p.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 146 893 8322
Subcomité de Concientización de LGBTQ 25 ene. 2022 12:30 p.m.-2 p.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 960 570 704	Subcomité de Concientización de Mujeres 26 ene. 2022 1-3 p.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 967 920 279	Subcomité de Concientización de Latinos 27 ene. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 966 009 041	Subcomité de Concientización de Adultos Mayores 27 ene. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 961 983 483
Subcomité de Concientización de Veteranos 7 feb. 2022 3-4:30 p.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 2482 788 1413	Subcomité de Concientización de Espiritualidad 8 feb. 2022 1-2:30 p.m. Únase a la reunión de WebEx O llame al (415) 655-0002 # de junta: 961 357 009	Subcomité de Concientización de Diagnostico Dual y Drogadicción 9 feb. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 961 777 142	Subcomité de Concientización de Discapacidades 10 feb. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 146 434 2208
Subcomité de Concientización de Asiáticos/ Isleños del Pacifico 11 feb. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 968 187 539	Subcomité de Concientización de Prevención del Suicidio 14 feb. 2022 10-11:30 a.m. Únase a la reunión de WebEx o llame al (415) 655-0002 # de junta: 146 264 6760		

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

www.SBCounty.gov

Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

Cultural Competency Advisory Committee and Community Policy Advisory Committee

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

CCAC Meeting	CPAC Meeting
Jan. 20, 2022 1 – 2:30 p.m. Join meeting Or call (415) 655-0002 Meeting Number 969 101 891	Feb. 17, 2022 10 a.m.-Noon Join meeting Or call (415) 655-0002 Meeting Number: 146 334 1893

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).

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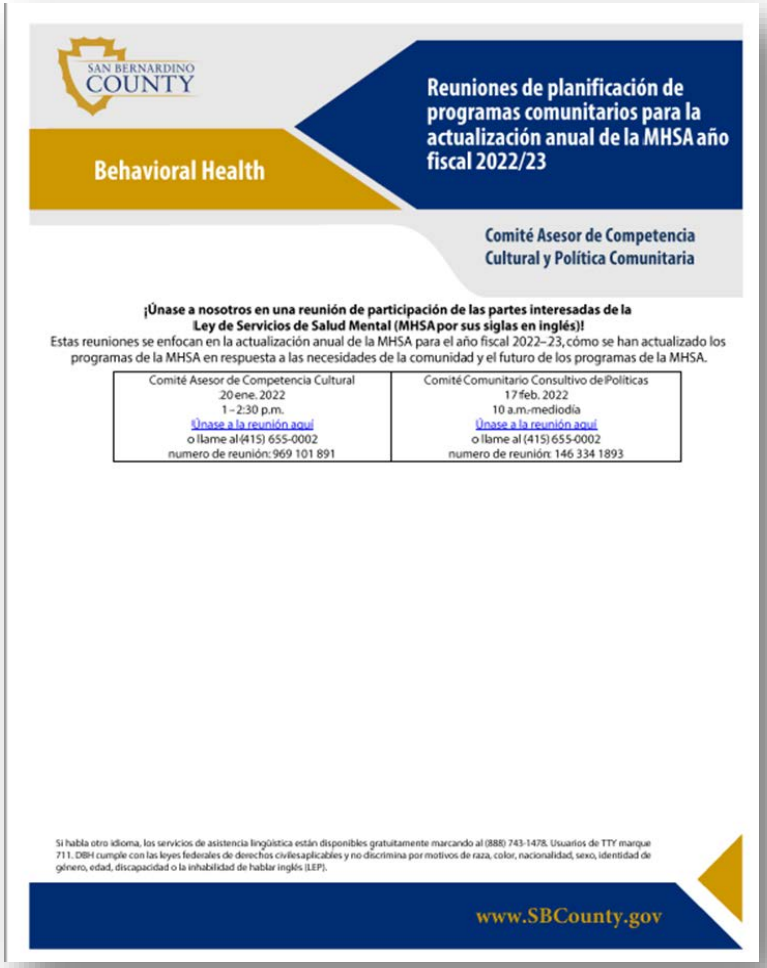
English Version



SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

Comité Asesor de Competencia Cultural y Política Comunitaria

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Comité Asesor de Competencia Cultural	Comité Comunitario Consultivo de Políticas
20 ene. 2022 1 – 2:30 p.m. Únase a la reunión aquí o llame al (415) 655-0002 numero de reunión: 969 101 891	17 feb. 2022 10 a.m.-mediodía Únase a la reunión aquí o llame al (415) 655-0002 numero de reunión: 146 334 1893

Si habla otro idioma, los servicios de asistencia lingüística están disponibles gratuitamente marcando al (888) 743-1478. Usuarios de TTY marque 711. DBH cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, sexo, identidad de género, edad, discapacidad o la inhabilidad de hablar inglés (LEP).

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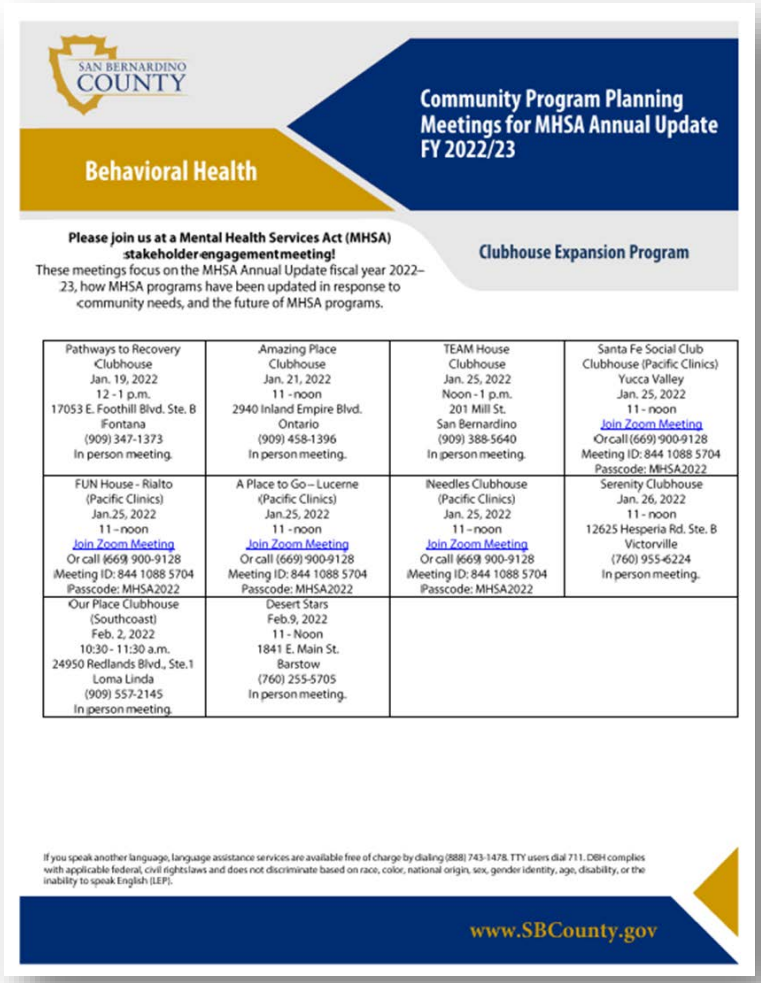
Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

Clubhouse Expansion Program

Pathways to Recovery Clubhouse Jan. 19, 2022 12 - 1 p.m. 17053 E. Foothill Blvd. Ste. B Fontana (909) 347-1373 In person meeting.	Amazing Place Clubhouse Jan. 21, 2022 11 - noon 2940 Inland Empire Blvd. Ontario (909) 458-1396 In person meeting.	TEAM House Clubhouse Jan. 25, 2022 Noon - 1 p.m. 201 Mill St. San Bernardino (909) 388-5640 In person meeting.	Santa Fe Social Club Clubhouse (Pacific Clinics) Yucca Valley Jan. 25, 2022 11 - noon Join Zoom Meeting Or call (669) 900-9128 Meeting ID: 844 1088 5704 Passcode: MHSA2022
FUN House - Rialto (Pacific Clinics) Jan.25, 2022 11 - noon Join Zoom Meeting Or call (669) 900-9128 Meeting ID: 844 1088 5704 Passcode: MHSA2022	A Place to Go – Lucerne (Pacific Clinics) Jan.25, 2022 11 - noon Join Zoom Meeting Or call (669) 900-9128 Meeting ID: 844 1088 5704 Passcode: MHSA2022	Needles Clubhouse (Pacific Clinics) Jan. 25, 2022 11 - noon Join Zoom Meeting Or call (669) 900-9128 Meeting ID: 844 1088 5704 Passcode: MHSA2022	Serenity Clubhouse Jan. 26, 2022 11 - noon 12625 Hesperia Rd. Ste. B Victorville (760) 955-6224 In person meeting.
Our Place Clubhouse (Southcoast) Feb. 2, 2022 10:30 - 11:30 a.m. 24950 Redlands Blvd., Ste.1 Loma Linda (909) 557-2145 In person meeting.	Desert Stars Feb.9, 2022 11 - Noon 1841 E. Main St. Barstow (760) 255-5705 In person meeting.		

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English Version

SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Programa de expansión de las casas club

Pathways to Recovery Clubhouse 19 ene. 2022 mediodía - 1 p.m. 17053 E. Foothill Blvd. Ste.B Fontana (909) 347-1373 Reunión en persona.	Amazing Place Clubhouse 21 ene. 2022 11 - mediodía 2940 Inland Empire Blvd. Ontario (909) 458-1396 Reunión en persona.	TEAM House Clubhouse 25 ene. 2022 mediodía - 1 p.m. 201 Mill St. San Bernardino (909) 388-5640 Reunión en persona.	Santa Fe Social Club Clubhouse (Pacific Clinics) Yucca Valley 25 ene. 2022 11 - mediodía Únase a la reunión aquí o llame al (669) 900-9128 numero de reunión: 844 1088 5704 contraseña: MHSA2022
FUN House - Rialto (Pacific Clinics) 25 ene. 2022 11 - mediodía Únase a la reunión aquí o llame al (669) 900-9128 numero de reunión: 844 1088 5704 contraseña: MHSA2022	A Place to Go – Lucerne (Pacific Clinics) 25 ene. 2022 11 - mediodía Únase a la reunión aquí o llame al (669) 900-9128 numero de reunión: 844 1088 5704 contraseña: MHSA2022	Needles Clubhouse (Pacific Clinics) 25 ene. 2022 11 - mediodía Únase a la reunión aquí o llame al (669) 900-9128 numero de reunión: 844 1088 5704 contraseña: MHSA2022	Serenity Clubhouse 26 ene. 2022 11 - mediodía 12625 Hesperia Rd. Ste. B Victorville (760) 955-6224 Reunión en persona.
Our Place Clubhouse (Southcoast) 2 feb.2022 10:30 - 11:30 a.m. 24950 Redlands Blvd., Ste.1 Loma Linda (909) 557-2145 Reunión en persona.	Desert Stars 9 feb. 2022 11 - mediodía 1841 E. Main St. Barstow (760) 255-5705 Reunión en persona.		

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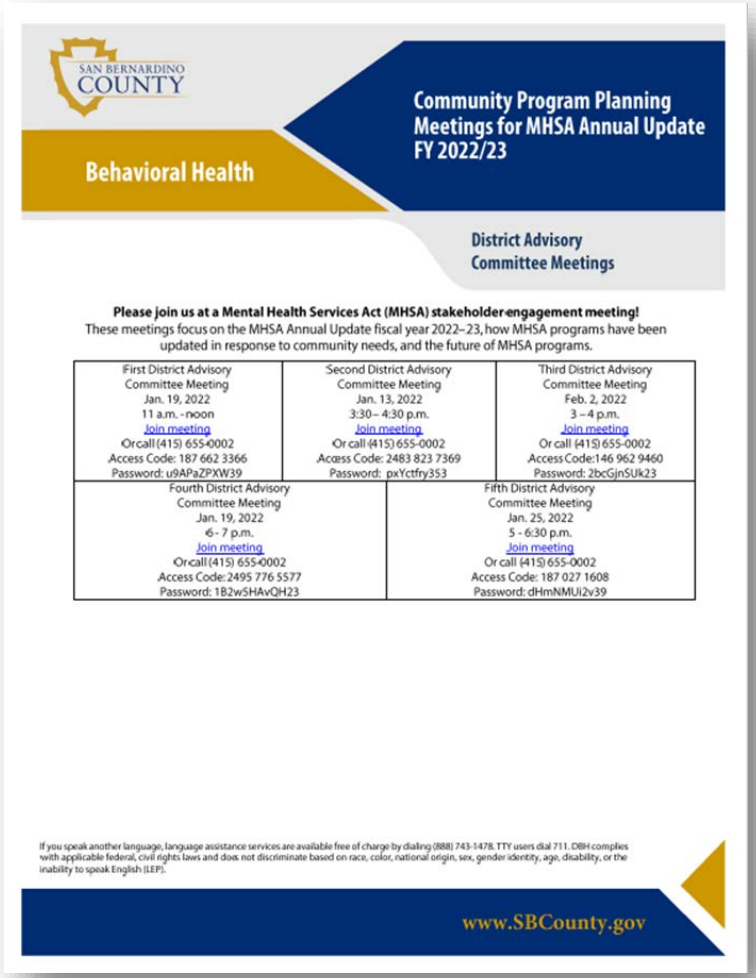
Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

District Advisory Committee Meetings

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

First District Advisory Committee Meeting	Second District Advisory Committee Meeting	Third District Advisory Committee Meeting
Jan. 19, 2022 11 a.m. - noon Join meeting Or call (415) 655-0002 Access Code: 187 662 3366 Password: u9APaZPXW39	Jan. 13, 2022 3:30 – 4:30 p.m. Join meeting Or call (415) 655-0002 Access Code: 2483 823 7369 Password: pxYctfry353	Feb. 2, 2022 3 – 4 p.m. Join meeting Or call (415) 655-0002 Access Code:146 962 9460 Password: 2bcGjnSUk23

Fourth District Advisory Committee Meeting	Fifth District Advisory Committee Meeting
Jan. 19, 2022 6 - 7 p.m. Join meeting Or call (415) 655-0002 Access Code: 2495 776 5577 Password: 1B2w5HAvQH23	Jan. 25, 2022 5 - 6:30 p.m. Join meeting Or call (415) 655-0002 Access Code: 187 027 1608 Password: dHmNMUi2v39

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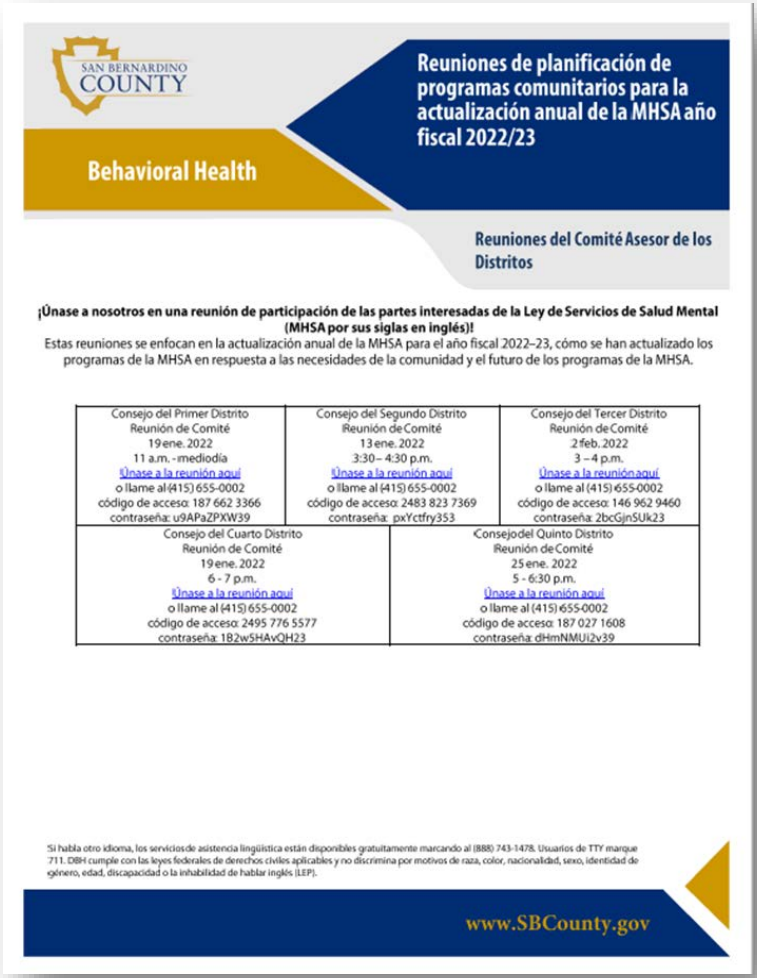
English Version



SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

Reuniones del Comité Asesor de los Distritos

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Consejo del Primer Distrito	Consejo del Segundo Distrito	Consejo del Tercer Distrito
Reunión de Comité 19 ene. 2022 11 a.m. - mediodía Únase a la reunión aquí o llame al (415) 655-0002 código de acceso: 187 662 3366 contraseña: u9APaZPXW39	Reunión de Comité 13 ene. 2022 3:30 – 4:30 p.m. Únase a la reunión aquí o llame al (415) 655-0002 código de acceso: 2483 823 7369 contraseña: pxYctfry353	Reunión de Comité 2 feb. 2022 3 – 4 p.m. Únase a la reunión aquí o llame al (415) 655-0002 código de acceso: 146 962 9460 contraseña: 2bcGjnSUk23

Consejo del Cuarto Distrito	Consejo del Quinto Distrito
Reunión de Comité 19 ene. 2022 6 - 7 p.m. Únase a la reunión aquí o llame al (415) 655-0002 código de acceso: 2495 776 5577 contraseña: 1B2w5HAvQH23	Reunión de Comité 25 ene. 2022 5 - 6:30 p.m. Únase a la reunión aquí o llame al (415) 655-0002 código de acceso: 187 027 1608 contraseña: dHmNMUi2v39

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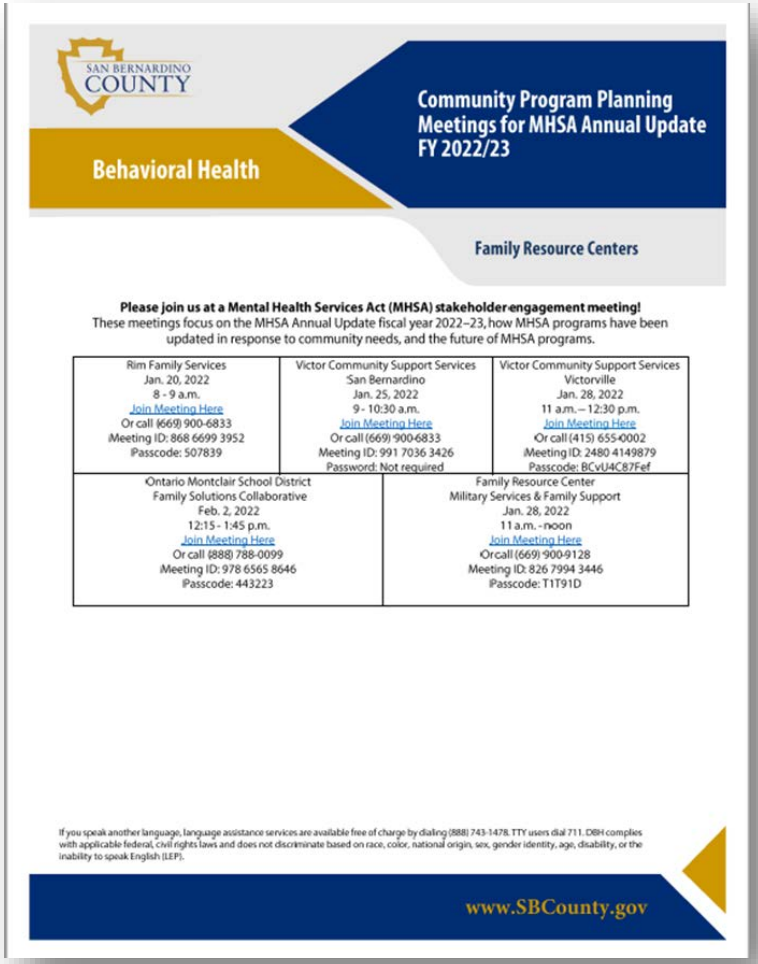
Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

Family Resource Centers

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

Rim Family Services Jan. 20, 2022 8 - 9 a.m. Join Meeting Here Or call (669) 900-6833 Meeting ID: 868 6699 3952 Passcode: 507839	Victor Community Support Services San Bernardino Jan. 25, 2022 9 - 10:30 a.m. Join Meeting Here Or call (669) 900-6833 Meeting ID: 991 7036 3426 Password: Not required	Victor Community Support Services Victorville Jan. 28, 2022 11 a.m. – 12:30 p.m. Join Meeting Here Or call (415) 655-0002 Meeting ID: 2480 4149879 Passcode: BCvU4C87Fef
Ontario Montclair School District Family Solutions Collaborative Feb. 2, 2022 12:15 - 1:45 p.m. Join Meeting Here Or call (888) 788-0099 Meeting ID: 978 6565 8646 Passcode: 443223	Family Resource Center Military Services & Family Support Jan. 28, 2022 11 a.m. - noon Join Meeting Here Or call (669) 900-9128 Meeting ID: 826 7994 3446 Passcode: T1T91D	

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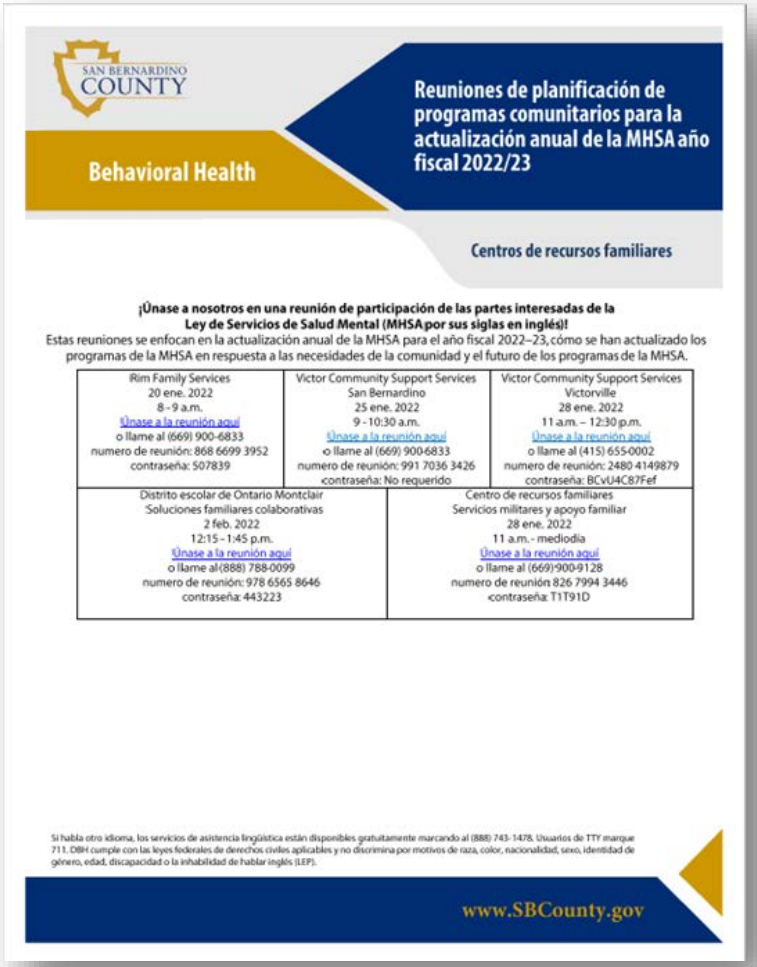
English Version



SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

Centros de recursos familiares

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Rim Family Services 20 ene. 2022 8 - 9 a.m. Únase a la reunión aquí o llame al (669) 900-6833 numero de reunión: 868 6699 3952 contraseña: 507839	Victor Community Support Services San Bernardino 25 ene. 2022 9 - 10:30 a.m. Únase a la reunión aquí o llame al (669) 900-6833 numero de reunión: 991 7036 3426 contraseña: No requerido	Victor Community Support Services Victorville 28 ene. 2022 11 a.m. – 12:30 p.m. Únase a la reunión aquí o llame al (415) 655-0002 numero de reunión: 2480 4149879 contraseña: BCvU4C87Fef
Distrito escolar de Ontario Montclair Soluciones familiares colaborativas 2 feb. 2022 12:15 - 1:45 p.m. Únase a la reunión aquí o llame al (888) 788-0099 numero de reunión: 978 6565 8646 contraseña: 443223	Centro de recursos familiares Servicios militares y apoyo familiar 28 ene. 2022 11 a.m. - mediodía Únase a la reunión aquí o llame al (669) 900-9128 numero de reunión 826 7994 3446 contraseña: T1T91D	

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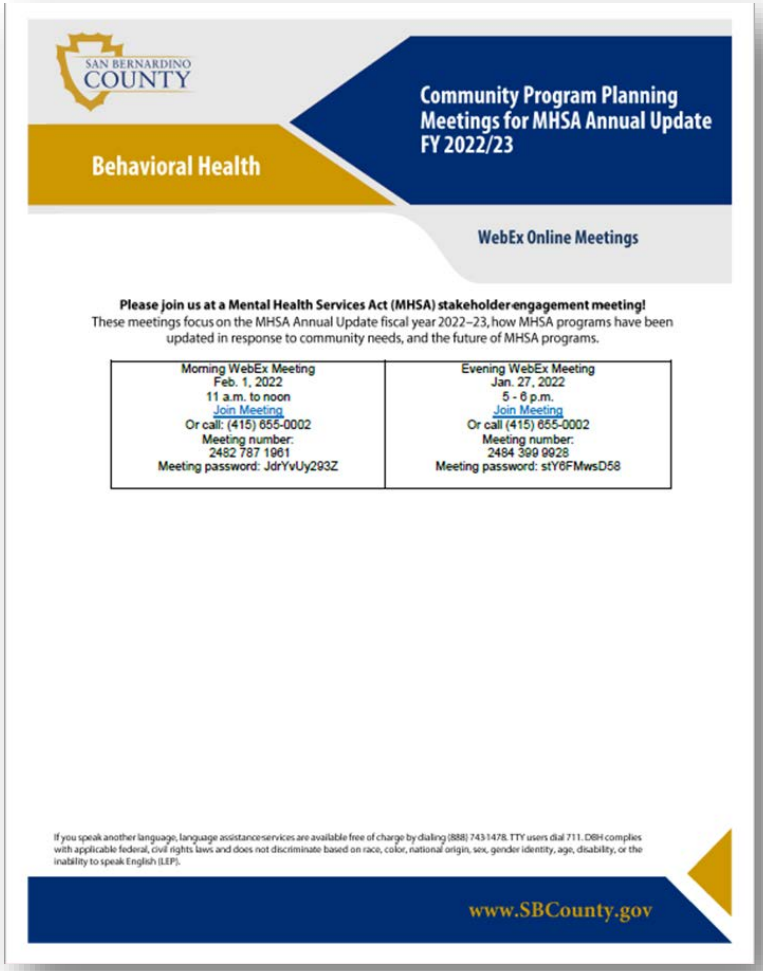
Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

WebEx Online Meetings

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

Morning WebEx Meeting	Evening WebEx Meeting
Feb. 1, 2022 11 a.m. to noon Join Meeting Or call: (415) 655-0002 Meeting number: 2482 787 1961 Meeting password: JdrYvUy293Z	Jan. 27, 2022 5 - 6 p.m. Join Meeting Or call (415) 655-0002 Meeting number: 2484 399 9928 Meeting password: stY6FMwsD58

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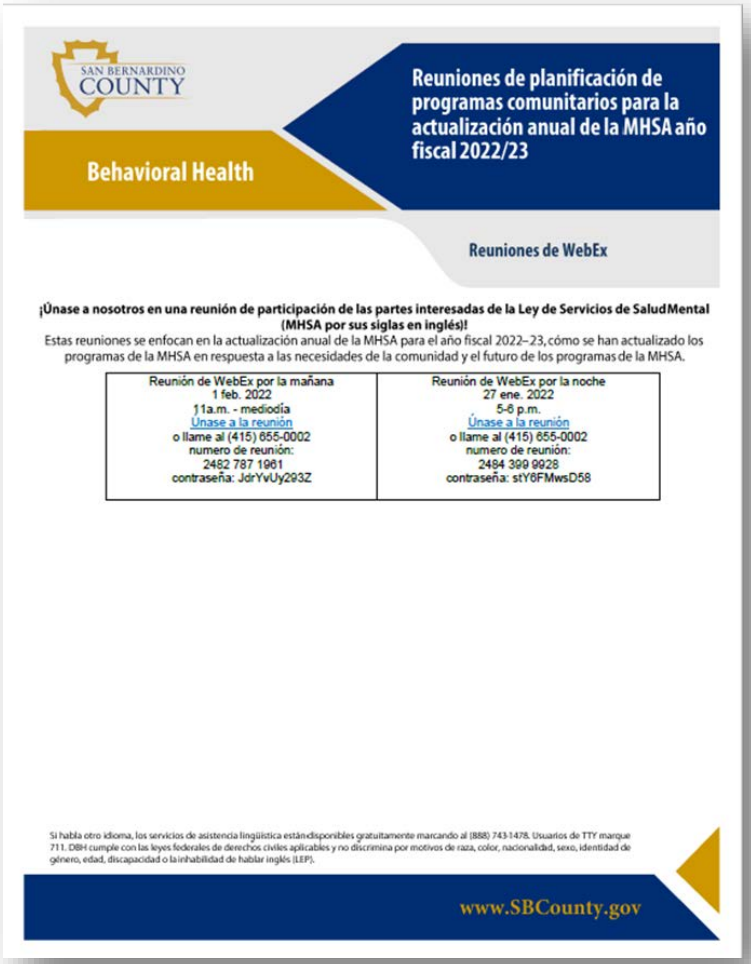
English Version



SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

Reuniones de WebEx

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Reunión de WebEx por la mañana	Reunión de WebEx por la noche
1 feb. 2022 11a.m. - mediodía Únase a la reunión o llame al (415) 655-0002 numero de reunión: 2482 787 1961 contraseña: JdrYvUy293Z	27 ene. 2022 5-6 p.m. Únase a la reunión o llame al (415) 655-0002 numero de reunión: 2484 399 9928 contraseña: stY6FMwsD58

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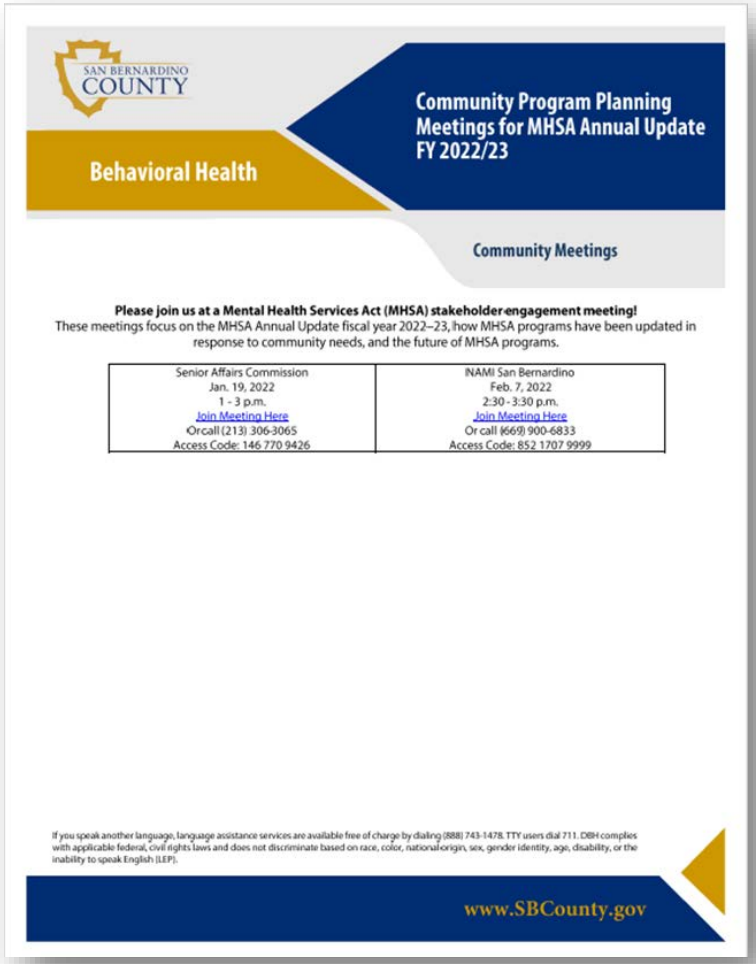
Spanish Version

Community Program Planning: Stakeholder Meeting Flyer, cont.



SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for MHSA Annual Update FY 2022/23

Community Meetings

Please join us at a Mental Health Services Act (MHSA) stakeholder engagement meeting!
These meetings focus on the MHSA Annual Update fiscal year 2022–23, how MHSA programs have been updated in response to community needs, and the future of MHSA programs.

Senior Affairs Commission	NAMI San Bernardino
Jan. 19, 2022	Feb. 7, 2022
1 - 3 p.m.	2:30 - 3:30 p.m.
Join Meeting Here	Join Meeting Here
Orcall (213) 306-3065	Or call (669) 900-6833
Access Code: 146 770 9426	Access Code: 852 1707 9999

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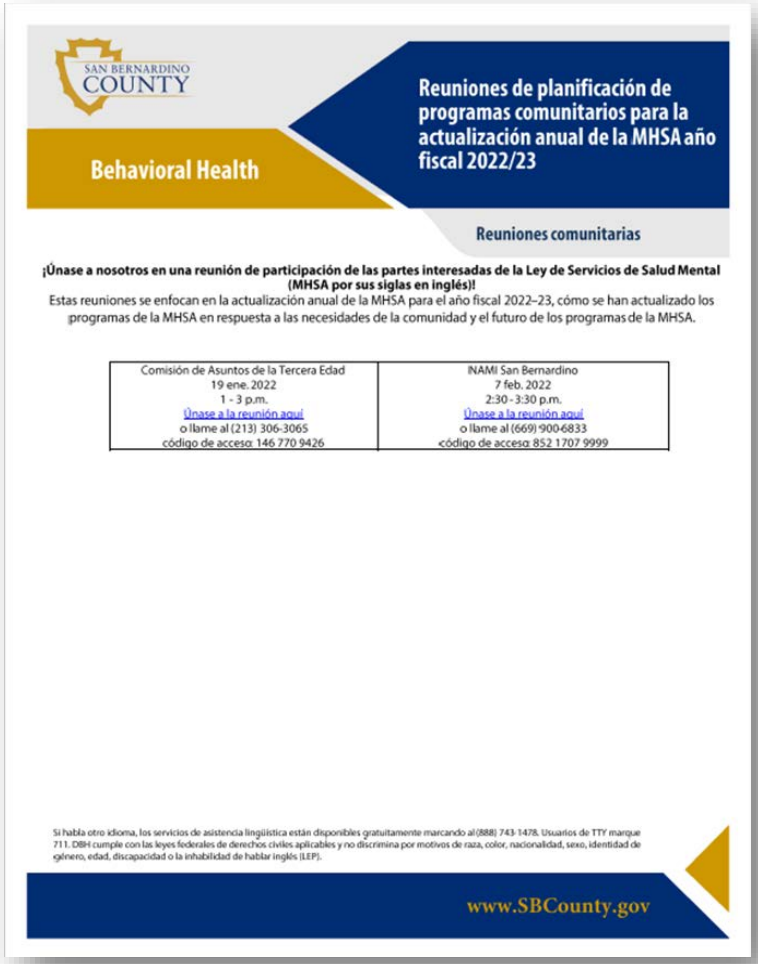


SAN BERNARDINO COUNTY

Behavioral Health

Reuniones de planificación de programas comunitarios para la actualización anual de la MHSA año fiscal 2022/23

Reuniones comunitarias

¡Únase a nosotros en una reunión de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)!
Estas reuniones se enfocan en la actualización anual de la MHSA para el año fiscal 2022–23, cómo se han actualizado los programas de la MHSA en respuesta a las necesidades de la comunidad y el futuro de los programas de la MHSA.

Comisión de Asuntos de la Tercera Edad	NAMI San Bernardino
19 ene. 2022	7 feb. 2022
1 - 3 p.m.	2:30 - 3:30 p.m.
Únase a la reunión aquí	Únase a la reunión aquí
o llame al (213) 306-3065	o llame al (669) 900-6833
código de acceso: 146 770 9426	código de acceso: 852 1707 9999

Si habla otro idioma, los servicios de asistencia lingüística están disponibles gratuitamente marcando al (888) 743-1478. Usuarios de TTY marque 711. DBH cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, sexo, identidad de género, edad, discapacidad o la inhabilidad de hablar inglés (LEP).

www.SBCounty.gov

Spanish Version

Summary of Program Changes

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

The following are proposed changes in programs and components:

Prevention and Early Intervention

The Family Resource Center (FRC) – Program Expansion

A budgetary increase will provide additional Family Resource Centers in underserved areas. These areas could include Big Bear, Yucaipa, Fontana, Rancho Cucamonga, Colton, Upland, or Needles. The plan expansion also includes introducing a department administered Family Justice Center to provide FRC services specifically for families with justice involved youth. The expansion intends to serve an estimated 10,000 more individuals per year.

Inland Empire Opioid Crisis Coalition (IEOCC) – New Program

The opioid dependence and misuse crisis impacts individuals, families, and communities everywhere, including San Bernardino County. 43% of DBH Substance Use Disorder and Recovery Services (SUDRS) consumers served have a primary diagnosis of Opioid Use Disorder (OUD). 23% of DBH SUDRS consumers have co-occurring behavioral health conditions.

The IEOCC will be a coordinated local response with the goals of: 1) Community stigma reduction and pharmacy stigma reduction associated with Medication-Assisted Treatment (MAT) for Opioid Use Disorder, 2) Increasing access and linkage to Medication-Assisted Treatment to reduce symptoms and improve outcomes for consumers receiving behavioral health treatment, and 3) Increase availability of harm reduction services such as community access to Narcan and community capacity building through Substance Use Disorder/co-occurring/MAT awareness activities.

Student Assistance Program (SAP) – Program Expansion

DBH was awarded one-time, short-term funding of $5,900,000 through the Mental Health Student Services Act grant. This award is an external grant, not local MHSA funding, that will be leveraged with existing PEI dollars to expand services. This funding will allow for the expansion of Student Assistance Program services to help increase behavioral health access by removing barriers and establishing a multi-tiered system of support in identified school districts: Colton Joint, Yucaipa-Calimesa Joint, and Silver Valley Unified School Districts. Funding will also be used to improve effective interventions needed in the classroom.

Community Services and Supports

Homeless Full-Service Partnership (FSP) – Program Expansion

The expansion of the program will increase the estimated number of consumers served by approximately 400 homeless individuals. FSP or other needed mental health services will be provided for individuals living with mental illness who are entering permanent supportive housing (managed by the Coordinated Entry System (CES)).

Community Services and Supports (cont.)

Shelter Beds for all FSPs – Program Expansion

The increase 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 will additional time and case management while placed in emergency shelter, to allow for an appropriate and successful transition to stable housing. The total increase across the Department will provide for an additional 61,204 bed days annually and will serve an additional 260 consumers annually.

Wraparound and Success First/Early Wrap/ChRIS – Program Expansion

The increase will allow contract expansion with existing Wraparound providers to meet new State mandates. Those mandates are:

- Effective October 1, 2022, Family First Prevention Services Act (FFPSA) will require all youth leaving a Short-Term Residential Therapeutic Program (STRTP) to a family-based level of care will receive high fidelity wraparound services to support the youth during the transition.
- On July 1, 2021, SBC-DBH was notified of a State initiative: Family Urgent Response System (FURS). FURS required implementing an immediate response program for current and former foster youth and current wards of the court. This requirement also requires counties to respond to the calls made by youth to a statewide hotline with the needed in-person local response within one to three hours. Coverage of this hotline is required 24-hours a day, 365 days a year.

This expansion will increase the estimated number of consumers served by 700 per fiscal year.

Triage, Engagement, and Support Teams (TEST) – Program Expansion

The increase will provide staffing at the new co-location site with the Colton Police Department. The number of behavioral health-related emergency calls to the Colton 9-1-1 dispatch center has increased substantially in the last year. Therefore, Colton PD has proposed a partnership with the DBH TEST program to provide a specialized response to these behavioral health crisis calls. This expansion will increase the estimated number of consumers served by 500 per fiscal year.

Recovery Based Engagement Support Teams (RBEST) – Program Expansion

The increase will allow RBEST expansion by supporting two regionalized teams for the Valley and High Desert regions. This expansion will include expanded services to acute hospitals, including psychiatric and medical, to engage consumers in the hospital or the emergency departments. This expansion will increase the estimated number of consumers served by 150 per fiscal year.

Clubhouse Expansion Program – Program Name Change and Expansion

The Clubhouse Expansion Program will be renamed Clubhouse and Community Connections. An increase will provide funding for the addition of more clubhouse locations. Clubhouses continue to be valued as an influential and important part of our system of care. In addition to peer support, it will be essential to have clubhouses available for teams to access resources and as a central point of contact. Clubhouses expansion will also address the needs of the un-housed individuals in San Bernardino County by providing that central point to access resources. The expansion also includes the addition of alcohol and drug counselors for the county-run clubhouses. This expansion will increase the estimated number of consumers served by 5,000 per fiscal year.

Community Services and Supports (cont.)

Community Crisis Response Team (CCRT) – Program Expansion
The increase will allow CCRT to build infrastructure in preparation for the AB-988 mandate, which requires establishing a Crisis Contact Center (CCC) that receives all behavioral health crisis calls through a single crisis number. CCC will complete a warm hand-off with a field responder in a regionally-based Mobile Crisis Unit (MCU) when a field response is needed. This expansion will increase the number of estimated calls handled by 2,285 calls for a total of 7,425 calls a year.

Access, Coordination, and Enhancement (ACE) – Program Expansion
The number of individuals served through ACE has doubled in recent years. The program is proposed for expansion to keep pace with the needs of community. The increase will allow ACE to expand to include:

- Serving children and youth,
- Preemptively connect with hospitalized clients to facilitate aftercare at the local clinic,
- Facilitate access to all levels of care needed at the time (e.g., facilitate access to psychiatric hospitalization), and
- Establish a new ACE team at the new clinic in Apple Valley.

This expansion will increase the estimated number of consumers served by 4,000 per fiscal year.

Adult Transitional Care Programs – Program Expansion
Program expansion will provide the additional support of Enhanced Board and Care. This expansion will allow for the addition of ten beds to provide appropriate treatment and placement options for consumers referred and released from State Hospitals due to overcrowding. This expansion supports Community Reintegration Services to allow monthly travel to visit consumers placed in contracted Enhanced Board and Care facilities in other parts of the state. This ensures consumers continue to receive services during placement and assistance to step down to the community when appropriate.

Crisis Residential Treatment (CRT) – Program Expansion
This enhancement allows for increased staffing expenditures to remain competitive with private healthcare agencies in hiring and retaining qualified staff, includes funds for outreach and education in the community, and supports the need for contractors to retain sanitation supplies, testing equipment, and processing vendors to remain compliant with COVID-19 related requirements for residential service delivery.

Crisis Stabilization Units (CSU) – Program Funding Reallocation
DBH will be realigning allocation to more closely approximate actual program spending, with no anticipated change to program service delivery or numbers served.

Criminal Justice – Program Name Change
The Criminal Justice program will be renamed Forensic Services. This name change does not affect the services provided or the contact information.

