THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number

21-441

SAP Number

Department of Behavioral Health

Department Contract Representative	Ellayna Hoatson
Telephone Number	909-388-0858
Contractor	California Department of Health Care Services
Contractor Representative	Mental Health Services Division
Telephone Number	916-552-9536
Contract Term	July 1, 2020 through June 30, 2023
Original Contract Amount	$370,388,948
Amendment Amount	($7,019,414)
Total Contract Amount	$363,369,534
Cost Center	Various

Briefly describe the general nature of the contract:
The Mental Health Services Act (MHSA) provides funding to the Department of Behavioral Health for programs and services outlined in the MHSA Annual Update Plan for Fiscal Year 2021-22. Expenditures outlined in the Plan for the period of FY 2021-22 total $116,401,434.

FOR COUNTY USE ONLY

Approved as to Legal Form
DocuSigned by:
Dawn Martin
8ED744A7697047B...
Dawn Martin, Deputy County Counsel
Date 5/13/2021

Reviewed for Contract Compliance
DocuSigned by:
Natalie Kessee
4AA4DEA956D9425...
Natalie Kessee, Contracts Manager
Date 5/13/2021

Reviewed/Approved by Department
DocuSigned by:
Veronica Kelley
B120EF1A8595...
Veronica Kelley, Director
Date 5/24/2021

SAN BERNARDINO COUNTY

Behavioral Health

Mental Health Services Act

Annual Update for Fiscal Year 2021 - 2022

Message from the Director

Welcome

Thank you for your interest in San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Annual Update Plan Fiscal Year 2021/22. Since the inception in 2005, MHSA funded programs have provided enhancements to the public behavioral health system of care that promote wellness, recovery, and resilience and include the values of equity, community-based collaboration, and meaningful inclusion of diverse consumers and family members in all aspects of behavioral health planning and services.

The implementation of MHSA has allowed the Department the opportunity to focus on developing a cohesive system of behavioral health services and care and the inclusion of all diverse stakeholders in the development, implementation, and evaluation of services.

The Annual Update Plan provides the opportunity for the Department to highlight the achievements of DBH and contracted partner programs of the previous fiscal year, engage the community in stakeholder-informed decisions, and provide updates to the MHSA Three-Year Integrated Plan Fiscal Years 2020/21-2022/23.

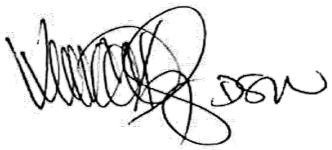
DBH engages in continuous evaluation of programs and fiscal projections to ensure services are available within the continuum of care. In light of SARS CoV-19, DBH continued to remain open providing essential services to consumers throughout the County. However, immediate adjustments and evaluations were made to ensure safety to those we serve and staff.

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

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

Until the next time, catch you on the well side!

Sincerely,



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

Mensaje de la Directora

Bienvenido

Gracias por su interés en el Plan de actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en ingles) para el año fiscal 2021/22 del Departamento de Salud Mental (DBH por sus siglas en ingles) del Condado de San Bernardino. Desde el inicio en 2005, los programas financiados por la MHSA han brindado mejoras al sistema público de atención de salud conductual que promueven el bienestar, la recuperación y la resiliencia e incluyen los valores de equidad, colaboración comunitaria e inclusión significativa de diversos consumidores y familiares en todos los aspectos de la planificación y los servicios de salud mental.

La implementación de la MHSA le ha dado al departamento la oportunidad de concentrarse en desarrollar un sistema cohesivo de servicios y atención de salud mental y la inclusión de todos los interesados en el desarrollo, implementación y evaluación de los servicios.

El Plan de actualización anual brinda la oportunidad para que el departamento destaque los logros de DBH y los programas de socios contratados del año fiscal anterior, involucre a la comunidad en decisiones informadas por las partes interesadas y proporcione actualizaciones al Plan integrado de tres años de la MHSA Años fiscales 2020/21-2022/23.

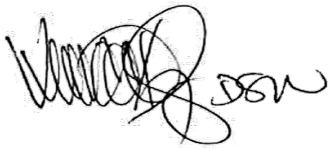
DBH participa en la evaluación continua de programas y proyecciones fiscales para garantizar que los servicios estén disponibles dentro del continuo de la atención. A la luz del SARS CoV-19, el departamento continuó abierto proporcionando servicios esenciales a los consumidores en todo el condado. Sin embargo, se realizaron ajustes y evaluaciones inmediatos para garantizar la seguridad de aquellos a quienes servimos y del personal.

Para obtener información específica sobre la respuesta inicial de DBH del condado de San Bernardino al SARS CoV-19, consulte la Actualización de la MHSA al plan del año fiscal 2020/21: Respuesta al SARS CoV-19 en https://wp.sbcounty.gov/dbh/admin/mhsa/. Los futuros planes de actualización anual demostrarán los impactos duraderos del SARS CoV-19.

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

Hasta la próxima, que estén bien!

Sinceramente,



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

Table of Contents

Title	Page
Message from the Director	1
Message from the Director (Spanish)	2
Table of Contents	3
MHSA County Compliance Certification	5
MHSA County Fiscal Accounting Certification	6
Community Program Planning (CPP)	7
Summary of Program Changes	18
Prevention and Early Intervention (PEI)	25
Introduction	25
Stigma and Discrimination Reduction	
PEI CI-3: Native American Resource Center	29
Outreach for Increasing Recognition of Early Signs of Mental Illness	
PEI CI-1: Promotores de Salud/Community Health Care Worker	32
PEI CI-4: Behavioral Health Ministries Pilot Project	38
Access and Linkage to Treatment	
PEI SE-2: Child and Youth Connection	40
Prevention	
PEI SI-2: Preschool PEI Program	43
PEI SI-3: Resilience in Promotion in African American Children	46
PEI SE-1: Older Adult Community Services	49
PEI SE-5: Lift	52
PEI SE-6: Coalition Against Sexual Exploitation (CASE)	55

Title	Page
Prevention and Early Intervention	
PEI CI-2: Family Resource Center	58
PEI SE-3: Community Wholeness and Enrichment	61
PEI SE-4: Military Services and Family Support	64
PEI SI-1: Student Assistance Program (SAP)	67
Early Intervention	
PEI SE-7: Early Psychosis Program	70
Community Services and Support (CSS)	72
Introduction	72
Crisis System of Care	73
A-5: Diversion Programs	74
A-6: Crisis System of Care Programs	80
Crisis Stabilization System of Care	85
A-4: Crisis Walk-In Centers (CWIC)/Crisis Stabilization Units (CSU)	86
A-10: Crisis Residential Treatment Program (CRT)	
• Adult	92
• Transitional Age Youth	95
Peer Support Programs	98
A-1: Clubhouse Expansion	99

Table of Contents

Title	Page
Outreach, Access, and Engagement Programs	102
A-9: Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	103
A-15: Recovery Based Engagement Support Teams (RBEST)	108
Full Service Partnerships	111
Introduction	111
C-1: Comprehensive Children and Family Support Services (CCFSS)	113
C-2: Integrated New Family Opportunities (INFO)	117
TAY-1: Transitional Age Youth (TAY) One Stop Centers	119
A-2: Adult Criminal Justice Continuum of Care	123
A-3: Assertive Community Treatment Model FSP Services	128
A-11: Regional Adult Full Service Partnership (RAFSP)	131
OA-1: Age Wise	134
Homeless Services, Long-Term Supports, and Transitional Care Programs	137
Introduction	137
A-7: Housing and Homeless Services Continuum of Care Programs	138
A-13: Adult Transitional Care Programs	145

Title	Page
Innovation (INN)	151
Introduction	151
INN-08: Innovative Remote Onsite Assistance Delivery (InnROADs)	152
INN-09: Eating Disorder Collaborative	158
IINN-10: Multi-County Full Service Partnership (FSP)	159
INN-11: Cracked Eggs	160
Workforce Education and Training (WET)	164
Capital Facilities and Technological Needs (CFTN)	176
Fiscal	179
MHSA Budgets	180

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Bernardino

☐ Three-Year Program and Expenditure Plan

☒ Annual Update

Local Mental Health Director	Program Lead
Name: Veronica Kelley, DSW,LCSW	Name: Michelle Dusick
Telephone Number: (909) 388-0820	Telephone Number: 909-252-4046
E-mail: vkelley@dbh.sbcounty.gov	E-mail: MHSA@dbh.sbcounty.gov
Local Mental Health Mailing Address:	Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 8, 2021.

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.

Veronica Kelley
Local Mental Health Director (PRINT)

DocuSigned by:
Veronica Kelley
B128EF1A85354BD...
Signature

06/08/21
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Bernardino

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Veronica Kelley, LCSW Telephone Number: (909) 388-0820 E-mail: vkelley@dbh.sbcounty.gov	Name: Ensen Mason, CPA, CFA Telephone Number: 909-382-7000 E-mail: Ensen.Mason@atc.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.

Veronica Kelley
Local Mental Health Director (PRINT)

DocuSigned by: Veronica Kelley B128EF1A85354BD...
Signature

06/08/21
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated February 1, 2021 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, 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.

Michael Alexander
County Auditor Controller / City Financial Officer (PRINT)

DocuSigned by: Michael Alexander A5C1D58A188048A...
Signature

06/08/21
Date

Introduction

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

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

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

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

Community Program Planning

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

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

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

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

Meetings are documented through agendas, sign-in sheets, 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 cultural 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 in person attendance is recorded through meeting sign-in sheets and stakeholder feedback forms. Virtual meeting attendance is captured via the "chat" feature contained in the virtual platform, through a recording of the meeting, as well as stakeholder comment surveys. These forms/surveys 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 to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. The CCO or OEI staff regularly sit on boards or committees to provide input or effect change regarding program planning or implementation. OEI also provides support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meeting, and training events. Language regarding cultural competence is included in all department contracts with community-based organizations and individual providers to ensure contract services are provided in a culturally competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation (WPE).

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

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

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 additional meetings hosted in multiple venues and available to each region of the County, monolingual Spanish sessions, and Family Resource Centers.

A total of 33 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

MHSA Annual Update CPP Demographics

Age

0% 0-15
4% 16-25
84% 26-59
12% 60+

Language

83% English
16% Spanish
1% Arabic

Gender Identity

12% Male
85% Female
1% Transgender
1% Gender Nonbinary

NOTE: 1% Declined to State

Race/Ethnicity

12% African-American/Black
26% Caucasian/White
4% American Indian or Alaskan Native
4% Declined to State
3% Asian/Pacific Islander
45% Latinx/Hispanic
7% More than One Race

NOTE: Due to rounding, total equals 100%.

N=159 **NOTE: Not every respondent answered every question. For some questions, respondents selected more than response.**

health system, and evolved out of the original CPP initiated in 2005. As a result of the COVID-19 pandemic, all meetings were held virtually to ensure safety for the stakeholders and presenters.

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, and Vietnamese interpretation, upon request, at each meeting. As an incentive for participation, Clubhouse members were delivered snacks to enjoy during stakeholder sessions.

MHSA Annual Update CPP Demographics

Region

13% Central Valley
19% Desert/Mountain
33% East Valley
19% West Valley
17% Declined to State

Groups Represented

<1% Law Enforcement
6% Education
7% Social or Human Service Program/Agency
23% Healthcare – Behavioral/ Mental Health
1% Veterans Organization
22% Family Member or Loved One
1% Alcohol and Drug Service Program
19% Federal, State, County, or City Government
2% Faith-Based Organization
8% Community-Based Organizations
11% Consumer of Mental Health Services
<1% Consumer of Substance Use Disorder Services

N=159

NOTE: For Groups Represented, total exceeds 100% due to rounding and demonstrating representation of all groups.

Community Program Planning

In order to increase opportunities for participation across the county, the department hosted additional online sessions on January 19, 2021, from 10:00 a.m. to 12:00 p.m. and February 2, 2021, from 5:00 to 7:00 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 provide feedback. The link to the survey was provided in the presentation and participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the MHSA Issue Resolution that can be accessed at: http://wp.sbcounty.gov/dbh/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 18, 2021. 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 **630** stakeholders attended this year's Community Program Planning (CPP) stakeholder sessions and DBH received **149** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions. Of the those who completed a survey, **84%** were either satisfied or very satisfied with the CPP meeting, the Plan, and its goals.

Stakeholder Comments

"Very encouraging."

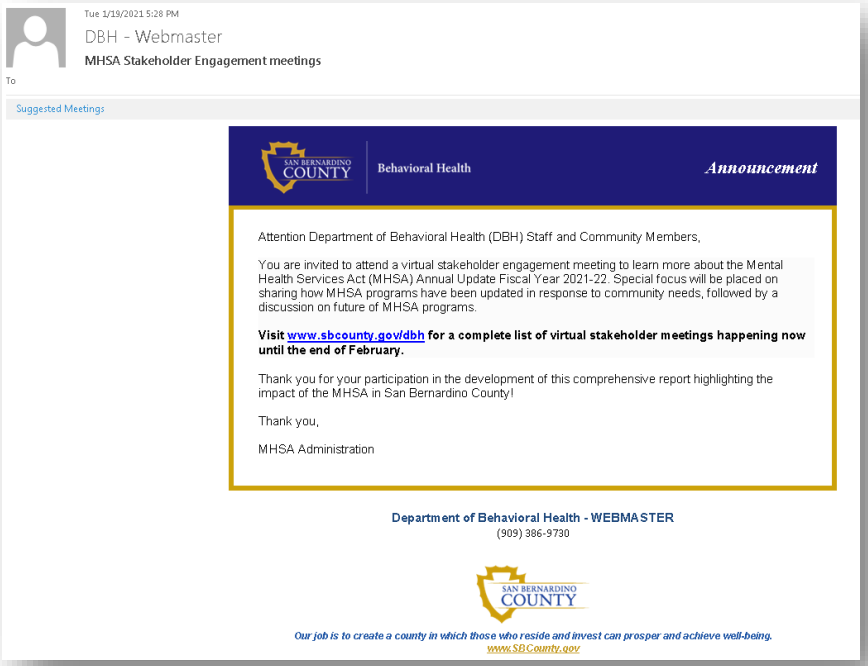
"You always give us information. Thank you for always telling us what is happening."

"I was impressed at how funding decisions were made in order to meet the needs of the community during this difficult time."

"It was really amazing to see how DBH was able to prioritize needs and re-direct funding so that in the middle of a pandemic, services were not interrupted or needed, regardless of the economic impact of this public health emergency. Thank you for your creativity, transparency and always taking into consideration stakeholder input."

Community Program Planning

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



Tue 1/19/2021 5:28 PM

DBH - Webmaster

MHSA Stakeholder Engagement meetings

To

Suggested Meetings

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 2021-22. 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 www.sbcounty.gov/dbh for a complete list of virtual stakeholder meetings happening now until the end of February.

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

Home | Countywide Vision | Services A-Z | Visiting | Living | Working | Contacts | E-Subscriptions | Translate: Select Language

Member Services: 24/7 Access & Referral Helpline: 1.888.743.1478, 909.386.8256 or 711 for TTY users or visit the Member Services: Access & Referral webpage.

For substance use disorder and recovery services call: 1.800.968.2636 | In Crisis, but don't need 911? Call 909.386.8256

SAN BERNARDINO COUNTY Behavioral Health

Promoting Wellness, Recovery and Resilience

About DBH | Administration | Crisis Services | Mental Health Services | Alcohol & Drug Services | For Providers | Careers | News & Events

Home > Announcement > MHSA Stakeholder Engagement Meeting Schedule

Search

MHSA Stakeholder Engagement Meeting Schedule

Meeting Schedule (English and Spanish)

SAN BERNARDINO COUNTY

Behavioral Health

MHSA

STAKEHOLDER MEETINGS

Fiscal Year 21/22

You're invited to attend an online community stakeholder engagement meeting for the MHSA Annual Update Fiscal Year 2021-22. 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. Please join us!

For complete list of meeting dates and links, visit www.sbcounty.gov/dbh or call (800) 722-9866.

Community Program Planning

SAN BERNARDINO COUNTY | Behavioral Health

Mental Health Services Act (MHSA)
Stakeholder Engagement Meeting Schedule

These community stakeholder engagements will focus on the MHSA Annual Update Fiscal Year 2021-22. 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. Please join us at any of the following on-line events!

Note: Event date/times/locations may change. To confirm, please call (800) 722-9866. For questions, concerns, interpretation services or requests for disability-related accommodations, call (909) 386 – 8223. DBH complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, gender identity, age, disability or LEP. MHSA (Proposition 63) is funded by a 1% tax surcharge on personal income over $1 million per year. REV 1/15/20

1. 2nd District Advisory Committee (DAC)
   Jan. 14, 2021 from 3:30 - 4:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mb4f214a55389ad7352b33b9987db1a81
2. Kiwanis Club of Greater San Bernardino
   Jan. 19, 2021 from 8:30 - 9:30 a.m.
   https://apu.zoom.us/j/81682922470
3. Online WebEx Meetings
   Jan., 19, 2021 from 10 a.m.- Noon
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m0ff2e5533e591be2f3d2f3d3851ef128
4. Native American Awareness Subcommittee
   Jan., 19, 2021 from 2 - 3:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m507b22673aed8126ee6becf676c02f85
5. Clubhouse Meeting
   Jan. 20, 2021 from 1-2 p.m.
   https://zoom.us/j/98596760766?pwd=NUNjZUVlOEJBblh6bWlEcTJCRVlwdz09
6. 4th District Advisory Committee (DAC)
   Jan. 20, 2021 from 6-7 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m9f012333feb705fbaa7907f0f8527093
7. Co-Occurring and Substance Use Subcommittee (COSAC)
   Jan. 21, 2021 from 3 - 4:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mff2856d29fed4830d18b172e7605fce6
8. Consumer and Family Member Awareness Subcommittee
   Jan. 25, 2021 from 11 a.m.- Noon
   https://zoom.us/j/92670362543#success
9. African American Awareness Subcommittee
   Jan., 25, 2021 from 2 - 3:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m022f4db15f496d534d4ffa86cd0f9f2f
10. NAMI of San Bernardino
    Jan. 25, 2021 from 3 - 4:30 p.m.
    https://zoom.us/j/96345191150?pwd=M2gzSjVOczVXTmpLdzlOQ1pYYlIzQT09
11. LGBTQ Awareness Subcommittee
    Jan. 26, 2021 from 12:30 - 2 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mbb31fb1a2213d01f2482db9f262800a1
12. 5th District Advisory Committee (DAC)
    Jan. 26, 2021 from 5-6:30 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mf51b4844b32110a42fe99c974d974919
13. Victor Community Support Services
    Jan. 27, 2021 from 9-10:30 a.m.
    https://global.gotomeeting.com/join/901618541
14. Women's Awareness Subcommittee
    Jan. 27, 2021 from 1 - 3 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mfb5561319c2e6d5b2458dd5fa9e750a1
15. Older Adults Awareness Subcommittee
    Jan. 28, 2021 from 10 -11:30 a.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m5902acfe42c245d87493af6b3953f5af
16. Latino Awareness Subcommittee
    Jan. 28, 2021 from 10 -11:30 a.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mab4f56b3ccd30ca6e60efc35e7244813
17. Pacific Clinics-Yucca Valley
    Jan. 29, 2021 from 9 -10 a.m.
    https://us02web.zoom.us/j/88401895782?pwd=V0RNWUxUWGVVWThqK0c3UTVwV1dGQT09
18. Veterans Awareness Subcommittee
    Feb. 1, 2021 from 3 - 4:30 p.m.
    Call in only: Access Number (877) 820-7831
    Participant passcode: 512040#
    * You must enter # after numbers in passcode.
19. Online WebEx Meetings
    Feb. 2, 2021 from 5 - 7 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mf70086a7e9493eb8e3e7298e80ab0312
20. Rim Family Services
    Feb. 3, 2021 from 10 - 11:30 a.m.
    Meeting passcode: 161018
    https://rimfamilyservices.zoom.us/j/91084072024
21. 3rd District Advisory Committee (DAC)
    Feb. 3, 2021 from 3 - 4 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m59f7555fbcbc6020057c7b3e27c7d4a0
22. Victor Community Support Services
    Feb. 5, 2021 from 2 - 3 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m61e7c5be8a58743999351c3a97476e39
23. Suicide Prevention Awareness
    Feb. 8, 2021 from 10 -11:30 a.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m071eb6cf47bcb2af69151a0a73431543
24. Spirituality Awareness Subcommittee
    Feb. 9, 2021 from 1 - 2:30 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m835b6ae60fcb0aac1314210c8efc7b6b
25. Disabilities Awareness Subcommittee
    Feb. 11, 2021 from 10 - 11:30 a.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m919a2f1fe972f4a615fc7693e189a542
26. Asian Pacific Islander Awareness Subcommittee
    Feb. 12, 2021 from 10 - 11:30 a.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=meb5f8ed37229bdce7def661c76dc9f43
27. Ontario Montclair School District
    Feb. 12, 2021 from 10-11 a.m.
    https://omsd.zoom.us/j/96992358146?pwd=WlUM3U3R3g2Q2VTYjNycytWcDFGQT09
28. Transitional Age Youth Awareness Subcommittee
    Feb. 17, 2021 from 11 a.m. – Noon
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m7ff60a63669bf855af7cbb1bff29bda6

Community Program Planning

29. 1st District Advisory Committee (DAC)
    Feb. 17, 2021 from 11 a.m. - Noon
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=ma5351c0a7d51276ab84ee4e263c75308

30. Senior Affairs Commission
    Feb. 17, 2021 from 1 - 3 p.m.
    https://hs-sbcounty.webex.com/join/daassac

31. Community Policy Advisory Committee (CPAC)
    Feb. 18, 2021 from 10 a.m. - Noon
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m1e2e253c01f6289e11752b95751c8e73

32. Cultural Competency Advisory Committee (CCAC)
    Feb. 18, 2021 from 1 - 2:30 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m976fb32a6ef3ef621aeeea0bb86e2d8c

SAN BERNARDINO COUNTY | Behavioral Health

Calendario de reuniones de participación de las partes interesadas de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)

Estas reuniones de las partes interesadas de la comunidad se centrarán en la actualización anual de la Ley de servicios de salud mental (MHSA por sus siglas en inglés) para el año fiscal 2021-22. Se prestará especial atención en compartir cómo se han actualizado los programas de MHSA en respuesta a las necesidades de la comunidad y una discusión sobre el futuro de los programas de MHSA.

La fecha/hora/ubicación del evento puede cambiar; para confirmar, llame al (800) 722-9866. Para servicios de asistencia de idioma o solicitud para acomodamientos relacionados a discapacidad, gratuitos, llame al (909) 386 – 8223. DBH cumple con las leyes federales de derechos civiles aplicables, y no discrimina basado en raza, color, nacionalidad, sexo, identidad de género, edad, discapacidad, o competencia de inglés limitada (LEP por sus siglas en inglés). La Ley De Servicios de Salud Mental (Proposición 63) por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

1. Comité Asesor del 2do Distrito (DAC)
   14 de enero de 2021 de 3:30 - 4:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mb4f214a55389ad7352b33b9987db1a81

2. Kiwanis Club of Greater San Bernardino
   19 de enero de 2021 de 8:30 - 9:30 a.m.
   https://apu.zoom.us/j/81682922470

3. Online WebEx Meetings
   19 de enero de 2021 de 10 a.m.- mediodía
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m0ff2e5533e591be2f3d2f3d3851ef128

4. Subcomité de Concientización de Nativos Americanos
   19 de enero de 2021 de 2 - 3:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m507b22673aed8126ee6becf676c02f85

5. Clubhouse Meeting
   20 de enero de, 2021 de 1-2 p.m.
   https://zoom.us/j/98596760766?pwd=NUNjZUVlOEJBblh6bWlEcTJCRVlwdz09

6. Comité Asesor del 4to Distrito (DAC)
   20 de enero de 2021 de 6-7 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m9f012333feb705fbaa7907f0f8527093

7. Subcomité de Concientización de Diagnostico Dual y Drogadicción (COSAC)
   21 de enero de 2021 de 3 - 4:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mff2856d29fed4830d18b172e7605fce6

8. Subcomité de Concientización de Consumidores y Miembros de Familias
   25 de enero de 2021 de 11 a.m.- mediodía
   https://zoom.us/j/92670362543#success

9. Subcomité de Concientización de Afroamericanos
   25 de enero de 2021 de 2 - 3:30 p.m.
   https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m022f4db15f496d534d4ffa86cd0f9f2f

10. NAMI of San Bernardino
    25 de enero de 2021 de 3 - 4:30 p.m.
    https://zoom.us/j/96345191150?pwd=M2gzSjVOczVXTmpLdzlOQ1pYYlIzQT09

11. Subcomité de Concientización de LGBTQ
    26 de enero de 2021 de 12:30 - 2 p.m.
    https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mbb31fb1a2213d01f2482db9f262800a1

Community Program Planning

12. Comité Asesor del 5to Distrito (DAC)
26 de enero de 2021 de 5-6:30 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mf51b4844b32110a42fe99c974d974919

13. Victor Community Support Services
27 de enero de 2021 de 9-10:30 a.m.
https://global.gotomeeting.com/join/901618541

14. Subcomité de Concientización de Mujeres
27 de enero de 2021 de 1 - 3 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mfb5561319c2e6d5b2458dd5fa9e750a1

15. Subcomité de Concientización de Adultos Mayores
28 de enero de 2021 de 10 -11:30 a.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m5902acfe42c245d87493af6b3953f5af

16. Subcomité de Concientización Latino
28 de enero de 2021 de 2021 de 10 -11:30 a.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mab4f56b3ccd30ca6e60efc35e7244813

17. Pacific Clinics-Yucca Valley
29 de enero de 2021 de 2021 de 9 -10 a.m.
https://us02web.zoom.us/j/88401895782?pwd=V0RNWUxUWGVVWThqK0c3UTVwV1dGQT09

18. Subcomité de Concientización de Veteranos
1 de feb. de 2021 de 3 - 4:30 p.m.
Llama a: (877) 820-7831
Contraseña: 512040#
Debe ingresar # después de los números en la contraseña.

19. Online WebEx Meetings
2 de feb. de 2021de 5 - 7 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=mf70086a7e9493eb8e3e7298e80ab0312

20. Rim Family Services
3 de feb. de 2021 de 10 - 11:30 a.m.
Contraseña: 161018
https://rimfamilyservices.zoom.us/j/91084072024

21. Comité Asesor del 3er Distrito (DAC)
3 de feb. de 2021 de 3 - 4 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m59f7555fbcbc6020057c7b3e27c7d4a0

22. Victor Community Support Services
5 de feb. de 2021 de 2 - 3 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m61e7c5be8a58743999351c3a97476e39

23. Subcomité de Concientización de Prevención del Suicidio
8 de feb. de 2021 de 10 -11:30 a.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m071eb6cf47bcb2af69151a0a73431543

24. Subcomité de Concientización de Espiritualidad
9 de feb. de 2021 de 1 - 2:30 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m835b6ae60fcb0aac1314210c8efc7b6b

25. Subcomité de Concientización de Discapacidades
11 de feb. de 2021 de 10 - 11:30 a.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m919a2f1fe972f4a615fc7693e189a542

26. Subcomité de Concientización de Asiáticos/ Isleños del Pacifico
12 de feb. de 2021 de 10 - 11:30 a.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=meb5f8ed37229bdce7def661c76dc9f43

27. Distrito Escolar de Ontario Montclair
12 de feb. de 2021 de 10-11 a.m.
https://omsd.zoom.us/j/96992358146?pwd=WlIUM3U3R3g2Q2VTYjNycytWcDFGQT09

28. Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)
17 de feb. de 2021 de 11 a.m. – mediodía
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m7ff60a63669bf855af7cbb1bff29bda6

29. Comité Asesor del 1er Distrito (DAC)
17 de feb. de 2021 de 11 a.m. - mediodía
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=ma5351c0a7d51276ab84ee4e263c75308

30. Comisión de Asuntos para personas mayores
17 de feb. de 2021 de 1 - 3 p.m.
https://hs-sbcounty.webex.com/join/daassac

31. Comité Comunitario Consultivo de Políticas (CPAC)
18 de feb. de 2021 de 10 a.m. - mediodía
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m1e2e253c01f6289e11752b95751c8e73

32. Comité Consultivo de Competencia Cultural (CCAC)
18 de feb. de 2021 de 1 - 2:30 p.m.
https://sbcountybh.webex.com/sbcountybh/j.php?MTID=m976fb32a6ef3ef621aeeea0bb86e2d8c

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 new Early Psychosis Care Program will not become immediately operational as initially described in the MHSA Three-Year Integrated Plan Fiscal Years 2020/21 - 2022/23 and will shift focus to training, capacity building, and referral and linkage activities. The program will be implemented in a phased approach with a primary intention of training and building capacity to identify those that are at clinical high risk for developing psychosis. Due to the financial impacts of the COVID-19 pandemic, the plan to hire staff for this program was modified. Initial hiring will be for staff to assist in the coordination of referral and linkage trainings.

Two existing PEI programs, Coalition Against Sexual Exploitation (CASE) and Community Wholeness and Enrichment (CWE), are experiencing funding adjustments. MHSA funding has been removed from some CASE program positions. The positions will continue to exist as the position funding shifted to different funding sources. The DBH operated portion of the Community Wholeness and Enrichment program has ended and the staff were reassigned.

Community Services and Supports

In addition to sub-programs added to the CSS component, several CSS programs experienced programmatic, funding, and/or name changes. For instance, the Triage Transitional Services (TTS) program expanded funding to implement the Placement after Stabilization (PAS) program that is co-located at each Crisis Residential Treatment (CRT) location. The PAS program utilizes a team of Clinical Therapists, an Office Assistance, and Clinic Supervisor to provide discharge planning to support individuals transitioning out of residential crisis services to community-based services.

Crisis Residential Treatment (CRT) program also increased funding due to a higher number of averaged days spent in a CRT and higher rate of utilization than anticipated. The CRT program services were initially estimated to provide 14 to 28 days of residential treatment services per consumer to achieve stability and regain optimum wellness. However, current consumer stays are averaging 38 days. Additionally, the preliminary budget for the four adult CRT locations estimated a bed utilization rate of 90% for each location. The program instead maintaining an average utilization of 93% leading to increased costs.

