



Artwork by Raquel Acosta

Mental Health Services Act Annual Update FY 2015-16



Behavioral Health

Message from the Director

Welcome to the San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Fiscal Year (FY) 2015/2016 Annual Update. Since the inception in 2005, MHSA funded programs have provided enhancements to the public behavioral health system of care that promote wellness, recovery, and resilience and include the values of cultural competency, community-based collaboration, and meaningful inclusion of clients and family members in all aspects of behavioral health planning and services.

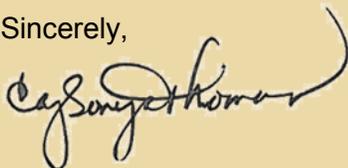
The Annual update is the opportunity for the Department to highlight the accomplishments of the previous fiscal year, engage the community in stakeholder-informed decisions, and update the Fiscal Year (FY) 2014/15 through FY 2016/17 MHSA Three-Year Integrated Plan.

The last year marked the development and implementation of the MHSA Three-Year Integrated Plan, allowing the department the opportunity to focus on a cohesive system of behavioral health services and care. With that movement, came the opportunity to enhance program and system evaluation efforts and improve upon our already robust Community Program Planning (CPP) process – both exciting features reflected in this Annual Update. Highlights include enriched community education, development of additional community-friendly materials and reports, and involvement in system-wide program and process evaluation activities. All of this information, and more, can be found in this comprehensive document.

It is my hope that you find the Annual Update informative and a reflection of both the progress of the Department in meeting the intent of the MHSA and the Wellness Component contained within the Countywide Vision. Together we move to support a healthy county that values prevention programs, superior healthcare services, and reducing chronic disease and socio-economic disparities through health education, promotion of healthy lifestyles, and development of outcome-based health services. We look forward to continuously increasing the collaboration between and among providers and community-based organizations.

Thank you for taking the time to review and provide feedback on this plan. The DBH Office of Program Planning and Development looks forward to receiving your input at DBH-MHSA@dbh.sbcounty.gov.

Sincerely,



CaSonya Thomas, MPA, CHC
Director, Department of Behavioral Health
County of San Bernardino



Our job is to create a county in which those who reside and invest can prosper and achieve well-being.

Mensaje de parte de la Directora

Bienvenido a la Actualización Anual del Año Fiscal (FY, por sus siglas en inglés) 2015/2016 de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) del Departamento de Salud Mental (DBH, por sus siglas en inglés) del Condado de San Bernardino. Desde el inicio el año 2005, los programas financiados por MHSA han brindado mejoras en el sistema de atención pública de salud mental que promueven el bienestar, la recuperación y la resiliencia y que incluyen los valores de la competencia cultural, la colaboración basada en la comunidad y la inclusión significativa de clientes y familiares en todos los aspectos de la planificación y servicios de salud mental.

La actualización anual es la oportunidad para que el Departamento destaque los logros del año fiscal anterior, involucre a la comunidad en las decisiones informadas de las partes interesadas y actualice el Plan Integrado de Tres Años del año fiscal (FY, por sus siglas en inglés) 2014/15 al FY 2016/17.

El año pasado marcó el desarrollo y ejecución del Plan Integrado de MHSA de Tres Años, lo que permite al departamento la oportunidad de centrarse en un sistema coherente de servicios y cuidados de salud mental. Con ese movimiento llegó la oportunidad de mejorar los esfuerzos del programa y la evaluación del sistema y mejorar nuestro proceso ya sólido de Planificación de Programas Comunitarios (CPP, por sus siglas en inglés) - ambas características interesantes se reflejan en esta Actualización Anual. Los puntos destacados incluyen enriquecimiento de educación comunitaria, desarrollo de materiales e informes adicionales favorables a la comunidad, y la participación en los programas y procesos de las actividades de evaluación de todo el sistema. Toda esta información, y más, se puede encontrar en este documento integral.

Es mi esperanza que usted encuentre la Actualización Anual informativa y un reflejo tanto de los avances del Departamento en el cumplimiento de la intención de MHSA y el componente de bienestar contenido dentro de la visión del Condado. Juntos nos movemos para apoyar un condado saludable que valora los programas de prevención, los servicios superiores de salud, y la reducción de las enfermedades crónicas y las disparidades socio-económicas a través de la educación de salud, la promoción de estilos de vida saludables, y el desarrollo de los servicios de salud basados en los resultados. Esperamos aumentar continuamente la colaboración de y entre los proveedores y las organizaciones basadas en la comunidad.

Gracias por tomarse el tiempo en revisar y ofrecer retroalimentación en este plan. La Oficina del Programa de Planificación y Desarrollo de DBH espera recibir sus opiniones en DBH-MHSA@dbh.sbcounty.gov.

Atentamente:



CaSonya Thomas, MPA, CHC
Directora, Departamento de Salud Mental
Condado de San Bernardino



Nuestra labor es crear un condado en el cual los que viven e invierten puedan prosperar y lograr el bienestar.

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MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

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: CaSonya Thomas	Name: Larry Walker
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E-mail: cthomas@dbh.sbcounty.gov	E-mail: larry.walker@atc.sbcounty.gov
Local Mental Health Mailing Address: 303 East Vanderbilt Way San Bernardino, CA 92415-0026	

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.

CaSonya Thomas
Local Mental Health Director (PRINT)

Veronica A. Kelley, LCSW
[Signature] 7/2/15
Signature Date

I hereby certify that for the fiscal year ended June 30, 2014, 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 12/19/14 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, 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.

Sonia Hermosillo, Chief Deputy, Disbursements
County Auditor Controller / City Financial Officer (PRINT)

[Signature] 7/2/15
Signature Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)



Behavioral Health Commission Meeting

Executive Summary

Executive Summary

Introduction

The Mental Health Services Act (MHSA) is a driving force behind the transformation of the public mental health system. Through the MHSA, county agencies ensure that the community has input into defining how programs should operate and is involved in the development, implementation, and evaluation of MHSA funded programs. This approach assists the Department of Behavioral Health (DBH) in integrating the needs of diverse individuals, families, and communities in its programming.

The San Bernardino County Mental Health Services Act (MHSA) Fiscal Year (FY) 2015/16 Annual Update provides a comprehensive overview of the MHSA programs and services that contribute to sustaining the health and wellness of the County populace. It highlights the recent robust community planning process conducted by DBH with the community, highlights Behavioral Health program goals and related outcomes, provides updates to the approved FY 2014/15 through 2016/17 MHSA Integrated Plan, as well as demonstrates the ongoing planning that DBH and their stakeholder committees have been engaging in over the last decade. The programs contained in the Update are designed to develop a continuum of services in which consumers, family members, providers, county agencies, staff, and faith and community-based organizations can work together to systematically improve the public mental health system.

The Annual Update is an example of the Department of Behavioral Health's (DBH) efforts to continue to weave programs together in an uninterrupted pathway to recovery that is easy to travel and provides access in a way that individuals do not have to bear the burden of navigation on their own. Program successes are described and areas of opportunity are included, such as continued efforts to improve evaluation of programs across multiple domains, enhancing the use of technology in clinical care, the need to build out the service continuum, and successful client engagement strategies. The overall purpose of the Annual Update is to inform community stakeholders, leadership and policy makers in the administration and management of public Behavioral Health Programs of changes in the provision of services, as well as meet the regulatory requirements of the MHSA.

Background

In November 2004, California voters passed Proposition 63, which imposed a 1% tax on adjusted annual income over \$1,000,000 to adopt the Mental Health Services Act (MHSA) (effective January 1, 2005). According to the MHSA, the intent of the funding is "to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness..." In addition, local mental health delivery systems have been charged to "create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with serious mental illness and resilience for children and youth with serious emotional disorders and their families." The MHSA identifies five (5) primary program components for funding that are locally developed via a Community Program Planning (CPP) process that is now integrated into a Three-Year Program and Expenditures Plan (Plan). An update to the Plan, such as this document, is required on an annual basis. The components include:

- ◆ Prevention and Early Intervention.
- ◆ Community Services and Support.
- ◆ Innovation.
- ◆ Workforce Education and Training.
- ◆ Capital Facilities (buildings and housing) and Technology Needs.

In alignment with the Mental Health Services Act (MHSA) Transformational Framework, San Bernardino County Department of Behavioral Health (DBH) has embraced the concepts of community-driven, culturally competent, recovery services.

Executive Summary

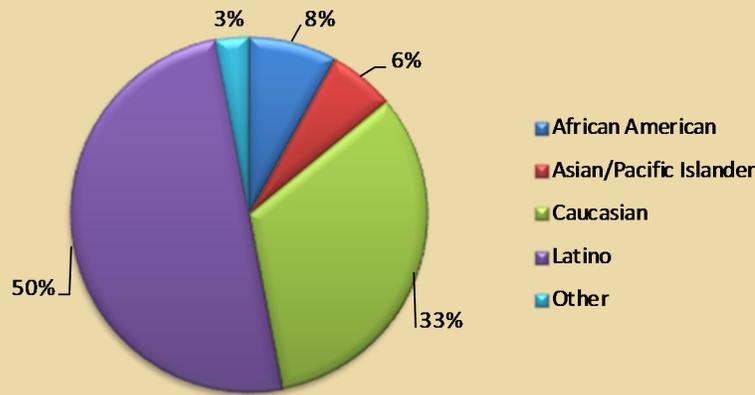
Overview of San Bernardino County

San Bernardino County is located in Southeastern California, approximately **60** miles inland from the Pacific Ocean. The County is the largest, in terms of land mass, in the continental United States, covering over **20,000** square miles. There are **24** cities in the County and multiple unincorporated and census designated places. Over **80%** of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). According to the California Department of Finance, the estimated population for 2014 is **2,085,669**. Approximately **75%** of the County population resides in the Valley region of the County, which accounts for only **2.5%** of the land.

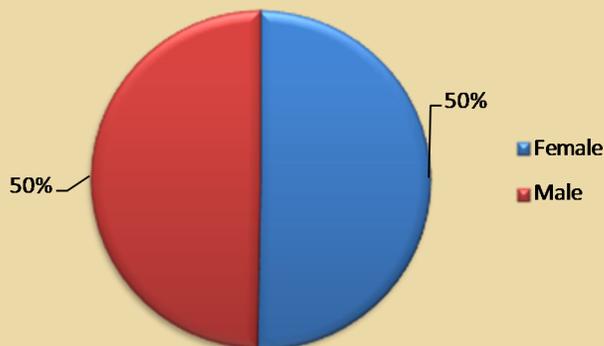
The County has four (**4**) military bases, utilizing **14%** of the land, which include: Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

San Bernardino County is the fifth largest county in the State of California in terms of population and ethnic diversity. The largest population in the county is Latino, with **50%**, followed by Caucasian, then African American, Asian/Pacific Islander, then Native American. The gender breakdown is nearly even, with **50.3%** male and **49.7%** female.

Countywide Ethnicity



Countywide Gender

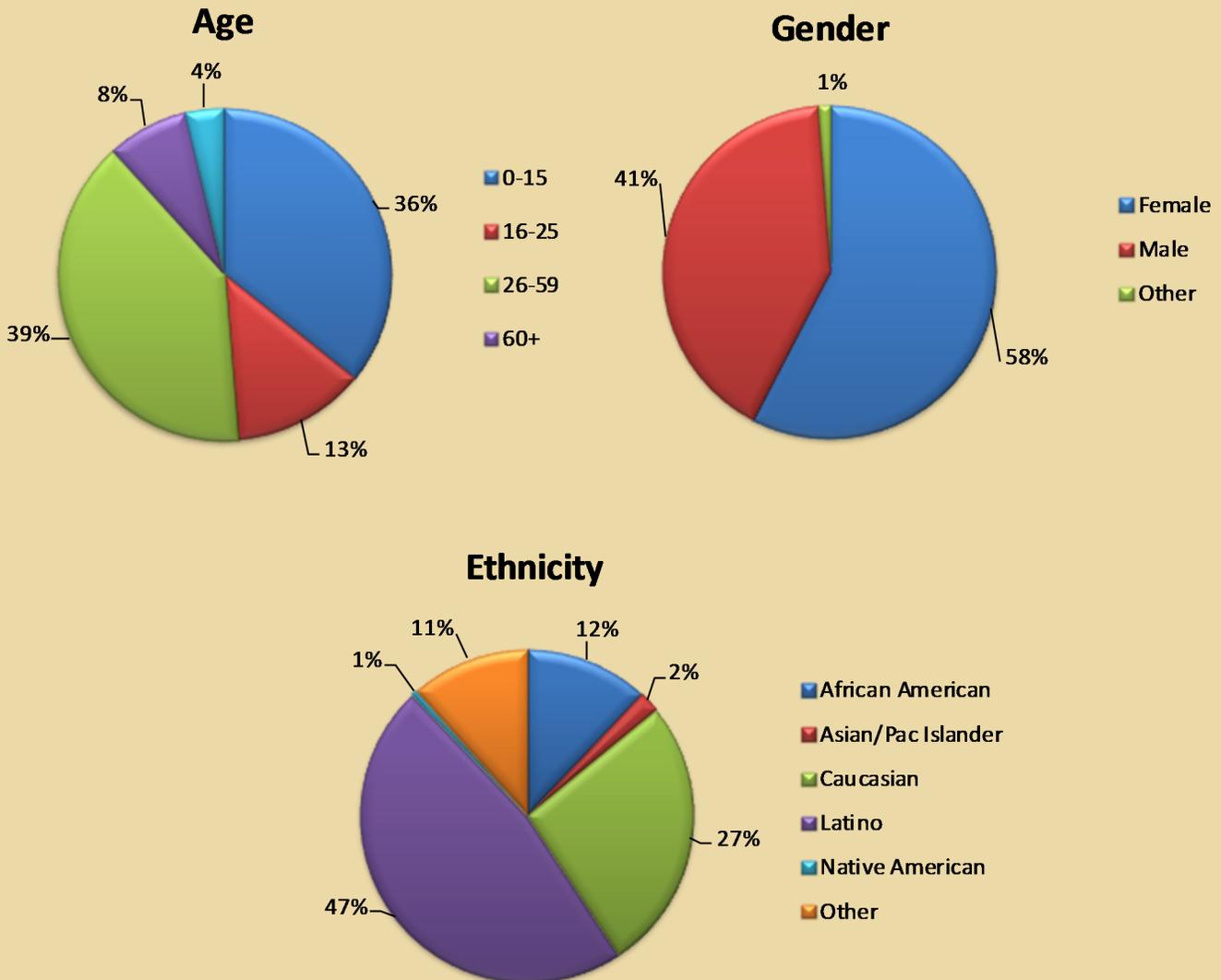


Executive Summary

Demographic Overview of Community Members Served in MHSA Programs

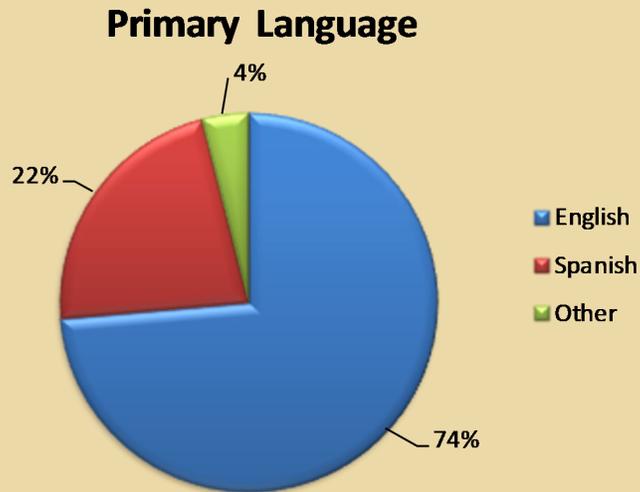
MHSA services are far reaching and span the continuum of care by providing prevention, early intervention, outpatient, full service partnership, and recovery services. Clients served in Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation (INN) components in Fiscal Year 2013/14 totaled **219,000**. This includes individuals that participated in outreach and education activities.

The demographic breakdown related to age category, gender, and ethnicity are as follows:

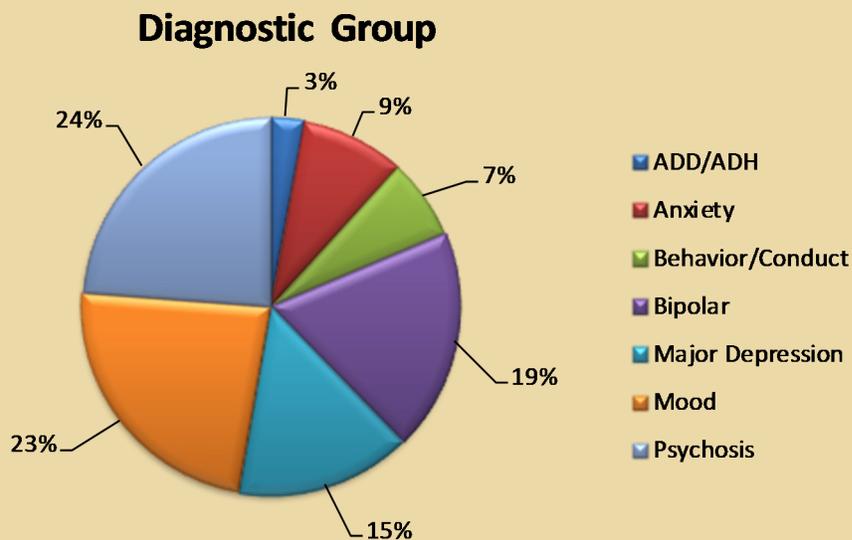


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The demographic breakdown of individuals served across Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation (INN) related to primary language categories are as follows:



The Diagnostic group category describes the primary diagnosis of individuals participating in therapeutic services in Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation.



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Brief Overview of the Components of MHSA

Prevention and Early Intervention

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

The overall Mental Health Service Act (MHSA) goals of PEI include:

- Suicide reduction.
- Reduction of juvenile justice involvement.
- Reduction of school failure/dropout rates.
- Reduction of unemployment among mental health consumers.
- Reduction of prolonged suffering.
- Reduction of homelessness among consumers.
- Reduction of stigma and discrimination associated with mental illness.
- Reduction in the number of minor consumers removed from their home.



PEI incorporates the values of cultural competence, consumer and community empowerment, collaboration and inclusion in providing services that emphasize recovery, wellness and resiliency. PEI programs work to transform the public mental health system by meeting both the priority needs identified by local community stakeholders and the key community and priority population needs outlined in the MHSA. Services are designed to meet the needs of three distinct populations:

- Those that are not identified on the basis of individual risk;
- Individuals or groups with known risk factor(s) that can contribute to behavioral health problems;
- Individuals exhibiting early signs of a mental illness or early onset of mental illness or emotional disturbance with psychotic features.

While prevention and early intervention can occur across the entire mental health intervention spectrum, the purpose of the PEI component is to provide programs at the early end of the continuum of care. Prevention programs and services can occur prior to diagnosis and address research identified risk factors. The Early Intervention component provides early access to mental health services for those individuals experiencing their first symptoms of mental illness. PEI also provides relapse prevention and supports. MHSA funding directed toward Prevention and Early Intervention (PEI) services is mandated at **20%** of the overall MHSA funding received.

Since 2008 and with stakeholder input, thirteen (**13**) PEI programs have been developed and implemented. Prevention and Early Intervention programs are designed to allow participants to access services in natural settings where individuals might go for other non-mental health services or activities. Based on these access points, programs have been categorized to fit within three initiatives:

- 1) **School-based Initiatives** - Designed to strengthen student health and wellness by working to reduce behavioral risk factors, barriers and/or stressors, build protective factors and supports, and provide appropriate interventions at schools and after school programs.
- 2) **Community-based Initiatives** - Designed to build and strengthen the capacity of communities to provide prevention and early intervention opportunities in natural settings.
- 3) **System Enhancement Initiatives** - Designed to build and strengthen collaboration across public service organizations and work to implement efforts to promote wellness across all systems.

Executive Summary

School-based Initiative programs include:

- **Student Assistance Program (SAP)** - This program is a science-based model that minimizes barriers to learning as a result of behavioral health issues and supports students in developing academic and personal success. Identified students receive appropriate interventions at school or through referrals. Services can include; group and individual counseling, anger management classes, or curriculum based psychosocial education. A portion of the program is dedicated toward building the capacity of schools to appropriately identify and respond to student behavioral health needs. The estimated funding for this program for FY 2015-16 is \$3,152,746 to serve approximately **33,100** individuals.
- **Preschool PEI Program** - The Preschool PEI program provides support for preschool children (ages 3-5) and education for their parents and teachers. The intent of this program is to prevent and reduce the occurrence of aggressive and oppositional behavior in preschool children in an effort to reduce problem behaviors later in life. There is a bereavement and loss component that works with children to address loss related to death, separation and/or divorce. This program serves children enrolled in the County's Head Start program. The estimated funding for this project is \$425,000 to serve approximately **900** individuals.
- **Resilience Promotion in African-American Children (RPiAAC)** - This program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families by incorporating African American values, beliefs and traditions in mental health educational programs. This program promotes resilience in African American children in order to mediate the development of mental health and/or substance abuse disorders. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, on-going weekly interventions, career-related presentations, parent support/education and linkage to additional resources. The estimated funding for this project is \$672,477 to serve approximately **2,000** individuals.

Community-based Initiative Programs include:

- **Promotores de Salud/Community Health Workers (PdS/CHW)** - The PdS/CHW program is designed to increase awareness and access to community-based prevention and mental health services without stigma or fear of discrimination. This program promotes health awareness, education and available resources for the members of various culturally-specific populations throughout the county in a culturally and linguistically appropriate manner. Services are specifically targeted at unserved and underserved groups, including Latino and Spanish-speaking communities, African-American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities. The estimated funding for this program is \$1,148,630 to serve approximately **31,400** individuals.
- **Family Resource Centers (FRC)** - FRCs offer various culturally and linguistically competent services tailored to meet the identified needs of the communities they serve. This program serves all ages and includes the following: personal development activities; parent/caregiver support and education; behavioral health education workshops; after school programs for children/youth/transitional age youth; health education workshops; adult skill-based education (e.g. education and employment assistance); community counseling and individual counseling. The estimated funding for this project is \$3,348,583 to serve approximately **22,000** individuals.
- **Native American Resource Center** - The Native American Resource Center functions as a one-stop center offering several prevention and early intervention resources for American Indian and

Executive Summary

Alaskan Native participants of all ages. The center provides services utilizing strength-based traditional Native-American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development and education assistance. The estimated funding for this program is \$500,000 to serve approximately **2,200** individuals.

- **National Curriculum and Training Institutes (NCTI)® Crossroads Education Program** - NCTI® is a curriculum-based education strategy that fosters positive, pro-social behavior in children (ages 10-15) and transitional age youth (ages 16-25) with emphasis on prior offenders. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process. The curriculum focuses on the relationship between values, attitudes and behaviors as they relate to the decision making process. Class topics include: anger management; life skills; parent education; substance abuse prevention; gang involvement; truancy intervention; graffiti prevention. Parenting classes are offered to the families of those participating in the program. The estimated funding for this program is \$532,900 to serve approximately **4,500** individuals.