Capital Facilities and Technological Needs

Systems and Operations Support Team Expansion
Budgetary increase will allow IT to add staffing positions to the Systems and Operation Support Team. These positions will support the increased technological needs of SBC-DBH staff.

Behavioral Health Management Information Systems Expansion
This expansion is necessary to support claiming and billing functions that allow DBH to receive revenue. 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.

Public Review

The MHSA Annual Update was posted on the department's website for stakeholder review and comment from January 21, 2022 through February 28, 2022 at https://wp.sbcounty.gov/dbh/programs/mhsa/. The Public Hearing to affirm the stakeholder process took place at the regularly scheduled Behavioral Health Commission Meeting on April 7, 2022, which was held virtually from 12:00 p.m. until 2:00 p.m.

Summary and Analysis of Substantive Changes

An analysis of substantive recommendations received during each part of the robust community program planning process is required for each MHSA Three-Year and Annual Update Plan.

The overview is included in the Public Posting and Comment section of the MHSA Annual Update. DBH is open to ongoing stakeholder feedback, outside of the formal Community Program Planning structure. Comments/recommendations can be submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov. During the time the MHSA Annual Update draft is posted for public comment, stakeholders are informed that comments can be received anytime through the year, but will not be included in the final MHSA Annual Update unless provided during the 30-day comment period. The MHSA Annual Update is required to be posted for 30-days, per Welfare and Institutions Code 5848. DBH exceeded that standard by making the Plan available for 38 days between January 21, 2022 and February 28, 2022.

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

During stakeholder meetings, community members asked how they might get additional information on what behavioral health services are available in the County. The County has an Access Unit that can be called for assistance in locating services and can be reached at **1-888-743-1478.** Service directories are also available online at 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 and housing for their areas. The Department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs.

RFPs may be accessed at the County website per the following link: https://wp.sbcounty.gov/purchasing/getting-started/#procurement.

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

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs provided. To address concerns related to DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Annual Update and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf

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

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

Once the MHSA Annual Update is written and posted, feedback is regularly solicited on the content of plans/programs while plans are posted for public review. Feedback/comments can be submitted via email 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 Annual Update, or if not incorporated, addressed in the final MHSA Annual Update, as to why it was not incorporated.

Depending on the program proposal, services can be provided by DBH clinics or organizational contract providers. In many cases, programs are implemented using both DBH clinics and organizational contract providers working together to provide services in a system of care framework. For services provided by organizational providers, an RFP/procurement process is required.

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

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

Assistance for Disabled Individuals:

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

Reduction of Discrimination and Stigma:

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

Support for Parents and Caregivers:

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

Innovation Projects:

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

Shelter Beds and Homeless Assistance:

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

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

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

Overview of Public Posting and Comment Period

The Department of Behavioral Health would like to thank those who participated in the public review and comment portion of the stakeholder comment process. The 30-day public posting of the MHSA Annual Update occurred from January 21, 2022 through February 28, 2022. During this time, DBH promoted the 30-day public posting and provide informational meetings related to the MHSA Annual Update. A press release, in English and Spanish, notifying the public of the posting was sent to 50 media outlets. 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 Annual Update were available online for electronic viewing along with physical copies available at Clubhouse, clinics, and distributed at meetings upon request. Electronic submission of the comment forms were available in English and Spanish; hard copies were available upon request.

As a result, 70 completed surveys were received during the 30-day public posting and comment period, which provided general comments and support for the draft MHSA Annual Update. Overall, 72% of stakeholders who specifically responded to the 30-day public posting indicated they were very satisfied or satisfied with the draft MHSA Annual Update and stakeholder process.

Summary and Analysis of Substantive Comments

DBH would like to thank everyone who reviewed the plan and/or submitted a comment. The following contains a summary and analysis of a sample 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: Do you have any concerns not addressed?

Comment: More facilities offering showers and washers and dryers for their members and homeless community. Possible more hours of clubhouses open and/or days.

Response: Thank you for your response and feedback. DBH's Clubhouses are recovery oriented centers that provide programs using a Recovery, Wellness, and Resilience model. The Clubhouses are primarily run by adult consumers with minimal support from department staff. Members provide input related to program and activity choices. All clubhouses have an elected board of peers which make all decisions related to planning, budget, and cooperation issues. Each clubhouse holds weekly board and community meetings. At these meetings any member can propose an activity or interest that they would like to run for Clubhouse participation. DBH intends to expand the Clubhouse and Community Connections program and anticipates being able to fund additional sites.

Question: Do you have any concerns not addressed?

Comment: Use money to open a comic book store so clubhouse members can have jobs.

Response: Clubhouses offer several employment supports including resume building assistance, clothing assistance for interviews, transportation for job interviews and employment groups conducted by Community Connections. In addition, Clubhouses are primarily staffed by peer and family advocates. This recruitment is heavily advertised in the Clubhouses. To qualify for this supported position an individual must have lived experience with mental health. Interested consumers are assisted in the application process.

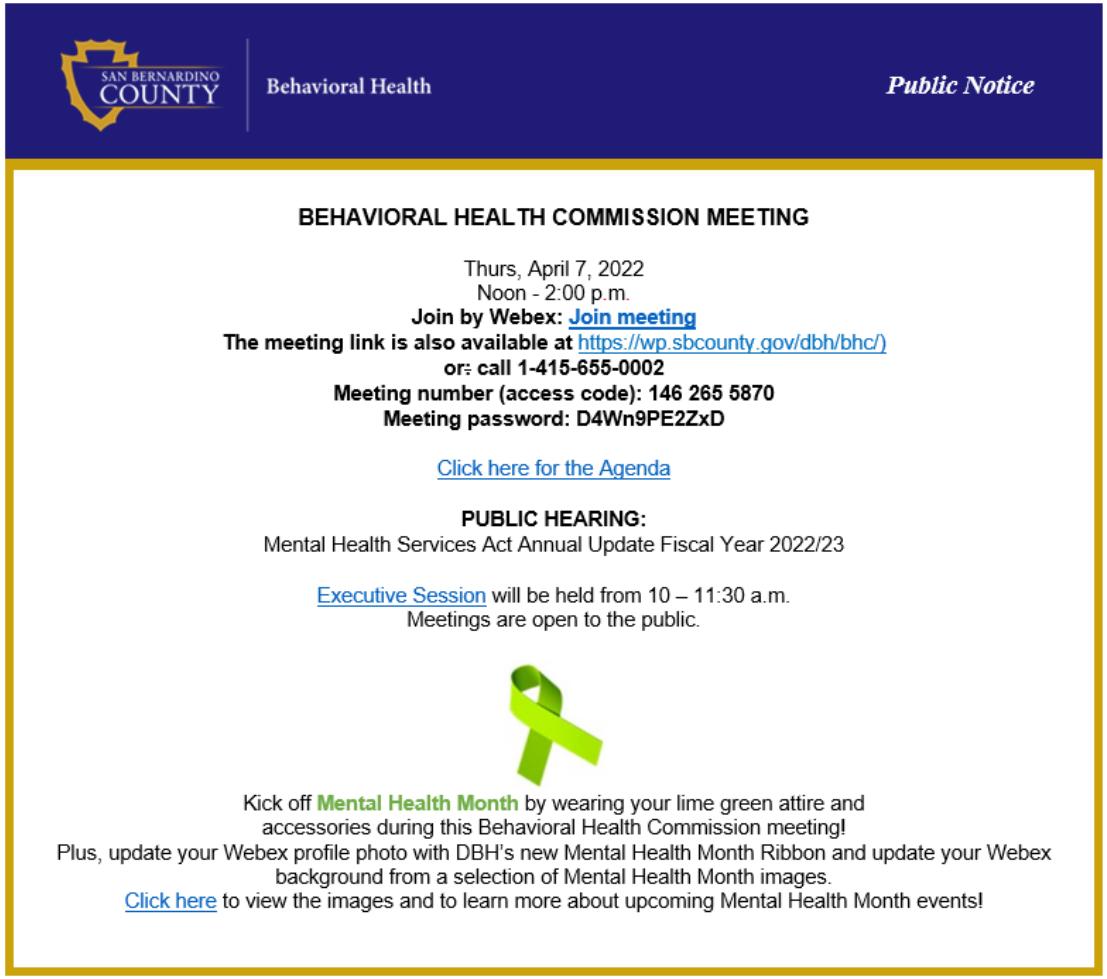
Public Hearing

The Public Hearing was hosted by the San Bernardino County Behavioral Health Commission was conducted on April 7, 2022 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, interpretive services and materials were available upon request.

One comment was received from the Behavioral Health Commissioners. The comment and question focused on how CPP presentations were handled for stakeholders with hearing issues or hearing loss. In response, it was shared that closed captioning is available at all virtual meetings in addition to having an American Sign Language (ASL) interpreter available to attend any meeting either in person or virtually.

The Behavioral Health Commission affirmed that the DBH adhered to the MHSA CPP process and supported the submission of the MHSA Annual Update Fiscal Year 2022/23 to the San Bernardino County Board of Supervisors tentatively scheduled for approval in May 2022 meeting and the subsequent submission to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.

Community Program Planning: Public Hearing



SAN BERNARDINO COUNTY | Behavioral Health — *Public Notice*

BEHAVIORAL HEALTH COMMISSION MEETING

Thurs, April 7, 2022
Noon - 2:00 p.m.
Join by 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

Click here for the Agenda

PUBLIC HEARING:
Mental Health Services Act Annual Update Fiscal Year 2022/23

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

Kick off **Mental Health Month** by wearing your lime green attire and accessories during this Behavioral Health Commission meeting!
Plus, update your Webex profile photo with DBH's new Mental Health Month Ribbon and update your Webex background from a selection of Mental Health Month images.
Click here to view the images and to learn more about upcoming Mental Health Month events!

Prevention and Early Intervention

Introduction

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

Strategies and activities are applied early on to avert the onset 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

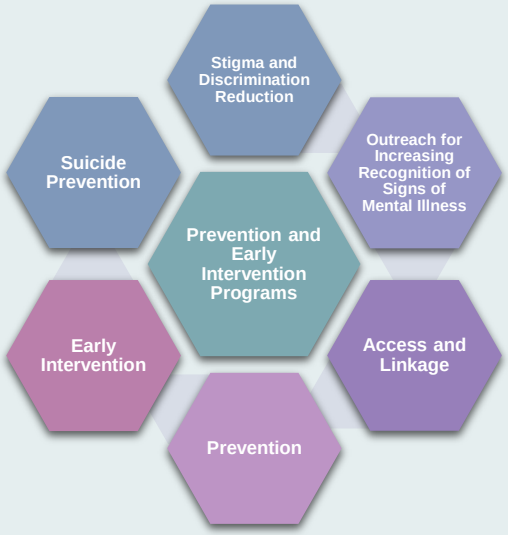
- Native American Resource Center

Outreach for Increasing Recognition of Signs of Mental Illness

- Promotores de Salud
- Community Health Workers
- Behavioral Health Ministries Project

Access and Linkage to Treatment

- Child and Youth Connection



Prevention

- Preschool PEI Program
- Resilience Promotion in African American Children
- Lift
- Coalition Against Sexual Exploitation
- Older Adult Community Services

Early Intervention

- Family Resource Center
- Military Services and Family Support
- Community Wholeness and Enrichment
- Student Assistance Program
- PEI Early Psychosis Program

Suicide Prevention

Introduction, cont.

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

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.

The three (3) statewide projects include:

1. Stigma and Discrimination Reduction
    - **Goal**: Eliminating stigma and discrimination against individuals with mental illness
2. Student Mental Health Initiative
    - **Goal**: Strengthening school (K-12) and higher education mental health programs
3. 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 Each Mind Matters: California's Mental Health Movement.

Technical assistance (TA) is provided to San Bernardino County and local community organizations by CalMHSA PEI Project contractors. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences.

During Fiscal Year 2020-21, 30 TA emails covered topics such as Suicide Prevention month, week and day, SanaMente, a Holiday series, self-care during the COVID-19 pandemic, May is Mental Health Month, and more.

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. In response to the mandates implemented in March as a result of the COVID-19 pandemic, San Bernardino County hosted a virtual Directing Change Recognition Ceremony on May 19, 2021, to honor the San Bernardino County filmmakers.

Thirty-nine films were submitted from the following schools and youth organizations in San Bernardino County: Apple Valley High School, Jurupa Hills High School, Rim of the World High School, Upland High School, Middle College High School, Rim of the World High School, San Bernardino Valley College, and Summit High School.

Introduction, cont.

San Bernardino County Local Impact

In FY 20/21, mini-grants and sponsorship awards meant to grow the Each Mind Matters movement across the state through increasing reach and dissemination and implementing community events and activities included:

Foundation for California Community Colleges (CCC) Student Wellness Ambassadors: 20 Student Wellness Ambassadors received an in depth two day training to serve their campuses by promoting health and wellness resources through peer to peer outreach. Collectively, the Ambassadors reached a total of 30,018 students across sixteen campuses.

CCC Health & Wellness Sponsorship: CCC Health & Wellness released a sponsorship opportunity for California community colleges to organize and coordinate events to raise awareness and decrease the stigma around mental health challenges throughout the month of May. Each sponsorship awarded was in the amount of $1,500.

Each Mind Matters SanaMente Mini-Grant: Awardees of this mini-grant promoted mental health awareness, suicide prevention, and reduce the stigma and discrimination associated with mental health challenges specific to Latinx communities.

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention.

Over the last four fiscal years 3,159 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
Kognito Suicide Prevention and Mental Health trainings	Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
Directing Change Judges Training	Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, giving volunteer judges criteria to apply in evaluating student-submitted Directing Change videos.
Community College Outreach Events	The Foundation for California Community Colleges and their local campuses conduct mental health outreach to campuses utilizing Each Mind Matters materials and messaging.
Each Mind Matters Tabling	The Each Mind Matters Outreach & Engagement Team and Resource Navigators tables at various conferences to engage conference attendees with Each Mind Matters materials and messages.
Each Mind Matters Insiders Newsletter	A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.

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 2022-23	$500,000
Cost Per Client FY 2022-23	$285
Services Offered	Talking Circles Wellness Circles Drumming Circles Daughters of Tradition Cultural education and awareness Cultural arts therapy Cognitive therapy groups

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. An increase in the number of individuals accessing behavioral health services tells us that the barriers to accessing behavioral health services are decreasing. The utilization of behavioral health services increased from 3,911 to 9,338 between FY 2018-19 to FY 2020-21 as shown in the table to the right.

Surveys used in this program include:

- Measures, Outcomes, and Quality Assessment (MOQA) / 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 has grown from 3,025 in FY 2018-19 to 8,469 in FY 2020-21. This is demonstrative of an increase in seeking and accepting assistance for behavioral health concerns.

The total participation increased dramatically in FY 2020-21, more than doubling from the previous years. This increase is primarily due to the NARC providing mental health resources and education at COVID-19 testing and vaccination sites during the pandemic. The increased visibility provided a greater audience for education and outreach.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	1,751	3,025	3,555	8,469
Number of Services	2,544	3,911	4,169	9,338

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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals Provided	6	7	6
Number of referrals to County-funded / administered programs	0	0	0
Number of referrals to other programs	6	7	6
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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals Provided	184	127	139

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 2018-19	14%	12%	33%	6%	35%
FY 2019-20	5%	8%	19%	3%	65%
FY 2020-21	1%	1%	3%	0%	95%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	1%
FY 2019-20	<1%
FY 2020-21	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	3%
FY 2019-20	3%
FY 2020-21	<1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	31%	62%	0%	7%
FY 2019-20	17%	45%	<1%	38%
FY 2020-21	9%	18%	<1%	73%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	100%	0%	0%	0%
FY 2019-20	100%	0%	0%	0%
FY 2020-21	100%	0%	0%	0%

Native American Resource Center (NARC), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	3%	3%	0%
	American Indian or Alaska Native	50%	50%	4%
	Asian	1%	1%	0%
	Native Hawaiian or Pacific Islander	1%	0%	0%
	More than One Race	14%	13%	0%
	Caucasian/White	8%	4%	1%
	Other Race	0%	0%	0%
	Declined to Answer	14%	26%	93%
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	1%	0%	0%
	Hispanic/Latino	9%	8%	10%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	0%	0%	0%
	More than one ethnicity	69%	65%	1%
	Declined to Answer	29%	33%	99%

Demographic Observations

- The NARC program provides services that are culturally appropriate to the Native American community.
- The program has been consistently successful in providing services to the Native American community in FY 2018-19 and FY 2019-20 with 50% of participants self-identifying as Native American.
- The number of participants served increased significantly in FY 2020-21. This was a result of increased visibility at COVID-19 test and vaccination sites. However, data gathering efforts were hampered by COVID-19 public health emergency restrictions. Traditionally, this program gathers demographic survey data from in-person services. This ensures a greater probability that surveys will be completed. Restrictions that limited contact with participants reduced the ability to distribute and collect surveys. The transition to electronic surveys was only mildly successful. A majority of participants were less comfortable completing an electronic demographic survey online.
- While the program serves all age groups, the TAY-aged group show the highest utilization of services. This age group is helping to encourage future generations in help-seeking behaviors.

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.

There was a fluctuation in historical trauma surveys due to size and frequency. The Historical Trauma Conference held in FY 2018-19 was presented to a broad audience as part of a large conference whereas the subsequent events held in FY 2019-20 and FY 2020-21 were developed and intended for smaller group participation events.

The response to the Measurements, Outcomes, and Quality Assessments (MOQA) surveys and the Stigma Reduction Questionnaire (SRQ) surveys has steadily increased as we provide more streamlined access to submit surveys to a centralized data collection system.

Program Outcome Tools		
Survey Name	Historical Trauma Survey	MOQA / 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 2018-19: 148 FY 2019-20: 46 FY 2020-21: 74	FY 2018-19: 78 FY 2019-20: 195 FY 2020-21: 205

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 to allow participants the opportunity for discussion and reflection.

These educational sessions allow opportunities for rich discussions that help to recognize and acknowledge intergenerational trauma experienced by Native American communities so that healing can begin. By increasing understanding, we can improve cultural competency and treatment strategies for the Native American community.

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.

Historical Trauma Conference, November 2018

The Historical Trauma Conference provided education to the community as well as facilitated discussion with other agencies to offer a different perspective in treating Native American populations.

Surveys from the Historical Trauma Conference held in November 2018 included traditional data collection methods. The Native American Resource Center worked collaboratively with DBH to discover innovative and culturally preferred methods of collecting data. As a result, a free form question was intentionally added which encouraged participants to use storytelling or to share images that captured their experience during the event. Of the 118 surveys collected, 57 participants chose to create an image or series of words indicating success in collecting meaningful feedback.

Some of the common themes expressed in these images included:

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

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

The Wellbriety Movement: Journey to Forgiveness, June 2019

The Wellbriety Movement: Journey to Forgiveness was presented as part of a Diversity Film Series. This documentary showcases voices and stories from Native American elders about their challenging life experiences such as forced attendance at off-reservation boarding schools. It is an exploration of intergenerational trauma as the root cause of alcoholism, substance use, domestic violence, sexual abuse, and suicide.

The presentation is intended to reduce stigma among community members by helping them to recognize and understand the negative effects of historical trauma. It helps service providers recognize and understand the importance of providing services in a culturally sensitive manner to reduce behavioral health stigma and allow healing to begin.

The film was shown in a setting that allowed attendees to discuss and share thoughts surrounding the subject matter. Participants completed surveys about how the film impacted their understanding. The results of these surveys are shown in the image to the right. The event was well received. Over 90% of the individuals surveyed agreed that they understand more about the impact of historical trauma. This increased awareness ensures that the Native American community has access to services that are considerate of the specific wellness challenges they experience.

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

Dawnland, July 2019, November 2020, May 2021

Dawnland provides a behind-the-scenes look at the Truth and Reconciliation Commission investigation into the historic removal of Native American children from their homes. This involuntary removal resulted in emotional harm, shame, and destruction of culture. Dawnland also explores the impact of the Indian Children Welfare Act (ICWA) of 1978 which governs the removal and out-of-home placement of Native American children. Recognizing and acknowledging behaviors and actions that resulted in emotional harm are the first steps towards healing and change.

After viewing the film, viewers were given a survey to encourage discussion and collect feedback. Survey questions were revised after the initial presentation in 2019, beginning with the November 2020 presentation. This was done to measure the impact of the presentation on the participant compared to measuring the increase in knowledge.

The adjacent table below shows the percentage of respondents who agree or strongly agree with the statements shown.

The updates to the survey from 2019 to 2020 resulted in slight variances to data. Overall, more than 90% agree that by acknowledging these behaviors and actions, they can begin to address the needs of the Native American community more effectively.

Dawnland Survey Responses

	July 2019	November 2020	May 2021
Before viewing this film, I knew quite a bit about ICWA, the conditions that brought about its existence, and the policies that continue to be institutionally violated.	45%	Question modified in subsequent survey	
It is important to recognize how traumatic removal of children can influence current trust in mental health services.	Modified Question	98%	100%
I believe that it is important for staff and community members to be aware of historical traumatic events such as this.	100%	Question modified in subsequent survey	
I have a better understanding of the impact of trauma has on at-risk populations.	Modified Question	98%	100%
I have a better understanding of the effect of ICWA violations has on accessing services.	Modified Question	93%	100%
I am more willing to acknowledge and address the effects of historical trauma when working with American Indian and Alaskan Native clients.	100%	100%	100%

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

Measure, Outcomes, and Quality Assurance (MOQA) / Stigma Reduction Surveys

The Native American Resource Center participated in a pilot to improve statewide reporting on stigma reduction programs. It began with administering the Measure, Outcomes, and Quality Assurance (MOQA) Stigma Reduction survey in FY 2018-19 and FY 2019-20. MOQA is a county-driven, DHCS-supported effort to improve statewide reporting on outcomes resulting from programs supported through Mental Health Services Act (MHSA, Prop 63) funds.

As part of ongoing quality assurance measures, the survey was updated in FY 2020-21 to the Stigma Reduction Questionnaire (SRQ) to be less stigmatizing and improve responsiveness. The survey was certified by the Consumer Evaluation Council as being inclusive and appropriate prior to implementing the survey. Overall this revision improved the methods in which the effectiveness of the program is evaluated. 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.

The responses increased as the survey was modified to a more dynamic format. Prior to 2020, the survey was only available in a hard copy format. It is now available in both hard copy and electronic versions. The data from the survey is centrally located, allowing a more efficient manner of the collection and analysis of the data.

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

	FY 2018-19 N=78	FY 2019-20 N=195	FY 2020-21 N=205
More likely to seek mental health support if needed	48%	61%	76%
More likely to talk to a friend or family member about mental health needs	50%	64%	77%
More likely to socialize with someone who has a mental illness	37%	62%	80%
More likely to take action to prevent mental health discrimination	35%	60%	78%
More likely to actively and compassionately listen to someone in distress	44%	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 Native American Resource Center began administering the California Institute for Behavioral Health Solutions Measurements, Outcomes, and Quality Assessment (MOQA) questionnaire to collect survey data from the program's participants. Due to the anonymous nature of this questionnaire, program participants were more receptive towards completion of the surveys. The Stigma Reduction Questionnaire (SRQ) was developed as an updated, inclusive version of the MOQA survey to assess effectiveness of the stigma reduction programs. The SRQ is the survey currently in use in the Native American Resource Center program.

Another challenge identified by the Native American Resource Center is a lack of societal awareness about the impact of historical trauma in the Native American community. They recognized that this was an unaddressed disparity within the community. Special outreach and education events were offered to increase awareness and knowledge of the impact of historical trauma. The Native American Resource Center collaborated with the Department of Behavioral Health to facilitate special training events focusing on the impact of historical trauma on the Native American community. The trainings included a facilitated discussion between Indian Child Family Services, a San Manuel Tribal Judge, the Department of Social Services, and community members. The conversation centered around the impact of historic trauma on mental health and substance use.

Lessons Learned

Western service delivery models alone are not effective in culturally specific programs. Creative use of traditional Native American practices such as storytelling reduces the stigma surrounding accessing therapeutic services. The NARC has been successful in adapting cultural activities into the service delivery model. Effective programming should include strategies that reduce the stigma and discrimination caused by historical trauma. Most importantly, building rapport with the Native American community increases engagement, acceptance, and collaborations.

Program Updates

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

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

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	35,385
Annual Budget FY 2022-23	$1,264,429
Cost Per Client FY 2022-23	$33
Services Offered	Mental Health and Substance Use Screenings and Assessments Mental Health Educational Presentations Case Management Resource Referrals Peer Counseling

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

Program Highlights

The Promotores de Salud/Community Health Worker (PdS/CHW) program provides outreach and education services to underserved cultural populations 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 to deliver services. Provider agencies actively encourage persons with lived experience or family members to become PdS and CHW workers.

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 program has a total of 52 Promotores de Salud and Community Health Workers. Over 75% identify their primary language as Spanish. Additionally, over 90% of the current Promotores de Salud and Community Health Workers have worked with the program for the last three fiscal years.

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	42
	Asian Pacific Islander	7
	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 229,170 participants from FY 2018-19 through FY 2020-21. This figure includes people in the community who are in a position of identifying the early signs of mental illness and are able to refer individuals to behavioral health services. These people are known as the community's potential responders.

The overall unduplicated participant count has seen a decline over the last three fiscal years.

The table below shows the projected numbers served and the actual participant counts over the last three fiscal years. This is due partly to restrictions set in place by the COVID-19 public health emergency. The restrictions were implemented in FY 2019-20 and continued in FY 2020-21. 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 Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	35,385	90,643	72,088	66,439
Number of Services	40,905	93,015	71,667	67,987

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

Program Highlights, cont.

Outreach

The program captures information on the number of potential responders trained each year. This helps to track the increase of mental health awareness in the community. On average, the program engages 76,100 potential responders per year.

Potential Responders			
	Number of Potential Responders		
	PdS	*CHW*	*Total*
FY 2018-19	64,169	26,133	90,302
FY 2019-20	58,565	13,441	72,006
FY 2020-21	50,539	15,607	66,146

Potentiall responders can include family members, employers, primary health care providers, school personnel, community service 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
- School personnel
- Family law practitioners
- Children and Family Services personnel
- Law enforcement personnel
- Emergency medical providers
- Peer providers

Promotores de Salud and Community Health Workers organically become trusted members of their communities. These relationships facilitate 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.

When members of an underserved population feel supported by those willing to advocate for their needs and help ensure those needs are met, they are more willing to seek services. Engaging participants in non-traditional settings has built trust and reduced stigma in the targeted populations. The most commonly used settings to engage potential responders for the PdS/CHW program are listed below:

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

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

Program Highlights, cont.

Improving Timely Access to Underserved Populations

As participants engage and the stigma around seeking mental health services is reduced, the program moves towards increasing timely access to services. An individual or family member who needs mental health services receives appropriate services as quickly as possible. The program ensures that referrals to timely prevention, early intervention, and/or treatment beyond early onset services are provided for those requiring additional services.

The grassroots approach of engaging the community leads to an increase in the timely access to mental health services. Post-referral data is difficult to track. The program continues to experiment with solutions to increase the data collection after a referral is made. The CHS/PdS program has been successful in connecting these underserved populations to timely services.

The program averages approximately 376 referrals per fiscal year. The referrals made in FY 2019-20 were on track to meet or exceed the previous years. In early 2020, the program's community interaction was drastically reduced due to the COVID-19 public health emergency. Securing referrals on virtual platforms was not as effective as with in person interactions. The program is actively examining program design to increase referrals.

Improving Timely Access Referrals			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
# of Referrals Provided	443	392	294
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	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	8%	14%	64%	8%	6%
FY 2019-20	8%	15%	62%	9%	7%
FY 2020-21	13%	18%	52%	7%	10%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	0%
FY 2019-20	0%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	0%
FY 2019-20	0%
FY 2020-21	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	1%
FY 2019-20	5%
FY 2020-21	1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	30%	50%	0%	20%
FY 2019-20	41%	51%	0%	8%
FY 2020-21	38%	54%	0%	8%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	7%	87%	0%	6%
FY 2019-20	9%	83%	0%	8%
FY 2020-21	6%	88%	1%	5%

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

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	1%	1%	< 1%
	American Indian or Alaska Native	2%	2%	< 1%
	Asian	1%	1%	1%
	Native Hawaiian or Pacific Islander	2%	1%	< 1%
	More than One Race	8%	2%	< 1%
	Caucasian/White	30%	46%	46%
	Other Race	12%	12%	12%
	Declined to Answer	44%	35%	40%
Ethnicity	African	1%	< 1%	< 1%
	Asian Indian/South Asian	< 1%	< 1%	< 1%
	Cambodian	< 1%	< 1%	< 1%
	Chinese	< 1%	< 1%	< 1%
	Eastern European	< 1%	< 1%	< 1%
	European	< 1%	< 1%	< 1%
	Hispanic/Latino	62%	65%	69%
	Filipino	< 1%	< 1%	< 1%
	Japanese	< 1%	< 1%	< 1%
	Korean	< 1%	< 1%	< 1%
	Middle Eastern	< 1%	< 1%	< 1%
	Vietnamese	< 1%	< 1%	< 1%
	Other	2%	< 1%	9%
	More than one ethnicity	2%	5%	1%
	Declined to Answer	30%	29%	10%

Demographic Observations

- For all three fiscal years, the PdS program served its primary target population, with the majority of participants identifying as Latinx/Hispanic.
- The primary language for participants for all three fiscal years was identified as primarily Spanish, which aligns with the program.
- 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 sever 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 these 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. 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.

Various tools are used to evaluate program effectiveness. Reflective surveys are amongst the most commonly used in this program. They 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 tools used and a brief description.

Program Outcome Tools		
Survey Name	Stigma Discrimination Reduction Surveys	Measures, Outcomes, and Quality Assessment (MOQA) 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)	MOQA (Measurements, Results, and Quality Assessment) is an effort led by counties to improve statewide reporting on outcomes from programs funded by the Mental Health Services Act (MHSA, Prop 63)
Survey Type	Post – after each Stigma Reduction presentation	Post – after each Stigma presentation
Number completed	FY 2018-19: 3,527 FY 2019-20: 3,752 FY 2020-21: 3,699	FY 2018-19: 1,650 FY 2019-20: 107 FY 2020-21: 93

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 from one cultural group to another. In some groups, neighborhood canvassing is an effective way to generate interest in learning more about mental health and wellness. They are more open to the idea of "knock and talk", where they knock on people's doors and initiate a conversation. In other groups it is less well received. Not all cultures experience the same level of comfort with this approach. The program, as a whole, 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.

Program Outcome Tools		
Survey Name	Modular Presentations	PEI Outreach Survey
Description of Method	Outreach education curriculum on various mental health topics. Often used in the form of a flipchart or PowerPoint presentation.	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 modular presentation	Pre and Post each educational Outreach activity
Number completed	FY 2018-19: 1,877 FY 2019-20: 3,645 FY 2020-21: 3,606	FY 2018-19: N/A FY 2019-20: 73 FY 2020-21: 72

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

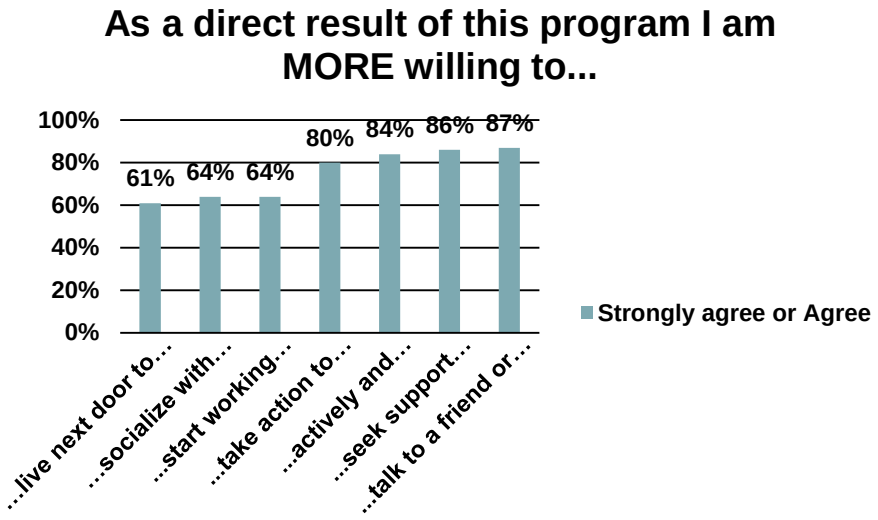
Outcome Discussion

The Measures, Outcomes, and Quality Assessment (MOQA) surveys were administered by San Bernardino County in FY 2018-19 and a portion of 2019-20. The MOQA is a county-driven, DHCS-supported effort to improve statewide reporting on outcomes resulting from programs supported through Mental Health Services Act (MHSA, Prop 63) funds. The purpose is to measure stigma-related outcomes. The participants are asked if they have a change in how they feel after participating in an event or activity. Sample questions include:

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

- …live next door to someone with a serious mental health condition
- …socialize with someone who had a serious mental health condition
- …start working closely on a job with someone who had a 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 that more than 60 % Agree or Strongly Agree with these statements as a direct result of what they learned. The MOQA was only intended to collect data for a short time, but it was found that the survey proved to be a great tool for collecting data. The data collected is represented in the charts below. The Fiscal Year 2019-20 is only partial data. The survey was revised and renamed as the Stigma Reduction Questionnaire (SRQ) in 2020. The results demonstrate that the stigma activities and education participants received resulted in an overall reduction of stigma surrounding mental health.

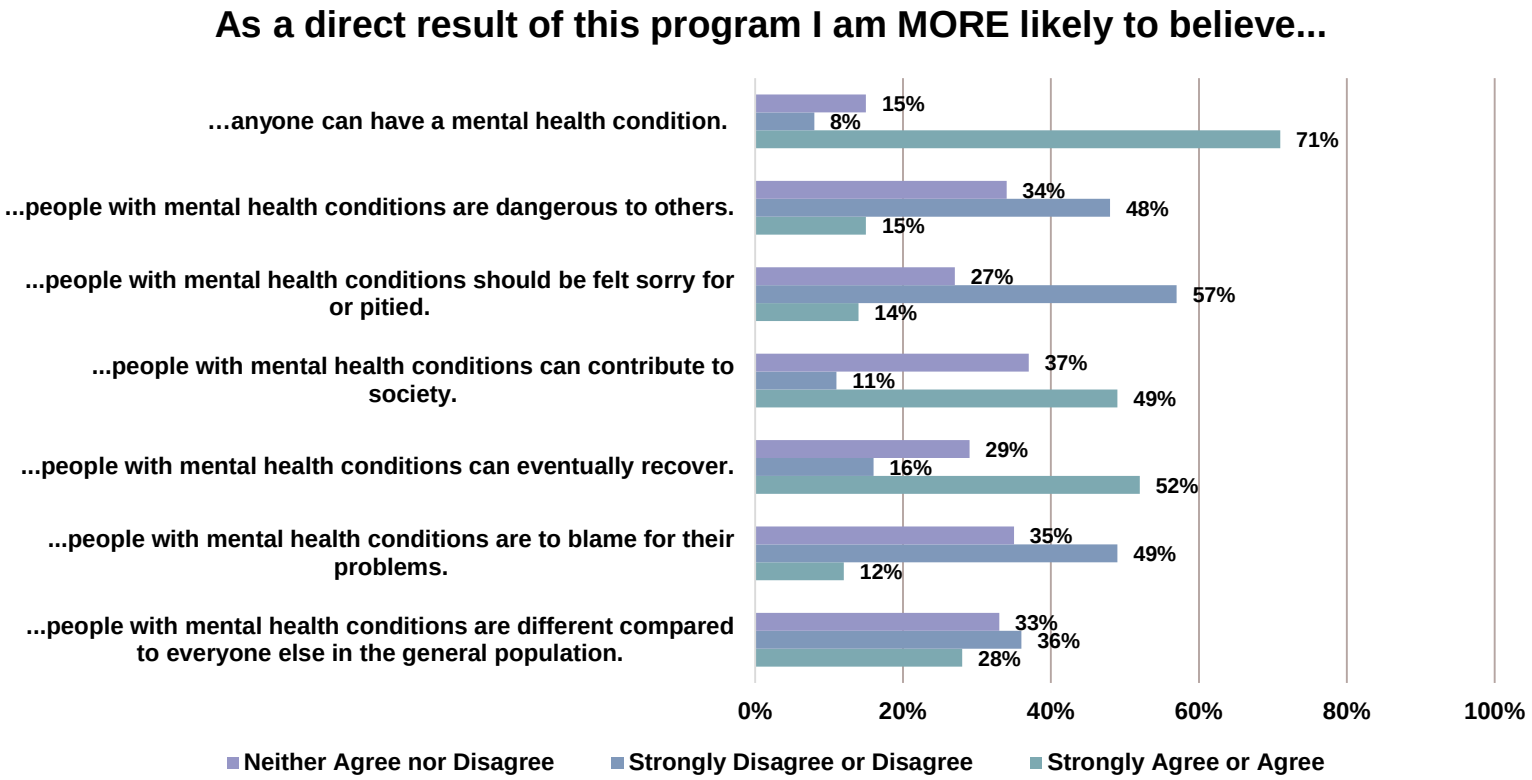


Promotores de Salud/Community Health Workers (PdS/CHW), cont.

Outcome Discussion, cont.

The additional MOQA survey results below demonstrate a change in attitudes of the participants who received a stigma-reduction activity. This is demonstrated by 71% of participants agreeing or strongly agreeing that anyone can have a mental health condition.

Additionally, 52% of participants agreed or strongly agreed that people with a mental health condition can recover. Also, 49% of participants disagreed or strongly disagreed that people with mental health conditions are to blame for their problems.

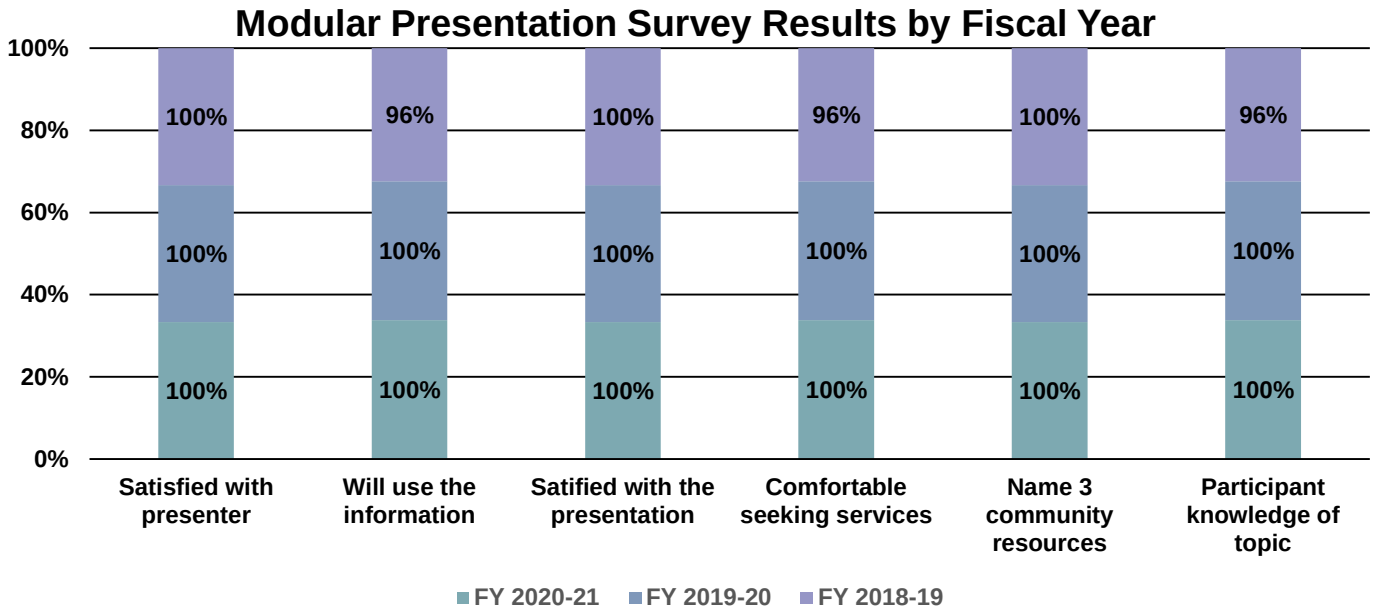


Promotores de Salud/Community Health Workers (PdS/CHW), cont.

Outcome Discussion, cont.

The graph below illustrates a sample of the modular presentation survey results for the PdS/CHW programs. This graph demonstrates that participants who received a modular presentation education activity almost all agreed the presenter was knowledgeable, the information was useful, and would be used in the future.

The Survey results also show improvement in an overall reduction in stigma and intent to seek mental health services. Education and promoting behavioral health prevention and wellness, as well as community resources are successful strategies to use with encouraging engagement in historically underserved populations.



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

Program Challenges/Solutions

One of the most persistent challenges in the Promotores de Salud program is the stigma of discussing mental illness or seeking treatment within the Latinx communities. Hispanic/Latinx individuals may not seek treatment because they may not recognize the signs and symptoms of mental health conditions or know where to find help. Because privacy is highly valued in the Latinx communities, it can be viewed as taboo to discuss mental health. This creates difficulty in seeking services as there is a concern of bringing shame or unwanted attention to family members.

By recruiting and retaining Promotores de Salud and Community Health Workers who are part of the target population, volunteers are able to build a rapport with the communities they serve and begin to break down the stigma associated with cultural norms. When a participant is assisted by someone who they can better relate to, it helps to ease the fears of discussing mental health and seeking services to address any concerns.

The Community Heath Worker program as a whole finds it difficult to recruit and retain CHWs and Peer Providers. There are similarly titled programs in the general healthcare field associated with local hospitals that pay significantly more than what our program can match. A pathway from CHW to a permanent well-paying position would significantly benefit this program.

Often the first time a participant has had a mental health discussion is with a community health worker. For this reason, trust and consistency is critical to success of this program. Many PdS/CHWs found it difficult to stay involved and connected to the community during the pandemic. Social Media pages were extremely helpful with outreach. It would be beneficial to PdS/CHW providers to have an engaging social media presence where participants can find reliable current information related to their target population.

Lessons Learned

Virtual engagement through social media posts, blogs, and virtual meetings were all ways that kept engagement through the social distancing restrictions imposed as a result of the COVID-19 pandemic. However, these outreach strategies were not as helpful with collecting and reporting participant data. The PdS/CHW will continue to explore creative ways to keep participants engaged and build in data collection methods to evolve with the times.

Program Updates

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

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). This project collaborates with a network of faith-based organizations to assist in identifying the unmet behavioral health needs of the faith-based, African American Community. The program provides participants with education and resources to address the behavioral health needs of their congregations within church settings. They 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	340
Annual Budget FY 2022-23	$100,000
Cost Per Client FY 2022-23	$294
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. Research shows that the African American community often views the church as a supportive family unit that remains important throughout the life cycle. Evidence also suggests that spirituality often contributes to the resiliency of African Americans who are navigating societally entrenched oppression and discrimination. The American Psychiatric Association published a report entitled, "Assessment and Treatment Recommendations for Marginalized populations", that reports incorporating individual strengths such as family support, spirituality, and community are helpful in treating the African American community. The strong connection to spirituality has been a huge factor in successful treatment outcomes. 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. 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 program was implemented in April 2021. The following information represents the data collected thus far.