The Adult Criminal Justice (ACJ) Continuum of Care added a new full service partnership program, the Corrections Outpatient Recovery Enhancement (CORE), beginning January 2021. This new program was created as a result of the state eliminating funding for the Integrated Services for Mentally Ill Parolees (ISMIP). CORE provides intensive behavioral Health treatment services to adult parolees diagnosed with a serious mental

illness who are receiving enhanced outpatient program or correctional case management system services prior to release from state prison. Cost savings from other ACJ programs will be utilized to support CORE. Such cost savings measures include the reduction of programs costs for the Forensic Assertive Community Treatment (FACT)/Community Forensic Assertive Community Treatment (CFACT) program costs, due to reduction in program capacity from 50 to 35 consumers. The initial capacity of 100 consumers was subsequently reduced to 50, and after additional review, it was decided to amend the contract to reduce capacity from 50 consumers to 35 to more closely align with the number of actual consumers served per fiscal year.

To best align with program intent, the previously known Members Assertive Positive Solution (MAPS)/Assertive Community Treatment (ACT) program was renamed to Assertive Community Treatment (ACT) Model FSP Services.

Clubhouse Expansion program has clubhouses located geographically throughout San Bernardino County. The San Bernardino TEAM house will relocate to a new facility in June 2021. The Barstow Desert Stars Clubhouse will also relocate to a new facility during the summer of 2021. The Desert Stars relocation will allow for the expansion of services to include showers and laundry. The vacated space will be repurposed for non-MHSA Substance Use Disorder services.

In last year's MHSA Three-Integrated Year Plan, the Rialto Crisis Walk-In Center was renamed the Behavioral Health Urgent Care Center (BHUCC). Effective August 28, 2020, the BHUCC was closed. Through previous years of additional funding, an expansion of crisis services resulted (i.e., Crisis Stabilization Units (CSUs), Crisis Residential Treatment (CRT) facilities, and Triage, Engagement, and Support Teams (TEST).

Over time with the increase of psychiatrists and nursing staff in outpatient clinics and the opening of the CSUs and CRTs, the BHUCC experienced a 30% reduction in utilization. A thorough evaluation of department operations and the need to streamline the effectiveness of services concluded the need to discontinue BHUCC operations. Existing consumers were diverted to CSUs and outpatient clinics upon closure. This closure can also be noted in the DBH COVID Response document available at https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/01/Annual-Update-COVID-Response.pdf.

The Transitional Age Youth (TAY) One Stop Centers were previously approved a $500,000 funding increase in the MHSA Three-Year Integrated Plan. However, due to COVID-19 financial impacts, the increased funding was eliminated resulting in a reduction in the number of consumers served. There was also a reduction to the TAY Memorandum of Understanding (MOU) with Probation.

Under the Housing and Homeless Services Continuum of Care Program, the No Place Like Home (NPLH) and future MHSA CSS dollars are planned to be used to support Capitalized Operating Subsidy Reserves (COSR) for additional units. COSR is a fund that helps pay for operating deficits over time such as, but not limited to, subsidized rent over time. Because of the strict timelines associated with housing programs, DBH may not be able to specify the number of increased units in this update. However, to meet the needs, stakeholders agree that updates and future encumbrances will be reflected in subsequent updates to the MHSA Plan. This allows DBH to be responsive and meet multiple timelines. In addition, this program will increase the delivery of Full Service Partnership Services to an additional individuals that qualify for permanent supportive housing via new developments.

Innovation

The Innovative Remote Onsite Assistance Delivery (InnROADs) project is shifting from the original design for its teams. The Clinical Therapist ll assigned to the Morongo Basin will be used as a leadership floater throughout the county to assist with leadership needs at other locations as needed.

For the Eating Disorder Collaboration, the project is expected to begin January 1, 2021 with reduced staff due to hiring constraints. The staff will now include two Clinical Therapist ls, one Social Worker ll, and one Office Assistant ll.

In response to the COVID-19 pandemic, the Cracked Eggs project will shift platforms. The project will begin the utilize a virtual platform for workshops in lieu of the previously planned in-person workshops.

Capital Facilities and Technological Needs

A few areas under the Capital Facilities and Technological Needs component will receive increased funding. These include the Electronic Health Record (EHR), telehealth and network infrastructure, and the Data Warehouse. The increased funding for the EHR will support new Client and Service Information (CSI) and Network Adequacy Certification Tool (NACT) reporting requirements. New services models and telehealth services required DBH to increase the existing bandwidth and dual network support to all sites with access from outside field locations for all services providers. Data Warehouse required increased funding for the addition of the SAS Remove Server support on a limited time and material basis needed. This service ensures the continued viability of the data warehouse server.

Public Review

The MHSA Annual Update was posted on the department's website for stakeholder review and comment from February 23, 2021 through March 24, 2021 at http://wp.subcounty.gov/dbh/admin/mhsa/. The Public Hearing to affirm the stakeholder process took place at the regularly scheduled Behavioral Health Commission Meeting on April 1, 2021, which was held virtually from 12:00 p.m. until 2:00 p.m.

Summary and Analysis of Substantive Comments

An analysis of substantive recommendations is included in the Public Posting and Comment section of the final MHSA Annual Update. 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 scheduled to be posted for 30-days, per Welfare and Institutions Code 5848, between February 23, 2021 and March 23, 2021 at http://wp.sbcounty.gov/dbh/admin/mhsa/ .

If you would like to provide comments/recommendations after the close of the 30-day posting period, you may request a comment form be sent to you by contacting DBH at MHSA@dbh.sbcounty.gov or calling 1-800-722-9866 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 http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/06/Directory_Service_Eng.pdf.

During stakeholder meetings, it was noted that community members would like information about how to access funds related with MHSA programs 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: http://www.sbcounty.gov/main/Pages/rfp.aspx. More information on the Department's RFP process will be provided over the course of the next year at the Regional District Advisory Committee meetings.

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

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

Community members do not have to wait for a meeting to provide feedback to the Department. Feedback can be provided 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. The RFP process can be accessed via the link here and is as follows http://www.sbcounty.gov/main/Pages/rfp.aspx.

Additional information about past MHSA approved plans can be accessed at the following link http://wp.sbcounty.gov/dbh/admin/mhsa/. If you have any questions about MHSA programs in general or programs as detailed in this MHSA 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 February 23, 2021 through March 24, 2021. During this time, DBH continued to promote the 30-day public posting and provide information 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, county public libraries, 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, 10 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, 100% 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:
We need to update the information for Ontario-Montclair School District FRC. Name is no longer Family Solutions or MCC; correct name is Family & Collaborative Services and the correct phone number is for the Montclair location is (909) 445-161 ext. 1618. The Ontario-Montclair School District FRC also includes case management.

Response:
Thank you for your response and feedback. The consistent coordination and communication between DBH and contracted providers ensure stakeholders have access to accurate and current information. The program update will be reflected in the final version of the MHSA Annual Update.

Question: What else would you like to know about MHSA programs?

Comment:
I would like to know how the county develops new programs/services for the Innovations component.

Response:
Thank you for your response and interest. We are always interested in considering stakeholder ideas for potential future Innovation Projects. You may contact us at 1-800-722-9866 and ask to speak to the DBH Innovation Unit.

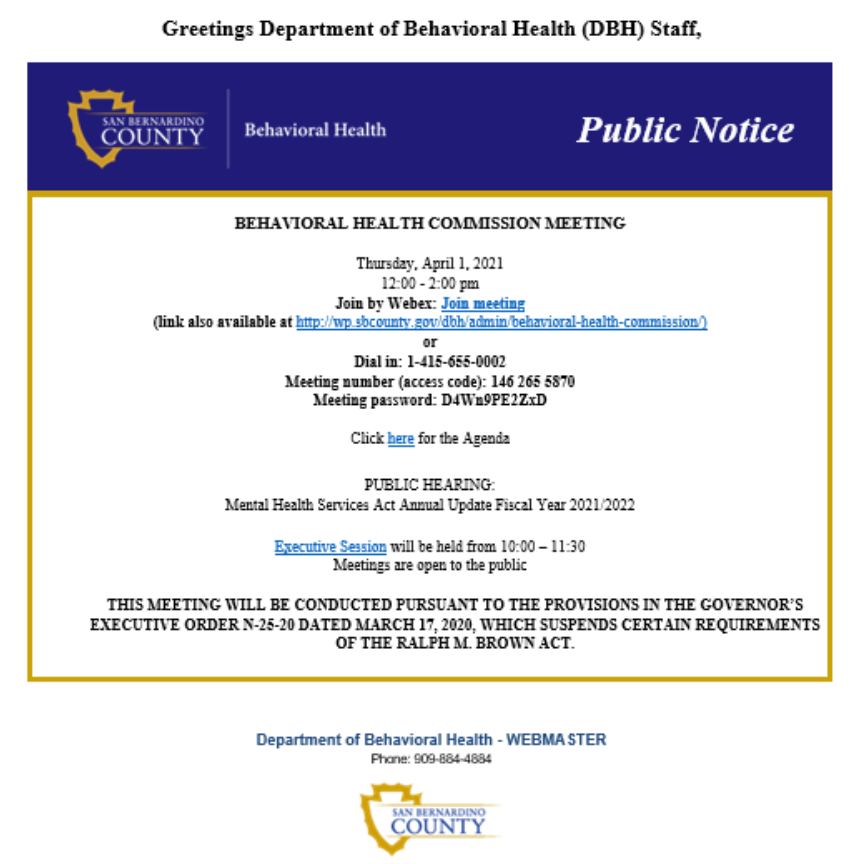
Public Hearing

The Public Hearing was hosted by the San Bernardino County Behavioral Health Commission was conducted on April 1, 2021 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.

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 2021/22 to the San Bernardino County Board of Supervisors tentatively scheduled for approval in May 18, 2021 meeting and the subsequent submission to the Mental Health Services Oversight and Accountability Commission.

One comment was received from the Behavioral Health Commissioners. The comment and question focused on information related to accessing services. DBH utilizes a 24/7 Access and Referral Helpline at 1(888)743-1478 or 711 for TTY users. This information is available on the DBH website homepage and in the MHSA Annual Update Plan Fiscal Year 2021/22.

Below is a copy of the flyer distributed to promote the MHSA Annual Update Public Hearing at the Behavioral Health Commission meeting:



Greetings Department of Behavioral Health (DBH) Staff,

SAN BERNARDINO COUNTY | Behavioral Health | ***Public Notice***

BEHAVIORAL HEALTH COMMISSION MEETING

Thursday, April 1, 2021
12:00 - 2:00 pm
Join by Webex: Join meeting
(link also available at http://wp.sbcounty.gov/dbh/admin/behavioral-health-commission/)
or
Dial in: 1-415-655-0002
Meeting number (access code): 146 265 5870
Meeting password: D4Wn9PE2ZxD

Click here for the Agenda

PUBLIC HEARING:
Mental Health Services Act Annual Update Fiscal Year 2021/2022

Executive Session will be held from 10:00 – 11:30
Meetings are open to the public

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

Department of Behavioral Health - WEBMASTER
Phone: 909-884-4884

SAN BERNARDINO COUNTY

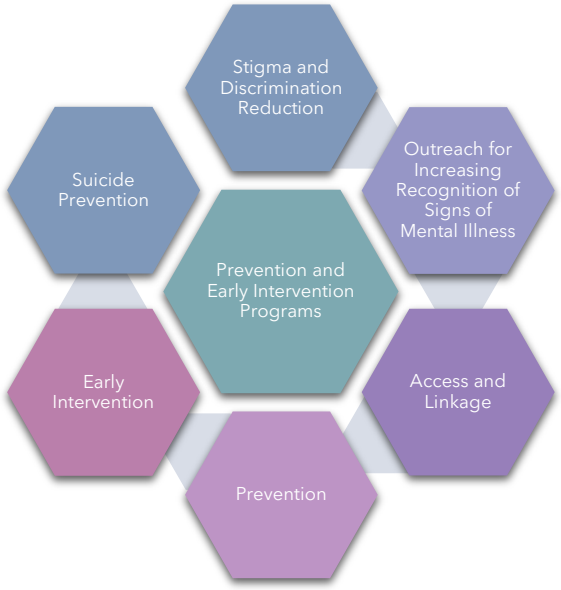
Prevention and Early Intervention (PEI)

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

There are six **(6)** State-Defined Prevention and Early Intervention Programs:



Local PEI Construct:

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

Prevention and Early Intervention (PEI)

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.

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 agencies. 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 individual with mental illness
2. Student Mental Health Initiative
    - **Goal**: Strengthening schools (K-12) and higher education mental health
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 Statewide PEI Project contractors. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. During the FY 19/20, 49 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 services 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 pandemic, San Bernardino County hosted its first virtual Directing Change Recognition Ceremony in May 21, 2020, to honor the San Bernardino County filmmakers.

67 films were submitted from the following schools and youth organizations in San Bernardino County: A.B. Miller High School, Apple Valley High School, Apple Valley School District, Cajon High School, Encore High School, Encore High School Hesperia for the Arts, Fontana Unified School District, Los Osos High School, Redlands East Valley High School, Redland Unified, Rim of the World High School, San Bernardino Community College, San Bernardino Valley College, Summit High School, and Upland High School.

In FY 19/20, mini-grants and sponsorships 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 Student Wellness Ambassadors: Over the Fall 2019 and Spring 2020 semesters, 20 Student Wellness Ambassadors received an in depth 2-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 were to promote 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 year 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, as a platform for judging submitted Directing Change videos.
Community College Outreach Events	The Foundation for California Community Colleges and their local campuses conduct mental health outreach to campuses utilizing Each Mind Matters materials and messaging.
Each Mind Matters Tabling	The Each Mind Matters Outreach & Engagement Team and Resource Navigators tabled at various conferences to engage conference attendees with Each Mind Matters materials and messages.
Each Mind Matters Insiders Newsletter	A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.

San Bernardino County Local Impact, cont.

Applied Suicide intervention Skills Training (ASIST) is a training for individuals who want to feel more confident and competent in helping to prevent the immediate risk of suicide of those at risk. In San Bernardino County, starting July 2011 through June of 2020, 1,634 individuals have been trained in ASIST as part of an early investment that allowed local individuals to become certified trainers. The County continues to capitalize on the investment by continuing to provide trainings for stakeholders throughout the county.

safeTALK is a suicide alertness training that prepares caregivers, students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and athletes to become suicide-alert helpers. Beginning July 2011 through June 2020, San Bernardino County in partnership with local providers has trained 2,287 community members on how to identify early signs of suicidal ideation for someone who may be at risk of suicide, how to start a discussion about suicide, and how to access resources available to connect someone in need of a suicide intervention to appropriate supports.

Artwork by B. Hammer

Artwork by Unknown

Native American Resource Center (NARC)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Stigma and Discrimination Reduction	3,421	3,895	$500,000	$286
Total Projected for FY 21/22	1,750	2,544		

Program Serves	Service Regions	Community Partnerships
Children, TAY, Adults, Older Adults	Central Valley, Desert/Mountain, East Valley, West Valley	Native Connections Tribal Prep (Positive Parenting Program) Native Youth Initiative for Leadership, Empowerment, and Development (ILEAD)

Target Population and Program Description

The Native American Resource Center (NARC) is a Stigma and Discrimination Reduction program. This program functions as a one-stop center offering prevention and early intervention services designed to reduce stigma and discrimination surrounding mental health services for Native American community members of all ages. The center provides culturally-based services using traditional and strength-based 6Native American practices.

The Native American Resource Center provides education on mental health through a historical and cultural context. 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.

NARC services include:

- Healthy choices prevention activities
- Cultural education and awareness
- Cultural parenting programs and education
- Drumming Circles
- Talking Circles
- Youth empowerment

Artwork by E. Curtis

Consumer Demographics Highlights FY 2019-20

Age

5% Children
8% TAY
19% Adult
3% Older Adul

N=3,555
*65% of participants declined to answer

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

15% Male

39% Female

1% Transgender

45% Decline to Answer

Ethnicity/Race

3% African-American/ Black
1% Asian/ Pacific Islander
4% Caucasian/White
3% Latinx/Hispanic
50% American Indian/ Alaska Native
13% Multiple Races/Other

*26% of participants declined to answer

Additional Consumer Demographics

Primary Language

100% English

Veterans Status

1%
(34 participants) identified as a veteran

Disability

1% Difficulty Seeing
3% Other Disability
23% No Disability

*73% of participants declined to answer

NARC Program Positive Results FY 2019-20

Stigma and Discrimination Reduction:

The Native American Resource Center uses a holistic approach, recognizing that the mental, physical, spiritual, and emotional self are all interconnected.

Changes in attitudes, knowledge, and behaviors is measured using surveys to gauge how the participant's perception of mental illness has changed in several key areas as a result of the activity or presentation the individual participated in.

In addition, a change in attitudes, knowledge, and behaviors is demonstrated by observing an increase in individuals seeking mental health services, as well as an increase in family support for participants who are seeking mental health services.

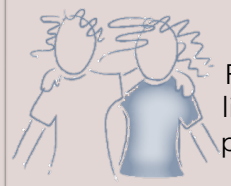
Historical Trauma:

Stigma is reduced by providing education regarding historical trauma and the effects on individual, family, and community functioning, which begins the process of healing unresolved grief and the loss of cultural identity. Through education of the history of Native Americans, the Native American Resource Center gives insight into the issues and obstacles that affect the ability to access services.

61%
Participants who are more likely to seek mental health support, if needed

64%
Participants who are more likely to talk to a friend or family member about mental health needs

62%
Participants who are more likely to socialize with someone who has a mental illness



58%
Participants are more likely to take action to prevent mental health discrimination

Challenges:

The COVID-19 pandemic has created additional stressors to at risk communities, at a time when in-person services were limited.

Solutions Addressing Challenges:

The Native American Resource Center implemented various strategies to provide education, support, and resources to Resource Center participants; utilizing Telehealth, social media, and other virtual methods to ensure participants had access to services.

Program Updates:

There are no program updates to report for FY 2021/22.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 82-97.

Artwork by Unknown

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

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Prevention Services	82	135	$968,165	$27
FY 19/20 Outreach Services	72,003	72,690		
Total Projected for FY 21/22	35,385	40,905		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
All ages	Central Valley, Desert/Mountain, East Valley, West Valley	72,003	Community-based organizations, faith-based organizations, participant homes, county facilities

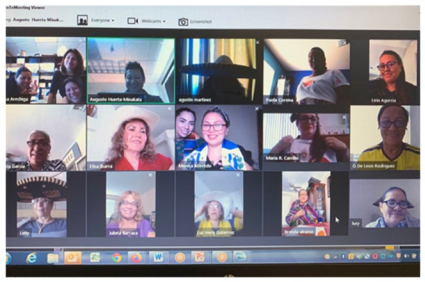
Target Population and Program Description

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

PdS/CHW Services:

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

Community Health Workers at a community event providing outreach education services. The CHW program has 7 CHWs and 21 peer providers.



Promotores de Salud volunteers working together to complete their 40 hour annual training virtually. The PdS program has 38 volunteers.

Promotores de Salud (PdS)

Target Population and Program Description

The Promotores de Salud program provides outreach and education to the Latinx population. Providers deploy services into the community using various culturally specific outreach methods. Spanish speaking members of the community are recruited to become Promotores de Salud in order to serve the Latinx population in the most comfortable manner possible. Promotores are members of the community and share many social, cultural and socio-economic characteristics held by the Latinx community. Because if this familiarity, Promotores are more easily able to provide culturally appropriate services.

PdS Services:

In addition to the services provided by the program as a whole, additional PdS services include:

- Knock and Talk presentations and neighborhood canvasing
- Modular presentations on specific topics including depression and anxiety
- Presentations at locations specific to the target populations including the Mexican and Guatemalan Consulates
- Field-based peer counseling and support
- Case management that includes referrals and linkage to mental health services and other necessary resources

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 98.

Consumer Demographics Highlights FY 2019-20

Age

8% Children
14% TAY
62% Adult
9% Older Adult
7% Declined to Answer

N=58,562

Sexual Orientation

> 1% of consumers identified as LGBTQ+
*22% of participants declined to answer.

Gender Identity

41% Male
59% Female

*Less than 1% identified as genderqueer, another gender, or questioning. *8% declined to answer.

Race/Ethnicity

0% African-American/ Black
0% Asian/ Pacific Islander
30% Caucasian/White
43% Latinx/Hispanic
0% American Indian/ Alaska Native
8% Multiple Races/ Other

*19% of participants declined to answer.

Additional Consumer Demographics

Primary Language

9% English
83% Spanish
8% Declined to answer

Veterans Status

> 1%
(8 participants) identified as a veteran

Disability

4% Other
1% Difficulty Seeing
20% Declined to answer

*75% of participants had no identified disability.

"This program has helped me renew my entire story as a human being, as before I felt I was trapped in a dead-end alley. I am thankful for all the resources that were offered to me and that without hesitation I openly received. I am now a better person with firm decisions and empathy towards others."

- PdS Consumer

PdS Program Positive Results FY 2019-20

Outreach:
PdS providers were able to creatively transition their outreach services to a virtual platform. They were able to provide outreach via social media and video platforms, as well as implementing the use of incentives to engage participants.

Types of responders reached:
Community members, leaders of faith-based organizations, consumer family members, school staff, emergency medical service providers, and peer providers.

Challenges:
All challenges for this program for FY 2019/20 were related to COVID-19. Please see the COVID-19 specific section for challenges observed with this program.

Solutions Addressing Challenges:
Please see the COVID-19 specific section for solutions this program developed.

Program Updates:
There are no program updates for this fiscal year.

100%
Participants agreed they received helpful information post-presentation

100%
Participants agreed the presenter knew a lot about the topic presented

100%
Participants agreed they learned something new by attending the presentation

99%
Participants plan to use the information received from the presentation

Community Health Worker (CHW)

Target Population and Program Description

The Community Health Worker program provides outreach and education to the African American, Asian Pacific Islander (API), LGBTQ+, and Native American communities. Providers deploy services to the community using culturally specific outreach methods. Members of the community that are bilingual in an API language or are representative of the target populations are recruited in order to serve the target populations in the most comfortable manner possible. Community Health Workers are members of the target population and share many social, cultural and socio economic characteristics with their respective communities. Because of this familiarity, CHW's have better success assisting community members access culturally appropriate services.

CHW Services:

In addition to the services provided by the program, additional CHW services include:

- Culturally specific presentations and outreach activities
- Modular presentations on specific topics that affect each community disproportionately
- Presentations at locations specific to the target populations including the places of worship and college/university campuses
- A peer counseling component where peer providers provide support to participants wherever they are most comfortable
- Case management coordination that includes referrals and linkage to additional mental health services, as well as other necessary resources

Consumer Demographics Highlights FY 2019-20

Age

7% Children
7% TAY
17% Adult
7% Older Adult
62% Declined to Answer

N=12,523

Sexual Orientation

2% of consumers identified as LGBTQ+

*93% of participants declined to answer.

Gender Identity

12% Male
21% Female

*2% identified as genderqueer, another gender, or questioning. *65% declined to answer.

Race/Ethnicity

6% African-American/ Black
4% Asian/ Pacific Islander
6% Caucasian/White
>1% Latinx/Hispanic
8% American Indian/ Alaska Native
16% Multiple Races/ Other

*60% of participants declined to answer.

Prevention and Early Intervention: CHW

PEI CI-1

Additional Consumer Demographics

Primary Language

81% English
>1% Spanish
1% Other

*18% of participants declined to answer.

Disability

>1% Hard of Hearing
>1% Physical
76% Declined to answer

*22% of participants did not have a disability

CHW Program Positive Results FY 2019-20

Prevention:
The Community Health Worker program uses case management to deliver prevention services. The programs provide one on one assistance to individuals that need additional support in navigating the medical, mental health and other basic needs services. The CHW are able to deliver culturally sensitive and linguistically appropriate assistance that helps participants reduce anxiety and fear towards accessing needed services.

Outreach:
CHW's reached the following types of responders: Families, community service providers, leaders of faith-based organizations, military personnel, law enforcement personnel, peer providers, other providers, employers, mediators, emergency medical service providers, and consumer family members. The top three settings in which potential responders were engaged were: cultural organizations, community events, and churches.

Challenges:
The Asian Pacific Islander population encountered several challenges with recruiting and maintaining community health workers and peer providers. Local healthcare organizations employ healthcare workers that target the same population as the CHW program. Some of these organizations offer higher pay, making it difficult for program providers to remain competitive.
COVID -19 increased the discrimination surrounding the Asian population, and social distancing requirement limited access to potential candidates in the community.

Solutions Addressing Challenges:
The Asian Pacific Islander population plans to address their challenges by continuing to work with the Department of Behavioral Health on finding creative ways to compete with the pay disparity between the Community Health Worker PEI program and health care organizations. They will also implement online training and recruiting practices via social media and online meeting platforms.

Program Updates:
There are no planned program updates at this time.

71%
Participants of SDR presentations now believe anyone can have a mental health condition

69%
Participants of SDR presentations now will take action to prevent discrimination against people with mental health conditions

77%
Participants of SDR presentations are more willing to seek support from a mental health professional if needed

61%
Participants of SDR presentations believe that the presenters were respectful of their culture

Prevention and Early Intervention: PdS/CHW

PEI CI-1

African American Sister Circle

Gender Health Keynote Speakers

Native American Healing Garden

Asian/Pacific Islander CHWs

Behavioral Health Ministries Project (BHMPP)

	Number to be Trained	Number to be Served	Annual Budget
Total Projected for FY 21/22	40 church Pastors and Leaders	300 IECAAC Members and Congregants	$100,000

Program Serves	Service Regions
All age groups	Central Valley

Target Population and Program Description

The Behavioral Health Ministries Pilot Project is a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC). The project seeks to collaborate with a network of faith-based organizations and assist in identifying the unmet behavioral health needs of the faith-based, African American Community. The goal is to provide participants with education and resources to address the behavioral health needs of their congregations within church settings and provide appropriate and timely resources for members to access needed behavioral health resources.

The pilot project will be developed through the following phases:

Phase I: Needs Assessment

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

Phase II: Behavioral Health Education and Awareness

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

Phase III: Community Engagement

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

Phase IV: Reporting

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

BHMPP Updates:

Actions completed

The pilot project workgroup is established and includes representatives from Prevention and Early Intervention (PEI), Research and Evaluation (R&E), Office of Equity and Inclusion (OEI) and Inland Empire Concerned African American Churches (IECAAC) leadership. Some of the pilot project phases that are completed include; establishing a timeline for the entire project, initiated internal procurement process to establish a contract with IECAAC to implement program, and a job description for Project Coordinator was developed.

Pending

Currently a contract is pending to establish a formal agreement between DBH and IECAAC for services. Once a contract is established, implementation actions and services can begin. The IECAAC is in the process of recruiting and hiring staff for the project.

Next Steps Planned

A project coordinator will be hired to manage and implement the project phases, and act as a liaison for IECAAC and DBH. The implementation of Phase I will begin and includes; Needs and Strengths Assessment, Mapping of Existing Resources, Recruitment of participants, Survey Tool development, Data Collection and Reporting Training.

Child and Youth Connection (CYC)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	6,328	70,969	$19,094,445	$2,075
FY 19/20 Prevention	62	62		
FY 19/20 Outreach	673	786		
Projected for FY 21/22	9,200	70,969		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
Children 0-15	Central Valley, Desert/Mountain, East Valley, West Valley	673	Community agencies, resource fairs

Target Population and Program Description

The Child and Youth Connection (CYC) program is categorized as an Access and Linkage to Treatment program that connects children experiencing severe emotional disturbances to medically necessary care and treatment. The CYC program is a collaborative of the following:

- Screening, Assessment, Referral, and Treatment (SART)
- Early Identification and Intervention Services (EIIS)
- Children's Assessment Center (CAC)
- Juvenile Public Defender's Office
- Mentoring Network

CYC Services:

CYC provides a variety of services for children ages 0-15:

- SART provides comprehensive treatment services for children ages 0-6.
- EIIS offers services to children ages 0-8 who are experiencing social, physical, behavioral, developmental, and/or psychological issues but do not require the intensive interventions from SART.
- DBH partners with Loma Linda University Children's Hospital to support the development of a therapeutic alliance prior to forensic interviews and medical examinations for evaluation of child abuse allegations.
- The Juvenile Public Defender's Office offers in-home screenings to youth involved in the juvenile justice system. Social workers provide supportive services to juveniles identified as having chronic truancy issues.
- The Department of Behavioral Health collaborates with Children's Network to conduct mentoring needs assessments of at-risk children and youth through a collaborative effort involving several County departments.

Consumer Demographics Highlights FY 2019-20

Age

86% Children
4% TAY
5% Adult
1% Older Adult
4% Declined to Answer

N=5,999

Sexual Orientation

0% of consumers identified as LGBTQ+

Gender Identity

3% Male

10% Female

*87% declined to answer

Race/Ethnicity

10% African-American/ Black
2% Asian/ Pacific Islander
17% Caucasian/White
3% Latinx/Hispanic
1% American Indian/ Alaska Native
38% Multiple Races/ Other

*29% declined to answer

Prevention and Early Intervention: CYC

Additional Consumer Demographics

Primary Language

92% English
7% Spanish
1% Other

Veterans Status

0%
(0 individuals) participants identified as a veteran

Disability

1% Hard of Hearing
21% Declined to Answer

*78% identified no disability.

Primary Diagnosis

6% Depression
28% Anxiety
3% Child/Adolescent Disorder
5% Impulse Control
7% Neurodevelop.
25% Other

*26% of participants had no diagnosis or it was deferred.

CYC Program Positive Results FY 2019-20

Prevention:
The CYC program providers offer prevention activities in order to reduce risk factors and increase protective factors to improve overall mental health function. These activities include screenings and assessments and various parenting groups.

Early Intervention:
SART and EIIS programs are a component of CYC that provides early intervention services which includes interventions and treatments to address children who have experienced trauma and/or display impaired functioning. These services can range from Parent-Child Interaction Therapy (PCIT) to Infant Massage, occupational therapy, and comprehensive multidisciplinary assessment. The JCBHS and CAC programs collectively assessed 1,007 children for mental health needs. Over half were provided a written referral to a mental health provider who could meet those needs.

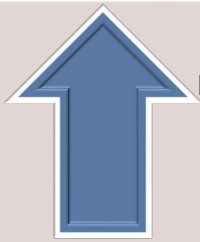
Outreach:
The primary outreach activity provided by the CYC program is the Mental Health First Aid which is used to teach potential responders how to recognize the signs and symptoms of an emerging mental illness. Using their training, these potential responders can assist those experiencing the possible onset of a mental illness to find the services they may need.

Potential responders include community providers, school personnel, leaders of faith-based organizations, and consumer family members.

69%
Participants improved in life functioning

41%
Participants successfully completed treatment plan

71%
Participants improved in the strengths domain



72%
Participants improved in the behavioral and emotional needs CANS domain

*Based on CANS domains

Challenges:

One of the biggest challenges with the CYC SART and EIIS program is providing early intervention services to the younger children as it can be difficult to have caretakers participate in the child's therapy by providing transportation and other support to the child.