System Enhancement Initiative Programs include:

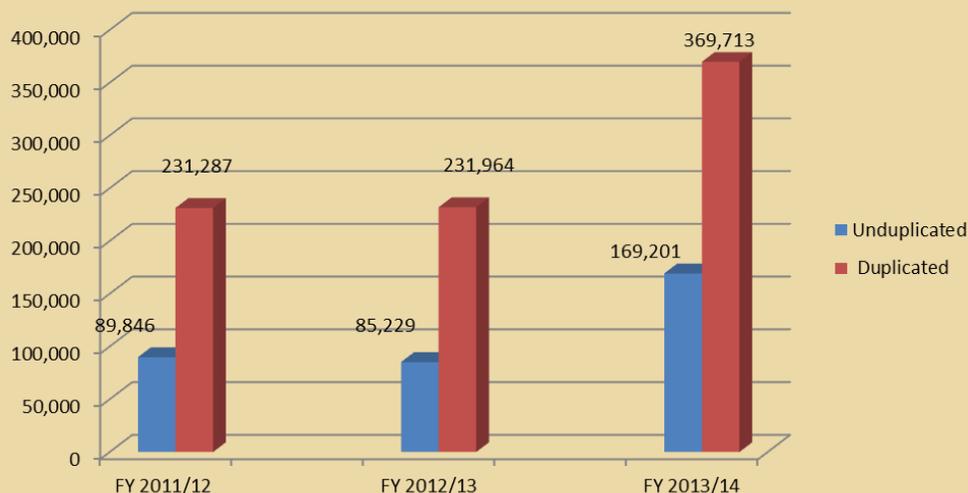
- **Older Adult Community Services (OACS)** - OACS is designed to promote a healthy aging process for older adults (ages 60+) by providing prevention and early intervention services to assist in maintaining positive mental health. Services include mental health and substance abuse screenings, wellness activities, home safety education, suicide prevention services, case management and therapeutic interventions. These services are delivered via a mobile unit, in senior centers, community centers and in the home. The estimated funding for this program is \$900,000 to serve approximately **6,000** individuals.
- **Child and Youth Connection (CYC)** - CYC provides prevention services to children and transitional age youth involved in the foster care and juvenile justice systems. This program is a collaborative between the Department of Behavioral Health (DBH), the Juvenile Public Defender's Office, Children's Network, Children and Family Services (CFS) and local contract providers. Services include mental health screenings, drug assessments therapeutic interventions, and consultations regarding the mental health needs of minors for appointment of appropriate experts to facilitate changes in plan hearings or change of placements. Additionally, a Mentoring Resource Network is maintained where various agencies and stakeholders meet to conduct needs assessments and create mentoring opportunities for system involved youth. The estimated funding for this program is \$3,191,123 to serve approximately **8,500** individuals.
- **Community Wholeness and Enrichment (CWE)** - This program serves transitional age youth (ages 16-25) and adults (ages 26-59) who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder. Services include risk/depression/substance use screenings, community mental health support and education; support groups (including suicide bereavement groups) and short term mental health services. The estimated funding for this program is \$1,442,553 to serve approximately **5,000** individuals.
- **Military Services and Family Support (MSFS)** - The MSFS program addresses the effects of traumatic events and other unique challenges of military life by providing prevention and early intervention services to military personnel and veterans and their families in-home or in other community locations, and includes mental health and substance abuse screenings, case management, and individual and/or family counseling. The estimated funding for this program is \$725,000 to serve approximately **3,500** individuals.

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- **LIFT Home Visitation Program** - The LIFT program seeks to improve the health, well-being and self-sufficiency of low-income mothers and their children. Services are delivered in the home by nurses who provide educational information that promotes the physical and emotional care of children by their mothers, family members and caretakers. Program nurses link family members with needed physical and mental health services. Services also include prenatal screenings, postpartum depression screenings, maternal attachment support, substance use/abuse screenings, support, parenting education/support, life and employment skills development, case management, and assistance with developmental milestones for the child. These services last for the duration of the mother's pregnancy up until the child is two years old. The estimated funding for this program is \$396,000 to serve approximately **100** individuals.
- **Coalition Against Sexual Exploitation (CASE)** - CASE is a collaborative approach between ten public agencies that serve sexually exploited children (ages 12-15) and youth (ages 16-25), or those at risk for sexual exploitation, through a centralized referral mechanism. This former Innovation funded project had community support to continue successful practices as a PEI program. The program coordinates community outreach and education, as well as direct services. Services include mental health assessments, crisis intervention, case management, school enrollment assistance, therapeutic interventions, transportation, placement and linkage/referral to community resources. Collaborating agencies include County Department of Behavioral Health, Department of Public Health, Children and Family Services, Children's Network, District Attorney's Office, Probation Department, Public Defender, San Bernardino County Superintendent of Schools, and Superior Court of California-Juvenile Court Division. The estimated funding for this program is \$436,356 to serve approximately **3,050** individuals.

Highlights of Key PEI Outcomes

The implementation of MHSA services has yielded many positive results. The chart below shows the level of PEI services provided over a three year period. Overall, there has been an average increase in unduplicated services of **19%** and average increase in duplicated services of **22%** over the three year period. This demonstrates an increase in participation in Prevention and Early Intervention services over time.

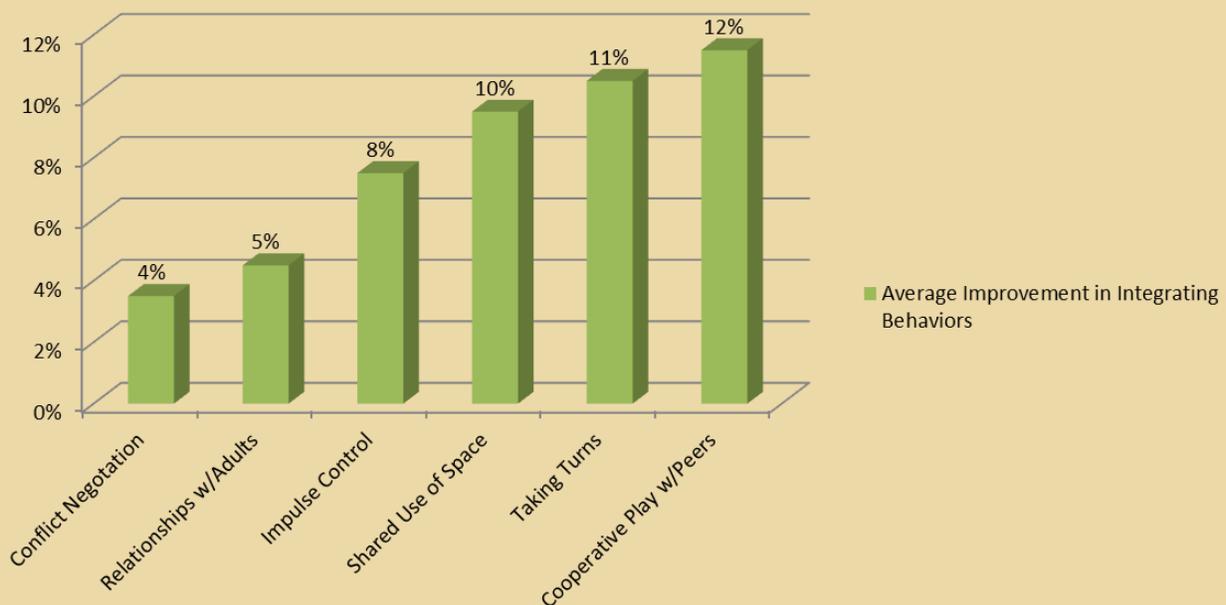


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As previously indicated, an important goal under the Prevention and Early Intervention component is to reduce school failure associated with behavioral health concerns.

The data below provides information about young children involved in PEI services that were exhibiting aggressive behaviors in the preschool classroom environment. Research shows such behaviors have been linked to negative health and psychological outcomes in adolescence and adulthood; early aggressive behavior is also a distinct risk factor for conduct disorders. Additionally, research indicates that the best predictor of delinquent behavior in adolescence is aggression. Delinquency increases the likelihood school failure/dropout; therefore, addressing aggression early on through PEI services builds the protective factors of self regulation, mastery of communication and language skills, and positive social interaction with peers.

**Preschool Students Integrating Positive Behaviors
FY 2011/12 - FY 2013/14**



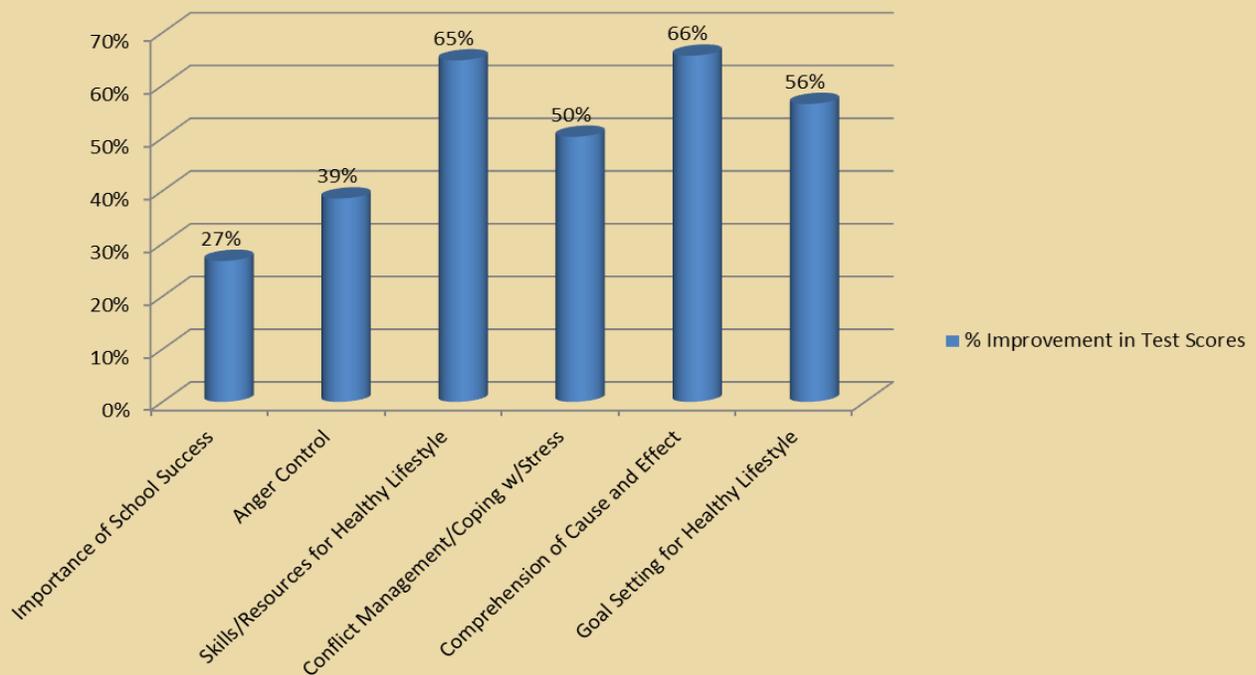
The data illustrates the pre/post test improvement results for preschool students who were engaged in PEI services for a three month period; the test measures the percentage of students that are “integrating” positive behaviors. The chart reflects the average percentage improvement for FY 2011-12 and FY 2013/14 (n=1,285); average improvement across all areas was 8%. “Integrating” behaviors is determined through a variety of observations/documentation; integration means the child is appropriately applying skills and behaviors in the various measurement areas.

Reduction of juvenile justice involvement is an additional goal in the PEI component. NCTI® Crossroads Education© is a curriculum-based education strategy designed to foster positive, pro-social behavior in children (ages 10-15) and transitional age youth (ages 16-25) with emphasis on prior offenders or those at risk of justice involvement. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process.

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The following chart reflects the average percentage of improvement in children/youth's level of understanding/learned objectives in various curriculum areas from the NCTI® Crossroads© program for FY 2011/12 - FY 2013/14 (n= 20,738). The chart shows progress in improving learning and building of protective factors that directly impact and reduce the aforementioned risk factors. This includes: Individual - building positive social orientation, changing perceptions about consequences for breaking the law; Family – building supportive relationships and engaging parental involvement; School – improving commitment in school, recognition of involvement in positive/acceptable activities. Overall, “improvement” across all curriculum areas averaged **50%**.

**Children/Youth Skills-Knowledge
FY 2011/12 - FY 2013/14**



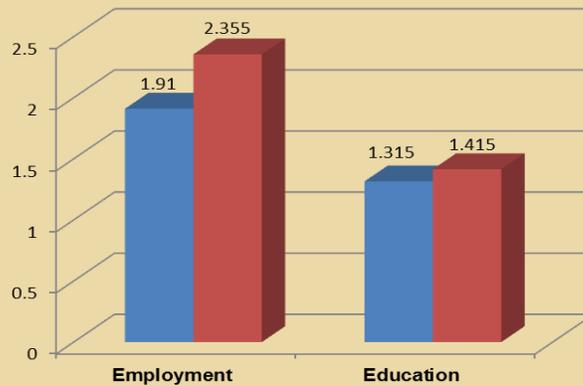
Another important MHSa goal for PEI programs is to decrease unemployment for mental health consumers. An important step toward decreasing unemployment is increasing employment-readiness skills and vocational strengths.

The chart on the following page reflects pre and post scores collected in FY 2013/14 (n=213) (LIFT Program and the Family Resource Centers) in the areas of Employment and Education. As shown, there was an average increase of **24%** in the employment scale and **8%** in education scale. The Employment Scale pre-score shows that individuals had “occasional-seasonal or multiple entry-level jobs” and post shows “stable employment in low-income job.” The Education Scale pre-score shows individual had “less than a 12th grade education” and post-score shows “graduation with a GED or High School Diploma (HSD).”

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Employment Readiness Skills FY 2013/14

**Employment:
24% Average
Increase**



**Education:
8% Average
Increase**



■ Pre
■ Post

Pre – “occasional/seasonal or multiple entry-level jobs”

Post – “stable employment in low income job”

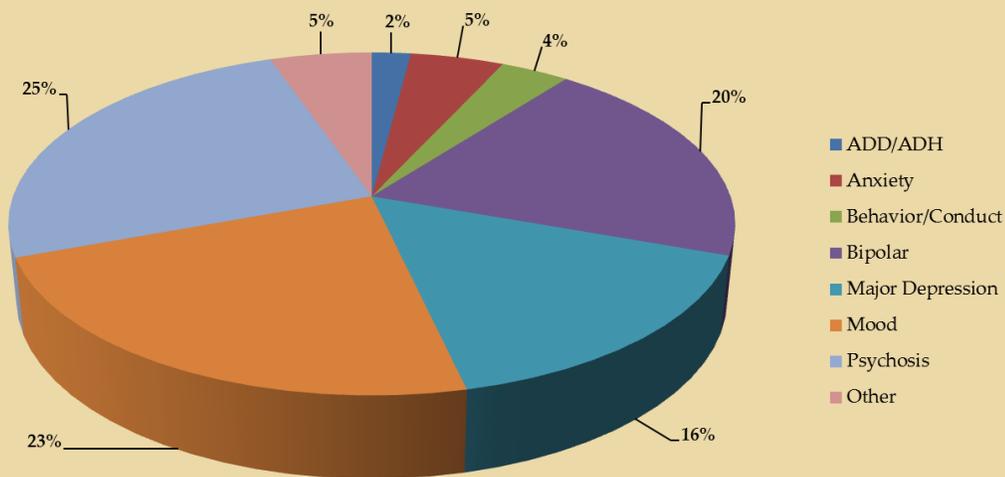
Pre – “less than 12th grade graduation”

Post – “graduation with a GED or HSD”

Community Services and Supports

The majority of MHSA funding (**80%**) is mandated to be directed toward the Community Services and Supports (CSS) component. CSS provides access to mental health services and targets Seriously Emotionally Disturbed (SED) children, youth, and populations with Serious Mental Illness. SED, as defined by regulation, refers to children and youth with difficulty functioning in multiple life domains, such as school, home, and/or community. Serious Mental Illness (SMI) is a term defined by Federal regulations that generally applies to mental disorders that significantly interfere with some area of functioning. The chart below provides an overview of the primary diagnosis of consumers receiving CSS services.

Primary Diagnosis of CSS Clients



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CSS has four primary service purposes:

1) To provide Full Service Partnership (FSP) programs designed for individuals who have been diagnosed with a severe mental illness or serious emotional disturbance and would benefit from an intensive service program. FSP programs continue to develop and improve by identifying and implementing key practices that consistently promote good outcomes for mental health clients and their families.

2) To develop General System Development (GSD) strategies intended to improve programs, services and supports for the identified initial full service populations and for other clients consistent with the MHSA target populations. GSD funds help counties

improve programs, services and supports for all clients and families to change their service delivery systems and build transformational programs and services.

3) To conduct outreach and engagement activities that are specifically aimed at reaching unserved populations. The activities help to engage those reluctant to enter the system and provides funds for screening of children and youth.

4) To develop a Mental Health Services Act (MHSA) Housing Program that offers financing and capitalized operating subsidies for the development of permanent supportive housing, including both rental and shared housing, to serve persons with serious mental illness and their families who are homeless or at risk of homelessness.

The overall Mental Health Service Act (MHSA) goals, as defined by law, for CSS include:

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
- Reduce homelessness and increase safe and permanent housing.
- Increase in self-help and consumer/family involvement.
- Increase access to treatment and services for co-occurring problems; substance abuse and health.
- Reduce 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.

Program strategies under MHSA must address the legislated goals listed above.

This component has greatly contributed to the ongoing transformation of the public mental health system by augmenting existing services, establishing a system of care for crisis services, developing programming to address the needs of Transitional Age Youth (TAY), developing supportive housing and maximizing MHSA funds for housing opportunities and enhancing and expanding wraparound services to children and youth.

There are currently fourteen (14) CSS programs designed to serve all age groups.

- **Comprehensive Children and Family Support Services (CCFSS)** - The Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for inclusion in Full Service Partnerships (FSP) to provide

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“Wraparound” services to diverse children and youth with emotional disturbances and co-occurring disorders. The estimated funding for this program is \$4,520,798 to serve approximately **882** individuals.

- **Integrated New Family Opportunities (INFO)** - The Integrated New Family Opportunity (INFO) program provides mental health services for diverse in-custody and post-custody juvenile children/youth (ages 13-18) and their families that have been unserved or underserved and who are on probation. The estimated funding for this program is \$1,078,845 to serve approximately **55** individuals.
- **Transitional Age Youth (TAY) One Stop Centers** - TAY One Stop Centers provide integrated mental health services to individuals age 16 to 25 with mental and/or emotional problems who may be emancipating from: foster care, group homes, the juvenile justice system, or county jail. The estimated funding for this program is \$4,291,028 to serve approximately **1,400** individuals.
- **Clubhouse Expansion Program** - Clubhouses are recovery oriented centers for members, 18 years or older that operate with minimal support from department staff. Clubhouses provide Wellness, Recovery and Resilience Model programs in stigma free environments for the Seriously Mentally Ill (SMI) population. The estimated funding for this program is \$2,919,505 to serve approximately **8,250** individuals.
- **Forensic Integrated Mental Health Services (FACT, STAR and CIT)** - This program consists of three distinct components:
 - **Forensic Assertive Community Treatment (FACT):** FACT provides a variety of mental health treatment options to meet the needs of probationers with mental illness, using the Assertive Community Treatment (ACT) Model. FACT is a full service partnership.
 - **Supervised Treatment After Release (STAR):** The Supervised Treatment After Release (STAR) program is the treatment provider for the courts in several regions of the County. The STAR program is a full service partnership. Services are delivered as part of a voluntary Mental Health Court.
 - **Crisis Intervention Training (CIT):** Crisis Intervention Training (CIT) is a partnership between law enforcement and behavioral health. Law enforcement staff attends a 32 hour CIT Academy regarding behavioral health issues, alternatives to 5150s in the field and within the officers assigned patrol, and culturally competent interventions.

The estimated funding for this program is \$4,603,199 to serve approximately 475 individuals.

- **Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)** -The ACT program provides intensive case management services 24/7 to maintain high risk clients in the community and provide a system of care to those ready to transition from a locked facility into a lower level of care. The estimated funding for this program is \$2,325,423 to serve approximately **185** individuals.
- **Crisis Walk-in Centers (CWIC)** - The Crisis System of Care provides urgent mental health services to residents of the County of San Bernardino. Crisis Walk-In Clinics (CWIC) provide crisis intervention, crisis risk assessments, medications, referrals to county, contract and community resources, education and, when necessary, evaluations for hospitalization. The estimated funding for this program is \$2,388,710 to serve approximately **8,202** individuals.
- **Psychiatric Triage Diversion Program** - The Triage Diversion Unit is located at Arrowhead Regional Medical Center (ARMC) and provides interventions for those at-risk of hospitalization. Services include screening and assessment, crisis intervention, linkage and referral, placement, transportation, mental health education, discharge planning, and consultation. The estimated funding for this program is \$2,195,270 to serve approximately **4,090** individuals.

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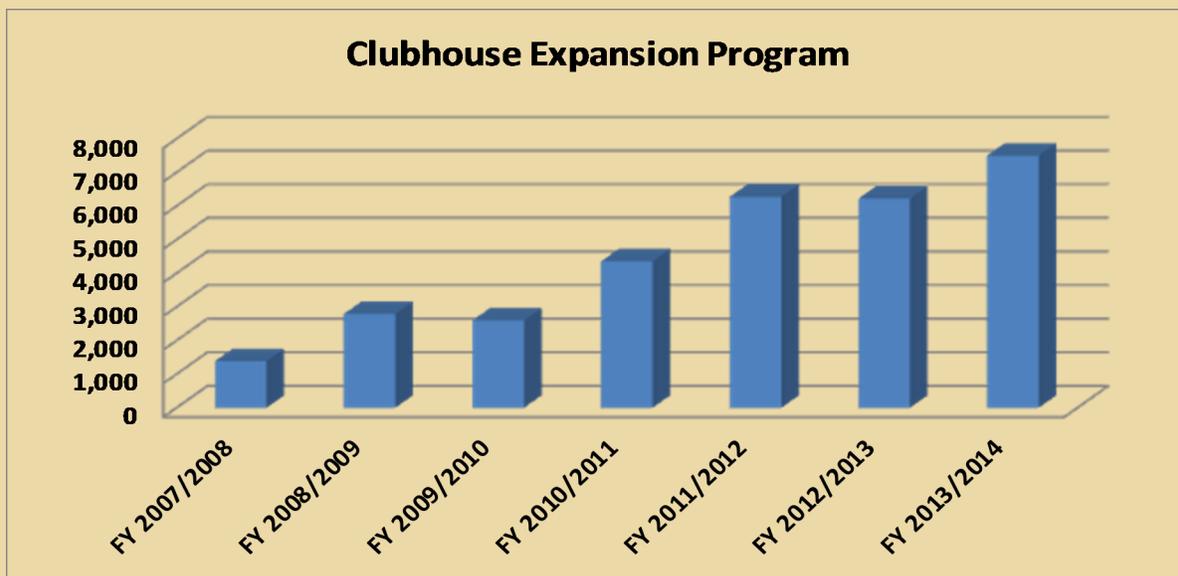
- **Community Crisis Response Team (CCRT)** -The Community Crisis Response Team (CCRT) utilizes specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, medication referrals, and linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations. The estimated funding for this program is \$3,185,633 to serve approximately **5,844** individuals.
- **Homeless Intensive Case Management and Outreach Services** -The Homeless Intensive Case Management and Outreach program is comprised of three focus areas: **Intensive Outreach and Case Management, Integrated Housing and Employment** and **Homeless Outreach Support Team (HOST)** to provide engagement, case management services, emergency shelter beds and permanent supportive services. The estimated funding for this program is \$7,824,164 to serve approximately **1,104** individuals.
- **Big Bear Full Service Partnership** -The Big Bear Full Service Partnership is an alliance of mental health service providers in the geographically isolated Big Bear Lake area that provides mental health services to children and adults. The estimated funding for this program is \$231,345 to serve approximately **145** individuals.
- **Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services** - ACE enhances screening and assessment services at each of DBH's major clinics to expedite access to mental health services, specifically for individuals recently discharged from an inpatient psychiatric hospital. The estimated funding for this program is \$3,237,431 to serve approximately **2,400** individuals.
- **AgeWise-Circle of Care** - The Age Wise Program is a non-traditional mental health program for the high-risk and underserved older adult population. Services include mobile case management services, counseling services, groups provided in the community, and the Senior Peer Counseling program. The estimated funding for this program is \$2,247,902 to serve approximately **194** individuals.
- **AgeWise-Mobile Response** - The program is located in the high desert and provides crisis intervention and mobile response services to prevent hospitalizations and homelessness for older adults in that area. Both the mobile response unit and the Full Service Partnership (FSP) intensive case management services work to identify mentally ill older adults and help them be stable in their own homes and the community. Older adult programs work collaboratively with the Department of Aging and Adult Services. The estimated funding for this program is \$792,757 to serve approximately **150** individuals.