BHMPP Outreach Activities

	# of Events	Number of Participants
Townhall	1	20
Focus Groups	1	12
Outreach Presentations	0	0
Resource Mapping / Key Informant Interviews	1	19

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2020-21	FY 2021-22	FY 2022-23
Unduplicated Participants	340	32	19	TBD
Number of Services	600	32	19	TBD

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

The pilot project is divided into four phases. The first phase includes development and delivery of a needs and strengths assessment designed to gather the status of the current behavioral health landscape of IECAAC member churches. The results of phase one guides the program services delivered by the Behavioral Health Ministries Pilot Project established at IECAAC churches. A needs assessment was conducted in May 2021. The Needs Assessment consisted of a focus group, town hall, key informant interviews and surveys.

The following summarizes results obtained from the needs assessment:

Focus Group - DBH and IECAAC hosted a 2-hour focus group session on May 25, 2021. DBH facilitated a virtual event with seven (7) individuals representing IECAAC. The development of the focus group questions was a collaborative effort between DBH and IECAAC. The goal of the focus group was to gauge the level of existing services available in the community for accessing mental health services. The discovery was that while there were some formalized behavioral health programs, there was still a need for additional supports. The questions and related findings can be found in the following tables.

Focus Group Key Findings

Topic	Findings
Current programming centered on behavioral health in the congregations	• Several congregations' members specified that their congregation had developed formalized behavioral health programs that held events on a weekly, monthly, or quarterly basis. • Programs included behavioral health education programs and counseling support session groups. • Other congregations noted that they did not have a formal program but did have congregation members who worked in the behavioral health field who provided support to other members.
Current accessibility to behavioral health resources.	• Many of the focus group participants stated that there is a lack of resources, and more departmental support is needed. • Currently, participants are linking congregation members to resources like homeless shelters, food banks, and other community resources. • Partnerships between congregations with formalized programs and congregations with programs in development were emphasized to accelerate progress among congregations.
Areas of potential support for existing and future Behavioral Health Ministries programs.	• Participants emphasized crisis support, aftercare resources, supportive on-going treatment, and access to resources after business hours and on weekends. • Prevention programming, such as de-escalation trainings and trainings centered on empathy, were discussed.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

Focus Group Key Findings cont.	
Topic	Findings
The different perspectives of behavioral health amongst the different congregations.	• Congregation members express themselves in different ways, sometimes not outright communicating that they may be facing mental health struggles. • In the focus group session, participants noted that congregation members indirectly indicated their struggles by asking for different resources such as food and transportation. • Different phrases are also commonly used to allude to mental health struggles such as “not feeling well” or “having a hard time right now”. • Congregation members mainly refrain from explicitly using the phrases “mental health” or “behavioral health”.
The role that faith-based communities can play and currently play in improving behavioral health education.	• Participants specified that the congregations were making strides to incorporate and bring to the forefront the concept of behavioral health. • Behavioral health was a concept that was often overlooked but focus group participants feel that congregations have the ability to reach members through listening, love, and compassion. • Leaders in the congregations realize the importance of behavioral health by taking care of their health too.

Townhall - As part of the needs and strengths assessment, the DBH and IECAAC hosted a two-hour public town hall session on June 29, 2021. The DBH facilitated the virtual event, and twelve (12) individuals representing IECAAC were in attendance. In order to maximize participation and obtain additional feedback, questions were also distributed to other congregations via electronic and hard copy surveys. There were 34 responses received from individuals representing seven (7) churches.

Key findings from the survey are as follows:

- Each situation is unique, and it is important to provide different avenues of expression in congregations being supporting spaces.
- Resources were the biggest need emphasized. For instance, it was noted that there is a need for the development of a resource guide that details all services that are available.
- Participants also mentioned the need for funding in order to support congregation mental health activities. Congregations have many strengths that they can build upon such as 1) having prayer sessions for individuals who were going through mental health challenges, 2) usage of in-house resources such as providing clothing to homeless individuals via a clothing closet, and 3) assisting individuals with the referral process and directing them to known DBH services.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

Key findings from the Townhall survey are as follows (cont.):

- Participants listed prayer as a fundamental resource and support when facing mental health challenges. A support system that utilizes prayer is seen as essential in persevering over a mental health challenge. Compassion and community organizing are principal qualities that participants associated with their churches. Participants turn to churches for support and information. These strengths are instrumental to the success of this project.
- Participants mentioned that having well-trained resource navigators is of paramount importance in ensuring readiness for linking individuals to services, providing education, and motivating the community to seek services if needed.

Key Informant Interview – BHMPP began the process of Key Informant Interviews (KII) with IECAAC leadership. The purpose of conducting KII's is to collect information from community leaders and experts in a systemic and structured format. The information from the Focus Group and Town hall was used to ask more specific questions to the IECAAC leaders regarding their individual needs and resources to build a more comprehensive ministry program. Additional information will be reported in future annual updates.

As one member stated, "Faith-based communities are an integral part of the fabric of the community. We shape values and share ideals that are projected in the community…It is critically important out of love that we teach and educate positively about mental health."

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics

BHMPP is currently still in Phase I of the program so limited demographics were captured for the program. Preliminary demographic information for Fiscal Year 2021-22 are displayed in the following charts.

Fiscal Year	Age (yrs. old)			
	0-15	16-25	26-50	60+
FY 2020-21	N/A	N/A	N/A	N/A
FY 2021-22	0%	0%	90%	10%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2020-21	N/A
FY 2021-22	0%

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	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2020-21	N/A	N/A	N/A	N/A
FY 2021-22	10%	90%	0%	0%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2020-21	N/A	N/A	N/A	N/A
FY 2021-22	99%	0%	1%	0%

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics, cont.

	Race / Ethnicity		
		FY 2020-21	FY 2021-22
Race	African-American/Black	N/A	85%
	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	8%
	Caucasian/White	N/A	7%
	Other Race	N/A	0%
	Declined to Answer	N/A	0%
Ethnicity	African	N/A	0%
	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	7%
	More than one ethnicity	N/A	89%
	Declined to Answer	N/A	0%

Demographic Observations

- To date, demographic information collected from BHMPP indicates that the program is meeting the targeted audience of African-American Adults.
- As the program progresses and begins training and outreach, it is expected to see increased diversity in the racial and ethnic categories as well as age groups.
    - Although the program is targeting African-American churches, the congregations are representative of the communities in which the churches reside.
- The majority of participants identify as female (90%) indicating that there is still some stigma surrounding mental health services for those that identify as other than female.
- No participants identified as veterans or military members. The BHMPP is looking for opportunities to outreach to veteran groups within their congregations to increase awareness.

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 plans to accomplish this goal in Phase II which will begin in late 2022 with Behavioral Health Education and Awareness and Community Engagement activities. The program is expected to reach an estimated three-hundred and forty (340) unduplicated participants with these efforts.

Program Outcome Tools		
Survey Name	Behavioral Health Education and Awareness - Pre and Post Surveys	Community Engagement – Pre and Post Surveys
Description of Method	A seven (7) question survey developed in collaboration with DBH to evaluate the education and awareness performance targets outlined in the BHMPP contract. Participants will receive a Pre and Post Survey for each BHMPP outreach event held.	Community Engagement– Participants will receive a Pre and Post Survey for each BHMPP Engagement activity held.
Survey Type	Before and after each outreach event	Before and after each engagement activity
Targeted Surveys	170	170

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Outcome Discussion

Overall, there is an upward trend in religious communities encouraging the importance of mental health. Members of IECAAC congregations who participated in the survey and townhall are optimistic about the role their congregations can play with the appropriate support and resources. Congregations are vital places that help shape the lives of members and are instrumental in shaping the positive narratives around behavioral health.

A common theme from all of Phase I efforts resides in the notion that encouraging individuals to seek help wherever is right for them and clarifying that existing treatment methods may be combined with a faith-based perspective, are important actions that can help decrease the present stigma. The church can be at the forefront of starting conversations around behavioral health challenges. They can bring people together and provide a safe environment where individuals are comfortable sharing their experiences. Support groups and events connect individuals who are open to talking about behavioral health with those who have reservations about mental health. Blending both groups incites conversations that reduce stigma.

These activities that will be conducted in Phase II to meet outcome goals. Further detailed information will be provided in future reports and annual updates.

Behavioral Health Education and Awareness:

- Increase knowledge about mental health, mental illness and services/resources available by 90%
- Increase knowledge of Substance Use Disorders and services/resources available by 90%.
- 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 by 80%
- Increase the ability and comfort to address and present behavioral health topics to church members/congregants by 80%

Community Engagement:

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

Behavioral Health Ministries Pilot Project (BHMPP), cont.

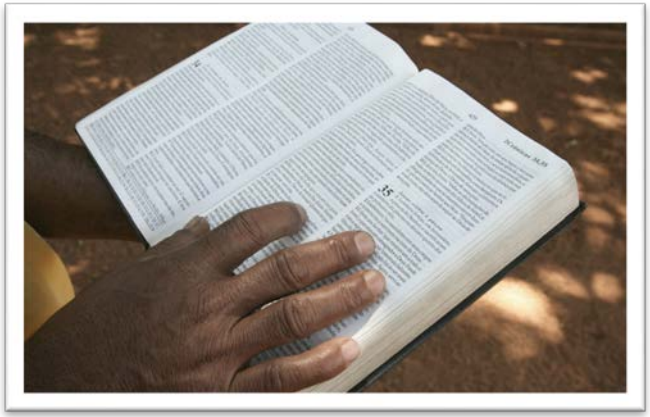
Program Challenges/Solutions

BHMPP experienced several challenges in the start-up phase of the project. Recruiting and onboarding a qualified Program Coordinator proved to be a difficult task. The limited-term contract, pay, and full-time hours were discouraging factors for many applicants. Providing job security and competitive wage will be important to sustain the program beyond the pilot project time limit.

BHMPP also experienced challenges with implementing initial training schedules. Many taskforce members are volunteers that that have full-time day schedules. This conflicted with the availability to schedule the trainings. Evening and weekend availability will be instrumental in maximizing participation at training events.

Lessons Learned

The Prevention and Early Intervention state administrative reporting requirements and deadlines are difficult for new providers to navigate. They require a higher level of guidance from DBH. Longer technical assistance trainings will be built into future programming efforts. The dedicated team of Research and Evaluation, Office of Equity and Inclusion, and Prevention and Early Intervention were instrumental in providing the needed guidance to assist the program in transitioning from Phase I into Phase II.



Program Updates

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

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 provides assistance to 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	6,500
Annual Budget FY 2022-23	$ 5,943,039
Cost Per Client FY 2022-23	$914
Services Offered	Assessments Comprehensive Treatment Services Case Management Services Mental Health Education

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 number of unduplicated participants per year exceeded projections. 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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	6,529	13,086	22,778	4,501
Number of Services	70,969	165,269	273,465	80,256

Prevention Participants / Services

	FY 2018-19	FY 2019-20	FY 2020-21
Prevention Participants	455	62	174
Number of Services	1,055	62	1,156

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. In Fiscal Year 2019-20, there was a decrease in the number of participants who met their treatment goals. This was due to the stressors associated with the onset of the COVID-19 pandemic, and the implementation of telehealth services for this young population.

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 2018-19	FY 2019-20	FY 2020-21
Potential Responders	2,443	673	1,144

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2018-19	3,742	2,335	53%
FY 2019-20	3,459	1,583	29%
FY 2020-21	7,072	3,096	51%

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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals	3,638	2,091	2,390
County-funded	3,638	2,091	2,390
Non-County Funded	0	0	0
Participants Engaged	2,600	1,621	1,686

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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals Provided	4,446	3,370	844

Child and Youth Connection (CYC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	92%	4%	3%	0%	1%
FY 2019-20	80%	4%	11%	1%	3%
FY 2020-21	82%	1%	7%	1%	9%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 2018-19	0%
FY 2019-20	0%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 2018-19	0%
FY 2019-20	0%
FY 2020-21	0%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	4%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	1%	0%	0%	99%
FY 2019-20	3%	9%	0%	88%
FY 2020-21	52%	45%	0%	3%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	94%	6%	0%	0%
FY 2019-20	92%	7%	0%	1%
FY 2020-21	90%	6%	4%	0%

Child and Youth Connection (CYC), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	16%	14%	14%
	American Indian or Alaska Native	1%	1%	2%
	Asian	1%	0%	1%
	Native Hawaiian or Pacific Islander	3%	2%	0%
	More than One Race	7%	9%	2%
	Caucasian/White	29%	23%	16%
	Other Race	42%	45%	0%
	Declined to Answer	2%	5%	66%
Ethnicity	African	0%	1%	0%
	Asian Indian/South Asian	0%	0%	1%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	1%	0%	0%
	Hispanic/Latino	10%	5%	15%
	Filipino	1%	1%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	1%	0%	0%
	Other	0%	0%	0%
	More than one ethnicity	1%	0%	0%
	Declined to Answer	96%	97%	0%

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 times this is because it has been deemed inappropriate to ask this particular 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 2018-19: EIIS: N = 660 SART: N = 843 FY 2019-20: EIIS: N = 447 SART: N = 871 FY 2020-21: EIIS: N = 603 SART: N = 869

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

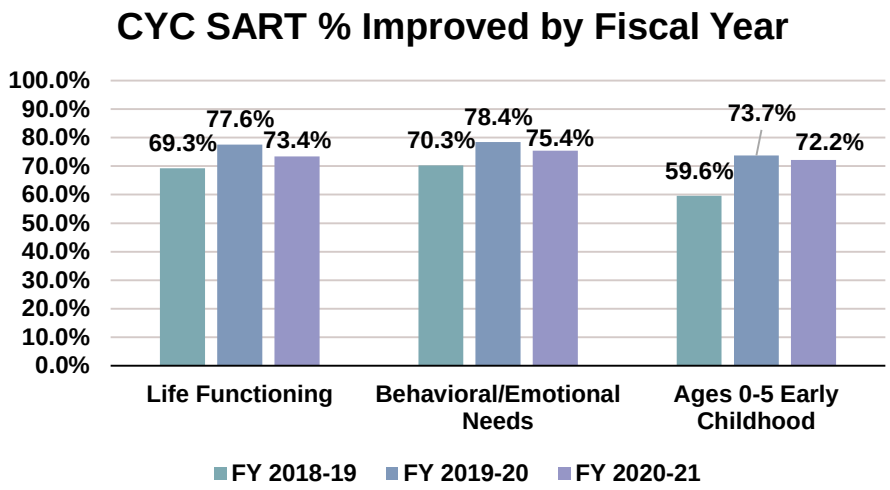
The Behavioral/Emotional Needs sub-domains include the following:

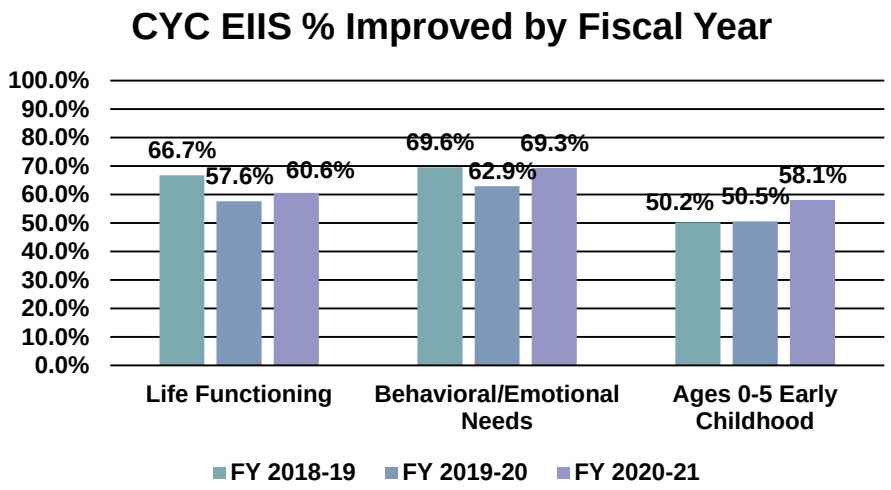
- Depression which rates the symptoms of the child such as irritable or depressed mood, social withdrawal, and loss of motivation.
- Anxiety which rates the symptoms of the child such as excessive fear and anxiety and related behavioral disturbances. Panic attacks can be a prominent type of fear response.
- Anger Control 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 still remain above a 50% improvement in all domains.

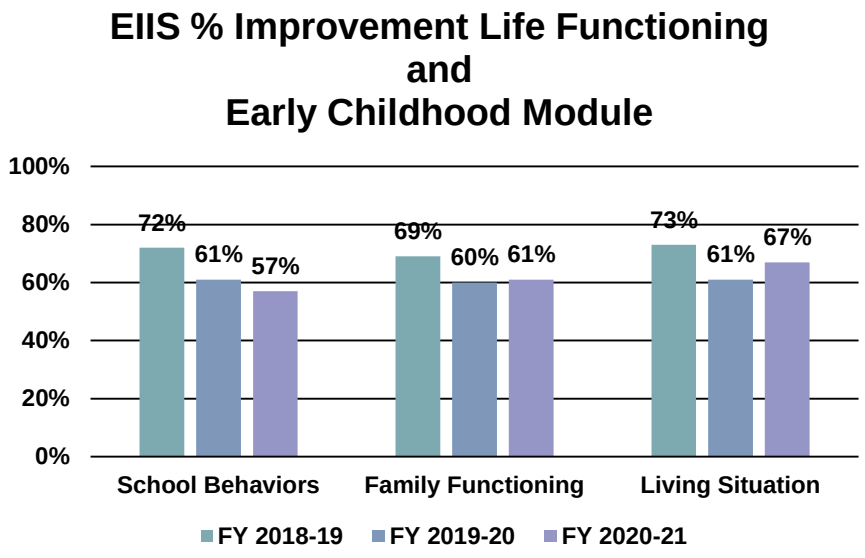


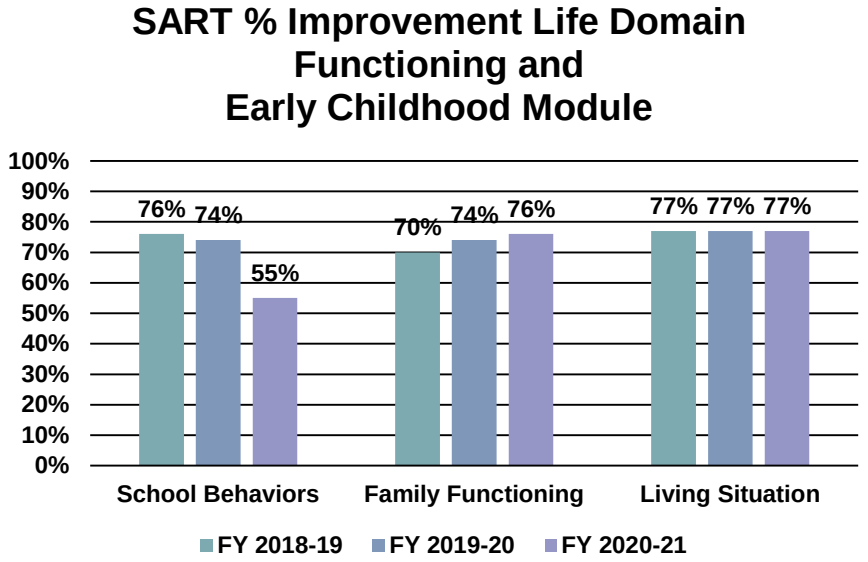


Child and Youth Connection (CYC), cont.

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.

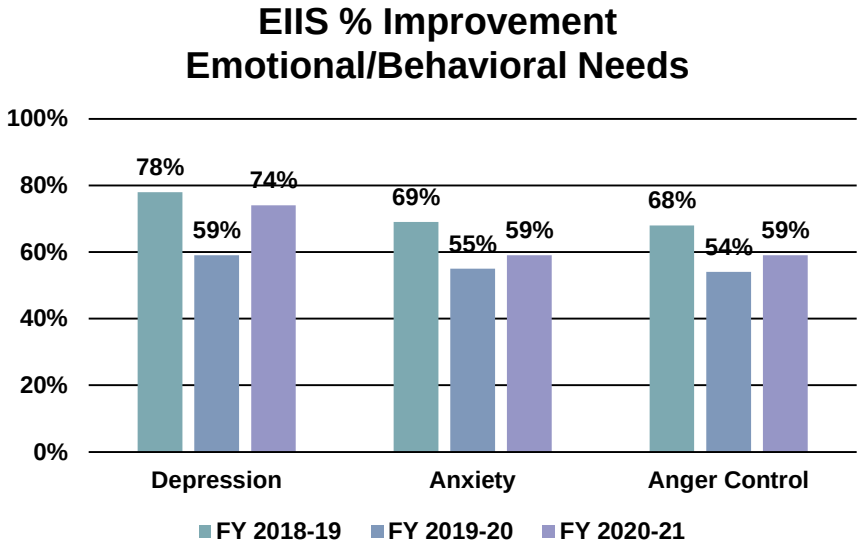


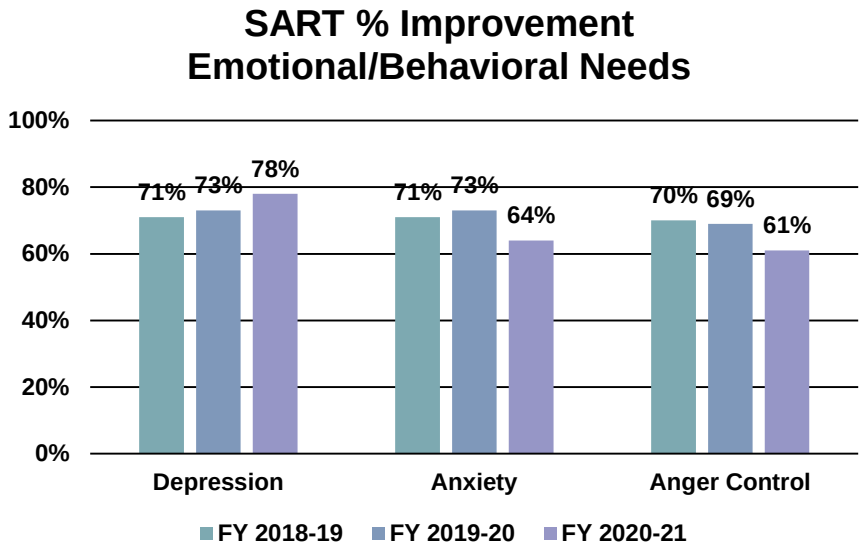


Child and Youth Connection (CYC), cont.

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 72% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 64%. Reducing anxiety leads to improved behavioral and emotional functioning. The program maintains an average improvement of 65% 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

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

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.

To promote the early development and meet the needs of the whole child, the PPP program collaborates with a wide range of community partners and agencies, including but not limited to the following:

- Making a Difference Association
- County Library
- First 5 San Bernardino
- Desert Mountain Children's Center
- Lutheran Social Services
- Children's Fund
- Foster & Kinship CARE Education
- Cal Baptist University MFT Intern Program
- Victor Community Support Services

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 2022-23	$302,256
Cost Per Client FY 2022-23	$200
Services Offered	Social-emotional development Screenings & assessments Trauma support Resources & referrals Behavioral health plan development Family support

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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	1,508	806	1,172	750
Number of Services	3,757	3,540	2,659	2,659

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 Fiscal Year 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 2018-19	FY 2019-20	FY 2020-21
73	90	60

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, eleven (11) participants were given referrals to the Screening, Assessment, Referral, and Treatment (SART) program and two (2) participants were given referrals to independent service providers for higher level services beyond the preventative services offered by the PPP program. Of those who received referrals, three (3) engaged in the SART program and one (1) participant engaged in treatment with an independent service provider. Nearly 70%, nine (9) families, declined services for their children while two (2) families did not engage in services due to COVID-19. Engagement in higher level of care services has been limited due to the continuing stigma surrounding mental health services.

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.

Access & Linkage to Services							
	SART Program				Independent Service Providers		
Fiscal Year	# Referred	# Engaged in Services	# Declined Services	# Did not engage due to Covid	# Referred	# Engaged in Services	# Declined Services
FY 2018-19	1	0	1	N/A	2	1	1
FY 2019-20	10	0	8	2	0	0	0
FY 2020-21	0	0	0	0	0	0	0
Total	11	0	9	2	2	1	1

Note: There were no children participating in the Preschool PEI program during FY 2020-21 who needed referrals to higher level services.

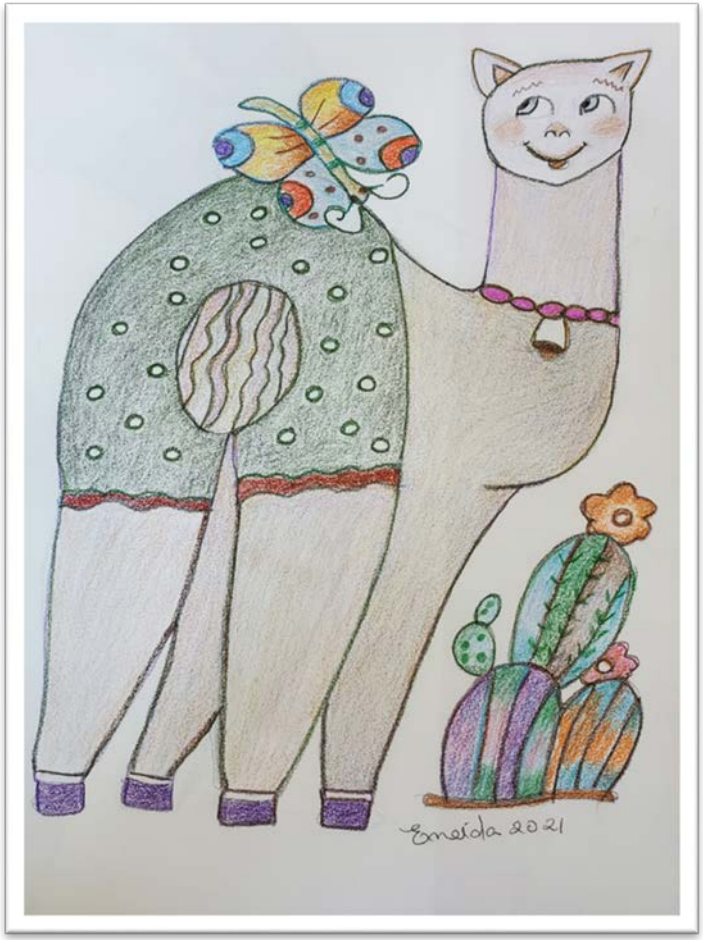
Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Needs Assessment

Parents engaged within the TLC group component of the PPP program completed surveys indicating specific ways in which the families could benefit from the PPP program. The feedback that was received aligns with the program goals. Families indicated that 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 it's 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.



Artwork by Eneida Reboucas

Preschool PEI Program (PPP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	56%	2%	33%	1%	8%
FY 2019-20	61%	2%	30%	1%	6%
FY 2020-21	61%	3%	26%	1%	9%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	6%
FY 2019-20	3%
FY 2020-21	1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	25%	28%	0%	47%
FY 2019-20	22%	32%	1%	45%
FY 2020-21	20%	39%	1%	40%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	79%	10%	1%	9%
FY 2019-20	87%	5%	2%	6%
FY 2020-21	79%	7%	10%	4%

Preschool PEI Program (PPP), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	13%	12%	11%
	American Indian or Alaska Native	0%	0%	1%
	Asian	0%	2%	2%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	3%	3%	2%
	Caucasian/White	18%	22%	28%
	Other Race	0%	0%	1%
	Declined to Answer	30%	28%	22%
Ethnicity	African	2%	1%	0%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	2%
	Eastern European	0%	0%	0%
	European	1%	0%	0%
	Hispanic/Latino	34%	32%	34%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	1%	5%
	Vietnamese	0%	0%	0%
	Other	0%	3%	0%
	More than one ethnicity	89%	0%	0%
	Declined to Answer	6%	91%	89%

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. The Life Skills Progression (LSP) Tool is used in an in-home setting to help families understand their existing strengths and needs and to help develop a supportive plan for families who accept in-home family support services.

Program Outcome Tools		
Survey Name	Desired Results Developmental Profile (DRDP)	Life Skills Progression (LSP) Tool
Description of Method	Measures whether the child is at or above the California Learning Foundations age expectations in social-emotional development.	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	Fall, Winter, Spring	2 times Initial & completion
Number Completed	FY 2018-19: 806 FY 2019-20: 1,172 FY 2020-21: 750	FY 2018-19: 39 FY 2019-20: 27 FY 2020-21: 25

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 2018-19**			**FY 2019-20**			**FY 2020-21**		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Identity of Self in Relation to Others	3.905	5.898	1.993	43%	78%	35%	47%	71%	24%
Social and Emotional Understanding	3.75	5.788	2.038	38%	71%	33%	48%	71%	23%
Relationships and Social Interactions with Familiar Adults	3.683	5.695	2.012	45%	78%	33%	48%	75%	27%
Relationships and Social Interactions with Peers	3.817	5.712	1.895	49%	80%	31%	not assessed*		
Symbolic and Sociodramatic Play	3.705	5.691	1.986	26%	55%	29%	25%	41%	16%

* 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.

Note: From FY 2018-19 to FY 2019-20, as a result of on-going program assessment, a change in measurement methods was administered, changing from reporting numerical scores in FY 2018-19 to percentages in FY 2019-20 with the intent to provide a more meaningful demonstration of participant growth.

Preschool PEI Program (PPP), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

The Life Skills Progression survey is used to assess the strengths and needs of participating families. The tool measures 35 parental life skills in areas such as relationships, resources, medical health, mental health, and basic essentials. The results of this tool are used to determine areas of need for families. It also gauges improvement in these areas. Each skill is assigned a ranking between 1-5. Skills with lower rankings indicate areas with greater need for improvement. The LSP is completed by the Family Support Partner upon the initial session and also upon completion of participation in the program with an average participation timeframe of three months.

Significant 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

These improvements indicate that families that are engaging in the program are increasing the protective factors for their children. It shows that parents and caregivers have increased confidence in their ability to care for their children in a safe and healthy manner.

The results of this tool help families increase the overall health and well being. They identify risk factors that could cause long term effects if left unaddressed.

Life Skills Progression Results

Fiscal Year	Pre	Post	Increase	% Increase
FY 2018-19	88.55	99.31	10.76	12.2%
FY 2019-20	94.6	103.73	9.13	9.7%
FY 2020-21	103.54	109.99	6.45	6.2%

Preschool PEI Program (PPP), cont.

Program Challenges/Solutions

One challenge has been supporting parents and caretakers at home as they are managing their child's self-regulation concerns.

As a result of these changing needs, the PSD Behavioral Health Team meets with the parents/caretakers and classroom teacher to develop goals and provide strategies that the parent can implement at home. The team also provides additional resources for the parent to help support their efforts.

Another challenge is overcoming stigma surrounding receiving mental health services. Of the families who received referrals for in-home family services, approximately 59% declined to accept services. This highlights the need to continue educational efforts to reduce stigma related to mental health services that may be affected by promoting mental health through conversation and increasing public awareness.

In response to a challenge that was previously identified in FY 2018-19 related to updating curriculum to meet best practices, Preschool Services has implemented the Teaching Pyramid curriculum for inclusion in the current year.

Lessons Learned

The Life Skills Progression Tool is currently being used to measure improvement in families participating in the Family Support Program. While the current evaluation method provides some insight into key areas of significant growth, future reports should provide additional information by providing additional data within the individual skill areas. This would allow a more complete evaluation of each area, possibly pointing to trends for existing strengths as well as common areas of need within our community.

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.

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 2022-23	$1,076,493
Cost Per Client FY 2022-23	$257
Services Offered	Cultural awareness and empowerment workshops Professional development presentations Mental health / SUD screenings Mental health / SUD education Counseling services Case management Homework assistance

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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	4,190	4,671	6,691	2,153
Number of Services	10,451	7,076	11,839	3,491

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

Early Intervention

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

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

The program also uses Columbia Suicide Severity Rating Scale, and Life Events Checklist to assess for the severity of assistance needed with special attention to suicide risk. If students are in need of 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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	26	207	23
Total Services	101	1,360	118

The COVID-19 pandemic halted much of the RPiAAC services in 2020 and 2021 as evidenced by the significant dip in unduplicated participants and total services. Also, in 2021 one of the RPiAAC providers voluntarily withdrew from providing services due to unforeseen circumstances. DBH is working closely with the remaining provider to ensure that services are provided to all original contracted areas.

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 2018-19	FY 2019-20	FY 2020-21
Treatment Successful	0%	20%	50%
Treatment Partially Successful	100%	80%	50%
Treatment Not Successful	0%	0%	0%

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

Program Highlights, cont.

Outreach

Outreach and education services are designed to incorporate cultural and historical education for African American student populations. This encourages positive social identity and generates awareness regarding the importance of mental health and wellness in all students. RPiAAC providers infuse themselves in the culture of each school that they partner with. They engage with school leadership, teaching staff and students to reduce the stigma associated with mental health services and encourage seamless access to services. Examples of outreach activities include Principal's Meet and Greet, Meet a Pro, cultural awareness presentations and activities, and participation in school assemblies.

RPIAAC was able to reach the most participants in FY 2019-20. The COVID-19 pandemic opened many avenues for outreach via social media platforms and food distribution activities. However, as the pandemic continued through 2020 and 2021, illness, virtual meeting fatigue, and reduced social media engagement contributed to decreases in participation. The table below illustrates the decrease in number of potential responders reached in FY 2020-21.

Potential Responders Reached	
Fiscal Year	**Number of Potential Responders**
2018-19	3,874
2019-20	5,880
2020-21	1,835

Outreach Settings

- Schools
- Community events
- Family Resource Center
- Community based organization facility

Types of Potential Responders

- Families
- Law Enforcement
- School Personnel
- People who serve homeless population
- 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 2018-19	31%	5%	12%	3%	49%
FY 2019-20	38%	5%	17%	3%	37%
FY 2020-21	3%	3%	35%	1%	58%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	2%
FY 2019-20	2%
FY 2020-21	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	4%
FY 2019-20	4%
FY 2020-21	2%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	19%	29%	0%	52%
FY 2019-20	17%	25%	0%	58%
FY 2020-21	1%	5%	0%	94%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	47%	9%	1%	43%
FY 2019-20	58%	10%	1%	31%
FY 2020-21	58%	2%	0%	40%

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

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	21%	16%	6%
	American Indian or Alaska Native	0%	0%	0%
	Asian	0%	0%	1%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	7%	4%	0%
	Caucasian/White	7%	11%	3%
	Other Race	11%	11%	10%
	Declined to Answer	53%	56%	81%
Ethnicity	African	22%	12%	5%
	Asian Indian/South Asian	0%	0%	1%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	27%	36%	12%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	7%	3%	1%
	More than one ethnicity	4%	3%	0%
	Declined to Answer	66%	82%	93%

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.

The Children and Adolescent Needs and Strengths Assessment (CANS-SB) is one of the main tools used to identify risk factors in need of intervention and protective factors that can be strengthened. This tool is used by a licensed clinician to aid in treatment planning for participants. If a student is identified as needing this level support, an assessment is performed at intake and every six months until discharge or a significant life event change.

Program Outcome Tools	
Survey Name	Children 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	Intake, six months, discharge, significant life events
Number Completed	FY 2018-19: 11 FY 2019-20: 34 FY 2020-21: 5

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

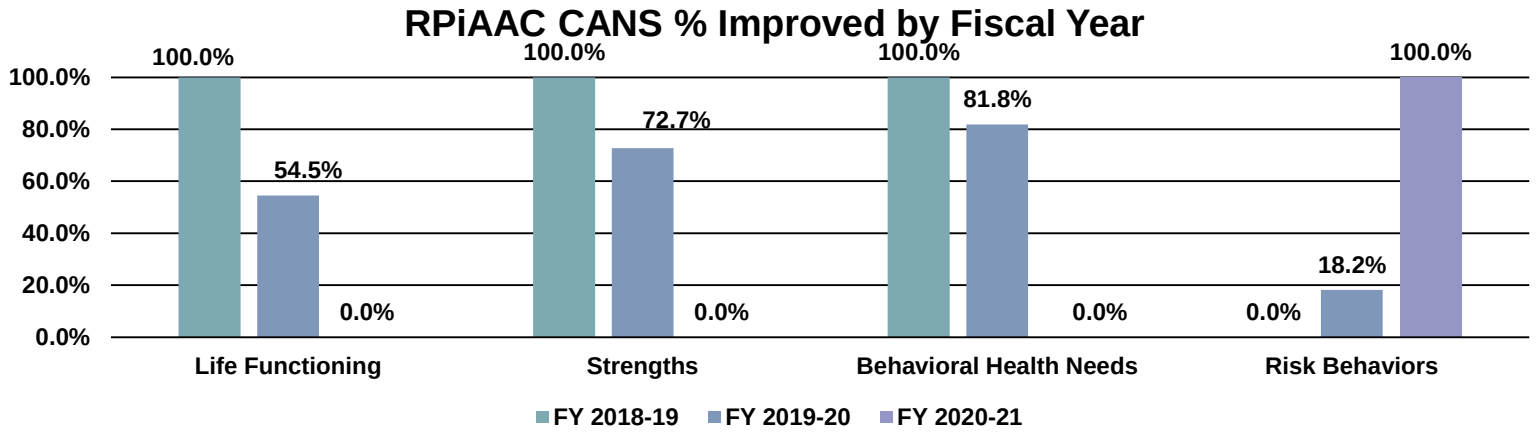
Outcome Discussion

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

The following chart shows that clients that start services with needs in Life Functioning, Strengths, Behavioral Health Needs and Risk Behaviors show signs of improvement by the completion of their services.

Early Intervention participation was highest in FY 2019-20 which led to a higher variance of improvement. In FY 2019-20 and 2020-21 early intervention efforts were focused on students with the highest risk needs due to the social distancing requirements in effect. All participants that received a CANS improved in the Risk Behaviors domain in FY 2020-21. Due to the challenges with participation during the COVID-19 pandemic, there was no measurable improvement in the small number of participants for FY 2020-21.



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

Program Challenges/Solutions

Parent engagement continues to be a challenge in this program. Parent participation remains low due to scheduling conflicts. The stigma surrounding participation in mental health and wellness education continues to be a barrier.

Providers for the program are exploring innovative ways to incentivize parent participation. Program providers also plan to develop stigma reduction activities for students and parents to address the high stigma that remains prevalent within the community.

COVID-19 pandemic and social distancing requirements posed huge barriers to providing effective services for this program. RPiAAC is reliant on access to school campuses and student behavior, grades, and disciplinary information to plan and provide services. Providers found it difficult for sufficient and timely information sharing when school staff and students were no longer co-located. Traditional afterschool services were no longer available to students and parents that were working and attending school from their homes.

Offering platforms, where students can access mental health services virtually from their phones, has proven to be an increased need for program participants. Although many students have computers provided by their schools, they are not able to access websites and applications intended to access mental health services on these devices. The devices provided by their school can only be used for educational purposes.

Lessons Learned

Another challenge faced by RPiAAC providers was changes with data collection and reporting requirements implemented by DBH. RPiAAC struggled with staff turnover and training the appropriate level staff on the new database collection requirements. RPiAAC providers are working closely with DBH to ensure data is being captured timely and correctly.

Program Updates

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

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 particular 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
Number of Consumers to be Served	6,398
Annual Budget FY 2022-23	$708,265
Cost Per Client FY 2022-23	$111
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

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'll find a list of prevention activities and the associated risk and protective factors.

Providers of OACS 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 a number of 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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	6,398	4,781	3,219	6,718
Number of Services	9,358	11,656	13,150	9,861

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 10,683 participants, also known as potential responders, from FY 2018-19 through 2010-21.

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 are able to 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

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

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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants/Open Episodes at any time during FY	47	33	24

The Early Intervention component has decreased over the last three fiscal years, as seen in the table above. The majority 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. The majority of older adult participants in early intervention services do not have access to computers or smart phones.

Treatment Success by Fiscal Year			
	FY 2018-19	FY 2019-20	FY 2020-21
Treatment Successful	32%	35%	36%
Treatment Partially Successful	34%	26%	27%
Treatment Not Successful	34%	39%	27%
Missing or Other	N/A	N/A	10%

The above table illustrates the discharge status at the conclusion of treatment. The majority of 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 of 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	26-50	60+	UNK
FY 2018-19	0%	4%	9%	79%	8%
FY 2019-20	1%	<1%	1%	80%	17%
FY 2020-21	<1%	<1%	2%	95%	2%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	2%
FY 2020-21	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	<1%
FY 2019-20	<1%
FY 2020-21	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	1%
FY 2019-20	4%
FY 2020-21	9%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	26%	58%	0%	15%
FY 2019-20	13%	35%	<1%	51%
FY 2020-21	14%	36%	0%	50%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	61%	27%	2%	11%
FY 2019-20	64%	10%	1%	25%
FY 2020-21	16%	1%	<1%	83%

Older Adult Community Services (OACS), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	10%	2%	2%
	American Indian or Alaska Native	1%	1%	0%
	Asian	3%	1%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	0%	0%	0%
	Caucasian/White	53%	27%	8%
	Other Race	13%	9%	2%
	Declined to Answer	19%	53%	78%
Ethnicity	African	4%	6%	0%
	Asian Indian/South Asian	2%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	1%	1%	0%
	Eastern European	0%	0%	0%
	European	9%	17%	13%
	Hispanic/Latino	35%	16%	13%
	Filipino	2%	1%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	1%	0%	0%
	Other	10%	0%	1%
	More than one ethnicity	10%	1%	38%
	Declined to Answer	62%	0%	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 after the pandemic restrictions are lifted.

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 2018-19: 16 FY 2019-20: 18 FY 2020-21: 29	FY 2018-19: 28 FY 2019-20: 112 FY 2020-21: 108	FY 2018-19: n/a FY 2019-20: n/a FY 2020-21: 49	FY 2018-19: 190 FY 2019-20: 61 FY 2020-21: 110

Older Adult Community Services (OACS), cont.