Solutions Addressing Challenges:

Agencies developed protocols and technology trainings to assist family members with accessing services if transportation or other familial problems are an issue. Also having clinicians well-versed in providing technical assistance to caretakers provides support to caretakers as well.

Program Updates:

There are no planned program updates.

By Artist Unknown

Preschool PEI Program (PPP)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Prevention	1,172	3,167	$377,725	$250
Total Projected for FY 21/22	1,508	3,757		

Program Serves	Service Regions
Children, TAY, Adults, Older Adults	Central Valley, Desert/Mountain, East Valley, West Valley

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.

PPP services include:

- Child, parent, and teacher training to help strengthen children's social and emotional skills
- Trauma, Loss, and Compassion (TLC) program for children who have experienced a trauma or loss
- Resources and referrals
- Development of behavioral support plans
- Family support

Consumer Demographics Highlights FY 2019-20

Age

61% Children
2% TAY
30% Adult
7% Older Adul

N=1,172

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

22% Male

31% Female

47% Decline to Answer

Ethnicity/Race

12% African-American/ Black
2% Asian/ Pacific Islander
21% Caucasian/White
32% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/ Other

*28% of participants declined to answer

Additional Consumer Demographics

Primary Language

100% English

Veterans Status

1%
(34 participants) identified as a veteran

Disability

2% Difficulty Hearing
1% Other Disability
27% No Disability

*70% of participants declined to answer

"After participating in the Preschool PEI Program, I learned how to help my child develop social skills and get along better with others."

- PPP Participant

PPP Program Positive Results FY 2019-20

Prevention:
The Desired Results Developmental Profile (DRDP) 2015 is an assessment tool used to determine whether the preschool-aged child is at or above the California Foundations age expectations in several areas of developmental stages. The assessment is based on teacher and family observations as well as examples of the children's work. The assessments are completed in the fall, winter, and spring. The results shown on the right show the percentage of children who were at or above the California Foundations age expectations at the conclusion of the spring assessment compared to the fall assessment. As children age over the course of the year, developmental expectations increase. For this reason, it is not expected to see huge increases between assessment periods.

Life Skills Progression (LSP):
The Life Skills Progression Tool is an outcome measurement tool used to monitor participants' strengths and needs. Measuring 35 parental life skills in areas such as relationships, parent & child health, and mental health & substance abuse, the LSP also tracks aspects of child development. The families who participated in the LSP assessment had an average pre LSP score of 94.60 and an average post LSP score of 103.73 illustrating a 9.13 point (9.65%) improvement during Fiscal Year 2019/20.

33%
Improvement in social and emotional understanding

21%
Improvement in self control of feelings and behaviors

35%
Improvement in imitating behaviors

35%
Improvement in identity of self in relation to others

The Trauma, Loss, and Compassion program is offered to enrolled children who have experienced a trauma, loss, or separation from a significant care provider. Children and their parents or care providers participate in the TLC group and have a setting to share feelings, thoughts, and stories with others who are also experiencing trauma or loss. Examples include children who have lost one or more of their parents due to death, divorce, separation, military deployment, incarceration, or placement in foster care.

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

Solutions Addressing Challenges:
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.

Artwork by V. Talbot

Success Story

"Susan" was experiencing high anxiety, fear of being alone, frequent bursts of temper tantrums, and was aggressive both at school and at home. Educational interventions included strategies for improving coping skills, emotional regulation, and self-esteem. Through working with the PPP staff, the participant learned some important social skills such as respecting others, resolving conflict, cooperation, and teamwork. Within two months of learning new strategies, Susan demonstrated remarkable improvements in her social development, emotional development, and intellectual development.

Program Updates:

There are no program updates to report for FY 2021/22.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 137-147.

Resilience Promotion in African American Children (RPiAAC)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	207	1,360	$991,597	$237
FY 19/20 Prevention	604	4,598		
FY 19/20 Outreach	5,880	5,880		
Total Projected for FY 21/22	4,190	10,451		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
Children and TAY Ages 5-18	Central Valley, Desert/Mountain	5,880	Community Organizations, Community Events, Schools and Family Resource Centers

Target Population and Program Description

The Resilience Promotion in African American Children (RPiAAC) program is a Prevention and Early Intervention program that targets African American children and youth. The RPiAAC program embraces African American values, beliefs, and traditions, and incorporates the culture into educational behavioral health services. The goal of the program is to promote resilience in African American children to reduce the risk factors that lead to the development of a mental illness and/or substance use disorder activities.

RPiAAC services include:

- Peacemaker curriculum workshops
- NCTI Youth© Crossroads curriculum workshops
- Effective Black Parenting curriculum workshops
- Professional development presentations
- Conflict resolution trainings
- Cultural awareness and empowerment workshops
- Weekly interventions
- Screenings and Assessments
- Individual and family therapy
- Supportive group sessions, and
- Access and linkage to additional services

Consumer Demographics Highlights FY 2019-20

Age

38% Children
5% TAY
17% Adult
3% Older Adult

N=6,691

* 37% participants declined to answer

Sexual Orientation

2% of consumers identified as LGBTQ +

N=6,691

Gender Identity

17% Male

25% Female

58% Decline to Answer

*87% declined to answer

Race/Ethnicity

12% African-American/ Black
0% Asian/ Pacific Islander
8% Caucasian/White
27% Latinx/Hispanic
0% American Indian/ Alaska Native
12% Multiple Races/ Other

*41% declined to answer

Prevention and Early Intervention: RPiAAC

PEI SI-3

Additional Consumer Demographics

Primary Language

58% English
10% Spanish
1% Other

* 31% participants decline to Answer

Veterans Status

1%
(49 individuals)
Participants identified as a veteran

Disability

4% Other
36% No Disability
60% Declined to Answer

Primary Diagnosis

32% Depression
9% Anxiety
7% None/Deferred
20% Impulse Control
7% Neurodevelop.
25% Other

N=44

RPiAAC Program Positive Results FY 2019-20

Prevention:
The RPiAAC program provides a variety of prevention activities and social skill groups through their evidence base curriculums, Peacemakers and NCTI Youth Crossroads. Services are targeted toward children who are identified as struggling with emotional difficulties, maintaining passing grades, absenteeism, and tardiness.

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

Early Intervention:
RPiAAC providers utilize various screening and assessment tools to ensure participants receive treatment services as soon as mental health concerns are identified. In collaboration with partnering school teachers, program Mental Health Specialist provide early identification services to student who might benefit from individual and/or family therapy. Therapeutic services aim to recognize and reduce behavioral health challenges early in its development to decrease possible long-term impact on the student.

Regularly used tools include:

- San Bernardino Child and Adolescent Needs and Strengths (SB-CANS),
- Columbus Suicide Severity Rating Scale, and
- Life Events Checklist

43%
Participants improved in the CANS Behavioral/Emotional Needs domain for ADHD

47%
Improved their knowledge in conflict management strategies

83%
Participants improved in the CANS Behavioral/Emotional Needs domain for anxiety

67%
Participants improved education and social challenges

Outreach:
Outreach and education services are designed to incorporate cultural and historical education for African American student populations to encourage a positive social identity and generate awareness regarding the importance of the mental health and wellness of all students at specific school sites.

Types of responders reached:
- Families
- Law Enforcement
- School Personnel
- Others in a positions to identify potential of serious mental illness.

Challenges:
The program continues to struggle with the attendance in the Effective Black Parenting classes. Parent participation remains low. The stigma surrounding mental health continues to be a barrier.

Solutions Addressing Challenges:
Providers for the program exploring ways to incentivize participation in the Effective Black Parenting classes. Program providers also plan to develop stigma reduction activities to address the high stigma that remains prevalent within the community.

Program Updates:
There are no program updates to report for FY 2021/22.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 148-159.

Older Adult Community Services (OACS)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	126	630	$896,682	$137
FY 19/20 Prevention	955	7,044		
FY 19/20 Outreach	2,107	5,442		
Projected for FY 21/22	6,546	10,033		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
Older Adults 60+	Central Valley, Desert/Mountain, West Valley	2,107	Senior centers, community events, CBO Office

Target Population and Program Description

Older Adult Community Services (OACS) program is categorized as a Prevention State program that also provides early intervention services. OACS program services target older adults (ages 60+) that are at risk for developing mental health concerns. The program was designed to address key indicators like depression, isolation, chronic physical health conditions, and lack of family support system that may lead to mental health concerns. The OACS program utilizes tools to assess for risk of suicide, health concerns, close supports and depression during their program intake to link participants to the appropriate services.

OACS Services

- The Mobile Resource Unit - delivers mental health and substance use screenings to older adults who are in geographically isolated or economically challenged areas.
- The Older Adult Wellness Services - provides comprehensive services which include assistance with securing transportation to and from medical appointments, basic life needs, and activities for older adults.
- The Older Adult Home Safety program - assists older adults in maintaining the appropriate level of personal and home safety. Older adults receive services and education in personal safety, home safety, preventing falls, and medication management.
- The Older Adult Suicide Prevention program - provides suicide prevention education, screenings, and direct support services in a culturally appropriate manner for the program target population.

Consumer Demographics Highlights FY 2019-20

Age

1% Children
0% TAY
1% Adult
78% Older Adult
20% Declined to answer

N=2,595

Sexual Orientation

>1% of consumers identified as LGBTQ+

Gender Identity

14% Male

39% Female

47% declined to answer

Race/Ethnicity

1% African-American/ Black
1% Asian/ Pacific Islander
27% Caucasian/White
8% Latinx/Hispanic
>1% American Indian/ Alaska Native
8% Multiple Races/ Other

55% declined to answer

Prevention and Early Intervention: OACS

PEI SE-1

Additional Consumer Demographics

Primary Language

62% English
9% Spanish
29% Other

Veterans Status

1%
(28 participants) identified as a veteran

Disability

>1% Hard of Hearing
2% Physical
3% Had no disability
89% Declined to answer
3% Chronic health condition
8% Mental condition not mental illness

Primary Diagnosis

66% Depression
17% Anxiety
17% Other

N=35

OACS Program Positive Results FY 2019-20

Prevention:
The case management and home safety services allowed participants to feel safer and secure in their home. The participants reported that the increased phone communication has helped to reduce anxiety, loneliness, and isolation.

Early Intervention:
The program utilizes the Adult Needs and Strengths Assessment (ANSA) as a guide for delivering therapeutic services. OACS participants improved in the areas of Life Domain Functioning, Strengths, Behavioral Health needs and Risky Behaviors at the completion of their treatment.

Outreach:
Outreach Services are designed to help participants recognize and respond to early signs and symptoms of mental health concerns. Before the pandemic and social distancing requirements, the outreach activities consisted of monthly luncheons, healthcare fares and community events. Providers also completed mobile health screenings at Senior Centers and central locations throughout the various communities. Due to pandemic restrictions, these services are being converted to virtual platforms.

22%
Participants successfully completed treatment plan

160
Participants received a Wellness Package

33%
Stigma reduction presentation participants stated they will seek support from a mental health professional if needed

23%
Stigma reduction presentation participants feel that people with mental illness can eventually recover.

Outreach (cont.)

Types of responders reached:
Community Service Providers, Consumer and/or Family Members, Emergency Medical Providers, Leaders of faith based organizations, Those who provide services to the homeless, and Primary health care providers.

Artwork by: Karla Q.

OACS Program Positive Results FY 2019-20

Challenges:
Older Adults continue to face challenges with transportation, isolation, and stigma surrounding receiving mental heath services. This year the COVID-19 pandemic exacerbated theses challenges. Providers have found increased difficulty with contacting seniors due to social distancing requirements and technological needs. The Covid-19 pandemic also created greater food insecurity challenges for seniors without reliable transportation and a good support system.

Solutions Addressing Challenges:
Many of the providers partnered with food distribution programs to assist with transportation and food insecurity challenges. Telephone support groups and increased phone contact were piloted to address the isolation and technology challenges. Some providers created wellness packages that included wellness activities that encouraged positive coping strategies, relaxation skills and promoted creativity.

Program Updates:
Beginning in FY 20/21, the number of providers was be reduced, but the remaining providers have expanded their coverage areas to include the areas covered by the former providers.

Artwork by: L. Moses

For additional information please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 160-184.

Lift

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Prevention	125	1,095	$469,425	$3,912
Total Projected for FY 21/22	120	1,728		

Program Serves	Service Regions	Types of Outreach Settings
Children, TAY, Adults	Central Valley, Desert/Mountain, East Valley, West Valley	Community hospitals, Faith-based organizations, Homeless shelters, Pregnancy resource centers, SB County Juvenile Probation Dept.

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 first-time pregnant and parenting mothers, their children, and families. Services are delivered in the individual's home with nurses providing education to promote the physical and emotional care of newborn children.

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

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.

Lift services include:

- Parent education and support
- Post natal depression screenings
- Nurturing activities to increase maternal attachment
- Developmental milestones education
- Community referrals

Consumer Demographics Highlights FY 2019-20

Age

24% Children
18% TAY
41% Adult

N=125

*17% of participants declined to answer

Sexual Orientation

11% of consumers identified as LGBTQ+

Gender Identity

10% Male

74% Female

16% Decline to Answer

Ethnicity/Race

15% African-American/ Black
0% Asian/ Pacific Islander
25% Caucasian/White
31% Latinx/Hispanic
1% American Indian/ Alaska Native
13% Multiple Races/ Other

*15% of participants declined to answer

Prevention and Early Intervention: Lift

PEI SE-5

Additional Consumer Demographics

Primary Language

53% English
10% Spanish
11% Other

*26% of participants declined to answer

Veterans Status

1%
(1 participant) identified as a veteran

Disability

3% Difficulty seeing
1% Difficulty hearing
3% Other disability
75% No disability

*18% of participants declined to answer

"With the Lift program by my side, I achieved my goals and I overcame what seemed impossible for me: I was free from anxiety and depression, and I have a healthy baby."

- Lift Consumer

Lift Program Positive Results FY 2019/20

Prevention:
Lift prevention services provide a variety of activities designed to increase protective factors such as strengthening the nurturing bond within the family, building community supports and social connections, providing concrete supports in times of need, and increasing personal reliance.

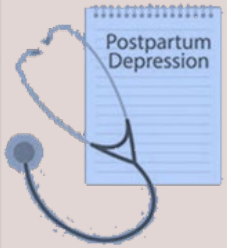
Pregnant mothers receive in-home visits from registered nurses who provide education about the connection between physical and mental health, as well as information about the developmental stages of their children.

The Maternal Fetal Attachment and the Edinburgh Postnatal Depression scales are used as assessment tools. Key measures of the Maternal Fetal Attachment scale include whether pregnant mothers are willing to give up activities that are harmful to their child, body image, hopefulness towards their future, and reading to their unborn baby.

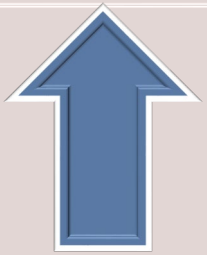
The Edinburgh Postnatal Depression Scale is an assessment conducted by Lift nurses to recognize signs that might indicate a new mother might be experiencing postpartum depression. Nurses provide early support, education, and resources to help new mothers navigate through their symptoms.

20%
Participants improved in the area of mother-baby attachment

32%
Participants improved feelings of certainty regarding the future



29%
Reduced indicators of postnatal depression



72%
Participants increased protective factors

In addition, Lift nurses help build program participants' self-reliance, independence, and hopefulness about their future through high school diploma, career training, and apprenticeship programs.

Challenges:
A primary benefit of the Lift program is obtained through the nurse home visits. Providing these in-home services during the Covid-19 pandemic has been challenging.

Solutions Addressing Challenges:
The Lift nurses found other avenues to communicate with their clients. Lift nurses provided telehealth visits and communicated with the participants via phone calls and text. This resulted in increased contact between participants and nurses.

Program Updates:
There are no program updates to report for FY 2021/22.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 174-184.

Artwork by J. Mendez

Coalition Against Sexual Exploitation (CASE)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Prevention	100	737	$217,666	$145
FY 19/20 Outreach	1,716	1,716		
Projected for FY 2021/22	1,500	1,500		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
TAY	Central Valley, Desert/Mountain, East Valley, West Valley	1,485	Community Resource Fairs Sherriff Academy

Target Population and Program Description

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

This program provides direct services to those who have been identified as Commercially Sexually Exploited Children(CSEC). Services are provided by a multidisciplinary team which consists of social workers from Children and Family Services, Public Defender's Office, and Behavioral Health; Attorneys from the District Attorney's Office and Public Defender's 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.

CASE Services

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

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 187.

Consumer Demographics Highlights FY 2019-20

Age

12% Children
38% TAY
43% Adult
4% Older Adult
3% Declined to answer
N=2,570

Sexual Orientation

4% of consumers identified as LGBTQ+

Gender Identity

18% Male **78%** Female

4% unknown/declined to answer

Race/Ethnicity

39% African-American/ Black
2% Asian/ Pacific Islander
40% Caucasian/White
1% Latinx/Hispanic
1% American Indian/ Alaska Native
9% Multiple Races/ Other

8% declined to answer

Prevention and Early Intervention: CASE

Additional Consumer Demographics

Primary Language

99% English
1% Spanish
0% Other

Veterans Status

0%
(0 individuals) participants identified as a veteran

Disability

1% Difficulty seeing
1% Other
90% Declined to answer
8% Did not have a disability

Primary Diagnosis

30% Depression
8% Anxiety
11% Bipolar
10% Disruptive
6% Other
1% Psychosis
1% Neurodevelopmental
32% None/deferred
2% Substance

CASE Program Positive Results FY 2019-20

Prevention:

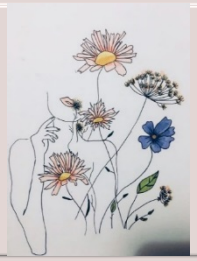
CASE uses the following prevention activities and services to assist participants with reducing risk factors and increasing protective factors associated with untreated mental illness as a result of their involvement with commercial sexual exploitation (CSEC):

- Multi-disciplinary and multi-agency team meetings (MDT) to provide case management services.
- Crisis intervention
- Sexual exploitation risk and mental health screenings
- Trauma informed care training and service delivery
- Juvenile "Girls Court" – opportunity to have juvenile records sealed if successfully completed after six month commitment
- Mentoring/advocacy support services

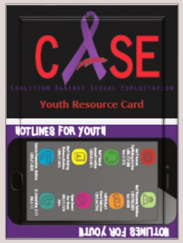
CASE uses a count of participants that access and engage in services as measurement of reduction in risk factors.

Early Intervention:

CASE team members do not provide direct early intervention and substance use treatment services under the CASE program. Team members screen and assess youth using the Child and Adolescent Needs and Strengths (CANS) assessment for possible substance use and mental health concerns and connect youth with appropriate mental health and or substance use interventions. The CANS results show that CASE participants improved in the categories of Resiliency and School Attendance. As a result of treatment, these youth have increased their ability to recognize internal strengths and use them in daily life and in stressful times.

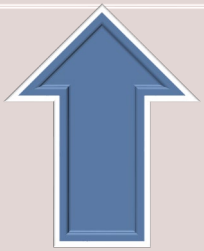


60%
Participants successfully completed Girls Court



100
CSEC participants were served throughout FY 2019/20

17%
Participants with planned discharges showed an increase in resiliency



28%
Participants with planned discharges showed an improvement in school attendance

Prevention and Early Intervention: CASE

Early Intervention (cont.):
Research shows that young people who feel connected to their school are less likely to engage in many risk behaviors, including; early sexual initiation, substance use, violence, and gang involvement. An increase in school attendance is a protective factor for youth at risk of sexual exploitation.

Outreach:
CASE provides free CSEC awareness, identification, and assessment trainings throughout the San Bernardino County.

In January 2020, CASE partnered with the County Sheriffs department to host a two day long Human Trafficking symposium where several subject matter experts presented on Human Trafficking subjects. At the end of the month, CASE hosted the 10th annual "Human Trafficking Awareness Walk" inviting the community and professionals to walk in unity in support of victims and survivors. The event assembled county dignitaries and over 24 community vendors/agencies. During the event, survivors of labor and sex trafficking provided testimony to over 200 attendees.

The potential responders included in CASE activities are: Child serving agency service providers, law enforcement, school personnel, medical professionals, educators, community service providers, faith based leaders, child protective services, families, others that have access to and influence over children

The most common settings in which potential responders were reached include: churches, community based organizations, community events, county facilities, law enforcement departments, and schools.

Challenges:
CASE team members have expressed the following top three challenges with providing services: Maintaining appropriate and consistent placements for identified youth; Reduction of availability of resources and services due to the Covid-19 pandemic social distancing restrictions; Engaging youth and building a trusting relationship due to their complex traumas, mental health and/or substance use challenges, and stigma of utilizing services from government/law enforcement service providers.

Solutions Addressing Challenges:
CASE plans to implement the following solutions to address the challenges mentioned above; One, the team will continue to work with CFS and placement agencies to develop a network of CSEC appropriate placements which includes training and supports of service and placement providers regarding CSEC specific needs.; Two, CASE team members are continually adopting service delivery methods to accommodate social distancing guidelines. They have increased phone communications with youth and transitioned trainings and events to virtual formats.; Three, to engage new clients and maintain current relationships the case team members are using online/virtual platforms and cell phones to stay connected while building relationships.

Program Updates:
The CASE program will undergo structural changes in the upcoming fiscal year to centralize the behavioral health services and streamline the data collection and reporting flow.

184
Attendees participated in the 10th Annual CASE Walk

112
People participated in the Human Trafficking Symposium hosted by CASE and Sheriff Department

89%
CSEC Domestic Minor Trafficking presentation attendees now know of available services, providers, and resources to assist CSEC

95%
Community members that attended CSEC trainings increased knowledge and awareness of CSEC

Family Resource Center (FRC)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	1,090	8,456	$3,390,760	$126
FY 19/20 Prevention	7,414	22,052		
FY 19/20 Outreach	22,355	19,071		
Total Projected for FY 21/22	26,945	51,011		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
Children, TAY, Adults, Older Adults	Central Valley, Desert/Mountain, East Valley, West Valley	22,355	Recreation Centers, Schools, Churches, Community Events, Cultural Centers

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 within local communities allows services to be tailored to the specific needs and cultural requirements of individualized communities. Early Intervention eligibility requires a participant's diagnosis be a mild to moderate behavioral health condition that is treatable with low-intensity interventions that can improve within one year.

FRC services include:

- After school youth projects and activities
- Behavioral health education workshops
- Maternal mental health
- Personal development activities
- Skills-based education for adults
- Family counseling
- Individual therapy
- Case management services

Consumer Demographics Highlights FY 2019-20

Age

22% Children
9% TAY
51% Adult
3% Older Adult

N=30,916

*15% of participants declined to answer

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

12% Male

25% Female

63% Decline to Answer

Ethnicity/Race

6% African-American/ Black
1% Asian/ Pacific Islander
16% Caucasian/White
38% Latinx/Hispanic
1% American Indian/ Alaska Native
20% Multiple Races/ Other

*18% of participants declined to answer

Prevention and Early Intervention: FRC

PEI CI-2

Additional Consumer Demographics

Primary Language

74% English
24% Spanish
2% Other

Veterans Status

1%
(242 participants) identified as a veteran

Disability

1% Difficulty seeing
1% Difficulty hearing
1% Other disability
10% No disability

*87% of participants declined to answer

Primary Diagnosis

22% Depression
13% Anxiety
2% Disruptive
1% Substance Use Disorder
20% None/Deferred
41% Other Diagnosis
1% Neurodevelopmental Disorder

FRC Program Positive Results FY 2019/20

Prevention:
Prevention activities include parenting classes, NCTI Crossroads© and Real Colors © workshops, art programs, computer skills workshops, resume and job search workshops, and assistance in accessing basic needs through online applications. These activities help support mental wellness by developing protective factors to strengthen community involvement, nurture family engagement, and build resilience and self-reliance.

Many prevention activities were adapted to virtual formats allowing Family Resource Center participants to continue benefiting from services while remaining safely distanced from crowds.

Early Intervention:
Early intervention activities include individual and family therapy, using evidence-based practices such as cognitive behavioral therapy and solution focused therapy. The Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) are used to measure progress. Highlights of the positive outcomes are shown to the right.

Many individuals opted to receive services virtually through telehealth services. Family Resource Center participants report greater access to services while relieving the stigma associated with seeking behavioral health services.

52%
Participants successfully completed treatment plan

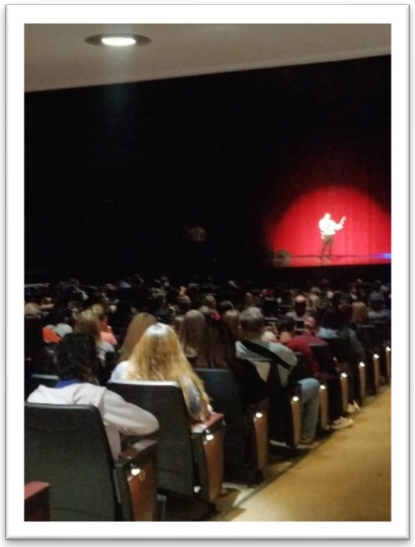
78%
Adult participants improved in life functioning

57%
Child participants improved in the strengths domain

55%
Child participants improved in life functioning

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.

One outreach event was a community screening of *Angst*. This film provided a look at anxiety and helped audience members identify and understand the associated symptoms. Presented in partnership with the Ontario High School Jag Mental Wellness Club and the local NAMI Chapter, the event featured a question and answer session with a panel of mental health professionals. Audience members were given the option to submit questions by text to encourage participation without the stigma of standing at a public microphone.



Other community outreach events included participation at community health fairs, a presentation at the Consulate de Mexico during Hispanic Heritage Month, and participation in back-to-school nights at local schools.

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.

Challenges:
Some of the challenges observed include ensuring that participants were able access services virtually.

Solutions Addressing Challenges:
Family Resource Center staff set aside additional time in sessions to help participants learn how to set up and use the virtual meeting platforms.

Program Updates:
The Ontario –Montclair School District's FRC changed program name from Family Solutions to Family & Collaborative Services.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 197-215.

Community Wholeness and Enrichment (CWE)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	689	3,057	$878,379	$297
FY 19/20 Prevention	648	955		
FY 19/20 Outreach	1,001	1,079		
Projected for FY 21/22	2,956	7,809		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
TAY and Adults	Central Valley, Desert/Mountain, East Valley, West Valley	1,001	Community-based organizations, faith-based organizations, schools

Target Population and Program Description

The Community Wholeness and Enrichment (CWE) program is categorized as a Prevention and Early Intervention program that targets Transitional Age Youth (TAY) ages 16-25, adults ages 26-59, and family members of those living with a behavioral health condition. The CWE program is for those who are experiencing the initial onset of a mental or emotional disturbance and/or substance use disorder.

CWE Services

- Screenings and assessments
- Case management, linkage, and referrals
- Support groups (including suicide bereavement)
- Psychoeducation to support individuals living with a mental health condition and their families
- Individual, couple, and family therapy using evidence-based practices
- Educational presentations and trainings to potential responders about ways to recognize and respond effectively to the early signs of mental health conditions

Consumer Demographics Highlights FY 2019-20

Age

0% Children
22% TAY
59% Adult
11% Older Adult
8% Declined to Answer

N=2,365

Sexual Orientation

2% of consumers identified as LGBTQ+

Gender Identity

24% Male
52% Female
3% Transgender
21% Declined to answer

Race/Ethnicity

6% African-American/ Black
1% Asian/ Pacific Islander
22% Caucasian/White
19% Latinx/Hispanic
0% American Indian/ Alaska Native
28% Multiple Races/ Other

*24% of participants declined to answer.

Prevention and Early Intervention: CWE

Additional Consumer Demographics

Primary Language

99% English
0% Spanish
1% Other

Veterans Status

2%
(39 individuals) participants identified as a veteran

Disability

7% Physical mobility
6% Chronic condition
57% Declined to answer

*The remaining 31% identified as no disability, difficulty seeing/hearing, or other.

Primary Diagnosis

39% Depression
32% Anxiety
26% Other
1% Bipolar Disorder
1% Psychosis
1% None/Deferred

CWE Program Positive Results FY 2019-20

Prevention:
Prevention activities reduce risk factors and increase protective factors for mental health. The CWE program uses multiple types of surveys, following group sessions for example, to measure a reduction in risk factors and increase in protective factors.

Early Intervention:
Early intervention services use tools such as the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs (CANS) to measure the reduction of symptoms.

Outreach:
CWE providers were able to creatively transition their outreach services to a virtual platform. They were able to provide outreach via social media and video platforms, as well as implementing the use of incentives to engage participants.

Potential responders reached include: community members, leaders of faith-based organizations, consumer family members, school staff, emergency medical service providers, and peer providers.

Challenges:
The biggest challenges CWE providers report is with prevention based activities. Specifically, attendance at support groups is an ongoing challenge as participants find the group setting an intimidating format to discuss their mental health needs.

35%
Participants successfully completed treatment plan

37%
Participants improved in life functioning

30%
Participants improved in the strengths domain

30%
Participants improved in the behavioral and emotional needs CANS domain

*Based on CANS domains

Solutions Addressing Challenges:
One solution has been to begin to draw in participants through outreach efforts. In developing a familiarity of the agency with participants at outreach events, providers have been able to increase comfort levels of these participants. As a result, the participants are more willing to join prevention groups and continue to attend.

Program Updates:
Due to a reduction in funding, the DBH operated portion of this program, Integrated Health, has ended and the staff has been reassigned.

Success Story

"Suzy" sought behavioral health treatment to address her suicidal ideation. Suzy learned coping skills such as grounding, thought field work, and mindfulness practice techniques. She uses these techniques in challenging her thoughts and ideation. She successfully engaged in individual therapy and completed her therapy goals. Suzy is confident in her new skills to cope with new stressors and maintaining the progress she has made.

Military Services and Family Support (MSFS)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	332	2,258	$690,288	$191
FY 19/20 Prevention	2,589	4,238		
FY 19/20 Outreach	1,695	1,730		
Projected for FY 21/22	3,605	6,990		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
All ages	Desert/Mountain, East Valley	1,695	Community events, schools, behavioral health clinics, military bases

Target Population and Program Description

The Military Services and Family Support (MSFS) program is a Prevention and Early Intervention program that targets active military members, veterans, service members of the Reserves and National Guard, retired veterans, and their families. The program addresses the negative effects of traumatic events, and other unique challenges of military life, by providing in-home and/or community-based prevention and early intervention services.