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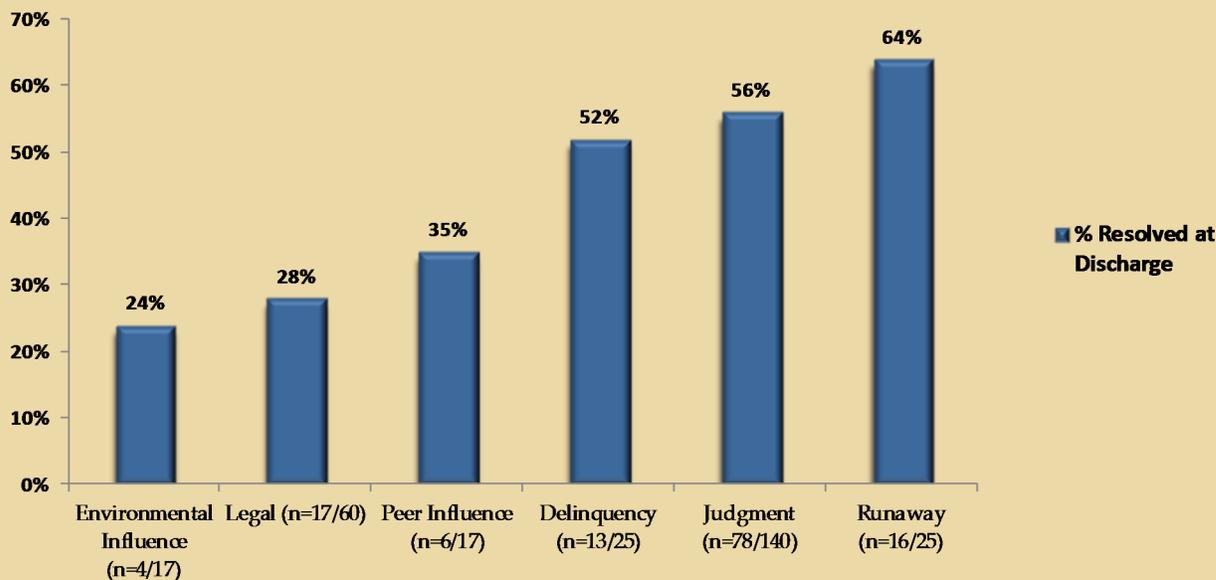
Highlights of Key CSS Outcomes

One of the goals of the MHSA CSS component is to increase self-help and consumer involvement. The design of the Clubhouses is intended to accomplish this objective. The data demonstrates the increasing number of adults participating in adult, consumer run, peer support programs. This is just one of many examples of the numerous outcomes that have resulted from the implementation of the Mental Health Services Act.



Reduction in the juvenile justice system is an important goal for children and youth serving CSS programs. DBH Children Services uses the Child and Adolescent Needs and Strengths (CANS) tool for treatment planning and to monitor clinical progress (See Attachment). For children, mental health services normally occur within the context of a family or with caregivers. The graph below demonstrates decreased delinquency and identified factors that can contribute to delinquency and justice involvement.

Reduce Juvenile Justice Involvement: Decrease Delinquency & Contributing Factors



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Note, in reviewing the data, each line on the graph represents a different domain that is measured. For instance legal issues, runaway behaviors, delinquency behaviors, etc. The number of individuals varies from domain to domain, as it represents the number of children and youth who presented with a challenge in those domains. Not every child/youth has a concern in each domain so there is variance.

The chart demonstrates the percentage of children/youth that resolved issues in each domain area by the time of discharge. For instance: of the **140** children/youth that were identified as having challenges in exercising sound judgment at intake, **56%** of those improved in using positive judgment as a result of services, to the point of the issue being resolved at discharge.

- **64%** eliminated runaway behaviors.
- **52%** eliminated delinquency behaviors.
- **35%** were no longer influenced by negative peer influences.
- **28%** resolved all legal issues.
- **24%** resolved being influenced by their environment.

Percentage of Persons Discharged to Psychiatric Hospitals from Emergency Departments

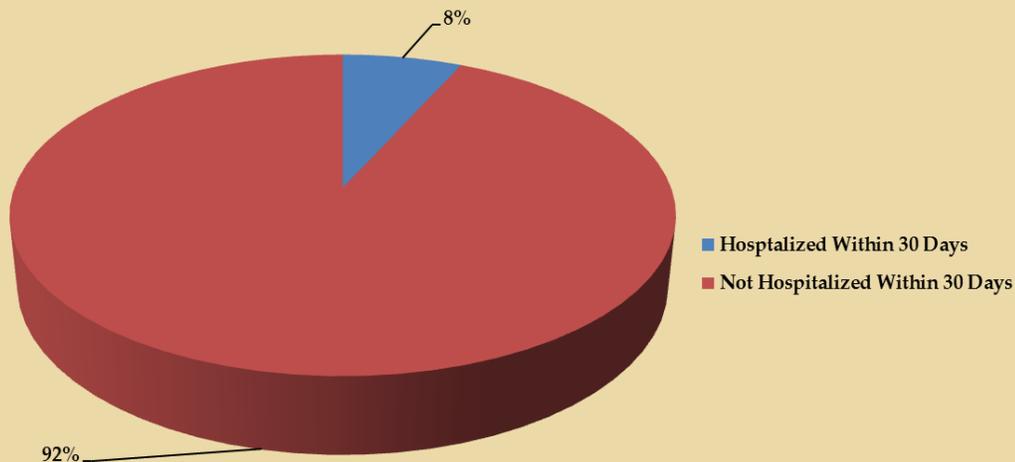


Reducing the rate of unnecessary psychiatric hospitalizations was identified as a desired outcome during early stages of MHSA community planning for CSS programs and continues to be a priority across the system. Review of San Bernardino County specific Emergency Room data from the Office of Statewide Planning and Development spanning from 2005 through 2012 indicates that the number of people across the entire county, from all hospitals, that are discharged from hospital emergency departments to psychiatric hospitals from 2005 through 2012 began decreasing in 2008 through 2010 and then demonstrated a mild increase after that time period (which appears to be leveling off). The slight increase is likely representative of an increase in the overall number of Emergency Department encounters. The chart above shows the percentage of people discharged to psychiatric hospitals across the entire county, from all hospitals, from 2005 through 2012. This graph is a measure to help us consider and review the impacts of Crisis Walk-In Centers.

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The Crisis Walk-in Centers (CWIC) function as an alternative to the Emergency Department for intervening in a mental health crisis. The CWIC provided **4,401** clients with crisis intervention services in fiscal year 2013/14. Of those served, **4,078**, or **92%**, were successfully diverted from unnecessary psychiatric hospitalization and remained in the community for at least 30 days after a treatment episode, which is in alignment with community feedback regarding decreasing inappropriate hospitalizations and overcrowding of Emergency Rooms.

Percentage of Clients Hospitalized Within 30 Days
After a CWIC Visit FY 2013/2014



Innovation

The purpose of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the mental health needs of unserved and underserved populations by expanding or developing services and supports that produce successful outcomes, are considered to be innovative, novel, creative, and/or ingenious mental health practices that contribute to learning rather than a primary focus on providing services. Innovation projects form an environment for the development of new and effective practices and/or approaches in the field of mental 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 mental health care by doing one of the following:

- Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing mental health practice or approach, including, but not limited to, adaption for a new setting or community.
- Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health context or settings.

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This component is unique, as 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).

Every Innovation project must identify one of the following primary purposes:

- **Increase** access to underserved groups.
- **Increase** the quality of services, including better outcomes.
- **Increase** access to services.
- **Promote** interagency collaboration.

Innovation component regulations are currently under review and are pending approval. Changes in the pending regulations include a refined description of the elements in any Innovation project; a clear distinction that Innovation Projects are considered time-limited pilot projects and should have an end date that is not more than four (4) years from the start date of the project; successful parts of the project may continue under a different funding source or be incorporated into existing services; projects may be terminated prior to planned end date; and reporting requirements are defined.

Currently, there are four (4) INN projects in various stages of implementation. In previous years, three (3) INN projects have come to the scheduled end with successful strategies integrated into the system of care and have been discussed in previous annual updates and stakeholder processes. Two more INN projects are coming to a coordinated end, June 30, 2015. At the time of this report, county stakeholders have provided input for how successful strategies can be continued under current programming. The projects that are ending include the Interagency Youth Resiliency Team (IYRT) and Holistic Campus.

In fiscal year (FY) 2015/16, there will be two remaining active INN projects:

- **TAY Behavioral Health Hostel (The STAY)** - This hostel project is a short-term, 14-bed, crisis residential program for the Transition Age Youth (TAY) population, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization. Services are culturally and linguistically appropriate crisis stabilization services, with particular emphasis on diverse youth (African American, Latino, LGBTQ youth, etc.). The hostel is designated to be **80%** peer run, by individuals representing the County's diverse ethnic communities and cultures. The estimated annual funding for this project is \$1,382,256 to serve approximately **96** individuals. Innovation funding for services related to this time-limited project is set to end March 2017 with the final report anticipated for inclusion in the Fiscal Year 2018/19 Annual Update.
- **Recovery Based Engagement Support Team (RBEST)** - The RBEST project provides community (field-based) services throughout San Bernardino County for those mentally ill individuals who are noncompliant and/or resistant to necessary psychiatric care in an effort to "activate" the individual into the mental health system to receive appropriate services. The estimated annual funding for this project is \$1,786,064 to serve approximately **300** individuals. Innovation funding for services is set to end November 2017 with the final report anticipated in subsequent Annual Update.

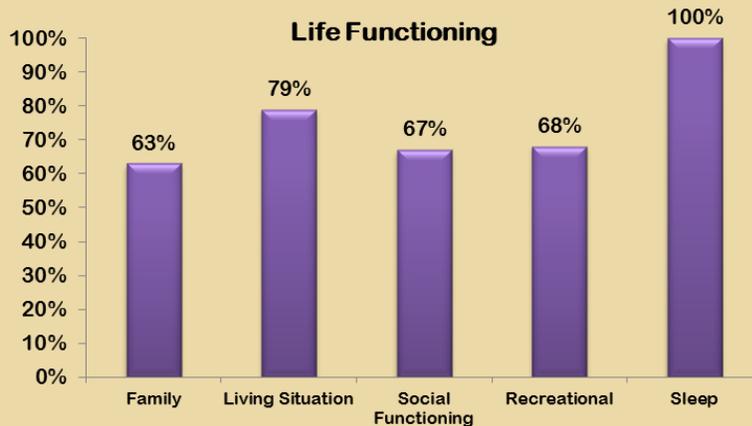
Highlights of INN Outcomes

The TAY Behavioral Health Hostel contributes to learning by making a change to an existing mental health practice that in theory is being practiced in behavioral health systems but is not specific to the TAY population and is not peer run. Previously in San Bernardino County, TAY in crisis could enter the DBH system through interagency referrals, outpatient clinics, TAY centers, and/or Community Crisis teams. TAY could be immediately referred to outpatient treatment or in severe cases inpatient hospitalization in a locked facility. This approach is being tested to determine if the quality of services will be increased, including better outcomes.

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All of the residents at The STAY participate in completing a Child and Adolescent Needs and Strengths (CANS-SB) assessment at time of enrollment and discharge from The STAY. The assessment identifies the youth's difficulties, needs and strengths.

The graph below represent the percentage of youth in FY 2013/14 who presented with a significant issue on a specific item within that domain, and had the issue resolved by the completion of the program.

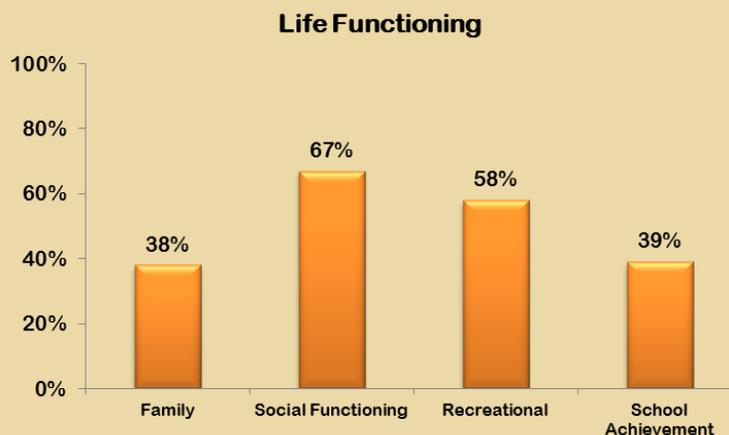


The Interagency Youth Resiliency Team (IYRT) is an intensive trauma informed, culturally appropriate mentoring project developed to more meaningfully connect youth with supportive adults and increase their ability to successfully transition to independence. The primary purpose of the IYRT project is to **increase access to underserved groups**.

IYRT employs mentors who are former foster or probation youth, who understand the unique difficulties and dynamics inherent in being system involved through their own lived experience. By appropriately matching mentors with mentees, culturally appropriate, intensive, trauma-informed mentoring services are provided to youth and their caregivers/resource providers, involved with (or at risk of being involved with) the foster care and/or probation systems.

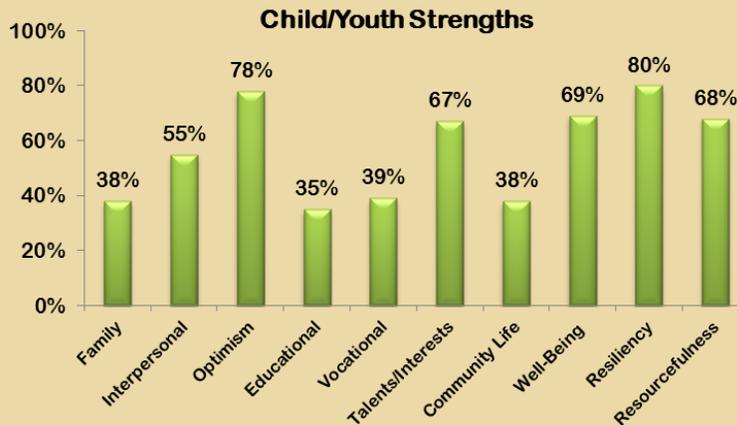
The preliminary outcomes for the project are measured through review of client demographic, episode and service information and analysis of the Child and Adolescent Needs and Strengths Assessment-San Bernardino (CANS-SB) that are completed at designated intervals.

The data in the chart demonstrates the percentage of children/youth who entered services with challenges in specific life domains and who had resolved those issues by discharge.



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The graph below demonstrates areas in which IYRT participants built strengths.



Workforce Education and Training

California's public mental health system has suffered from a shortage of public mental health workers, misdistribution of certain public mental health occupational classifications, a recognized lack of diversity in the workforce, and under-representation of professionals with consumer and family member experience, and of racial, ethnic, and cultural communities in the provision of services and support. To address the public mental health workforce issues, the MHSAs included a component for Workforce Education and Training (WET) programs.

WET carries forth the vision of the MHSAs to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups such as infants, children, adolescents, transition age youth, adults and older adults.

The goals for the WET component include:

- Address workforce shortages and deficits Identified in the Workforce Needs Assessment.
- Designate a WET Coordinator.
- Educate the workforce on incorporating the general standards.
- Increase the number of clients and family members of clients employed in the public mental health system.
- Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance.
- Recruit, employ and support the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence.
- Provide financial incentives to recruit or retain employees within the public mental health system.
- Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities.
- Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities.
- Establish regional partnerships.
- Coordinate WET programs and/or activities.

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Highlights of WET Outcomes

To meet the MHSA Legislative Goal of *Increasing the Number of Clients and Family Members of Clients Employed in the Public Mental Health System*, Peer and Family Advocates (PFA) are hired to provide various services in both county and contracted programs. PFAs are mental health consumers and/or family members who provide crisis response services, peer counseling, and linkages to services and supports for consumers of DBH services; assist with the implementation, facilitation and on-going coordination of activities of the CSS plan in compliance with MHSA requirements; and perform related duties as required.

Peer and Family Advocates (PFA) are individuals who have lived experience with behavioral health, either for themselves or a family member. PFAs offer a perspective of services from "the other side of the desk." There has been a significant increase in PFAs hired by DBH. As of February 19, 2015, there are **23** filled PFA positions in DBH. In comparison, in 2006, the Department only had four (**4**) PFA positions budgeted. This is significant increase. In addition, there are **11** additional newly created, vacant PFA positions that are in the process of being filled.

At the time of this report, DBH contracted providers agencies employ **42** Peer and Family Advocate equivalents as part of their service delivery system.

To meet the MHSA Legislative Goal of *Establishing Regional Partnerships*, the Southern Counties Regional Partnership (SCRIP) was created in 2009. SCRIP 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 mental health system workforce when those programs are more easily coordinated at a regional level. The ten member counties are Kern, Imperial, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tri Cities and Ventura.

San Bernardino County was the fiscal agent of SCRIP until June 30, 2014. Santa Barbara County is now the fiscal agent for SCRIP.

Capital Facilities and Technological Needs

Each County's Capital Facilities and Technological Needs Component Proposal and the Capital Facilities and/or Technological Needs Project Proposals must support the goals of the MHSA and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

These efforts include development of a variety of technology uses and strategies and/or of community-based facilities which 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 a technological infrastructure for the mental health system to facilitate the highest quality, cost-effective services and supports for clients and their families.

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Community Program Planning

The County of San Bernardino Department of Behavioral Health (DBH) is dedicated to including diverse consumers and stakeholders from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. These efforts include informing stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities as well as obtaining feedback. DBH has consistently demonstrated commitment to incorporating best practices in our planning processes that allow our stakeholder partners to participate in meaningful discussions around critical behavioral health issues. DBH considers Community Program Planning (CPP) a constant practice and as a result, this component has become a robust, year-round practice incorporated into standard operations. Like the other MHSA components, the CPP process undergoes review and analysis which allows us to enhance and improve engagement strategies.



Community Policy Advisory Committee

DBH's CPP protocol over the years has included a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning and implementation, and financial resources affiliated with behavioral health programs. This practice has allowed DBH to be responsive to changes in the public behavioral health environment, be proactive in identifying areas of improvement, and continue to educate diverse stakeholder and consumers about the MHSA, behavioral health resources and the public behavioral health system as a whole.

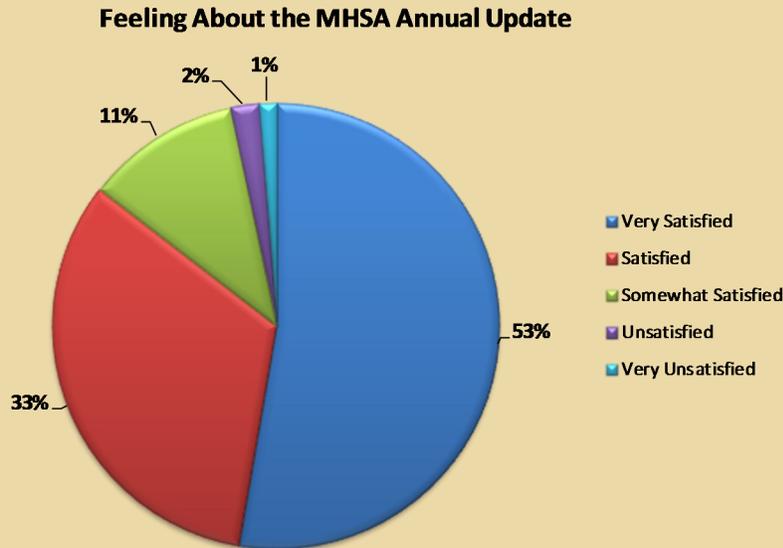
DBH is fully committed to a year round stakeholder engagement process. Preparation and development of this Annual Update to the Integrated Plan included meetings hosted in multiple venues in each region of the County, an interactive countywide webinar and a monolingual Spanish session hosted in collaboration with the Consulate of Mexico in San Bernardino.

To meet the requirements of the MHSA, extensive outreach was conducted to promote the Annual Update Planning Process. A variety of methods were used at multiple levels to give stakeholders the opportunity to have their feedback included and their voice heard. This included press releases to all local media outlets and distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions and regularly scheduled stakeholder meetings such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to reach representatives of our diverse population. Social media sites such as Facebook were also used to extended the reach of the department in connecting interested community members with the stakeholder process.

During the stakeholder meetings for the Annual Update, several community members voiced their support and approval of the Update, as well as the enhanced CPP process that has occurred over the last year.

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The following represents the level of satisfaction reported from attendees from the MHSA Annual Update stakeholder meetings. **241** of the **294** individuals that participated in a Community Planning Meeting for the MHSA Annual Update completed a survey. Of the participants that completed a survey, **97%** indicated they were somewhat to very satisfied with the Annual Update.



Summary of Program Expansions

While there have been no significant changes, DBH, with input from stakeholders has identified several program areas that require expansion of services in Fiscal Year 2015/16. This expansion is due to increased demand as well as changes in the organizational focus of the state agencies providing oversight of MHSA. Because the expansion of programs would be for currently approved programs, the increased services and activities are not characterized as substantive changes. The service philosophy and array of services will not be changed, but rather extended and made accessible to more community members. This extension of services will also address the expanded requirements related to evaluation of program outcomes.

Expansion efforts as detailed below are contingent on MHSA funding estimates which are based on tax receipts and monthly cash projections. If cash projections change such that expansion is not feasible, program efforts detailed within this report will not be implemented as services provided under MHSA are contingent upon available funding.

The following provides a brief summary of proposed program changes. Detailed information can be found in the Summary of Program Changes section of this document.

The updates below are being proposed to a few of the CSS programs based on stakeholder feedback:

- The Comprehensive Children's and Family Support Program will expand to include additional targeted and intensive case management and mental health services directed toward foster children. The expansion will allow the Department, along with our Children and Family Services department stakeholders, to serve an additional **150** system involved children.

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- The Forensic Integrated Mental Health program will expand services to include an additional **50** slots for full service partnership services. The Forensic Assertive Community Treatment (FACT) component of the program works with the target population of probationers living with severe mental illness.
- The Members Assertive Positive Solutions (MAPS)/Assertive Community Treatment (ACT) program will expand to include additional slots for clients and provide a new service. This includes expanding the program to increase access to voluntary adult residential treatment services for adults. Based on available funding, anywhere from 6-30 beds could be made available to assist the clients that are stepping down from long higher levels of care.

Adult residential treatment services are provided in a non-institutional, residential setting for consumers who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The services include a range of activities and services that support consumers in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available **24** hours per day, seven (**7**) days per week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral services.

No new programs are included in the Prevention and Early Intervention component. However, the scope of work will be updated in the following programs.

- The scope of work for the Family Resource Centers during the next Request for Proposal cycle will change to include targeted relapse prevention groups for individuals living with serious mental illness or screening, identification, and supports for at-risk groups such as mothers experiencing postpartum depression or challenges.
- The inclusion of peer counseling services as part of the scope of work of the Older Adult Community Services program and the Promotores de Salud program will occur. This strategy was found to be very effective in the Holistic Campus service design (funded by Innovation) in meeting the needs of the Latino community. In FY 2013/14, **27,391** people were served in the Holistic Campus. One provider of Holistic Campus services found the Peer Counseling services the most effective door way into mental health. Of those individuals served in Peer counseling services, **90%** of those individuals identified as Latino. This strategy has also been effective in assisting older adults. The scope of work will be updated to include this additional service and we will continue to monitor the effectiveness of the approach for consideration in other programs or parts of the entire system of care.

Additional planned program changes for the Workforce Education and Training (WET) component include:

- WET will expand the Psychiatry Residency Program by adding additional residents from Loma Linda University Medical Center and Arrowhead Regional Medical Center to help address the Psychiatrist shortage in the County.
- DBH will expand the Marriage and Family Therapy (MFT) Internship Program by adding a doctoral MFT intern. Currently, all intern positions are filled with clinical interns. There is a need for a succession plan for health informatics and research to support outcomes driven programming that adding a doctoral MFT intern would address.
- The expansion of the Employee Internship Program is the final planned expansion for FY 2015/16. This will include, the addition of Bachelor in Social Work (BSW) and Alcohol and Drug Counselor employee interns.