Outcome Discussion

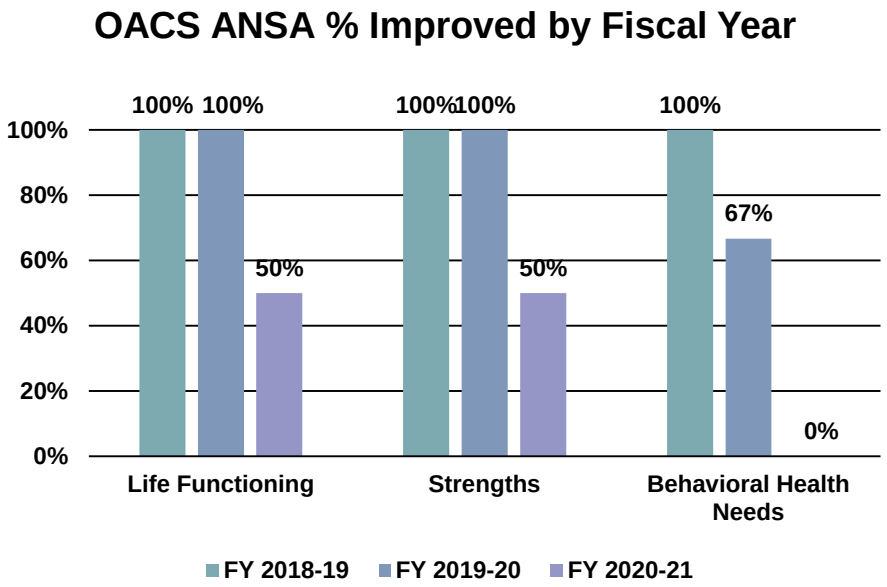
Early Intervention

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

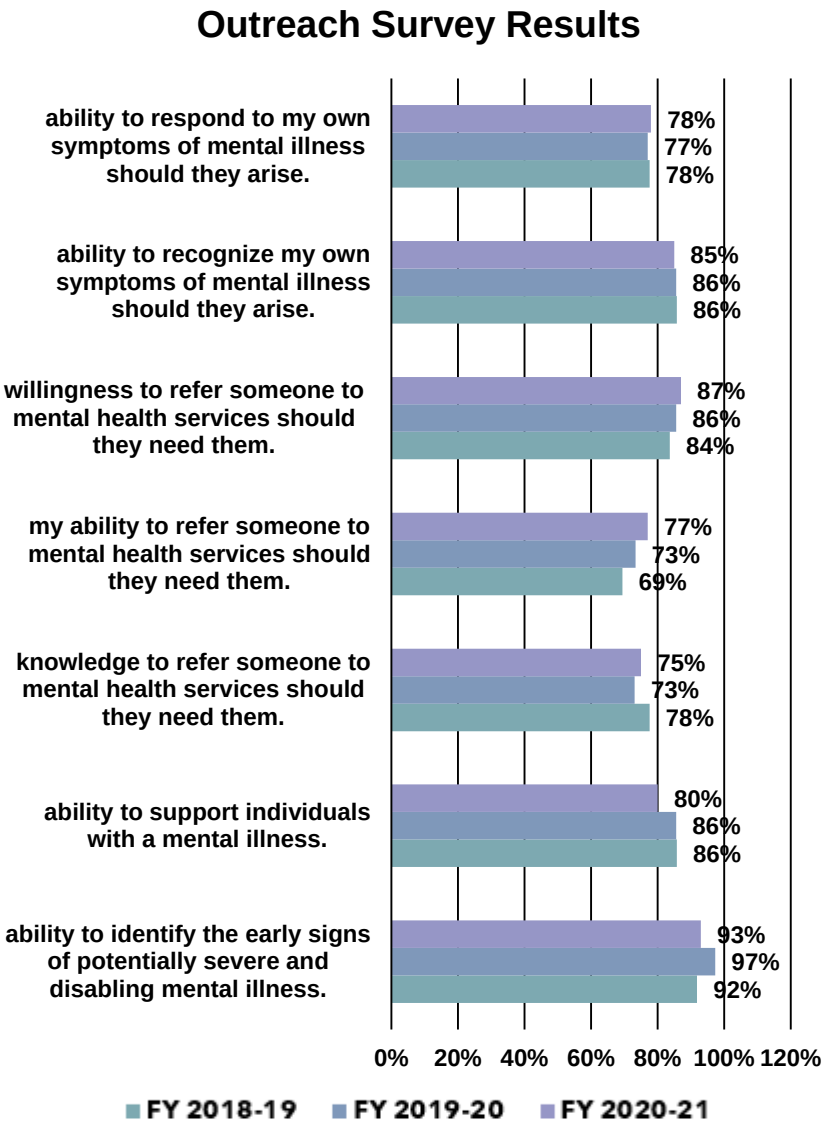
Outreach Survey Results

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 be in need of 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.



Older Adult Community Services (OACS), cont.

Program Outcomes, cont.

Client Satisfaction Surveys

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 programing 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 effects on their physical health
33% stated improvements in quality time spent with friends and family

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

83% of OACS participants agreed or totally agreed that participants improved knowledge on mental health and stigma reduction
84% of OACS Wellness presentation participants agreed that the presentations were useful and the speaker delivered information.

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

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

Older Adult Community Services (OACS), cont.

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 Department of Aging and Adult Services 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 2022-23	$504,780
Cost Per Client FY 2022-23	$4,207
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

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. The participation rates in fiscal year 2018-19 were relatively low due to stigma surrounding participation in a mental health program and lack of trust in having in-home visitors. 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.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	120	65	125	114
Number of Services	1,728	656	1,095	1,094

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. As shown in the table below, the percentage of new mothers experiencing postnatal depression enrolled in the Lift program has historically been higher than the national average

Identification of Depression Related Mental Health Needs

	FY 2018-19 (N= 65)	FY 2019-20 (N= 93)	FY 2020-21 (N= 60)
Exhibited signs of depression	25 (38%)	28 (30%)	9 (15%)
Received mental health supportive services	25 (100%)	28 (100%)	9 (100%)
Required clinical intervention	1 (4%)	0 (0%)	1 (11%)

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 V. Talbot

Lift Program, cont.

Program Highlights, cont.

Fagerstrom Test for Nicotine Dependence

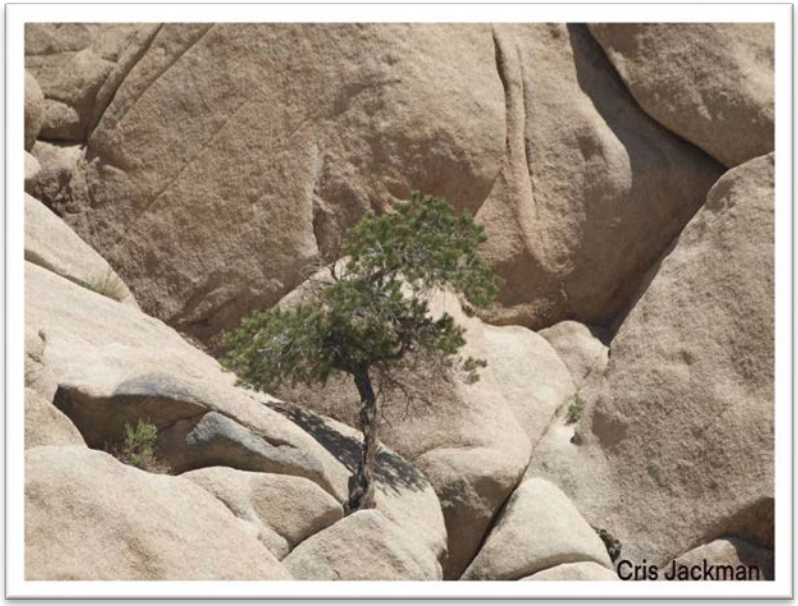
Smoking during pregnancy is a risk factor associated with adverse pregnancy outcomes. It negatively impacts the development of the unborn child, decreases impulsivity control, and causes delays in developmental milestones. Risk factors associated with neurochemical imbalance and substance use/reliance 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 2018-19	FY 2019-20	FY 2020-21
% of mothers who smoke less than 10 cigarettes per day	12%	8%	2%
% of mothers who are non-smokers	78%	92%	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.



Artwork by Cris Jackman

Lift Program, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	41%	28%	31%	0%	0%
FY 2019-20	24%	18%	41%	0%	17%
FY 2020-21	34%	19%	44%	0%	3%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	2%
FY 2019-20	1%
FY 2020-21	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	11%
FY 2019-20	11%
FY 2020-21	12%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	4%
FY 2019-20	7%
FY 2020-21	4%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	15%	80%	2%	3%
FY 2019-20	10%	74%	0%	16%
FY 2020-21	18%	79%	0%	3%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	83%	15%	2%	0%
FY 2019-20	53%	10%	11%	26%
FY 2020-21	77%	6%	5%	12%

Lift Program, cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	17%	16%	19%
	American Indian or Alaska Native	2%	1%	1%
	Asian	0%	0%	0%
	Native Hawaiian or Pacific Islander	2%	0%	0%
	More than One Race	17%	8%	9%
	Caucasian/White	9%	25%	32%
	Other Race	12%	5%	3%
	Declined to Answer	34%	15%	8%
Ethnicity	African	31%	29%	19%
	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	70%	71%	68%
	Filipino	0%	1%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	0%	1%
	Vietnamese	0%	0%	0%
	Other	1%	0%	0%
	More than one ethnicity	2%	10%	1%
	Declined to Answer	3%	59%	57%

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 2018-19: 65 FY 2019-20: 93 FY 2020-21: 60	FY 2018-19: 65 FY 2019-20: 108 FY 2020-21: 60

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 2018-19	FY 2019-20	FY 2020-21
I desire this baby / I'm not sorry I became pregnant	100%	97%	100%
I am willing to give up certain things to protect my baby	100%	72%	100%
I read to my baby / unborn child	31%	80%	80%

Lift Program, cont.

Program Highlights, cont.

Family Supports			
	FY 2018-19	FY 2019-20	FY 2020-21
My mate wants this pregnancy	26% No	41% No	0% No
My pregnancy interferes with my relationship with my mate	15% Yes	4% Yes	0% Yes
My family supports my pregnancy	62% Yes	69% Yes	95% Yes
My family will help in caring for my baby	100% Yes	85% Yes	96% 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 2018-19	FY 2019-20	FY 2020-21
I feel uncertain as to what the future holds for me and my baby	46%	32%	23%

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 child care. 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 2018-19 and 2019-20 there is a strong correlation between the education level and stable employment. Although the percentage of participants with less than a high school education decreased, the percentage of participants who were unemployed increased in FY 2020-21. This may be partially related to increased unemployment rates associated with the COVID-19 pandemic.

Participant Education Level and Employment Stability

	FY 2018-19	FY 2019-20	FY 2020-21
Less than high school education	58%	25%	10%
Unemployed / work occasionally	86%	76%	95%
Some college	11%	23%	18%
Stable employment	14%	24%	5%

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 Kayla Baum

Lift Program, cont.

Program Challenges/Solutions

Maintaining a full staff of three full-time Registered Nurses has been a challenge. A high demand for nurses combined with limited capacity of nursing programs has led to a nationwide shortage of nurses. This shortage continues to make it difficult to recruit, hire, and retain Registered Nurses.

To address this challenge, the program collaborated with Westcoast Nursing School to place job announcements in the forefront. The program has also connected with local colleges to advertise current job openings. They have teamed with the Department of Public Health to keep abreast of all of the changes in the field and to collaborate on efforts to recruit Registered Nurses. This collaboration resulted in a full roster of Registered Nurses serving the Lift program in FY 2019-20 and FY 2020-21.

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.

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 2022-23	$300,125
Cost Per Client FY 2022-23	$200
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

Coalition Against Sexual Exploitation (CASE), cont.

Program Highlights

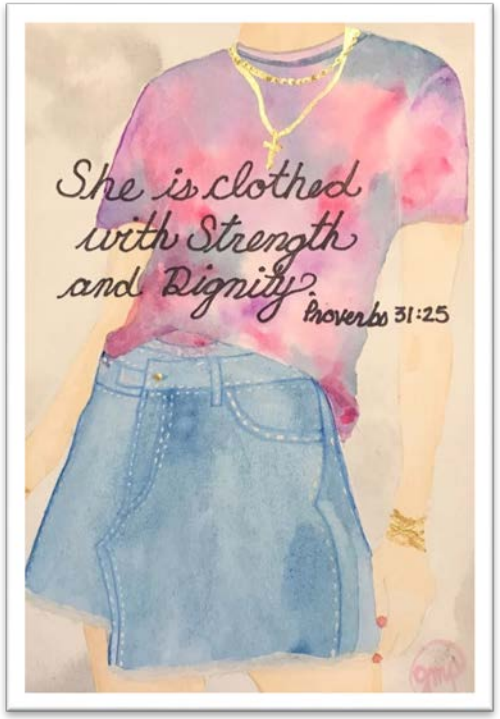
CASE seeks to reduce the number of those who are commercially sexually exploited or at risk of commercial sexual exploitation. The multi-agency collaboration model supports the state Prevention categorization through the services aimed at decreasing risk factors associated with children becoming commercially 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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	1,500	1,374	1,529	1,352
Number of Services	1,500	2,277	2,453	3,269



Artwork by Gena Pliss

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 Actual vs. Projected			
	FY 2018-19	FY 2019-20	FY 2020-21
Prevention Participants	69	100	64
Number of Services	848	737	1,981

Girls' Court Completion Rate			
	FY 2018-19	FY 2019-20	FY 2020-21
Completion Rate	50%	60%	60%

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 4,022 potential responders from FY 2018-19 through 2020-21. 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.

Artwork by Lakesha L.

Potential Responders Reached			
	FY 2018-19	FY 2019-20	FY 2020-21
Outreach Participants	1,305	1,429	1,288
Number of Services	1,429	1,716	1,288

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

Coalition Against Sexual Exploitation (CASE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	1%	26%	60%	6%	7%
FY 2019-20	12%	38%	43%	4%	3%
FY 2020-21	3%	30%	32%	0%	35%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	0%
FY 2019-20	0%
FY 2020-21	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	0%
FY 2019-20	4%
FY 2020-21	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	0%
FY 2019-20	2%
FY 2020-21	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	27%	68%	0%	5%
FY 2019-20	18%	78%	0%	4%
FY 2020-21	6%	31%	1%	62%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	92%	0%	0%	8%
FY 2019-20	99%	1%	0%	0%
FY 2020-21	100%	0%	0%	0%

Coalition Against Sexual Exploitation (CASE), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	49%	40%	4%
	American Indian or Alaska Native	0%	0%	0%
	Asian	0%	2%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	9%	1%	0%
	Caucasian/White	16%	40%	3%
	Other Race	21%	7%	0%
	Declined to Answer	5%	8%	93%
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	2%	2%	1%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	1%	0%
	Vietnamese	0%	0%	0%
	Other	0%	0%	4%
	More than one ethnicity	0%	0%	0%
	Declined to Answer	0%	0%	96%

Demographic Observations

- CASE has consistently served the targeted demographics over the last three fiscal years. Females between the ages of 15 – 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 ethnic and racial make up of CASE participants has fluctuated over the last three years. However, participants identify as African-American and Latinx represent the majority. There was a spike of participants identifying as Caucasian in FY 2019-20.
- 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.

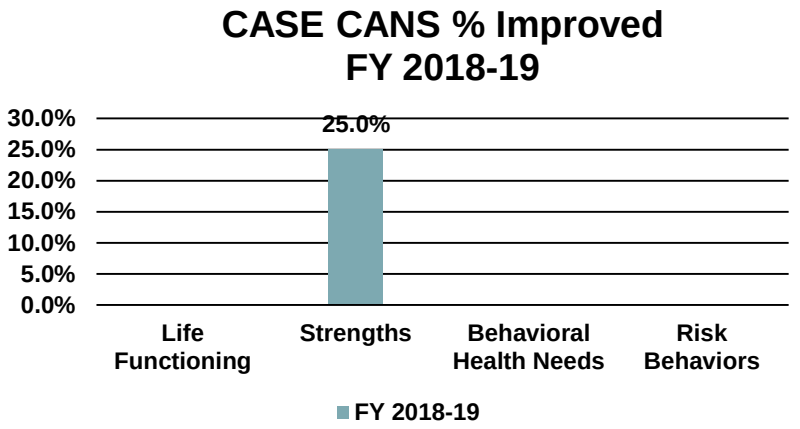
Program Outcome Tools	
Survey Name	Child and Adolescent Needs and Strengths (CANS)
Description of Method	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning. Only those youth connected to a mental health Medi-Cal Provider are required to have a CANS.
Survey Type	Intake, every 6 mo., and discharge
Number Completed	FY 2018-19: 8 FY 2019-20: 18 FY 2020-21: 53

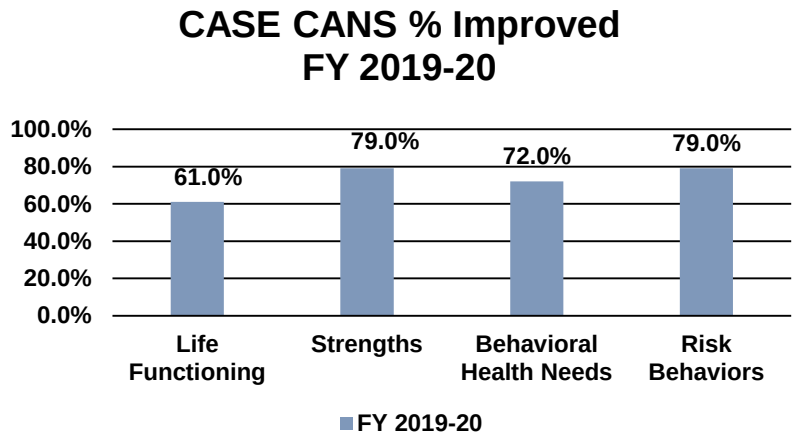
Coalition Against Sexual Exploitation (CASE), cont.

Outcome Discussion, cont. (if needed)

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.

CANS data showed 25% of participants improved in the Strengths domain in FY 2018-19. During FY 2019-20, additional domains were assessed and reported, providing a broader picture of the impact of the CASE program, with 61% of participants improving in the Life Functioning domain, 79% improving in the Strengths domain, 72% improving in Behavioral Health Needs, and 79% improving on Risk Behaviors. Due to challenges associated with data collection during the COVID-19 pandemic, data for FY 2020-21 is not available at this time.





Coalition Against Sexual Exploitation (CASE), cont.

Program Challenges/Solutions

Educating MOU partners, as well as County and Community partners, about CSEC, at-risk behaviors to be aware of, and efforts the community can take to prevent and keep children safe, has been an effective technique.

The education the community partners receive allows them to be the eyes and ears of the program, ensuring that adolescents in need of these resources are referred appropriately.

Due to COVID-19 restrictions, many outreach services were be suspended in FY 2019-20. As a result of this issue, the team implemented innovative strategies to use social media and virtual training options to maintain the momentum that had been built before the pandemic. To retain service delivery flexibility, the CASE team will continue to use a virtual and hybrid approach to community outreach.

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.

Program Updates

CASE is currently being assessed for program expansion in Fiscal Year 2022-23.

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 the specific needs and cultural requirements of individualized communities. Services and activities are offered at non-traditional locations, such as community centers, where other collateral services are also offered. This reduces 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, 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, and 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 2022-23	$3,992,896
Cost Per Client FY 2022-23	$148
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

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 number of services to be provided per year along with the actual numbers of participants served and services provided per year. The Family Resource Centers serve an average of 27,513 participants annually.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	26,945	29,133	30,973	22,434
Number of Services	51,011	54,746	49,967	37,881

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 2018-19	969 total episodes	915 closed episodes
	57% of participants met their treatment goals (523 of 915)	
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)	

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 are able to 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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals Provided	195	68	91
Number of referrals to County-funded / administered programs	191	61	72
Number of referrals to other programs	4	7	19
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	148	15	5

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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals Provided	482	393	119

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.

Types of responders reached:

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 2018-19	FY 2019-20	FY 2020-21
Number of Potential Responders Reached	20,006	21,874	8,992

Previous years have 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 reached was significantly impacted.

Surveys modelled 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.

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 though 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 are able to 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 2018-19	24%	9%	34%	6%	27%
FY 2019-20	22%	9%	51%	3%	15%
FY 2020-21	9%	4%	19%	1%	67%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	1%
FY 2019-20	<1%
FY 2020-21	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	4%
FY 2019-20	2%
FY 2020-21	2%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	14%	25%	<1%	60%
FY 2019-20	11%	25%	<1%	63%
FY 2020-21	12%	30%	<1%	57%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	60%	16%	0%	24%
FY 2019-20	74%	24%	2%	0%
FY 2020-21	71%	16%	11%	2%

Family Resource Center (FRC), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	5%	6%	3%
	American Indian or Alaska Native	0%	1%	0%
	Asian	1%	1%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	2%	2%	22%
	Caucasian/White	14%	16%	15%
	Other Race	12%	18%	8%
	Declined to Answer	24%	19%	51%
Ethnicity	African	2%	1%	0%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	1%	9%	9%
	Hispanic/Latino	20%	38%	22%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	15%	18%	5%
	More than one ethnicity	1%	5%	1%
	Declined to Answer	71%	66%	84%

Demographic Observations

- The FRC program has consistently served the targeted demographics over the last three fiscal years. In Fiscal Years 19-20 and 20-21 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 particular needs and challenges of these populations.
- All current FRC providers have committed to continuing to offer a mix of in-person and telehealth options after the pandemic restrictions are 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 2018-19: 51 FY 2019-20: 49 FY 2020-21: 56	FY 2018-19: 206 FY 2019-20: 231 FY 2020-21: 209	FY 2018-19: 106 FY 2019-20: 115 FY 2020-21: 91	FY 2018-19: 165 FY 2019-20: 149 FY 2020-21: 141

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 through the use of 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 which 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 2018-19	FY 2019-20	FY 2020-21
Life Functioning Domain	49.5%	55.2%	69.6%
Strengths Domain	51.9%	56.9%	69.6%
Behavioral Health Needs Domain	38.2%	49.8%	70.7%

Children and youth participating in the Family Resource Centers 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 2018-19	FY 2019-20	FY 2020-21
Life Functioning Domain			
Family Functioning	78%	87%	80%
Social Functioning	80%	80%	80%
School Achievement	71%	100%	50%
Strengths Domain			
Family Strengths	77%	90%	81%
Interpersonal	90%	100%	63%
Resiliency	82%	100%	94%
Resourcefulness	33%	57%	86%
Behavioral Health Needs			
Depression	86%	100%	87%
Anxiety	100%	88%	84%
Anger Control	100%	100%	80%
Risk Behaviors			
Suicide Risk	50%	100%	100%
Non-Suicidal, Self-Injurious Behavior	100%	N/A	50%

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 Fiscal Year 2020-21 with the COVID-19 pandemic. 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's behavioral health services to support decision making, including 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 2018-19	FY 2019-20	FY 2020-21
Life Functioning Domain	73.7%	78.4%	83.9%
Strengths Domain	57.1%	75.7%	79.6%
Behavioral Health Needs Domain	51.1%	66.2%	77.4%

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 2018-19	FY 2019-20	FY 2020-21
Life Functioning Domain			
Family Functioning	71%	92%	92%
Family Functioning	82%	90%	92%
Decision-Making /Judgment	70%	95%	93%
Parenting Roles	64%	84%	82%
Strengths Domain			
Family Strengths/Family Support	68%	89%	94%
Community Connection	71%	78%	78%
Natural Supports	N/A	89%	89%
Resiliency	68%	92%	97%
Resourcefulness	80%	100%	97%
Behavioral Health Needs Domain			
Depression	79%	90%	95%
Anxiety	76%	91%	94%
Adjustment to Trauma	54%	91%	88%
Eating Disturbances	67%	100%	89%

Eating disorders is an emerging concern. During FY 2018-19, there were nine participants presenting with eating disturbances whereas there were 27 participants during FY 2020-21. 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 2018-19	58%	72%	24%
FY 2019-20	6.26	7.22	15%
FY 2020-21	8.61	9.48	10%

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.

Although we see a decrease of the percentage of improvement over the past three years, down from 24% to 10%, we see a corresponding increase in the average pre and post test scores, indicating a higher level of overall knowledge.

Life Skills Progression (LSP)

Life Skills Progression surveys are developed by considering in-depth information about the family through interviews, conversation, 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 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 basic 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 also 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 2018-19	14.1%	23.8%	7.8%	58.1%	11.8%
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%

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 the majority 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 who provide these resources or provide education and assistance in accessing these resources through virtual and web-based services.

Participant Satisfaction Survey Results

	FY 2018-19	FY 2019-20	FY 2020-21
Improved mental health	48%	93%	87%
Services were helpful	91%	98%	83%
Would participate in the program again	97%	97%	80%
Will use the information in the future to support good mental health	100%	99%	74%
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 a balance in providing safe and effective mental health services in the midst of a pandemic with limited face-to-face interaction. While all of the Family Resource Centers implemented telehealth and distanced-based options for continuing services, some have had more success than others. Many Family Resource Centers found that telehealth options allowed greater access to services through telephone and internet-based sessions because clients had easier access, reduced travel time, and alleviated many transportation-based issues. Other Family Resource Centers have reported that distance-based services are less accessible to participants with technological challenges, lack of reliable and consistent internet resources, as well as a lack of private space to participate in sessions.

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

The FRC program will expand to provide additional FRCs in underserved areas. These areas may include Yucaipa, Fontana, Rancho Cucamonga, Colton, Upland, Big Bear, and Needles. The expansion will also include the introduction of a Family Justice Center to serve system involved children, youth, and TAY, and their families.

Community Wholeness and Enrichment (CWE)

Target Population and Program Description

The Community Wholeness and Enrichment (CWE) program is a categorized as 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 are able to evaluate a participant's risk factors. The screenings also address past 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
Location of Services	Central Valley, Desert/Mountain, East Valley, West Valley
Number of Consumers to be Served	1,751
Annual Budget FY 2022-23	$1,358,669
Cost Per Client FY 2022-23	$776
Services Offered	Screenings/Assessment Case Management, Linkage & Referrals Support Groups (includes suicide bereavement) Mental Health Education Early Intervention Counseling Services

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 used strategies to increase and improve linkage and timely access to services. The program consistently meets or exceeds their target number of unduplicated participants per year.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	2,956	5,570	2,341	3,634
Number of Services	7,809	5,735	5,622	8,306

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.

Prevention Participants / Services			
	FY 2018-19	FY 2019-20	FY 2020-21
Prevention Participants	4,035	1,373	2,588
Number of Services	4,066	1,685	3,160

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.

Program Highlights, cont.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 2018-19	240	200	43%
FY 2019-20	260	200	46%
FY 2020-21	480	319	41%

There was an increase in total number of episodes in Fiscal Year 2020-21. This is due to an increase in the availability of telehealth services due to the COVID-19 pandemic. 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 2019-20. This was due to the transition to virtual outreach during the onset of the COVID-19 pandemic. In FY 2020-21, providers had adjusted and were able to continue providing a similar number of services as FY 2018-19.

Potential Responders Reached			
	FY 2018-19	FY 2019-20	FY 2020-21
Potential Responders	2,755	1,001	2,789

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 one referral to treatment beyond early onset over the last three fiscal years. This participant was engaged in the program to which they were referred eleven days after date of referral.

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 four 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. The referrals made in FY 2019-20 are due to the agencies adjusting to the COVID-19 pandemic protocols.

Improve Timely Access to Services			
	FY 2018-19	FY 2019-20	FY 2020-21
Number of Referrals	0	4	0
Participants Engaged	0	2	0
Average # of Days Participant Engaged	0	6.5	0

Within the Improve Timely Access strategy, CWE providers served the following underserved populations:

Underserved Populations	
• Trauma-exposed • Co-occurring • Justice-involved • TAY age foster children	• LGBTQ+ • Homeless • African-American • Latinx

Suicide Prevention

One primary focus of the CWE program is to provider supports 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.

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 4,702 participants in suicide prevention over the last three fiscal years.

Suicide Prevention Trainings			
	FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	3,695	665	342

Community Wholeness and Enrichment (CWE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2018-19	0%	33%	38%	7%	22%
FY 2019-20	1%	22%	57%	12%	8%
FY 2020-21	6%	30%	35%	0%	29%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	1%
FY 2019-20	3%
FY 2020-21	1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	2%
FY 2019-20	5%
FY 2020-21	3%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	14%
FY 2019-20	15%
FY 2020-21	9%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	26%	41%	0%	33%
FY 2019-20	24%	53%	3%	20%
FY 2020-21	27%	53%	1%	19%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	67%	15%	0%	18%
FY 2019-20	75%	11%	3%	11%
FY 2020-21	90%	7%	0%	3%

Community Wholeness and Enrichment (CWE), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	8%	9%	5%
	American Indian or Alaska Native	3%	1%	1%
	Asian	2%	2%	2%
	Native Hawaiian or Pacific Islander	0%	0%	1%
	More than One Race	5%	18%	9%
	Caucasian/White	34%	31%	24%
	Other Race	18%	24%	21%
	Declined to Answer	30%	16%	29%
Ethnicity	African	2%	1%	2%
	Asian Indian/South Asian	0%	1%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	1%	1%
	Eastern European	3%	1%	0%
	European	4%	13%	14%
	Hispanic/Latino	31%	28%	29%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	0%	0%
	Vietnamese	0%	0%	0%
	Other	6%	1%	3%
	More than one ethnicity	5%	7%	7%
	Declined to Answer	77%	19%	23%

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 to 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 commonly diagnosed mental illnesses.

Community Wholeness and Enrichment (CWE), cont.

Program Goals

The primary objective of the CWE program is to address mental health disorders early on in their development by utilizing prevention and early intervention services to avert or lessen the severity of a mental illness.

While prevention and early intervention can be implemented throughout a person's lifetime, the benefits are greatest when young people are targeted at or near the onset of mental health disorders.

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 on 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 2018-19: 120 FY 2019-20: 142 FY 2020-21: 291

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.

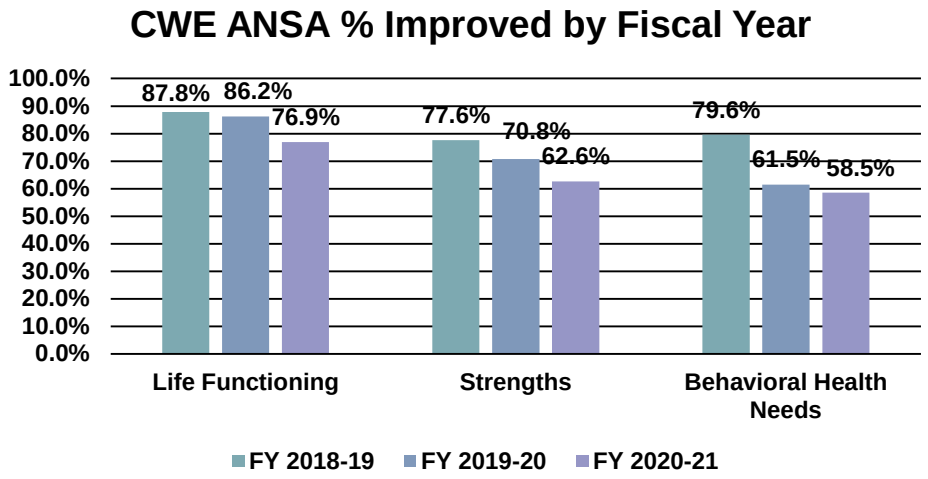
ANSA is an information integration tool for adults with behavioral health challenges. The tool is used to support individual case planning and the planning and evaluation of service systems. When the ANSA is administered, each of the dimensions is rated on its own four-point scale. The ANSA is administered at intake and at six month intervals until discharge.

The ANSA measures the readiness of early intervention participants to engage in services. 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, 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. These factors were influenced by the strain and isolation caused by the COVID-19 pandemic restrictions.

These challenges contributed to the gradual decrease over the three 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.



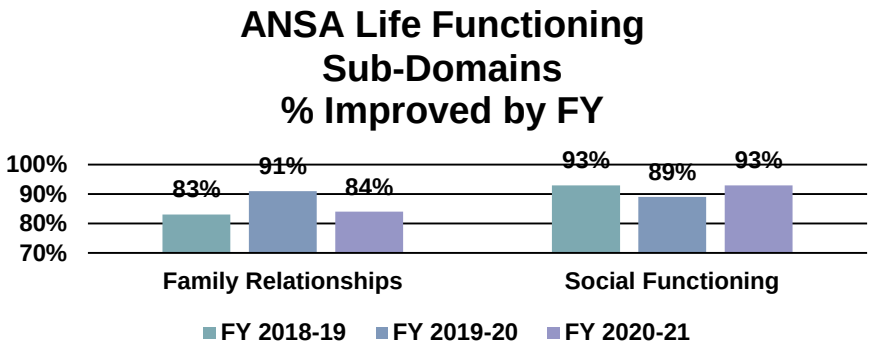
Community Wholeness and Enrichment (CWE), cont.

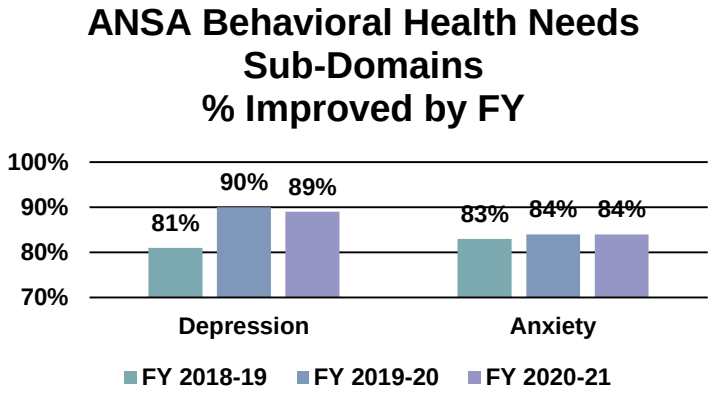
Outcome Discussion, cont.

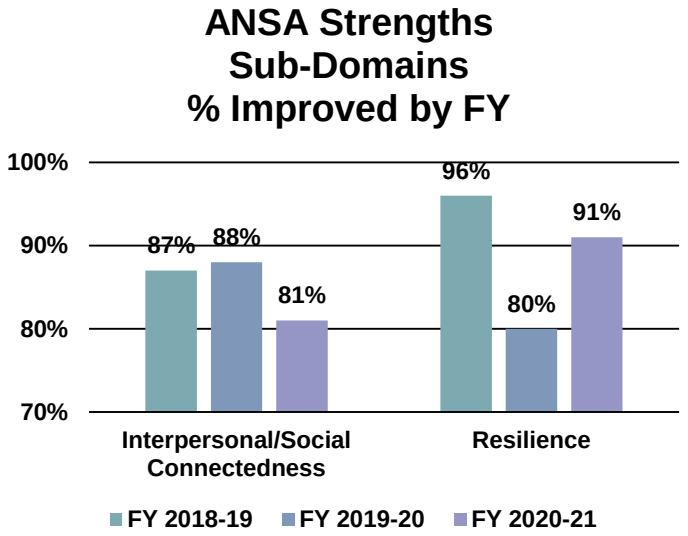
Each domain contains sub-domains that measure:

- 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 family members, especially with the suicide bereavement groups which provide support to those who have lost a loved one to suicide. Through stakeholder feedback, CWE providers have discovered the community found the groups settings intimidating.

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 in regards to suicide of a loved one. The CWE program will continue to advocate for the importance of attending a suicide bereavement group for survivors of those who have died by suicide.

Lessons Learned

PEI has learned that over the last three fiscal years, 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.

Additionally, in Fiscal Year 2020-21, there were challenges with the implementation of the new PEI database system, making data collection and aggregation difficult. The providers are now only entering their data into the PEI database system.

Program Updates

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

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 is able to offer and assure confidential services. These services are offered in any setting which makes the participant comfortable. This 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	3,605
Annual Budget FY 2022-23	$748,567
Cost Per Client FY 2022-23	$208
Services Offered	Mental Health Education Mental Health/Substance Use Disorder screenings Case Management and Referrals Psychoeducation Counseling Services Suicide Prevention

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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	3,605	3,983	5,377	6,050
Number of Services	6,990	7,625	9,345	10,718

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 2018-19	FY 2019-20	FY 2020-21
Prevention Participants	1,969	2,976	3,329
Number of Services	3,946	5,125	5,138

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 increase in total episodes in Fiscal Year 2020-21. This could be attributed to an increase in the availability of telehealth services.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 2018-19	161	84	40%
FY 2019-20	174	75	61%
FY 2020-21	301	95	38%

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 their friends and family, as well as within themselves.

Potential Responders Reached			
	FY 2018-19	FY 2019-20	FY 2020-21
Potential Responders	1,191	1,695	2,453

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Community service providers • Families • Military personnel/veterans • School personnel • Leaders of faith-based organizations • Peer providers • Consumer family members	• Community events • Hospitals • Social media outreach • Faith-based organizations • Schools • Military facilities • 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, as early in the onset of these conditions as possible, to care and treatment that will meet their needs.

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 are able to 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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals	17	18	9
County-Funded	17	17	8
Non-County Funded	0	1	1
Participants Engaged	16	18	9

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 four 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 2018-19	FY 2019-20	FY 2020-21
Number of Referrals	204	126	171
Participants Engaged	167	117	83
Average # of Days Participant Engaged	2.55	4.08	3.12

Underserved Populations

- Trauma-exposed
- Co-occurring
- Justice-involved
- 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	26-50	60+	UNK
FY 2018-19	17%	11%	54%	8%	10%
FY 2019-20	18%	7%	54%	6%	15%
FY 2020-21	1%	2%	7%	1%	89%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	24%
FY 2019-20	18%
FY 2020-21	5%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	1%
FY 2019-20	1%
FY 2020-21	1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	8%
FY 2019-20	5%
FY 2020-21	1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	22%	22%	1%	55%
FY 2019-20	13%	17%	0%	70%
FY 2020-21	3%	8%	0%	89%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	100%	0%	0%	0%
FY 2019-20	100%	0%	0%	0%
FY 2020-21	74%	0%	0%	26%

Military Services and Family Support (MSFS), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	8%	5%	4%
	American Indian or Alaska Native	1%	6%	0%
	Asian	1%	2%	0%
	Native Hawaiian or Pacific Islander	1%	1%	0%
	More than One Race	7%	6%	1%
	Caucasian/White	41%	31%	10%
	Other Race	12%	12%	3%
	Declined to Answer	26%	43%	86%
Ethnicity	African	1%	3%	0%
	Asian Indian/South Asian	0%	2%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	3%	1%	0%
	Hispanic/Latino	13%	16%	4%
	Filipino	1%	2%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	2%	1%	1%
	More than one ethnicity	2%	1%	0%
	Declined to Answer	78%	84%	68%

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.
- In the last three fiscal years, the MSFS program lifted its restriction on providing services to those who served on or after 9/11. The program is now available to any participant with military service and/or their families.
- The largest age group served consistently was the adult population. This would align with the program's goal of serving those with military service.

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:

- 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.
- 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 2018-19: 28 FY 2019-20: 108 FY 2020-21: 42	FY 2018-19: 31 FY 2019-20: 22 FY 2020-21: 5

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.

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.

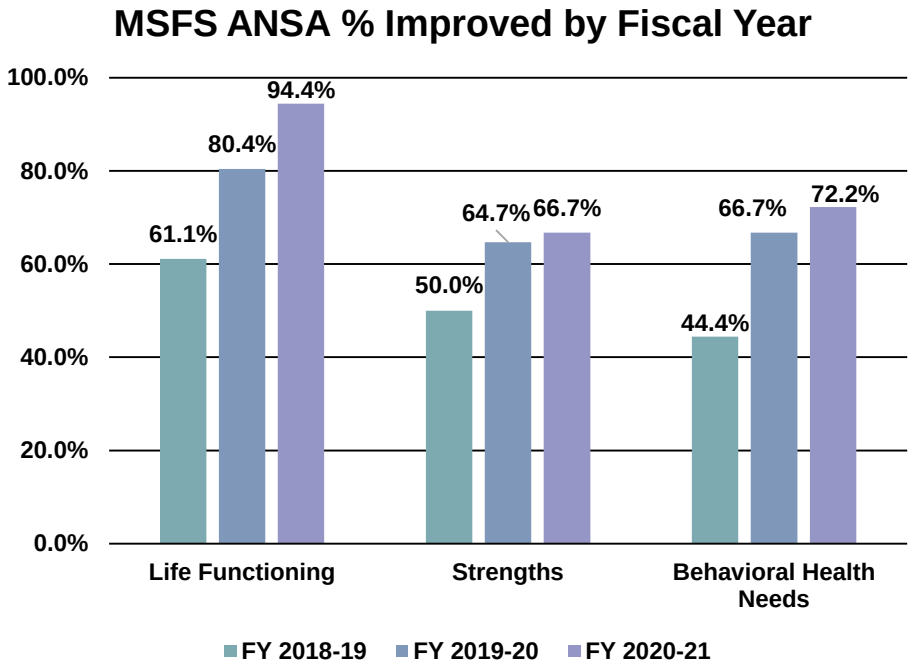
An improvement in these domains leads to improved recovery including emotional and relational functioning. These improvements reduce the prolonged suffering related to an untreated mental health concern.

These sub-domains are used to measure the specific service needs of each individual.

The Life Functioning Domain saw a steady increase over the three year period. Increasing an average of 16% per year.

The strengths improved remained steady at approximately 60% each year.

Behavioral Health needs increased as more people accessed early intervention services during the COVID-19 pandemic.



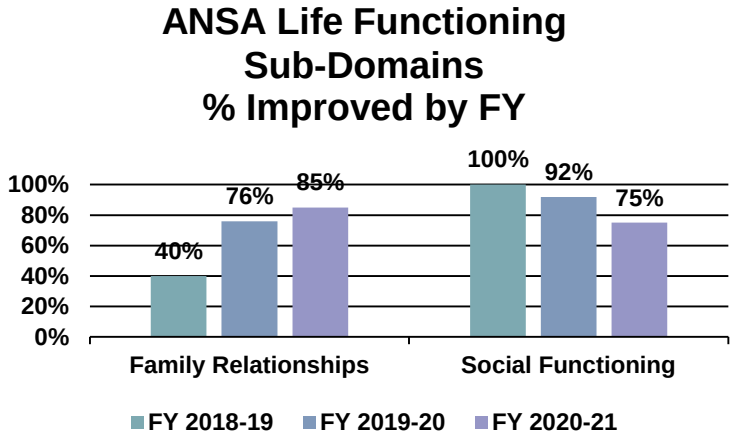
Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

Each domain discussed earlier includes subdomains 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.

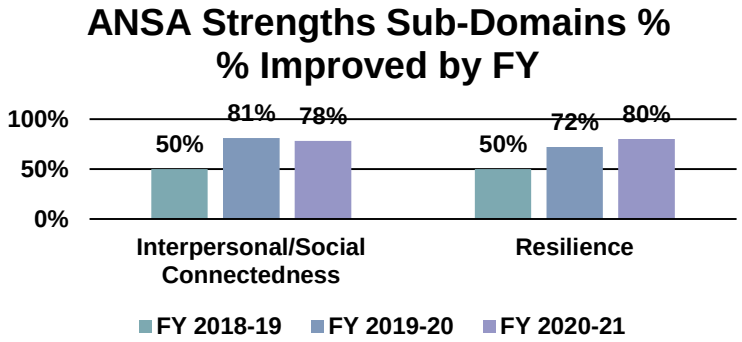


In the domain of Strengths, the sub-domain of interpersonal/social connectedness measures a participant's social and relationship skills. An improvement in this domain indicates the participant had a need to increase social functioning to avoid unhealthy isolation.

The domain of resilience measures a participant's ability to recognize their own internal strengths and use them to manage their daily life. Improvement in this domain indicates the participant was unable to identify their personal strengths, and/or utilize them effectively.

The Interpersonal/Social Connectedness drastically improved from year one to year two. It decreased slightly in year three due to the impact of the COVID-19 public health crisis.

The Resilience subdomain steadily improved over the three year period. This demonstrates the effectiveness of early intervention services on MSFS participants' abilities to identify and utilize their personal strengths.

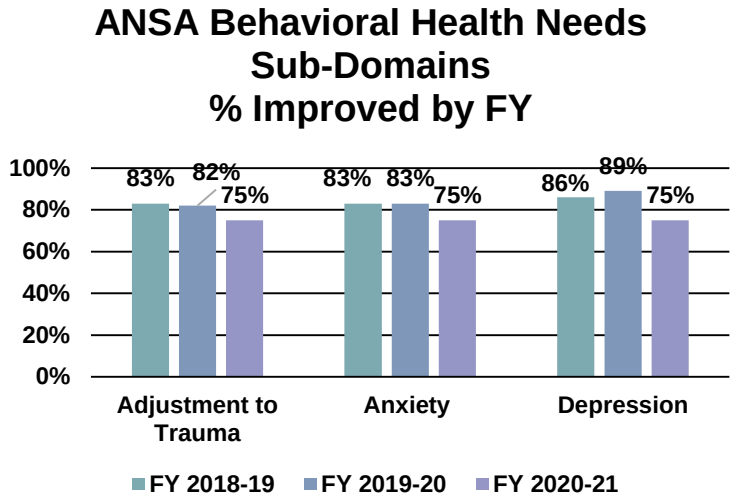


Military Services and Family Support (MSFS), cont.

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.