To increase access to services and decrease stigma associated with mental health in the military, the MSFS program services are delivered in the homes of participants as well as at various sites that are conveniently located throughout San Bernardino County.

MSFS Services

MSFS individual and family services include:

- In-home screenings and assessments
- Case management and referrals to connect participants with long term mental health services and other resources, including those offered through the County Department of Veterans Affairs
- Peer support groups led by trained individuals who have similar experiences and designed to meet the unique needs of military families

Consumer Demographics Highlights FY 2019-20

Age

18% Children
7% TAY
55% Adult
5% Older Adult
15% Declined to Answer

N=5,322

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

13% Male
16% Female
2% Transgender
>1% Gender non-binary

*68% declined to answer

Race/Ethnicity

3% African-American/ Black
0% Asian/ Pacific Islander
18% Caucasian/White
4% Latinx/Hispanic
0% American Indian/ Alaska Native
9% Multiple Races/ Other

*66% declined to answer

Prevention and Early Intervention: MSFS

Additional Consumer Demographics

Primary Language

99% English
1% Other

Veterans Status

21%
(1,063 individuals) participants identified as a veteran

Disability

1% Hard of hearing
1% Physical
1% Difficulty seeing
1% Chronic health condition
1% Cognitive disability
80% Declined to answer

*15% reported no disability.

Primary Diagnosis

17% Depression
24% Anxiety
2% Bipolar Disorder
1% Psychosis
1% Neurodevelop.

*33% reported other or deferred diagnosis. 22% had none/deferred diagnosis.

- Psychoeducation for individuals and their families, to help empower them to educate individuals and manage their condition in the best way
- Therapeutic mental health services and counseling for individuals, couples, and families using evidence-based practices such as Brief Strategic Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Parent Child Interaction Therapy

MSFS Program Positive Results FY 2019-20

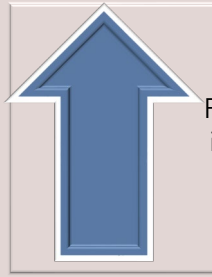
Prevention:
The prevention activities offered by the MSFS program are designed to reduce risk factors for developing a potentially serious mental illness while building protective factors and increasing support. These activities range from support groups such as the Vets Supporting Vets group, to Equine Assisted Therapy and Learning which helps participants to learn to trust and uncover underlying factors affecting their mental health.

Early Intervention:
The MSFS program provides early intervention services to address and promote recovery and related functioning at the earliest signs of a mental health condition. To assess participants and their PTSD symptoms, the MSFS program uses the Post Traumatic Stress Disorder (PTSD) Checklist. One evidence-based practice used is the Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a form of interactive psychotherapy that helps individuals heal from trauma or distressing life experiences.

35%
Participants improved in life functioning

26%
Participants successfully completed treatment plan

30%
Participants improved in the strengths domain



34%
Participants improved in the behavioral and emotional needs CANS domain

*Based on CANS domains

Prevention and Early Intervention: MSFS

Outreach:
The MSFS program providers have developed relationships with their surrounding military establishments in order to provide outreach services on or near these military bases. They have also developed relationships with local agencies ands schools to further their outreach efforts.

Types of responders reached:
School personnel, community providers, military personnel, peer providers, and consumer family members

Challenges:
Prevention activities are the biggest challenge for MSFS providers. Due to stigma surrounding mental health, especially in the military, providers struggle with prevention activity attendance.

Solutions Addressing Challenges:
Working collaboratively, MSFS providers are creating solutions for prevention activity attendance. One solution has been to begin to draw in participants through outreach efforts. When participants become comfortable in an outreach setting, they are more comfortable returning to the agency for additional activities.

Program Updates:
There are no planned program updates.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 232 -251.

Artwork by Gabriel Horne

Student Assistance Program (SAP)

	Total Unduplicated	Total Services	Annual Budget	Est. Cost per Person
FY 19/20 Early Intervention	1,085	11,821	$4,467,240	$290
FY 19/20 Prevention	3,749	12,239		
FY 19/20 Outreach	7,932	6,645		
Projected for FY 21/22	15,381	20,682		

Program Serves	Service Regions	# of Outreach Responders Reached	Types of Outreach Settings
Grades K-12	Central Valley, Desert/Mountain, East Valley, West Valley	7,932	County facility, Schools, Community event

SBCSS provide Positive Behavioral Intervention and Supports (PBIS) training and implementation support as well as school system navigation training and coordination to the SAP services providers.

The target population served with this program includes children and youth. adults, and older adults 60+, and families are targeted through outreach services.

Target Population and Program Description

SAP uses a school-based team approach to identify, refer, and provide services to kindergarten through 12th grade students needing interventions for behavioral health, emotional, and/or social concerns.

The SAP program provides support and education to the County's schools and school districts through partnership with the San Bernardino County Superintendent of Schools (SBCSS).

SAP Services

- Mental health and substance use screenings and assessments
- Mental health educational presentations
- Critical incident stress debriefing
- Social skill/coping skills groups
- Caregiver support
- Alcohol and drug education and intervention
- Case management
- Suicide prevention support and presentations
- Individual and group counseling
- Life/social skill building

Consumer Demographics Highlights FY 2019-20

Age

0% Children
6% TAY
82% Adult
12% Older Adult

N=360

Sexual Orientation

23% of consumers identified as LGBTQ+

Gender Identity

61% Male

35% Female

2% Transgender

2% Gender non-binary

Race/Ethnicity

15% African-American/ Black
2% Asian/ Pacific Islander
45% Caucasian/White
17% Latinx/Hispanic
4% American Indian/ Alaska Native
17% Multiple Races/ Other

Prevention and Early Intervention: SAP

Additional Consumer Demographics

Primary Language

89% English
6% Spanish
5% Other

Veterans Status

Less than >1%
(17 participants) identified as a veteran

Disability

10% Hard of Hearing
3% Physical
87% Declined to answer

Primary Diagnosis

17% Anxiety
28% Depression
11% Disruptive
8% Neurodevelopmental/ Cognitive
7% None/Deferred
29% Other

SAP Program Positive Results FY 2019/20

Prevention:

The criteria used to determine a student's eligibility for the SAP program consists of a review of the students' school attendance, behavioral concerns at home or school, decrease in school achievement, youth at risk of juvenile justice involvement, early onset of mental health concerns, and exposure to trauma. School counselors, teachers, and/or parents can make referrals to the SAP program providers for screening and assessments. The SAP providers also provide general prevention services to their designated schools school wide in the form of presentations at school assemblies and afterschool group activities.

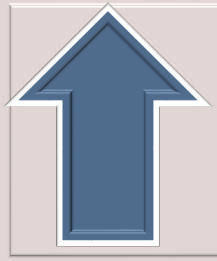
Early Intervention:

Early Intervention services provided are available at the child's home, school, or in the provider's clinic office. This FY there was a consistent increase in successful early intervention treatment services. Successful treatment is defined by a participant completing their treatment goals by the end of their individual treatment plan timeframe. Most SAP early intervention treatment plans are completed within six months.

55.1%
Participants improved in life functioning

75.1%
Participants successfully completed treatment plan

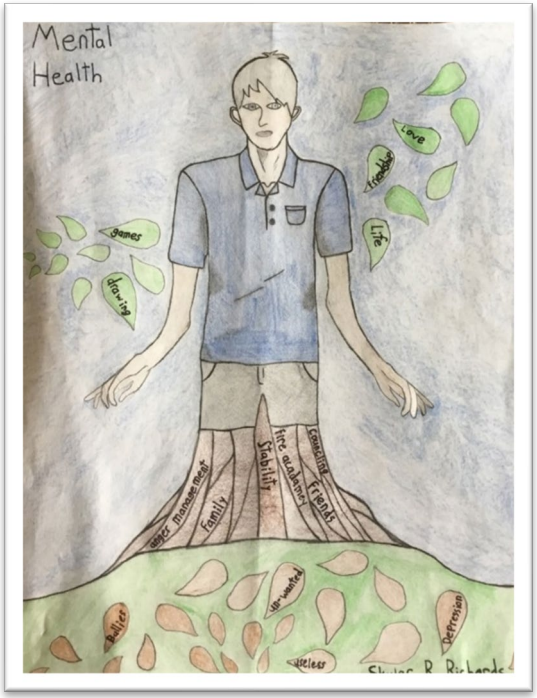
64.8%
Participants improved in the strengths domain



21.3%
Participants improved in the behavioral and emotional needs CANS domain

*Based on CANS domains

SAP Program Positive Results FY 2019-20



Artwork by S. Richards

Outreach:
Outreach training for the SAP program consisted of Mental Health First Aid, Asist, and SafeTalk.

Types of responders reached: include community service providers, families, providers, school personnel, law enforcement personnel, consumer family member, people who provide services to those that are homeless, and peer providers.

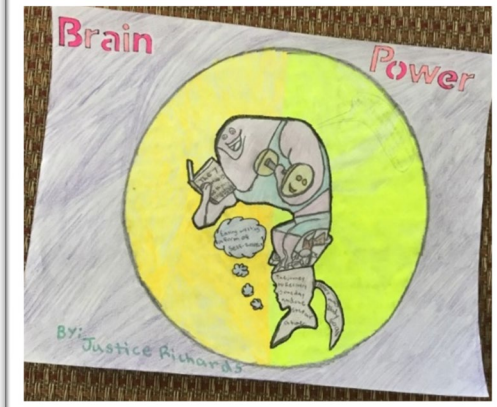
Challenges:
Meeting students in schools and providing group services was a challenge during the FY 19/20 due to social distancing restrictions.

Solutions Addressing Challenges:
Providers have transitioned many therapy and group services to online virtual platforms and worked with schools to be able to utilize their platforms for greater student access. Also, provider clinics have remained open to accommodate those that needed to participate in person on an appointment only basis.

Program Updates:
There are no planned program updates.

For addition information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 252.

Artwork by: Parker, P.



Artwork by J. Richards

Early Psychosis Care (EPC)

	Total Unduplicated Participants to be Served	Annual Budget	Est. Cost per Person
Total Projected for FY 21/22	26	$1,000,000	$38,462

Program Serves	Service Regions	Types of Outreach Settings
Ages 16 - 25	Central Valley, Desert/Mountain, East Valley, West Valley	Schools-based organizations, Mental Health organizations, Community-based organizations

Target Population and Program Description

The Early Psychosis Care (EPC) program is an early intervention program. The intent of the program is to identify individuals with a clinical high risk (CHR) for developing psychosis and intervene as soon as possible during the first episodes of psychosis. Individuals presenting with early psychosis usually present with multiple problems such as suicidal ideation, aggressive behavior, legal difficulties, school challenges, and are often diverted to other systems the do not include mental health supports. The program will focus services on Transitional Aged Youth populations.

Existing Efforts

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

EPC Updates:

The original timeline of the EPC program introduced in the FY 2020/21 Three Year Integrated Plan has been modified as a result of funding reductions due to COVID-19. Program administrators continue to plan to use the existing infrastructure within the continuum of services offered by the Department of Behavioral Health. However, adjusted funding for the program will require a phased approach to program implementation.

Due to hiring constraints, the first fiscal year of services will be likely be reduced.

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 CHR.

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 resources 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:

- Recruiting 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.
- Recruiting a program Office Assistant II to support clinical staff and facilitate access and linkage services

Phase III: High Clinical 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, and
- Premier program staff

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages. 59-63.

Artwork by Unknown

Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is mandated to be directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED).

Community Services and Supports Goals
• Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth
• Reduce homelessness and increase safe and permanent housing
• Increase in self-help and consumer/family involvement
• Increase access to treatment and services for co-occurring problems, substance use, and health
• Reduction in disparities in racial and ethnic populations
• Reduce the number of multiple out-of-home placements for foster care youth
• Reduce criminal and juvenile justice involvement
• Reduce the frequency of emergency room visits and unnecessary hospitalizations
• Increase a network of community support services

The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component. There are eight Full Service Partnership (FSP) Programs that are contained in the FSP section; and FSP programs that provide housing, long term supports, and transitional care are also contained within their own section. The Peer Support Programs section highlights programs that are consumer driven and work from a lived experience perspective. The goal of all CSS programs is to provide the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

Community Services and Supports Programs
Crisis System of Care • A-5: Diversion Programs • A-6: Crisis System of Care Programs
Crisis Stabilization Continuum of Care • A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs) • A-10: Crisis Residential Treatment (CRT) – Adult – Transitional Age Youth (TAY)
Peer Support Programs • A-1: Clubhouse Expansion
Outreach, Access, and Engagement Programs • A-9: Access, Coordination, and Enhancement (ACE) • A-15: Recovery Based Engagement Support Team (RBEST)
Full Service Partnerships • C-1: Comprehensive Children and Family Support Services (CCFSS) • C-2: Integrated New Family Opportunities (INFO) • TAY-1: Transitional Age Youth (TAY) One Stop Centers • A-2: Adult Criminal Justice Continuum of Care • A-3: Assertive Community Treatment 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

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 who return for 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 2019/2020 thru 2022/2023, 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 2021/22:

	Program Name	Fiscal Year	Ages Served	Service Area*
Diversion Programs	Triage Transitional Services	2021/22	300 TAY 1,000 Adult 100 Older Adult	1,400 GSD
			TOTAL = 1,400	TOTAL = 1,400
	Triage, Engagement, and Support Teams	2021/22	300 Children 440 TAY 960 Adult 300 Older Adult	2,000 GSD 675 O&E
			TOTAL = 2,000	TOTAL = 2,675
Crisis System of Care Programs	Community Crisis Response Team	2021/22	1,467 Children 1,185 TAY 1,862 Adult 478 Older Adult	4,992 GSD 17,500 O&E
			TOTAL = 4,992	TOTAL = 22,492
	Crisis Intervention Training	2021/22	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 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Triage Transitional Services	1,982	1,400	$6,399,922*	$1,882*

*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). TTS determines 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 2019/2020 thru 2022/2023, 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 2019-20

Age

0% Children
15% TAY
68% Adult
6% Older Adult
11% Unknown

Language

97.3% English
2.2% Spanish
0.2% Other
0.3% Unknown

Gender Identity

69% Male
31% Female

Race/Ethnicity

22% African-American/ Black
1% Asian/Pacific Islander
37% Caucasian/White
36% Latinx/Hispanic
0% American Indian/ Alaska Native
4% Multiple Races/Other

N=1,982

Positive Results

In Fiscal Year 2019/20, a total of 1,982 consumers were served. A total of 61% were diverted from unnecessary hospitalization. Of this 61%,

- 502 consumers were voluntary walk-in consumers diverted from admission to the psychiatric emergency department via services provider through TTS staff.
- 707 consumers were provided additional referrals and linkages from the psychiatric emergency department, avoiding a psychiatric inpatient hospitalization.

Challenges and Solutions

The TTS program is currently experiencing specific challenges related to the COVID-19 pandemic. This program is co-located in a psychiatric hospital, requiring staff to meet with consumers for in-person services. The COVID-19 pandemic has brought some unique challenges to the program, with respect to ensuring consumer and staff safety while providing in-person services. Additionally, some barriers faced during this fiscal year stemmed from ongoing changes to the co-located site and procedures with partner agencies.

Challenges and Solutions (cont.)

The TTS program continues to collaborate with partner agencies, outpatient clinics, and community agencies to improve services and provide additional linkages for consumers. Centralized Hospital Aftercare Services (CHAS) administration participates monthly in collaborative meetings between DBH and respective hospital administrators and supervisors. These monthly meetings allow for improved communication and collaboration, as well as quickly problem solving any new challenges that arise. In addition, TTS staff continually attend training opportunities to learn improvement methods for service delivery.

Outreach and Engagement

For Fiscal Year 2019/20, outreach and engagement activities were not completed by the TTS program.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

- **1.9%** Anxiety disorders
- **8.0%** Bipolar disorders
- **35.6%** Depressive disorders
- **3.5%** None/deferred
- **46.3%** Psychosis disorders
- **2.3%** Substance use disorders
- **2.4%** Other

N=1,982

Artwork by David F.

Program Updates

The Triage Transitional Services program has been expanded to provide discharge planning and act as a liaison for discharge planning at each of the four (4) contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County: San Bernardino, Joshua Tree, Victorville, and Fontana. 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 2019/20, these expanded services assisted a total of 536 consumers.

- 331 remained in the CRT program long enough to receive discharge services
- 294 (89%) successfully discharged to safe and sustainable community placements.

Success Story

When moving to San Bernardino County, "James" was facing obstacles in navigating the Medi-Cal system and sought behavioral health triage services. TTS staff were able to make collateral contact with a family member. They assisted James in securing a new room and board placement and provided support to James and his family in switching his benefits to the new county of residence. James and his family expressed appreciation for TTS. Since being connected to appropriate services in the County, he has not returned for psychiatric emergency services.

Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Triage, Engagement, and Support Teams	2,263	2,000	$6,399,922*	$1,882*

*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 through reducing the amount of time law enforcement spends with individuals needing a mental health crisis intervention, thus reducing the number of encounters between law enforcement and individuals in mental 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 2019/2020 thru 2022/2023, pages 292-305.

Consumer Demographics Highlights FY 2019-20

Age

11% Children
22% TAY
47% Adult
15% Older Adult
5% Unknown

Language

89% English
3% Spanish
8% Other/ Unknown

Gender Identity

49% Male
46% Female
2% Unknown
3% Declined to state

Race/Ethnicity

13% African-American/ Black
4% Asian/Pacific Islander
36% Caucasian/White
34% Latinx/Hispanic
6% Mixed Races/ Other
7% Unknown

N=2,263

Positive Results

Direct field-based outcomes for Fiscal Year 2019/20 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, there were 5,926 encounters (initial and ongoing) and 10,500 referrals provided to behavioral health and community resources.

- In comparison to Fiscal Year 2018/19, TEST experienced an increase of 22% in encounters and a 5.5% decrease in the number of referrals.
- There was an 680.71% 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 2018/19 to Fiscal Year 2019/20.
- 68.4% of TEST crisis interventions were diverted from hospitalizations, which is an increase of 4.4% over the previous Fiscal Year 2018/19.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

3.67% Anxiety disorders
10.55% Bipolar disorders
39.81% Depressive disorders
1.42% Disruptive disorders
1.07% Neurodevelopmental/cognitive disorders
0.12% None/deferred
20.02% Psychosis disorders
0.83% Substance use disorders
22.51% Other

N=2,263

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. Office Assistant staff remained at the DBH office; however, there was a need to socially distance other staff which also caused a temporary workflow interruption while workspaces were restructured to meet CDC social distancing guidelines. The 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 the TEST staff and follow-up was conducted via telephone. Protective barriers are being installed in all TEST vehicles so that TEST is better able to safely transport consumers.

Outreach and Engagement

For Fiscal Year 2019/20, 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.

Success Story

TEST was dispatched out in the field by law enforcement in response to a call regarding an adolescent. The parents reported the adolescent was self-harming and experiencing suicidal ideations. TEST conducted a risk evaluation. During the evaluation, the adolescent expressed feeling that they had no one to talk with. The adolescent's potential hospitalization was diverted to a crisis stabilization unit (CSU). TEST staff assisted the adolescent's parents with safety planning. They also followed-up with the adolescent's parents after several weeks to ensure follow through of the adolescent's discharge plan. The consumer was linked to therapeutic services the following week. The parents expressed gratitude for the support and help as they now feel better equipped to support their child's behavioral health needs.

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Community Crisis Response Team	4,538	4,992	$7,886,926*	$1,128*

*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 intervention
- Assessment
- Medication referrals
- Linkage to non-behavioral health resources and services
- 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 2019/2020 thru 2022/2023, pages 306-320.

Consumer Demographics Highlights FY 2019-20

Age

26% Children
21% TAY
33% Adult
7% Older Adult
13% Unknown

Language

91.891% English
4.407% Spanish
0.044% Vietnamese
1.234% Other
2.424% Unknown

Gender Identity

48% Male

48% Female

1% Transgender
3% Unknown

Race/Ethnicity

11.2% African-American/ Black
1.7% Asian/Pacific Islander
19.1% Caucasian/White
31.8% Latinx/Hispanic
0.4% American Indian/ Alaska Native
2.4% Multiple Races/ Other
33.4% Unknown

N=4,538

Positive Results

In Fiscal Year 2019/20, 1,469 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 12% increase in diversions from the previous fiscal year. CCRT collaborated with 143 community partners, an increase of 9.16% (131 community partners) from Fiscal Year 2018/19.

Challenges and Solutions

With the COVID-19 pandemic, direct field-based services were suspended as of March 18, 2020 and continue to be suspended. CCRT staff were required to telework, 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.

Staff's county cell phones were also set up to provide texting options to consumers due to the inability to provide in-person responses. Efforts to resume direct field-based services include policy development to provide updated protocols for field-based staff. CCRT staff were successfully provided network access to perform telehealth services.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

7.4% Anxiety disorders

5.1% Bipolar disorders

48.8% Depressive disorders

5.2% Disruptive disorders

2.5% Neurodevelopmental/ cognitive disorders

15.6% Psychosis disorders

15.4% Other

N=1,819

Outreach and Engagement

For Fiscal Year 2019/20, the CCRT program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Community presentation/meetings	47	1,795
Referral and linkage calls	3,683	3,683
Law enforcement briefings/collaborative meetings	55	81
School outreach	26	272
Hospital/medical offices	15	16
Total	**3,826**	**5,847**

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

Program Updates

CCRT anticipates an increase in services and number served as they will provide crisis intervention supportive services to the Emergency Departments (EDs) throughout the County. CCRT staff will be deployed to EDs to assist medical personnel by conducting screenings for risk factors that align with danger to self and/or others criteria and serve individuals in the EDs who are experiencing a mental health crisis.

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Crisis Intervention Training	1,551	2,000	$7,886,926*	$1,128*

*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 2019/2020 thru 2022/2023, pages 306-320.

Services Provided

- In collaboration with San Bernardino County Sheriff's Department:
  - Quarterly 40-hour CIT course (formerly 32-hour course which transitioned to 40 hours in September 2019)
  - Quarterly 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT course
- In collaboration with Probation:
  - Bi-weekly 8-hour CIT course
- Multiple monthly collaborative partner trainings

Consumer Demographics Highlights FY 2019-20

Age

0% Children
12% TAY
85% Adult
3% Older Adult

Language

99% English
1% Spanish

Gender Identity

60% Male
39% Female
1% Other

Race/Ethnicity

16% African-American/ Black
2% Asian/Pacific Islander
46% Caucasian/White
35% Latinx/Hispanic
1% American Indian/ Alaska Native
0% Multiple Races/Other

N=360

Positive Results

In Fiscal Year 2019/20, 1,551 law enforcement and community partners received training from the CIT program.

- 96 law enforcement personnel completed the 40-hour CIT course
- 99 Field Training Officers (FTO) completed the 8-hour FTO CIT course
- 861 community partners, including fire, public employees, and emergency departments received specialized training from the CIT program

A total of 535 CIT consumer contact forms were completed by the CIT Social Worker II, which resulted in a total of 565 successful linkages to resources.

Challenges and Solutions

In response to the COVID-19 social gathering restriction imposed by the County Public Health and state orders pandemic, the CIT program pulled back from providing in-person trainings to law enforcement and community partners.

While in-person trainings are not allowed for groups over ten, the CIT program has successfully implemented virtual CIT training opportunities for law enforcement and community partners. The first online training was launched in July 2020. Using virtual meeting and learning platforms, the CIT program makes each training as interactive as possible to engage participants.

Outreach and Engagement

For Fiscal Year 2019/20, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Behavioral Health Capacity Building meeting	1	25
Behavioral Health Criminal Justice Consensus	1	10
Adverse Childhood Experience Task Force	1	25
Crisis Program Ride-Along	3	6
Intern Interview	1	2
Coffee with a Cop (various law enforcement agencies)	12	400
Council on Criminal Justice and Behavioral Health	1	35
County Fire	1	4
Crisis Residential Treatment Community Event	1	30

Outreach and Engagement (cont.)

Activity Type	Number of Activities	Total Number of Participants
Cultural Competency Advisory Committee and subcommittees	20	232
Drug Enforcement Administration (DEA) Opioid Taskforce	1	4
Emergency Management System Project Stakeholder meeting	1	45
Fontana Community Assistance Program (CAP)	1	16
High Desert Mental Health Summit Committee	1	15
Hesperia Unified School Police Department	2	15
National Nights Out	1	100
Police Briefings	40	1,431
Police Swearing in Ceremony	1	60
Town Hall meetings	4	300

Outreach and Engagement (cont.)

Activity Type	Number of Activities	Total Number of Participants
Rialto Unified School District Safety Campus Crisis Response	2	27
Rialto Fire Open House	1	100
Re-Entry Collaborative	1	30
State Counsel on Developmental Disabilities	2	20
West End Community Collaborative	1	15
Total	**101**	**2,947**

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 this division are centered on providing immediate intervention along with stabilization services to consumers who are experiencing a mental health crisis. These care options are accessible through various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman-Petris-Short (LPS) hospitals, Crisis Stabilization Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

- Crisis Walk-In Centers (CWICs) are unlocked, voluntary 24-hour psychiatric urgent care centers that offer a positive, safe, and quiet environment to consumers of all ages experiencing a mental health crisis in this county. Consumers can be evaluated for a higher level of care, if necessary.
- Crisis Stabilization Units (CSUs) operate almost identically to CWICs. CSUs provide crisis stabilization through clinical and psychiatric assessment, therapy, peer support, and other stabilization services for up to 23 hours, 59 minutes. The goal is to stabilize individuals experiencing psychiatric crisis and to provide linkage to community outpatient services. Each facility has sixteen spaces for consumers aged 18 and older and four spaces for adolescent consumers aged 13 to 17.
- Crisis Residential Treatment (CRT) facilities within CSCC are voluntary 16-bed facilities for adults ages 18 to 59 needing a structured treatment environment for 30 days with two possible 30-day extensions, not to exceed 90 days.

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 2021/22:

Program Name		Fiscal Year	Ages Served	Service Area*
Crisis Walk-In Center		2021/22	251 Children 541 TAY 1,604 Adult 171 Older Adult	2,567 GSD 1,187 O&E
			TOTAL = 2,567	TOTAL = 3,754
Crisis Stabilization Unit		2021/22	209 Children 547 TAY 1,998 Adult 122 Older Adult	2,876 GSD 905 O&E
			TOTAL = 2,876	TOTAL = 3,781
Crisis Resident Treatment	Adult CRT	2021/22	50 TAY 424 Adult	474 GSD 350 O&E
			TOTAL =474	TOTAL = 824
	TAY CRT	2021/22	97 TAY	97 GSD 165 O&E
			TOTAL = 97	TOTAL = 262

*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 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Crisis Walk-In Center (CWIC)	2,285	2, 567	$16,932,627*	$3,111*

*Annual budget and cost per client represent both CWIC and CSU.

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

*SED = Serious emotional disturbance and SMI = serious mental illness

Target Population and Program Description

The Crisis Walk-In Centers (CWICs) are unlocked, voluntary, 24-hour psychiatric urgent care centers located in Yucca Valley (Morongo Basin Region) and Victorville (High Desert Region). They offer urgent psychiatric behavioral health services to people 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 2019/2020 thru 2022/2023, pages 321-327.

Services Provided

- Crisis intervention
- Crisis stabilization
- Medical evaluation services
- Linkage to resources

Consumer Demographics Highlights FY 2019-20

Age

11% Children
22% TAY
62% Adult
6% Older Adult

Language

97.5% English
1.2% Spanish
0.2% Thai
1.1% Other/Unknown

Gender Identity

50% Male
50% Female

Race/Ethnicity

15.4% African-American/ Black
1.4% Asian/Pacific Islander
43.0% Caucasian/White
16.0% Latinx/Hispanic
0.9% American Indian/ Alaska Native
23.3% Multiple Races/Other

N=2,285

Positive Results

The CWICs provided a combined total of 3,851 services to 2,285 unduplicated consumers in Fiscal Year 2019/20. Of these services, 3,616 (93.90%) were successfully diverted from hospitalization. The following referrals and linkages (3,533) were provided to the CWIC consumers:

- 278 (7.9%) linkages for medication support
- 400 (11.32%) referrals to outpatient clinics
- 1,165 (33%) referrals to community resources such a housing, legal, and food banks
- 1,622 (45.9%) referrals to other resources

Annually, the program surveys consumer satisfaction. For Fiscal Year 2019/20, the program received 2,035 responses. The chart below represents the percentage of those who agreed "somewhat" or "very much":

Challenges and Solutions

In Fiscal Year 2019/20, the COVID-19 pandemic created challenges for the CWICs as several of the community partners providing transportation services had to halt services due to social distancing requirements. As a result, the number of individuals able to benefit from these programs was greatly reduced. As the state reopens, a gradual increase in referrals is anticipated. COVID-19 guidelines required that the CWIC's update their internal policies and procedures (ex. when the facility was exposed to a positive COVID-19 test result.) Screenings were implemented upon arrival to each facility to ensure the safety of the staff and consumers. Visitations were limited during state-wide stay at home orders unless clinically indicated for the consumer's treatment. Visitors were required to adhere to screening protocols and face coverings at all times.