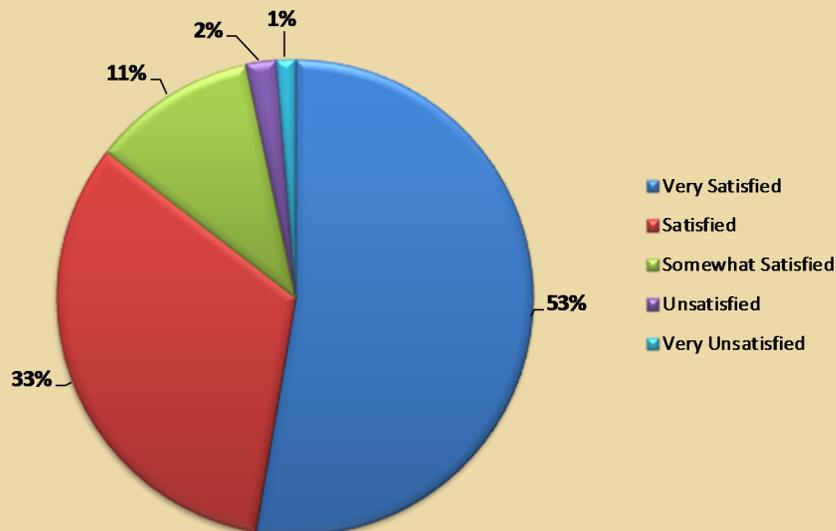
Executive Summary

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

Public Posting and Hearing

The Annual Update was posted for public comment from **March 20, 2015 through April 20, 2015** on the DBH website at www.sbcounty.gov/dbh with a request to review the draft document and take the opportunity to comment. During the thirty (30) day public posting of the MHSA Annual Update, DBH continued to promote the thirty (30) day posting and provided overviews and information related to the MHSA Annual Update. As a result of these efforts, nine (9) comments were received. All of the comments were received on the Stakeholder Comment Form that was available to all stakeholders. All nine (9) comment forms received indicated the stakeholders were satisfied to very satisfied with the MHSA Annual Update and affiliated stakeholder process. The graph below illustrates the reported general feelings about the MHSA Annual Update from stakeholders that participated in Community Program Planning and provided feedback during the 30-Day Public Comment period. In total, **241** individuals completed a stakeholder comment form. Of the respondents, **97%** indicated they were satisfied to very satisfied with the MHSA Annual Update, **2%** indicated they were dissatisfied, and **1%** indicated they were very dissatisfied.

Feeling About the MHSA Annual Update



A Public Hearing hosted by the San Bernardino County Behavioral Health Commission was conducted on **May 7, 2015**, as part of the regular Commission meeting. No substantive recommendations were received. The Behavioral Health Commission affirmed that the Department had adhered to the MHSA Community Program Planning process and supported the submission of the MHSA Annual Update to the San Bernardino County Board of Supervisors for approval.

For a full description of the 30 Day Public Posting and Comment period and Public Hearing, please refer to the Community Program Planning section of this MHSA Annual Update.

Executive Summary

Conclusion

The development and preparation of San Bernardino County's Mental Health Services Act Fiscal Year (FY) 2015/16 Annual Update resulted from concentrated efforts from the community, consumers, family members, service providers, county agencies, and representatives of interested organizations throughout the county.

Services provided under the Mental Health Service Act (MHSA) continue to make a difference in the lives of San Bernardino County residents and across the state. According to a report released by the Steinberg Institute for Advancing Behavioral Health Policy & Leadership on March 11, 2015, data show that MHSA services provided relief to people living with mental illness and their families across the state while also reducing the demands on the criminal justice, healthcare and social services systems. Significant statewide outcomes include:

- **47%** reduction in homelessness.
- **79%** reduction in emergency mental health and substance abuse care.
- **42%** reduction in psychiatric hospitalizations.
- **82%** reduction in arrests.
- **27%** reduction in incarcerations.
- **14%** increase in independent living.
- **60%** reduction in child out-of-home placements.
- **22%** improvement in academic achievement.

In conclusion, the MHSA Plan and the programs and services provided throughout the continuum of care will continue to improve and transform public behavioral health services at the local level.

Should you have any questions, would like to provide additional input, receive additional information about San Bernardino County MHSA services or activities, or be included on our distribution lists please contact:

**Department of Behavioral Health
Office of Program Planning and Development
1950 S. Sunwest Lane, Ste. 200
San Bernardino, CA 92415
(909) 252-4017
MHSA@dbh.sbcounty.gov**



November 2014—Community Policy Advisory Committee Stakeholder Engaged Evaluation Meeting

Community Program Planning (CPP)

Overview of Stakeholder Process

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

CCR Title 9 Section 3300 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.

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse consumers and stakeholders from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. These efforts include informing stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities as well as obtaining feedback. DBH has consistently demonstrated commitment to incorporating best practices in our planning processes that allow our stakeholder partners to participate in meaningful discussions around critical behavioral health issues. DBH considers community program planning a constant practice and as a result, this component has become a robust, year-round practice incorporated into standard operations. Like the other MHSA components, the community program planning process undergoes review and analysis which allows us to enhance and improve engagement strategies.



DBH's Community Program Planning (CPP) protocol over the years has included a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning and implementation, and financial resources affiliated with behavioral health programs. This practice has allowed DBH to be responsive to changes in the public behavioral health environment, be proactive in identifying areas of improvement, and continue to educate diverse stakeholder and consumers about the MHSA, behavioral health resources and the public behavioral health system as a whole. A published schedule for these ongoing meetings is available to stakeholders and is distributed widely to the public. To ensure participation from diverse stakeholders, scheduled meetings include interpreter services, as well as meetings that are held in languages other than English. Monthly meetings are documented through agendas, sign-in sheets and detailed minutes and include the following regularly scheduled meetings:

- Behavioral Health Commission (BHC).
- District Advisory Committee meetings five (5) monthly meetings, one (1) held in each of the five (5) supervisorial districts within the county and led by the Behavioral Health Commissioners in that district.

Overview of Stakeholder Process

- Community Policy Advisory Committee (CPAC).
- Cultural Competency Advisory Committee (CCAC), along with twelve (12) separate cultural subcommittees/coalitions.
- Transitional Age Youth (TAY) Center Advisory Boards.
- Consumer Clubhouse Advisory Boards.
- Quality Management Action Committee (QMAC).
- MHS Executive Committee.
- Association of Community Based Organizations (ACBO).
- Room and Board Advisory Coalition.
- Screening, Assessment, Referral and Treatment (SART) Collaborative.
- System-wide Program Outcomes Committee (SPOC).



Additional regular stakeholder engagement and education meetings include:

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

Stakeholder attendance is recorded through meeting sign-in sheets and consumer feedback forms. These sign-in sheets 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 ensures 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 twelve (12) monthly cultural subcommittees and coalitions, a Cultural Competency Advisory Committee, and the Office of Cultural Competence and Ethnic Services (OCCES) which reports to the DBH Director. These elements are an essential part of the stakeholder process including the use of the regularly scheduled committee and subcommittee meetings to obtain feedback and input on services and programs. The Cultural Competency Officer (CCO) and the OCCES work in conjunction with each MHS program lead to provide feedback and input into all programs. This targeted coordination ensures the delivery of culturally and linguistically competent and appropriate services. The CCO or OCCES staff regularly sit on boards or committees to provide input or effect change regarding program planning or implementation. OCCES also provides support by translating documents for the department as well as coordinating translation services for stakeholder outreach, meeting and training events. Language regarding cultural competence is included in all department contracts with community based organizations and individual providers to ensure contract services are provided in a cultural competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation.

Overview of Stakeholder Process

DBH is highly committed to including consumers and stakeholders within all levels of our organizational structure. From the highest level of commission oversight, the Behavioral Health Commission, to the administrative structure within DBH, it has been our mission to include consumers and family members as an active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs is elevated, reporting to the Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the Office of Consumer and Family Affairs as well as the department Public Information Office, Community Outreach and Education division, DBH's four (4) TAY centers and DBH's eleven (11) consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHPA activities.

Consumer engagement occurs through community events, department activities and committee meetings. Consumer membership in department committees include meetings in which meaningful issues are discussed and actual decisions made. Consumer input, along with staff and community input, is always considered when making MHPA related system decisions in the Department of Behavioral Health. This includes decision makers such as the Director, Assistant Director, Medical Director, Deputy Director, Program Manager, Clinic Supervisor, Clinicians, and clerical staff.

Improvement in Progress

Stakeholder feedback received during the Community Program Planning (CPP) process for the Three-Year Integrated Plan indicated that stakeholders would like more education in specific areas:

- MHPA programs and services available in their region of the county.
- MHPA program and system outcomes.

Using this information as an opportunity for improvement, the department placed deliberate focus on building on our already robust CPP process over this past year.



Community Education Forums

During the months of August and September 2014, the department hosted thirteen (13) MHPA Community Forums. The forums were presented in various locations across the five (5) districts of San Bernardino County. Several communication channels were enlisted to advertise the forums in English and Spanish, including community and news press releases, web blasts, electronic mail invitations to contract providers, as well as the use of the Department Facebook and Twitter accounts. The overarching goals of the forums were to provide information on how to access and understand MHPA resources and educate interested community members in the ways they can engage and participate in the ongoing stakeholder opportunities. The objectives of the forums included:

- Expanding community awareness about local mental health and substance abuse programs and services, and how to access them.
- Education about resources available in the community.
- Sharing with community how to remain informed and engaged.
- Collecting community feedback.

Overview of Stakeholder Process

During these forums, the facilitator provided an overview of the MHSA, how it was voted into law, where the funding is derived, and rules for allocating the resources. Additionally, an outline of the MHSA requirements for program planning, implementation, and evaluating program and/or services was provided as follows:

- Community Collaboration, as defined in **Section 3200.060**.
- Cultural Competence, as defined in **Section 3200.100**.
- Client Driven, as defined in **Section 3200.050**.
- Family Driven, as defined in **Section 3200.120**.
- Wellness, Recovery, and Resilience Focused.
- Integrated Service Experiences for clients and their families, as defined in **Section 3200.190**.

The facilitators discussed the MHSA Integrated Plan and informed participants about the various Community Program Planning and Education Meetings that take place throughout the county to educate stakeholders on how to engage in the ongoing CPP. Diverse stakeholders were presented with flyers and information on various meetings which included times and locations. All materials were provided in English and Spanish and translation services were provided at each forum. Service providers representing agencies in the region where the forum was being held, were invited to participate. This provided forum participants the opportunity to directly connect with the service providers in their geographic region, receive clarifying information, and gain an understanding of how to access services.

An overview of each MHSA component was provided during the presentation including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). It included the purpose, goals, funding, and target population of each component. The presentation of the PEI component included a highlight of the Statewide Programs that are managed in collaboration with the California Mental Health Services Authority (CalMHSA). These PEI Statewide Programs are comprised of Stigma and Discrimination Reduction, Student Mental Health, and a Suicide Prevention Program. Following the overview, local behavioral health service providers presented information about the resources, support, and services provided by their respective agencies in the region.

Participant Information

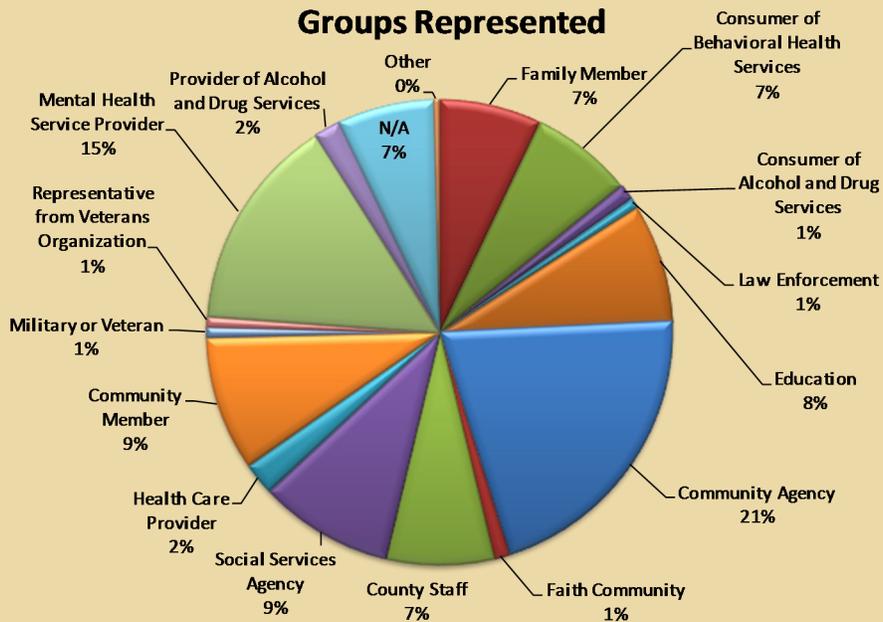
Approximately **184** stakeholders completed pre and post-forum survey and comment forms at each of the MHSA Community Education Forums, focusing on actual services available. Each meeting was held in the community at sites where consumers, stakeholders, and providers were already familiar and would feel comfortable attending. Many of those in attendance represented more than one group (i.e. community member and education). Any one individual identifying as representing more than one group was counted as a member for each group they selected. Outreach to the populations reflecting low attendance will be a focus for future stakeholder meetings/forums.

I was able to learn from this meeting the many programs you have for youth.
-MHSA Stakeholder

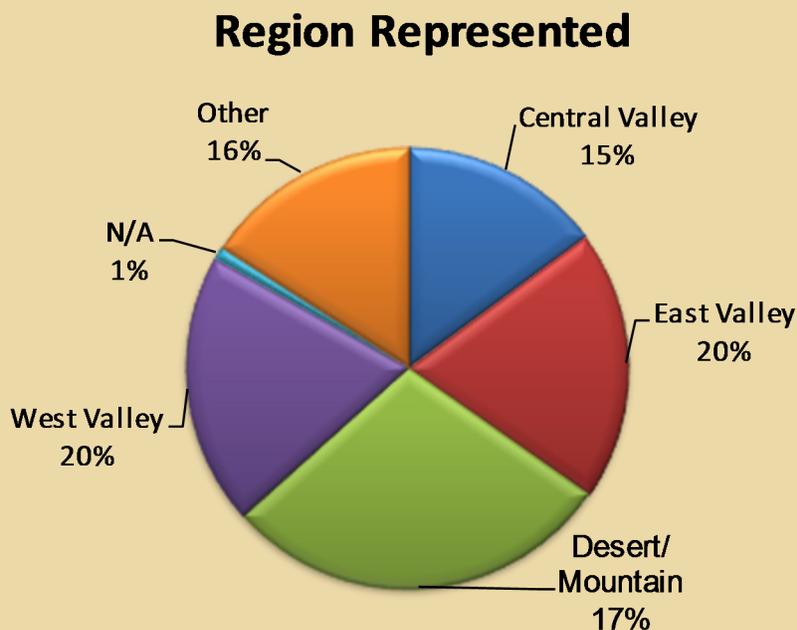
It was a very good pre survey. I have enjoyed coming and listening to your speakers. Learned about MHSA, and I learned about 211. Thank you.
-MHSA Stakeholder

Overview of Stakeholder Process

The following demographic information was collected from the meetings:



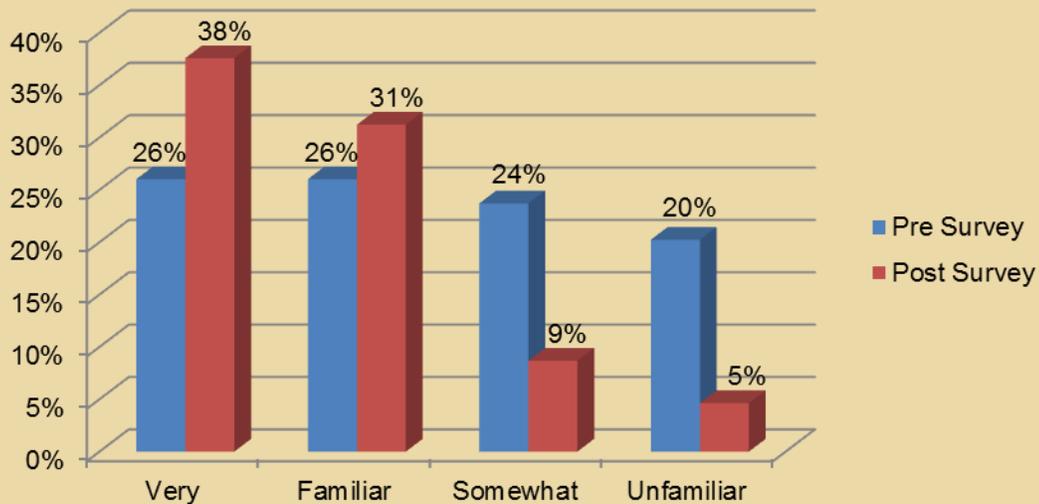
Participants identified which region of the county they represented. The regions represented were the West Valley, the East Valley, the Central Valley, and the Desert Mountain. The pie chart below illustrates the breakdown of the regions of attendees.



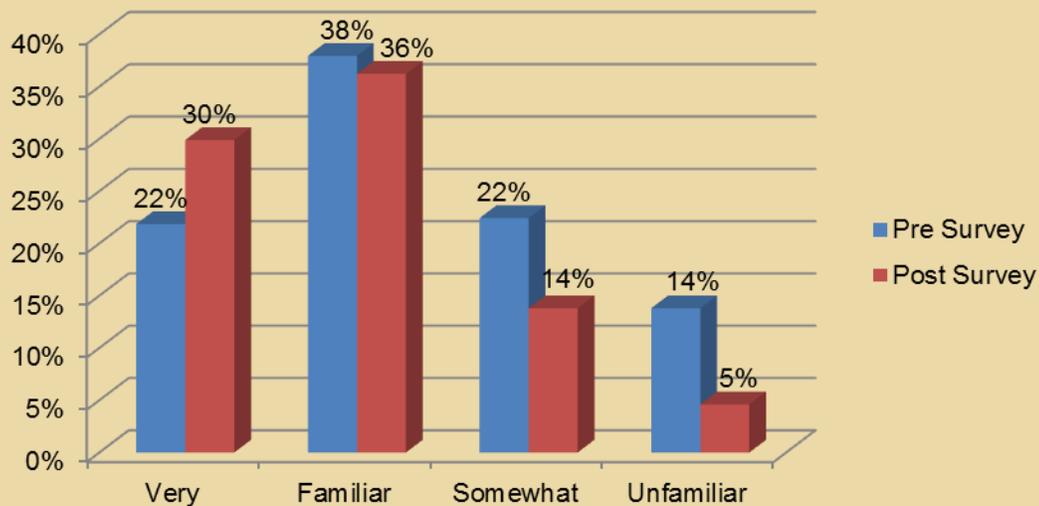
Overview of Stakeholder Process

In order to measure the knowledge gained by participants at MHSA Community Forums, three questions were asked regarding familiarity with MHSA before and after the event. The responses to those questions are as follows:

How familiar are you with the Mental Health Services Act (MHSA) Prop 63?

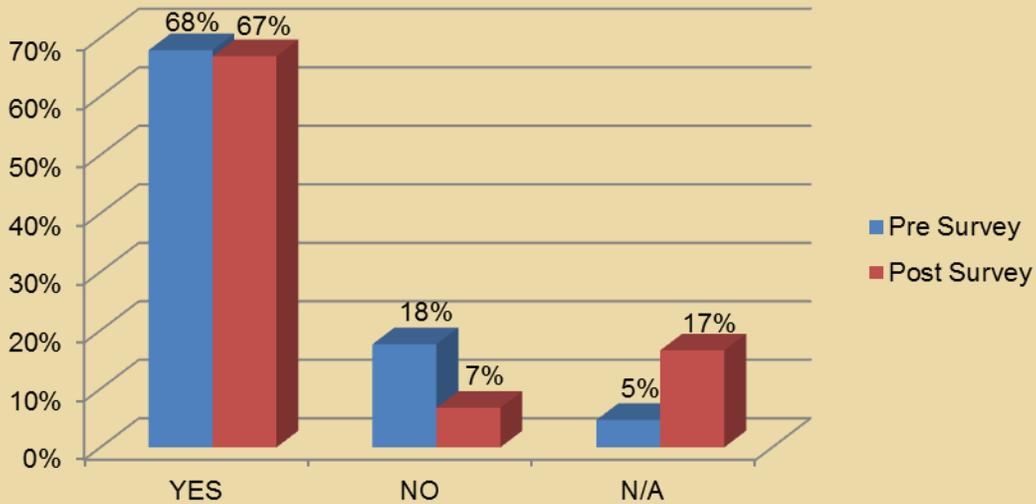


How familiar are you with the services that are available in your local area?



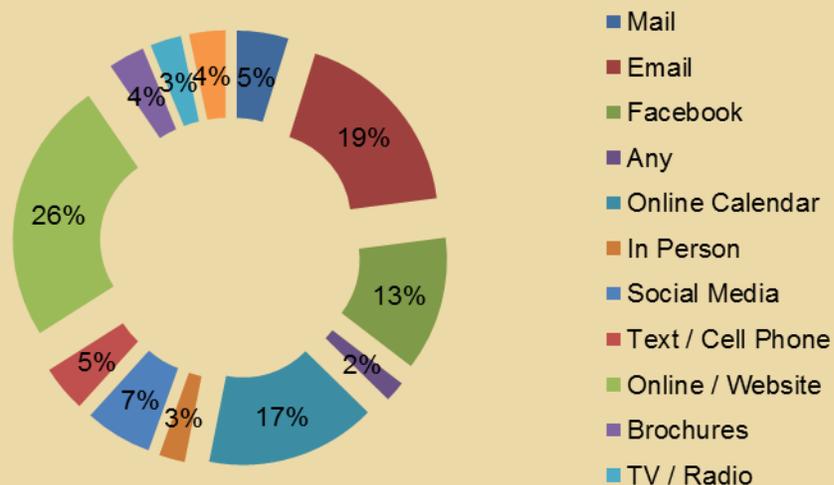
Overview of Stakeholder Process

Do you know how to access these services?



In addition to the survey, there was a segment of the Community Forum that allowed for an open dialogue between the facilitator, providers and participants. Participants were also asked to submit their comments and thoughts as part of the pre/post survey in order to record this feedback. The following is an example of the results of stakeholder comments submitted from the Community Forums.

What is the best/easiest way for you to receive information?



Overview of Stakeholder Process

Stakeholder Engaged Outcome Evaluation

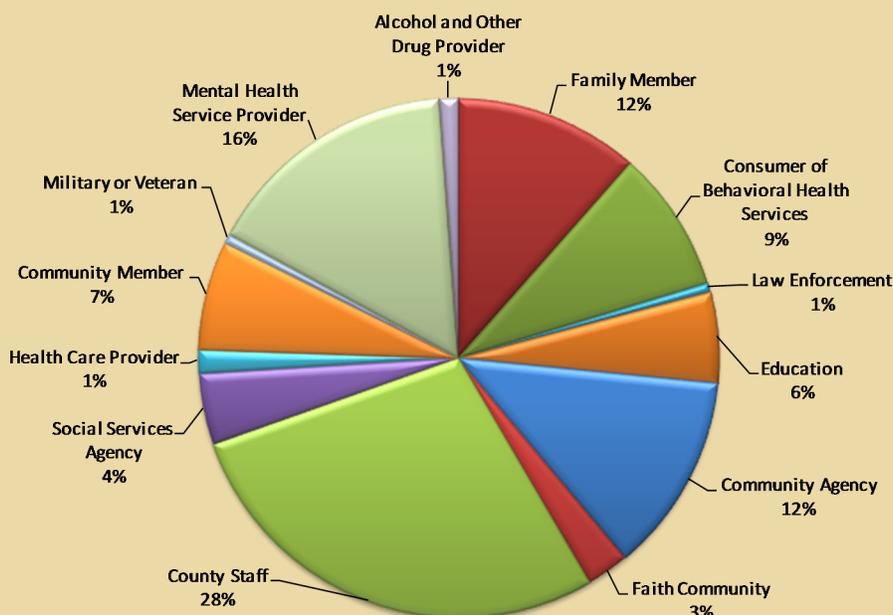
To address the request to provide more information about program and system outcomes for MHSA Programs, the DBH Office of Program Planning and Development utilized the monthly Community Policy and Advisory Committee meeting to host a series of special sessions dedicated to discussing outcomes related to MHSA. These special sessions began in October 2014 and were repeated on a monthly basis through January 2015 to allow review, analysis, and stakeholder feedback on each MHSA component. The focus of each session was to present and evaluate the progress made toward meeting the legislated goals and key outcomes outlined in each of the MHSA components. Translation services were offered at each session and materials were offered in both English and Spanish. The room was set up in a manner that allowed for convenient small group discussion for **2-9** people at each pod of tables, including pods for individuals who felt more comfortable participating in Spanish. Data and information related to MHSA goals and key outcomes was presented in short **15-20** minute allotments of time. Diverse participants were then instructed to engage in a facilitated discussion and rate the progress being made toward meeting the goal on a survey. The same process was repeated throughout the presentations. At the end of each event, the facilitators requested suggestions on improving the format and incorporated these suggestions into subsequent sessions. The February 2015 session followed the same format, however, the discussion topic was related to the planned ending of an Innovation project and an analysis of the preliminary data.