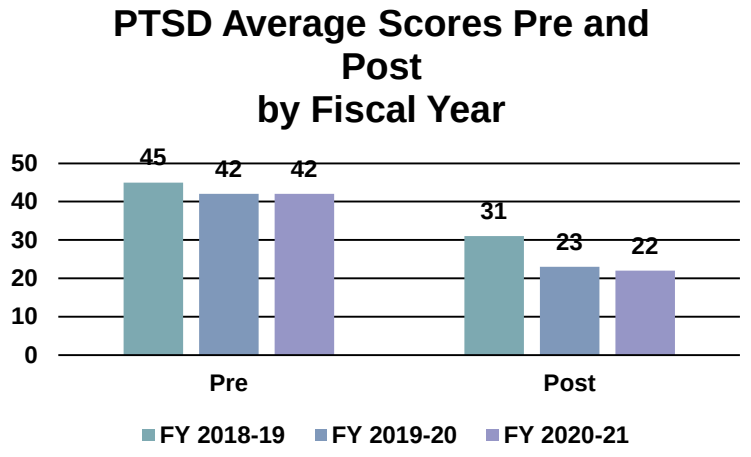
The anxiety sub-domain rates the symptoms of anxiety as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Improvement in this domain indicates a participant improved anxiety symptoms such as excessive fear and anxiety related to behavioral disturbances.

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 assesses 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 43 points out of a total of 85 on the PCL-M. At the end of treatment, on average participants scored 25 points, indicating a significant reduction in total symptom severity.



Military Services and Family Support (MSFS), cont.

Program Challenges/Solutions

The most persistent challenge to the MSFS program over the last three fiscal years has been the need for referral resources for psychiatric treatment services. Psychiatric providers are geographically unavailable, or they do not accept military health insurance, or have long waitlists for appointments, so it can be difficult to receive the necessary therapeutic services for those who require a higher level of care.

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.

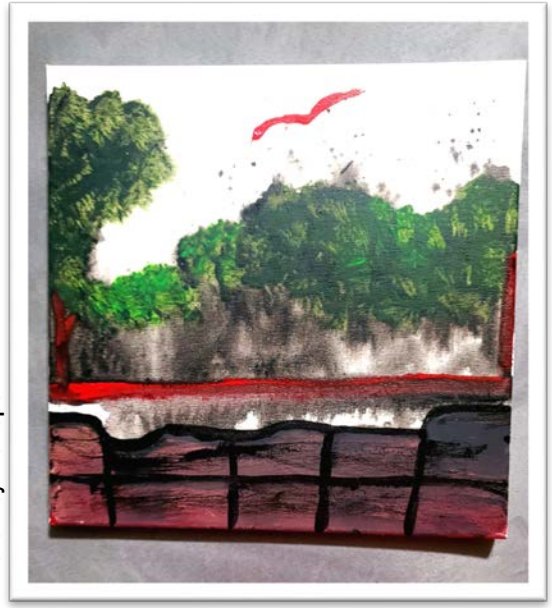
Lessons Learned

Over the last three fiscal years, PEI has discovered the process of handling MSFS data within the agencies has made it difficult to retrieve and evaluate. In the future, providers will improve their data handling methods so that it is more easily accessible to them and DBH.

In addition, there were challenges with the introduction of the new PEI database system in Fiscal Year 2020-21, making data collecting and aggregation challenging. The providers are now only entering into the PEI database, resolving this issue.

Program Updates

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



Artwork by Bre Lopez

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 supports 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, 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, and 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	15,381
Annual Budget FY 2022-23	$4,398,703
Cost Per Client FY 2022-23	$286
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

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 supports. 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 supports.

The SAP falls into the State Prevention and Early Intervention Program reporting structure. The program includes both prevention and early intervention activities to provide student 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 afterschool 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 relationship
- Psychoeducational/social skill building
- Grief Processing / Critical Incident Debriefing
- Suicide prevention

The chart below compares the total number of unduplicated participants and 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 the reporting due the implementation of distance learning.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	15,381	30,349	12,766	9,147
Number of Services	20,682	32,425	30,705	20,378

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 2018-19	FY 2019-20	FY 2020-21
Unduplicated Participants	919	927	805
Total Services	9,086	12,252	9,654

SAP early intervention services rely heavily on school site referrals originating from prevention services. When schools transitioned to distance learning, the prevention services were temporarily suspended. The result was a slight decline in participants in the last reporting year.

The chart below provides an overview of client's success. Data shows their treatment plans drop slightly over the last three fiscal years. Client were being displaced during the pandemic and moving out of their program service area causing interruption in services. Some clients did not have 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 2018-19	FY 2019-20	FY 2020-21
Treatment Successful	62%	58%	52%
Treatment Partially Successful	15%	11%	13%
Treatment Not Successful	20%	21%	26%
Missing or Other	3%	5%	9%

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 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 2018-19	72%	16%	7%	1%	5%
FY 2019-20	69%	7%	17%	1%	6%
FY 2020-21	34%	6%	28%	1%	31%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2018-19	<1%
FY 2019-20	<1%
FY 2020-21	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2018-19	0%
FY 2019-20	<1%
FY 2020-21	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2018-19	1%
FY 2019-20	<1%
FY 2020-21	<1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2018-19	48%	51%	0%	2%
FY 2019-20	42%	51%	1%	6%
FY 2020-21	16%	32%	0%	51%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2018-19	89%	6%	1%	4%
FY 2019-20	85%	8%	0%	7%
FY 2020-21	74%	3%	0%	22%

Student Assistance Program (SAP), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2018-19	FY 2019-20	FY 2020-21
Race	African-American/Black	8%	10%	13%
	American Indian or Alaska Native	2%	5%	1%
	Asian	2%	1%	2%
	Native Hawaiian or Pacific Islander	0%	1%	1%
	More than One Race	9%	5%	6%
	Caucasian/White	23%	21%	28%
	Other Race	22%	25%	9%
	Declined to Answer	33%	33%	41%
Ethnicity	African	3%	1%	3%
	Asian Indian/South Asian	2%	0%	1%
	Cambodian	1%	0%	0%
	Chinese	1%	0%	0%
	Eastern European	3%	0%	0%
	European	5%	1%	2%
	Hispanic/Latino	47%	44%	31%
	Filipino	5%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	1%
	Vietnamese	1%	0%	0%
	Other	61%	4%	4%
	More than one ethnicity	0%	2%	8%
	Declined to Answer	18%	0%	80%

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 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 goals is to reduce symptoms and improve recovery, including mental and relational functioning.

The SAP program is designed to meet the State 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 2018-19: 477 FY 2019-20: 766 FY 2020-21: 489
Behavior Assessment Form (BAF)	The BAF includes a series of questions that indicate if the client struggles behaviorally using a Likert scale. The BAF is completed by a school official. This tool is used to evaluate the progress that the client makes as a result of participating in a skill building group. This tool can also be used to determine the effectiveness of the evidence-based curriculum/services provided.	1st and last day of group services	FY 2018-19: 208 FY 2019-20: 157 FY 2020-21: 78
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 2018-19: N/A FY 2019-20: 108 FY 2020-21: 67
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 2018-19: 1,273 FY 2019-20: 367 FY 2020-21: 237

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.

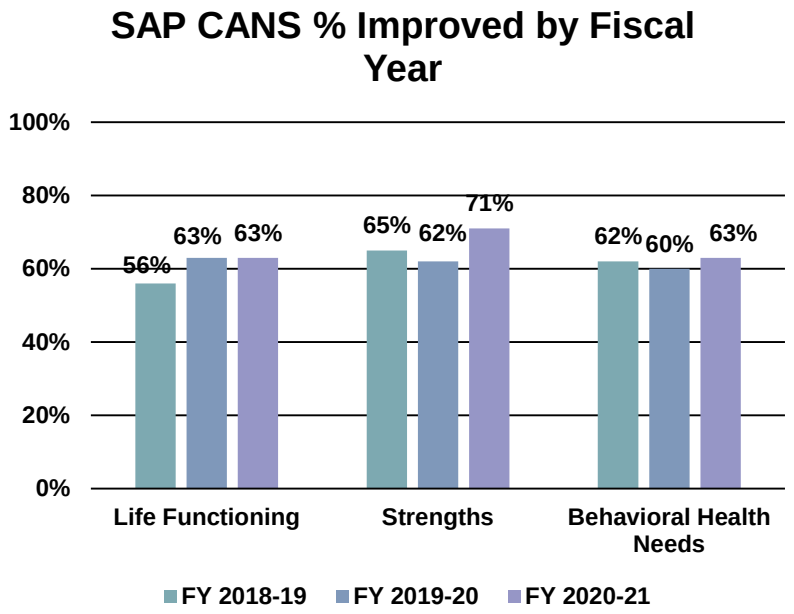
Within the first 30 days of receiving assistance, children and TAY receive the initial CANS-SB assessment. Every three to six months, follow-up assessments are conducted, and a final assessment is completed at the conclusion of services.

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, participants of the SAP program.

The results demonstrate consist success of approximately 63% all three domains. The increase leads overall improvement in reducing symptoms and recovery, including mental and relational functioning.



Student Assistance Program (SAP), cont.

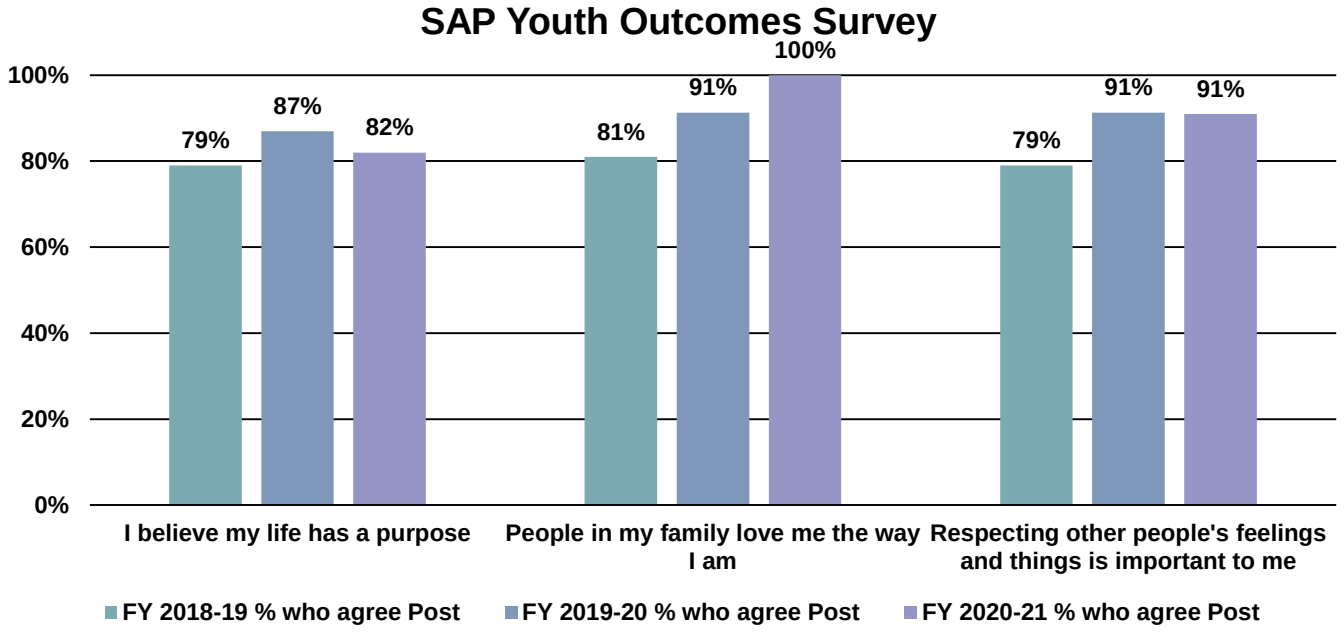
Outcome Discussion, cont.

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.

At post-test, an average of 83% of participants agreed that they believe their life had a purpose. This increase reduces the potential for suicidal ideations as well as identifying personal strengths that lead to resiliency.

An even higher percentage feel that they are fully supported by their family. On average, 91% per year feel that they are accepted by those people that are closest to them. Increasing the feeling of acceptance strengthens the family bonds and provides strong supportive circles they can rely on.

Approximately 87% agree that respecting other people's feelings and things are important to them. This awareness leads to a healthier personal development.



Student Assistance Program (SAP), cont.

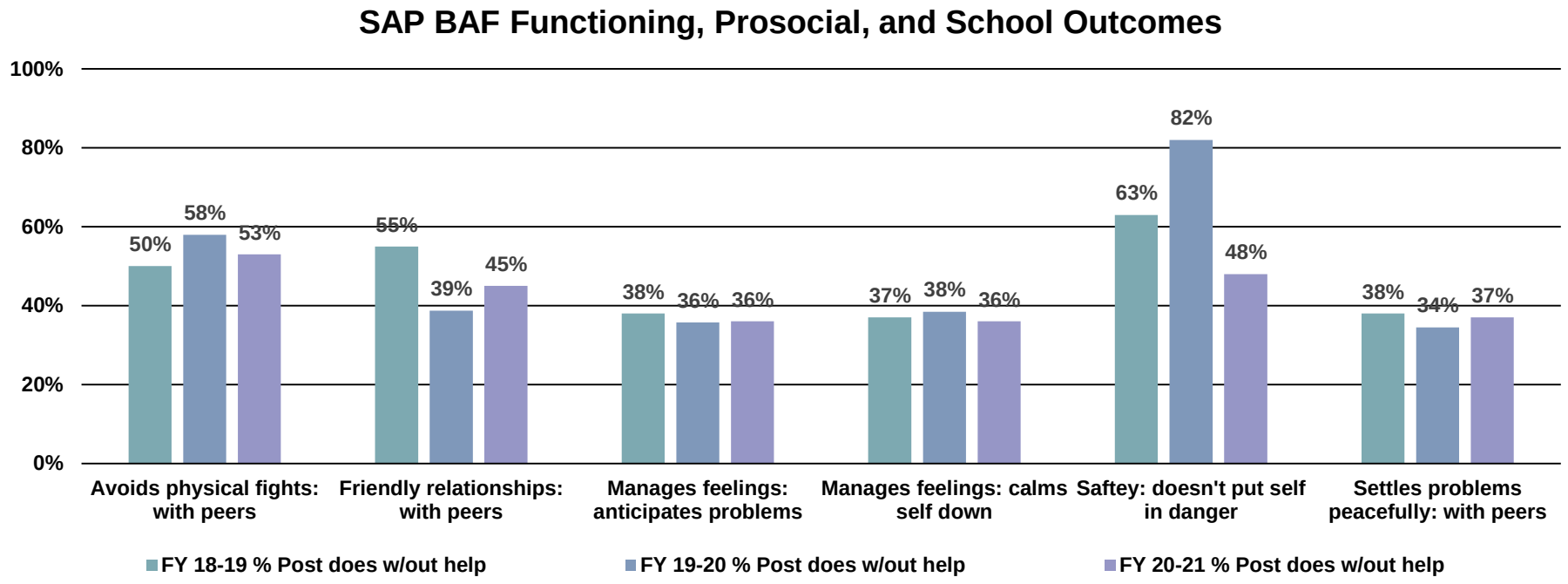
Outcome Discussion, cont.

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.

The overall results were lowest with those who experienced issues with managing their feelings. There was only an average of 37% improvement for those who felt they could manage their feelings when it came to anticipating problems or calming themselves.

The largest improvement appears in the safety category. There was a significant increase in year two of this reporting period. Since the schools transitioned to distance learning there has been a spike in suicide risks in this age group. This led to the large dip in improvement scores.

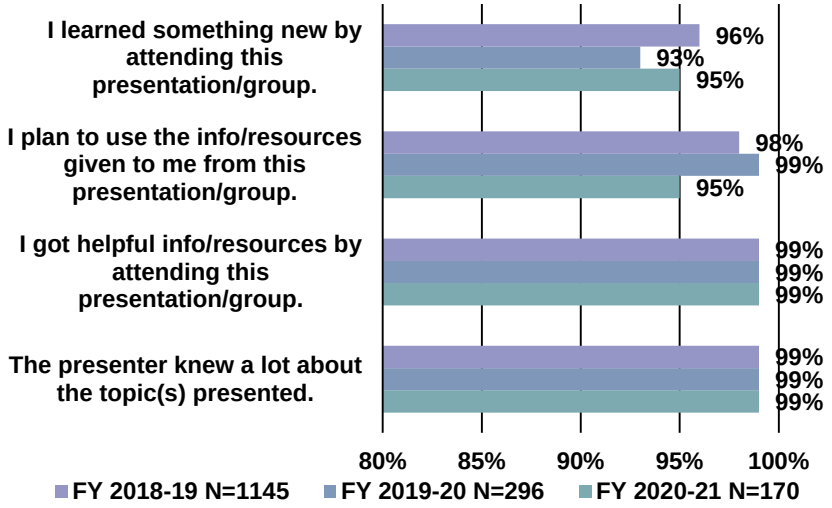


Student Assistance Program (SAP), cont.

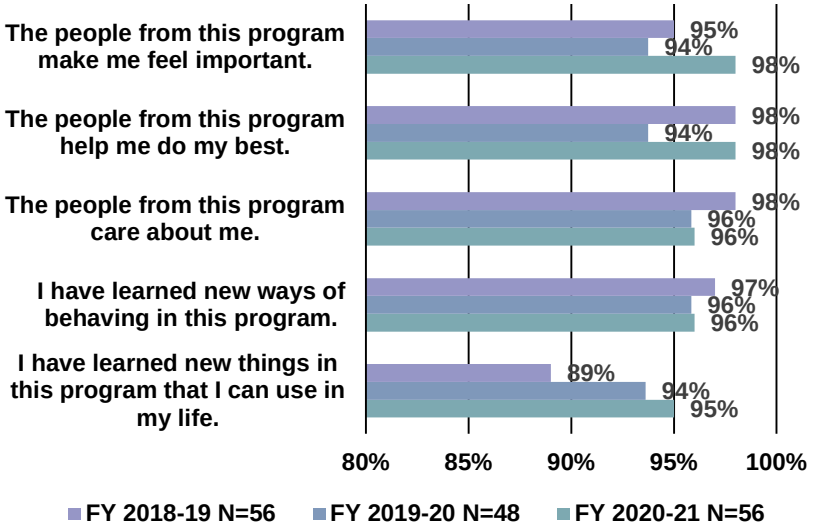
Client Satisfaction Surveys

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.

SAP PEI Survey



SAP Child Satisfaction Results



The PEI survey results show that the majority of those who participated in a SAP presentation agreed that they learned something new.

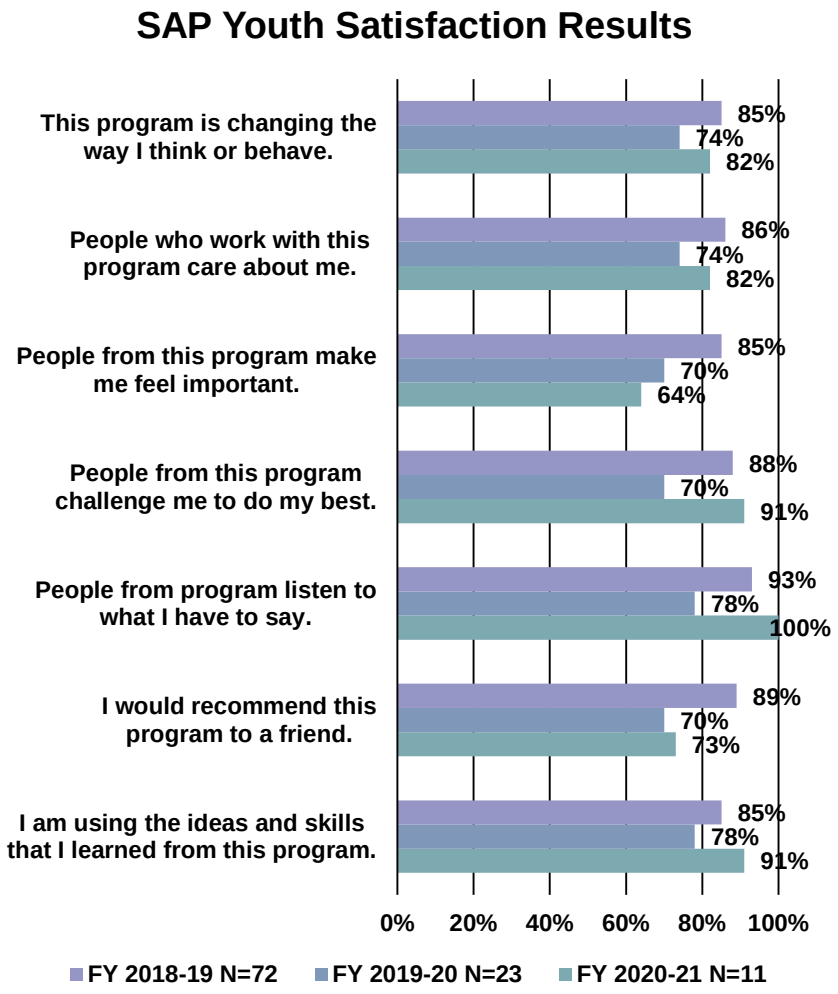
Over 95 % agreed that the information they received was helpful, and they plan on using the information/resources provided.

The Child Satisfaction survey relates to 3rd to 5th grade students who participated in the SAP program.

The majority of students agreed that the SAP staff made them feel important and cared about. In addition, participants agreed that they learned new ways of behaving as a result of the program, and that they learned new things that they can use in life.

Student Assistance Program (SAP), cont.

Client Satisfaction Surveys, cont.



The SAP Youth Satisfaction survey shows that the majority of the youth who participated in the SAP program agreed that they felt program staff cared about them and made them feel important.

In addition, the respondents indicated 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.

Lastly, the majority agreed they would recommend the program to a friend.

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 supports 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 FY 2018-19, SAP program providers had a hard time finding appropriate space on school campuses to provide confidential and non-stigmatizing services. This problem was exacerbated in Fiscal Years 2019-20 and 2020-21 with 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.

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

Early Psychosis Care Program (EPC)

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 Early Psychosis Care (EPC) program is to identify patients at clinical 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 EPC seeks to serve a total of 125 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	125
Annual Budget FY 2022-23	$1,000,000
Cost Per Client FY 2022-23	$8,000
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

Early Psychosis Care Program (EPC)

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.

EPC Updates:

As stated in the previous annual update the original structure and scope of the EPC program introduced in the FY 2020-21 Three Year Integrated Plan has been modified as a result of stafing and hiring challenges realted 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 timelines 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 updated from 105 participants per year to 125 participants per year.
- The EPC 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 coordination of referrals and development of trainings and workshops that aim to build the Department's and partnering agencies capacity to identify and 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.

Early Psychosis Care Program (EPC)

The EPC program will be developed through the following phases:

The EPC 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 trainings and workshops to program staff within the DBH infrastructure.

Trainings will be provided to:

- Prevention and Early Intervention program providers
- TAY program administrators
- Premier program staff.

For more information, please reference the MHSA 3-Year Plan (pgs. 59-63).

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	$154,126
Cost Per Client FY 2022-23	$45
Services Offered	Medication Assisted Treatment (MAT) Substance Use Disorder Services Referrals Behavioral Health Services Referrals Community Education and Awareness

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. Intense prevention and intervention responses from government and health care began in 2013 and have continued to grow in complexity, dimensions, and scope up to now. 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. This growth was vital.

Local data from both Inland Empire counties indicate a similar trend, with the spike of opioid-related deaths in Riverside County between 2018 and 2019 to be more severe. This disturbing rise speaks to the continuous value of the IEOCC, as well as its ability to keep adapting as the make-up of the opioid crisis shifts. Growing evidence points to this recent increase of rate in opioid deaths being caused by the presence of fentanyl, which means a different, more harm-reduction informed approach (e.g., assuring safe drug use by testing for the presence of fentanyl) is needed for effective overdose prevention efforts.

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 goals and strategies for the IEOCC program will address the following risk factors:

- Lack of access to reduction and recovery community services, treatment, including Medication-Assisted Treatment and other harm.
- Decrease in customer stigma at the pharmacy level and continued opioid medication treatment access.
- Reduce continued opioid overdose through prevention efforts, such as education and early intervention services.
- Lessen the lack of information, prevention services and early intervention services by promoting notices about available opioid resources.

The program focus will be 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.

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.

The significance of harm reduction and lessening stigma at the pharmacy level could be especially helpful to participants. Pharmacy Partnerships for Harm Reduction, will address this challenge with a multi-pronged stigma reduction campaign.

In addition, the IEOCC program will allow San Bernardino County Substance Use and Recovery Services (SUDRS) direct access and coordination of ongoing continued conversation across sectors within the Inland Empire with improved collaboration and information-sharing across counties and disciplines.

Inland Empire Opioid Crisis Coalition (IEOCC), cont.

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 Overview

Program implementation with San Bernardino County SUDRS taking the lead, is planned to be a gradual process; the warm-hand off will begin in January of 2022, with the goal of DBH's full implementation accomplished by April 2022. Program staffing will include a Program Manager I, Media Specialist II and an Alcohol and Drug Counselor.

DBH will continue with current services and efforts currently in place by the IEOCC. Referrals to current DBH Mental Health and Substance Use programs will be provided based on request. These preventative and early intervention services will also be available to family members. Intervention or treatment will be available throughout San Bernardino County and will be delivered by DBH, Community-Based Organization, and Contracted service providers.

Services will include the following:

- Medication-Assisted Treatment (MAT) and other Harm Reduction and recovery community services; with a focus on methamphetamine while keeping the primary emphasis on opioids.
- Substance Use and Mental Health services referrals on a 24-hour basis through our Substance Use Disorder Screening, Assessment, and Referral Center (SARC) and Access County operated programs.
- Outreach and Education to pharmacies and the community at large regarding opioid medication and treatment resources.
- Opioid overdose monitoring with the use of an opioid dashboard.

Inland Empire Opioid Crisis Coalition (IEOCC), cont.

Program Overview cont.

The following strategies will be used toward reaching participants:

- Media campaigns specifically targeted to opioid prevention and intervention.
- Written flyers about opioid resources and referral processes.
- In person community presentations and trainings via IEOCC members and their network.
- Recruitment of additional partner agencies.

IEOCC planned activities and targets are as follows:

- Conduct quarterly meetings.
- Establish a website with extensive professional and community resources and news reaching 1,000 stakeholders annually,
- Create a member's section for meeting materials and internal resources and documents.
- Issue a monthly newsletter, with distribution to over 800 individuals.
- Increase social media presence, reaching 600 stakeholders annually.
- Host special events: townhalls, webinars, presentations to professional, educational, and community audiences with the target of engaging 1,000 stakeholders annually.
- Provide member organizations support and spread strategies across services and sectors, and between the two counties.
- Select and allow the core leadership group to continue participation in the statewide California Overdose Prevention Network (COPN) technical assistance and peer learning activities.
- Ensure the Steering Committee and coalition members support each other and the coalition in seeking and securing grant funding for their efforts.

Measures of Effectiveness:

Data collection/analysis can be a key resource in understanding the extent of the opioid crisis in the Inland Empire and will be used ongoing to monitor effectiveness. The IEOOC Program will utilize multiple strategies and data tracking to measure outcomes by tracking and measuring:

- Meeting attendance.
- Number of community meeting presentations and measured learning.
- Number of professional webinars and measured learning.
- Track number of substance use disorder and behavioral health treatment referrals.
- Continue with current data collection processes.
- County real-time opioid dashboard data collection and annual county report through the California Opioid Dashboard.
- Social media and website analytics including follows, video views and impressions.

Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is 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. There are seven Full Service Partnership (FSP) Programs contained in the FSP section and two FSP programs as part of Homeless Services, Long-Term Supports, and Transitional Care programs. FSP programs provide "whatever it takes" services.

Peer Support Programs are consumer driven and feature a lived experience perspective. The goal of all CSS programs is providing 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: Diversion Programs • A-6: Crisis System of Care Programs
Crisis Stabilization Continuum of Care • A-4: Crisis Walk-In Centers (CWIC)/Crisis Stabilization Units (CSU) • A-10: Crisis Residential Treatment (CRT) – Adult – Transitional Age Youth (TAY)
Peer Support Programs • A-1: Clubhouse and Community Connections
Outreach, Access, and Engagement Programs • A-9: Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services • A-15: Recovery Based Engagement Support Teams (RBEST)
Full Service Partnerships • C-1: Comprehensive Children and Family Support Services (CCFSS) • C-2: Integrated New Family Opportunities (INFO) • TAY-1: Transitional Age Youth (TAY) One Stop Centers • A-2: Adult Criminal Justice Continuum of Care • 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 (FSP)

Crisis System of Care

Introduction

The primary goal of Crisis System of Care programs is 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 in need of additional crisis services within a short timeframe.

Crisis System of Care (CSOC) programs serve MHSA populations utilizing system development strategies that help develop 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 provided by these programs are prompted by calls from the community, agency partners, or consumers experiencing a behavioral health crisis and facilitate access to walk-in clinics and centers, stabilization units, and crisis residential facilities in an effort to divert from psychiatric hospitalization when a more appropriate level of care is available.

Programs under the CSOC are:

- Diversion Programs
  - Triage Transitional Services (TTS)
  - Triage, Engagement, and Support Teams (TEST)
- Crisis System of Care Programs
  - Community Crisis Response Team (CCRT)
  - Crisis Intervention Training (CIT)

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 287-291.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by age and service category for Fiscal Year 2022-23:

	Program Name	Fiscal Year	Ages Served	Service Category*
Diversion Programs	Triage Transitional Services	2022-23	300 TAY 1,300 Adult 100 Older Adult	1,700 GSD
			TOTAL = 1,700	TOTAL = 1,700
	Triage, Engagement, and Support Teams	2022-23	550 Children 800 TAY 1,600 Adult 500 Older Adult	2,700 GSD 750 O&E
			TOTAL = 3,450	TOTAL = 3,450
Crisis System of Care Programs	Community Crisis Response Team	2022-23	6,903 Children 5,050 TAY 7,425 Adult 1,350 Older Adult	4,003 GSD 16,725 O&E
			TOTAL = 20,728	TOTAL = 20,728
	Crisis Intervention Training	2022-23	300 TAY 1,600 Adult 100 Older Adult	2,000 O&E
			TOTAL = 2,000	TOTAL = 2,000

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Triage Transitional Services (TTS)

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Triage Transitional Services	1,916	1,400	$7,193,303*	$2,116*

*Annual budget and cost per client represent both TTS and TEST.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18+	SMI*	Clinic-based	Experiencing a behavioral health crisis

*SMI = serious mental illness

Target Population and Program Description

Triage Transitional Services (TTS) 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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 292-305.

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

Consumer Demographics Highlights FY 2020-21

Age

0% Children
15% TAY
71% Adult
4% Older Adult
10% Unknown

Language

98.4% English
1.2% Spanish
0.2% Other
0.2% Unknown

Gender Identity

66% Male
34% Female

Race/Ethnicity

23.83% African-American/Black
2.01% Asian/Pacific Islander
30.45% Caucasian/White
39.35% Latinx/Hispanic
0.45% American Indian/Alaska Native
1.10% Multiple Races/Other

N=1,916

Positive Results

In Fiscal Year 2020-21, TTS staff served a total of 1,916 consumers. A total of 988 (52%) of those consumers were diverted from unnecessary hospitalization

Challenges and Solutions

Over the past year, the TTS program has experienced staffing challenges related to the COVID-19 pandemic. Program staff have been experiencing low morale and anxiety as they are required to meet with consumers from a highly at-risk population for in-person services. Additionally, staff members encountered a high number of severe substance related issues and decreased community resources due to COVID-19 community precautions.

The TTS program was provided with Personal Protective Equipment (PPE) by DBH to ensure staff safety. Supervisory staff encouraged staff wellness as a high priority to keep morale as high as possible throughout the pandemic spikes.

Challenges and Solutions (cont.)

In addition, Supervisory staff remained transparent and provided up-to-date information to the staff to ensure everyone was well-informed. TTS staff continuously reached out to community partners to gain new resources, 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 any time TTS will be diverting a consumer to the CSU for follow up services.

Outreach and Engagement

For Fiscal Year 2020-21, a combined total of 233 participants attended three health fairs where staff members from the TTS program were available to discuss their program and offer resources.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

- **1%** Anxiety disorders
- **10%** Bipolar disorders
- **20%** Depressive disorders
- **1%** None/deferred
- **53%** Psychosis disorders
- **4%** Substance use disorders
- **11%** Other

N=1,916 (as reported by program)

Program Updates

The Triage Transitional Services (TTS) program has been expanded to provide discharge planning and act as a liaison for discharge planning at each of four (4) contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County: San Bernardino, Joshua Tree, Victorville, and Fontana, with plans to include co-location within the Transitional-Age Youth (TAY) CRT in San Bernardino. TTS works collaboratively with CRT staff to provide services intended to divert and reduce psychiatric inpatient hospitalization, assist consumers with maintaining self-sufficiency, increase housing stability, and assist consumers with successfully reintegrating into the community.

TTS Clinical Therapists are co-located at each CRT site to provide the following services:

- Screening for discharge services
- Assessments
- Discharge planning
- Placement assistance
- Transportation

In Fiscal Year 2020-21, these expanded services assisted a total of 404 consumers.

- 346 (85%) remained in the CRT program long enough to receive discharge services
- 256 (74%) successfully discharged to safe and sustainable community placements.

The Placement After Stabilization program, which falls under the TTS umbrella within MHSA, will be expanding to provide for a Mental Health Specialist (MHS) position, deemed a "Placement Navigator", which will navigate the ongoing placement needs for consumers in time limited emergency shelter housing which require immediate case management services.

Program Updates (cont.)

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.

Success Story

A voluntary walk-in consumer in crisis, “Joe” came in seeking assistance. A large part of the crisis stemmed from conflict with his room and board placement. TTS staff were able to work with him to divert hospitalization and provide additional resources. “Joe” was able to describe his concerns and worked with TTS staff to find a placement in a different room and board facility. In addition, TTS staff linked “Joe” with Social Security to ensure he had a way to gain control of his income.

Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Triage, Engagement, and Support Teams	3,378	2,000	$7,193,303*	$2,116*

*Annual budget and cost per client represent both TTS 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

Target Population and Program Description

The main objective for TEST is the mitigation of unnecessary expenditures for law enforcement by reducing the amount of time law enforcement spends with individuals needing a behavioral health crisis intervention, thus reducing the number of encounters between law enforcement and individuals in behavioral health crisis. TEST staff are co-located within 31 internal and external County partner agencies, including, but not limited to, law enforcement agencies, hospital emergency departments, and college campuses. 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

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 292-305.

Consumer Demographics Highlights FY 2020-21

Age

16.0% Children
21.0% TAY
49.9% Adult
12.5% Older Adult
0.6% Unknown

Language

94% English
2% Spanish
4% Other/ Unknown

Gender Identity

48.49% Male
46.95% Female
3.46% Unknown
0.45% Other
0.65% Declined to state

Race/Ethnicity

12% African-American/ Black
3% Asian/Pacific Islander
38% Caucasian/White
32% Latinx/Hispanic
4% Mixed Races/ Other
11% Unknown

N=3,378

Positive Results

Direct field-based outcomes for Fiscal Year 2020-21 were severely impacted by the COVID-19 pandemic. TEST's primary responsibility is to respond in the field with law enforcement, and/or provide field-based services on college campuses and hospital emergency departments. Due to COVID-19 restrictions, TEST staff ceased providing any field-based services from March to August 2020, thereby reducing the total number of direct field-based services. Throughout the pandemic, TEST has continued to provide phone-based behavioral health services which has enabled them to continue to provide referral source information and ongoing case management.

In Fiscal Year 2019-20, TEST experienced an increase of 15% in encounters and a 1% decrease in the number of referrals in comparison to the prior fiscal year. The program provided 10,542 encounters and 10,503 referrals to behavioral health and community resources which resulted in:

- 29.73% 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 2019-20 to Fiscal Year 2020-21.
- 62.3% of TEST crisis interventions were diverted from hospitalizations, a decrease of 6.1% compared with Fiscal Year 2019-20.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

7.2% Anxiety disorders

0.8% None/deferred

7.5% Bipolar disorders

23.5% Psychosis disorders

27.3% Depressive disorders

9.1% Substance use disorders

2.2% Disruptive disorders

21.3% Other

1% Neurodevelopmental/cognitive disorders

N=787 (as reported by program)

NOTE: This does not add to 100 due to rounding.

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. The immediate need to prepare multiple individuals to telecommute caused a temporary workflow interruption. TEST staff that were assigned to telecommute were provided laptops and access to all necessary workplace tools.

Field-based services resumed August 5, 2020, with the development of a new policy and protocol for field response during an infectious disease outbreak. Referrals from the hospital were provided to TEST staff and follow-up was conducted via telephone. Protective barriers were installed in all TEST vehicles so that staff is better able to safely transport consumers.

TEST staff continued to provide phone services to consumers as appropriate and as soon as it was safe to return to the field, staff began responding in the field with their collaborative partners to provide supportive and case management services. If staff halt field-based services again due to the ongoing COVID-19 pandemic, TEST now has protocols and procedures in place to ensure their consumers are still receiving services.

Outreach and Engagement

For Fiscal Year 2020-21, the TEST program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Victor Valley College	1	12
Redlands Police Department Homeless Outreach	1	4
Apple Valley Public Advisory Committee	1	12
Rialto Police Department Homeless Event	1	2
Chino Hills Town Hall	1	40
Law Enforcement Briefings/Collaborative Meetings	915	8,811
Referral and Linkage Calls	10,503	6,436
Totals	**11,423**	**15,317**

*Due to the COVID-19 pandemic, all outreach and engagement activities were suspended effective March 2020.

Program Updates

During Fiscal Year 2020-21, the number of behavioral health related emergency calls to Colton 9-1-1 dispatch center has increased substantially. Therefore, Colton PD has requested to partner with the DBH TEST program in order to provide a more specialized response to these behavioral health crises calls.

Program Updates (cont.)

TEST has added 15 sites since 2018 and is currently at 27 sites. Due to expansion of the TEST program services to include the Colton PD station there will be a need for an additional staff co-located within this site and equipment.

Success Story

A TEST staff member assigned to a co-location site worked with a law enforcement partner to assist a known homeless consumer who in the past, had consistently declined any type of behavioral health assistance. Through their conversation, it was determined that the consumer was gravely disabled and therefore, a 5150 hold was appropriate. The TEST staff member accompanied the consumer to the designated LPS facility and stayed by the consumer's side until they were able to complete a warm hand-off to the social workers and medical staff at the facility. Before departing the facility, the TEST staff member stayed to answer any questions that the consumer had to ensure they knew what was happening. Through the collaboration of TEST staff and law enforcement, the consumer received care necessary to improve their quality of life.

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Community Crisis Response Team	4,043	4,992	$8,791,646*	$1,257*

*Annual budget and cost per client represent both CCRT and CIT.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	N/A	Field-based	Experiencing a behavioral health crisis

Target Population and Program Description

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)

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 306-320.

Consumer Demographics Highlights FY 2020-21

Age

18% Children
20% TAY
37% Adult
7% Older Adult
18% Unknown

Language

91.2% English
5.0% Spanish
0.0% Vietnamese
1.3% Other
2.5% Unknown

Gender Identity

48% Male
47% Female
1% Transgender
4% Unknown

Race/Ethnicity

10% African-American/ Black
1% Asian/Pacific Islander
15% Caucasian/White
27% Latinx/Hispanic
0% American Indian/ Alaska Native
3% Multiple Races/ Other
44% Unknown

N=4,043

Positive Results

In Fiscal Year 2020-21, 1,091 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 74% decrease in diversions from the previous fiscal year due to restricted field responses during the global pandemic. Also due to the COVID-19 pandemic, outreach efforts were put on hold until field operations resumed on March 22, 2021. Outreach efforts are expected to return to pre-COVID-19 numbers for Fiscal Year 2021-22.

Challenges and Solutions

With the COVID-19 pandemic, direct field-based services were put on hold as of March 18, 2020 but were resumed on March 22, 2021. CCRT staff were required to continue providing services remotely, which required each staff member be provided with access to the DBH network and virtual meeting platforms. Telework provisions allowed staff to provide virtual assistance to individuals in crisis.

Texting capabilities were added to staff's county issued cell phones in order to facilitate communication via phone and limit in person intervention. CCRT staff were successfully provided network access to perform telehealth services.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

9% Anxiety disorders

2% Neurodevelopmental/ cognitive disorders

7% Bipolar disorders

17% Psychosis disorders

44% Depressive disorders

2% Substance Use

3% Disruptive disorders

16% Other/None

N=1,199 (as reported by program)

Outreach and Engagement

For Fiscal Year 2020-21, the CCRT program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Community presentation/meetings	2	83
Referral and linkage calls	3,589	3,589
Law enforcement briefings/collaborative meetings	14	167
School outreach	3	37
Hospital/medical offices	4	16
Total	**3,612**	**3,892**

*Due to the COVID-19 pandemic, all outreach and engagement activities were suspended from March 2020 through March 2021.

Program Updates

Community Crisis Services (CCS), a CCRT expansion, proposes expanding and enhancing the county 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 field responder in regionally-based Mobile Crisis Units (MCU). Specially trained 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.

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Crisis Intervention Training	1,346	2,000	$8,791,646*	1,257*

*Annual budget and cost per client represent both CCRT and CIT.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18+	N/A	Field-based	First responders

Target Population and Program Description

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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 306-320.

Services Provided

- In collaboration with San Bernardino County Sheriff's Department:
  - Quarterly 40-hour CIT course
  - Quarterly 8-hour Senate Bill (SB) 29 Field Training Officer (FTO) CIT course
- In collaboration with Probation:
  - Bi-weekly 8-hour CIT course
- Multiple monthly collaborative partner trainings

Consumer Demographics Highlights FY 2020-21

Age

0% Children
12% TAY
27% Adult
1% Older Adult
60% Declined to State

Language

39% English
0% Spanish
61% Unknown

Gender Identity

31% Male

9% Female

60% Other

Race/Ethnicity

3% African-American/ Black
2% Asian/Pacific Islander
15% Caucasian/White
18% Latinx/Hispanic
0% American Indian/ Alaska Native
62% Multiple Races/Other

N=1,346

Positive Results

In Fiscal Year 2020-21, 1,346 law enforcement and community partners received training from the CIT program.

- 257 law enforcement personnel completed the 40-hour CIT course
- 87 Field Training Officers (FTO) completed the 8-hour FTO CIT course
- 51 Probation Officers and Probation Correctional Officers completed the 8-hour CIT course
- 951 community partners, including fire, public employees, and emergency departments received specialized training from the CIT program

CIT program staff attended a total of 33 virtual outreach and engagement events, in addition to completing 40 formal trainings to first responders and community partners.

Challenges and Solutions

In response to the COVID-19 pandemic and restrictions on indoor gatherings imposed by the state and public health mandates, some collaborative partners canceled a number of CIT trainings as their agencies and staff did not have the technological capacity for virtual trainings. In addition, the CIT program staff were challenged to convert the previously all in-person instruction curriculum to new virtual format trainings.

CIT staff worked collaboratively to find new virtual engagement software systems and conducted the first online training in July 2020. CIT was able to utilize an online platform that allowed staff to create interactive presentations that gave training facilitators the ability to use live polls, quizzes, word clouds, and question and answer sessions in real time.

Challenges and Solutions (cont.)

By using virtual training environments, staff were able to keep their audience engaged and verify learning was occurring in real time. Staff continued to use other virtual platforms in order to host online trainings as seamlessly as possible and provide the best virtual training experience.

Outreach and Engagement

For Fiscal Year 2020-21, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Collaborative Meetings	27	1,129
Gang and Drug Task Force Meetings	4	147
Coffee with a Cop (Various law enforcement agencies)	1	10
Networking Event	1	12
Total	**33**	**1,298**

Crisis Stabilization Continuum of Care

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 behavioral 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, medications, 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 four (4) CRTs within CSCC and one (1) CRT serving the Transitional-Age Youth (TAY) population. Each CRT in CSCC has sixteen (16) beds and serves adults aged 18-59. TAY CRT has fourteen (14) beds and serves youth from the age of 18 through the youth's 26th birthday. 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.