COVID-19 mandates and requirements have increased the need for personal protective equipment (PPE). As a result, surgical masks have been provided to both staff and residents as well as purchasing cloth face coverings for consumers. Staff have been following guidelines for cleaning and disinfecting; every hour and after every client served.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

- **16%** Anxiety disorders
- **15%** Bipolar disorders
- **35%** Depressive disorders
- **1%** Disruptive disorders
- **2%** Neurodevelopmental/ cognitive disorders
- **24%** Psychosis disorders
- **1%** Substance use disorders
- **6%** Other

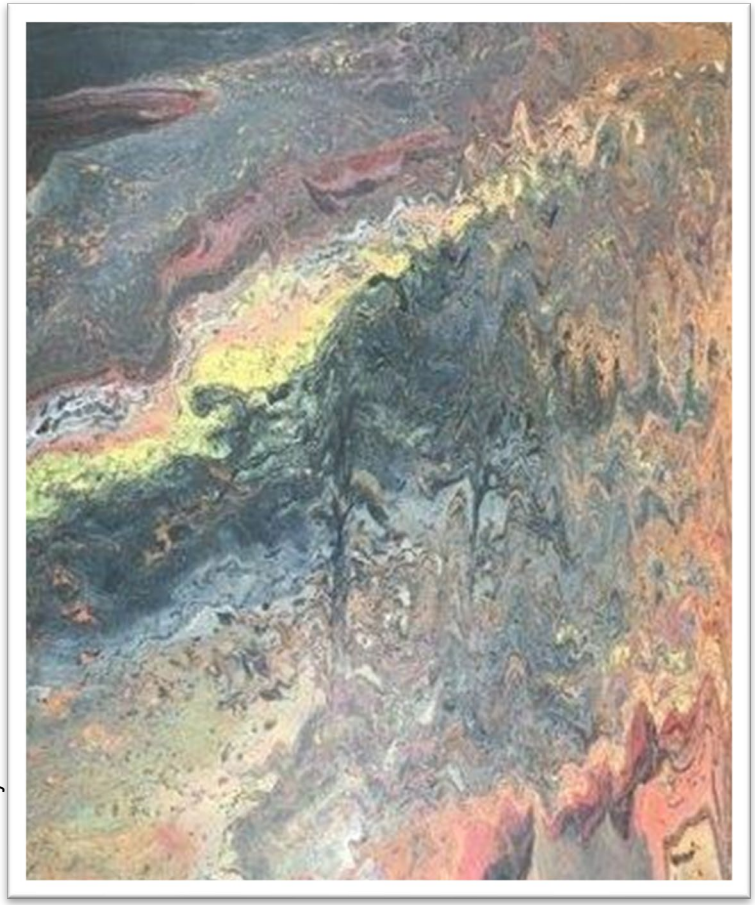
N=2,285

Outreach and Engagement

For Fiscal Year 2019/20, the CWIC program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Law enforcement briefings	5	53
School presentations	8	470
Community partnership outreach	24	347
Healthcare partner clinics/outreach	23	148
Totals	**60**	**1,018**

*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 Tim H.

Crisis Stabilization Unit

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Crisis Stabilization Unit (CSU)	3,501	2,876	$16,932,627*	$3,111*

*Annual budget and cost per client represent both CWIC and CSU.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 13+	N/A	Clinic-based	Experiencing a behavioral health crisis

Target Population and Program Description

The Crisis Stabilization Units (CSUs) provide voluntary crisis stabilization services to consumers ages 13 and older. Each facility has sixteen spaces for consumers age 18 and older, and four spaces for adolescent consumers age 13 to 17. Consumers may stay up to 23 hours and 59 minutes to receive psychiatric urgent care services. CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, 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 2019-20

Age

0% Children
6% TAY
82% Adult
12% Older Adult

Language

93% English
4% Spanish
3% Other

Gender Identity

56% Male
44% Female

Race/Ethnicity

19.54% African-American/ Black
1.94% Asian/Pacific Islander
29.33% Caucasian/White
41.82% Latinx/Hispanic
0.74% American Indian/ Alaska Native
6.63% Multiple Races/Other

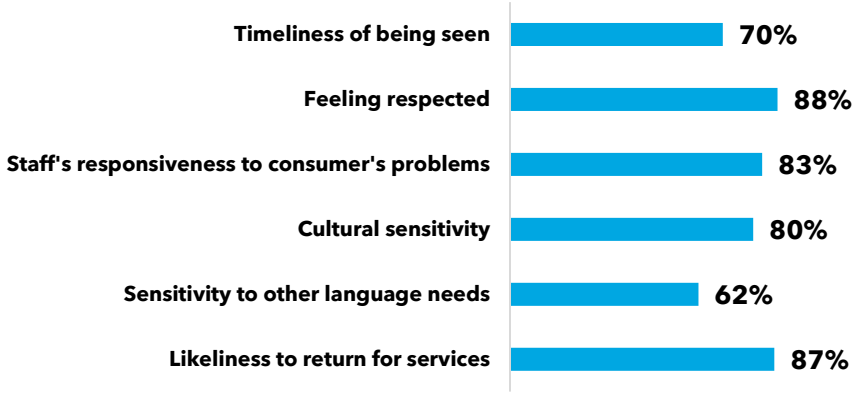
N=3,501

Positive Results

The CSUs provided a combined total of 4,608 services to 3,501 unduplicated consumers in Fiscal Year 2019/20. Of these services, 3,882 (84.24%) were diverted from unnecessary hospitalization. The following linkages and referrals were provided:

- 3,564 (77.34%) referrals to peer support and self-help groups
- 512 (11.1%) referrals or linkages to housing assistance
- 723 (15.9%) referral or linkage for transportation, including bus passes
- 661 (8.7%) referrals or linkages to DBH or DBH-contracted mental health clinic
- 528 (11.5%) referrals for medication management services
- 68 (0.9%) linkage to crisis residential treatment (CRT) facilities
- 3,882 (84.2%) 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 2019/20, 2,005 responses were received from consumers. The chart below represents those who agreed "somewhat" or "very much":



Challenges and Solutions

In Fiscal Year 2019/20, the COVID-19 pandemic created challenges for the CSUs as several of the predominant referral sources stopped providing transportation services which decreased the number of people being taking to these programs. As the state reopens and restrictions are lifted, an increase of referrals is anticipated.

COVID-19 measures required the CSU update their internal policies and procedures. For example, consumers who visit the CSU are screened for COVID-19 prior to admission to the program. Symptomatic individuals are brought into the building and treated in a separate area. During their stay, they are isolated and treated in a separate area from the other residents to avoid possible exposure to others. All consumers that visit the CSU are required to wear face coverings, which are supplied upon admission to the program. Staff who treat COVID-19 symptomatic individuals wear a mask, gloves, gown, and eyewear. The CSU is sanitized during and after each shift. Increased funding was directed toward supplying personal protective equipment (PPE) and sanitization products for clients and staff.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

10% Anxiety disorders
9% Bipolar disorders
31% Depressive disorders
1% Disruptive disorders
3% None/deferred
28% Psychosis disorders
18% Other

N=3,501

Challenges and Solutions (cont.)

Psychiatry providers are operating on a hybrid schedule, coming in at times when the CSUs are experiencing a higher than normal volume of consumers and utilizing telehealth when they are not. Group therapy services have been more limited at the CSUs during the COVID-19 crisis. Therapeutic services are primarily occurring on an individual basis only when safe social distancing can be maintained.

Outreach efforts to inform community partners about services and develop and maintain collaborative relationships have shifted from in person meetings and community presentations to phone contact only. The CSU staff have remained committed to a continued collaboration with our community partners through telephone and online meeting platforms.

Artwork by E. French

Outreach and Engagement

For Fiscal Year 2019/20, the CSU program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Law enforcement briefing	20	406
School contacts and presentations	34	267
Community partnership outreach	82	934
Healthcare partner clinics/outreach	94	286
Totals	**230**	**1,893**

*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

On August 28, 2020, the Behavioral Health Urgent Care Center (BHUCC) located in Rialto was closed. This psychiatric urgent care center previously provided walk-in outpatient services to consumers of all ages. The closure left a gap in needed services for children, ages 12 and under. In an effort to bridge the gap, and in the interest of seeking every opportunity to expand the eligible consumer base for CSUs where available, the current contract provider has agreed to renegotiate age-specific provisions of the existing contract, thus opening CSU services to consumers of all ages, including children ages 12 and under.

Adult Crisis Residential Treatment

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Adult Crisis Residential Treatment	558	474	$15,616,219*	$27,349*

*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 ranges from 30 days initially, with the option of two 30-day extensions. The length of stay is on medical necessity, and does not exceed a total of 90 days. Services are intended for individuals who are experiencing an acute psychiatric episode or crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRTs consist of a home-like environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. Services are offered 24-hours a day, 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 2019/2020 thru 2022/2023, pages 336-344.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
12% TAY
87% Adult
1% Older Adult

Language

97% English
1% Spanish
2% Other

Gender Identity

65% Male
35% Female

Race/Ethnicity

25% African-American/ Black
1% Asian/Pacific Islander
35% Caucasian/White
31% Latinx/Hispanic
1% American Indian/ Alaska Native
7% Multiple Races/Other

N=558

Positive Results

558 unique consumers were served at the four adult CRT facilities during Fiscal Year 2019/20. In order to approximate the effects of CRT on hospitalization, this data includes consumers who were discharged between July 1, 2019 and June 30, 2020, and hospitalization was examined within six months before and six months following treatment.

- Of the 470 consumers discharged between July 1, 2019 and June 30, 2020, 263 consumers (60%) were determined to have been psychiatrically hospitalized prior to CRT admission.
- The number of hospitalizations for these consumers decreased by 32.8%, from 684 hospitalizations in the six-month period prior to CRT admission, to 460 hospitalizations in the six-month period following CRT discharge.
- The combined total number of acute bed days in a hospital decreased by 25.7%, from 3,462 bed days in the six-month period prior to CRT admission, to 2,574 bed days in the six-month period following CRT discharge.

Positive Results (cont.)

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

- 117 (19.8%) received referrals to peer support and self-help groups
- 95 (16%) received referral or linkage to housing assistance
- 30 (5.08%) received referrals or linkages to Substance Use Disorder Recovery Services (SUDRS)
- 30 (5.1%) received referrals or linkage to a DBH or DBH-contracted mental health clinic
- 133 (22.5%) received referrals for medication management services
- 183 (31%) were linked to Medi-Cal and dental benefits

*If a consumer was given multiple referrals, percentages were based on the primary referral listed in the reporting tools.

Challenges and Solutions

In Fiscal Year 2019/20, the COVID-19 pandemic created challenges with admissions and facility requirements. CRTs were required to update their contagious disease business practices to include obtaining and utilizing personal protective equipment (PPE) as well as increased cleaning and sanitizing requirements. In order to mitigate the spread of COVID-19, some CRTs have restricted admissions for up to 28 days upon notification of a positive COVID case within the facility. Additionally, residents who cannot admit with a recent negative COVID-19 test result, must remain under quarantine until COVID-19 test results can be obtained. In order to expedite this process, facility nursing personnel conduct COVID-19 testing within the facility. Residents are provided with detailed information regarding quarantine protocols, prior to admission to ensure compliance.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

3.76% Anxiety disorders

13.80% Bipolar disorders

31.54% Depressive disorders

0.18% Disruptive disorders

48.57% Psychosis disorders

0.36% Substance use disorders

1.79% Other

N=558

Challenges and Solutions (cont.)

As an additional safety precaution, residents are screened for COVID-19 symptoms and have their temperatures taken twice a day. In addition, staff at the facilities participate in COVID-19 testing. Each facility tests 10% of staff every 14 days.

Outside activities and visitors have been limited during statewide stay-at-home orders in California. As businesses begin to open, residents will be provided options to attend outside activities and visitation will restored as programs are able to meet testing demands and ensure PPE is readily available.

Success Story

"Walter" arrived at the adult CRT program experiencing challenges with severe depression and substance use disorder. He also recently had a significant loss which was impacting him. After adjusting to the CRT setting, Walter began getting in involved in the program, attending the groups, taking notes on skills that could help him, and assisting with meals and household duties. He started to show improvement in his mood and attitude. Through the adult CRT's co-occurring education, he was able to focus on his substance use recovery. After discharge, Walter plans to participate in support groups and attend peer support training.

Outreach and Engagement

For Fiscal Year 2019/20, the adult CRT program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Law enforcement briefings	3	59
Law enforcement presentations	10	206
Collaboratives	10	144
Community partnerships	33	340
Totals	**56**	**749**

*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

CRT anticipates an increase of funding in Fiscal Year 2021/22. Program services were initially estimated to provide 14 to 28 days of residential treatment services per consumer to achieve stability and regain optimum wellness. However, current consumer stays are averaging 38 days resulting in additional costs. In addition, the preliminary budget for the four CRT programs estimated a bed utilization rate of 90% for each location. The programs are consistently maintaining an average of 93% utilization. As a result, costs associated with CRT utilization rates have also increased.

TAY Crisis Residential Treatment

Program Name	Actual Number Served FY 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
TAY Crisis Residential Treatment	189	97	$15,616,219*	$27,349*

*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 is a short term, residential treatment center for voluntary TAY participants. The STAY accepts consumers ages 18-25 who are experiencing an acute psychiatric episode or crisis. The 14-bed center operates in a capacity that is higher than a board and care residential, but lower than psychiatric hospitalization. The STAY increases access to appropriate mental health services for TAY aged individuals in a mental health crisis. Program services are delivered through contracted provider, Valley Star Behavioral Health, Inc. (Valley Star).

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 345-352.

Services Provided

- Therapeutic and psycho-educational groups,
- Activities that focus on daily living skills-training
- 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 2019-20

Age

0% Children
93% TAY
7% Adult
0% Older Adult

Language

98% English
2% Spanish

Gender Identity

63.5% Male
35.4% Female
1.1% Other

Race/Ethnicity

25% African-American/ Black
1% Asian/ Pacific Islander
27% Caucasian/White
37% Latinx/Hispanic
0% American Indian/ Alaska Native
10% Multiple Races/ Other

N=189

Positive Results

Results from the Adult Needs and Strengths Assessment (ANSA), for the period of July 1, 2017 through June 30, 2020, show the percentage of youth who presented with significant issues in Risk Behaviors and Physical/Medical domains who also had the issues improved by the program completion.

- 94% (16/17) of youth who presented a significant issue in Danger to Others improved in this area.
- 93% (27/29) of youth who presented a significant issue in Non-Suicidal Self-Injurious Behaviors (Self-Mutilation) improved in this area.
- 71% (22/31) of youth who presented a significant issue in Command Hallucinations improved in this area.
- 94% (107/114) of youth who presented a significant issue in Primary Care Physician (PCP) Connected improved in this area.
- 48% (13/27) of youth who presented a significant issue in Health Care Adherence improved in this area.

Challenges and Solutions

For Fiscal Year 2019/20, the TAY CRT exceeded costs/contract amount for the previous fiscal year and will continue to exceed in current fiscal years. This was due to a higher utilization rate that originally estimated. As a solution, an increase and review of contract funding was conducted resulting in a funding increase for the TAY CRT and other CRTs experiencing the same issue.

In light of COVID-19, the TAY CRT implemented increased prevention, mitigation, and containment measures. This resulted in additional tasks such as a weekly inventory of needed medical supplies. To protect consumers and staff, protective wear such as masks, isolation gowns, gloves, and other items were requested. Due to the shortage of supplies, there was a delay in receiving items, but are now currently in use by the staff and consumers. Additionally, all outside activities were cancelled to limit the risk of exposure to COVID-19.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

5% Anxiety disorders

27% Depressive disorders

11% Bipolar disorders

57% Psychosis disorders

N=189

"If you are always trying to be normal, you will never know how AMAZING you can be."

- TAY CRT consumer

Outreach and Engagement

For Fiscal Year 2019/20, the TAY CRT program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Rialto School District presentation	1	60
TAY Center Psychologist meeting	1	4
Probation training presentation	9	384
Hospital collaboration meeting	1	25
Vista Community Counseling presentation	1	20
Total	**13**	**493**

*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 I. DeLaCruz

Introduction

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

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

Each Clubhouse uses a Recovery, Wellness and Resilience Model programs in stigma free environments in an effort to improve the consumers' overall wellness in alignment with their personal recovery goals. The classes and activities assist consumers with developing skills that improve their relationships and assist with community reintegration.

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 2021/22:

Program Name	Fiscal Year	Ages Served	Service Area*
Clubhouse Expansion	2021/22	33,352 Adults	11,352 GSD 22,000 O&E
		TOTAL = 33,352	TOTAL = 33,352

*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 Adriana Donis

Clubhouse Expansion Program

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Clubhouse Expansion	9,145	33,352	$3,113,864	$93

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

*SMI = severe mental illness

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 serious mental illness. There are ten clubhouses located throughout the county that are dedicated to enhancing and supporting recovery.

The main objectives of the Clubhouse Expansion Program are to assist members in making their own choices, providing peer support, and reintegrating into the community as contributing members, thereby achieving a fulfilling life in alignment with their personal recovery goals. Clubhouses are operated by the members through peer elected governing boards. In an effort to increase overall functioning and community reintegration, members meet regularly and are encouraged to provide input to program and activity choices.

Numerous support groups and activities provide growth opportunities for members to assist in their ability to reintegrate and cope within their community. Members plan and facilitate daily activities and determine workshop topics 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 in the community and with each other.

Consumer Demographics Highlights FY 2019-20

Age

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

Region

16% East Valley
19% West Valley
28% Central Valley
37% Desert/Mountain

Gender Identity

53% Male

47% Female

Race/Ethnicity

28% African-American/ Black
4% Asian/Pacific Islander
32% Caucasian/White
29% Latinx/Hispanic
4% American Indian/ Alaska Native
3% Multiple Races/ Other

N=9,145

Clubhouse Expansion Program A-1

Services Provided

- Supportive group meetings
- Social activities
- Life skills classes
- Physical health classes
- Job skills classes
- Nutrition classes
- Cooking demonstrations
- Food distribution
- Laundry machines
- Showers (at select Clubhouses)
- Volunteer opportunities
- Community integration excursions
- Transportation to stakeholder meetings
- Technical support for virtual platforms

Artwork by Dave Forsyth

Positive Results

The program began providing in-kind space for Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings during this fiscal year.

The program coordinated various events in collaboration with community partners. Friends and family were invited to participate in these events to help support their loved ones in their mental health recovery.

Clubhouse experienced growth in the number of members attending, number of groups being offered, and the amount of participation in each group which was successfully transitioned to a virtual platform.

During the last quarter (April to June 2020) of the fiscal year, the Clubhouse Expansion staff assisted members in accessing basic necessities including 3,657 food distributions, 1,648 showers, 1,057 loads of laundry, and 1,275 hygiene items.

> At the clubhouse I get to paint and show everyone what I can do. I am not looked at [differently] because of my illness.
>
> - Clubhouse member

> Clubhouse allows me to be around other people like me so that I can learn more about myself.
>
> - Clubhouse member

Challenges and Solutions

The COVID-19 pandemic that began in March 2020 posed safety measures which resulted in an array of challenges. The Clubhouse Expansion program adapted and expanded their services to focus on meeting the needs of those that were unsafely housed and experiencing food insecurity. The program responded by coordinating provisions such as showering facilities, laundry, hygiene items and food.

The regular in-person groups were transitioned into virtual groups via Zoom in order to reduce the effects of physical isolation. Staff provided members with technical support to address challenges with the accessing a virtual platform.

Capturing effective evaluation methods to reflect peer-based, self reported outcomes, and demographic information continues to be a challenge. The Consumer Evaluation Council has designed and developed an appropriate Clubhouse evaluation method that will be utilized once the COVID-19 restrictions are lifted and in-person services resume.

A suitable site for the Needles Clubhouse was not found during this fiscal year. However, services continue to be delivered by offering online social supports and food distributions.

Program Updates

The San Bernardino Clubhouse, Teamhouse, will be relocating within San Bernardino in June of 2021. The new location will be in closer proximity to behavioral health services and will allow easier access to Clubhouse participation as part of a continuum of services offered.

Outreach and Engagement

For Fiscal Year 2019/20, the Clubhouse Expansion Program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
All Clubhouse Holiday Gatherings	8	2,375
Educational Presentations	20	325
Health Fairs	6	3,000
Community Service Activities	10	820
Crisis Intervention Team Building	24	1,450
Community Presentations	22	1,850
Cultural Competency Events	30	2,000
Evening With the Stars Education and Recognition Event	1	50
Behavioral Health Wellness Triathlon	3	1,200
Clinic Appreciation Events	6	1,350
Community Food Distribution	60	5,000
Community Speakers	45	875
Mental Health Solidarity Day	2	1,400
Inter-Clubhouse Outreach Day	1	250
Homeless Outreach	10	1,100
Consumer Advisory Board	4	120
Consumer Evaluation Council	16	320
Total	**268**	**23,485**

Introduction

Outreach, Access, and Engagement programs are programs that provide expeditious access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital, or a walk-in clinic, referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible. The Access, Coordination, and Enhancement (ACE) program provides evaluations between 7 days of a hospital discharge and within fourteen days of a walk-in clinic requests.

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

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 2021/22:

Program Name	Fiscal Year	Ages Served	Service Area*
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	2021/22	2,652 Hospital referrals	
		TOTAL = 2,652	
Recovery Based Engagement Support Teams	2021/22	300 Adults	300 O&E
		TOTAL = 300	TOTAL = 300
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 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-23
ACE	2,788	2,652	$3,537,355	$1,334

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

With implementation of the Affordable Care Act (ACA) and Medi-Cal expansion, the ACE program enhanced the redesign of the outpatient care system to ensure that consumers receive the right services customized to meet their needs. ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the consumer. ACE provides evaluations within 7 days of a hospital discharge and within 14 days of walk-in clinic requests. The goal is to provide rapid access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital, or walk-in clinic, referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible.

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

Consumer Demographics Highlights FY 2019-20

Age

19% Children
22% TAY
53% Adult
6% Older Adult

Language

89% English
10% Spanish
1% Other

Gender Identity

46% Male
54% Female

Race/Ethnicity

16% African-American/ Black
1% Asian/ Pacific Islander
28% Caucasian/White
51% Latinx/Hispanic
1% American Indian/ Alaska Native
3% Multiple Races/ Other

N=2,788

Services Provided

- Mental 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 alternative crisis interventions including Crisis Stabilization Units, Community Crisis Response Team and after hour crisis hotlines has reduced the frequency of emergency room visits and unnecessary hospitalizations.

There were a total of 1,764 referrals to the ACE program for new consumers discharged from acute care psychiatric hospitals. Of the 1,764 referrals, 74% (1,307) were scheduled for an appointment within seven days of discharge from the hospital and 1,580 (90%) were scheduled for an appointment within 14 days of discharge.

Challenges and Solutions

The COVID-19 pandemic restrictions including social distancing has been a challenge. ACE staff is predominately working from home, the staff remaining in the clinic continue to serve the needs of the community. Staff working from home are learning to better utilize telehealth to help alleviate the strain placed on staff in the clinic.

During the COVID-19 pandemic, sessions all needed to be changed to telephonic sessions, ACE staff experienced difficulties engaging our consumers in clinical assessments. The no show rate to the telephonic assessment appointments is prevalent.

Improving the receipt of the consumer's hospital discharge medical records to the DBH clinics prior to the initial appointment continues to be a challenge. Significant no show rate to assessments at the clinic continues to be a challenge.

Recruiting, hiring and retaining qualified staff continues to be a challenge and has been increasingly difficult with the current hiring freeze our county is experiencing. ACE increased staff availability by utilizing staff from another program to ensure the goal of scheduling appointments and clinical assessments timely is met. The Workforce, Education and Training component is developing strategies to recruit, hire and retain more staff.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

12% Anxiety	**2%** Disruptive/impulse control and conduct	**18%** Psychosis
13% Bipolar	**10%** Neurodevelopmental/ neurocognitive	**1%** Substance related
35% Depression	**3%** None/deferred diagnosis	**6%** Other

N=2,788

Outreach and Engagement

For Fiscal Year 2019/20, the Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Health Fair	2	200
Recovery Happens	1	250
Community panels	2	100
College panels	1	25
Montclair Health and Wellness Fair	1	30
Totals	**6**	**605**

*Outreach activities ceased due to the COVID-19 pandemic in March 2020.

Success Story

"Brian" was hospitalized a couple of times for mental health concerns He had a history of trauma and substance use which exacerbated his mental health symptoms. The ACE program was able to help Brian get stabilized with medications, weekly rehabilitation, and daily living educational sessions. In time, Brian built and developed a solid skill set that allowed him to better manage his symptoms and learned how to reach out for help when needed to avoid a future mental health crisis. Brian has not been hospitalized and has not needed to seek help at a crisis center for months. Brian is excited about enrolling back to school at a local community college.

Behavioral Health Urgent Care Center (BHUCC)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
BHUCC	1,490	0	0	0

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 evaluates consumers experiencing a behavioral health crisis and provides 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 was trained to use the Listen, Empathize, Agree and Partner (LEAP) engagement model to educate and encourage consumers to seek appropriate services.

Services Provided

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

Consumer Demographics Highlights FY 2019-20

Age

5.3% Children
20.3% TAY
68.3% Adult
6.1% Older Adult

Language

91.6% English
7.8% Spanish
0.6% Other

Gender Identity

51% Male

49% Female

Race/Ethnicity

22% African-American/ Black
2% Asian/ Pacific Islander
29% Caucasian/White
39% Latinx/Hispanic
1% American Indian/ Alaska Native
7% Multiple Races/ Other

N=1,490

Outreach and Engagement

For Fiscal Year 2019/20, the BHUCC program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Crisis Intervention Trainings	10	350
Totals	**10**	**350**

Artwork by Crystal De Veon

Consumer Demographics Highlights FY 2019-20

N=1,490

Primary Diagnosis

12% Anxiety

13% Bipolar

35% Depression

10% Neurodevelopmental/ neurocognitive

3% None/deferred diagnosis

18% Psychosis

1% Substance related

6% Other

Recovery Based Engagement Support Teams (RBEST)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
RBEST	312	300	$1,637,501	$5,458

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 strives to connect and activate them 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 elicit possible care preferences.

The target population includes adults and older adults that 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, Individuals who access treatment at points in the health care system that do not deliver effective care in meeting the psychiatric needs of that individual (category added after project implementation), the "invisible" consumer who is being cared for by family members and not linked or known to the public mental health system, individuals who are 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 those Unable to navigate the behavioral health system of care to obtain appropriate treatment.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
14% TAY
76% Adult
10% Older Adult

Language

91% English
3% Spanish
6% Other

Gender Identity

53% male

47% female

Race/Ethnicity

21.8% African-American/ Black
1.9% Asian/ Pacific Islander
29.2% Caucasian/White
38.8% Latinx/Hispanic
0.6% American Indian/ Alaska Native
7.7% Multiple Races/ Other

N=312

Target Population and Program Description (cont.)

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 base among family members/caretakers about issues relating to mental illness while providing a safe space for sharing and peer support.

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

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

Recruiting, hiring and retaining staff has been a challenge and has been heightened due to the COVID-19 pandemic. RBEST utilizes student interns to alleviate staff shortages and to encourage families to participate in group activities through Connecting Families.

As a result of the COVID-19 pandemic, field-based services were temporarily ceased to ensure safety for the consumers, their family, and the staff. To maintain relationships, the RBEST staff continued engagement remotely and made food deliveries to consumers. Field-based engagements have now resumed.

The RBEST staff transitioned from having in-person Connecting Families support groups to conducting the groups virtually to meet the needs of the community.

Family members and caretakers experienced technical challenges with virtual platforms. RBEST staff provided field based, bilingual technical support to family members and caretakers experiencing technical challenges with virtual platforms to assist with being able to access the Connecting Families group sessions.

"Thank you so much for all that you do. We felt hopeless before working with you."

- RBEST consumer

Outreach and Engagement

For Fiscal Year 2019/20, the RBEST program conducted the following outreach and engagement activities*:

Activity Type	Number of Activities	Total Number of Participants
Crisis Intervention Trainings	1	200
Asian Pacific Islander Coalition	1	12
Cultural Advisory Committee	1	40
Co-Occurring and Substance Use Subcommittee	1	7
Community Policy Advisory Committee	1	80
Totals	**5**	**339**

"Thank you so much! You saved her, and the entire family. You are such a blessing."

- RBEST consumer

Success Story

"Rose" was experiencing homelessness and suffered from a persistent mental illness. Rose disrupted the community due to her untreated metal health illness which resulted in ample law enforcement involvement. She was leery and resistant to RBEST staff and treatment. The RBEST staff persistently engaged with her until she eventually agreed to accept treatment. Her quality of life has dramatically increased. Rose's family and extended family were introduced to and attended the Connecting Family group sessions. They learned and utilized the Listen, Empathize, Agree and Partner (LEAP) training communication techniques. Rose currently lives in her own apartment, attends self-help groups weekly, and maintains healthy relationships with her family. She told the RBEST staff "Thank you so much. I am so grateful that you were my friend."

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, providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. The primary goals of FSP programs are to improve quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and high frequency use of psychiatric hospitalizations or emergency and crisis services. FSP programs strive to provide stabilizing services for the consumer at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.

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 2021/22:

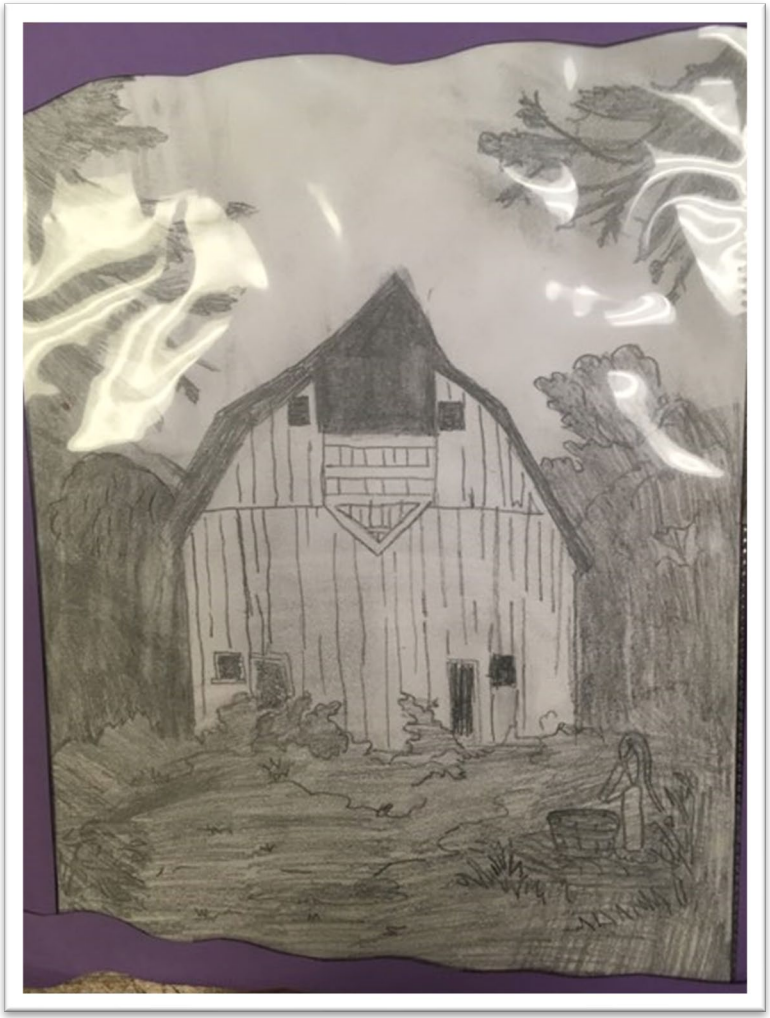
Program Name	Ages Served	Service Area*	Total
Comprehensive Children and Family Support Services (CCFSS)	5,342 Children 1,296 TAY	3,188 FSP 3,450 O&E	6,638
Integrated New Family Opportunities (INFO)	245 Children 167 TAY	160 FSP 252 GSD	412
Transitional Age Youth (TAY) One Stop Centers	10,324 TAY	447 FSP 550 GSD 9,327 O&E	10,324
Adult Criminal Justice Continuum of Care	647 Adults 25 Older Adults	672 FSP	672
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services	285 Adults	135 FSP 150 O&E	285
Regional Adult Full Service Partnership (RAFSP)	930 Adults	930 FSP	930
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.