CCR Title 9 Section 3320 states that counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration.
- Cultural Competence.
- Client Driven.
- Wellness, recovery, and resilience focused.
- Integrated service experiences for clients and their families.

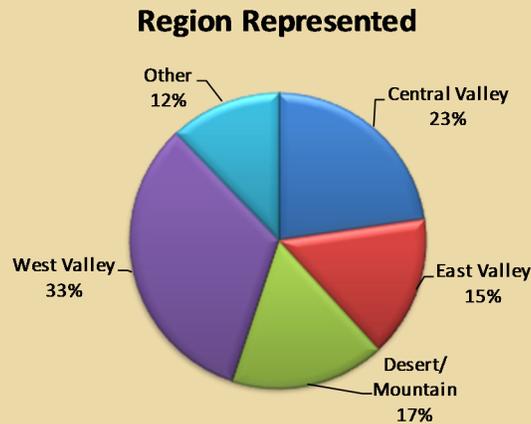
Surveys that contained demographic and feedback information were collected at the end of each session. An overview of the **339** surveys collected from all of the sessions indicated that representative from each region of the county and from diverse consumer and stakeholder groups were active participants in this important conversation.

Groups Represented

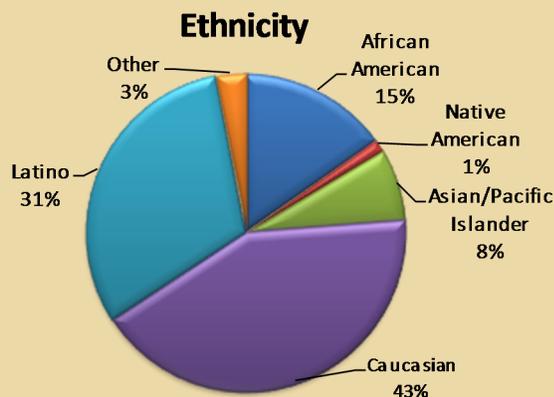
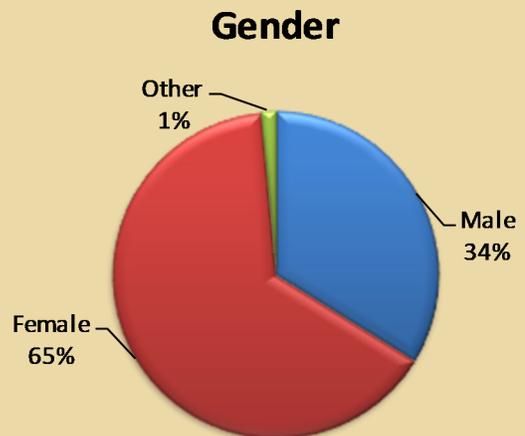
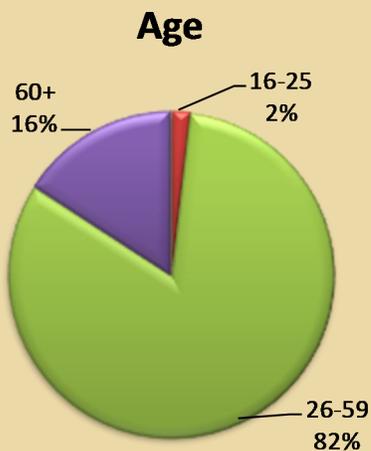


Overview of Stakeholder Process

The overview of the individuals that participated in the outcome evaluation activities indicates that representatives were present from each region of the county.

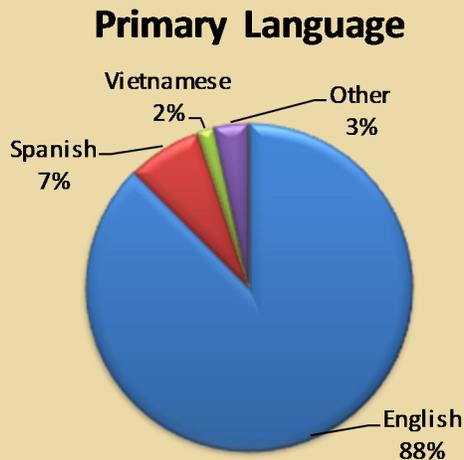


The demographic breakdown of participants that completed a survey is illustrated in the pie charts below. Please note that not every participant completed every section of every survey.



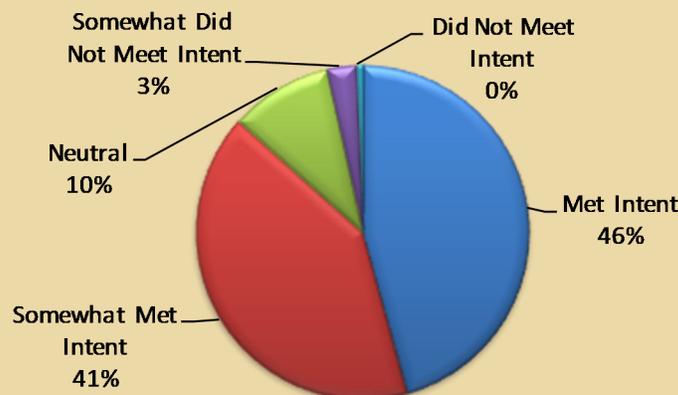
Overview of Stakeholder Process

Of the participants that completed a survey, **88%** indicated their primary language was English, **7%** reported Spanish as their primary language, **2%** reported Vietnamese as their primary language and **3%** reported another primary language.



As participants engaged in a facilitated discussion they were asked to rate, via multiple Likert scale surveys, the progress being made toward meeting various MHSA goals and/or projections. Overall, results indicate that **87%** of participants perceive that the department has met or somewhat met the intent of the MHSA goals, with **10%** reporting a neutral perception, and **3%** reporting a perception that the intent has somewhat not been met.

Please Rate if DBH Met the Intent of the MHSA Goals



Overview of Stakeholder Process

California Mental Health Planning Council Community Forum

DBH had additional opportunities to gain stakeholder input through participation in a Community Forum hosted by the California Mental Health Planning Council (CMHPC) on July 29, 2014, and California's Mental Health Services Oversight and Accountability Commission (MHSOAC) Community Program Planning (CPP) Promising Practices Summit on June 27, 2014.



A requirement of the CMHPC is to review and report on the public mental health system, including conducting public processes concerning the state mental health plan, Substance Abuse and Mental Health Administration (SAMHSA) block grant, and other related topics. Based on this, the CMHPC convened three stakeholder meetings across the state to engage stakeholders concerning more recent policy changes and the local impact that may be occurring as a result of those updates. One of the key topics included was a discussion about the MHSOAC.

The Community Forum held in San Bernardino hosted **112** consumer and family members as participants in the forum. These participants were asked a series of questions to prompt discussions regarding what is working well in the public mental health system, availability and access to services, family member support, and any recommended changes. Summarized stakeholder feedback from the forum included:

- Recognition of the successes in Crisis Intervention Training for law enforcement officers. Stakeholders further reported the desire for all law enforcement officers to be trained in Crisis Intervention for mental health with a recommendation that every law enforcement training academy should include this course as a requirement.
- A request to improve Perinatal Mental Health services in the county.
- An observation that school partners are providing more access and referrals to outpatient mental health services, resulting in decreased number of students being placed in residential treatment programs.
- The need for additional bilingual/bicultural Spanish speaking clinical staff.
- Ensure there are services available to treat mental health crisis and related evaluations by trained mental health staff in lieu of the Emergency Department.
- Explore successful respite programs and opportunities for Prevention and Early Intervention and to reduce recidivism.
- Expanded grief and loss support for children and families across the county.
- Expand outreach using the Promotores (Community Health Worker) model with other cultural groups.
- The desire to have continued funding for housing projects.
- Recognition of the increased collaboration between alcohol and drug, primary care, and early childhood programs.
- The need for additional supportive housing and employment.

In response to these and stakeholder recommendations from other forums, several updates to existing MHSOAC programs and service strategies have been included in this update and are detailed in the Program Changes section. Proposed updates will be implemented ensuring adequate resources are available.

Overview of Stakeholder Process

Mental Health Services Oversight and Accountability Commission (MHSOAC) Promising Practices Summit

Additionally, the Promising Practices Summit was coordinated through an MHSOAC contracted agency “to identify the most promising CPP activities by assessing the content and quality of CPP processes, MHSOAC outcomes that result from CPP processes such as the number and diversity of participants, the utility of CPP processes for quality improvement purposes, and the perceived impact these processes have on CPP participants and the public mental health system.” (*MHSOAC Community Program Planning Processes – Promising CPP Practices Deliverable 6: Final Report of Promising CPP Process Practices*, Page 4).

DBH was reviewed in this area and contributed to the development of the final deliverable to the MHSOAC, the completion of a comprehensive set of promising CPP practices that were subsequently utilized for informing stakeholder practices across the state. The full report can be accessed at http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/December/Evaluation/Eval_120214_Tab4_RDARReport_D6.pdf.



DBH is committed not only to improving the quality of care for consumers but to improving the stakeholder engagement process. The Promising Practice Report allowed the department to acknowledge the areas of success and identify opportunities for enhancement in ongoing processes. A review of the practices detailed in the Promising Practice Report indicates that the department is succeeding in many key practices including but not limited to:

- Use of MHSOAC principles as a foundation to develop and conduct all CPP activities.
- Leveraging of existing resources by using resources within the community to support CPP activities.
- Being strategic: Establishing thoughtful and deliberate preparation for the ongoing CPP, which includes planning in advance.
- Collaborative relationships have been established across multiple community sectors.
- Developing individual and organizational knowledge to participate in research and informed decision making.
- Providing opportunities for people to gather at convenient and comfortable locations and using a variety of approaches for meaningful engagement.

DBH will continue to evaluate and expand the already robust CPP process to include additional promising practice elements, as identified by the MHSOAC but not yet maximized in our local planning process.

Overview of Stakeholder Process

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

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

CCR Title 9 Section 3300 further includes:

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

Annual Update Community Program Planning (CPP) Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this Annual Update to the Integrated Plan included meetings hosted in multiple venues in each region of the County, an interactive countywide webinar and a monolingual Spanish session hosted in collaboration with the Consulate of Mexico in San Bernardino. A schedule of these meetings with dates, time and locations is provided in this document.

To meet the requirements of the MHSA, extensive outreach was conducted to promote the Annual Update Planning Process. A variety of methods were used at multiple levels to give stakeholders the opportunity to have their feedback included and their voice heard. This included press releases to all local media outlets, including cultural specific media, and distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions and regularly scheduled stakeholder meetings such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to reach representatives of our diverse population. Social media sites such as Facebook were also used to extend the reach of the department in connecting interested community members with the stakeholder process. DBH's Facebook is accessible at www.facebook.com/sbdbh. Finally, personal phone calls were made by MHSA staff inviting stakeholders to attend one or all of the CPP meetings.

The following pages provide examples of the flyers distributed to the community to promote the Annual Update Planning Process.

Overview of Stakeholder Process



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

District Advisory Committee Meetings



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

<p>First District</p> <p>Wednesday, February 18, 2015 11:00 a.m. - 12:00 p.m.</p> <p>Victor Community Holistic Campus 1540 Cholame Road Victorville, CA 92392 Contact: Chris Croteau (760) 955-7287</p>	<p>Second District</p> <p>Thursday, February 12, 2015 3:00 - 5:00 p.m.</p> <p>Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contact: April Guzman (909) 458-1381</p>	<p>Third District</p> <p>Tuesday, February 17, 2015 11:00 a.m. - 12:00 p.m.</p> <p>Our Place—Clubhouse 721 Nevada Street, Ste. 205 Redlands, CA 92373 Contact: Debbie Cazarez (909) 387-7219</p>
<p>Fourth District</p> <p>Thursday, February 12, 2015 3:00 - 5:00 p.m.</p> <p>Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contact: April Guzman (909) 458-1381</p>	<p>Fifth District</p> <p>Monday, February 23, 2015 5:30 - 7:30 p.m.</p> <p>New Hope Family Life Center Auditorium 1505 W. Highland Avenue San Bernardino, CA 92411 Contact: Crista Wentworth (909) 421-4606</p>	

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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

Revised 1/23/15



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

Reunión de Comité Consultiva de Distrito



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

<p>Primer Distrito</p> <p>Miércoles, 18 de febrero del 2015 11:00 a.m. - 12:00 p.m.</p> <p>Victor Community Holistic Campus 1540 Cholame Road Victorville, CA 92392 Contacto: Chris Croteau 760-955-7287</p>	<p>Segundo Distrito</p> <p>Jueves, 12 de febrero del 2015 3:00 - 5:00 p.m.</p> <p>Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contacto: April Guzman 909-758-1381</p>	<p>Tercer Distrito</p> <p>Martes, 17 de febrero del 2015 11:00 a.m. - 12:00 p.m.</p> <p>Our Place—Clubhouse 721 Nevada Street, Ste. 205 Redlands, CA 92373 Contacto: Debbie Cazarez 909-387-7219</p>
<p>Cuarto Distrito</p> <p>Jueves, 12 de febrero del 2015 3:00 - 5:00 p.m.</p> <p>Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contacto: April Guzman 909-758-1381</p>	<p>Quinto Distrito</p> <p>Lunes, 23 de febrero del 2015 5:30 - 7:30 p.m.</p> <p>New Hope Family Life Center Auditorium 1505 W. Highland Avenue San Bernardino, CA 92411 Contacto: Crista Wentworth 909-421-4606</p>	

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

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

Revised 1/23/15

Overview of Stakeholder Process



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

Cultural Competency Advisory Committee Sub-Committee Meetings



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

Asian Pacific Islander Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.	Spirituality Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Native American Awareness Sub-Committee February 17, 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.
Disabilities Awareness Sub-Committee February 18, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30 - 9:30 a.m.	Transitional Age Youth Awareness Sub-Committee February 18, 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.	Transitional Age Youth Awareness Sub-Committee February 19, 2015 Pacific Clinics — Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.
Co-Occurring and Substance Abuse Sub-Committee February 19, 2015 County of San Bernardino Health Services - Auditorium 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.	Consumer & Family Member Awareness Sub-Committee February 23, 2015 Department of Behavioral Health Administration, Rm 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.	LGBTQ Awareness Sub-Committee February 24, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.
Women's Awareness Sub-Committee February 25, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Veteran's Awareness Sub-Committee March 2, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	Latino Health Awareness Sub-Committee March 3, 2015 Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.
African American Awareness Sub-Committee March 9, 2015 Young Visionaries, 1580 N. Waterman Ave., San Bernardino, CA 92408, 2:00 - 3:00 p.m.		

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



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

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural



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

Subcomité de Concientización de Asiáticos/Islaños del Pacífico 10 de febrero del 2015 Administración de DBH—Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.	Subcomité de Concientización de Espiritualidad 10 de febrero del 2015 Administración de DBH—Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Subcomité de Concientización de Nativos Americanos 17 de febrero del 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.
Subcomité de Concientización de Discapacidades 18 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30am - 9:30 a.m.	Subcomité de Concientización de Jóvenes en Edad de Transición 18 de febrero del 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.	Subcomité de Concientización de Jóvenes en Edad de Transición 19 de febrero del 2015 Pacific Clinics—Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.
Subcomité de Concientización de Diagnóstico Dual y Drogadicción 19 de febrero del 2015 County of San Bernardino Health Services—Auditorio 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.	Subcomité de Concientización de Consumidores y Miembros de Familias 23 de febrero del 2015 Administración de DBH—Cuarto 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.	Subcomité de Concientización de LGBTQ 24 de febrero del 2015 Administración de DBH —Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.
Subcomité de Concientización de Mujeres 25 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Subcomité de Concientización de Veteranos 2 de marzo del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	Subcomité de Concientización Latino 3 de marzo del 2015 Consulado de México en San Bernardino—Sala de Espera 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.
Subcomité de Concientización de Afroamericanos 9 de marzo del 2015 Young Visionaries, 1580 N. Waterman Ave., San Bernardino, CA 92408, 2:00 - 3:00 p.m.		

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

Overview of Stakeholder Process



*Please join the Department of Behavioral Health
for a special presentation in Spanish at the
Mental Health Services Act Stakeholder Engagement!*



Consulate of Mexico in San Bernardino

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

Tuesday, March 3, 2015

Consulate of Mexico in San Bernardino — Lobby
293 North D Street
San Bernardino, CA 92401
9:00 - 11:00 a.m.

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

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

Revised 1/23/15



*Únase al Departamento de Salud Mental
para una presentación en Español. . .*

*¡Reunión comunitaria para partes interesadas sobre la
Ley de Servicios de Salud Mental!*



Consulado de México en San Bernardino

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

Fecha: 3 de marzo del 2015

Localización: Consulado de México en San Bernardino
293 North D Street, San Bernardino, CA 92401
Horario: 9:00 - 11:00 a.m.

*Para preguntas, dudas, servicios de interpretación o solicitudes de acomodaciones especiales por razones de incapacidad, por favor comuníquese con
Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es TTY; también puede ir a: aidery.hernandez@dbh.sbcounty.gov.
Por favor solicite estas acomodaciones por lo menos 7 días laborales previos al evento.*

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

Revised 1/23/15

Overview of Stakeholder Process



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



Special Online After-Hours Event

Participate from the comfort of your own home!

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

When: Thursday, March 12, 2015

Where: Online Adobe Connect Event

Time: 5:30 - 7:30 p.m.

Conference Number: US/CAN Toll Free: 1-877-820-7831

Passcode: 947294

To join the meeting please use the link below:

<https://sbcdbh.adobeconnect.com/r3sildf57pa/>

*Please note: This will be an English language session. For questions or concerns, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.*

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

Revised 1/23/15



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



Sesión en Línea por la Tarde

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

Fecha: Jueves, 12 de marzo del 2015

Localización: En línea evento "Adobe Connect"

Horario: 5:30 - 7:30 p.m.

Numero de Conferencia: US/CAN Toll Free: 1-877-820-7831

Contrasena: 947294

Para unirse a la reunión por favor utilice el siguiente enlace:

<https://sbcdbh.adobeconnect.com/r3sildf57pa/>

Por favor note: esta será una sesión solamente en inglés. Para preguntas o dudas, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov.

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

Revised 1/23/15

Overview of Stakeholder Process



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



Thursday, March 19, 2015

Community Policy Advisory Committee (CPAC) Meeting

9:00 a.m. - 12:00 p.m.

County of San Bernardino
Health Services—Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Facilitated by Director, CaSonya Thomas

Cultural Competency Advisory Committee (CCAC) Meeting

1:00 - 3:00 p.m.

County of San Bernardino
Health Services—Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Facilitated by Assistant Director, Veronica Kelley

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

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

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.
Please request accommodations at least 7 business days prior to the event.

Revised 1/23/15



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



Jueves, 19 de marzo del 2015

Comité Asesor de Política Comunitaria (CPAC)

9:00 a.m. - 12:00 p.m.

County of San Bernardino
Health Services—Auditorio
850 E. Foothill Blvd.
Rialto, CA 92376

Reunión facilitada por
Directora, CaSonya Thomas

Comité Consultivo de Competencia Cultural (CCAC)

1:00 - 3:00 p.m.

County of San Bernardino
Health Services—Auditorio
850 E. Foothill Blvd.,
Rialto, CA 92376

Reunión facilitada por
Subdirectora, Veronica Kelley

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

La Ley De Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de
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Revised 1/23/15

Overview of Stakeholder Process

The MHSa Coordinator and Component Leads, in conjunction with the offices of Cultural Competency and Ethnic Services (OCCES), and Community Outreach and Education (CORE), assumed responsibility for coordination and management of the CPP. This process was built upon existing stakeholder engagement components, mechanisms and collaborative networks within the mental health system and evolved out of the original CPP initiated in 2005. In many cases, meetings were held in the community at sites where consumers were already comfortable attending services, events and meetings. Participation of key groups of stakeholders included but were not limited to:

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families.
- Providers of mental health and/or related services such as physical health care and/or social services.
- Educators and/or representatives of education.
- Representatives of law enforcement.
- Veteran/Military population of service organizations.
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

As listed in the schedule, five (5) special sessions of the Behavioral Health Commission's District Advisory Committee (DAC) meetings were conducted in each geographic region of the county. This schedule ensured representation and participation in each of geographic regions of San Bernardino County. To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OCCES provided stakeholder engagement meetings for the Annual Update for each of their twelve (12) Cultural Competency Advisory subcommittees. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSa, the approved Three-Year Integrated Plan and proposed updates as well as obtain feedback and recommendations for system improvement. To ensure that stakeholders could fully benefit from the community meetings, Office of Cultural Competency and Ethnic Services (OCCES) staff arranged for Spanish, American Sign Language and Vietnamese interpretation upon request at each meeting.

In order to increase opportunities for participation across the county, the department hosted an Adobe Connect® webinar the evening of March 12, 2015 from 5:30 p.m. to 7:00 p.m. This evening session allowed individuals living in remote areas of the county to participate via computer, smart phones, and other technological devices. At the end of the presentation, the facilitator opened the phone line to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concluded, participants were redirected to a web-based survey as an additional opportunity 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 and phone number for the MHSa Coordinator.

To further support this Community Planning Process (CPP) effort, a special extended session of the Community Policy Advisory Committee (CPAC) was hosted by the DBH Director on March 19, 2015, to ensure the community had continued direct access to executive leadership during the stakeholder process. The session followed the same format as the previous CPAC meetings where the stakeholder informed evaluation had occurred. Attendees were seated in small groups, to allow for comfortable discussion opportunities, and provided the opportunity to provide written and verbal input after sections of information were presented. A subsequent special session of the Cultural Competency Advisory Committee was hosted by the DBH Assistant Director later in the afternoon on this same date, to ensure additional opportunities for stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the plan via verbal comment and a post survey in which stakeholders could provide written comments as well. Surveys were available in both English and Spanish and are included, along with a record of stakeholder comments received, for reference in the Appendix of this plan.

Overview of Stakeholder Process



During the stakeholder meetings for the Annual Update, several community members voiced their support and approval of the Update, as well as the enhanced community planning process that has occurred over the last year. Statements included in the meetings are reflected below.