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served by age and service categories for Fiscal Year 2022-23:

Program Name		Fiscal Year	Ages Served	Service Category*
Crisis Walk-In Center		2022-23	168 Children 541 TAY 1,340 Adult 151 Older Adult	2,200 GSD
			TOTAL = 2,200	TOTAL = 2,200
Crisis Stabilization Unit		2022-23	220 Children 900 TAY 2,500 Adult 180 Older Adult	3,800 GSD
			TOTAL = 3,800	TOTAL = 3,800
Crisis Resident Treatment	Adult CRT	2022-23	50 TAY 424 Adult	474 GSD
			TOTAL =474	TOTAL = 474
	TAY CRT	2022-23	97 TAY	97 GSD
			TOTAL = 97	TOTAL = 97

*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 Walk-In Center

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Crisis Walk-In Center (CWIC)	2,076*	2, 567	$13,274,654**	$2,385**

*This number does not include O&E.
**Annual budget and cost per client represent both CWIC and CSU.

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

Target Population and Program Description

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 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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 321-327.

Services Provided

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Integrated substance use disorder services/case management
- Therapeutic interventions
- Referral and linkage to culturally and linguistically appropriate services

Consumer Demographics Highlights FY 2020-21

Age

7% Children
23% TAY
63% Adult
7% Older Adult

Language

97.4% Spanish
1.3% English
0.0% Thai
1.3% Other/Unknown

Gender Identity

52.4% Male

47.4% Female

0.2% Unknown

Race/Ethnicity

16.7% African- American/ Black
1.7% Asian/Pacific Islander
44.0% Caucasian/White
15.8% Latinx/Hispanic
0.8% American Indian/ Alaska Native
21.0% Multiple Races/Other

N=2,076

Positive Results

The CWICs served a combined total of 2,076 consumers in Fiscal Year 2020-21. A total of 3,400 crisis stabilization services were provided to those consumers, potentially diverting up to 3,400 emergency room visits. Of those 3,400 consumer interactions, 95.5% were successfully diverted from psychiatric hospitalization at the time of receiving services.

Annually, the program surveys consumer satisfaction. For FY 2020-21, the program received 1,499 responses. Consumers were asked to rate their agreement with the following statements, using a Likert Scale, with 4 being "Very Much" and 1 being "Not at All." The following represents consumer agreement ratings overall:

- My needs and goals for using this service were met: **3.84**
- The setting was safe, clean, and comfortable: **3.90**
- Staff helped me feel safe and develop a safety plan if needed: **3.84**
- Staff took time to listen to what I needed: **3.9**
- I was introduced to resources in my community: **3.76**
- I was provided useful information about my medication and health: **3.73**
- I was introduced to WRAP (Wellness Recovery Action Plan): **3.43**
- Staff helped me develop a plan for after I leave this program: **3.77**
- I felt safe and supported during my crisis: **3.87**
- Staff communicated hope and confidence in me to overcome my struggle: **3.86**
- Staff understood my cultural background: **3.70**
- I was treated with dignity and respect by staff: **3.92**

Challenges and Solutions

In FY 2020-21, CWIC facilities were required to implement prevention, and mitigation measures due to the COVID-19 pandemic. As a result, weekly supply requests were required in order to ensure that adequate medical equipment was on hand to comply with mandates for weekly surveillance and/or COVID-19 testing. Programs were able to maintain full staffing when clients were present by flexing staff schedules.

In addition, CWIC had a particularly difficult time finding placements for older adult consumers due to many long-term care and older adult facilities limiting or restricting admission due to the pandemic. CWIC was able to work extensively with the Department of Aging and Adult Services (DAAS) Age Wise program to help find placement options for older adult consumers and to increase housing options.

CWIC staff also educated neighboring hospitals to ensure hospital staff knew to test patients for COVID-19 prior to a referral to the program if the hospital had the ability to do so. CWICs also worked with their laboratory partners to accommodate the increased volume of tests that needed rapid processing.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

15% Anxiety disorders

17% Bipolar disorders

28% Depressive disorders

1% Disruptive disorders

1% Neurodevelopmental/ cognitive disorders

29% Psychosis disorders

4% Substance use disorders

5% Other/None

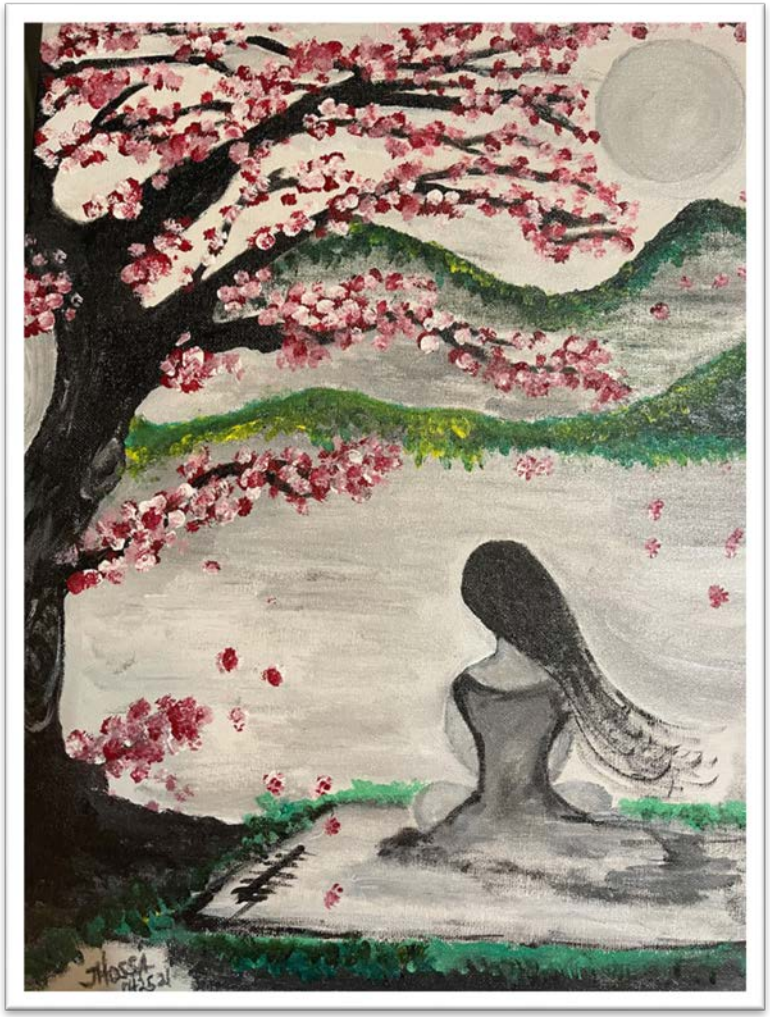
N=2,076

Outreach and Engagement

For Fiscal Year 2020-21, the CWIC program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Collateral Materials Delivery	39	43
Multidisciplinary Team Meetings	3	56
Virtual Conferences	2	86
Totals	**44**	**185**

*Due to the COVID-19 pandemic, outreach efforts were limited to phone calls, flyers, and emails for the period of April 2020 to June 2020.



Artwork by Jhossa Jackson

Crisis Stabilization Unit

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Crisis Stabilization Unit (CSU)	3,931*	3,800	$13,274,654**	$2,385**

*This number does not include O&E.
**Annual budget and cost per client represent both CWIC and CSU.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All Ages	All Levels	Clinic-based	Experiencing a behavioral health crisis

Target Population and Program Description

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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 328-335.

Services Provided

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Integrated substance use disorder services/case management
- Therapeutic interventions
- Referral and linkage to culturally and linguistically appropriate services

Consumer Demographics Highlights FY 2020-21

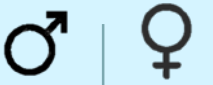
Age

5% Children
22% TAY
68% Adult
5% Older Adult

Language

96% English
3% Spanish
1% Other

Gender Identity



57% Male
43% Female

Race/Ethnicity

20% African-American/ Black
2% Asian/Pacific Islander
27% Caucasian/White
47% Latinx/Hispanic
1% American Indian/ Alaska Native
3% Multiple Races/Other

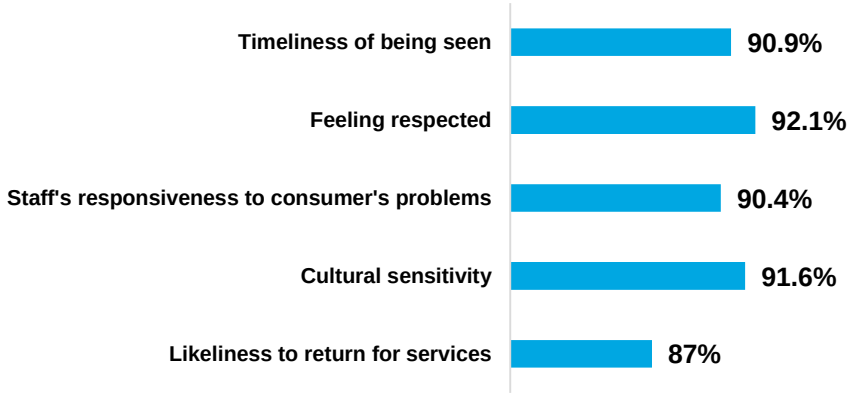
N=3,931

Positive Results

The CSUs served a combined total of 3,931 consumers in Fiscal Year 2020-21. The combination of outreach efforts resulted in an increase in services provided by the end of Fiscal Year 2020-21. These programs provided 5,540 crisis stabilization services to those consumers. Of those 5,540 admissions, 93.3% were successfully diverted from psychiatric hospitalization. The following linkages and referrals* were provided:

- 3,406 referrals to peer support and self-help groups
- 402 referrals or linkages to long-term housing assistance
- 543 referral or linkage for transportation, including bus passes
- 1,653 referrals or linkages to DBH or DBH-contracted mental health clinic
- 1,873 referrals for medication management services
- 95 linkage to crisis residential treatment (CRT) facilities
- 706 referrals or linkages to other resources, including legal assistance, Substance Use Disorder and Recovery Services (SUDRS), and food banks

Annually, the program surveys consumer satisfaction. For Fiscal Year 2020-21, 3,345 responses were received from consumers. The chart below represents those who agreed "somewhat" or "very much":



Note: The number of linkages/referrals exceeds number of consumers served due to multiple linkages/referrals provided to each consumer.

Challenges and Solutions

In Fiscal Year 2020-21, initial statewide shutdowns due to the COVID-19 pandemic led to a temporary decrease in consumers seeking services. To mitigate further census decrease, CSUs shifted outreach efforts to virtual formats and distributed educational materials locally to ensure that community partners are aware of CSU services. CSU staff began an intensive phone outreach effort where calls were made to community providers and county mental health clinics to encourage referrals for in person crisis stabilization services while many programs in the county shifted to telehealth services.

CSU staff also took a more creative approach to their outreach efforts and delivered their educational material regarding crisis services to testing sites, vaccine sites, urgent care centers, and emergency rooms to increase awareness about available services for individuals facing crisis during the pandemic. In addition, one CSU offered transportation to three neighboring outpatient clinics to improve access to the CSU when many local outpatient clinics had shifted solely to telehealth services.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

9% Anxiety disorders
13% Bipolar disorders
27% Depressive disorders
1% Disruptive disorders
1% None/deferred
35% Psychosis disorders
10% Other

N=3,931

NOTE: this number does not add to 100 due to rounding.

Challenges and Solutions (cont.)

CSUs also experienced challenges in recruiting efforts and with making necessary accommodations to expand services to include children aged 12 and under. To remain fully staffed and equipped to serve young children, CSUs increased wages, implemented COVID-19 pay incentives, and held multiple virtual hiring events and recruitment fairs with local universities. These collaborative efforts have resulted in a robust hiring pool of trained bachelor and masters level staff to fill vacancies across multiple program types. Additionally, the programs implemented new policies and procedures for treating young children, enhanced clinical training for existing staff, and developed a consultative child psychiatry support service.

Artwork by Tracy Hutchinson

Outreach and Engagement

For Fiscal Year 2020-21, the CSU program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
School contacts and presentations	22	84
Community partnership outreach	94	367
Healthcare partner clinics/outreach	31	258
Totals	**147**	**709**

*Due to the COVID-19 pandemic, outreach efforts were limited to phone calls, flyers, and emails from the period of April 2020 to June 2020.

Program Updates

As the current three-year CSU contracts will sunset on June 30, 2022, DBH will seek proposals to continue providing these services through the standard county procurement process for a contract to begin on July 1, 2022. At this time, DBH will be realigning allocation to more closely approximate actual program spending, with no anticipated change to program service delivery.

Adult Crisis Residential Treatment

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Adult Crisis Residential Treatment	511*	424	$14,349,542**	$27,542**

*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

Target Population and Program Description

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
- Psychiatric and medication support
- Life skills coaching
- Peer and family support networks
- Coping techniques
- Recovery education
- Community resource linkages

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 336-344.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
10% TAY
90% Adult
0% Older Adult

Language

97.65% English
1.57% Spanish
0.78% Other

Gender Identity

67% Male

33% Female

Race/Ethnicity

23% African-American/ Black
2% Asian/Pacific Islander
35% Caucasian/White
36% Latinx/Hispanic
1% American Indian/ Alaska Native
3% Multiple Races/Other

N=511

Positive Results

511 unique consumers were admitted to the four adult CRT facilities during Fiscal Year 2020-21. During this time, the programs also processed 494 discharges. Of the 494 discharges, 96.4% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services. However, 1.6% were hospitalized due to medical concerns and 1% were discharged to an arrest.

Additionally, the following referrals and linkages were provided to consumers upon discharge:

- 30 (5.9%) received referrals to peer support and socialization programs
- 107 (22.6%) received referral or linkage to long-term housing assistance
- 61 (12.9%) received referrals or linkages to Substance Use Disorder Recovery Services (SUDRS)
- 229 (48%) received referrals or linkage to a DBH or DBH-contracted mental health clinic or programs
- 48 (10%) received referrals for medication management services
- 46 (9.7%) were linked to medical, dental and/or vision benefits
- 28 (5.5%) were received referrals for transportation services
- 42 (8.2%) received referrals to other resources and services not listed.

Note: Number of linkages/referrals exceeds number of discharges due to multiple linkages and referrals provided to each consumer.

Challenges and Solutions

In Fiscal Year 2020-21, the COVID-19 pandemic 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-19 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-19 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.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

1.57% Anxiety disorders

56.56% Psychosis disorders

12.72% Bipolar disorders

6.65% Substance use disorders

19.96% Depressive disorders

2.15% Other

0.39% None/Deferred

N=511

Challenges and Solutions (cont.)

During to the ongoing pandemic, admission barriers to mental and healthcare facilities resulted in an increase in inappropriate referrals from outside agencies and requests for service from individuals who did not meet criteria for crisis residential treatment. To address that issue, CRTs increased outreach to community partners from whom inappropriate referrals were being received, providing education and coaching on the criteria required for an individual to receive crisis residential treatment. Individuals who were not admitted to CRTs were linked with agencies that were appropriate for their needs (e.g., housing, transportation, and food assistance resources).

In addition, program staff worked with neighboring hospitals to educate those who had the ability to test residents for COVID-19 prior to placement to avoid the need to quarantine at the CRT while still in crisis. The ability to immediately integrate into the service groups eased some of the consumer anxieties that may have impacted their willingness to enter the program.

Success Story

"Marissa" refused mental health services through the CHOICE program and was removed from her housing due to increased symptoms of psychosis. Marissa was able to seek psychiatric stabilization at Windsor CSU and was admitted to Casa Paseo CRT the next day. Over the course of five weeks, Marissa was able to maintain medication compliance and stabilize her symptoms of psychosis. Marissa was discharged after meeting her treatment plan goals and entered a residential Substance Use Disorder treatment program to address her additional needs.

Outreach and Engagement

For Fiscal Year 2020-21, the adult CRT program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Program Updates

As the current CRT contracts will sunset on June 30, 2022, DBH will seek proposals to continue providing these services through the standard county procurement process for a contract to begin on July 1, 2022. At this time, CRTs anticipate an increase of funding as DBH realigns allocation to more closely approximate actual program spending, with no anticipated change to program service delivery.

TAY Crisis Residential Treatment

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
TAY Crisis Residential Treatment	103	97	$14,349,542*	$27,542*

*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

Target Population and Program Description

The STAY, a specialty CRT for Transitional-Age Youth, 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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 345-352.

Services Provided

- 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
- Medication support
- Substance use disorder counseling and referrals
- Recreational therapy
- Educational assistance
- Pre-release and discharge preparation and planning

Consumer Demographics Highlights FY 2020-21

Age

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

Language

98% English
1% Spanish
1% Other

Gender Identity

62% Male

38% Female

Race/Ethnicity

20% African-American/ Black
0% Asian/ Pacific Islander
26% Caucasian/White
49% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/ Other

N=103

Positive Results

During Fiscal Year 2020-21, 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.

The following linkages and referrals were provided:

- 15 (14%) received referrals to DBH clinics.
- 23 (22%) received referrals to DBH-contracted mental health programs.
- 5 (4%) received referrals for long-term housing.
- 3 (2%) received referrals for Substance Use Disorder services.
- 31 (30%) were linked with medication services.
- 25 (24%) were linked with medical/dental/vision coverage agencies.
- 18 (17%) received referrals to peer support and socialization programs.
- 9 (8%) received referrals for transportation services.
- 26 (25%) received additional referrals to other resources and services not listed above.

Outreach and Engagement

For Fiscal Year 2020-21, the TAY CRT program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

3% Anxiety disorders

28% Depressive disorders

19% Bipolar disorders

45% Psychosis disorders

1% Substance Use disorder

4% Other/None

N=103

Challenges and Solutions

For Fiscal Year 2020-21, 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-19 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-19 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.

Success Story

"Brandon" was able to stabilize in 88 days, eliminating suicidal ideation, reducing/eliminating substance use, refraining from self-harm, and showing decreased symptoms of psychosis, depression, and trauma responses. Brandon was connected to TAY San Bernardino for continued mental health services.

Peer and Family Support Programs

Introduction

Peer Support Programs offer stigma-free, emotional support for consumers living with behavioral health challenges in recovery. This holistic, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Clubhouses are located throughout the County to assist and support consumers through their recovery.

Clubhouses are peer support centers that are recovery orientated for consumers 18 years or older that operate with minimal support from department staff. There are ten clubhouses located throughout the county dedicated to assisting consumers living with a behavioral health challenge. Clubhouses are primarily consumer operated, so members have significant opportunity for input related to support groups, classes, and activity choices.

Each Clubhouse uses a Recovery, Wellness and Resilience Model in a stigma-free environment in an effort to improve the consumers' overall wellness in alignment with their personal recovery goals. Classes and activities assist consumers with developing skills that improve their relationships and assist with community reintegration while supporting the consumer as the decision maker in their recovery path.

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served by age and service categories for Fiscal Year 2022-23:

Program Name	Fiscal Year	Ages Served	Service Category*
Clubhouse and Community Connections	2022-23	32,352 Adults	11,352 GSD 21,000 O&E
		TOTAL = 32,352	TOTAL = 32,352

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Artwork by Manny Cordoba

Clubhouse and Community Connections

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Clubhouse and Community Connections	8,461*	33,352	$3,709,135	$111

*This number does not include O&E.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	BHC*	Facility-based	Seeking recovery based support services

*BHC = Behavioral Health Challenges.

Target Population and Program Description

Clubhouses are peer-driven support centers for members in recovery. Clubhouses provide peer-run programs using a Recovery, Wellness, and Resilience model in a stigma free environment for adult members living with a behavioral healthy challenge. There are ten clubhouses located throughout the county that are dedicated to enhancing and supporting recovery.

The main objectives of the Clubhouse and Community Connections (formerly Clubhouse Expansion Program) are to assist members in making their own choices, providing peer support, and reintegrating into the community as contributing members, thereby achieving a fulfilling life in alignment with their personal recovery goals. Clubhouses are operated by the members through peer elected governing boards.

In an effort to support operations being peer led and driven while allowing members to navigate choices available for recovery, members meet regularly and are encouraged to provide direction and input to program and activity choices.

Numerous support groups and activities provide growth opportunities for members to assist in their ability to connect to their community in meaningful ways. Members plan and facilitate daily activities, determine workshop topics and sponsor regularly scheduled social and recreation activities, both on-site and in the community, which increases the members' ability to interact and develop skills that improve their relationships and sense of self-worth.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 355-364.

Consumer Demographics Highlights FY 2020-21

Age

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

Region

14% East Valley
16% West Valley
13% Central Valley
57% Desert/Mountain

Gender Identity

52% Male
47% Female
1% Other

Race/Ethnicity

29% African-American/ Black
7% Asian/Pacific Islander
27% Caucasian/White
27% Latinx/Hispanic
2% American Indian/ Alaska Native
8% Multiple Races/ Other

N=8,461

Clubhouse and Community Connections A-1

Services Provided

- 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
- Community integration excursions
- Transportation to stakeholder meetings
- Technical support for virtual platforms

Artwork by Andie Hayes

Positive Results

Throughout Fiscal Year 2020-21, Clubhouses adapted and expanded offered services to focus on meeting the needs of those that were unsafely housed and experiencing food insecurity during the COVID-19 pandemic. Clubhouses responded by providing showers, laundry, hygiene items, and food.

Virtual groups were also started in order to reduce the effects of physical isolation due to the COVID-19 pandemic and in June of 2021, Clubhouses expanded in-person services back to pre-pandemic levels with added safety precautions. All clubhouses have since re-instituted peer governing boards through new elections, re-established peer run groups including cooking and nutrition opportunities, and began accepting new members for the first time since the pandemic began.

I did not do well at all without coming to clubhouse. I stayed in my room and didn't want to talk to anyone. Now that I can come again I am starting to remember what it is like to be around people. It is kinda scary again but it is getting easier every time I come.

- Clubhouse member

During coronavirus, I felt useless. Now I am back and back on the clubhouse board. I can help people again and support my friends.

- Clubhouse member

Challenges and Solutions

The ongoing COVID-19 pandemic posed safety concerns which resulted in an array of challenges. The restricted services due to mandated pandemic safety rules caused delays in the ability to launch the consumer designed evaluation tool. In order to move forward with the evaluation tool, the tool is now being launched in coordination with service expansion. In addition to the issue with launching the tool, another issue during Fiscal Year 2020-21 was the need to rely on technology. This proved to be especially challenging for consumers with issues such as limited equipment, limited access to internet connection or internet availability, and strict data plans. To continue to support consumers, clubhouse staff helped by researching upgraded phone programs, low-income data plans, and when possible, increased access to Wi-Fi and computers at each location.

Another challenge faced due to the safety measures was restricted services which increased consumer isolation. Clubhouse staff have been working with consumers to ensure awareness that clubhouses are back to pre-pandemic level of service. In addition, peers are actively reaching out to those who have not returned to re-engage them in social supports.

Program Updates

The Clubhouse and Community Connections has expanded its resources to include consumer navigation assistance that helps consumers connect with their communities through paid employment, volunteerism and leaders of peer support. The change has warranted an increase in funding to establish a team who will be responsible for assisting referred consumers in navigating options for community connections.

In addition, the program plans to hire Alcohol and Drug Counselors (AOD), who will be on-site at county run clubhouses to provide direct linkage and support to consumers.

Program Updates (cont.)

In Fiscal Year 2022-23, additional planned changes include:

- Completing the expansion and relocation of two clubhouse facilities, San Bernardino and Barstow, to provide improved access and resources,
- Beginning the process of expanding and relocating services in Victorville to meet the needs of the growing number of individuals being served, and
- Expansion of clubhouse facilities by contracting for additional locations.

Outreach and Engagement

For Fiscal Year 2020-21, the Clubhouse and Community Connections conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Food Distributions	30	6,500
Clubhouse Cultural Celebrations via Zoom	10	250
Crisis Intervention Team Building	3	175
Behavioral Health Wellness Triathlon	3	325
Consumer Advisory Board	2	55
Consumer Evaluation Council	24	640
Homeless Outreach	12	1,400
Clubhouse Media Outreach	6	950
Peer Certification Stakeholder Process	10	280
Total	**100**	**10,575**

Community Connections

Target Population and Program Description

The Community Connections program (formerly Employment Services), with the support of the Department of Rehabilitation (DOR), focuses on coordinating and providing consumers employment education to promote job search skills, including an overview of the soft skills necessary to secure and maintain employment. Staff work to assist in integrating, reintegrating and supporting consumers from all points of entry to connect to their communities through paid employment, system volunteering, peer volunteering, community volunteering and other connection opportunities. These strategies build on and work in conjunction with each other to provide consumers with the necessary skills and supports needed to secure a paid or volunteer position as they move towards self-efficacy and self-sufficiency as part of their path towards recovery.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	BHC*	Clinic-based	Seeking employment and/or job skills

*BHC = Behavioral Health Challenges

Services Provided

- Intensive case management
- Education
- Career assessment
- Employment counseling
- Job development and coaching

Positive Results

In Fiscal Year 2020-21, the Community Connections program served a total of 149 consumers. Through program participation, 31 jobs were obtained by consumers. Additionally, the program saw 18 successful case closures after consumers retained employment for 90+ days.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
48% TAY
52% Adult
0% Older Adult

Language

95% English
4% Spanish
1% Other

Gender Identity

54% Male
45% Female
1% Transgender
0% Other

Race/Ethnicity

28% African-American/ Black
1% Asian/ Pacific Islander
31% Caucasian/White
38% Latinx/Hispanic
2% American Indian/ Alaska Native
0% Multiple Races/ Other

N=149

Challenges and Solutions

During Fiscal Year (FY) 2020-21, the Community Connections program was faced with the continuing difficulty of locating available jobs that fit consumer's scheduling needs and also in creating consumer awareness of the program.

To address these challenges, the program has continued to establish relationships with employers, other departments within the county, and has participated in networking events to identify potential places of employment for consumers. Community Connections acts as the liaison between the consumer and employer to bridge communication and creates awareness on mental health issues in the workplace.

Community Connections also attended monthly clinic staff meetings to promote awareness of the employment services available to the consumers. The employment referral process was streamlined last FY by creating an email address specifically for referrals which has been monitored.

Outreach and Engagement

For Fiscal Year 2020-21, the Community Connections program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Artwork by Cris Jackman

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

2.7% Anxiety disorders

34.9% Bipolar disorders

57.7% Depressive disorders

4.7% Other

N=149

Outreach, Access, and Engagement Programs

Introduction

Outreach, Access, and Engagement programs are programs that provide access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital, or a walk-in clinic, referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible. The Access, Coordination, and Enhancement (ACE) program provides evaluations within seven days of a hospital discharge and within 14 days of a walk-in clinic request.

Outreach, Access and Engagement programs are programs that also provide linkage to services, advocacy, case management services, care navigation, family education and support. The Recovery Based Engagement Support Team (RBEST) program is a voluntary, consumer-centered project, which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. Out of the need to support families, RBEST staff facilitated a support program called Connecting Families that is projected to expand to provide families with support, education and empowerment to continue caring for their loved ones in their community.

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served by age and service categories for Fiscal Year 2022-23:

Program Name	Fiscal Year	Ages Served	Service Category*
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	2022-23	739 Hospital referrals	
		TOTAL = 739	
Recovery Based Engagement Support Teams	2022-23	228 Adults	270 O&E
		TOTAL = 300	TOTAL = 270
Connecting Families	2021/22	120 Adults	120 GSD
		TOTAL = 120	TOTAL = 120

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

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

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
ACE	5,626*	2,652	$5,933,006	$2,237

*NOTE: this number is an approximation. Some consumers may not have been counted.

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

*SMI = severe mental illness

Target Population and Program Description

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 regional outpatient clinics (Phoenix in San Bernardino, Mariposa in Ontario, Mesa in Rialto, and Victor Valley in Victorville) and in the two rural outpatient clinics (Barstow and Needles) specifically for assessments, hospital discharges, and care coordination.

With implementation of the Affordable Care Act (ACA) and Medi-Cal expansion, the ACE program enhanced the redesign of the outpatient care system to ensure that consumers receive the right services customized to meet their needs. ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the consumer. ACE provides evaluations within seven days of a hospital discharge and within 14 days of walk-in clinic requests. The goal is to provide rapid access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital, or walk-in clinic, a referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 365-377.

Consumer Demographics Highlights FY 2020-21

Age

21% Children
20% TAY
51% Adult
8% Older Adult

Language

92% English
7% Spanish
1% Other

Gender Identity

46% Male
54% Female

Race/Ethnicity

17% African-American/ Black
2% Asian/ Pacific Islander
29% Caucasian/White
47% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/ Other

N=5,626

Services Provided

- Behavioral health assessments
- Psychiatric evaluations
- Substance use disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership programs, Crisis Stabilization Units, Crisis Residential Treatment Centers
- Access to appropriate services

Positive Results

The increased use of crisis interventions including Crisis Stabilization Units, Community Crisis Response Team and after hours crisis hotlines has reduced the frequency of emergency room visits and unnecessary hospitalizations.

There were a total of 2,652 referrals to the ACE program for new consumers discharged from acute care psychiatric hospitals.

I understand what is happening to me, this is the first time I have been understood.

- ACE member

Consumer Demographics Highlights FY 20-21

Primary Diagnosis

10% Anxiety	**2%** Disruptive/impulse control and conduct	**23%** Psychosis
15% Bipolar	**10%** Neurodevelopmental/ neurocognitive	**3%** Substance related
28% Depression	**2%** None/deferred diagnosis	**7%** Other

N=5,626

Challenges and Solutions

The ongoing COVID-19 pandemic made in-person services difficult, meaning that most services were provided via telephone. At this time, both telephone and face-to-face services are available with most services taking place in person. The program staff are hopeful that vaccination clinics for consumers will help services return to normal.

In addition, workflows had to be changed with the implementation of the Electronic Health Record (EHR). Staff had to learn to operate the EHR without disrupting services. This partnered with an ongoing problem of high rates of no-shows for hospital discharges created a challenge for program staff. To address that challenge, the Department of Behavioral Health programs are working to improve communication between the Fee-For-Service (FFS) psychiatric hospitals and outpatient facilities.

Outreach and Engagement

For Fiscal Year 2020-21, the Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services program conducted vaccination clinics staffed by nurses. Outreach activities ceased due to the COVID-19 pandemic beginning in March 2020.

Program Updates

In Fiscal Year 2022-23, ACE plans to begin to expand the scope to include:

- Serving children and youth,
- Preemptively connecting with hospitalized clients to facilitate aftercare at local clinics,
- Facilitating access to all levels of care needed at the time (e.g., facilitate access to psychiatric hospitalization), and
- Establishing a new ACE team at the new clinic in Apple Valley.

Behavioral Health Urgent Care Center (BHUCC)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
BHUCC	165	N/A	N/A	N/A

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

*SMI = severe mental illness

Target Population and Program Description

This is the last year Behavioral Health Urgent Care Center (BHUCC) will be reported on as the program has ended and will not be included in subsequent MHSA Plans. The BHUCC program was a psychiatric urgent care center that evaluated consumers experiencing a behavioral health crisis and provided a centralized location for triage, assessment, and scheduling for all County Outpatient Clinics.

BHUCC provided the opportunity for the community to seek an evaluation of their mental health, substance use, or physical health needs. BHUCC's staff were trained to use the Listen, Empathize, Agree and Partner (LEAP) engagement model to educate and encourage consumers to seek appropriate services.

Services Provided

- Behavioral health Assessments
- Psychiatric evaluations
- Substance use disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership programs, Crisis Stabilization Units, Crisis Residential Treatment Centers
- Linkage to medical care
- Provide education on the array of services available in the County

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 369-372.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
16% TAY
74% Adult
10% Older Adult

Language

96% English
4% Spanish
0% Other

Gender Identity

42% Male
58% Female

Race/Ethnicity

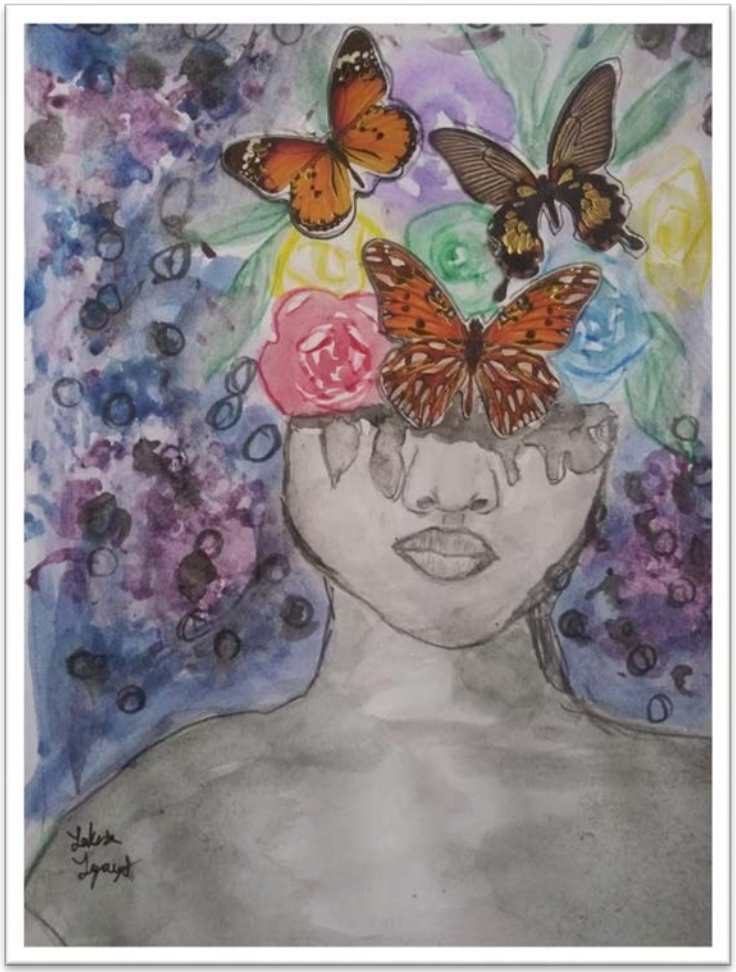
19% African-American/ Black
1% Asian/ Pacific Islander
19% Caucasian/White
58% Latinx/Hispanic
1% American Indian/ Alaska Native
2% Multiple Races/ Other

N=165

Outreach and Engagement

For Fiscal Year 2020-21, the BHUCC program conducted outreach and engagement activities by participating in vaccination clinics which were staffed by nurses from the program.

Artwork by Janet Montes De Oca



Artwork by Lakesha Lafayett

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

10% Anxiety	**0%** Neurodevelopmental/ neurocognitive	**1%** Substance related
18% Bipolar	**12%** None/deferred diagnosis	**6%** Other
27% Depression	**26%** Psychosis	

N=165

Recovery Based Engagement Support Teams (RBEST)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
RBEST	259	300	$1,935,349	$6,451

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

Target Population and Program Description

RBEST is a voluntary, consumer-centered program which provides community (field-based) services to individuals living with untreated or inappropriately treated mental illness that connects and activates consumers into treatment. RBEST is not a treatment model and does not provide endless mobile services to identified consumers. 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 that consumer eliminate obstacles. Multidisciplinary engagement teams provide a holistic, highly flexible approach that is 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, encourages deliberation, and elicits possible care preferences.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 378-382.

The target population includes adults and older adults who are:

- Not active or successful in seeking and receiving necessary psychiatric care,
- Known to the community and other safety net programs, but not known to the public mental health system,
- Accessing treatment at points in the health care system that do not deliver effective care in meeting the psychiatric needs of that individual,
- The "invisible" consumer who is being cared for by family members and not linked or known to the public mental health system,
- Difficult to engage using traditional strategies due to a neurological condition (i.e. anosognosia) which can disallow insight into their own behavioral health condition, and
- Unable to navigate the behavioral health system of care to obtain appropriate treatment.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
15% TAY
75% Adult
10% Older Adult

Language

94.2% English
3.5% Spanish
2.3% Other

Gender Identity

59% male

41% female

Race/Ethnicity

19% African-American/ Black
3% Asian/ Pacific Islander
25% Caucasian/White
49% Latinx/Hispanic
0% American Indian/ Alaska Native
4% Multiple Races/ Other

N=259

Services Provided

- 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) training

Connecting Families

The Connecting Families program is an educational support group for families and caretakers of individuals living with a severe and persistent mental illness. The goal is to increase awareness and knowledge among family members/caretakers about issues relating to mental illness while providing a safe space for sharing and peer support.

The Connecting Families Group experienced a disruption of services and temporary halt before exclusively conducting their meetings remotely with the use of telehealth.

Positive Results

The following data was collected from 191 RBEST consumers during the 180 days post RBEST engagement in comparison to the 180 days pre RBEST engagement.

- 33% decrease in psychiatric hospital bed days
- 69% decrease in psychiatric hospital admissions
- 287% increase in routine outpatient services including individual therapy, medication services, rehabilitation, activities of daily living, and residential services

Challenges and Solutions

As a result of the COVID-19 pandemic, RBEST experienced service delivery disruptions which included staff being unable to transport consumers to appointments and field-based services being temporarily ceased to ensure safety for consumers, their families, and staff. RBEST staff maintained engagement and support efforts utilizing phone and video conferencing however, an unfortunate consequence of the pandemic was staff losing contact and relationships with consumers due to the acuity of consumers. Field-based operations have resumed and the program has implemented safety precautions for both staff and consumer protection and safety. In addition, to meet the overwhelming demand for support services from family members and caretakers, RBEST clinicians are utilizing telehealth more frequently in their work with family members.

In addition to utilizing telehealth to conduct meetings, RBEST is making a concerted effort to increase participation and presence in various subcommittees sponsored by the Office of Equity and Inclusion, District Advisory Committees, Community Groups, and DBH Business Partners. This effort is being made to strengthen relationships necessary to obtain the level of flexibility that the population served by the program needs.

Another ongoing challenge faced this year was related to the system of care. Due to lack of information on anosognosia and challenges relating to the population being served, successful linkage and initiation of mental health treatment requires flexibility and an understanding of anosognosia to utilize LEAP (Listen Empathize Agree and Partner) communication techniques. To address this issue, LEAP training is being offered throughout the system of care and rendered to the Department of Behavioral Health staff and community partners.

Outreach and Engagement

For Fiscal Year 2020-21, the RBEST program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Program Updates

Since its inception, RBEST has consistently received 70% more referrals annually than originally projected and staffed for. RBEST is expanding to create two regionalized teams: Valley Region and High Desert Region. This expansion will allow for RBEST services to be provided across the County and to meet the increased need.

Additionally, RBEST will expand their services into a collaboration with acute hospitals (including psychiatric and medical) in an effort to begin to engage consumers while they are in the hospital or in the Emergency Departments (EDs). With this expansion, RBEST will have designated staff to assist hospitals with those consumers who are traditionally high utilizers of acute psychiatric services and EDs, in an attempt to engage and assist with connection to community based services before they are discharged.

"Thank you so much! I am here at the clubhouse every day. I am so grateful for you guys. I am doing great now!"

- RBEST consumer

Success Story

"Ronnie" was referred to RBEST by his family. He is an adult male who was living with an untreated mental illness. He had no insight into his mental illness and refused treatment. RBEST staff were able to develop a rapport and utilized LEAP techniques to better serve him. His family, including his extended family, attended Connecting Families group and adjusted their manner of communicating with "Ronnie" to establish and maintain boundaries. He eventually accepted treatment and is now on medication which has improved his quality of life. "Ronnie's" mother was extremely grateful for RBEST staff's perseverance and "Ronnie" also expressed his deep appreciation for the staff's efforts.

"Thank you for never giving up on me. I love you guys."

- RBEST consumer

Full Service Partnerships

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, and when appropriate their families, including supports. This framework includes providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. The primary goal of FSP programs is to improve quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and reducing high frequency use of psychiatric hospitalizations or emergency and crisis services. FSP programs strive to provide stabilizing services for the consumer at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by age and service categories for Fiscal Year 2022-23:

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Program Name	Ages Served	Service Category*	Total
Comprehensive Children and Family Support Services (CCFSS)	5,342 Children 1,296 TAY	3,751 FSP 2,887 O&E	6,638
Integrated New Family Opportunities (INFO)	89 Children 175 TAY	104 FSP 160 GSD	264
One Stop Transitional Age Youth (TAY) Centers	11,363 TAY	448 FSP 267 GSD 10,647 O&E	11,363
Forensic Services Continuum of Care	250 Adults 25 Older Adults	250 FSP	275
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services	135 Adults	135 FSP	135
Regional Adult Full Service Partnership (RAFSP)	640 Adults	320 FSP	640
Age Wise	1,220 Older Adults	220 FSP 1,000 O&E	1,220

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.
*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Full Service Partnerships

Services Provided

FSP consumers are provided with services including, but not limited to:

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

Artwork by Tracy Hutchinson

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 383-386.

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
CCFSS	3,751*	6,638	$45,173,338	$6,805

*This number does not include O&E.

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

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

Target Population and Program Description

The Comprehensive Children and Family Support Services (CCFSS) program uses the Core Practice Model (CPM) and provides services to children and youth living with severe emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their home environment in order to achieve a positive set of outcomes through unconditional care. The program is comprised of three unique Full Service Partnership (FSP) programs and the Children and Youth Collaborative Services (CYCS).

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 387-402.

The three individualized and targeted Full Service Partnership (FSP) subprograms are:

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

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

Consumer Demographics Highlights FY 2020-21

Age

68% Children
32% TAY
0% Adult
0% Older Adult

Gender Identity

55% Male
45% Female
0% Other

Race/Ethnicity

1% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
19% African-American/Black
20% Caucasian/White
49% Latinx/Hispanic
10% Other

N=3,751

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	97.9%	72.5%

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	87.8%	73.6%

Specific Areas of Life Functioning (Impact Report):

Item/Issue	Presented with a Need	Improvement of the Need
Family Difficulties	84%	65%
Social Functioning	71%	67%
Recreational	45%	64%
Sleep	53%	71%
School Behavior	45%	68%
School Achievement	58%	63%
School Attendance	36%	63%

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

Item/Issue	Presented with a Need	Improvement of the Need
Impulsivity/Hyperactivity	52%	60%
Depression	64%	73%
Anxiety	51%	65%
Anger Control	68%	74%
Adjustment to Trauma	60%	60%
Emotional and/or Physical Dysregulation	70%	68%

Consumer Demographics Highlights FY 2020-21

Primary Language

93% English

5% Spanish

2% Other

Primary Diagnosis

0.8% Psychosis
3.0% Bipolar Disorder
24.8% Depressive Disorder
1.1% Substance Use
13.5% Other
22.1% Anxiety Disorders
14.1% Disruptive
15.6% Neurodevelopmental/Cognitive
0.1% Childhood/Adolescent Onset
4.9% None/Deferred Diagnosis

N=3,751

Positive Results (cont.)

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%	93%
Children needing help improving their functioning within their living situation	57%	69%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	14%	68%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	40%	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%

"I like this program because I learned new ways to deal with my depression and the fun activities and how I made new friends."
-CCFSS Client

Challenges and Solutions

In Fiscal Year 2020-21, the continued impact of the COVID-19 pandemic was felt by the community, the staff, and the clients. CCFSS was impacted by the ongoing evolution of the ChRIS program, and the implementation of a new billing system, an Electronic Health Record (EHR), by the Department.