Services Provided

The full continuum of care is provided for FSP consumers with services including, but not limited to:

- FSP programs in all outpatient clinics in every region of the County
- Substance use treatment services (co-occurring disorders)
- Food, clothing, and transportation
- Outreach and engagement
- Clinical and risk assessments
- Case management and intensive case management
- Coordination of care
- Emergency shelter
- Counseling services (individual and/or family)
- Employment services (job search and coaching)
- Entitlement obtainment (SSI, subsidized housing, etc.)
- Crisis intervention/stabilization services
- Housing assistance/placement
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Vocational/educational training
- Peer mentoring (Peer Support Specialist)
- Food assistance
- Clothing assistance
- Housing supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Cost of health care treatment
- Respite care



Artwork by Karla Q.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 383-386.

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
CCFSS	3,519	6,638	$37,641,475	$5,671

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 0-15 16-25	SED and/or SMI*	Clinic and Field	Probation or Children and Family Services Involvement

*SED = Serious emotional disturbance and SMI = serious mental illness

Target Population and Program Description

The Comprehensive Children and Family Support Services (CCFSS) program uses the Integrated Core Practice Model (CPM) and provides services to children and youth living with severe emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their natural environment in order to achieve a positive set of outcomes through unconditional care. The program continues to be comprised of three unique Full Service Partnership (FSP) programs and a C-1 component of Children and Youth Collaborative Services (CYCS). All utilize the Core Practice Model (CPM) to serve children and youth.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, 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 sub-program is designed to assist children and youth in avoiding out-of-home placements or loss of current placement due to the severity of their emotional disturbance.

Consumer Demographics Highlights FY 2019-20

Age

72% Children
28% TAY
0% Adult
0% Older Adult

Gender Identity

62% Male
38% Female
0% Other

Race/Ethnicity

1% American Indian/ Alaskan Native
2% Asian/ Pacific Islander
20% African-American/Black
23% Caucasian/White
47% Latinx/Hispanic
7% Other

N=3,519

Comprehensive Children and Family Support Services C-1

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	98.3%	81.9%

Global Measurement of Behavioral and Emotional Needs:

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one significant behavioral or emotional need	98.4%	74.5%

Specific Areas of Life Functioning (Impact Report):

Item/Issue	Presented with a Need	Improvement of the Need
Family Difficulties	85%	65%
Social Functioning	76%	67%
Recreational	46%	64%
Sleep	47%	71%
School Behavior	59%	70%
School Achievement	61%	62%
School Attendance	30%	72%

Specific Areas of Behavioral and Emotional Needs (Impact Report):

Item/Issue	Presented with a Need	Improvement of the Need
Impulsivity/Hyperactivity	57%	53%
Depression	60%	69%
Anxiety	55%	62%
Anger Control	75%	72%
Adjustment to Trauma	62%	60%
Emotional and/or Physical Dysregulation	73%	66%

Consumer Demographics Highlights FY 2019-20

Primary Language

94% English

5% Spanish

1% Other

Primary Diagnosis

0.65% Psychosis
2.16% Bipolar Disorder
21.65% Depressive Disorder
0.14% Substance Use
11.51% Other
27.59% Anxiety Disorders
20.01% Disruptive
13.5% Neurodevelopmental/Cognitive
0.06% Childhood/Adolescent Onset
2.73% None/Deferred Diagnosis

N=3,519

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	7%	51%
Children needing help improving their functioning within their living situation	62%	68%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	18%	67%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	49%	55%

Specific indicators likely to increase juvenile justice involvement:

Item/Issue	Presented with a Need	Improvement of the Need
Delinquency	16%	60%
Danger to Others	33%	65%
Runaway	19%	66%
Conduct Disorder Behaviors	24%	65%
Oppositional Behaviors	60%	47%

"I'm so grateful for you and everyone who was involved in helping my son, thank you so much."

-CCFSS Parent

Challenges and Solutions

The notable events in CCFSS for FY 2019/20 were the significant expansion of the Success First/Early Wrap services, and the continued evolution of the ChRIS program. *The $9 million increase in the Success First/Early Wrap program was initiated to allow providers to meet additional service demands, including focusing on engaging probation youth in services. Compared to FY 2018/19, Success First/Early Wrap program was able to serve 423 additional youth and provide 24,417 additional services.

In FY 2019/20, the ChRIS program experienced an ongoing change of providers as some began, ended, or reduced their contracts leading to a decrease in youth served. However, as ChRIS providers became more adept at capturing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, the program provided an additional 5,243 services and completed and additional 1,476 service hours.

Most ChRIS providers continue to face challenges with the high standard of Medi-Cal documentation. The ChRIS program has been targeted with extensive support-orientation, on-going trainings, agency meetings, program meetings, audit tools, and an assigned CYCS clinician to each agency as a Liaison.

The COVID-19 pandemic dramatically impacted mental health services beginning March 2020. One of the first responses to begin conducting weekly Telehealth Consultation Webinars to give providers telehealth and COVID-19 clinical and community resources and share resources with one another.

*The budget increase was not available in the beginning of the fiscal year (see FY 2019/20 Amendment). In addition, COVID-19 began to fully impact service provision in the Fourth Quarter of FY 2019/20 (see MHSA 3-Year Plan Amendment COVID-19 Response).

Challenges and Solutions (cont.)

Juvenile Court Behavioral Health Services (JCBHS) staff immediately began making plans for telecommuting activities, adopting telehealth services for assessments and treatment, as well as having shorter but more frequent sessions. Supervisors revised and developed clinical forms and policies for the unique circumstances associated with remote services. Staff worked with families, youth, and providers to address the fear and uncertainty related to the COVID-19 pandemic, and to provide resources to families who lost income, employment, or both.

ChRIS staff generally provide mental health services to youths in group homes and many of the clinicians continued with their in-person sessions while utilizing telehealth services, when feasible, to minimize COVID-19 exposure. Other barriers including physical space and technology limitations that restricted the ability to provide telehealth services. Without adequate Wi-Fi, private space, and computer hardware, the youth could not adequately participate in remote sessions.

Initially, the COVID response plan called for programs to move to 90-95% telehealth services. Some clinicians initially reported that, telehealth services were novel and successful. However, in recent months, an increasing number of clinicians are finding that the youth want the personal touch of a face-to-face session.

In response, providers increased in-person sessions and currently, approximately 25% of therapy services are face-to face, as clinicians are finding ways to conduct an occasional sessions outdoors. They are also making quick visits to drop off various therapy tools or physical reminders of the treatment relationship. Providers have developed extensive procedures to ensure safe practices for youth, families, and staff, as well as purchasing technology equipment for families to overcome gaps in resources. COVID-19 and adapting to its effects will continue in 2020/21.

Additionally, in Fiscal Year 2020/21, San Bernardino County implemented an Electronic Health Record (EHR) for the Department of Behavioral Health (DBH). The implementation will benefit documentation efficiencies and quality controls as well as data gathering. Notably, the EHR will increase the coordination of treatment between providers and eliminate redundancies in information gathering from consumers, leading to better consumer care and improved treatment outcomes.

"I love this program because when my son was here, I felt the support from the treatment staff, from the therapist to the dorm staff. The program did not make me feel judged and I felt supported and they taught me tools to educate my younger kids. I also learned how to better support him and communicate with him."

-CCFSS Parent

Outreach and Engagement

For Fiscal Year 2019/20, 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)	3,183	5,294
Consultations (procedures 556, 551, 575, and 576 provided by CCICMS staff)	1,046	292
Total	**4,229**	**5,586**

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
INFO	330	412	$1,123,161	$2,726

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 13-17	SED*	Clinic and Field	Probation or Children and Family Services Involvement

*SED = Serious emotional disturbance

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 I know that due to all the things I could talk 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 2019/2020 thru 2022/2023, pages 403-409.

Consumer Demographics Highlights FY 2019-20

Age

33% Children
67% TAY
0% Adult
0% Older Adult

Gender Identity

81% Male
19% Female
0% Other

Race/Ethnicity

0% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
31% African-American/Black
10% Caucasian/White
56% Latinx/Hispanic
2% Other

N=330

Integrated New Family Opportunities C-2

Positive Results

During FY 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 FY 2018/19 to 3,244 in FY 2019/20, increasing the number of encounters with family members and informal supports by 16%.

Challenges and Solutions

The greatest challenge in FY 2019/20 was the transitioning to telehealth due to COVID-19 as the INFO implementation model has been historically community-based. This created challenges in acclimating to the "team" approach via telehealth and telecommuting. To address this issue, the INFO program has been teaching the team the roles, responsibilities and legalities necessary to conduct sessions via telehealth methods as well as educating new clinicians virtually on a model developed to be delivered in the home of the consumer.

The INFO program began 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.

"I learned communication skills for real life and I was able to get a job as a Construction Apprentice because of it."
-INFO Consumer

Consumer Demographics Highlights FY 2019-20

Primary Language

85.8% English

4.5% Spanish

9.7% Other

N=330

Primary Diagnosis

12% Disruptive

3% Anxiety Disorders

3% Depressive Disorder

74% None/Deferred Diagnosis

8% Other

N=211

Transitional Age Youth (TAY) One Stop Centers

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
TAY	332	10,324	$5,298,586	$513

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 San Bernardino County. TAY Centers provide integrated services to the unserved, underserved, and inappropriately served youth of San Bernardino County. The target populations for the program are youth who are below 200% of the federal poverty level, living with mental health concerns, and includes an emphasis on Latino and African American youth who are disproportionately over-represented in the justice system and in out-of-home placements (e.g., foster care, group homes, and institutions).

Centers provide drop-in services to TAY and, when appropriate, their families. These services address employment, educational opportunities, housing, behavioral health, physical well-being, drug and alcohol use, legal issues, trauma, domestic violence, and physical, emotional, and/or sexual abuse. Additionally, Full Service Partnership (FSP) services include behavioral health outpatient services for youth with serious emotional disturbances (SED) and/or serious mental illness (SMI). Centers also offer TAY participants shower and laundry facilities, a resource room with computer and internet access, recreational activities, access to co-located services, and referrals to appropriate community-based services.

Outreach and Engagement services and events are provided to unserved TAY, and when appropriate their families, to engage and educate them on the County's behavioral health system. Services include, but are not limited to, health fairs, job fairs, street outreach, and weekly orientations.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 410-423.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
94% TAY
6% Adult
0% Older Adult

Gender Identity

50% Male

50% Female

Race/Ethnicity

1% American Indian/ Alaskan Native
3% Asian/ Pacific Islander
14% African-American/Black
25% Caucasian/White
52% Latinx/Hispanic
5% Other

N=332

Transitional Age Youth One Stop Centers TAY-1

Positive Results

Results from the ANSA for the period of July 1, 2017 through June 30, 2020* 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	77%	58%
Educational Attainment	66%	58%
Family/Family Strengths/Support	137%	57%
Interpersonal/Social Connectedness	156%	60%
Optimism/Hopefulness	99%	69%
Educational Setting	40%	53%
Community Connection	124%	63%
Resilience	90%	65%
Resourcefulness	86%	65%
Living Skills	103%	59%
Residential Stability	56%	63%

Item/Issue	Presented with a Need	Improvement of the Need
Family Relationships	89%	67%
Social Functioning	105%	64%
Recreational	78%	66%
Legal	9%	53%
Physical/Medical	21%	68%
Sleep	90%	71%
Living Skills	61%	59%
Residential Stability	35%	63%
Self-Care	49%	61%
Medication Compliance	24%	80%
Decision-Making/Judgement	84%	61%

*Due to the length of time most TAY consumers spend in the program, data was pulled for FY 2017/18-2019/20 in order to showcase the level of progression that TAY members experience over time.

Consumer Demographics Highlights FY 2019-20

Primary Language

95% English

5% Spanish

Primary Diagnosis

14.16% Psychosis
14.76% Bipolar Disorder
45.48% Depressive Disorder
3.61% Other
18.67% Anxiety disorders
1.81% Disruptive
1.51% Neurodevelopmental/Cognitive

N=332

Challenges and Solutions

The major challenge for the TAY program was in restructuring the program to provide direct services during the COVID-19 pandemic, especially with the SB TAY Center having to relocate to a new building due to the center being designated as a COVID isolation center for Children and Family Services (CFS) youth.

TAY staff who were able to telecommute incorporated telehealth, individual and group services, through virtual platforms, while those who were not were relocated to other venues. TAY staff visit housing sites 4-5 times per week for check-ins and have implemented creative ways to engage the youth in online services. The TAY advisory board was tasked with outreaching and creating an event to further engage youth and Victorville TAY has partnered with Yucca Valley TAY virtually conducting 4 REACH events during the first quarter of FY 2020/21.

Both the Victorville and Yucca Valley TAY One Stop Centers experienced reduced staffing in FY 2019/20 however remaining staff continued to work with new members to increase education of, and enrollment in, FSPs while providing drop-in and/or counseling services. Along with staff engagement, consumer word of mouth also created interest in TAY programs. Additional staff were hired in FY 2020/21 as the census need grew.

There were also challenges in recruiting and hiring clinicians outside of the Morongo Basin. Support was supplemented with two new Peer and Family Advocates (PFAs), as well as administrative support staff, while continuing to recruit locally and in neighboring communities.

Both the Victorville and Yucca Valley TAY One Stop Centers experienced a limited amount of emergency shelter beds for the TAY population in FY 2019/20. The lack of shelter beds caused consumers relocate away from supports within their community in order to receive housing assistance.

Housing contracts for FSP members have been updated to ensure those receiving assistance are progressing toward independent living arrangements. Individual and group participation is required as well as the development of viable plan to transition toward permanent living arrangements (e.g., creating a savings account or finding and affordable room to rent), and sobriety. The team increases support to improve success based on the member's needs.

Employment is always a challenge in rural areas, but even more so considering the pandemic. In order to assist members with establishing employment, TAY also partnered with the First Institute Training Program to provide members with an externship opportunity to gain the skills and experience necessary to become employable. In the Morongo Basin, however, with limited jobs and supportive services, these employment challenges are expected to continue into 2021.

Increased substance use has also been a challenge with the limited number of both inpatient and outpatient services in the Morongo Basin. Many consumers do not want to leave their community in order to receive support. Ongoing support, counseling, and education is being utilized to assist consumers in addressing these challenges.

"Every day may not be good, but there is something good in every day."

-TAY Consumer

Outreach and Engagement

For Fiscal Year 2019/20, the Transitional Age Youth One Stop Centers program conduction the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Career Fair/Conference	10	705
Resource Fair	5	144
Program Tours	2	15
Health Fair	2	100
Presentation	76	1,864
Street Outreach	147	183
Orientation	271	492
Collaborative Meeting	77	5,827
Total	**590**	**9,330**

Success Story

"Lizzy" came into the program after living in a car with her family and was moved to housing with Molding Hearts. While there, Lizzy worked to complete skills certification courses and went on to become employed. She is now living independently, in her own housing, and is eagerly awaiting her first child.

Success Story

"Mike" entered the program after being homeless and living on the street. Immediately upon receiving housing services, he began working toward his career goals. Earlier this year, Mike was hired to his desired position and has since relocated for work.

Adult Criminal Justice Continuum of Care (ACJ)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
ACJ	356	672	$8,446,653	$12,569

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 25-59	SMI*	Clinic and Field	Justice Involvement

*SMI = serious mental illness

Target Population and Program Description

The 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 and 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) (new)**

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 2019/2020 thru 2022/2023, pages 424-437.

Consumer Demographics Highlights FY 2019-20

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=356

Target Population and Program Description (cont.)

The **Supervised Treatment After Release (STAR)** and **Forensic Assertive Community Treatment (FACT)** Full Service Partnership programs serve consumers living with SMI who are under formal supervision of the Mental Health Courts (MHC) and agree to voluntarily participate in the programs as a condition of their probation. Currently, there are four participating MHC jurisdictions located in the cities of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree.

STAR provides both intensive day treatment and outpatient mental health services to individuals with a history of recidivism (re-incarcerations) who are living with severe and persistent mental illness. MHC participants usually participate in the STAR/FACT program for 18 to 24 months.

The FACT program differs from STAR as it assists 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)** Full Service Partnership programs operate in the same capacity as STAR and FACT; however, consumers are no longer under formal supervision but would still benefit from voluntarily participating in mental health and substance use services for a short period of time. CSTAR is a community-based referral program that also provides mental health treatment services to consumers transitioning from the CHOICE program as well as Mental Health Diversion (MHD) Court., whereas CFACT consumers transition from the FACT program as the sole consumer base.

The **Corrections Outpatient Recovery Enhancement (CORE)** program is a new Full Service Partnership (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 2019-20

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=356

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 2019/2020, the ACJ programs provided housing for:

Program	Number of consumers Housed
CHOICE	225
STAR	40
CSTAR	48
FACT	24
CFACT	33
ACJ Total	**370**

In comparison to pre-enrollment levels, participants enrolled in the Adult Criminal Justice programs have shown high rates of diversion from incarceration. The following data represents the reduction in jail days for FY 2019/2020.

Program	Percentage Reduction
STAR	94%
JT MHC	-1%
FACT	87%

Outcomes in the JT MHC have been impacted by COVID-19, which greatly decreased consumer participation, as well several personnel changes 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 2019/2020:

Program	Percentage Reduction
STAR	100%
CSTAR	48.85%
CHOICE	54%
JT MHC	3%
FACT	91%
CFACT	81%

Success Story

"Valerie" entered the FACT program and is currently celebrating two years of sobriety. She has resolved all legal issues including completing probation, and just received her third promotion at work. She has maintained steady employment for years now and is enjoying her new position as Site Manager.

Challenges and Solutions

The ACJ programs endured various challenges throughout FY 2019/2020. Some program challenges consisted of having to provide direct mental health services via telephone due to the COVID-19 pandemic. Face-to-face services were available for instances where there were increased risks of decompensation or crisis intervention. Group modalities were suspended due to spacing limitations and distancing requirements. In addition, superior court closures impacted court monitoring for consumers participating in treatment as part of Mental Health Diversion (MHD) terms.

ACJ staff have approached telemedicine in various ways. Packets and worksheets are delivered to consumers to facilitate discussions with clinicians and case managers. Mental Health services continue as modified by the COVID-19 emergency measures implemented, along with the utilization of virtual platforms to conduct group treatment for consumers. Additionally, transportation services were resumed for consumers to attend their scheduled court hearings as part of their MHD monitoring.

In addition to challenges related to the pandemic, the ACJ programs experienced restrictive office space, several vacant positions, decreased reimbursement for Day Treatment rehabilitation services, difficulty coordinating residential placements for consumers currently in custody, decreased referrals through MHC due to court closures, increased denials of referrals by the District Attorney, and the inability of new consumers to be provided with medications/prescriptions from the jail unless they were housed in the Severely Mentally Ill or Severely Mentally Ill Lockdown units.

ACJ has addressed office space issue by scheduling staff to telecommute and facilitating lateral transfers to fill vacant positions. Supervisory staff are transitioning from the Day Treatment modality to intensive outpatient services.

For residential placements, staff began having consumers released from jail prior to referring them for placement through the MHC, consumers are approved and released from jail in expedited timeframes. To ensure continuity of care, consumers released without medication, are being provided with same or next day assessments and psychiatric evaluations.

ACJ experienced an increase of participants in need of housing with limited spacing, due to the rural location of the program. Another challenge that the program endured was lack of participation and increase of Substance Use Disorder (SUD) relapse due to isolation caused by the COVID-19 pandemic. To address this need, ACJ is working toward fostering mutually beneficial relationships with landlords to increase housing opportunities. Consumers are being connected with local SUD providers and JT MHC is offering recovery groups with staffed Alcohol and Drug Counselors.

ACJ is working through lack of participation by requesting consumer input on group topics which are being facilitated by staff. Staff have also been reminding consumers of their court ordered program requirements and encouraging participation for MHC success.

Additionally, ACJ programs are working to streamline a collaborative referral process with the MHCs and local SUD programs to increase participation and access to services. Training and increased presence in MHC proceedings will also assist in the increase of MHC referrals. Likewise, administration has been working with their recruitment department to develop an online job fair with local colleges and other behavioral health agencies or programs to expand their marketing for staffing recruitment and retentions rather than solely relying on job postings.

Outreach and Engagement

In Fiscal Year 2019/20, the Adult Criminal Justice Continuum of Care program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
FACT Mental Health Court Graduations	7	27
Recovery Happens	1	4
Valley STAR Mental Health Graduations	1	6
NAMI Walk	1	10
Total	**10**	**47**

Program Updates

Multiple budget adjustments are being applied in the ACJ programs. For the CHOICE program, there will be a decrease in funding as a result of reducing program staffing at the Barstow location. The reduction in staffing is based on the low volume of potential consumers screened and assessed at the Barstow CHOICE location, who can be referred to and served by the local DBH outpatient clinic that offers mental health and substance use disorder (SUD) treatment services. CHOICE will no longer utilize MHSA funds for operations.

Program staffing will decrease to include one Mental Health Specialist (MHS), Alcohol and Other Drug (AOD) Counselor, and Office Assistant (OA). Services at this site will focus on screening, referral, and linkage to the local DBH Barstow outpatient programs and/or community-based organizations within the area to best address the mental health and/or SUD treatment needs of the consumer. Transportation assistance may also be provided as needed to facilitate linkage to appropriate programs.

Additionally, the FACT and CFACT programs experienced a decrease of $315,000 in program costs. This decrease comes after the initial capacity of 100 consumers was reviewed and subsequently reduced to 35 consumers served per year to align with the actual number of consumers served. Overall, program services will remain unchanged other than the number of consumers served. To ensure the maximum number of program participants are served by the Mental Health Court (MHC), the ratio will be changed to 20 FACT consumers and 15 CFACT consumers). The FACT funding reduction allows for the incorporation of the new Corrections Outpatient Recovery Enhancement (CORE) FSP program.

The other major change to the ACJ programs was the introduction of the CORE Program. Due to state funding eliminating Integrated Services for Mentally Ill Parolees (ISMIP) funding for the CORE program, CORE will be added to the ACJ continuum of care beginning January 2021.

The budget increase will expand the services currently offered to include up to 50 adult parolees who have been diagnosed with serious mental illness and designated by California Department of Corrections sand Rehabilitation as receiving Enhanced Outpatient or Correctional Clinical Case Management System services while in custody. Many are registered sex offenders, violent offenders, have co-occurring substance use issues, and have physical health conditions among other treatment needs.

The final notable change is the Corrections to a Safer Community (CTASC) program being formally renamed to Re-Integrative Supportive Engagement Services (RISES) and removed from the Annual Update. While the program continues to operate as an essential part of the ACJ continuum of care by providing outreach and engagement services, it is not MHSA funded.

Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
ACT Model FSP Services	172	285	$2,788,412	$9,784

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 resident adults, 18 years and older, living with a behavioral health condition. This program exists to assist consumers in living successfully within the community and support positive progress towards achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization.

In FY 2019/20, the Assertive Community Treatment Program consisted of Members Assertive Positive Solutions (MAPS) and Assertive Community Treatment (ACT) subprograms, however in FY 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, 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 2019/2020 thru 2022/2023, pages 438-447.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
6% TAY
74% Adult
20% Older Adult

Gender Identity

54% Male
43% Female
3% Other

Race/Ethnicity

1% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
23% African- American/Black
42% Caucasian/White
27% Latinx/Hispanic
6% Other

N=172

Positive Results

Of the 172 members served in FY 2019/20, 100% maintained stable housing, experiencing one or more of the following living arrangements:

Living Arrangement	MAPS	ACT
Living independently, alone, or with a family member	29	14
Unlicensed but supervised placement	39	12
Licensed community care facility (Board and Care)	13	51
Hospital or locked facility	7	2
Acute living facility	2	1
Assisted living facility	1	1

In FY 2019/20, Maps served 91 consumers and ACT served 81. The following represents MAPS and ACT outcomes and percentages of consumers that meet the criteria:

Outcome	MAPS	ACT
Percentage able to successfully manage their symptoms with medication and avoid psychiatric hospitalization	91%	90%
Had family involved in treatment	26%	30%
Linked to residential programs	14%	5%
Encouraged to attend substance use support groups	22%	19%
Went voluntarily to the hospital	11%	19%
Went involuntarily to the hospital	10%	10%
Of those hospitalized, percentage that were admitted for mental health	16%	25%
Of those hospitalized, percentage that were admitted for substance use	4%	4%
Percentage of members diverted from hospitalization completely	77%	72%

Consumer Demographics Highlights FY 2019-20

Primary Language

98% English

2% Spanish

Primary Diagnosis

1% Psychosis
7% Bipolar Disorder
8% Depressive Disorder
1% Agoraphobia
1% Anxiety Disorders
1% Substance Related
54% Schizoaffective
27% Other

N=172

Challenges and Solutions

The challenges in FY 2019/20 included communication with hospitals that do not notify supportive services programs of discharges or changes in medication. This creates difficulty in locating members, and concern as members are discharged with different medication than what their psychiatrist has prescribed. Members are often disconnected or disengaged with family due to not wanting to burden their families. These ongoing challenges are addressed through diligence, support, and education.

Additionally, COVID-19 and State restrictions have created barriers when providing face to face services; therefore, the program had to increase use of phone and telepsychiatry services. Members have experienced challenges staying engaged over the phone and miss interacting with staff in a pre-COVID setting.

The program has addressed this challenge by educating members on the COVID-19 pandemic, and the importance of safety while complying with State mandates. They continue to engage members on a weekly basis, have increased contact with members as needed, and identified situations where it will be safe for staff to assist members while complying with pandemic precautions.

Housing continues to be a challenge as the programs works to locate alternate housing and financial resources for those who need assistance. ACT Model FSP Services continues to work with Room and Boards and Licensed Board and Cares to help maintain members in placement. This includes working with existing providers to network with new facilities, advocate to accept members, and educate new providers about the services that can reduce concerns while at their facilities.

Outreach and Engagement

For Fiscal Year 2019/20, the ACT Model FSP Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Harvest Festival	1	48
Thanksgiving Day Lunch	1	43
Holiday Party	1	54
Total	**3**	**145**

Program Updates

The notable change in FY 2019/20 was the renaming of the program from Assertive Community Treatment Programs featuring the Members Assertive Positive Solutions (MAPS) and Assertive Community Treatment (ACT) subprograms, to one program renamed as ACT Model FSP Services which encompasses the entire continuum of care.

Success Story

"Joe" has been able to gain independence and is doing so well. He was able to travel outside of the country by himself, and during his time with the program, staff assisted him in gaining citizenship.

Regional Adult Full Service Partnerships (RAFSP)

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
RAFSP	532	930	$6,128,243	$6,590

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 the various regions of San Bernardino County. The RAFSP programs provide access and linkage, as well as full wraparound care to consumers. These services include intensive at clinic and field-based, services that assist individuals in accessing various levels of care and housing, and/or step down to a lower level of care in the least restrictive setting possible.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is typically one to ten to allow for intense support for consumers 24 hours a day/7 days per week but can include larger numbers as appropriate. RAFSP encourages individualized decision making and reinforces self-responsibility. Consumers within the FSP programs are actively involved in ongoing planning, review of progress towards goals, and evaluation of their treatment. Additional services include activities that support consumers in their efforts to restore, maintain, and develop interpersonal and independent living skills through the wellness, recovery, and resilience model, and by providing culturally competent, evidence-based practices.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 448-459.

Consumer Demographics Highlights FY 2019-20

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. The following illustrates the percentage of hospitalizations and bed days for RAFSP consumers in FY 2019/20:

Provider Name	Unduplicated Consumers Served	% of Consumers Who Avoided Hospitalization Completely in FY 19/20
Barstow Counseling	46	**87%**
Mesa Counseling Services	53	**81%**
Victor Valley Counseling Center	104	**92%**
Phoenix FSP (Clinic Based)	80	**84%**
Valley Star FSP	81	**93%**
San Bernardino Action Program	124	**90%**
Mariposa Counseling Center	44	**89%**

Provider Name	Comparison between FY 2018/19 and FY 2019/20	
	% Change of Hospitalizations	% Change in Number of Hospital Bed Days
Barstow Counseling	700%	388%
Mesa Counseling Services	-8%	13%
Victor Valley Counseling Center	-56%	-47%
Phoenix FSP (Clinic Based)	-45%	-4%
Valley Star FSP	300%	340%
San Bernardino Action Program	67%	55%
Mariposa Counseling Center	0%	33%

In the graph above, positive numbers represent an increase from FY 2018/19 to FY 2019/20 and negative numbers represent a decrease. Overall, the RAFSP program increased the number of consumers served by 115% in FY 2019/20 compared to FY 2018/19. RAFSP overall also experienced an 8% increase in consumers hospitalized. Due to the excessively low numbers of consumers hospitalized in FY 2018/19, a slight increase in hospitalization led to a dramatic increase in percentages of hospitalizations and hospital bed days. For example, in FY 2018/19, Barstow Counseling only had one consumer experience a hospitalization. In FY 2019/20, this number increased to 8 leading to a 700% increase in hospitalizations; however, 87% of consumers served managed to avoid hospitalization completely. Hospitalization outcomes were also affected by the COVID-19 pandemic.

Consumer Demographics Highlights FY 2019-20

Primary Language

94% English

4% Spanish

2% Other

Primary Diagnosis

49% Psychosis

24% Bipolar disorder

2% Other

4% Anxiety disorders

21% Depressive disorder

N=532

Challenges and Solutions

The major challenges for the RAFSP program include the limitations that came with the COVID-19 pandemic. This greatly impacted the ability to network, provide housing, and field-based intervention. Additionally, the pandemic created limitations when it came to transportation assistance, processing social security disability claims, and further limited resources in the High Desert. RAFSP staff have been trained in utilizing WebEx and Zoom and continue to provide telehealth services, and linking consumers to resources, throughout the County.

During the 2020/21 Fiscal Year, RAFSP will continue partnering with the Inland Empire Health Plan (IEHP) Health Homes program which provides medical case management support to the most vulnerable consumers. The collaboration of the team with our FSP team has benefited consumers and allowed them to access medical treatment they had been unable to previously. Medication reconciliation and appointment accompaniment has been incredibly helpful.