CPP Participant Comments

I learned what programs MHSAs has, what the programs are for and how they can help.
- MHSAs Stakeholder

I learned about a variety of other projects that can be beneficial for my organization.
- MHSAs Stakeholder

[I learned] about the Crisis Residential Program that will be built & the process to update the technological information system.
- MHSAs Stakeholder

That DBH promotes and supports more bilingual mental health professionals not only in Spanish but other languages.
- MHSAs Stakeholder

MHSAs reaches a lot of people!
- MHSAs Stakeholder

I learned a little more about the services.
- MHSAs Stakeholder

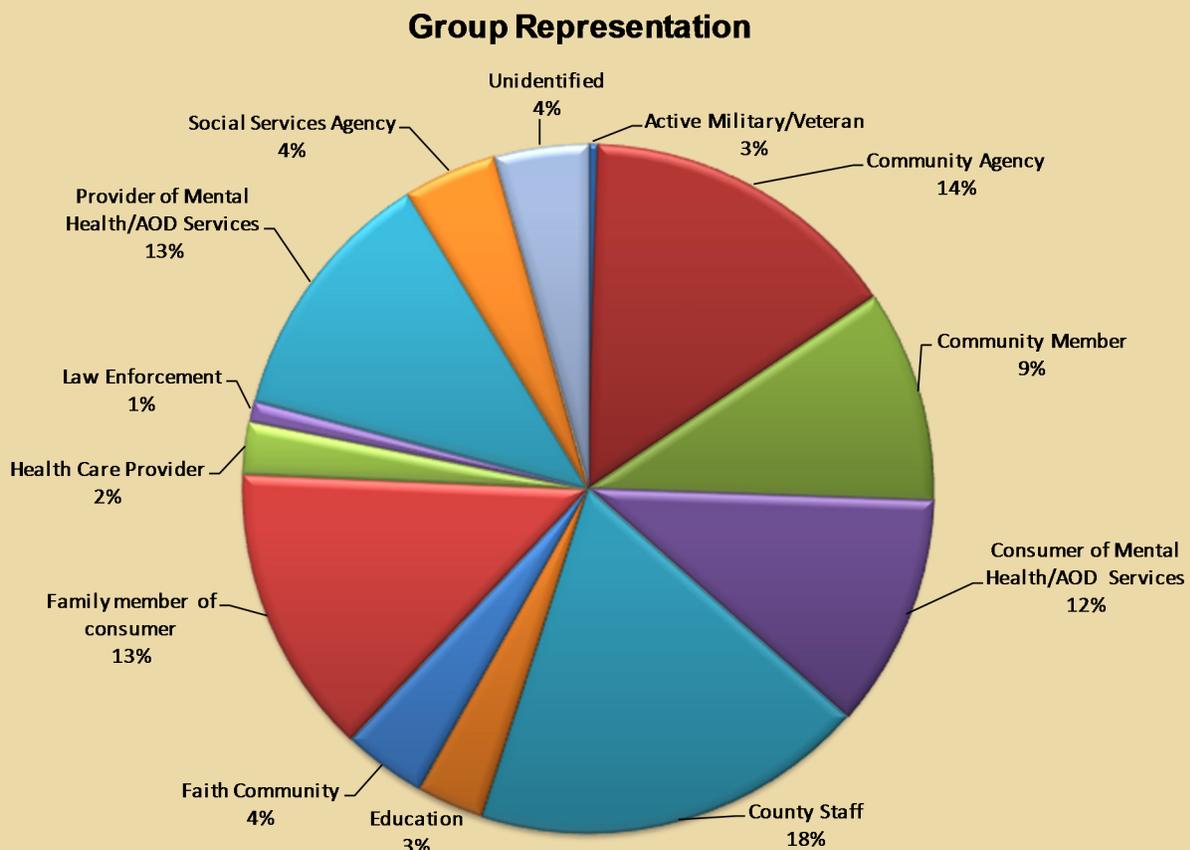
1st time here. Everything was new so I learned a lot.
- MHSAs Stakeholder

I really liked the Adobe Connect®. I was able to participate from my cell phone.
- MHSAs Stakeholder

Overview of Stakeholder Process

At each meeting participating stakeholders were provided with copies of the presentation materials and program resources. The DBH Public Information Office posted a copy of the presentation materials on the DBH website, allowing interested stakeholders the opportunity to download the materials at their own convenience. At the end of each meeting, diverse stakeholders were provided information concerning the planned Public Comment and Review time period (**March 20, 2015 through April 20, 2015**) as well as instructions about how to access the posted Annual Update (<http://www.sbcounty.gov/dbh/mhsa/mhsa.asp#>).

Approximately **241** stakeholders completed a stakeholder comment form in the MHSa Annual Update special community planning sessions held throughout February and March of 2015, with **294** individuals attending the meetings as documented by sign-in sheets and as a result of the public comment period. Each participant was asked to complete a comment form available in English and Spanish (see attachments for actual forms) that included questions regarding demographic information. Stakeholders that checked multiple boxes were counted in each category in which they identified. While not all attendees completed a stakeholder comment form, all attendees signed in on meeting sign-in sheets.



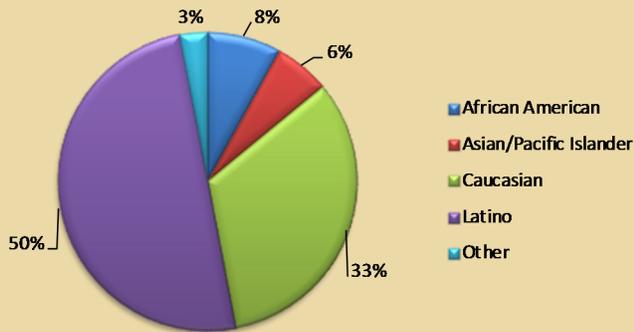
San Bernardino County is located in Southeastern California, approximately **60** miles inland from the Pacific Ocean. The County is the largest, in terms of land mass, in the continental United States, covering over **20,000** square miles. There are **24** cities in the County and multiple unincorporated and census designated places. Over **80%** of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). According to the California Department of Finance, the estimated population for 2014 is **2,085,669**. Approximately **75%** of the County population resides in the Valley region of the County, which accounts for only **2.5%** of the land.

Overview of Stakeholder Process

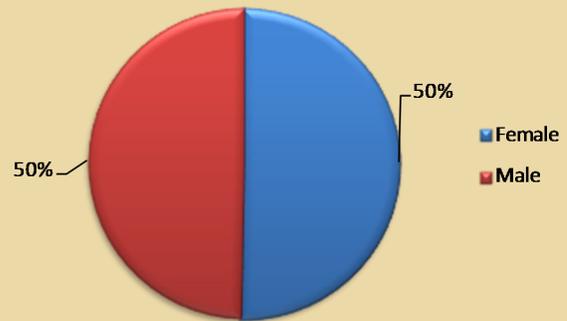
The County has four (4) military bases, utilizing 14% of the land, which include: Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

San Bernardino County is the fifth largest county in the State of California in terms of population and ethnic diversity. The largest population in the county is Latino, with 50%, followed by Caucasian, then African American, Asian/Pacific Islander, then Native American. The gender breakdown is nearly even, with 50.3% male and 49.7% female.

Countywide Ethnicity

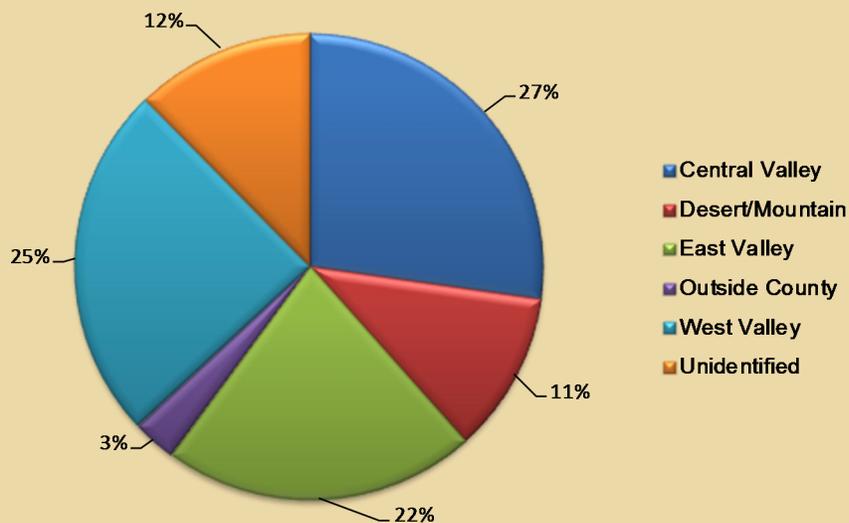


Countywide Gender



The stakeholders completing the comment forms identified which region of the county they represented. The regions represented were the West Valley, the East Valley, the Central Valley, and the Desert/Mountain. Some of the stakeholders did not identify with a specific region.

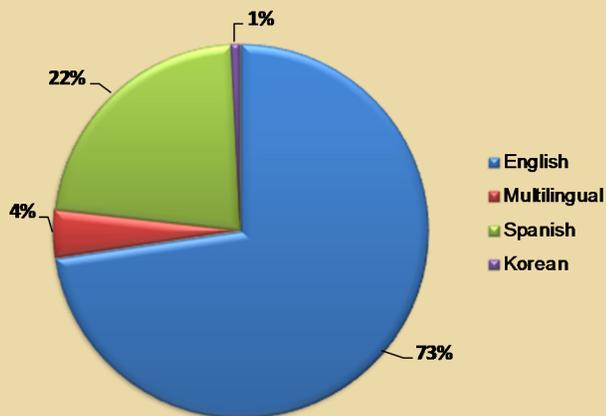
Regional Representation



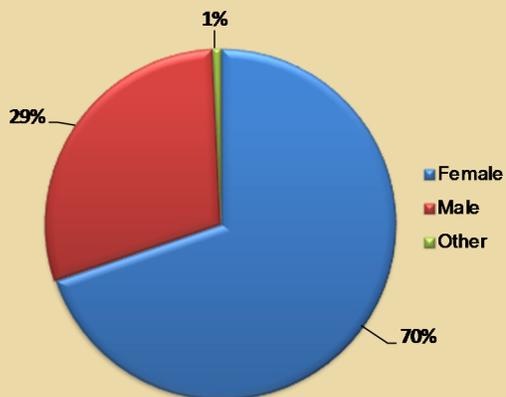
Overview of Stakeholder Process

The demographic breakdown of participants that completed a stakeholder comment form is illustrated below.

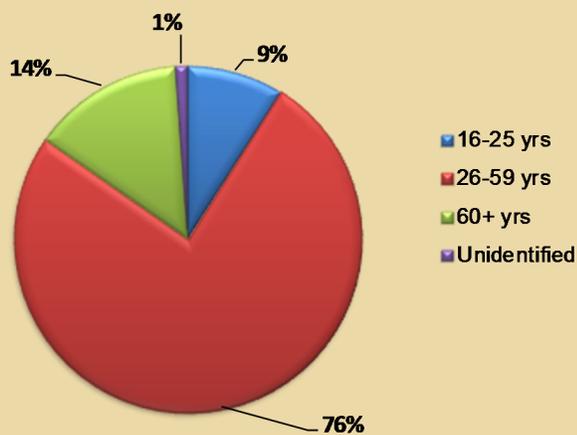
Primary Language



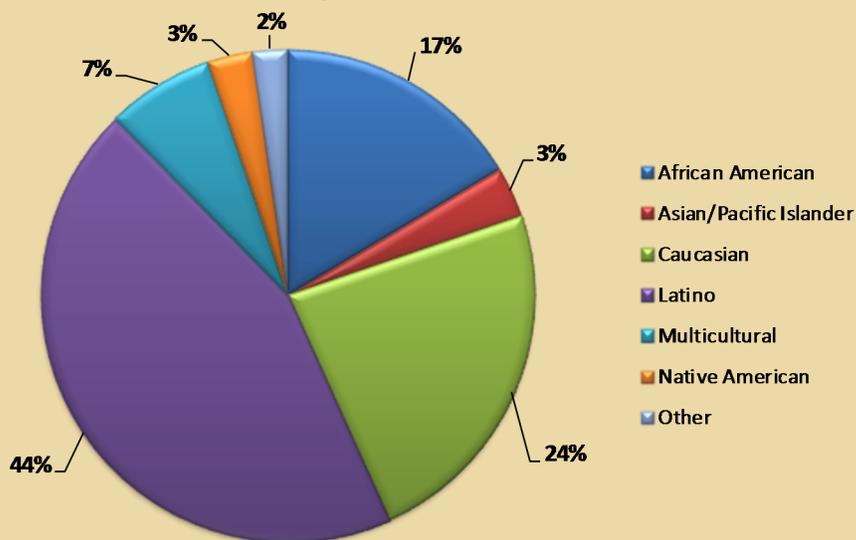
Gender



Age



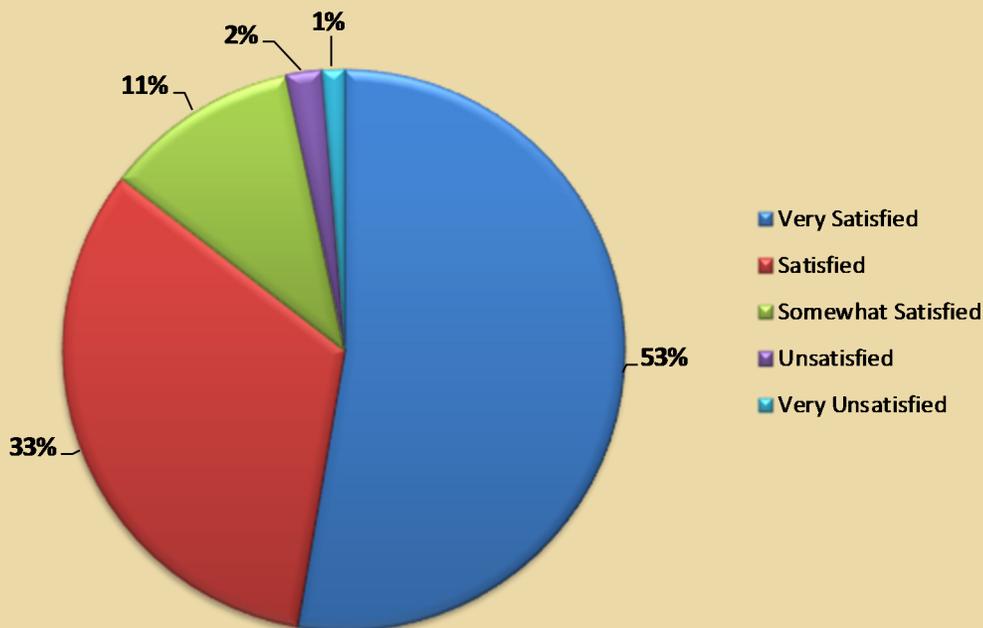
Ethnicity



Overview of Stakeholder Process

Participants completing the stakeholder comment form were asked to rate their satisfaction with the MHSOAC Annual Update. Overall results indicate that **97%** of participants were Very Satisfied, Satisfied or Somewhat Satisfied with the MHSOAC Annual Update.

Feeling About the MHSOAC Annual Update



Summary of Program Changes

While there have been no programs with significant changes, DBH, with input from stakeholders, has identified several program areas that require expansion of services in Fiscal Year 2015/16 . This expansion is due to increased demand as well as changes in the organizational focus of the state agencies providing oversight of MHSOAC. Because the expansion of programs would be for currently approved programs, DBH would not characterize increased activities as substantive changes. The service philosophy and array of services will not be changed, but rather extended and made accessible to more community members. This extension of services will also address the expanded requirements related to evaluation of program outcomes.

Expansion efforts as detailed below are contingent on MHSOAC funding estimates which are based on tax receipts and monthly cash projections. If cash projections change such that expansion is not feasible, program efforts detailed within this report will not be implemented as services provided under MHSOAC are contingent upon available funding. Cost per client and clients served estimates are included in the cost per client grids included with this report and are based on gross costs per MHSOAC direction to counties in the current plan instructions. This means cost per client information includes both MHSOAC and other funding utilized to serve the clients in MHSOAC Integrated programs.

Overview of Stakeholder Process

The following programs will continue to operate as currently approved in the MHSA Integrated Plan:

- **Community Services & Supports**
 - ◆ TAY-1: Transitional Age Youth (TAY) One Stop Centers
 - ◆ A-1: Clubhouse
 - ◆ A-4: Crisis Walk-In Centers (CWIC)
 - ◆ A-5: Psychiatric Triage Diversion Program
 - ◆ A-6: Community Crisis Response Team (CCRT)
 - ◆ A-8: Big Bear Full Service Partnership
 - ◆ A-9: Access, Coordination, and Enhancement (ACE)
 - ◆ OA-1: AgeWise - Circle of Care
 - ◆ OA-2: AgeWise - Mobile Response

- **Prevention and Early Intervention**
 - ◆ PEI SI-1: Student Assistance Program
 - ◆ PEI SI-2: Preschool Prevention and Early Intervention Program
 - ◆ PEI SI-3: Resilience Promotion in African American Children
 - ◆ PEI CI-3: Native American Resource Center
 - ◆ PEI CI-4: National Curriculum and Training Institute (NCTI) Crossroads Education Program
 - ◆ PEI SE-2: Child and Youth Connection
 - ◆ PEI SE-3: Community Wholeness and Enrichment (CWE)
 - ◆ PEI SE-4: Military Services and Family Support
 - ◆ PEI SE-5: LIFT
 - ◆ PEI SE-6: Coalition Against Sexual Exploitation (CASE)

- **Innovation**

- **Capital Facilities and Technological Needs**

The following programs may be expanded per funding availability to meet consumer needs in FY 2015/16 and are consistent with stakeholder priority areas identified in past and current stakeholder processes.

Community Services and Supports (CSS)

C-1: Comprehensive Children and Family Support Program

The Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for Full Service Partnerships (FSP) to provide "Wraparound" services to diverse children and youth with emotional disturbances and co-occurring disorders. Wraparound has proven to be an effective means by which children and youth receive assistance and avoid out-of-home placements or loss of current placements. Additionally, participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community.

Overview of Stakeholder Process

Fiscal year (FY) 2013-14 was the first full year in which the Katie A. Settlement, a lawsuit regarding access to mental health services for children and youth involved in the child welfare system, was being implemented. The CCFSS Program was selected as one of the primary means by which the Core Practice Model (CPM), a requirement of the settlement, would be implemented for dependents meeting the settlement specified subclass criteria. The CCFSS Full Services Partnerships serve dependents at home and in congregate care, all of whom potentially qualify for additional CPM services of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Existing Wrap-informed programs and CPM have strong similarities; therefore, utilizing these existing programs is appropriate. There are also strong similarities between CPM and these Wrap-informed programs, so utilizing these existing programs to implement CPM was deemed prudent. However, implementing CPM and new services (i.e., ICC & IHBS) presented a variety of challenges.



All of the existing program staff needed to be trained on the CPM, ICC, and IHBS. This process began prior to FY 2013-14, with the majority of the trainings occurring in FY 2013-14. In addition to the training, the infrastructure needed to support the provision of ICC and IHBS needed to be implemented. Although all staff were trained and appeared to quickly implement the requirements of the CPM, additional efforts continued throughout the year to ensure the CPM values and practices were implemented with fidelity. Having DBH staff involved in the implementation of the Child and Family Team Meetings (CFTM) was necessary throughout the year and additional resources are necessary to ensure continued success.

In this expansion, CCFS will continue the collaborative relationships that have been established with Children and Family Services (CFS) and will build on the existing relationship to serve an estimated **150** additional system involved children and youth. The CCFS Program is going to expand to include Outreach and Engagement efforts to serve dependents in congregate care. Clinical Therapists will be co-located at CFS regional offices in order to work closer with the CFS Social Workers caring for the children in placement. The clinical therapists will conduct mental health assessments at the group homes, provide ongoing Core Practice Model services as needed, and work toward the dependents being served by one of the three (**3**) existing CCFSS Programs. Children placed out of county and in need of an ongoing group home placement will be progressively linked to appropriate services. Children in group homes who are likely to be leaving congregate care in the next three months will be progressively linked to Wraparound or Success First/Early Wrap. These therapists will be in the field often and will require substantial support at the office. Support staff will be responsible for ensuring compliance with all required registration and tracking of activities.

The expansion will increase access to these already approved services thereby allowing the Department, along with our Children and Family Services department stakeholders, to serve an additional **150** system involved children.

Overview of Stakeholder Process

A-2: Forensic Integrated Mental Health Services

The Forensic Integrated Mental Health Services is composed of two (2) main components. The first includes the Supervised Treatment After Release (STAR) and the Forensic Assertive Community Treatment (FACT) programs, both which serve consumers who participate in the Mental Health Courts. The other component is the Crisis Intervention Training (CIT) program which focuses on training law enforcement personnel on ways to safely and effectively respond to consumers with mental health issues who are in crisis in the community.

The STAR program provides outpatient treatment services for the San Bernardino, Rancho Cucamonga and Victorville Mental Health Courts, while High Desert Medical Center (HDMC) is contracted to provide services for the Joshua Tree Mental Health Court. Individuals who have trouble keeping appointments at outpatient clinics are referred to the FACT program from all four (4) Mental Health Courts. These consumers are seen weekly, or as needed, at their homes. If they can't make it into the office, the consumers will also receive home visits by a psychiatrist. All of these programs provide intensive case management and treatment, medication support, drug and alcohol treatment, residential placement/housing assistance, and periodic court reviews. In addition, STAR provides a day treatment rehabilitation program. There is currently a need for additional slots for service to serve consumers outside of the mental health court.

Expansion of the existing STAR and FACT programs to develop a 'Community STAR' and 'Community FACT' program will increase access of existing approved FSP services to traditionally unserved and underserved populations and enhance prisoner reentry services. The target population will include adults with Severe and Persistent Mental Illness (SPMI) or co-occurring disorder who are high users of the criminal justice system and psychiatric hospitalizations, and who meet any of the following criteria:

- No oversight by Mental Health Court.
- No formal Probation Supervision.
- No Parole Supervision.
- Misdemeanors on Summary Probation (Proposition 47).
- Criteria no longer met for enrollment in the STAR, FACT or other community based treatment program which serves the Adult Forensic population, yet requires an additional short period (3-6 months) for the transition process.
- Transitioning from a correctional setting (i.e. Detention Centers, State Hospitals) through a seamless process with the least disruption to existing behavioral health treatment care upon release into the community.

A-3: Members Assertive Positive Solutions/Assertive Community Treatment

The Members Assertive Positive Solutions (MAPS) Program is a Assertive Community Treatment (ACT) program for individuals with serious mental illness. The program exists to help people live successfully in the community and make strides toward their hopes and dreams, achieving their personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The services and support include comprehensive assessment and treatment, crisis intervention and immediate support 24 hours/day 7 days/week, psychiatric assessment and treatment, medication management and support, risk focused assessment and intervention, physical health screening, care coordination and referral, substance abuse intervention and counseling vocational services, social skill building activities, case management, housing support, benefits and entitlements assistance, family support, education and life skills coaching, providing information and learning opportunities as support for individuals in their recovery, staff support and consultation when members are hospitalized and support to aid their transition back to the community upon discharge.

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A current challenge of the program is lack of affordable housing and co-occurring resources in the community. The planned expansion of this program will serve an additional **25** clients. Outreach and engagement activities are being conducted to reach the most difficult to activate clients in the community. This expansion will accommodate clients referred through these outreach activities, increasing access to new populations. Additionally, the proposed expansion will include access to voluntary crisis residential services for adults. Based on available funding, anywhere from **6-30** beds could be made available to assist the clients that are stepping down from higher levels of care.

Prevention and Early Intervention

PEI CI-1: Promotores de Salud/Community Health Workers

This program is designed to increase awareness and access to community-based prevention, early intervention, and mental health services without stigma or fear of discrimination. This program promotes health awareness, education and available resources for the members of various culturally-specific populations throughout the county in a culturally and linguistically appropriate manner. Services are specifically targeted at unserved and underserved cultural groups, including Latino and Spanish-speaking communities, African-American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities.

Through expansion, peer counseling services will be included as part of the scope of work of the Promotores de Salud program. This strategy was found to be very effective as part of the Innovation Holistic Campus service design in meeting the needs of the Latino community. Two (2) of the holistic campuses reported that **90%** of the users of their peer support and counseling services were part of the Latino community. The expanded provision of services will allow approximately **250** individuals to participate in counseling services being provided by experienced, well-trained and supervised peer and family advocates, thereby increasing access to potentially new populations. This additional service will be closely developed and evaluated to monitor the effectiveness of the approach for consideration in other programs or parts of the entire system of care.



PEI CI-2: Family Resource Center

This program offers various culturally and linguistically competent services tailored to meet the identified needs of the communities they serve. This program serves all ages and includes the following services: personal development activities; parent/caregiver support and education; behavioral health education workshops; after school programs for children/youth/transitional age youth; health education workshops; adult skill-based education (e.g. education and employment assistance); community counseling and individual counseling. Currently, the FRC program is designed to serve individuals exhibiting risk factors for behavioral health conditions or individuals first experiencing signs and symptoms of a mental health condition.

The Family Resource Center program has traditionally been implemented through contracted

Overview of Stakeholder Process

provider agencies. During the next Request for Proposal (RFP) cycle, the scope of work will be updated to include an additional required service of targeted relapse prevention groups for individuals living with serious mental illness. If the need is indicated, maternal mental health support services may also be included. The expansion of these already approved services in this program will increase access to new populations.

PEI SE-1: Older Adult Community Services

This program is designed to promote a healthy aging process for older adults (ages 60+) by providing prevention and early intervention services to assist in maintaining positive mental health. Services include mental health and substance abuse screenings, wellness activities, home safety education, suicide prevention services, case management and therapeutic interventions. These services are delivered via a mobile unit, in senior centers, community centers and in the home.

Over the course of the year, analysis was conducted to identify any gaps in the continuum of care for the Older Adult population. Based on review of services offered in the CSS Agewise Program, it was determined that peer counseling services offered in Agewise could enhance the scope of work of the PEI OACS program as an additional service strategy, thereby increasing access to services. This updated strategy will be implemented in FY 2015/16 and reflected in the Request for Proposal (RFP) issued to procure for the program services.