The ongoing pandemic continued to cause challenges with the delivery of mental health services due to multiple spikes in infections and outbreaks, the implementation of vaccinations, and providers facing great difficulties in providing services. In July of 2020, providers were starting to fully implement telehealth practices; however, many youth and families expressed a dislike for that medium and declined services. In addition, some residential programs had outbreaks which required clients to quarantine and even caused the temporary closure of sites.

In the latter part of Fiscal Year 2020-21, programs reported that with vaccinations, staff were able to provide in-person services while still complying with CDC guidelines. Providers reported that typically they were able to match staff comfortable with in-person sessions with youth and families that preferred that medium of service. Once the vaccine was approved for certain youth, youth availability for in-person sessions increased.

Another challenge faced during Fiscal Year 2020-21 was difficulty keeping staff and recruiting new staff to adequately serve the number of youth seeking services. This challenge particularly impacted the ChRIS program which, as a residential provider, resulted in limitations of youth accepted into the program. However, the most significant reduction of the ChRIS program was attributed to the three largest programs obtaining and utilizing Mental Health Contracts with other counties.

Challenges and Solutions (cont.)

In establishing contracts with other counties, the Short-Term Residential Therapeutic Programs (STRTP), no longer credited San Bernardino County for the mental health services for youth from other counties. That administrative change in addition to an increased episode length from an average of 222 days in Fiscal Year 2019-20 to 249 days in Fiscal Year 2020-21, accounts for the decrease in the number of youth served.

Additionally, the implementation of the Electronic Health Record (EHR) and new billing system caused a challenge for the programs. As a result of the implementation, difficulties in tracking data have occurred due to the learning curve of the new system, which has led to questions of data validity. While the issues are being addressed, service and client data still require extensive verification and the process of utilizing data feedback loops to calibrate activities has been put on hold for months.

Program Updates

The Family First Prevention Services Act (FFPSA) requires that all youth leaving a Short-Term Residential Therapeutic Program (STRTP) to a Family-Based level of care receive high fidelity wraparound services to support the youth during the transition. This requirement is to be in place prior to October 1, 2022, and details that the length of wraparound services is 6-months. The implementation of these services in San Bernardino County will be through an expansion of contracts with our existing Wraparound providers.

On July 1, 2021, Mental Health Plans in the State of California were required to implement an immediate response program for current and former foster youth and current wards of the court in an initiative titled, Family Urgent Response System (FURS). This program requires counties to respond to calls made by youth to a state-wide hotline with a local response.

Program Updates (cont.)

In San Bernardino County, the FURS program is implemented through existing Success First-Early Wrap (SF/EW) providers who are on standby to answer FURS calls referred by the Children and Family Services (CFS) hotline and provide the required 1-3 hour in-person response under most conditions. Beyond responding to the immediate crisis, the SF/EW teams arrange for a Child and Family Team Meeting as soon as possible and transition the youth and family to ongoing services.

Outreach and Engagement

For Fiscal Year 2020-21, 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
Coordination and Outreach (e.g., AB 1299 and ASC)	7,782	9,756
Consultations (procedures 556, 551, 575, and 576 provided by CCICMS staff)	1,528	232
Total	**9,310**	**9,988**

"Thank you therapist for being supportive with me. Thank you for taking your time to talk with me. Thank you for being yourself. Thank you for being positive. Thank you for making me smile. Thank you for making me laugh. Thank you for taking me on walks and talking to me. Thank you very much for being a kind person. Thank you for being a lovely person. Thank you for being my therapist."

-CCFSS Client

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
INFO	190	264	$1,452,311	$5,501

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

*SED = Serious emotional disturbance

Target Population and Program Description

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.

"My INFO experience will last me forever, thank you for the support."

-INFO Consumer

"I know that due to all the things I talked to my therapist and probation officer about that now I can move forward in life."

-INFO Consumer

For more information, please reference the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 403-409.

Consumer Demographics Highlights FY 2020-21

Age

15% Children
87% TAY
0% Adult
0% Older Adult

Gender Identity

86% Male
14% Female
0% Other

Race/Ethnicity

0% American Indian/ Alaskan Native
0.5% Asian/ Pacific Islander
27.9% African-American/Black
7.0% Caucasian/White
64.2% Latinx/Hispanic
0.5% Other

N=190

Positive Results

During Fiscal Year 2019-20, youth who completed the program served fewer days in detention after the program (*Mean* = 15.84) than those who terminated (*Mean* = 58.82) and those who declined to participate (*Mean* = 36.63).

Youth who completed the program had fewer sustained misdemeanor or felony offenses after the program (*Mean* = .21) than those who terminated (*Mean* = .46) and those who declined to participate (*Mean* = .40).

Youth who completed the program were detained fewer after the program (22.4% of the youth) than those who terminated (57.3%) and those who declined to participate (44.5%).

Youth who completed the program recidivated fewer after the program (rate of 15.4%) than those who terminated (29.3%) and those who declined to participate (26.3%).

Additionally, the INFO program increased collateral contacts from 2,782 in Fiscal Year 2018-19 to 3,244 in Fiscal Year 2019-20, increasing the number of encounters with family members and informal supports by 16%.

Challenges and Solutions

The greatest challenge in Fiscal Year 2020-21 was the continued use of telehealth due to COVID-19 as the INFO implementation model has been historically community-based. This created ongoing challenges for both staff and consumers in acclimating to the "team" approach via telehealth and telecommuting. To address the ongoing issue, the INFO program has continued teaching their team the roles, responsibilities, and legalities necessary to conduct sessions via telehealth, as well as, educating new clinicians virtually on a model developed to be delivered in the consumers' home.

The INFO program continues hosting weekly huddle meetings via WebEx to preserve fidelity to the Functional Family Therapy (FFT) model and keep the communication necessary to support an intact team. In doing this, providers developed the new skill set necessary for the team to facilitate FFT via telehealth.

Program Updates

The INFO program plans to add an additional Probation Officer in the High Desert region to better serve consumers and support the program.

Consumer Demographics Highlights FY 2020-21

Primary Language

97% English

2% Spanish

1% Other/Unknown

Primary Diagnosis

5.8% Substance Use Disorder

17.9% Anxiety Disorders

1.6% Psychosis

12.6% Depressive Disorder

28.4% None/Deferred Diagnosis

2.1% Neuro/dev

13.2% Other

1.6% Bipolar Disorder

16.8% Disruptive

N=190

One Stop Transitional Age Youth (TAY) Centers

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
TAY	444*	11,363	$6,192,938	$545

*This number does not include O&E.

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

Target Population and Program Description

The Department of Behavioral Health supports four One Stop Transitional Age Youth (TAY) Centers in each region of the 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 out-of-home placements (e.g., foster care, group homes, and institutions).

One Stop TAY Centers provide drop-in services to TAY and, when appropriate, their families. These services address employment, educational opportunities, housing, behavioral health, physical well-being, substance 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.

Access to participation in outreach and engagement services and events are provided to unserved TAY, and when appropriate their families, to engage and educate them on the County's behavioral health system. Services include, but are not limited to health fairs, job fairs, street outreach, and weekly orientations.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 410-423.

Consumer Demographics Highlights FY 2020-21

Age

0.2% Children
93.5% TAY
6.3% Adult
0% Older Adult

Gender Identity

46% Male

54% Female

Race/Ethnicity

0% American Indian/ Alaskan Native
2% Asian/ Pacific Islander
19% African-American/Black
24% Caucasian/White
49% Latinx/Hispanic
6% Other

N=444

Positive Results

Results from the Adult Needs and Strengths Assessment (ANSA) for the period of July 1, 2017 through June 30, 2021* show the percentage of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and had that issue improve by the completion of the TAY program:

Item/Issue	Presented with a Need	Improvement of the Need
Intimate Relationships	33%	54%
Educational Attainment	35%	60%
Family/Family Strengths/Support	68%	53%
Interpersonal/Social Connectedness	72%	56%
Optimism/Hopefulness	48%	61%
Educational Setting	43%	58%
Community Connection	63%	58%
Resilience	44%	65%
Resourcefulness	39%	58%
Residential Stability	35%	59%

Item/Issue	Presented with a Need	Improvement of the Need
Family Relationships	72%	61%
Social Functioning	79%	61%
Recreational	66%	64%
Legal	11%	41%
Physical/Medical	11%	57%
Sleep	57%	69%
Living Skills	48%	55%
Self-Care	35%	54%
Medication Compliance	14%	65%
Decision-Making/Judgement	64%	58%

*Due to the length of time most TAY consumers spend in the program, data was pulled for FY 2017/18-2020-21 in order to showcase the level of progression that TAY members experience over time.

Consumer Demographics Highlights FY 2020-21

Primary Language

98% English

2% Spanish

Primary Diagnosis

16% Psychosis
12% Bipolar Disorder
42% Depressive Disorder
1% None/Deferred
1% Substance Use
18% Anxiety disorders
3% Disruptive
1% Neurodevelopmental/Cognitive
6% Other

N=444

Challenges and Solutions

The major challenge for the TAY program was the ongoing COVID-19 pandemic and an increase in positive COVID-19 cases amongst consumers, especially at the Ontario center. In Victorville, it was reported that the youth began to struggle with maintaining motivation toward participation in telehealth services for both individual and group sessions. The program also found that returning to onsite was a challenge with getting the ratio of staff and consumers right since there is limited capacity for 10 consumers on site per day, which means that there can only be 2-3 consumers on site at a time so as not to exceed the capacity of the location.

To address the safety concerns regarding COVID-19, the Ontario TAY center increased safety measures to keep staff and consumers safe while continuing to provide therapy, case management, and medication services. The staff received reminders and information on self-care and COVID-19 safety in order to help manage their fears, and to recognize those fears exist. For the issue of youth struggling to stay motivated while receiving telehealth services, the Victorville TAY program implemented a "Five Senses" activity in the hope of recapturing some of their "TAY Magic." Program staff mailed out personalized items to consumers or personally delivered when possible. For the Victorville TAY, consumers are being rotated on the days they can come in with certain staff for the groups that are held onsite. The program is trying to be as flexible as possible to accommodate consumers wanting face to face services.

For all TAY programs the implementation of the new Electronic Health Record (EHR) was a challenge; however, TAY staff provided additional EHR trainings and worked out issues in the system that occurred partially in part to working with multiple programs that have different requirements. Additionally, the San Bernardino TAY center has two trained EHR "super users" that are available to assist all TAY program staff.

The Victorville TAY center faced severe emotional stress that impacted program staff and made it difficult for them to maintain their composure when providing services to clients. Each staff member had multiple emotional stressors including the passing of a clinician, staff member's loss of family members, staff testing positive for COVID-19, and several days with internet and/or phone outages throughout the High Desert. Yet, despite the many emotional stressors experienced by staff, it was reported that the team went above and beyond expectations with units of service provided to consumers. Management also provided support to each staff member by ensuring they had enough time to process what was going on and that they knew they had someone to reach out to if they needed to talk.

The Yucca Valley TAY center reported a challenge with their consumers managing psychiatric medications. To address that challenge, program staff continued to communicate with the consumer's psychiatric provider so that the provider could continue to discuss the adverse effects of not taking medications as prescribed. The psychiatric provider also requests labs routinely to ensure clients' medication levels were appropriate. All Yucca Valley TAY program staff continue to communicate the importance of taking medications as prescribed and routinely refer clients to the psychiatric provider as needed.

Another challenge faced at the Yucca Valley TAY center has been substance use among a few of the consumers which has negatively impacted their housing, employment, and participation in program activities. The consumers struggling with substance use are meeting with the program's AOD counselor and being provided additional resources.

"I love TAY because TAY has helped me feel less lonely."
-TAY Consumer

Outreach and Engagement

For Fiscal Year 2020-21, the One Stop Transitional Age Youth Centers program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Conference Resource Booth	3	734
Mental Health Events Attended	2	61
Open House	1	20
Health/Resource Fair	4	545
Presentations	15	578
Community Outreach	524	3,058
Orientation	410	464
Collaborative Meeting	212	8,552
Online Media	44	1,920
Other (e.g., Food Box distribution)	158	257
Total	**1,373**	**16,189**

Program Updates

Recently TAY Centers have experienced a 55% increase in client referrals for TAY FSP services (resulting in 43% increase in FSP). The Eating Disorder Collaborative program has also started referring additional clients for TAY FSP services, and in the future the Early Psychosis program will be referring youth to the program, which further increases the need for more staff to provide services (anticipated additional 10% increase in referrals).

Program Updates (cont.)

To be able to serve these clients, the TAY program will need one additional Social Worker II and one additional Clinical Therapist II.

Success Story

"Tom" came into the program several years ago. Over the years program staff have seen him grow in his engagement in the program and dedication to improving himself. As a result of his hard work in individual therapy, group therapy, and case management services, he has successfully completed his probation, obtained verification of legal residency, and has moved out of Emergency Shelter Bed housing into self-paid housing.

Success Story

A TAY consumer reported that he has been happy since he started attending the TAY Center and enjoys participating in all the events. The consumer's mother also reports the consumer is happier at home and she has seen improvements in his behavior.

Adult Forensic Services (AFS)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
AFS	288	250	$9,815,399	$39,262

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

*SMI = serious mental illness

Target Population and Program Description

The Adult Forensic Services (AFS) [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 six (6) sub-programs designed to target specific populations. The targeted subprograms are:

- Choosing Healthy Options to Instill Change and Empowerment (CHOICE)
- Supervised Treatment After Release (STAR)
- Community Supervised Treatment After Release (CSTAR)
- Forensic Assertive Community Treatment (FACT)
- Community Forensic Assertive Community Treatment (CFACT)
- Corrections Outpatient Recovery Enhancement (CORE)

The **Choosing Healthy Options to Instill Change and Empowerment (CHOICE)** program, while no longer MHSA funded, provides necessary services to probationers. The CHOICE program is co-located in the San Bernardino County Probation Day Reporting Centers (DRCs) in Fontana, San Bernardino and Victorville, as well as in the probation offices in Barstow and Joshua Tree. The CHOICE program design enables a "one stop shop" for screening and linkage to FSP services for those who meet the FSP criteria, and standard behavioral health services for those who do not but are still in need of assistance.

For additional information, pleaser refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 424-437.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
13% TAY
84% Adult
3% Older Adult

Gender Identity

65% Male
35% Female

Race/Ethnicity

0% American Indian/ Alaskan Native
2% Asian/ Pacific Islander
20% African-American/Black
39% Caucasian/White
31% Latinx/Hispanic
8% Other

N=288

Target Population and Program Description (cont.)

The Supervised Treatment After Release (STAR) and Forensic Assertive Community Treatment (FACT) Full Service Partnership (FSP) programs serve consumers living with SMI who are under formal supervision by 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 assists consumers who have difficulty participating in traditional outpatient mental health services. FACT services are community based; however, intensive program services, supportive case management, and psychiatric services are provided in the home for those individuals who need a higher level of care.

The Community STAR (CSTAR) and Community FACT (CFACT) FSP programs operate in the same capacity as STAR and FACT; however, consumers are no longer under formal supervision but would still benefit from voluntarily participating in mental health and substance use services for a short period of time. CSTAR is a community-based referral program that also provides mental health treatment services to consumers transitioning from the CHOICE program as well as Mental Health Diversion (MHD) Court whereas CFACT consumers transition from other Forensic Services programs or general community but must be referred through DBH Forensic Services.

The Corrections Outpatient Recovery Enhancement (CORE) program is a FSP program that provides intensive behavioral health treatment services to adult parolees diagnosed with a serious mental illness 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.

Consumer Demographics Highlights FY 2020-21

Primary Language

96% English

2% Spanish

2% Other

Primary Diagnosis

41% Psychosis
19% Bipolar Disorder
11% Depressive Disorder
2% Other
3% Anxiety disorders
2% Substance Related
22% None/Deferred Diagnosis

N=288

Positive Results

Through participation in the program (typically 1.5 to 2 years), homelessness for all participants decreased nearly to 0% since the programs facilitate or provide housing. In FY 2020-21, the FS programs provided housing for:

Program	Number of consumers Housed
JT MHC	17
STAR	48
CSTAR	34
FACT/CFACT	30
CORE	38
FS Total	**167**

In comparison to pre-enrollment levels, participants enrolled in the Forensic Services programs have shown high rates of diversion from incarceration. The following data represents the reduction in jail days for FY 2020-21.

Program	Percentage Reduction
STAR	87%
CSTAR	98%
JT MHC	66%

Outcomes in the JT MHC program have been impacted by COVID-19, which greatly decreased consumer participation, as well several personnel changes in the MHC treatment team.

In comparison to pre-enrollment levels, participants enrolled in the Mental Health Court and or CHOICE programs have shown high rates of diversion from psychiatric hospitalization. The following data represents the reduction in psychiatric hospital admissions for FY 2020-21:

Program	Percentage Reduction
STAR	58%
CSTAR	67%
CORE	80%
JT MHC	100%
FACT/CFACT	36%

Success Story

"Mike" successfully completed the CHOICE program and was referred to CSTAR for additional support services. He was linked with DBH employment service and received support from the Department of Rehabilitation. In November of 2020, he obtained employment, is still employed with the same company and is doing well.

Challenges and Solutions

The Adult Forensic Services (AFS) programs endured various challenges throughout Fiscal Year 2020-21. Some program challenges included limited availability of group treatments, increased reliance on telehealth, court closures and delays in referrals, increased SUD program referrals, and shortage of available shelter beds combined with increased need for shelter placements. Additionally, AFS programs have seen a significant increase in demand for Mental Health Diversion (MHD) clients brought on by changes in state level placement and funding. MHD consumers are being treated through the CSTAR program, however, programs specific for this population are needed to ensure consumers are receiving proper treatment.

Adult Forensic Services program staff have returned to providing in person services. In person intensive outpatient services continue and a plan to restart Day Treatment is currently in place. Clinics are still limited in available space; staff are encouraged to practice social distancing, monitor their health, and take other preventative measures for their safety and the safety of the consumers they serve.

To address the need for additional resources, a contract for Residential SUD treatment services is now in place to assist in placing and treating clients with co-occurring SUD in addition to the outpatient mental health treatments they are receiving. Also, a new contract for FACT and CFACT programs begins October 2021, with an approved client load of 50, up from the 35 in the previous contract.

Additionally, the AFS division is continuing to develop and implement streamlined referrals and approvals for clients going into the FACT and CFACT programs as well as further developing relationships with the MHCs and Mental Health Diversion Courts to identify and place not competent to stand trial (IST) and potential IST clients more efficiently.

"I have seen immense personal growth and I am confident in myself and my ability to communicate with others. I'm proud of myself and what I have accomplished during my time with Telecare."

-FACT Consumer

"Believe that good things are possible, and if they trust in the program good things can be possible for them. It's important that you be patient with the process especially in the beginning and at the end of it all you'll meet many different people who you'll be able to call friend."

-FACT Consumer

Outreach and Engagement

In Fiscal Year 2020-21, the Adult Forensic Services (AFS) Continuum of Care program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
USDA Food Distribution	6	67
East Valley Steering Committee meeting	9	162
Family Assistance Program meeting	4	28
Virtual NAMI Walk	1	10
Desert Mountain Children's Center meeting	5	19
Reach Out meeting	9	84
SB Teams Clubhouse meeting	4	10
Morongo Basin Coalition meeting	3	27
Morongo Unified School District meeting	4	18
Interagency Council of Homelessness meeting	1	64
Homeless Providers Network meeting	2	11
San Bernardino Mentoring Program meeting	1	19
Yucca Valley Town Council meeting	3	5
Basin Wide Foundation meeting	1	29
Community Outreach meeting	4	16
Copper Mountain College meeting	3	19
Total	**60**	**995**

Program Updates

In Fiscal Year 2022-23, there will be an increase in the FACT/CFACT and CSTAR programs budget in the resulting in changes in program services. The program changes will include:

- CSTAR – Addition of dedicated probation officer to the program who will support services for Mental Health Diversion Court clients who are not under formal supervision with probation.
- FACT/CFACT - New contract approved to serve 50 clients (increased from 35). There is a projected increase in demand based on the mental health diversion population, a new group of clients served through the CFACT program in response to legislation that went into effect in January of 2020 (PC 1001.36).

In addition, the AFS Continuum of Care plans to fill three positions:

- One Grant Analyst, who will work with AFS management to research, analyze, apply for, track, monitor, and report on grants that will provide funding to cover costs of supporting the forensic population, and
- Two Mental Health Specialist (MHS) positions, deemed "Placement Navigators," who will navigate the ongoing placement needs for consumers in time limited emergency shelter housing which require immediate case management services to assist with completing the application process for housing vouchers, assisting with the process of locating appropriate housing, and completion of the housing voucher process. These Placement Navigators will also work with consumers on a permanent housing plan, which may eventually be transitioned to another Division within the Department as appropriate.

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

Program Name	Actual Number Served FY 20-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
ACT Model FSP Services	166	135	$2,827,757	$20,946

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

Target Population and Program Description

The Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services program serves San Bernardino County adult residents, 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.

In Fiscal Year 2019-20, the Assertive Community Treatment program consisted of Members Assertive Positive Solutions (MAPS) and Assertive Community Treatment (ACT) subprograms; however, as of Fiscal Year 2020-21, the subprograms have been consolidated into the ACT Model FSP Services program. The ACT Model FSP Services program specializes in assisting those who may be transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs), or locked psychiatric facilities, and 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 the program builds on traditional Assertive Community Treatment standards with an approach based on the belief that "recovery can happen" and creating an environment that promotes personal resiliency. Key components of the ACT model are treatment and support services that are individualized and guided by the consumer's hopes, dreams and goals for behavioral health and overall wellness.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 438-447.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
5.4% TAY
78.3% Adult
16.3% Older Adult

Gender Identity

57% Male
43% Female
0% Other

Race/Ethnicity

0% American Indian/ Alaskan Native
2% Asian/ Pacific Islander
19% African- American/Black
43% Caucasian/White
30% Latinx/Hispanic
6% Other

N=166

Positive Results

In Fiscal Year 2020-21, MAPS and ACT served a total of 166 consumers. The following represents MAPS and ACT outcomes and percentages of consumers that meet the criteria:

Outcome	MAPS	ACT
Percentage able to maintain stable housing	100%	100%
Percentage that avoided psychiatric inpatient hospitalization	96.8%	94.3%
Percentage that liked the services	94%	95%
Percentage that felt staff believed they could grow, change, and recover	91%	87%
Percentage that believed staff provided services in a manner that was sensitive to their cultural background	86%	97%

Outreach and Engagement

For Fiscal Year 2020-21, the ACT Model FSP Services program was unable to conduct outreach and engagement activities due to the COVID-19 pandemic.

Consumer Demographics Highlights FY 2020-21

Primary Language

96% English

1% Spanish

3% Other

Primary Diagnosis

80% Psychosis
10.6% Bipolar Disorder
7.6% Depressive Disorder
1.2% Anxiety Disorders
0.6% Substance Related

N=166

Challenges and Solutions

The program encountered challenges during the pandemic in providing direct services to consumers. Placement programs restricted visits, transportation was limited, and many consumers struggled with telehealth psychiatry and services via phone. To address those concerns, teams utilized cell phone access to increase engagement which included teams scheduling contacts with providers in conjunction with video conference calling. Placements were provided with pre-paid phones along with a schedule of when staff would be contacting consumers to provide services and ensure consumers were receiving needed support.

Housing was a significant challenge for many consumers as placements have a difficult time accepting consumers who have a history of violence and/or drug use. In addition, consumers with existing medical conditions have difficulty finding placement since some housing locations are not equipped to provide necessary medical support for these individuals. One method used to address the concern of housing was to utilize email communication to connect the contract provider with Public Guardian staff, thus streamlining the communication process. By reducing communications gaps, DBH staff were able to quickly communicate consumers' additional support needs and more promptly secure housing opportunities for them.

Keeping staff and consumers safe was the top priority for the program; however, some clients refused to wear masks or did not understand the use of masks, which proved challenging for continued services. To address the safety concerns of both staff and consumers, additional Personal Protective Equipment (PPE) was provided to clients, and staff coordinated with placements to reinforce safety procedures to help keep everyone as safe as possible. The closure of programs such as wellness groups or any outside community events also impacted clients, which exacerbated many symptoms. Staff also coordinated field visits with members and their families to help build trust and continue to reinforce safety practices.

Success Story

"Steven" came to the program struggling with extreme social anxiety and rarely left his home because he was afraid of experiencing a panic attack while out. With interventions from the team and their support, he is now ready and willing to participate in day programs and his social anxiety has decreased significantly. "Steven" shared that he now engages with others in his home and ventures out into the community more often. He has shown significant growth since first joining the program and is consistently taking his medication. He also asks for assistance when he needs it and has learned appropriate communication skills to assist in getting his needs met. In addition, "Steven" has been clean and sober for 11 years.

Regional Adult Full Service Partnerships (RAFSP)

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
RAFSP	532	930	$6,098,545	$6,557

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

Target Population and Program Description

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 Hi-Desert Medical Center and Valley Star Behavioral Health, Inc., to provide additional FSP services throughout San Bernardino County. The RAFSP programs provide access and linkage, as well as, full wraparound care to consumers. These services include intensive clinic and field-based services that assist individuals in accessing various levels of care and housing.

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. 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.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 448-459.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
8.64% TAY
81.77% Adult
9.59% Older Adult

Gender Identity

46% Male

54% Female

Race/Ethnicity

1.32% American Indian/ Alaskan Native
2.26% Asian/ Pacific Islander
17.48% African-American/Black
41.35% Caucasian/White
32.33% Latinx/Hispanic
5.26% Other

N=532

Positive Results

Consumers are provided the full array of FSP services in order to reduce hospitalizations and hospital bed days. In the charts below, positive numbers represent an increase from FY 2019-20 to FY 2020-21 and negative numbers represent a decrease. Most RAFSP programs had less hospitalized consumers, less hospitalizations, and less bed days overall. Hospitalization outcomes were also affected by the ongoing COVID-19 pandemic. Overall, the RAFSP program increased the number of consumers served by 92% in FY 2020-21 compared to FY 2019-20.

Provider Name	Unduplicated Consumers Served	% of Consumers Who Avoided Hospitalization Completely in FY 20/21
Barstow Counseling	44	**93%**
Mesa Counseling Services	58	**86%**
Victor Valley Counseling Center	93	**90%**
Phoenix FSP (Clinic Based)	71	**89%**
Valley Star FSP	79	**99%**
San Bernardino Action Program	129	**92%**
Mariposa Counseling Center	37	**95%**

Provider Name	Comparison between FY 2019-20 and FY 2020-21	
	% Change of Hospitalizations	% Change in Number of Hospital Bed Days
Barstow Counseling	-50%	-47%
Mesa Counseling Services	-50%	-13%
Victor Valley Counseling Center	-35%	-37%
Phoenix FSP (Clinic Based)	0%	-17%
Valley Star FSP	-63%	-52%
San Bernardino Action Program	-37%	-56%
Mariposa Counseling Center	-83%	-20%

Consumer Demographics Highlights FY 2020-21

Primary Language

94% English

4% Spanish

2% Other

Primary Diagnosis

49% Psychosis

24% Bipolar disorder

2% Other

4% Anxiety disorders

21% Depressive disorder

N=543

Challenges and Solutions

The major challenges for the RAFSP program were mostly caused by the ongoing COVID-19 pandemic. Face-to-face services were difficult to conduct and there were limited community resources available for consumers. As a result of mental health symptoms some FSP consumers struggled with the many pandemic safety precautions/requirements, obtaining vaccines, and maintaining regular mask use. In addition, some consumers were transferred from medications being administered via injections to oral medications which impacted their stability and progress. Other consumers struggled with increased isolation as group supports such as Clubhouses and clinical groups were stopped as a safety precaution due to social distancing requirements and limited space. Some consumers also reported increased substance use/abuse to subsidize their isolation.

At this time, both telephone and face-to-face services are available with the majority of consumers choosing to receive most services in person. This is important because the health of the Tier III population necessitates periodic visual assessment. Allowing clients some flexibility in how they receive care is extremely helpful since some are cautious about coming into the clinic again. In addition, injectable medications are being administered at the clinic sites once again.

COVID-19 vaccination clinics for consumers continue which has been helpful in getting services back to normal. This also allows for more staff and consumers to be back in group settings as well.

Outreach and Engagement

For Fiscal Year 2020-21, the Regional Adult Full Service Partnership program was unable to conduct outreach and engagement activities due to the pandemic.

Program Updates

Full Service Partnership (FSP) programs provide intensive case management for consumers living with serious mental illness (SMI) or severe emotional disturbance (SED). The full-service partnership framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of consumers, and when appropriate their families, including supports, providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. 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. In Fiscal Year 2022-23, an expansion of the Full-SP programs at Victorville, Barstow, Needles, Mariposa, and Phoenix clinics is planned. This will allow the provision of additional intensive FSP services in all the clinics in the Desert Mountain Region to prevent hospitalizations, incarcerations, and homelessness in some more remote areas, while providing additional support for the programs in the valley.

Success Story

"Alex", a Phoenix FSP consumer struggling with an eating disorder progressed from daily purging and food restriction to significantly decreased purging. They also obtained their driver's license and got their first job.

Age Wise

Program Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Age Wise	122*	1,220	$2,524,659	$2,069

*This number does not include O&E.

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

Target Population and Project Description

The Age Wise program provides Full Service Partnership (FSP) behavioral health and case management services throughout San Bernardino County to older adults ages 59+ living with the most severe mental health diagnoses. Age Wise works to increase access to services for the older adult community and decrease the stigma associated with the behavioral health and wellness system. Age Wise program services are provided through the San Bernardino County Department of Aging and Adult Services – Office of the Public Guardian (DAAS-OPG).

Age Wise focuses on assisting unserved and underserved 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 aging needs of the older adult population.

"The depression feels like being in a dark room and you can't get out. If someone would talk to me, it would be like a window has been opened."

-Age Wise Consumer

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 460-468.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
0% TAY
1% Adult
99% Older Adult

Gender Identity

28% Male
72% Female

Race/Ethnicity

2% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
14% African-American/Black
51% Caucasian/White
27% Latinx/Hispanic
5% Other

N=122

Positive Results

The following table represents the measured Age Wise outcome domains and the percentage of consumers who met the criteria in each category and service area:

Outcome Domain	San Bernardino Area	High Desert Area
Maintained low or reduced risk of subjective suffering as determined by the DCR	93%	78%
Maintained safe and stable housing	100%	100%
Are stable and able to seek outside assistance to locate their own resources	58%	51%
Consumers linked to a Primary Care Physician	100%	100%
Reported an ethnicity other than Caucasian	45%	13%
Diverted from hospitalization for psychiatric care	100%	100%

Challenges and Solutions

Due to the COVID-19 pandemic and the Center for Disease Control (CDC) associated restrictions, several challenges have been ongoing. As one of the most vulnerable populations affected by COVID-19, older adults continued to express their fears and anxieties due to unknown and changing information about the pandemic. This has resulted in social isolation which contributed to higher levels of anxiety, depression, and loneliness. COVID-19 restrictions and mandates created additional challenges such as access to medical care and transportation, housing needs, and the ability to obtain food and clothing. Stimulus payments provided by the government as part of the COVID-19 relief efforts were also an unforeseen challenge, as the older adult population was often the target of fraud and scams as it related to the release of those funds.

In response to the pandemic and the ongoing needs of the older population, the Department of Aging and Adult Services – Office of the Public Guardian (DAAS-OPG) implemented the Age Wise 24/7 Senior Hotline to enhance senior's access to assistance and resources. The hotline has continued to serve seniors struggling with social isolation and other challenges such as food insecurity. The hotline also provides an immediate connection to a licensed clinician who can help connect seniors with behavioral health services and other necessary resources.

Consumer Demographics Highlights FY 2020-21

Primary Language

83% English

12% Spanish

5% Other

Primary Diagnosis

16.4% Psychosis

2.5% Anxiety disorders

18% Bipolar Disorder

61.5% Depressive Disorder

0.8% Substance Use Disorder

0.8% Other

N=122

Challenges and Solutions (cont.)

In January of 2021, DAAS-OPG collaborated with the Department of Public Health to assist with vaccination clinics for older adults. The clinics were tailored to seniors to support one of the most at-risk populations by providing a safe and accessible place for vaccinations. DAAS-OPG and Age Wise staff made significant outreach efforts, including calling older adults throughout the county to inform them of available clinics and assist with scheduling their appointments. Age Wise staff were also present onsite at the Vaccination Clinics to help with scheduling second appointments. Age Wise Clinicians were onsite to provide behavioral health interventions for those experiencing anxiety related to the vaccination, or difficulties coping through the pandemic. The older adult Vaccination Clinics were an essential component to addressing the health and safety of a vulnerable population. Additionally, Age Wise staff used their presence at the Vaccination Clinics as an opportunity to provide outreach which included education about Age Wise program services and the distribution of more than 4,000 Age Wise brochures and service flyers advertising the Age Wise 24/7 Senior Hotline.

To address the concerns regarding possible fraud and scams, Age Wise staff took a proactive approach and accessed Social Security Administration updates and public information announcements regarding scam alerts. Clients were contacted, informed, and educated on how to handle situations in which they may be the target.

Success Story

"Hector" is an older adult male who only speaks Spanish. He has a history of mania, irritable mood, paranoid delusions, and hostile attitude. In addition, he has tangential speech, interpersonal conflicts, and limited self-hygiene. Before he came to Age Wise, "Hector" had a history of being homeless for many years, living in his car until he received MHSA housing. With support from the Age Wise multidisciplinary team over the past year, "Hector" has maintained adherence to his medication and generally accepted therapy. He has increased his ability to self-regulate and has not experienced a manic episode in over a year. Additionally, the program has provided advocacy for accommodations resulting in a live-in caretaker.

Outreach and Engagement

For Fiscal Year 2020-21, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
In-Service Presentations	13	156
Vaccination Clinics	41	4,179
Total	**54**	**4,335**

Introduction

The Housing and Homeless Services Continuum of Care Program (HHSCCP) is a robust continuum of services for individuals that are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness and/or substance use disorder. HSCCP is comprised of Homeless Outreach Support Team (HOST), Emergency Shelter Services, Full Service Partnership and Supportive Services, and the Employment Services Program.

Outreach and engagement services are offered to participants and their families in an effort to provide resources that will aid them in obtaining permanent supportive housing. Wraparound services are provided to program participants and assist individuals with maintaining housing and in becoming resilient in the community. The programs provide empowerment for self-sufficiency, as well as linkage to other services.

HHSCCP services also include community outreach and response, housing navigation, emergency shelter, emergency shelter case management, bridge housing, permanent supportive housing, employment services, and Full Service Partnership supportive services.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by service categories for Fiscal Year 2022-23:

	Program Name	Fiscal Year	Service Category*
Housing and Homeless Services Continuum of Care Programs	Homeless Outreach Support Team	2022-23	375 O&E
			TOTAL = 375
	Project Roomkey	2022-23	452 GSD
			TOTAL = 452
	Full Service Partnership and Supportive Services	2022-23	713 FSP 294 GSD
			TOTAL = 807

*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.

Housing and Homeless Services Continuum of Care

Program Name	Actual Number Served FY 2020-21	Estimated Number to be Served FY 2022-22	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
HHSCCP	1,852	1,553	$14,810,789	$9,536

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

*SMI = serious mental illness

Target Population and Project Description

The Housing and Homeless Services Continuum of Care Program (HHSCCP) provides an extensive system of care to homeless residents living with a serious mental illness and/or substance use disorder. The target population 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 a comprehensive service. The Homeless Continuum has adapted and changed to meet the expanding needs of the homeless population and incorporate new and changing funding options.

The HHSCP is comprised of Homeless Outreach Support Team (HOST), Emergency Shelter Services, Full Service Partnership and Supportive Services, and the Employment Services Program.

Services Provided

- Homeless Outreach and Support Team
  - Outreach and Engagement
  - Community Outreach and Response
  - Emergency Housing Navigation
- Emergency Shelter Services
  - Shelter and Bridge Housing
  - Emergency Shelter Case Management
- Full Service Partnership and Supportive Services
  - Full Service Partnership and/or mental health services for residents in Permanent Supportive Housing
  - Eviction prevention

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 469-486.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
2% TAY
73% Adult
25% Older Adult

Language

94% English
4% Spanish
2% Other

Gender Identity

40% Male

60% Female

Race/Ethnicity

31% African-American/ Black
1% Asian/Pacific Islander
37% Caucasian/White
26% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/Other

N= 1,852 Note: Demographics represents all Housing and Homeless Services Continuum of Care programs.

Homeless Outreach and Support Team

Target Population and Project Description

The Homeless Outreach and Support Team (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

- Homeless outreach and engagement
  - Partners with city law enforcement and San Bernardino County Sheriff Homeless Outreach and Proactive Enforcement (HOPE) team
  - Links consumers to supportive services and treatment
- Housing navigation for Housing Authority of the County of San Bernardino (HACSB) clients
  - Assesses consumers for housing eligibility
- Community outreach and response
  - Consultation to community partners
  - Provides resources at community events
  - Provides expertise with other outreach teams

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

9% Anxiety

28% Psychosis

21% Bipolar

1% Other

41% Depression

N= 1,852

Outreach and Engagement

For Fiscal Year 2020-21, outreach and education opportunities were limited due to the ongoing COVID-19 pandemic, however, Housing Navigation was able to conduct outreach to 68 participants.

Program Update

There will be an increase in delivery of supportive services to consumers through permanent supportive housing. The supportive services include:

- Linkage to mental health services
- Substance use disorder services
- Case management
- Tenancy supports

In addition, it is anticipated that there will be an increase in the number of housing vouchers and permanent supportive housing.

Success Story

"Christian," was referred to one of the emergency homeless shelters after experiencing a manic episode and being hospitalized. He shared that he was depressed after a breakup and once he started living on the streets he dropped out of his treatment. In the shelter, he said he felt safer and was able to finally sleep. After a short adjustment period, "Christian" was able to restart treatment and work towards his goals. He worked with this case manager to gain employment as a long distance truck driver and accepted odd jobs while he sorted out issues with his license but he never lost sight of his goal. He was hired on the spot after his first interview and test drive with a trucking company. A few days later, he moved out of the shelter and thanked his case manager for giving him a second chance.

Full Service Partnership and Supportive Services

Program Name	Number of clients served in FSP FY 2020-21	Estimated Number of clients in PSH FY 2020-21	Number of clients in MHSA Housing FY 2020-21	Estimated Number of clients housed in FY 2022-23
FSP/Supportive Services	513	150	94	807

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

Target Population and Project Description

Full Service Partnership with Permanent Supportive Housing

- 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 in PSH but not enrolled in FSP program.
- Services are provided by the Department of Behavioral Health and through contracts with community-based organizations.

Artwork by Sara Snyder

Services Provided

- Assessment
- Medication management
- Intensive and ongoing case management
- Linkage to services
- Rehabilitation
- Counseling
- Therapy
- Crisis Services
- Assistance with accessing benefits and entitlements
- Eviction prevention
- Linkage to health services (mental health, substance use disorder, medical, and dental)
- Social supports coordination

Positive Results

"Project Homekey"
San Bernardino County is continuing to submit applications for grants to fund the purchase and rehabilitation of properties that will be converted into interim or permanent housing for vulnerable homeless residents. This housing will be available to those who were affected by COVID-19, including those in Project Roomkey.

MHSA Housing
DBH continues to support seven MHSA housing projects that include 104 Permanent Supportive Housing (PSH) units, housing those who are living with a serious mental illness and/or substance use disorder. Bloomington 3 opened during Fiscal Year 2020-21 which added an additional 10 units to MHSA housing.

No Place Like Home
DBH, in partnership with housing developers and the Community Development and Housing Department, are in the process of responding to a Notice of Financial Award (NOFA) for round 4 of No Place Like Home funds. Due to the time it takes to complete housing development projects, CSS dollars will be utilized and encumbered, as needed. Funding changes will be reflected in future MHSA Plan updates.

Permanent Supportive Housing
Full Service Partnership (FSP) Services – DBH is responsible for providing supportive services for the majority of the County's Permanent Supportive Housing (PSH). Services are provided to all consumers to maintain their housing stability and well being.

Challenges and Solutions

The greatest challenges experienced during Fiscal Year 2020-21 included the lack of housing inventory, food insecurity, limitations in transportation, and office closures or limited availability of in-person services to obtain the needed documentation for housing. Most of those challenges have been resolved as COVID-19 restrictions have been lifted which improved access and availability of services for consumers.

Outreach and Engagement

For Fiscal Year 2020-21, outreach and education opportunities were limited, however, Project Roomkey was able to conduct outreach to 452 participants.

Program Updates

For Fiscal Year 2022-23, there will be an increase in delivery of Supportive Services to consumers in PSH. These services include the provision of and linkage to mental health services, substance use disorder services, case management and tenancy supports. There is also the anticipation that there will be an increase in the number of housing vouchers and PSH available.

The Housing Authority has obtained additional funding from the Department of Housing and Urban Development (HUD) to provide Emergency Housing Vouchers to the community. DBH will work to expand their contract with the Full Service Partnership vendors to provide the needed services for those that are experiencing serious mental illness (SMI) to increase housing stability and retention and linkages to necessary services.

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.

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 subcomponents that comprise the continuum of services in each program 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.

The Adult Transitional Care program is comprised of three focus areas:

- Adult Residential Facilities Certified in Social Rehabilitation Services
- Community Reintegration Services
- Enhanced Assisted Living Program

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 494-495.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by age and service categories for Fiscal Year 2022-23:

Program Name		Fiscal Year	Ages Served	Service Category*
Adult Transitional Care Programs	Adult Residential Facilities Certified In Social Rehabilitation Services	2022-23	80 Adult	80 GSD
			TOTAL = 80	TOTAL =80
	Community Reintegration Services (FSP)	2022-23	50 Adult	55 FSP
			TOTAL = 50	TOTAL = 55
	Enhanced Assisted Living Program	2022-23	4 Adult	4 FSP
			TOTAL = 4	TOTAL = 4

*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 Name	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Adult Transitional Care Programs*	129	80	$12,664,128*	$158,301*

*Please see previous page for all Adult Transitional Care programs.

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

Target Population and Program Description

These 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.

Services Provided

- Residential treatment
- Rehabilitative services

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 496-503.

Positive Results

In Fiscal Year 2020-21, the program served a total of 129 consumers. Of these, only 1.6% (2 of 129) of consumers were hospitalized for varying psychiatric or medical reasons, and 98.4% (127 of 129) were able to successfully avoid hospitalization due to the interventions of this program.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
10.1% TAY
84.5% Adult
5.4% Older Adult

Language

97% English
1% Spanish
2% Other

Gender Identity

50% Male
50% Female

Race/Ethnicity

24.03% African-American/Black
1.55% Asian/ Pacific Islander
38.76% Caucasian/White
31.78% Latinx/Hispanic
1.55% American Indian/Alaska Native
2.33% Multiple Races/ Other

N=129

Challenges and Solutions

As a result of COVID-19, there has been difficulty in trying to keep consumers engaged in treatment due to the inability to conduct community activities and closure of facilities for discharge to lower levels of care. In response, the program has purchased laptops for their consumers to continue with their scheduled telehealth appointments and ensure they continue with their treatment.

Outreach and Engagement

For Fiscal Year 2020-21, the Adult Residential Facility (ARF) Certified in Social Rehabilitation Services program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Success Story

"Christine," an adult female on legal conservatorship stepped down from a locked psychiatric facility. She actively participated in the program and individual therapy. After overcoming her self-identified discharge barriers and developing a viable discharge plan, she was removed from conservatorship. Upon discharge from the program, she was able to demonstrate appropriate coping skills and identify all prescribed medications. She gained knowledge and insight into her emotional, physical, and spiritual needs. Once discharged, she was linked to community resources and established a routine with her doctors. "Christine" is now successfully living independently in the community.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

- **2%** Bipolar disorders
- **4%** Depressive disorders
- **89%** Psychosis disorders
- **1%** Substance use disorders
- **1%** Anxiety disorders
- **3%** Other

N=129

Community Reintegration Services (FSP)

Target Population and Program Description

The Community Reintegration Services (CRS) program is a Full Service Partnership designed to serve adults who are living with severe mental illness or untreated co-occurring disorders who, in many cases, have recently been 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.