Another positive solution, over the past year, has been the collaborative efforts of the Department of Behavioral Health (DBH) along with managed care organizations in assisting high risk consumers, with a disordered eating diagnosis, to access partial hospitalization programs at Loma Linda University Behavioral Medicine Center and Valenta Treatment Centers.

Outreach and Engagement

For Fiscal Year 2019/20, the Regional Adult Full Service Partnership program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Health Fair	1	200 attendees
Training to Barstow College Staff	1	20 staff
Indian Health Presentation	1	15 attendees
Community Holiday Events	3	200 attendees
Total	**6**	**435**

Success Story

"Riley" had been living in vouchered shelters for a long period of time while attempting to obtain entitlement benefits. With the continued support of her case manager and the RAFSP program, Riley was able to receive benefits, successfully move to Room and Board housing, and finally, afford housing. Riley continues to thrive with the support of the RAFSP program.

Age Wise

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Age Wise	268	1,220	$2,974,689	$2,438

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) mental health, substance use, and case management services throughout San Bernardino County to older adults living with mental illness and/or co-occurring disorders. Age Wise works to increase access to services for the older adult community and decrease the stigma associated with mental illness. The Age Wise program is managed through the Department of Adult and Aging Services of San Bernardino County.

Through collaboration, Age Wise focuses on assisting unserved, underserved, and inappropriately served older adults to develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population.

"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 that opens."

-Age Wise Consumer

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 460-468.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
0% TAY
2% Adult
98% Older Adult

N=121

Gender Identity

28% Male

72% Female

N=268

Race/Ethnicity

1% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
11% African-American/Black
28% Caucasian/White
23% Latinx/Hispanic
36% Other

N=268

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	73%	78%
Maintained safe and stable housing	100%	100%
Are stable and able to seek outside assistance to locate their own resources	71%	51%
Consumers linked to a Primary Care Physician	100%	100%
Reported an ethnicity other than Caucasian	57%	13%
Diverted from hospitalization for psychiatric care	95%	100%

Challenges and Solutions

A pressing concern that continues for the older adult population, as they retire on a limited income, is affordable housing. Housing, coupled with the loss of lifelong support persons through illness and death, as well as managing medical issues of their own, presents great challenges for staff who attempt to address multiple complex issues with case management and a mental health service plan.

An additional challenge presented was the COVID-19 pandemic and the lockdown restrictions associated with it. Being identified as a particularly vulnerable group to this disease (i.e., older people, and people with underlying medical conditions) created a great deal of anxiety and fear within the Age Wise population served. The increased isolation made it more difficult to address the needs of consumers regarding housing, access to medical care, and the obtaining of basic needs such as food and clothing. Reliable transportation became an even greater challenge than normal due to social distancing concerns.

Consumer Demographics Highlights FY 2019-20

Primary Language

82% English

12% Spanish

6% Other

Primary Diagnosis

19% Psychosis

20% Bipolar Disorder

1% Other

4% Anxiety disorders

56% Depressive Disorder

N=121

Challenges and Solutions (cont.)

Financial elder abuse by means of scams perpetrated by technologically savvy con-artists, who utilize fear tactics, or lures of significant enrichment to bait vulnerable seniors, remained a concern. These scams often made telephone contact with consumers more challenging, as many have increasingly become more averse to answering their phones because of the anticipation of unwanted calls and solicitations.

As the served population ages, there continue to be other factors such as memory, cognitive, and substance abuse disorders, which factor into the overall condition of consumers and present challenges to determining the clear and accurate diagnoses imperative for determining the most appropriate treatment.

Utilizing an approach that parallels a telehealth type of service, has been beneficial to consumers who have high anxiety and concerns regarding social distancing and keeping themselves safe from COVID-19 exposure.

Innovative housing programs, such as Project Roomkey and At Home, have increased availability of shelter options for consumers most in need. Age Wise sought collaboration with these programs to provide any needed mental health and supportive case management services to maximize the efficacy of these programs.

Age Wise also collaborated with getting the Great Plates program up and running, which offers complete meals delivered to qualifying seniors, addressing the challenges of accessing adequate food resources during the time of pandemic. Finally, Age Wise instituted an after-hours call line in order to have a licensed clinician available for consumers to address fears and anxieties or obtain information regardless of the time of day.

Success Story

"Jackson" was having difficulty managing the symptoms of his behavioral health condition. He frequently used crisis services, had difficulty communicating with family, and was at risk of losing his basic needs when he entered the Age Wise program. Age Wise assisted in bridging the gaps in services, retaining entitlement benefits and housing, helping to facilitate a supportive relationship with Jackson's family, and improve his quality of life.

Age Wise has become a stabilizing component in Jackson's life. As a result of Jackson's participation in the program, his family has been provided supportive services to aid them in assisting their family member.

Outreach and Engagement

For Fiscal Year 2019/20, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Church Group	1	6
In-Service Presentations	5	163
Senior Centers	1	6
Total	**7**	**175**

Housing and Homeless Services Continuum of Care

Introduction

The Housing and Homeless Services Continuum of Care Program (HHSCCP) is a robust continuum of care 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), 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.

The Employment Program focuses on coordinating and providing consumers employment education to promote job search skills to secure and maintain employment. The employment program provides employment preparation, on the job training, job training and placement, professional counseling and education.

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.

The program continues to change and expand to meet the fluid needs of San Bernardino County residents.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by service categories for Fiscal Year 2021/22::

	Program Name	Fiscal Year	Service Area*
Housing and Homeless Services Continuum of Care Programs	Homeless Outreach Support Team	2021/22	75 O&E
			TOTAL = 75
	Project Roomkey	2021/22	260 GSD
			TOTAL = 260
	Full Service Partnership and Supportive Services	2021/22	513 FSP 294 GSD
			TOTAL = 807
	Employment Services Program	2021/22	140 GSD
			TOTAL = 140

*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 2019-20	Estimated Number to be Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
HHSCCP	1,204	1,625	$9,977,638	$6,140

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 to be served include transitional age youth, adults, older adults, and families.

The Homeless Continuum 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 the Homeless Outreach and Support Team (HOST), Emergency Shelter Services, and Supportive Services.

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

Consumer Demographics Highlights FY 2019-20

Age

0% Children
2% TAY
73% Adult
25% Older Adult

Language

94% English
4% Spanish
3% 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= 704 Note: Demographics represents all Housing and Homeless Services Continuum of Care programs.

Homeless Outreach and Engagement

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 Sherriff 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 community events
  - Provides expertise with other outreach teams

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

9% Anxiety

28% Psychosis

21% Bipolar

1% Other

41% Depression

N= 704

Outreach and Engagement

For Fiscal Year 2019/20, the Homeless Outreach and Engagement program conducted the following outreach and engagement activities:

Activity Type	Total Number of Participants
Outreach and Engagement in the field with law enforcement	50
Project Roomkey – Hotel Guests Served	202
Project Roomkey – Glen Helen	59
Total	**311**

Program Update

The programs will be reorganized, and the cost centers will be consolidated. Supportive Services, Shelter, HOST, InnROADs, and Employment. HOST and Shelter will be defining their roles and there will be more training on housing planning.

- Increased focus on housing navigation
- Increased focus on contract monitoring
- Streamlining administrative processes to maximize efficiencies

HOST staff were diverted from doing outreach to providing services to homeless individuals in Project Roomkey, a state-funded non-congregate care isolation opportunity for homeless individuals. This allowed homeless individuals to isolate from COVID-19 in hotel rooms. Those homeless

Program Update (cont.)

consumers that tested positive for COVID-19 were given the opportunity to quarantine in the trailers at Glen Helen Regional Park. HOST staff provided the case management and daily contacts to the homeless guests at both the hotels and Glen Helen.

Success Story

"Joseph" entered the program utilizing a warming shelter, homeless, and living with a mental illness. Desiring to show appreciation for the services he received, Joseph began to volunteer at the warming shelter. After a bit of time volunteering at the shelter, Joseph gained the necessary skills and experience to apply for a part-time position and is now employed at the shelter. Through HOST, Joseph can meet with his therapist once a week. He has shown great appreciation for the program.

HOST is navigating housing on Joseph's behalf.

Artwork by Karla Quintero

Full Service Partnership and Supportive Services

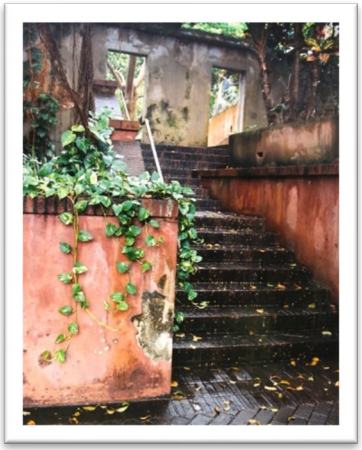
Program Name	Number of clients served in FSP FY 2019-20	Estimated Number of clients in PSH FY 2019-20	Number of clients in MHSA Housing FY 2019-20	Estimated Number of clients housed in FY 2021-22
FSP/Supportive Services	513	150	94	807

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 a community-based organizations.



Artwork by Brad Borrero

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)
- Employment services including assessment for employment, group job skills training, and employment leads
- Social supports coordination

Positive Results

"Project Homekey"

San Bernardino County is submitting 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 that were affected by COVID-19 which includes those in Project Roomkey.

MHSA Housing

DBH continues to support seven MHSA housing projects that include 94 Permanent Supportive Housing units, housing those who are living with a serious mental illness and/or substance use disorder. Bloomington 3 will open in this next fiscal year. It will add an additional 10 units to our MHSA housing project.

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 3 of No Place Like Home funds. If the County is successful, DBH intends to utilize a portion of CSS funds to cover the Capitalized Operating Subsidy Reserves (COSR) for a portion of the units. 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 Support Services – DBH is responsible for providing supportive services for the County's Permanent Supportive Housing (PSH). Services are provided to all consumers to maintain their housing stability and well being.

Challenges and Solutions

There is not enough affordable housing to house our homeless population. The County is currently searching for suitable properties that it hopes to acquire and renovate, with a goal of securing permanent housing for up to 100 households in the first round of the initiative.

There is a lack of shelter and housing for consumers with pets or significant others. DBH currently has funding to assist Permanent Supportive Housing (PSH) consumers with housing applications, credit check fees, deposits and "welcome home" supplies. Additional resources are being developed.

Individuals experiencing homelessness for less than a year are left with very few resources as the focus of the housing funding is on providing PSH for chronically homeless only. The Coordinated Entry System (CES) is working with County partners to meet the needs of the community.

Ongoing collaboration with Law Enforcement is expanding and improving. The HOST outreach teams work alongside the Sheriffs HOPE team and with the Redlands, Rialto, and Fontana Police Departments.

Program Updates

For Fiscal Year 2021/22, there will be a funding increase to serve an additional 40 consumers at the new housing development, All-Star Lodge located in San Bernardino.

Employment Services

Target Population and Program Description

The Employment Services Program, 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. 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+	SMI*	Clinic-based	Seeking employment and/or job skills

*SMI = serious mental illness

Services Provided

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

Positive Results

In Fiscal Year 2019/20, the Employment Services program served a total of 139 consumers. Through program participation, 31 jobs were obtained by consumers. Additionally, the program saw 18 successful case closures (consumer retained employment for 90+ days).

Consumer Demographics Highlights FY 2019-20

Age

0% Children
11% TAY
86% Adult
3% Older Adult

Language

97% English
2% Spanish
1% Other

Gender Identity

47.6% Male
51.6% Female
0.4% Transgender
0.4% Other

Race/Ethnicity

15% African-American/ Black
2% Asian/ Pacific Islander
45% Caucasian/White
17% Latinx/Hispanic
4% American Indian/ Alaska Native
17% Multiple Races/ Other

N=275

Challenges and Solutions

During Fiscal Year 2019/20, the Employment Services program was faced with difficulty in locating available jobs that fit the population's diverse scheduling needs and in creating consumer awareness of the program.

In addressing these challenges, the program has been establishing relationships with employers, other departments within the county, and attending networking events to establish potential places of employment for consumers. Employment Services acts as the liaison between the consumer and employer to bridge communication and creates awareness on mental health issues in the workplace.

Employment services began attending monthly clinic staff meetings to create awareness of the employment services available to the consumers. The employment referral process was streamlined by creating a email specifically for referral.

Outreach and Engagement

For Fiscal Year 2019/20, the Employment Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Potential Employers Reached
Community Action Partnership meetings	6	600
Community resource fairs	4	640
Network with other public service organizations	87	1,515
Network with Chamber of Commerce	8	480
Totals	**105**	**3,235**

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

1% Anxiety disorders

23% Bipolar disorders

30% Depressive disorders

2% Psychosis disorders

21% Schizoaffective disorder

1% Substance use disorders

21% Other

NOTE: Due to rounding, total is 99%.

N=274

Adult Transitional Care Programs

Introduction

Adult Transitional Care Programs provide a continuum of behavioral health services designed to serve unique consumers with serious behavioral health conditions who are exiting from higher levels of care and require additional services to reintegrate into the community. Services for this target population are intensive and specialized; therefore, the programs described have been grouped together to better streamline services and improve overall care. Services under this continuum implement a strength-based approach, promoting the principles of recovery, wellness, and resilience by maximizing the consumer's functioning to help them maintain a more satisfying quality of life.

Services in this continuum include comprehensive medical and psychiatric services designed to promote skill building and activities of daily living to assist consumers to move toward new 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 2019/2020 thru 2022/2023, 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 2021/22:

Program Name		Fiscal Year	Ages Served	Service Area*
Adult Transitional Care Programs	Adult Residential Facilities Certified In Social Rehabilitation Services	2021/22	80 Adult	80 GSD
			TOTAL = 80	TOTAL =80
	Community Reintegration Services (FSP)	2021/22	50 Adult	50 FSP
			TOTAL = 50	TOTAL = 50
	Enhanced Assisted Living Program	2021/22	5 Adult	5 FSP
			TOTAL = 5	TOTAL = 5

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.
*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

Adult Residential Facilities Certified in Social Rehabilitation Services

Program Name	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
Adult Transitional Care Programs*	197	135	$8,810,337*	$65,262*

*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 2019/2020 thru 2022/2023, pages 496-503.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
22% TAY
75% Adult
3% Older Adult

Language

96.55% English
0.86% Spanish
2.59% Other

Gender Identity

40.5% Male

58.6% Female

0.9% Other

Race/Ethnicity

20% African-American/ Black
3% Asian/ Pacific Islander
34% Caucasian/White
38% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/ Other

N=116

Positive Results

In Fiscal Year 2019/20, the program served a total of 116 consumers. Of these, only 23% (27 of 116) of consumers were hospitalized for varying psychiatric or medical reasons, and 77% (89 of 116) were able to successfully avoid hospitalization due to the stability and interventions of this program.

Challenges and Solutions

As a result of COVID-19, many emergency response teams were unable to respond in the field, which made it difficult for consumers to obtain emergency psychiatric resources. In response to this challenge, the program is coordinating with primary care physicians and psychiatrists to request emergency appointments when available. The program will also continue to utilize nurse hotlines, available through insurance providers, for assistance when possible and utilize available alternative crisis interventions, such as crisis stabilization units, crisis walk in centers, and crisis residential treatment as appropriate.

Program Updates

For Fiscal Year 2021/22, the overall funding allocation for program services was increased, as the contract provider requested additional cost per bed day in order to meet the amount of beds needed.

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

5.8% Bipolar disorders

0.8% Substance use disorders

5.0% Depressive disorders

6.7% Schizoaffective disorder

81.7% Psychosis disorders

N=120

Outreach and Engagement

For Fiscal Year 2019/20, the ARF Certified in Social Rehabilitation Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Meetings/ presentations	15	92
Open House	1	10
Totals	**16**	**102**

Success Story

"Brian," an adult male, first entered the Transitional Program in 2017. He was transferred from a higher level of care placement and was working toward stabilizing on a new medication regimen. He had previously resided with his family and continued to have strong family support. However, they were unable to provide the level of care Brian needed. After completing the Transitional Program, he was transferred into a long-term program that would continue to improve his mental health condition, hygiene habits, healthy daily routines, and medication compliance. He actively participates in both individual and family therapy sessions as part of his progress toward successful program completion. He hopes to live with his family again soon.

Community Reintegration Services

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

"Jenny," an adult female, living with anxiety and depression had a history of involuntary and voluntary hospitalizations. Through effective case management and Jenny's motivation for change, her number of hospitalizations began to reduce, with no hospitalizations in a 12-month period. She has become involved in her community and taken on active roles in a Clubhouse. Jenny's anxiety and depression have decreased enabling her to reconnect with family and live an independent lifestyle. She is actively working to graduate from the CRS program.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
6% TAY
79% Adult
15% Older Adult

Language

100% English

Gender Identity

69% Male
31% Female

Race/Ethnicity

13.5% African-American/ Black
1.9% Asian/Pacific Islander
44.2% Caucasian/White
38.5% Latinx/Hispanic
0% American Indian/ Alaska Native
1.9% Multiple Races/Other

N=52

Positive Result

In Fiscal Year 2019/20, 95% (76 of 80) of CRS consumers either had a reduced rate of emergency room visits for mental health concerns or had no emergency room visits.

There was a total of 20 visits to alternative crisis intervention sites. 75% (60 of 80) of CRS consumers were successful in remaining stable and did not need to utilize either crisis services (other than those provided by the CRS team) or hospitalization.

Challenges and Solutions

The most significant challenge experienced during Fiscal Year 2019/20 was the 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. This was a very challenging transition for both consumers and staff. Prior to the pandemic, services provided to the 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.

Challenges and Solutions (cont.)

CRS staff have become very skilled at finding ways to connect with the consumers in meaningful ways during the pandemic and have exercised creativity in facilitating linkage to needed supports and services. The staff have often prepared packets of materials that facilitate enhanced coping skills. These packages were distributed to consumers via mail in an effort to keep them active and engaged.

Outreach and Engagement

For Fiscal Year 2019/20, the CRS program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentation	1	10
Totals	**1**	**10**

Consumer Demographics Highlights FY 2019-20

Primary Diagnosis

12% Bipolar disorders

17% Depressive disorders

71% Psychosis disorders

N=52

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 loved ones and family support.

This program was implemented as of August 2020.

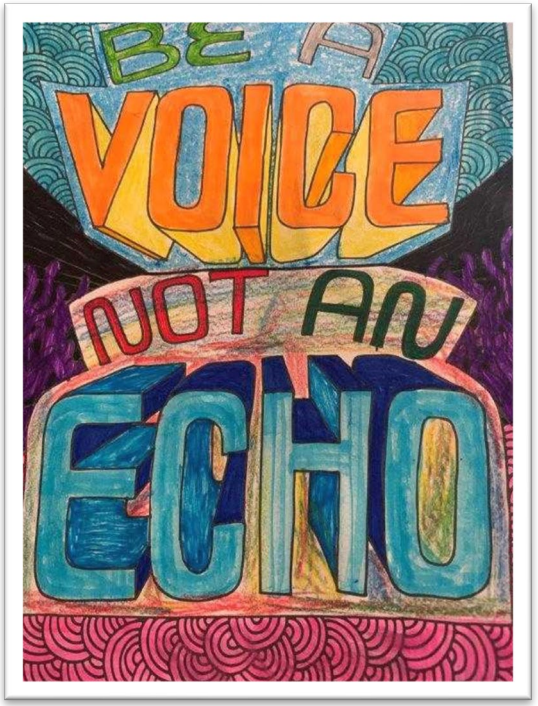
Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 50+	SMI*	Facility-based	Experiencing both behavioral health and critical medical concerns

*SMI = serious mental illness

Services Provided

- 24-hour observation
- Comprehensive medical and psychiatric services
- Medication management
- Social/life enrichment activities
- Therapeutic intervention and groups

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, pages 513-514.



Artwork by M. Nunez

Introduction

The goal of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the behavioral health needs of unserved and underserved populations through short-term projects. This is accomplished by expanding or developing services and supports that are considered to be innovative, novel, creative, and/or ingenious behavioral health practices that contribute to learning rather than a primary focus on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are designed to support and learn about new approaches to behavioral health care by doing one of the following:

- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral heath, including, but no limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

This component is unique because it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the local Behavioral Health Commission, San Bernardino County Board of Supervisors, and the MHSOAC.

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 2023**
Provides intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to consumers and their families where they live within homeless communities.

2020

Eating Disorder Collaborative: **January 2021 – January 2026**
A comprehensive flexible interagency model of interventions and services for those diagnosed with an eating disorder.

Cracked Eggs: **Approved by OAC**
A workshop that allows participants to discover, learn, and explore their mental states in a structured process of self-discovery through art.

Integrated Health Care : **On Hold**
A partnership with local managed cared agencies to provide integrated behavioral and physical health care to Medi-Cal enrollees where delivery, coordination, and payment of care is managed by a single accountable entity.

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 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021-22
InnROADs INN Project	1,123	280	$3,931,606	$14,041

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 accepting the Housing First Model due to traumatic experiences as a result of homelessness which has either led to substance use and mental illness or exacerbated a pre-existing condition,
- Experiencing homelessness within San Bernardino County rural and unincorporated communities, and/or
- Experiencing unsheltered homelessness within San Bernardino County.

What have we learned during FY 2019-20?

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:

Being consistent with not only consumers but community partners: Consistency has helped the InnROADs staff have form many relationships throughout the system with 211, SUD, and other services. These relationships helped to lessen the amount of wait time in many cases.

Small Successes as a Trust Building Activity: Team members found that small successes getting consumers necessary resources built the trust necessary for consumers to agree to treatment or move forward with housing goals.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 526.

Consumer Demographics Highlights FY 2019-20

Age

0% Children
5% TAY
46% Adult
14% Older Adult
35% Unknown

Sexual Orientation

1% of consumers identified as LGBTQ+

Gender Identity

25% Male
17% Female
58% Other

*Note: >1% of total was 'Declined to State'

Race/Ethnicity

14% African-American/ Black
1% Asian/Pacific Islander
48% Caucasian/White
18% Latinx/Hispanic
1% American Indian/ Alaska Native
18% Multiple Races/ Other

N=1123

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 2019-20

Veterans

4% of consumers identified as a veteran

Language

82% English

2% Spanish

16% Unknown

*Note: >1% listed primary language as sign language, Polish, or Tagalog

N=1123

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

To effectively support the needs of individuals experiencing homelessness, InnROADs provided the necessary linkages to assist the consumer on the pathway to permeant long-term housing. During FY19-20, the InnROADs team completed linkages that served this purpose. The following table outlines where the consumer was linked to, how many engagements were needed on average, and the number of days it took to secure those linkages.

Linkage to	No. of Linkages	Avg. No. of Engagements	Avg. No. of days taken
InnROADs Treatment Team	97	1.49	8.91
Short Term Housing	67	1.62	9.07
Temporary Housing	16	2.62	35
Long Term Housing	6	6.33	59.50
DBH Mental Health Services	27	1.85	11.70
DBH SUD Services	23	2.25	17.81
DBH TAY Services	5	4.33	30.67
DPH Programs	4	1.33	10.00
DAAS Programs	77	2.04	14.86
Sheriff's Programs	7	12.33	135.50

Note: One consumer may have more than one linkage.

Outcome Analysis Highlights, cont.

Learning Goal #1, cont.

Time Savings

During FY19-20, InnROADs had an estimated "time savings" of 1283 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?

Harm reduction, LEAP (Listen, Empathize, Agree, Partner), motivation interviewing, and relationship building were the main techniques used by InnROADs staff, but the single most important tool to successful outcomes (e.g., getting someone into treatment) is consumer trust. InnROADs staff sought to establish a track record of successful practical results and consistent follow-up. Small successes often add up to larger successes. To obtain results, InnROADs staff were willing to do 'what ever it takes,' from making phone calls with consumers, waiting with them while they are on hold, or sitting with them at hospitals/treatment centers for hours in order to get them seen. By being consistent also improved in-system relationships, InnROADs staff have formed many relationships throughout the system with 211, SUD, and other services. These relationships helped to lessen the consumer wait-time in many cases.

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?

The primary concern for the consumers engaged by InnROADs has been housing. Often the best outcomes begin with obtaining some type of shelter. Understandably for most individuals experiencing homelessness their priority is survival and other concerns, such as medical, behavioral health, or substance use treatment, are often set aside to worry about later. One of the many strengths of InnROADs has been being able to provide these types of services directly to individuals wherever they are. InnROADs staff have been able to provide wound care and medication services, link people to their primary care, or help continue treatment for chronic and acute conditions. InnROADs has been able to provide therapeutic services and to help link individuals to clinic for psychiatric services.

InnROADs Use of Incentives

There are two main types of motivation – intrinsic and extrinsic – that affect individuals' actions in different ways and manifest themselves differently in each person. Intrinsic motivation stems from internal rewards, like feelings of well-being, success, and satisfaction, and is cultivated over time. People with high intrinsic motivation will continue to do tasks even without rewards because they enjoy doing them or feel good about themselves when they accomplish them. Extrinsic motivation originates from something external. For example, a financial reward such as the promise of a performance bonus increases extrinsic motivation because it is using the promise of a monetary reward to encourage someone to do something they might otherwise not be inclined to do. Extrinsic motivators are often thought of as "if, then," since they generally rely on a contingency (e.g., if you meet your work quota, then you will get a raise). One potential issue with extrinsic motivators is that people may want to do something (i.e., have intrinsic motivation to do it), but the reward of an extrinsic motivator may crowd out their intrinsic motivation. The ultimate goal in using incentives – which are extrinsic motivators – is to increase intrinsic motivation to achieve long-term success. (Pavetti and Standley. Using Incentives to Increase Engagement and Persistence in Two-Generation Programs: A Review of the Literature with Key Insights. December 2016.)

Part of the InnROADs project plan is the use of extrinsic incentives to increase engagement with DBH's system of supports and services, while also tapping into a consumer's intrinsic motivation that will assist on the pathway to permanent supportive housing.

Incentives Given

Types of Incentives	No. Given
Identification Voucher	104
Food/Water	898
Dental Hygiene Items	40
Physical Hygiene Items	171
Feminine Hygiene Items	61
Clothing	65
Homewares	6
Pet Food	9
Other Pet Supplies	9
Transportation	14
Wash Clothes	1
Shower	1
Harm Reduction Items	23
Other Misc. Incentives	91

Note: It is too early in the innovation project timeline to begin an analysis of incentive use and consumer outcomes. That analysis will begin in Year 4 of the innovation project.

InnROADs Project Outcomes FY 2019-20

2,376
Records of Engagement for FY 2019-20

19
Medical Assessments documented

20
Incentives given for pet care services

1,040
Consumers referred or linked with other services

74
consumers linked with Short-term, Temporary, or Long-term Housing

1,123
unduplicated consumers received services during FY 2019-20

Program Updates

- The Morongo Basin Clinical Therapist II position will act as a floater throughout the County in order to fill in for leadership needs where appropriate. This is different from the original team organizational plan outlined in the InnROADs Innovation Project Plan.
- InnROADs is currently looking to obtain a Medi-Cal certified space to allow for Medi-Cal billing. The addition of billing will allow for field-based services to be expanded to include more mental health assessment and mental health services including medication management.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2022 - 21
EDC INN Project	0	835	$2,263,310	$2,711

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

The Eating Disorder Collaborative has two separate project components, each with different targeted populations:

Project Component	Target Population
Interventions and Treatment	Individuals 16 yrs. and older residing in San Bernardino County, diagnosed with an eating disorder.
Regional Knowledge and Resource Directory	The Inland Empire's behavioral health professionals (both public and private), primary care physicians, contracted providers, and community partners.

Program Updates

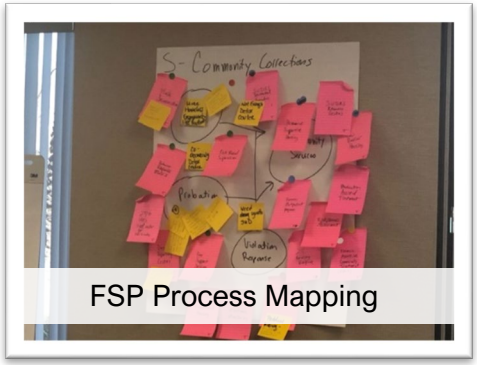
- Because of COVID-19, the program start date was moved from 4/2020 to 1/2021.
- The initial EDC staff composition has been modified. EDC will begin with two Clinical Therapist Is, one Social Worker II, and one Office Assistant II.
- The initial focus of staff will be on training associated with the diagnoses and treatment of eating disorders. Because of continued COIVD-19 precautions, initial training will be online.

For additional information, please refer back to the MHSA Three Year Integrated Plan for Fiscal Year 2019/2020 thru 2022/2023, page 533.

Multi-County Full Service Partnership Innovation Project

Innovation Projects	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2022 - 21
FSP INN Project	N/A	N/A	$136,039	N/A

Target Population and Project Description



FSP Process Mapping

The Multi-County Full Service Partnership (FSP) Innovation 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.

In partnership with Third Sector and the Mental Health Services Oversight and Accountability Commission (MHSOAC), a cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura — are participating in a 4.5-year Multi-County FSP Innovation Project that will leverage counties' collective resources and experiences to improve FSP 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 2019-20?

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.


FEB 2020 FSP Workgroup Meeting

Project Learning Goal Status

Learning Goals #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.

These six-county cohort meetings were essential to building a collective vision and aligning on 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 Goals #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:

- Graduation guidelines
- FSP eligibility requirements
- Data collection
- FSP referral forms and protocols

Learning Goals #3

Improve how counties define, collect, and apply priority outcomes across FSP programs.

San Bernardino County and the other five cohort counties are building 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. Over the course of 12 months, San Bernardino and the other five counties will focus on:

- *Population definitions:* Identify and standardize 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:* Identify 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.
- *State reporting recommendations:* Develop recommendations for revising the statewide Data Collection & Reporting (DCR) system. This may include suggested revisions to existing forms, metrics, and/or the format of reports that are shared with counties in order to increase the usefulness of statewide data and reduce reporting burden. This activity will begin in late Spring 2021 after the completion of the first two activities.

Learning Goals #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 gather standardized information to compare FSP programs across the state in the future. Additionally, the full list of implementation options could be used by future 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) to support performance management forums.
- 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 Goals #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 Project, these key stakeholders include FSP clients, clients' primary caregivers, and service providers. From July through September of 2020, 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 used that information to prioritize which program challenges the Innovation Project will address over the next year. This includes the identification of existing processes that need strengthening.

Multi-County FSP Project Activity Highlights FY 2019-20

13
Workgroup meetings with DBH program leads and support staff during JUL – SEPT 2020

10
Client interviews from DBH specialty adult FSP programs

4
Provider focus groups that included 23 frontline and managerial staff

Cracked Eggs

Innovation Projects	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2021-22	Estimated Annual Cost per Person FY 2021 - 22
Cracked Eggs INN Project	0	30	$296,956	$9,899

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.