Workforce Education & Training

Over the last several years, the San Bernardino County Workforce Education and Training (WET) component has been highly effective in reaching its targets by implementing all of the identified actions in the WET plan. There has been success in implementing and expanding Marriage and Family Therapist (MFT), Master in Social Work (MSW), and psychology internship programs. Moving forward, our focus will expand to include a nursing and License Professional Clinical Counselor (LPCC) internship programs over the next several years. We will also explore the need for a Physician's Assistant and Psychiatric Nurse Practitioner internship program. Additional planned program changes for the Workforce Education and Training component for FY 2015/16 include expanding the Psychiatry Residency Program by adding additional residents from Loma Linda University Medical Center and Arrowhead Regional Medical Center to help address the Psychiatrist shortage in the County. DBH is also expanding the MFT Internship Program by adding a doctoral MFT intern, as all current intern positions are filled with clinical interns and there is a need for a succession plan for health informatics and research to support outcomes driven programming that adding a doctoral MFT intern would address. The final program change is the expansion of the Employee Internship Program. Specifically, Bachelor in Social Work (BSW) and Alcohol and Drug Counselor (ADC) employee interns will be included. In addition WET will continue to implement clinical trainings such as CANS/ANSA and Cognitive Behavioral Therapy (CBT) training in a continued effort to support the development of our workforce as we move towards meeting performance outcomes that incorporate evaluation technology into the scope of work of many DBH programs.

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Capital Facilities and Technological Needs

The goals of Capital Facilities and Technological Needs are to methodically achieve an integrated, modernized, information systems infrastructure; Improve the quality, access, equity and efficiency of care by using a fully integrated electronic health record system, personal health information systems, and telemedicine; and Improve or replace existing capital projects to meet program infrastructure needs.

Program updates related to this component include an update on the status of the project described in the MHA Integrated Plan. Construction of a new Crisis Residential Treatment (CRT) facility is expected to begin during FY 2015/16. The facility will be modeled after DBH's previous Capital Facilities project, the Transitional Age Youth One Stop Center/Crisis Residential center. The project will demolish two uninhabitable county owned buildings and construct a newly designed structure on the site to meet the needs of the new facility. This project is funded through a state grant to support voluntary crisis services for adults and is expected to provide **16 beds**.



Overview of Stakeholder Process

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

Public Review

The DBH MHSA Annual Update was posted on the department's website from **March 20, 2015 through April 20, 2015**, at www.sbcounty.gov/dbh. The Public Hearing to affirm the stakeholder process was scheduled to take place at the regularly scheduled Behavioral Health Commission Meeting on **May 7, 2015** which is held from **12:00 p.m. until 2:00 p.m.**

The Department invited the public to review this and other plans and provide feedback or comments to the plan, not just during the 30 day comment period. Please see the next section of this report for detailed instructions on how to submit comments under the Substantive Comments/Recommendations section of this report.

Substantive Comments/Recommendations

An analysis of substantive recommendations is included in the Public Posting and Comment section of this final MHSA Annual Update for FY 2015/16. 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. Comments can be received anytime through the year but will not be included in the final plan. The plan was posted for 30-days per Welfare and Institutions code 5848 and was posted between **March 20, 2015 through April 20, 2015** at www.sbcounty.gov/dbh.

If you would like to request a comment form be sent to you please email please contact DBH at MHSA@dbh.sbcounty.gov or call **1-800-722-9866** for more information.

During the stakeholder meetings for this MHSA Annual Update 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://www.sbcounty.gov/dbh/dos/template/Default.aspx>.

During the stakeholder meetings, it was noted several times that community members would like information about how to access funds related with MHSA programs for their areas. The department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs.

RFP's may be accessed at the county website per the following link <http://www.sbcounty.gov/main/rfp.asp>. 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.

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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.

Additionally, several questions were asked about program outcomes, MHSA funding percentages and how new MHSA programs get developed. Program outcomes can be found through the “Current Programs” section of this MHSA Annual Update report. MHSA funding information related to specific programs can be found in the “Fiscal” section.

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 or phone at MHSA@dbh.sbcounty.gov or 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, clients 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 (i.e., inpatient, residential, long term care, day treatment, intensive outpatient, general outpatient care), and program needs are considered.

Assistance for Disabled Individuals:

A good resource for finding services to support developmentally and physically disabled adults would be to 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.

Once the plan is written and posted, feedback is regularly solicited on the content of plans/programs while plans are posted for public review. Feedback/comments can be submitted via email or via the phone at MHSA@dbh.sbcounty.gov or **1-800-722-9866**. If feedback is received it may be incorporated into the new program plan, or if not incorporated, addressed in the final draft MHSA Annual Update FY 2015/16, as to why it was not incorporated.

Depending on the program proposal, services can be provided by DBH clinics or organizational contract providers. In many cases, programs are implemented using both DBH clinics and organizational contract providers working together to provide services in a system of care framework. For services provided by organizational providers, an RFP/procurement process is required. The RFP process can be accessed via the link above and is as follows <http://www.sbcounty.gov/main/rfp.asp>.

Additional information about past MHSA approved plans can be accessed at the following link <http://www.sbcounty.gov/dbh/mhsa/mhsa.asp#>. If you have any questions about MHSA programs

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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 topics they would like more information about specifically. 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.

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, mental 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 that are 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; mental 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:

Current Innovation projects are discussed in detail in the Innovation Project section of this report. To date three (3) Innovation projects have ended. Two (2) have final reports published in the MHSA Three-Year Integrated Plan FY 2014/15—2016/17, and one (1) is included in this report, detailing project outcomes, successes and what practices will be continued based on learning during the project. Additional information regarding Innovation 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://www.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 websites 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.

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In addition to the available resources from the OHS regarding homeless services, DBH provides services from the Community Crisis Response Team (CCRT) and the Crisis Walk-in Centers (CWIC) 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 patient 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 Centers (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**.

Community Education and Resources:

Community Outreach and Education (CORE) provides outreach and education throughout San Bernardino County. It is a component found in many of our MHSa funded programs. In addition to providing education, resources, and linkages to services, it also assists with reducing stigma. The Community Outreach and Education (CORE) department within DBH attends and completes outreach to community events throughout the year. Additional information about CORE activities and obtaining information about department program and services can be obtained by calling **(909) 388-0938**.

Thank you for your participation in our county stakeholder processes. We greatly value your time and feedback as we work to serve the residents of San Bernardino County, as well as the opportunity to provide you this feedback on your requests for more information during the MHSa Annual Update stakeholder meetings.



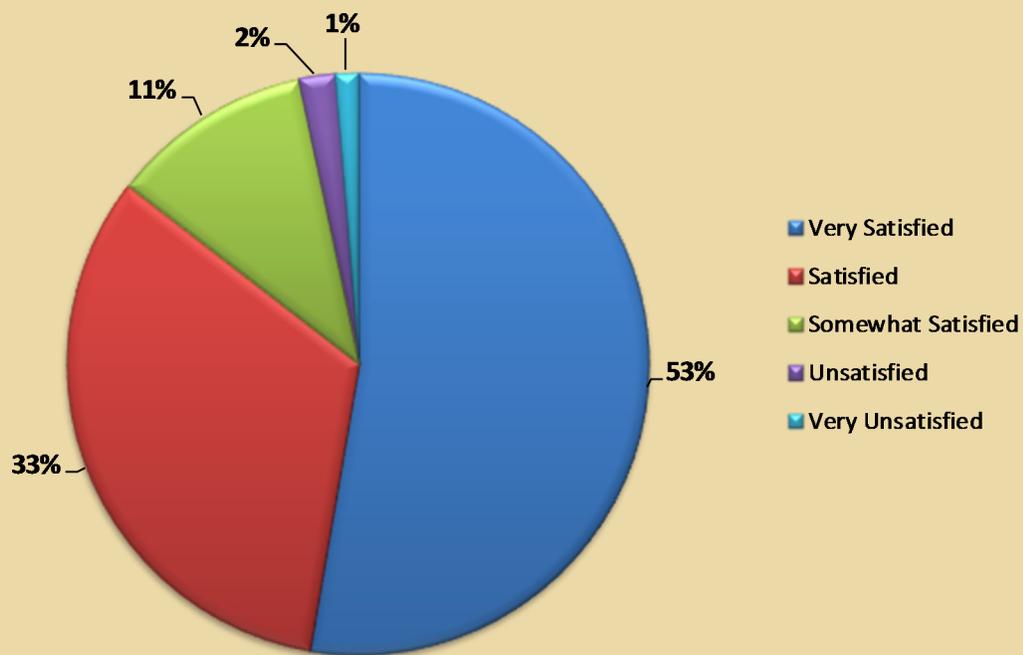
Overview of Stakeholder Process

Public Posting and Comment

DBH would like to thank those who participated in the public comment portion of the stakeholder process. During the thirty (30) day public posting of the MHSA Annual Update, DBH continued to promote the thirty (30) day posting and provided overviews and information related to the MHSA Annual Update. All thirty-three (33) San Bernardino County Public Libraries received a copy of the posted plan including instructions for submitting feedback. A press release, in English and Spanish, notifying the public of the posting was sent to fifty- one (51) media outlets. A series of web blasts were released to all DBH clinics, contracted provider agencies, the Community Policy Advisory Committee, the Cultural Competency Advisory Committee and all subcommittees, the Association of Community Based Organizations, the Behavioral Health Commission, were included on all DBH sponsored social media sites, including Facebook and Twitter, and was posted on the main San Bernardino County website. The MHSA Coordinator made printed copies of the plan, made them available at every stakeholder meeting and distributed three (3) hard copies to community and agency members, upon their request. As a result, nine (9) comments were received. All of the comments were received on the Stakeholder Comment Form that was available to all stakeholders.

DBH received one (1) additional comment via email from a stakeholder interested in receiving behavioral health services. The stakeholder was subsequently contacted by the DBH Access unit for follow up. All nine (9) comment forms received indicated the stakeholders were satisfied to very satisfied with the MHSA Annual Update and affiliated stakeholder process. The graph below illustrates the reported general feelings about the MHSA Annual Update from stakeholders that participated in Community Program Planning and provided feedback during the 30-Day Public Comment period. In total, 241 individuals completed a stakeholder comment form. Of the respondents, 97% indicated they were satisfied to very satisfied with the MHSA Annual Update, 2% indicated they were dissatisfied, and 1% indicated they were very dissatisfied.

Feeling About the MHSA Annual Update



Overview of Stakeholder Process

Summary and Analysis of Substantive Comments

A summary and analysis of all comments, along with responses, are included as follows:

Comments received on the MHSA Annual Update and stakeholder process, were supportive of the MHSA Annual Update and the Department's Community Program Planning process. Comments received included opportunities to correct wording; affirmation that investments in workforce development are positive; praise for the departments' commitment to providing culturally competent services and programs; support for prevention and early intervention programs; and positive feedback about MHSA programs, in general.

The following are direct questions, comments, or concerns received regarding the MHSA Annual Update posed within the written feedback that was received, along with appropriate responses. Requests for wording changes have been made and are not included below.

Comment: "I am a provider of MHSA services through one of the programs in this report. I have participated in several of the programs through WET including MSW internship program, MHSA loan assumption program, and am going to be taking advantage of the LEPP. However, due to recent pay cuts on top of existing sub-standard pay, I am strongly considering leaving the county so that I can make a decent living. Working on retaining employees should be a goal."

Response: Thank you for the support and acknowledgment of the value of the San Bernardino County Behavioral Health Workforce Education and Training (WET) programs. DBH is strongly invested in the continued development and retention of a diverse and competent workforce, as demonstrated in the department's strategic plan and by the programs described in the WET component section of this Annual Update. The department continues to address workforce and geographic shortage areas and is committed to continuous improvement and is aware of retention issues that need to be addressed, as well.

Comment: I learned about the "success of the services being implemented" by reviewing the MHSA Annual Update.

Response: Thank you for your comment. Behavioral Health is dedicated to ongoing monitoring and quality management of behavioral health programs and services and invites you to share your thoughts throughout the year. Comments can always be provided, not just during the Annual Update, by contacting the MHSA Office of Program Planning and Development at (909) 252-4017 or by emailing MHSA@dbh.sbcounty.gov.

Comment: In response to the survey question, Do you have any concerns not addressed in the 2015/16 MHSA Annual Update?: "Not necessarily concerns not addressed but in general there is always work to do and areas in which systems can improve. Work towards the reduction of disparities is a lifelong process to attain and maintain. I believe MHSA has contributed immensely to communities across the county. Being sensitive to cultural factors and designing programs based on needs identified by communities. I encourage county DBH to keep up the great work."
Additional comments included: I learned about "proposed changes to enhance existing services" and "The draft plan looks great. All partners in care deserve a big 'thank you' for their passion and commitment in the work they do."

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- Response:** Thank you for your comments and feedback. Behavioral Health is committed to continuous improvement and investment in the diverse communities of San Bernardino County.
- Comment:** “Regarding the demographic data, it would be good to be able to compare service delivery demographics with the actual demographics of the County. This would allow one to see if the service level is commensurate with the population. There are a lot of programs under the MHSA in San Bernardino County. DBH does an admirable job in working to keep the public informed about what services are provided with those funds.”
- Response:** The Department of Behavioral Health is pleased for the support for MHSA programs and services. We appreciate the comment related to countywide demographic data. The data can be located in the Community Program Planning section on page 59 of the MHSA Annual Update. To make comparison easier, the final plan also includes the demographic information in the Executive Summary on page 11 so you do not have to flip through pages to make the comparison.
- Comment:** “I would like to see a review of PEI services – find out if other programs have the huge demands for services that we are experiencing – and discuss possibilities for expansion of services. I wanted to compliment San Bernardino DBH in their diligent offers to reach out to the community and involve them in planning/decision making process. I have seen firsthand the many benefits of the PEI programs. The PEI programs that I am involved with are VERY busy and making positive inroads in the communities we serve and I am witness to a decrease in suffering, have examples of decreasing unemployment, and reducing stigma and discrimination. PEI proves that those in need will seek help if they know it is there, is easily accessible, and have no barriers - ie: insurance; having to meet diagnostic criteria.”
- Response:** Thank you for the support of Community Program Planning and the programs outlined in the Prevention and Early Intervention component. An important aspect of planning is ensuring the sustainability of programs over time. Behavioral Health has maximized the utilization of MHSA resources to invest in the delivery of Prevention and Early Intervention services but is open to leveraging opportunities for continued growth of the programs. You are invited to share your thoughts throughout the year. Comments can always be provided, not just during the Annual Update, by attending stakeholder meetings, contacting the MHSA Office of Program Planning and Development at (909) 252-4017, or by emailing MHSA@dbh.sbcounty.gov.
- Comment:** “I learned about the various resources our community offers regarding mental health.”
- Response:** Thank you for your comment. Comments are welcomed throughout the year and can be provided by contacting the MHSA Office of Program Planning and Development at (909) 252-4017 or emailing MHSA@dbh.sbcounty.gov. In addition, please share information about resources and how to access information about programs with your network of colleagues, friends, and family.

Overview of Stakeholder Process

Comment: I learned that there are a huge number of programs under this act. The program I was interested in most is the Prevention and Early Intervention Programs. This is great because, as I understand it, a lot of aspects of healthcare are attempting to shift from the costly treatment illnesses after they have reached their worst to the less expensive preventative treatment. I learned that innovation component is geared towards unserved and underserved populations. I also did not know how much went in to the planning process, with community involvement especially. This was very informative and worth the time to go through it”.

Response: Thank you for your comment. DBH strives to create a County where all persons have the opportunity to enjoy optimum wellness. In doing so, the DBH is supporting the community in achieving the Countywide Vision by ensuring all residents have the resources they need to provide the necessities of life to their families. Additional information regarding the Department of Behavioral Health can be found at www.sbcounty.gov/dbh. Comments can always be provided, not just during the Annual Update, by attending stakeholder meetings, contacting the MHSA Office of Program Planning and Development at (909) 252-4017, or by emailing MHSA@dbh.sbcounty.gov.

Comment: I learned “how important it is to gather all the data for the funding source.”

Response: Thank you for recognizing the importance of and role that accurate data collection and reporting plays in the program development, analysis, and improvement process. DBH strives for data accuracy but recognizes the need for continuous improvement.

There were no substantive recommendations for revisions to the FY 2015/16 MHSA Annual Update.



Screenshot of public posting notice on San Bernardino County website

Overview of Stakeholder Process

Public Hearing

A Public Hearing hosted by the San Bernardino County Behavioral Health Commission was conducted on May 7, 2015, as part of the regular Commission meeting. All attendees were provided with handouts which included an agenda, meeting regulations for MHSA Public Hearings, access to Comment Forms in English and Spanish, and a copy of the MHSA Public Hearing PowerPoint Presentation. As with all public meetings, interpretive services were offered and provided to Spanish speaking participants at the Public Hearing.

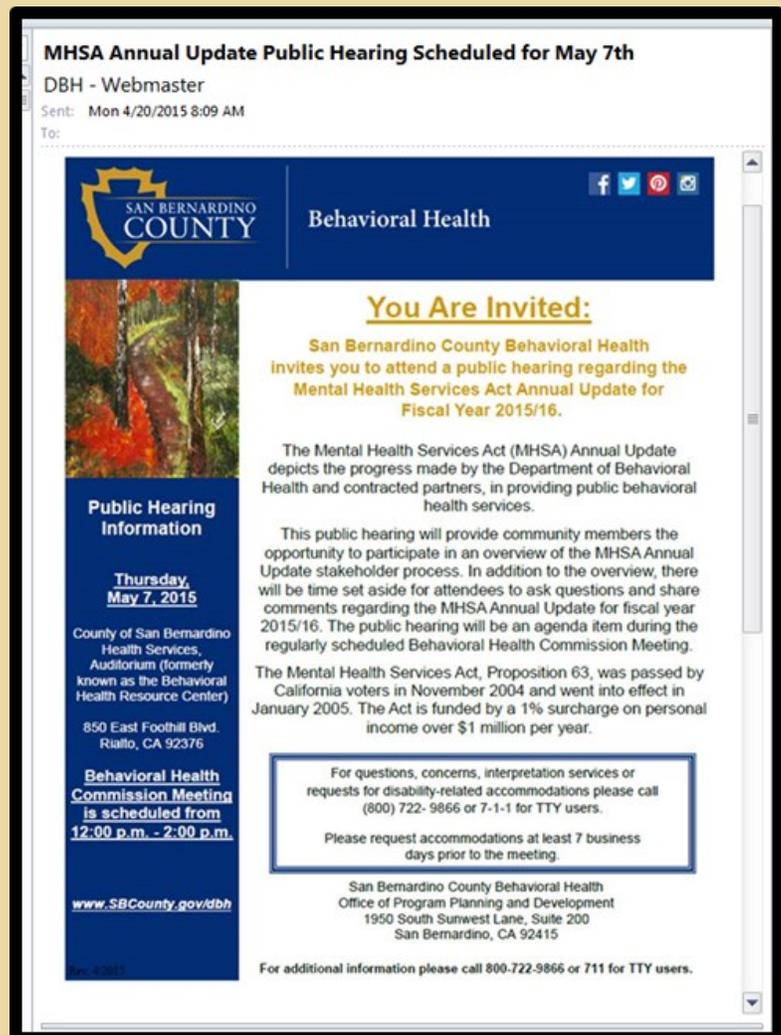
A flyer in English and Spanish advertising the Public Hearing was distributed to all DBH clinics and contracted provider agencies, all list servs, posted on the DBH Intranet and the Internet and the County internet site, included as a post on all social media sites, including Facebook and Twitter, and distributed by Community Outreach and Engagement and MHSA Program Planning and Development Staff at a variety of venues.

In addition, a press release was created and distributed to fifty-one (51) media outlets to inform all county residents of the Public Hearing.

People in attendance at the Public Hearing included consumers, family members, community members, service agency representatives, advocates, students of local universities, DBH staff, and Behavioral Health Commissioners as evidenced by sign-in sheets.

Participants were provided with Public Hearing Guidelines and the facilitator read through the guidelines at the beginning of the Public Hearing.

Two verbal comments were received, both which supported the investment in Prevention and Early Intervention services. No substantive recommendations were received. The Behavioral Health Commission affirmed that the Department had adhered to the MHSA Community Program Planning process and supported the submission of the MHSA Annual Update for Fiscal Year (FY) 2015/16 to the San Bernardino County Board of Supervisors for approval at the June 2, 2015 meeting and the subsequent submission to the Mental Health Services Oversight and Accountability Commission.



Screenshot of web blast for Public Hearing



Artwork by Lorraine Smith

Prevention and Early Intervention (PEI)

Prevention and Early Intervention

Introduction

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

PEI incorporates the values of cultural competence, consumer and community empowerment, collaboration and inclusion in providing services that emphasize recovery, wellness and resiliency. 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 MHSa PEI guidelines, and continue to transform the public mental health system. Services fall within three Institute of Medicine (IOM) categories: Universal, Selective, or Early Intervention. Universal services are targeted at an entire community not identified on the basis of individual risk; Selective services provide strategies to deter the onset of a mental illness among individuals and change community circumstances that contribute to behavioral health problems; Early Intervention services are directed toward individuals exhibiting early signs of a mental illness or early onset of mental illness or emotional disturbance with psychotic features.

MHSa Legislative Goals of PEI

The overall Mental Health Service Act (MHSa) goals of PEI include:

- Suicide reduction;
- Reduction of incarcerations;
- Reduction of school failure/dropout rates;
- Reduction of unemployment among mental health consumers;
- Reduction of prolonged suffering;
- Reduction of homelessness among consumers;
- Reduction of stigma and discrimination associated with mental illness; and



Artwork by Erica Porteous

San Bernardino County's PEI Plan

In 2008, San Bernardino County (County), Department of Behavioral Health (DBH) and community stakeholders embarked on an extensive community planning process to identify priorities and strategies and to develop concepts to be included in the PEI Component Plan for approval by the State.

DBH's PEI Plan was approved on September 25, 2008, which originally included twelve programs. A thirteenth program has been added as the result of a successful Innovations project. All programs are categorized under three initiatives or "access points".

1. School Based Initiative.
2. Community Based Initiative.
3. System Enhancement Initiative.

Prevention and Early Intervention

School Based Initiative

The School-Based Initiative is designed to strengthen student health and wellness. The goal is to reduce risk factors, barriers and/or stressors that can contribute to mental illness while building protective factors and supports, and providing appropriate interventions at schools and after school programs. Student-Based PEI programs include:

- Student Assistance Program (SAP).
- Resilience Promotion in African-American Children (RPiAAC).
- Preschool PEI Program (PPP).



Artwork by Erica Porteous

Community Based Initiative

The goal of the Community-Based Initiative is to build and strengthen the capacity of communities to provide prevention and early intervention opportunities and community empowerment activities in natural settings. Community Based PEI programs include:

- Family Resource Centers (FRC).
- Native American Resource Center.
- National Curriculum and Training Institutes (NCTI®).
- Crossroads Education Program.
- Promotores de Salud/Community Health Workers (PdS/CHW).

System Enhancement Initiative

The goal of the System Enhancement Initiative is to build and strengthen collaboration across public service organizations and work to implement efforts to promote wellness across all systems. System Enhancement PEI programs include:

- Older Adult Community Services (OACS).
- Child and Youth Connection (CYC).
- LIFT Home Visitation Program.
- Military Service and Family Support (MSFS).
- Community Wholeness and Enrichment (CWE).
- Coalition Against Sexual Exploitation (CASE).

PEI Statewide Projects

In 2010, DBH PEI assigned **\$8.6** million to support implementation of PEI Statewide Projects intended to build PEI capacity across the state via the California Mental Health Services Authority (CalMHSA). This effort was jointly initiated with other California counties, for the purpose of making a statewide impact.

The three statewide projects include:

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

Prevention and Early Intervention

PEI Statewide Projects, continued

The original funding expired in June 30, 2014, and counties were asked to provide continued contributions for a Phase II Plan for sustaining PEI statewide projects. During community planning meetings, DBH posed the question of continued support for these projects and stakeholders overwhelmingly expressed agreement to continue support, as long as local operations were not negatively impacted by the contribution. The requested contribution for larger counties, such as San Bernardino, was between **4%** and **7%**. At the conclusion of the community planning process in June 2014, the County DBH committed to the contribution of **4%** of the PEI allocation for our county to continue implementation of the Statewide PEI projects through June 30, 2015.