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

Services Provided

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

Success Story

"John," an adult male, was residing at a facility that was not accommodating his needs for improvement at the time of his enrollment in the CRS program. The CRS team assisted his transition to another assisted living facility where he flourished, improving his interactions with others, decreasing his level of paranoia, managing occurrences of auditory hallucinations, and decreasing his desire to smoke marijuana on a daily basis. With effective case management, "John" has moved into his own apartment, has had zero hospitalizations, and learned to prepare his own healthy meals.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
6% TAY
81% Adult
13% Older Adult

Language

99% English
1% Other

Gender Identity

63% Male
37% Female

Race/Ethnicity

14.3% African-American/ Black
1.4% Asian/Pacific Islander
40.0% Caucasian/White
42.9% Latinx/Hispanic
0% American Indian/ Alaska Native
1.4% Multiple Races/Other

N=70

Positive Result

In Fiscal Year 2020-21, 91% (64 of 70) of CRS consumers avoided hospitalization.

There were three times the amount of hospital diversions by use of crisis interventions than hospital admissions and overall, there were a total of nine hospital admissions and 27 hospital diversions.

Challenges and Solutions

The most significant challenge experienced during Fiscal Year 2020-21 was the ongoing change in service medium necessitated by the COVID-19 pandemic. As a result of the pandemic, all services were changed to telephonic and/or video conference format which resulted in a very challenging transition for both consumers and staff. Prior to the pandemic, services provided to CRS consumers often involved CRS staff helping consumers access community-based services. Without the opportunity to provide face to face services, many of those services could not be provided.

Consumer Demographics Highlights FY 2020-21

Primary Diagnosis

10% Bipolar disorders

10% Depressive disorders

71.4% Psychosis disorders

4.3% Substance Use disorders

1.4% Neurodevelopmental/ Cognitive disorders

2.9% Other

N=70

Challenges and Solutions (cont.)

CRS staff also faced the challenge of learning how to use the new Electronic Health Record (EHR) while still conducting their usual workload, this however, led to increased use of online training related to the EHR and consumer care. Staff also increased their frequency of consumer contact and received more training on engagement with consumers via video conferencing format. Overall, the CRS staff received more training as a result of the pandemic and adapted quickly to best support and serve consumers.

Outreach and Engagement

For Fiscal Year 2020-21, the CRS program was unable to conduct outreach and engagement activities due to the ongoing COVID-19 pandemic.

Program Updates

For Fiscal Year 2022-23, the program anticipates an additional $15,000 requested to allow for travel to visit consumers placed in newly contracted Enhanced Board & Care facilities located in Northern California. The travel budget will ensure that consumers continue to receive Full Service Partnership services during placement and assistance to step down into the community when appropriate, and will cover travel expenses for staff. This will also increase the number of consumers served. It is expected that the number served will increase by a minimum of 30 consumers in the next Fiscal Year.

Enhanced Assisted Living Program

Target Population and Program Description

The Enhanced Assisted Living Program is a newly added MHSA program to serve consumers 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.

This program was implemented as of August 2020.

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

Services Provided

- 24-hour observation
- Comprehensive medical and psychiatric services
- Medication management
- Social/life enrichment activities
- Therapeutic intervention and groups

Positive Result

In Fiscal Year 2020-21, 100% of all consumers in this program avoided emergency room visits for psychiatric reasons and use of crisis intervention services.

Success Story

"Bee" was placed in Crest Homes with behaviors of verbal and physical aggression and was considered very difficult to place. With Crest Homes support, she has improved in her ability to successfully communicate to staff in appropriate ways, decreased verbal aggression, decreased somatic complaints, and she has improved her health by decreasing her cigarette smoking, increased developing hobbies and effective coping skills. She has successfully maintained this placement with zero psychiatric hospitalizations.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, pages 513-514.

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 not limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

This component is unique because it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the San Bernardino County Board of Supervisors and the MHSOAC, with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.

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: **Began July 2021**
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.

Innovative Remote Onsite Assistance Delivery (InnROADs)

Innovation Projects	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
InnROADs INN Project	2,198	2,000	$4,026,681	$2,013

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 2020-21?

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

Persistent Engagement: Consumers are rarely ready to fully engage with the InnROADs team at first contact. Having a trusted member from or known to the homeless community make introductions can help, but if that option is not available, persistent engagement, where InnROADs makes multiple contacts that are brief and consistent, can build the trust necessary to begin meaningful engagement. Successful engagement requires multiple non-judgmental attempts at contact before the consumer trusts the team enough to begin to discuss supportive housing and/or behavioral health treatment.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-20 thru 2022-23, page 526.

Consumer Demographics Highlights FY 2020-21

Age

0% Children
6% TAY
71% Adult
16% Older Adult
7% Unknown

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

41% Male

20% Female

UNK

38% Other

*Note: >1% of total identified as Transgender; 1% Declined to State

Race/Ethnicity

12% African-American/ Black
1% Asian/Pacific Islander
52% Caucasian/White
22% Latinx/Hispanic
1% American Indian/ Alaska Native
12% Multiple Races/ Other

N=2,198

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 2020-21

Veterans

5% of consumers identified as a veteran

Language

81% English

2% Spanish

17% Unknown

*Note: >1% listed primary language as Other

N=2,198

Outcome Analysis Highlights

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?

Supporting the Needs of the Consumer

Each member of the InnROADs team has intimate service knowledge in their field and how to navigate these services. The connections in their individual fields have helped to gain remote clients access to services normally not available, including medical, mental health treatment, substance use treatment. In some cases, the team has been able to break down some of the barriers to receiving these services.

Linkage to	No. of Linkages	Avg. No. of days taken
Coordinated Entry System – Short Term Housing Assistance	94	33.48
Coordinated Entry System – Temporary Housing Assistance	50	23.86
Coordinated Entry System – Long Term Housing Assistance	24	107.20
DBH Mental Health Services (Clinic)	75	28.28
DBH Substance Use Disorder Services	79	52.56
DBH Transitional Aged Youth Services	4	127.75
Public Health Programs	15	44.27
Aging and Adult Service Programs	75	35.15
Sheriff's Programs	20	63.90

Note: One consumer may have more than one linkage.

Outcome Analysis Highlights, cont.

Learning Goal #1, cont.

Time Savings

During FY 2020-21, InnROADs had an estimated "time savings" of 3,237 hours. Time saved is based on a reduction of travel time to multiple county agencies to receive services. This savings was calculated by estimating an average of one hour (60 minutes) saved in transportation time saved for each field-based service provided where transportation to a physical location would normally be required.

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?

LEAP, Listen Empathize Agree and Partner, has been an integral intervention strategy. When using it, staff are able to meet clients where they are and provide supportive services that address their personal desires. By doing so, staff are able to eventually build deeper relationships and work with them on deeper problems. MI, Motivational Interviewing, is another way to help create client buy in by focusing on the most pertinent needs and wants of the clients. Consistent engagement week after week also creates long term trust. Other interventions that build trust are providing needs like water bottles and snacks, accompanying clients to appointments, helping them contact family and friends or other service providers, providing information on available services, and responding when they are in crisis.

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?

No one service is better than the other. InnROADs staff often work hand-in-hand with clients who have complex situations such as those with mental health and substance use issues. Each service provides a unique gateway to engaging clients. Someone might start by working with a nurse and eventually warm up to an Alcohol and Drug Counselor with whom they will work on substance use issues. Someone else might first seek therapy intervention and psych medication and eventually work with Department of Aging and Adult Services to seek housing. Each situation is unique. No one discipline towers over the others. It truly is a team effort and takes the team to address these complex situations.

InnROADs Collaborative Partners

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

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.

Immediate Supports Provided in the Field

Types of Supports	No. Given
Identification Voucher	381
Food/Water	2,544
Dental Hygiene Items	88
Physical Hygiene Items	190
Feminine Hygiene Items	42
Clothing	69
Homewares	6
Pet Food	216
Other Pet Supplies	26
Transportation	26
Wash Clothes	3
Shower	7
Harm Reduction Items	32
Other Misc. Incentives	97

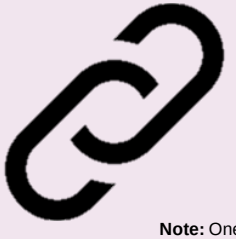
Note: It is too early in the innovation project timeline to begin an analysis of immediate support use and consumer outcomes. That analysis will begin in Year 4 of the innovation project.

InnROADs Project Outcomes FY 2020-21

5,530
Records of Engagement for FY 2020 - 21

66
Medical Assessments documented

1
Incentives given for pet care services



2,473
No. of total of linkages with other services

Note: One consumer may have more than one linkage.

760
Referrals made to Coordinated Entry System

2,198
unduplicated consumers received services during FY 2020-21

Program Updates

- The purchase of a Mobile Medical Unit has been delayed due to the use of the Public Health Mobile unit.
- COVID-19 prevented the InnROADs teams from conducting planned outreach activities during FY 2020-21.
- Modified estimated number of estimated consumers served from 240 to 2,000 unduplicated consumers. This adjustment will bring the estimated number of consumers closer to the number of actual consumers served over the past two years of the project.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2020-21	Estimated Number Served FY 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
EDC INN Project	37	835	$2,552,542	$3,057

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

Program Updates

- The program started mid-year in FY 2020-21 with limited staff.
- In FY 2021-22 EDC continued to work with managed care partner, IEHP, to coordinate eating disorder care for shared consumers exiting residential treatment, partial hospitalization, and/or intensive outpatient therapy.
- EDC team will begin individual and group treatment and will link consumers to appropriate Full Service Partnerships.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019-2020 thru 2022-2023, page 533.

Consumer Demographics Highlights FY 2020-21

Age

16% Children
51% 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

2% African-American/ Black
0% Asian/Pacific Islander
16% Caucasian/White
54% Latinx/Hispanic
0% American Indian/ Alaska Native
28% Multiple Races/ Other

N=37

Multi-County Full Service Partnership (FSP) Initiative

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	$136,040	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.

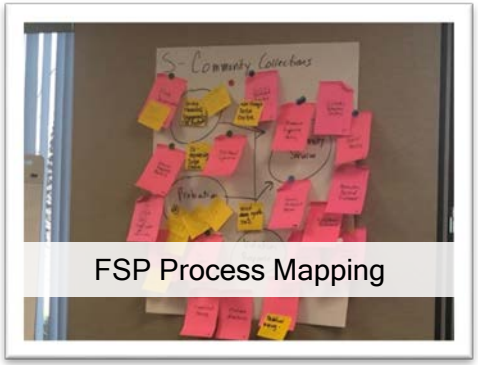
For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023.

What have we learned during FY 2020-21?

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design.

During the last fiscal year, SBC-DBH learned the following:

- Multi-county collaborations must balance appropriate levels of local customization, statewide consistency, and innovation. This FSP Innovation Project has made progress on identifying the most beneficial areas for statewide collaboration, as well as some areas that may be less appropriate for future collaborative efforts.
- The timing of statewide feedback is crucial. While counties across the state have a valuable perspective to offer on FSP best practices, it can be difficult to identify specific areas for feedback at the early stages of a collective project. It may be more appropriate to gather statewide feedback at later stages of collective projects.



FSP Process Mapping

Project Learning Goal Status

Learning Goal #1

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

Counties began this effort with a comprehensive Landscape Assessment phase (January - September 2020) to understand FSP programs, assets, and opportunities. Via a combination of meetings, working group sessions, document review, and stakeholder engagement, counties developed a comprehensive understanding of similarities and differences across FSP service design, populations, data collection, and eligibility/graduation practices.

The six-county cohort meetings were essential to building a collective vision and aligning priorities for the implementation phase. Counties and Third Sector identified almost 30 implementation options that would respond to stakeholder feedback and identified challenges. Over the course of both county-specific and cohort-wide meetings, each county and the collective group narrowed in on a feasible set of implementation activities that would create more data-driven FSP programs and build increased consistency in the way FSPs are designed, operated, and assessed.

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.

As part of this project, multiple counties are pursuing many of the same county-specific activities, but the results will vary across the state because of each county's unique population, geography, and needs. Counties can more efficiently and effectively tackle each of these improvements by sharing tools, processes, and ideas, benefitting from a cohort approach even as results show nuanced differences. San Bernardino has been in discussions with stakeholders, provider staff, and consumers in order to build the following processes:

- Stepdown guidelines
- Improved data collection
- Development of new dashboard reports
- FSP referral forms and protocols

Learning Goal #3

Improve how counties define, collect, and apply priority outcomes across FSP programs.

San Bernardino County and the other five cohort counties have built, and are in the process of finalizing, 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. Through November 2021, San Bernardino and the other five counties will focus on the following before moving into the sustainability phase beginning December 1, 2021:

- *Population definitions:* Finalize standardized definitions for the following priority FSP populations: "homeless;" "at risk of homelessness;" "justice-involved;" "at-risk of justice involvement;" "high-utilizers of psychiatric emergency facilities;" "at-risk high utilizers of using psychiatric emergency facilities."
- *Outcomes & process metrics:* Finalize 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 begin sharing data with RAND for the evaluation portion of the project and to compare outcomes across counties.
- *State reporting recommendations:* Finalize recommendations for revising the statewide Data Collection & Reporting (DCR) system.

Learning Goal #4

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

San Bernardino County and the other five cohort counties agree that information-gathering worksheets and templates can be used to compare FSP programs across the state in the future. Additionally, the full list of implementation options could be used by counties seeking inspiration for potential improvements to their FSPs. While all options could be applied to any geography, the cohort has learned that there are three categories under which these activities fall into:

- Activities around outcomes definition, metrics, and data collection are appropriate to be worked on collectively to achieve a unified result, such as shared state data reporting requirements (e.g., for the Data Collection Reporting, or DCR, system) with the acknowledgement that some criteria may not be feasible to capture consistently across counties due to differences in local reporting systems and limitations of the DCR.
- Other activities related to eligibility, graduation, and service design are more appropriate to be developed locally, while following parallel processes that can yield peer learning and resource sharing. This helps counties balance their varying geographies, populations, and histories while increasing efficiency.
- Activities related to referrals, collaboration with local institutions (e.g., jails, hospitals, etc.), and community feedback mechanisms may not be appropriate for collective projects, given the high variation in each county's local context and existing coordination processes.

Learning Goal #5

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

Stakeholder engagement and feedback has always been an important part of San Bernardino's continuous improvement efforts, and as such, will play an important role in understanding the goals and needs of those being served by San Bernardino's FSP programs and will inform how to design and execute each implementation activity in the year to come, resulting in more client-centered solutions. Effective stakeholder engagement also leverages knowledge and experience to provide a deeper understanding of challenges on the ground, while translating stakeholder needs into tangible goals and solutions. For the Multi-County FSP Innovation Initiative, these key stakeholders include FSP clients, clients' primary caregivers, and service providers. From July 2020 through June of 2021, Third Sector, along with San Bernardino and other participating counties engaged representatives from each of these groups to better understand FSP programs from their perspectives and obtain invaluable feedback on the solutions aimed to address the challenges and priorities identified in prior stakeholder interviews. These included the identification of existing processes that need strengthening.

Multi-County FSP Project Activity Highlights FY 2020-21

18
Workgroup meetings with DBH program leads and support staff during July 2020 – June 2021

24
Client interviews from DBH specialty adult FSP programs

6
Provider focus groups that included 28 frontline, peer, and managerial staff

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 72 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 2.5 years 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 2022-23	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022-23
Cracked Eggs INN Project	0	30	$305,862	$10,195

Program Serves	Symptom Severity	Location of Services
16+	N/A	Online

Target Population and Project Description

Cracked Eggs primary focus will be to explore the ways in which SBC-DBH's larger system of care can be enhanced and modified to create an empowered environment for individuals with lived-experience. To begin to learn and understand the best ways to accomplish this, DBH will provide funding and administrative support. The project will:

- Incorporate a peer-designed art workshop entitled "Cracked Eggs" into DBH's larger system of care.
- Determine if DBH can use different funding structures to provide the flexibility in billing that is needed by smaller non-profits and community groups without working capital, of which, may be peer-owned and operated.

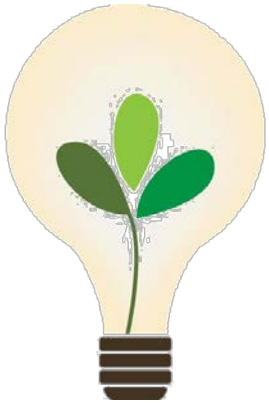
This workshop series is designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not see symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences.

The target population for this project are individuals living with mental illness that are individuals over the age of 18.

Program Updates

- Because of COVID-19, the program start date was postponed allowing time to move the initial workshops to an online format. The project will implement in-person workshops after COVID-19 precautions are no longer necessary.
- Workshop anticipated to begin January 2022.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 539.



Workforce Education and Training

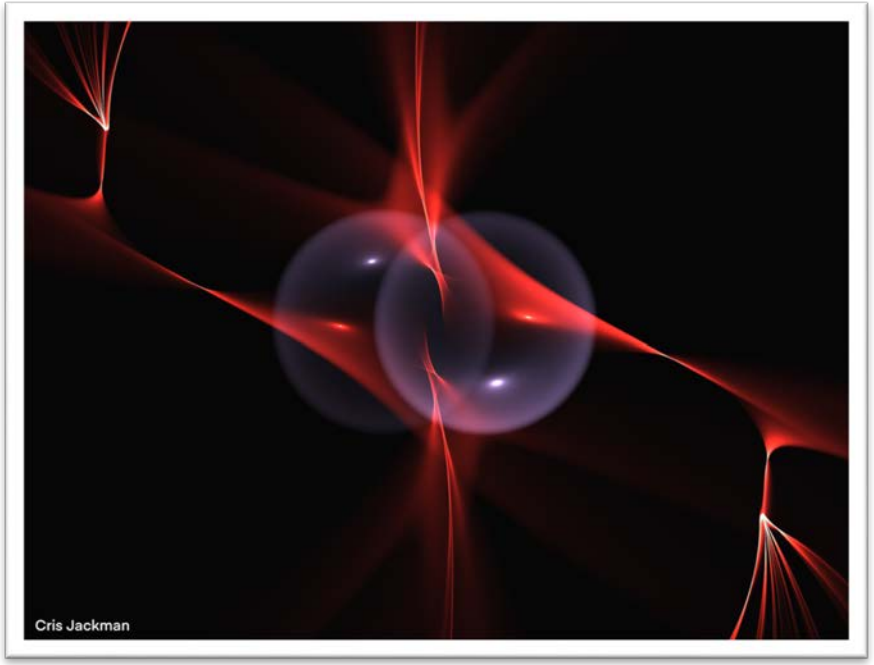
Introduction

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 Cris Jackman

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. Unfortunately, the data for Fiscal Year 2020-21 is not a true reflection of the work WET has done in this area due to the unique challenges encountered in Fiscal Year 2020-21. More progress is needed as there are still occupational shortages.

The WET program received an increase in applications for licensed positions in Fiscal Year 2020-21. However, as a result of the fiscal crisis caused by COVID-19, there was a downturn in available positions to recruit for. This resulted in closing the recruitment for Mental Health Education Consultant, Nurse Manager, and Peer and Family Advocates I, II, III.

Job Title	Number of Qualified Applications Received in FY 2020-21	Job Title	Number of Qualified Applications Received in FY 2020-21
Alcohol and Drug Counselor	33	Nurse Supervisor	13
Child Psychiatrist	6	Peer and Family Advocate I	N/A
Clinic Assistant	139	Peer and Family Advocate II	N/A
Clinic Supervisor	33	Peer and Family Advocate III	N/A
Clinical Therapist, LCSW	30	Pre-Licensed Clinical Therapist, LCSW	78
Clinical Therapist, MFT	19	Pre-Licensed Clinical Therapist, MFT	59
Clinical Therapist, Psychology	4	Pre-Licensed Clinical Therapist, Psychology	32
Clinical Therapist II	58	Pre-Licensed Clinical Therapist, LPCC	13
Mental Health Education Consultant	N/A	Program Manager I	27
Mental Health Nurse II	39	Program Manager II	19
Mental Health Specialist	70	Psychiatric Technician I	39
Nurse Manager	N/A	Psychiatrist	15

Workforce Education and Training

Positive Results (cont.)

Another program that WET oversees is the License Exam Preparation Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed. The table below illustrates the progress that LEPP has had to help staff obtain licensure for their discipline.

For LEPP 1-10, there has been, on average, an approximately **71%** 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	14	78%
LEPP 5	2013/14	41	37	90%
LEPP 6	2014/15	59	51	86%
LEPP 7	2015/16	65	53	82%
LEPP 8	2016/17	47	33	70%
LEPP 9	2017/18	41	19	46%
LEPP 10	2019/20	32	10	31%
LEPP 11	2020-21	24	6	25%
Grand Total		**462**	**327**	**71%**

Through 10 Cohorts of LEPP, Prior to Implementation of Revised LEPP*			
	Clinical Therapist I	**Clinical Therapist I Psychologist**	**Total**
Licensed	60	6	**66**
Pre-Licensed	82	2	**84**
Total	142	8	**150**
Percentage Licensed	42.3%	75%	**44%**

*DBH has seen an decrease of .2% in the percentage of licensed staff in Fiscal Year 2020-21.

"Marriage, Family and Therapy (MFT) Clinical Supervisors cooperated and adapted to challenges as needed to cover training and clinical supervision needs. Examples include taking over an intern's supervision while the assigned supervisor was out, developing new training methods and ways to connect with staff for shadowing/training, and developing new methods for interns to access help"

-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 2020-21, there were a total of 37 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.

"I am so thankful for the 20/20 program that is offered through DBH. I would have never been able to attend grad school if it wasn't for this program because I had to maintain full time employment."

-Social Work Intern Program

DBH is committed to hiring applicants that were previously interns. As seen in the following table, 38% of clinical hires in Fiscal Year 2020-21 were DBH interns. Ten DBH interns were hired as pre-licensed Clinicians with the department in Fiscal Year 2020-21.

Pre-Licensed Clinicians Hired	FY 2020-21
Total Number of Interns Hired	10
Total Number of Non-Interns Hired	16
% of Interns Hired	38%

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 67 NP students with six of those in FY 2020-21.

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 2020-21, 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 2020-21 is 4.2 out of 5. This rating reflects higher than average trainee satisfaction for the last five years. There was a 7% increase in attendance in Fiscal Year 2020-21, largely due to the training required in order to implement the DBH Electronic Health Record. WET continued to offer trainings despite the COVID-19 restrictions during Fiscal Year 2020/2021.

Throughout FY 2020-21, 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 2020-21.

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

The part of the rotation that had a lasting impact on my career choice was being challenged and encouraged to conduct interviews for all new cases as well as follow-up cases. It strengthened my commitment to becoming a Psychiatrist and I have learned to conduct a smoother interview.

-Medical Educational Program Student Intern

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 2013/2014	23
FY 2006/2007	19	FY 2014/2015	29
FY 2007/2008	24	FY 2015/2016	28
FY 2008/2009	24	FY 2016/2017	26
FY 2009/2010	21	FY 2017/2018	36
FY 2010/2011	20	FY 2018/2019	28 (Plus 7 Vacancies)
FY 2011/2012	24	FY 2019/2020	35 (Plus 7 Vacancies)
FY 2012/2013	25	FY 2021/2022	35 (Plus 7 vacancies)
		Total	**366**

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 2015/2016	4
FY 2011/2012	1	FY 2016/2017	3
FY 2012/2013	1	FY 2017/2018	5
FY 2013/2014	4	FY 2018/2019	6
FY 2014/2015	3	FY 2019/2020	11
		FY 2020/2021	2

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. However, the number decreased again in 2020-21 due to 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
Total	**421**	**44,090**

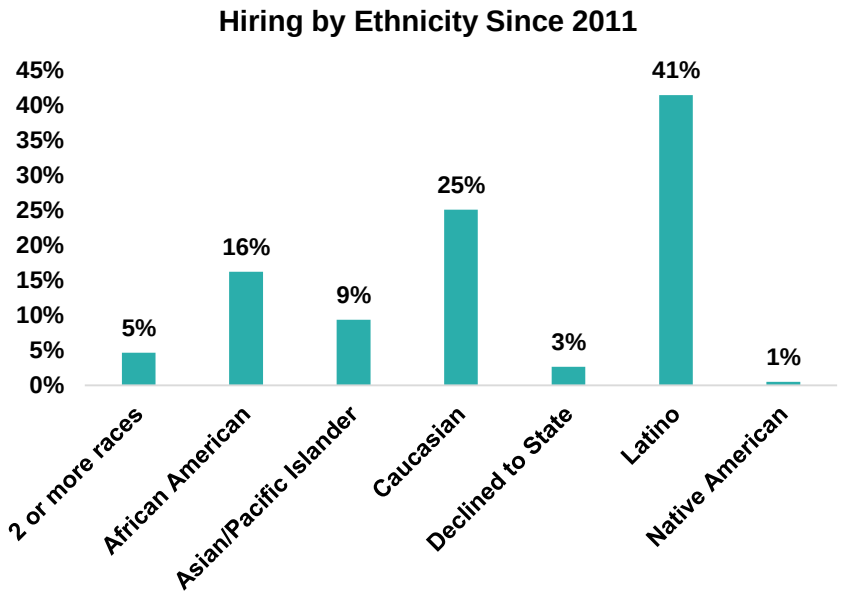
To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

Workforce Education and Training

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 2020-21. 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

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

"I enjoyed the entire internship because the environment was so welcoming and my colleagues were always helping me learn more and motivating me to take lead whenever possible. The intern program was a valuable experience."

-Social Worker Intern

Workforce Education and Training

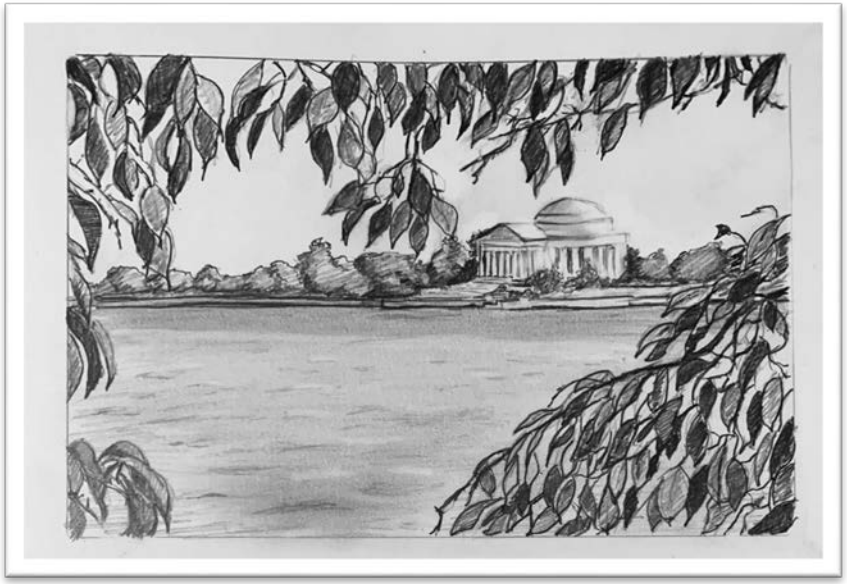
Positive Results (cont.)

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 2020-21, **42%** 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%
Total	**193**	**535**	**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 Tracy Hutchinson

Positive Results (cont.)

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

Fiscal Year	Associate	Bachelors	Masters	Certificate	Doctorate	Total Recipients
2012-13	2	5	5	0	0	12
2013-14	0	5	6	0	0	11
2014-15	0	4	3	1	0	8
2015-16	0	5	4	1	0	10
2016-17	1	5	2	1	0	9
2017-18	0	6	4	0	0	10
2018-19	0	2	1	0	0	3
2019-20	0	0	0	0	0	0
2020-21	0	1	2	0	1	4

Note: A total of 63 students obtained degrees through WET programs since FY 2012-13. In FY 2019-20, the program was paused due to budget concerns related to COVID-19, but went live again in FY 2020-21.

WET was able to add the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2020-21, 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 - One Stop/New Family located at the One Stop TAY Center (11/6/2020)
- San Bernardino Department of Behavioral Health – Phoenix Counseling Center (11/09/2020)
- San Bernardino Department of Behavioral Health – Mesa Counseling Center (11/16/2020)
- San Bernardino Department of Behavioral Health – Vista Counseling (11/16/2020)

Artwork by Gina Pliss

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	2016-17	1
2013-14	2	2017-18	3
2014-15	2	2018-19	10
2015-16	0	2019-20	1
		2020-21	1

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.

"I was given the experience of being completely out of my comfort zone, which provided me the opportunity to learn and enhance my skill level"

-Social Work 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.

Peer and Family Advocates (PFAs) train in collaboration with the Training and Development Specialists (TDS) at WET. As part of the Crisis Intervention Training (CIT), PFAs also conduct the Shaken Tree training. The training is an award winning documentary film that illuminates, through a collection of stories, the family's journey when one of its members has chronic and persistent mental illness. The film addresses their journey of pain, grief, feelings of helplessness, despair, and the stigma associated with mental illness, while giving the viewer hope and ways to survive and live life fully when sharing it with someone who has a mental illness.

After the documentary is viewed, the PFA leads a discussion regarding the film, and connects their own experiences with mental illness as a person in recovery and/or as a family member.

As of Fiscal Year 2014-15, the Shaken Tree training is shown in DBH New Employee Orientation in order to familiarize all new staff with the perspective of family members and consumers battling mental illness.

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.

"Overall, my experience within the WET team and the Volunteer Services Program team taught me what it is like to be part of a team that continues to work towards better trainings, better resources, and better services for the community of San Bernardino."

-Social Worker Internship 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 Stacy McLemore

Workforce Education and Training

Challenges and Solutions

The WET program experienced the following challenges in FY 2020-21:

- Addressing training needs of a growing and diverse workforce
- Increased demand for outreach services for the Volunteer Services Program
- Evaluation of pay rate and lack of advancement opportunities identified during a PFA focus group session in February 2019
- Insufficient number of site supervisors and meeting the needs of nontraditional schools for the internship programs
- Ending of state support for some financial incentives
- Recruiting Nurse Practitioners (NPs) and specialized psychiatrists such as Child and Adolescent Psychiatrists
- Lack of placement sites for the Volunteer Services Program, Internship Program, NP students, and psychiatric residents/fellows
- The Non-Financial Affiliation Agreement template became obsolete, requiring all schools to reestablish their affiliation agreements
- The COVID-19 restrictions impacted the internship program; changing many aspects of the program to a virtual or videoconferencing model, limiting the number of staff available to interact with, or shadow, which impacted training and the ability to provide services timely, disrupting clinical supervision when supervising staff were unavailable due to illness
- Due to the COVID -19 pandemic, all in person clinical rotations were suspended and were completed via Telemed
- Schools and businesses were closed which impeded the Volunteer Services program to conduct in person outreach services
- Inability to conduct in person training for DBH staff
- Peer and Family Advocates and volunteers became increasingly difficult to place with limited staff available to accept and train

The WET program has taken the following actions to address the challenges:

- Offering Continuing Education Units (CEUs) for more disciplines
- Partnered with other DBH programs to analyze and meet their training needs
- Updating program mission, objectives, policies, and procedures to align with new pipeline development requirements
- Addition of staff member to help with supervision load
- 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
- Partnering with other programs to increase quality and quantity of placement sites
- The internship program has coordinated with national organizations and programs to conduct training using virtual platforms
- Clinical rotations have resumed in person
- WET expeditiously developed virtual training models to continue providing training for DBH staff
- 50% of the number of schools have reestablished their affiliation agreements with DBH and there was a 15% increase in the number of new schools DBH affiliates with
- The internship program created several training guides and programs on the use of video conferencing platforms for therapy and assessment. Supervisors were provided training in telehealth and supervision, preparing future psychologists to treat individuals a variety of platforms. Two part-time Clinical Therapists were hired to assist with supervision and program development

Workforce Education and Training

Outreach and Engagement

In Fiscal Year 2020-21, 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	1	70
Classroom Presentations	18	1,850
Mock Interviews	3	155
Total	**59**	**5,818**

Artwork by Cris Jackman

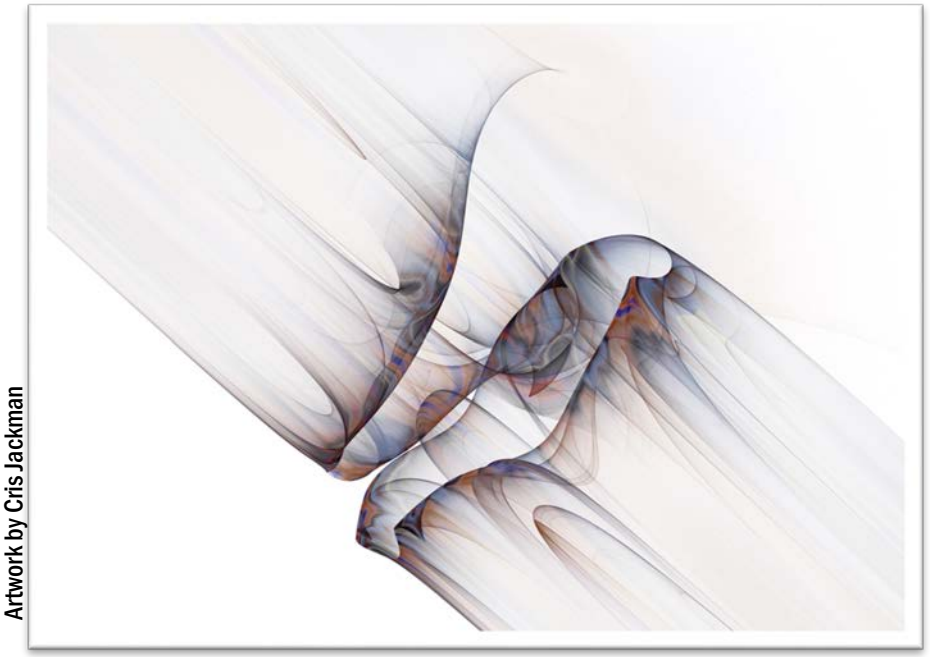
Capital Facilities and Technological Needs

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.



Artwork by Cris Jackman

Capital Facilities and Technological Needs

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 the final acceptance phase where updates to workflows and processes are being undertaken 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

- Implement, maintain, and improve the Electronic Health Record (EHR)
- 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
- 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
Phase II of the EHR was implemented on April 14, 2021.

Technological Needs
To address the goal of increasing access to services, DBH is utilizing the CalHealthCares program to support medical staff in obtaining and retaining federal financial support for repayment of student loans. Through CalHealthCares, 18 DBH physicians were awardees of the loan repayment program in exchange for a five-year service commitment. Additionally, by monitoring staffing needs, DBH is able to recruit and retain new staff by provider type and age groups served.

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 2020/21 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 technological needs of SBC-DBH staff

Behavioral Health Management Information Systems Expansion

- This expansion is necessary to support claiming and billing functions that allow DBH to receive revenue
- 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

Introduction

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

Artwork by L. Lafayett

Funding Summary FY 202/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

			MHSA Funding					
			A	B	C	D	E	F
			Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2022/2023 Funding								
	1.	Estimated Unspent Funds from Prior Fiscal Years	$ 143,904,962	$ 32,563,865	$ 13,555,084	$ 116,824	$ -	$
	2.	Estimated New FY 2022/2023 Funding	$ 113,800,000	$ 28,450,000	$ 7,490,000	$	$	$
	3.	Transfer in FY 2022/2023	$ (11,102,798)	$	$	$4,233,918	$ 6,868,880	$
	4.	Access Local Prudent Reserve in FY 2022/2023	$	$	$	$	$	$
	5.	Estimated Available Funding for FY 2022/2023	$ 246,602,164	$ 61,013,865	$ 21,045,084	$4,350,742	$ 6,868,880	$
B. Estimated FY 2022/2023 MHSA Expenditures			$ 115,036,950	$ 24,480,032	$ 6,908,279	$4,350,742	$ 6,868,880	$
G. FY 2021/2022 Unspent Fund Balance			$ 131,565,214	$ 36,533,834	$ 14,136,805	$ 0	$ -	$
H. Estimated Local Prudent Reserve Balance								
	1.	Estimated Local Prudent Reserve Balance on June 30, 2022	$ 21,655,429.00					
	2.	Contributions to the Local Prudent Reserve in FY 2022/2023	$					
	3.	Distributions from the Local Prudent Reserve in FY 2022/2023	$					
	4.	Estimated Local Prudent Reserve Balance on June 30, 2023	$ 21,655,429.00					

Prevention and Early Intervention FY 2022/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

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 Treament						
1. PEI SE-2 Child and Youth Connection	$ 19,986,138	$ 5,943,039	$ 7,467,493			$ 6,575,607
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Care Worker	$ 1,264,429	$ 1,251,353				$ 13,076
3. PEI CI-5 Inland Empire Opiod Crisis Coalition (IEOCC)	$ 154,126	$ 154,126				
4. PEI CI-4 Behavioral Health Ministries Pilot Project	$ 100,000	$ 98,966				$ 1,034
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 500,000	$ 494,829				$ 5,171
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 302,256	$ 299,130				$ 3,126
2. PEI SI-3 Resilience in Promotion in African American Children	$ 1,076,493	$ 1,065,361				$ 11,132
3. PEI SE-1 Older Adult Community Services	$ 708,265	$ 688,839				$ 19,426
4. PEI SE-5 Lift	$ 504,780	$ 499,560				$ 5,220
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 300,125	$ 297,022				$ 3,104
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Center	$ 3,992,896	$ 3,951,605				$ 41,291
2. PEI SE-3 Community Wholeness and Enrichment	$ 1,358,669	$ 1,344,619				$ 14,050
3. PEI SE-4 Military Services and Family Support	$ 748,567	$ 740,826				$ 7,741
4. PEI SI-1 Student Assistance Program (SAP)	$ 7,022,571	$ 2,778,081	$ 2,623,869			$ 1,620,622
Early Intervention						
1. PEI SE-7 Early Psychosis Program	$ 1,000,000	$ 989,659				$ 10,341
PEI Programs	$ 39,019,317	$ 20,597,015	$ 10,091,361	$ -	$ -	$ 8,330,940
PEI Administration	$ 3,355,826	$ 3,321,123				$ 34,703
PEI Assigned Funds	$ 561,894	$ 561,894				
Total PEI Program Estimated Expenditures	$ 42,937,037	$ 24,480,032	$ 10,091,361	$ -	$ -	$ 8,365,644

Community Services and Supports FY 2022/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

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)	$ 45,173,338	$ 26,776,330	$ 17,541,597			$ 855,412
2.	C-2	Integrated New Family Opportunity Program (INFO)	$ 1,452,311	$ 860,852	$ 563,958			$ 27,501
3.	TAY-1	TAY One Stop Center	$ 6,192,938	$ 3,670,841	$ 2,404,826			$ 117,271
4.	A-2	Adult Criminal Justice Continuum of Care	$ 9,815,399	$ 4,904,540	$ 3,811,491			$ 1,099,368
5.	A-3	Assertive Community Treatment Model FSP Services	$ 2,827,757	$ 1,676,142	$ 1,098,067			$ 53,547
6.	A-7	Housing and Homeless Services Continuum of Care	$ 14,810,789	$ 7,865,538	$ 5,751,288			$ 1,193,962
7.	OA-1	Age Wise	$ 2,524,659	$ 1,496,482	$ 980,369			$ 47,807
8.	A-11	Regional Adult Full Service Parnership (RAFSP)	$ 6,098,545	$ 3,614,890	$ 2,368,172			$ 115,483
Non FSP Programs			$ 88,895,736					
1.	A-1	Clubouse and Community Connections	$ 3,709,135	$ 3,638,898				$ 70,237
2.	A-4	Crisis Walk-In Centers (CWIC)/CrisisStabilization Units (CSU)	$ 13,274,654	$ 7,868,502	$ 5,154,780			$ 251,372
3.	A-5	Diversion Programs	$ 7,193,303	$ 4,263,804	$ 2,793,285			$ 136,214
4.	A-6	Community Crisis Response Team (CCRT)/Crisis Intervention Training (CIT)	$ 8,791,646	$ 5,211,216	$ 3,413,950			$ 166,480
5.	A-9	Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 5,933,006	$ 5,820,657				$ 112,349
6.	A-10	Crisis Residential Treatment Program (CRT)	$ 14,349,542	$ 8,505,638	$ 5,572,178			$ 271,726
7.	A-13	Adult Transitional Care Programs	$ 12,664,128	$ 7,506,615	$ 4,917,702			$ 239,811
8	A-15	Recovery Based Engagement Support Teams (RBEST)	$ 1,935,349	$ 1,147,171	$ 751,530			$ 36,648
		CSS Programs	$ 67,850,764					
		CSS Administration	$ 22,131,378	$ 20,208,833	$ 1,503,461			$ 419,084
		CSS MHSA Housing Program Assigned Funds	$					
		Total CSS Program Estimated Expenditures	$ 178,877,877	$ 115,036,950	$ 58,626,655	$ -	$ -	$ 5,214,272
		FSP Programs as Percent of Total	50%					

Innovation FY 2022/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

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)	$ 4,026,681	$ 3,337,447	$ 598,600			$ 90,634
2.	INN-09	Eating Disorder Collaborative	$ 2,552,542	$ 2,115,631	$ 379,457			$ 57,454
3.	INN-10	Multi County Full Service Partnership (FSP)	$ 136,040	$ 132,979				$ 3,061
4.	INN-11	Cracked Eggs	$ 305,862	$ 298,978				$ 6,884
		INN Programs	$ 7,021,125	$ 5,885,034	$ 978,058	$ -	$ -	$158,034
		INN Administration	$ 1,234,561	$ 1,023,245	$ 183,528			$ 27,788
		Total INN Program Estimated Expenditures	$ 8,255,686	$ 6,908,279	$ 1,161,586	$ -	$ -	$185,822

Workforce Education and Training FY 2022/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

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	$ 333,619	$ 333,619	$			$
2. Leadership Development	$ 21,287	$ 21,287	$			$
3. Intership Program	$ 1,607,378	$1,607,378	$			$
4. Psychiatric Residency Program	$ 992,067	$ 992,067	$			$
5. Financial Incentive Program	$ 51,500	$ 51,500	$			$
6.WET Training Institue	$ 25,000	$ 25,000	$			$
WET Programs	$ 3,030,851	$3,030,851	$ -	$ -	$ -	$ -
WET Administration	$ 1,123,438	$1,123,438	$			$
WET Contribution	$ 196,453	$ 196,453	$	$	$	$
Total WET Program Estimated Expenditures	$ 4,350,742	$4,350,742	$ -	$ -	$ -	$ -

Capital Facilities and Technological Needs FY 2022/23

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2022/23

	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						
	$					
	$					
	$					
CFTN Programs - Technological Needs Projects	$					
1. Data Warehouse Continuation Project Empowered Communication/Sharepoint Project	$ 432,554	$ 432,554				
2. Technology Empowered Communication/Sharepoint (ECM)	$ -					
3. Electronic Health Record (EHR) Project	$ -					
4. Behavioral Health Management Information Systems (BHMIS) Replacement Project	$ 3,857,818	$ 3,857,818				
CFTN Projects	$ 4,290,372	$ 4,290,372	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,578,508	$ 2,578,508				
Total CFTN Program Estimated Expenditures	$ 6,868,880	$ 6,868,880	$ -	$ -	$ -	$ -