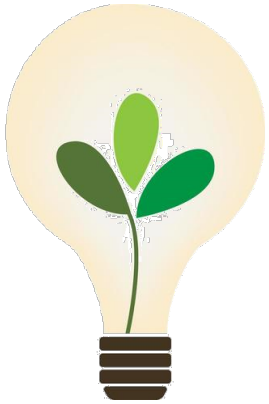
This workshop series is designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not see symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps 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 16.

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.
- The Crack Eggs project started the first online test workshop in 1/2021.

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

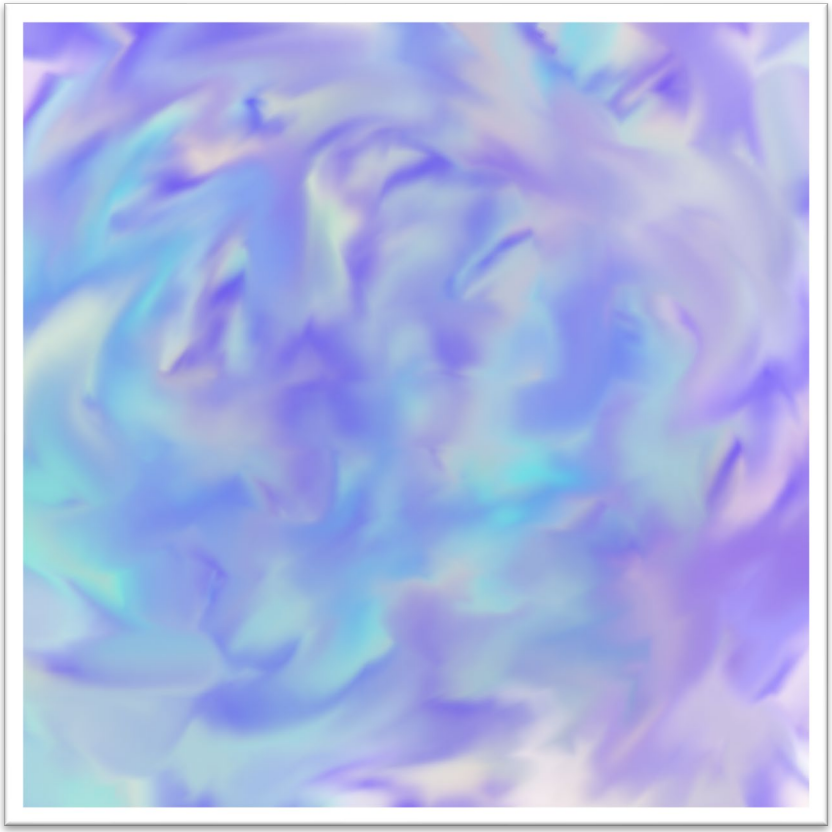
Introduction

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 various 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 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 R. French

Workforce Education and Training

Positive Results (cont.)

To meet the goal of addressing workforce shortages, a needs assessment was completed July of 2013 identifying 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 2019/20 is not a true reflection of the work WET has done in this area due to the unique challenges encountered in 2020. More progress is needed as there are still occupational shortages.

The WET program received an increase in applications for licensed positions in Fiscal Year 2019/20. 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 an increase exclusively for the number of Clinic Assistant, Mental Health Education Consultant, and Mental Health Specialist qualified applicants.

Job Title	Number of Qualified Applications Received in FY 2019/20	Job Title	Number of Qualified Applications Received in FY 2019/20
Alcohol and Drug Counselor	35	Nurse Supervisor	3
Child Psychiatrist	10	Peer and Family Advocate I	0
Clinic Assistant	73	Peer and Family Advocate II	0
Clinic Supervisor	19	Peer and Family Advocate III	0
Clinical Therapist, LCSW	41	Pre-Licensed Clinical Therapist, LCSW	41
Clinical Therapist, MFT	17	Pre-Licensed Clinical Therapist, MFT	40
Clinical Therapist, Psychology	0	Pre-Licensed Clinical Therapist, Psychology	2
Clinical Therapist II	56	Pre-Licensed Clinical Therapist, LPCC	18
Mental Health Education Consultant	35	Program Manager I	30
Mental Health Nurse II	64	Program Manager II	9
Mental Health Specialist	70	Psychiatric Technician I	20
Nurse Manager	35	Psychiatrist	1

Workforce Education and Training

Positive Results (cont.)

Another program that WET oversees is the License Exam Prep 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.

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%
Grand Total		**433**	**301**	**70%**

For LEPP 1-10, there has been, on average, an approximately **70%** licensure rate among the participants. DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP.

For LEPP 1-10, there has been, on average, an approximately 70% 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.

Through 9 Cohorts of LEPP, Prior to Implementation of Revised LEPP*			
	Clinical Therapist I	**Clinical Therapist I Psychologist**	**Total**
Licensed	67	5	**72**
Pre-Licensed	83	8	**91**
Total	167	11	**178**
Percentage Licensed	44.7%	38.5%	**44.2%**

*DBH has seen an increase of 6.5% in the percentage of licensed staff since Fiscal Year 2019/20.

"It was very helpful to have experienced what it would be to work in the county. I was able to learn about different programs the County provides. It was very beneficial being able to get my experience while getting paid. I was able to focus more on my school and practicum without having the financial burden. Overall, it was a good experience."

-MSW Intern

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 2019/20, there were a total of **35** 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.

"My supervisors were very knowledgeable about the mental health field and the resources available in the community and often provided me with insight on different interventions and techniques that were very beneficial to my clients."

-MFT Intern

DBH is committed to hiring applicants that were previously interns. As seen in the following table, 25% of clinical hires in Fiscal Year 2019/20 were DBH interns. These 9 DBH interns were hired as pre-licensed Clinicians with the department in Fiscal Year 2019/20.

Pre-Licensed Clinicians Hired	FY 2019/20
Total Number of Interns Hired	9
Total Number of Non-Interns Hired	27
% of Interns Hired	25%

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) additional 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 61 NP students with 17 of those in FY 2019/20.

Positive Results (cont.)

To meet the goal of educating the workforce on 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 2019/20, the following are example of trainings that incorporate the MHSA standards:

- Hearing Voices
- Mental Health First Aid

The table below provides additional information regarding trainings provided by WET in Fiscal Year 2019/20.

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

For several years, the WET Volunteer Services Coordinator has been a regular guest speaker in my classroom and has invested a full day to speak with my students and answer their questions […]. Several of my students have been in the program and they grew as individuals [while] starting the process to enroll in the program, and were so happy to have a close up with Mental Health Professionals that care and are willing to spend time with them. I deeply appreciate the Summer Program. It is a great opportunity for my students interested in mental health at Bloomington High School.

-Teacher at Bloomington High School

The training information table indicates that the evaluation average of the trainings in Fiscal Year 2019/20 is 4.7 out of 5. This rating reflects higher than average trainee satisfaction for the last 5 years. There was a 4.5% decrease in attendance in Fiscal Year 2019/20, largely because trainings were put on hold in the last quarter of the fiscal year while DBH dealt with the COVID-19 pandemic, however WET has maintained a consistently high volume of courses offered across the last two consecutive fiscal years.

Throughout FY 2019/20, WET was pleased to offer DBH staff the LEAP® Course, which is a one-day facilitator-led training workshop. 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.

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 below, 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 2005/06	4	FY 2013/14	23
FY 2006/07	19	FY 2014/15	29
FY 2007/08	24	FY 2015/16	28
FY 2008/09	24	FY 2016/17	26
FY 2009/10	21	FY 2017/18	36
FY 2010/11	20	FY 2018/19	28 (Plus 7 Vacancies)
FY 2011/12	24	FY 2019/20	35 (Plus 7 Vacancies)
FY 2012/13	25	**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 2007/08	3	FY 2015/16	4
FY 2011/12	1	FY 2016/17	3
FY 2012/13	1	FY 2017/18	5
FY 2013/14	4	FY 2018/19	6
FY 2014/15	3	FY 2019/20	11

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 in 2019/20 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
Total	**396**	**42,020**

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.

"The part of the rotation that had a lasting impact on my career choice was seeing the perspective of a lot of these patients, what they go through, makes it easier to be empathetic and understand."

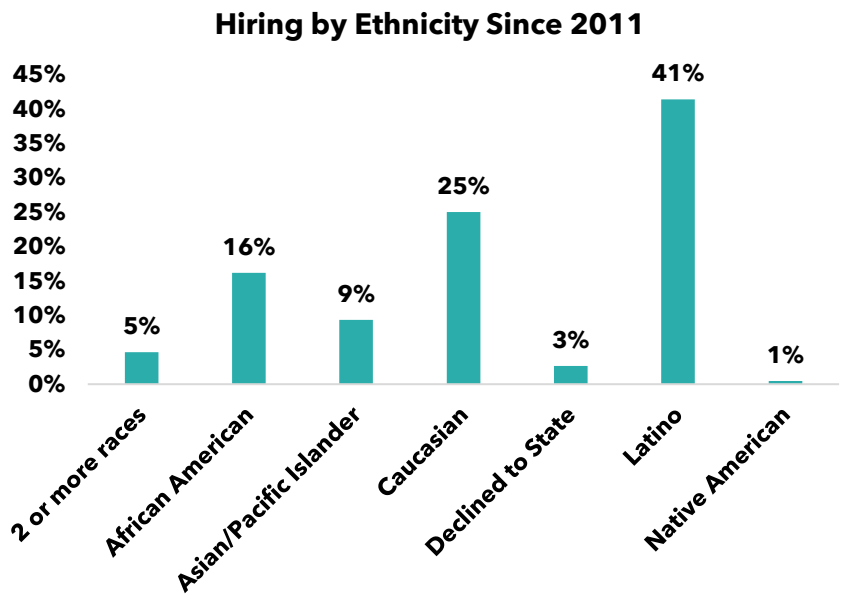
-Western University 3-Year Medical Student

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 2019/20. However, it remains a top priority of the department to continue to recruit and retain bilingual staff.

Fiscal Year	Number of Bilingual Staff	Fiscal Year	Number of Bilingual Staff
FY 2012/13	150	FY 2016/17	171
FY 2013/14	165	FY 2017/18	170
FY 2014/15	162	FY 2018/19	172
FY 2015/16	171	FY 2019/20	211

Most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

"I obtained an unforgettable experience that had prepared me for the next steps in my academic career. I am extremely thankful to have been allowed the opportunity to be a part of a team and collaborate with other professionals, therapists, and doctors, to serve such a special population within our communities.

-MFT Intern

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 2019/20, 54% of interns were bilingual. Of the bilingual interns, **92%** 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%
Total	**179**	**502**	**36%**

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.

The table below provides a breakdown of which degrees the awardees were pursuing.

Fiscal Year	Associate	Bachelors	Masters	Certificate	Total Recipients
12/13	2	5	5	0	12
13/14	0	5	6	0	11
14/15	0	4	3	1	8
15/16	0	5	4	1	10
16/17	1	5	2	1	9
17/18	0	6	4	0	10
18/19	0	2	1	0	3
19/20	0	0	0	0	0

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 is on track to go live again in FY 2020/21.

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

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.

"My supervisors were very knowledgeable about the mental health field, the resources available in the community, and often provided me with insight on different interventions and techniques that were very beneficial to my clients."

-MFT Intern

Success Story

One of the principle challenges as a result of COVID-19 was having to convert in person EHR trainings to online. As a training start date had already been established, the conversion had to be accomplished in less than three weeks. WET, along with IT, were able to meet that challenge and effectually provide training to end-users, and myAvatar launched as planned on July 1, 2020.

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.

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 Cultural Competency and Ethnic Services (OCCES) to help maximize the ability of the existing and potential workforce, contract agencies, and fee-for-service providers, to provide culturally and linguistically appropriate services to County residents by:

- Providing Cultural Competence training to all staff
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as 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

OCCES also works closely with the Workforce Development Discussion (WDD) committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the 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 during Fiscal Year 2014/15. San Bernardino County continues to participate in SCRP as a member county.

"Being able to serve the community in this particular area was an honor. It had special meaning to me because I was born and raised in the High Desert and always wanted to give back in a positive way. This rotation allowed me to do that. I hope to have made a lasting impact during my time spent in the area. Helping those who suffer from mental illness is rewarding. I hope to have made a lasting impact from my time spent here."

-California State University, Nurse Practitioner (NP) Student

Workforce Education and Training

Challenges and Solutions

The WET program experienced the following challenges in FY 2019/20:

- 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 by PFA focus group session in February 2019
- Insufficient number of site supervisors and meeting the needs of nontraditional schools for the Internship programs
- State support for some financial incentives has ended
- 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 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

"This internship enabled me to gain first-hand exposure to working in the real world. It also allowed me to harness the skill, knowledge, and theoretical practice I learned in school. The experience of trying something new is extremely beneficial. The experiences we go through are what shapes us. In my experience with DBH, internship has encouraged not only personal development but also greater self-understanding. Finding this level of clarity is difficult, but sometimes all it takes is trying something new, out of your comfort zone, and this program did just that. I am so grateful to have had such a valuable internship to put my knowledge to practice."

-BSW Intern

Outreach and Engagement

In Fiscal Year 2019/20, 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)	26	2,850
College Career Fairs	11	886
Classroom Presentations	19	1,970
Mock Interviews	3	112
Total	**59**	**5,818**

Capital Facilities and Technological Needs

Introduction

The Capital Facilities and Technological Needs Component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs' funds produce long-term impacts with lasting benefits that support the behavioral health system's movement towards the recovery, resiliency, cultural competence, a help first model, and expansion of opportunities for accessible community-based services for consumers and their families. These efforts include the development of a variety of technology uses and strategies and/or community-based facilities that support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

The San Bernardino County Department of Behavioral Health (DBH) has embraced the transformational concepts inherent to MHSA to develop a wellness focused Capital Facilities and Technological Needs component that supports the public behavioral health system and infrastructure to improve the delivery of services across the county.

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.

Program Description (cont.)

Technological Needs

The overarching goal of the technological needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in the quality of care, operational efficiency, coordination of care, and cost effectiveness across the Department.

Data Warehouse

Research and Evaluation manages the Data Warehouse which brings together data from diverse sources and are combined to provide consistency in advanced analytics. The reports generated from the data gathered is used to analyze services and trends to help improve the delivery of behavioral health services. Reports generated from the data assist in driving the evaluation of, and decision making around, program planning across the continuum of care. The information generated from the data is necessary in the application process when the County seeks to secure additional funds for the expansion of behavioral health services.

Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)

DBH is in the implementation phase of a BHMIS that will support secure access and exchange of health information by providers. Replacement of the Department of Behavioral Health's (DBH) 25 year old information system will consist of implementing a new integrated BHMIS that incorporates an EHR. The purpose of the EHR is to provide an efficient system to support better capturing of information, allowing providers to fully document care in a manner that fosters consumer and family interactions, and enables highly functional reporting and data aggregation, as well as enhances coordination of care between internal and external providers.

Capital Facilities and Technological Needs

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 data warehouse to generate reports
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Maintain the TeleMed 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 I of the Electronic Health Record was implemented on July 1, 2020. Phase II of the EHR is being implemented with a go-live target of the second quarter in 2021.

Technological Needs

Data Warehouse analyses data for better coordination of care within several county departments. Program outcomes analysis was performed to determine the impact of the Three Year Plan. Information was used to advocate for policies affecting consumers, department, and county.

Positive Results (cont.)

To address the goal to increase access to services, DBH is monitoring the time it takes from when a consumer had their initial appointment to the time it took for the consumer to receive services for mental health and substance use disorder (SUD) services. DBH has rolled out Avatar and the universal use of the Initial Contact Log which has provided DBH with substantial data than what was previously available. DBH is continuing to monitor appointment to service timelines to assist DBH in accomplishing its goal to ensure consumers receive timely access to services.

The implementation of the telehealth network and the expansion of remote access for staff, provided an enhanced service delivery model for DBH consumers and staff. The enhancement has become standard practice and is now being implemented in all capital improvement projects going forward. The enhancement also resulted in the ability to support the Trona Response Team in assisting the victims of the Trona earthquake in July of 2019 to remotely receive DBH services.

The new DBH Call Center commenced on August 1, 2020 in San Bernardino. The center centralizes all calls for the ACCESS Unit and the Substance Use Disorder and Recovery Services (SUDRS). The phone system utilizes the CISCO Unified Contact Center and was designed to allow DBH staff to answer calls remotely and connect to the phone center. Calls are routed calls to the next representative providing seamless access to services. The phone system provides features including call queuing, comprehensive reporting, call volume and dashboards for real time view of calls.

Challenges and Solutions

Technological Needs

The challenges with the Electronic Health Record (EHR) continue including sufficient staffing and recruiting staff with the unique skillset necessary to support the complexity of healthcare systems.

Transferring of data from legacy and supporting systems into the new system is also challenging due to the difference in configuration and compatibility between systems.

The continuous changes at the state and federal level poses the continuous challenge in meeting the goals for the Behavioral Health Management Information Systems (BHMIS) while the data in the new system is being configured.

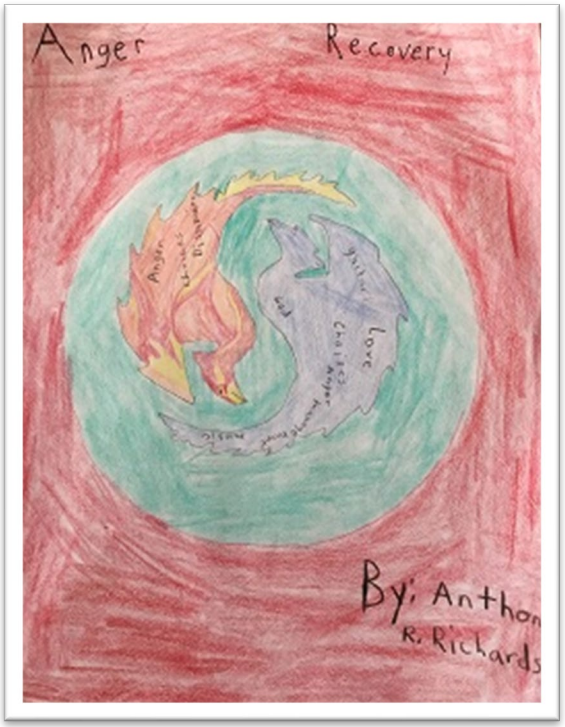
As of July 1, 2020, myAvatar went live and data began being captured in BHMIS. The transitioning of the data source from SIMON to BHMIS was delayed. The delay created timing issues with programming preparation in replacement of major data source feeding the Data Warehouse.

Network Adequacy reporting determined the need for additional clinical staff. This need was met by increasing clinical staff. Additionally, the Geographic Information System (GIS) mapping of clients and clinics is used to measure travel time and distance. As a result of identifying that consumers in Trona were not within a timely radius of services, an alternative access plan was created to facilitate services being rendered in Ridgecrest.

Program Updates

Technological Needs

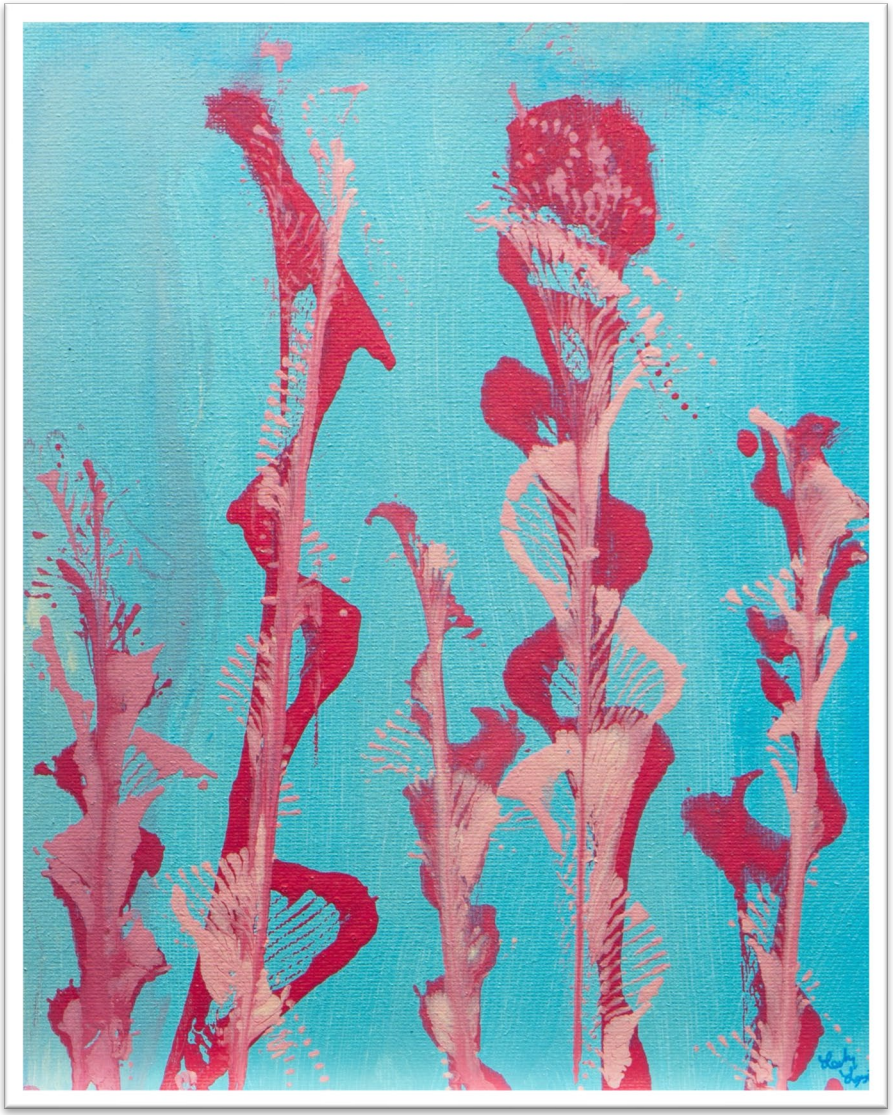
The contract with SAS has been modified to include installation updates to the Data warehouse in the amount of $5,400.00.



Artwork by Anthony Richards

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 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/2022 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 129,343,968	$ 18,982,491	$ 11,294,995	$ -	$ 358,942	$
2. Estimated New FY 2021/2022 Funding	$ 81,430,000	$ 20,360,000	$ 5,360,000	$	$	$
3. Transfer in FY 2021/2022	$ (9,406,160)	$	$	$ 3,981,392	$ 5,424,768	$
4. Access Local Prudent Reserve in FY 2021/2022	$	$	$	$	$	$
5. Estimated Available Funding for FY 2021/2022	$ 201,367,808	$ 39,342,491	$ 16,654,995	$ 3,981,392	$ 5,783,710	$
B. Estimated FY 2021/2022 MHSA Expenditures	$ 82,656,856	$ 17,995,062	$ 5,984,414	$ 3,981,392	$ 5,783,710	$
G. FY 2021/2022 Unspent Fund Balance	$ 118,710,952	$ 21,347,429	$ 10,670,581	$ (0)	$ -	$

H. Estimated Local Prudent Reserve Balance		
1.	Estimated Local Prudent Reserve Balance on June 30, 2021	$ 21,655,429.00
2.	Contributions to the Local Prudent Reserve in FY 2021	$
3.	Distributions from the Local Prudent Reserve in FY 2019/2020	$
4.	Estimated Local Prudent Reserve Balance on June 30, 2022	$ 21,655,429.00

Prevention and Early Intervention FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

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	$ 19,094,445	$ 3,240,150	$ 6,249,282		$ 3,010,336	$ 6,594,677
Outreach for Recognition of Early Signs of Mental Illness						$
1. PEI CI-1 Promotores de Salud/Community Health Care Worker	$ 968,165	$ 804,082			$ 152,636	$ 11,446
2. PEI CI-4 Behavioral Health Ministries Pilot Project	$ 100,000	$ 98,818				$ 1,182
Stigma and Discrimination Reduction						$
1. PEI CI-3 Native American Resource Center	$ 500,000	$ 494,089				$ 5,911
Prevention						$
1. PEI SI-2 Preschool PEI Program	$ 377,725	$ 373,259				$ 4,466
2. PEI SI-3 Resilience in Promotion in African American Children	$ 991,597	$ 979,874				$ 11,723
3. PEI SE-1 Older Adult Community Services	$ 896,682	$ 873,979				$ 22,703
4. PEI SE-5 Lift	$ 469,425	$ 463,875				$ 5,550
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 217,666	$ 215,092				$ 2,573
Prevention and Early Intervention						$
1. PEI CI-2 Family Resource Center	$ 3,390,760	$ 3,350,672				$ 40,088
2. PEI SE-3 Community Wholeness and Enrichment	$ 878,379	$ 867,994				$ 10,385
3. PEI SE-4 Military Services and Family Support	$ 690,288	$ 682,127				$ 8,161
4. PEI SI-1 Student Assistance Program (SAP)	$ 4,467,240	$ 2,248,091	$ 1,462,050		$ 704,283	$ 52,815
Early Intervention						$
1. PEI SE-7 Early Psychosis Program	$ 1,000,000	$ 988,177				$ 11,823
PEI Programs	$ 34,042,372	$ 15,680,278	$ 7,711,332	$ -	$ 3,867,255	$ 6,783,506
PEI Administration	$ 2,110,587	$ 1,752,889			$ 332,745	$ 24,953
PEI Assigned Funds	$ 561,894	$ 561,894				
Total PEI Program Estimated Expenditures	$ 36,714,853	$ 17,995,062	$ 7,711,332	$ -	$ 4,200,000	$ 6,808,459

Community Services and Supports FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

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)	$ 37,641,475	$ 18,103,594	$14,991,469		$ 3,668,262	$ 878,150
2. C-2 Integrated New Family Opportunity Program (INFO)	$ 1,123,161	$ 553,618	$ 447,321		$ 109,455	$ 12,767
3. TAY-1 TAY One Stop Center	$ 5,298,586	$ 2,612,054	$ 2,110,268		$ 516,361	$ 59,903
4. A-2 Adult Criminal Justice Continuum of Care	$ 8,446,653	$ 3,250,513	$ 3,364,048		$ 823,149	$ 1,008,943
5. A-3 Assertive Community Treatment Model FSP Services	$ 2,788,412	$ 1,374,567	$ 1,110,541		$ 271,738	$ 31,566
6. A-7 Housing and Homeless Services Continuum of Care	$ 9,977,638	$ 4,977,141	$ 3,973,794			$ 1,026,704
7. OA-1 Age Wise	$ 2,974,689	$ 1,713,771	$ 1,184,729			$ 76,189
8. A-11 Regional Adult Full Service Parnership (RAFSP)	$ 6,128,243	$ 3,020,493	$ 2,440,695		$ 597,214	$ 69,842
Non FSP Programs	$ 74,378,858	$				
1. A-1 Clubouse	$ 3,113,864	$ 3,078,448				$ 35,416
2. A-4 Crisis Walk-In Centers (CWIC)/CrisisStabilization Units (CSU)	$ 16,932,627	$ 7,889,384	$ 6,743,757		$ 1,650,129	$ 649,357
3. A-5 Diversion Programs	$ 6,399,922	$ 3,154,928	$ 2,548,897		$ 623,689	$ 72,407
4. A-6 Community Crisis Response Team (CCRT)/Crisis Intervention Training (CIT)	$ 7,886,926	$ 4,656,678	$ 3,141,126			$ 89,122
5. A-9 Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 3,537,355	$ 3,497,334				$ 40,021
6. A-10 Crisis Residential Treatment Program (CRT)	$ 15,616,129	$ 6,209,384	$ 6,219,435		$ 1,521,833	$ 1,665,477
7. A-13 Adult Transitional Care Programs	$ 8,810,337	$ 4,343,307	$ 3,508,893		$ 858,591	$ 99,547
8 A-15 Recovery Based Engagement Support Teams (RBEST)	$ 1,637,501	$ 807,181	$ 652,168		$ 159,579	$ 18,574
CSS Programs	$ 63,934,662	$	$			$
CSS Administration	$ 15,298,939	$ 13,414,462	$ 1,711,593			$ 172,883
CSS MHSA Housing Program Assigned Funds	$	$	$	$	$	$
Total CSS Program Estimated Expenditures	$ 153,612,459	$ 82,656,856	$54,148,733	$ -	$ 10,800,000	$ 6,006,868
FSP Programs as Percent of Total	%					

Innovation FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

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)	$ 3,931,606	$ 3,068,252	$ 689,107			$ 174,247
2.	INN-09	Eating Disorder Collaborative	$ 2,263,310	$ 1,766,303	$ 396,699			$ 100,309
3.	INN-10	Multi County Full Service Partnership (FSP)	$ 136,039	$ 130,010	$			$ 6,029
4.	INN-11	Cracked Eggs	$ 296,956	$ 283,795	$			$ 13,161
5.	INN-12	Integrated Behavioral Health Project	$ -	$	$			$
		INN Programs	$ 6,627,911	$ 5,248,359	$ 1,085,806	$ -	$ -	$ 293,746
		INN Administration	$ 943,168	$ 736,055	$ 165,312			$ 41,801
		Total INN Program Estimated Expenditures	$ 7,571,079	$ 5,984,414	$ 1,251,118	$ -	$ -	$ 335,547

Workforce Education and Training FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

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	$ 493,807	$ 493,807	$			$
2. Leadership Development	$ 20,085	$ 20,085	$			$
3. Intership Program	$ 1,247,159	$ 1,247,159	$			$
4. Psychiatric Residency Program	$ 830,000	$ 830,000	$			$
5. Financial Incentive Program	$ 15,450	$ 15,450	$			$
WET Programs	$ 2,606,501	$ 2,606,501	$			$
WET Administration	$ 1,178,438	$ 1,178,438	$			$
WET Contribution	$ 196,453	$ 196,453	$	$	$	$
Total WET Program Estimated Expenditures	$ 3,981,392	$ 3,981,392	$ -	$ -	$ -	$ -

Capital Facilities and Technological Needs FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2021/22

	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	$ 300,762	$ 300,762				
2. Behavioral Health Management Information Systems (BHMIS) Replacement Project	$ 1,279,151	$ 3,314,322				
CFTN Projects	$ 3,615,084	$ 3,615,084				
CFTN Administration	$ 2,168,626	$ 2,168,626				
Total CFTN Program Estimated Expenditures	$ 5,783,710	$ 5,783,710	$ -	$ -	$ -	$ -