During this fiscal year, Behavioral Health will again support the PEI statewide projects with the **4%** contribution. Phase II planning for substantiating PEI statewide projects is underway and all statewide initiatives (Stigma and Discrimination Reduction, Student Mental Health Initiative, and Suicide Prevention Program) are being marketed under one common statewide campaign: Each Mind Matters. Upon stakeholder feedback and agreement, and approval by the County Board of Supervisors, DBH will contribute to the PEI statewide projects in a manner supported by local stakeholders. Determinations concerning funding and project-based support will also be based on analysis and support across the state.

Stigma and Discrimination Reduction Initiative

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

ACTIVITIES:

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



Walk In Our Shoes-Chino Hills, CA

Student Mental Health Initiative

GOAL:

Eliminating stigma and discrimination against individuals with mental illness.

ACTIVITIES:

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

Prevention and Early Intervention

Suicide Prevention Program Initiative

GOAL:

Support and coordinate with counties on the implementation of the California Strategic Plan on Suicide Prevention.

ACTIVITIES:

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

San Bernardino County Local Impact

The **Know the Signs** Suicide Prevention Campaign informs Californians of three things: warning signs for suicide, how to talk to someone about suicide, and how to identify helpful resources. County residents received campaign information through TV, online and magazine ads, resulting in **47.2** million total estimated views (November 1, 2012 – January 15, 2014).

Directing Change is a statewide contest that engages students in creating videos about suicide prevention and stigma and discrimination reduction. **39** Directing Change submissions were received in 2014 and **21** were received in 2013. In addition, San Bernardino County and Riverside County held a joint award ceremony to recognize the 2014 student winners. Participating schools received several donated suicide prevention and stigma reduction materials.

The **Walk In Our Shoes** Campaign educates 4th-6th grade students through school plays and online engagement about individuals with mental health challenges, and develops compassion and acceptance. **7** Walk In Our Shoes school plays were held in San Bernardino County elementary schools from 2013-2014. In addition, there have been nearly **2,200** website visits from County residents to WalkInOurShoes.org (August 2013 – September 2014).

The **Speak Our Minds** speaker's bureau is an online resource to find speakers who can talk about mental health and suicide prevention, in an effort to end stigma, promote awareness, compassion and acceptance. Samaritan Counseling Center received **\$15,000** to implement up to **44** speaker bureau forums from July 1, 2013 – June 30, 2014; El Sol Neighborhood Education Center received **\$10,594** to implement up to **64** presentations from January 1, 2013 – December 31, 2013; Brightest Star received **\$15,000** to implement up to **54** presentations from January 1, 2013 – December 31, 2013.



Walk In Our Shoes-Chino Hills, CA

Prevention and Early Intervention

San Bernardino County Local Impact, continued

Applied Suicide intervention Skills Training (ASIST) is a training for caregivers who want to feel more confident and competent in helping to prevent the immediate risk of suicide of those at-risk for suicide. In San Bernardino County, **310** individuals were trained in *ASIST* through statewide funds (July 2011–September 2014).

safeTALK is a suicide alertness training that prepares caregivers, students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and professional athletes to become suicide-alert helpers. In San Bernardino County, **164** individuals were trained in *safeTALK* through statewide funds (July 2011–September 2014).

NAMI is the National Alliance on Mental Illness, which provides information on the impact of stigma and how to identify mental health concerns early on. **50** presentations were provided to San Bernardino County from NAMI programs including *Ending the Silence*, *In Our Own Voice*, *Parents and Teachers as Allies*, and *Provider Education* reaching more than **1,390** individuals (September 2011–September 2014).

CalMHSA has expanded 24/7 **crisis hotline services** as well as the types of crisis/support services they provide. Currently, San Bernardino County offers the Community Crisis Response Team Hotline as a resource for callers in any mental health crisis. Through the expanded efforts of CalMHSA, San Bernardino County is now served by the Didi Hirsch Suicide Crisis Hotline. Calls made to this hotline add an additional resource to our county that is directed toward assist those individuals who are at risk of suicide. More than **8,730** calls were made to Didi Hirsch's crisis hotline from July 2011 – September 2014.



School-Based Initiatives

Student Assistance Program (PEI SI-1)



Artwork by Julie Journey

The Student Assistance Program (SAP) is a school-based approach that focuses on services for diverse students (grades K-12) and their families who are in need of prevention education and early interventions for substance abuse, mental health, emotional and social issues. This program connects behavioral health, educators, programs and services to create a network of supports between schools and community based organizations, supporting students and their families. The SAP program aims to minimize barriers to learning, supports students in developing academic and personal successes, and shorten the duration of untreated behavioral health concerns. The core of the program is a professionally trained team that includes school staff and staff from community behavioral health agencies. SAP team members are trained to identify problems and make recommendations to assist both the student and parents, provide services to improve student wellbeing, and provide follow-up services. When the problem lies beyond the scope of

the program, the SAP team will refer the student and parents to resources and services within the community. The SAP team responds to all student and family concerns with respectful dialogue, individualized service, ongoing staff and parent training, community support and referrals to appropriate school or community based services as needed. SAP services utilize science or research based curriculum, programs and practices such as:

- Second Step.
- Project Alert.
- Social Skills Group Intervention (S.S.GRIN).

The Strengthening Families program and Positive Behavioral Interventions and Supports model are additional examples of the types of programs that can be delivered through SAP. In addition, evidence-based clinical interventions utilized in SAP include Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Motivational Interviewing.

MHSA Legislative Goals and Related Key Outcomes

- Reduce School Failure and Dropout Rates Related to Behavioral Health Concerns:
 - ◇ Increased school attendance.
 - ◇ Increased subjective school connectedness.
 - ◇ Lower rate of school dropouts related to behavioral health concerns.
 - ◇ Lower rate of failing students.
 - ◇ Decreased school behavioral problems.

Target Populations

- Children
- TAY
- Adults

Projected Number to be Served in FY 2015/16

- 24,500 Children
- 2,100 TAY
- 6,500 Adult

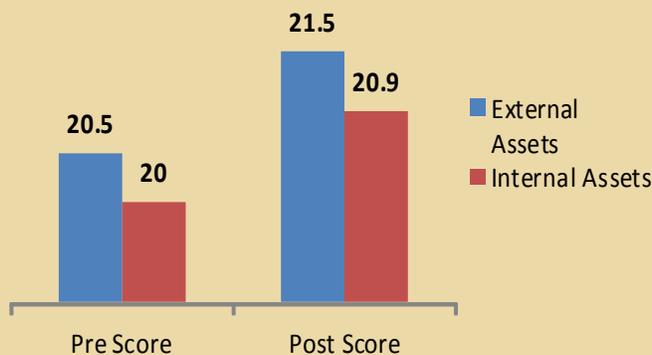
School-Based Initiatives

Positive Results

Student Assistance Program providers have served over **35,000** students in both prevention and early intervention services across the county in FY 2013/14. Providers use the Global Assessment of Functioning (GAF) scores to track outcomes for early intervention participants. GAF scores measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Participants' scores were noted at case opening and case closing. The GAF scores below are a comparison between GAF scores at intake and GAF scores at discharge. The results demonstrate a **7.4%** improvement in functioning after participating in SAP services.

FY 2013/14 Average GAF Scores for SAP Providers		
At Case Intake	At Case Discharge	Improvement
56.8	61	7.4%

Student Assistance Program (SAP) providers also use the Developmental Assets Survey to track Support, Empowerment, Boundaries & Expectations, Constructive Use of Time, Commitment to Learning, Positive Values, Social Competencies and Positive Identity components. The survey focuses on identifying strengths, supports, and skills that young people need to succeed and



N= Pre Score 162 / Post Score 149

overcome challenges. In addition, it allows providers to measure qualities that matter for youth development and education. The survey assists providers easy-to-understand, actionable information and results that can help engage youth and increase the impact in the lives of young people and allows youth to provide their own perspectives and experiences when developing services. These areas have been identified as building blocks of healthy development. In FY 2013/2014, the pre and post test scores from the survey indicate an average increase of **5%** across multiple domains.

Collaborative Partners

- Pacific Clinics
- Reach Out West End
- West End Family Counseling Services
- Lutheran Social Services of Southern California
- Family Service Agency of San Bernardino
- Desert/Mountain Children's Center
- South Coast Community Services
- Victor Community Support Services
- Rim Family Services
- San Bernardino County Superintendent of Schools (SBCSS)

"This opportunity truly gave me a new life, and a new hope. I look ahead with nothing but smiles and await the bright future I have ahead of me".
-SAP participant

School-Based Initiatives

Success Story

“This program is the best thing that could have ever happened to me. It changed me for the better, got me back on my feet, and assured me that I was going to be okay. Not only did it make me who I am but also it taught me an important life lesson that most don't usually get to learn in their entire life time. I learned that the past is a ghost and all you can do is walk forward and take each day one at a time with hope, optimism, and responsibility. I've sat and thought a lot about what I thought to be the sole purpose of this program, and at the beginning of the year I would have said to help get over the death of a family member, but I have learned the real reason. To me, the true reason or idea of this group grief lesson is not to stop crying, but to cry and be okay with it, to continue living your life, not forgetting your loved one but remembering them for who he/she was. It has definitely proved to be a difficult thing but it's not impossible. The aided constant support from all the other students in the group session has made it all the easier and allowed me to make new friends along the way and be able to relate to. As a result of this program, I am on a much brighter path than I would have been last year. I am now going to be heading to San Francisco State University to further my education. This opportunity truly gave me a new life and a new hope. I look ahead with nothing but smiles and await the bright future I have ahead of me.”



Challenges

The SAP program providers have identified challenges they faced during the course of the year. Those challenges included the need for more child psychiatrist, staffing changes which caused a gap in services, and challenges in obtaining accurate statistical data from third parties or not having a process in place to capture necessary data.

Another challenge SAP providers noticed is the slow start of the program at the beginning of the school year. Participation is minimal during the first couple months of the school year and tends to gradually pick up as the school year progresses. Along with a slow start to the program, some providers note that consistent participation during the course of the program could be improved.

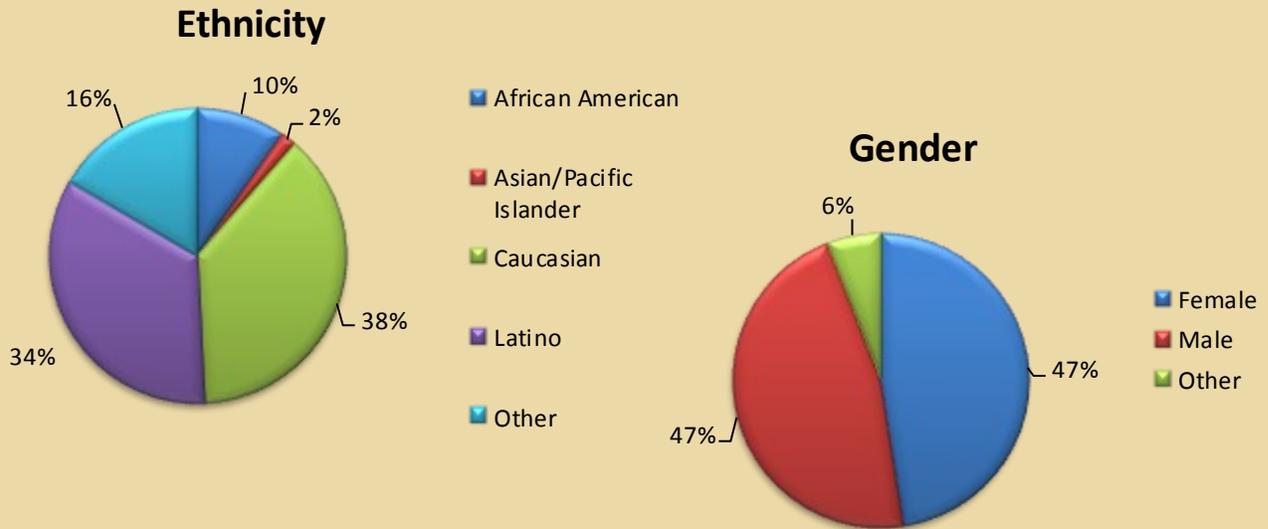


Solutions in Progress

In an effort to create a successful environment, SAP providers strive to create open lines of communication and trust between the child, parents and schools. The providers continue to monitor their staffing levels to be proactive and recruit before a vacancy occurs in an effort to reduce gaps in service. Providers, in collaboration with DBH and stakeholders, are establishing a structured outcome assessment and collecting data more consistently across the program. Providers are also searching for ways to provide their services during the months when school is out of session.

School-Based Initiatives

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The Student Assistance Program is primarily focused on providing prevention education and skill building services. Early Intervention services that are therapeutic in nature are included in the service design of the program. The table below demonstrates the breakdown between prevention services and early intervention services.

Service Type	Percentage
Prevention	89%
Early Intervention	11%

Preschool PEI Program (PEI SI-2)

The Preschool PEI Program (PPP) provides support for preschool children and education for their parents and teachers. The objectives are to prevent and reduce the occurrence of aggressive and oppositional behavior in preschool children in an effort to reduce problem behaviors later in life. This program serves students enrolled in the County's Head Start program and is being implemented by the Preschool Services Department (PSD) via a Memorandum of Understanding (MOU).

In order to accomplish program objectives, the program utilizes the Incredible Years curriculum to train teachers, parents and children. This evidence-based curriculum promotes social competence and helps prevent, reduce, and treat aggression and related conduct problems in very young children. The teacher component strengthens teaching and classroom management strategies to promote children's pro-social behaviors and school readiness (e.g. reading skills), and reduce classroom aggression and non-cooperation with peers and teachers. The parent component provides training to strengthen parenting competencies (e.g. monitoring, positive discipline, confidence, etc.) and encourage parental involvement in a child's school experiences.

When a child is referred to the PPP, a behavioral support plan is developed with the teacher and parent and include teacher/parent training and support; this allows the teacher and parent to use learned intervention techniques in response to the child's individual needs and the developed support plan.

School-Based Initiatives

Additionally, the bereavement and loss component works with preschool children to address losses related to death, separation (out-of-home placement) and divorce. The program provides direct support group services to preschool children with non-pathological grief, in the school setting.



MHSA Legislative Goals and Related Key Outcomes

- Reducing School Failure and Dropout Rates Related to Behavioral Health Concerns:
 - ◊ Increased school attendance.
 - ◊ Increased subjective school connectedness.
 - ◊ Lower rate of failing students.
 - ◊ Decreased school behavioral problems.
 - ◊ Decreased school achievement problems.

Positive Results

The PPP uses a science and research based assessment and evaluation tool called the Desired Results Development Profiles (DRDP).

The DRDP measures a range of developmental domains in preschoolers. Each student receives a rating on their progress within the continuum of developmental levels. These ratings range from “Exploring” at the lowest point to “Integrating” at the highest point.

Of the 12 developmental domains measured in Fiscal Year 2013/14, **four** areas were identified as the most challenging for children referred to Preschool Services for PEI services. In those **four** areas that were measured, children receiving PPP services were *more likely* than their peers to be “integrating” positive behaviors by the end of the school year. Practically speaking, children who were previously identified with aggressive behaviors in the classroom, were more likely than their peers to gain the social skills needed to succeed.

DRDP Domain	Percentage of Children Integrating Behaviors		What “Integrating” Behavior Looks Like in the Classroom
Impulse Control	PEI Students	5.10%	Student consistently uses a variety of socially acceptable strategies to stop self from acting impulsively.
	All Other Students	4.39%	
Conflict Negotiation	PEI Students	11.29%	Student considers the needs and interests of another child when there is a conflict and accepts or suggests some mutually acceptable solutions
	All Other Students	5.71%	
Relationships with Adults	PEI Students	3.21%	Student works cooperatively with an adult to plan and organize activities and to solve problems.
	All Other Students	3.13%	
Cooperative Play with Peers	PEI Students	9.09%	Student leads or participates in planning cooperative play with other children
	All Other Students	7.69%	

School-Based Initiatives

Target Populations

- Children
- Adults

Projected Number to be Served in FY 2015/16

- **657** Children
- **243** Adult

Success Story

A mother and father had both recently lost their jobs. The mother was pregnant and caring for the family's four children. The family was moving from one family member's home to another and ending up living in the back room of a local church. The children began exhibiting behavioral concerns in their preschool classrooms. The children showed signs of fear and anxiety, attachment issues, anger, and hyperactivity. The Preschool Services Department (PSD) Prevention and Early Intervention (PEI) team assisted this family in obtaining services through the PEI Trauma, Loss and Compassion (TLC) program for related trauma. The Marriage and Family Therapist (MFT) Interns taught the parents how to constructively support their children's fears and anxieties. PSD classroom staff

were provided classroom support strategies, and the Preschool Services Department Behavioral Health Specialists provided the family with home support including family counseling for stress and increased coping skills. This family successfully helped their children deal with their fears and anxieties. The family gained employment, was able to rent an apartment, and continues to participate in local family counseling support.

Challenges

The program is identifying ways to improve parental engagement and involvement in all aspects of the services and activities. In addition, improving methodologies to ensure accurate data collection and reporting are being explored.

Solutions in Progress

Preschool PEI Program (PPP) is working with DBH and stakeholders to identify accurate data and to create the structure for ongoing outcomes assessment. These efforts are intended to provide accurate outcome and program performance statistics. PPP is also working on implementing the use of the Life Skills Progression (LSP) assessment tool. PPP staff continue to work with parents and children to build trusting relationships to help promote a positive experience when utilizing the Preschool Services program. Currently, the PPP is working to thoroughly evaluate data. The data analysis is expected to reveal additional outcomes for social-emotional gains, as well as cognitive development gains in participants. Findings will be included in the next plan update.

Projections for Next Fiscal Year

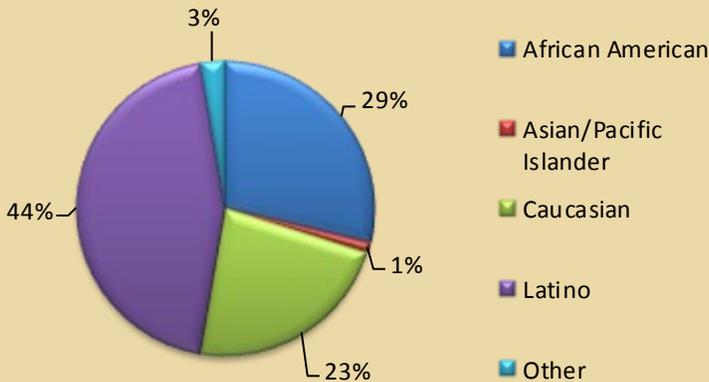
The Preschool Services Program is comprised exclusively of prevention activities geared to support very young children, their families, and educators. It is anticipated that **900** individuals will be served in Fiscal Year 2015/16. The majority of services, **73%**, will be directed toward meeting the needs of young children identified as in need of support. This will allow approximately **660** children to participate in the program across the county and provide for training and support for approximately **240** caregivers and educators across the county in this program.

Service Type	Percentage
Prevention	100%

School-Based Initiatives

Fiscal Year 2013/14 Program Demographics

Ethnicity



The graph on the left illustrates that **44%** of participants served in the Preschool PEI Program self-identified as Latino, **29%** as African American, **23%** Caucasian, **1%** as Asian Pacific Islander and **3%** identified as Other.

The graph on the right illustrates that **65%** of Preschool PEI Program participants identified as male and **35%** were identified as female.

Gender



Resilience Promotion in African-American Children (PEI SI-3)

The Resilience Promotion in African American Children (RPiAAC) provides mental health prevention services in culturally appropriate settings, incorporating African-American philosophies and traditions as a platform from which to offer mental health education programs promoting resiliency in African American youth. Services are offered at school site locations and focus on the strengths of the African American community. Educational workshops and group presentations are conducted to assist African Americans in feeling comfortable in seeking mental health preventative services from staff that are knowledgeable and capable of identifying needs and solutions for African American families and individuals.

Target Populations

- Children

Projected Number to be Served FY 2015/16

- **2,000** Children

The program utilizes evidence based programs such as National Curriculum and Training Institute Crossroads® Education, Peacemakers and Effective Black Parenting curriculums.

School-Based Initiatives



Artwork by David Pacheco

MHSA Legislative Goals and Related Key Outcomes

- Reducing School Failure and Dropout Rates Related to Behavioral Health:
 - ◇ Increased school attendance.
 - ◇ Increased subjective school connectedness.
 - ◇ Lower rate of school dropouts.
 - ◇ Lower rate of failing students.
 - ◇ Decreased school behavioral problems.
 - ◇ Decreased school achievement problems.
- Reducing Incarceration Related to Behavioral Health:
 - ◇ Lower rate of incarcerations.
 - ◇ Decreased delinquency behaviors which increase the likelihood of juvenile detainment.

Positive Results

The Resilience Promotion in African American Children (RPiAAC) program was projected to serve **2,000** unduplicated participants in FY 2013/2014. The program providers exceeded this projection and served a total of **3,693** unduplicated participants.

This program has created successful collaborative relationships with local schools by entering into agreements to be able to provide services on school campuses. Students participating in the Resilience Promotion program participants report improved school performance and behavior. In addition, program providers report establishing positive collaborative relationships with the faith-based community, and other African American community agencies such as, but not limited to, the African American Mental Health Coalition, Young Women Empowerment, and the Westside Action Group.

A post survey was administered by one of the contract provider agencies. Highlights of results demonstrated positive growth in the following areas:

- ◇ Improved communication skills.
- ◇ Improved ability to express feelings and emotions.
- ◇ Improved decision making.
- ◇ Improved peer relationships.

Success Story

“Sally” attends one of the middle schools and has consistently shown progress since her participation in the RPiAAC program. During Sally’s last follow up, she stated to staff, “Remember when I was the bully and I thought I had to prove myself to everyone? Now, I don’t get into trouble and I’m doing much better”. She started the program with resistance and reporting being negatively impacted by some of her life experiences. However, through collaborative effort between the program and her school, she demonstrated great resiliency. Her teachers confirmed Sally’s work performance improved substantially. Her overall grade point average has increased and she was awarded for her academic performance, citizenship, and attendance.

School-Based Initiatives

Challenges

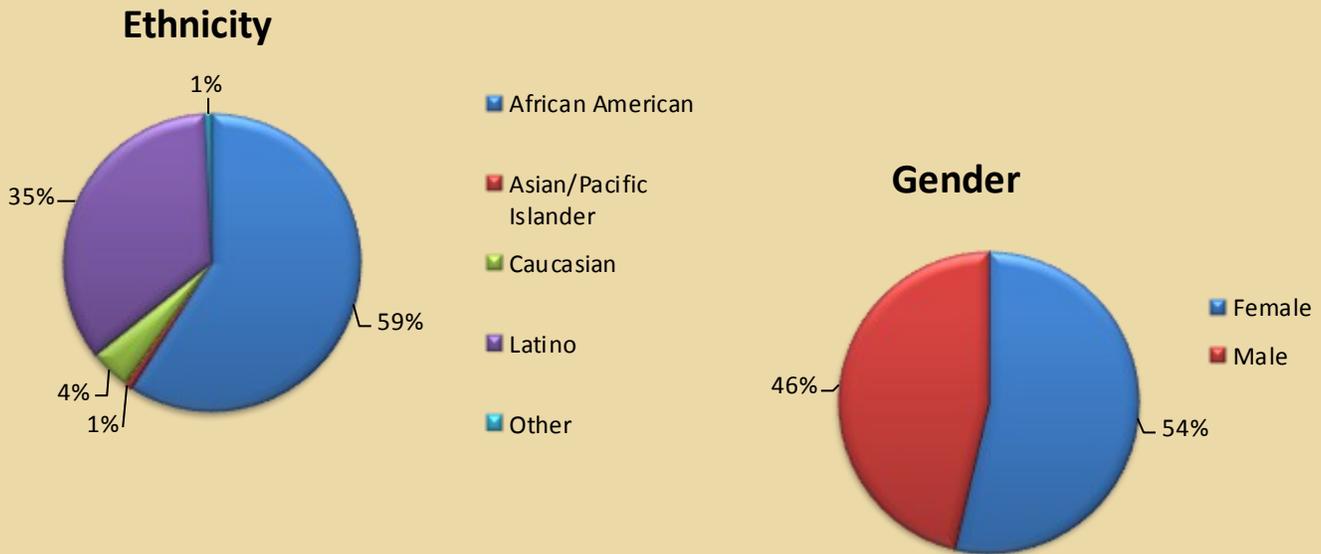
While the program has been well received and exceeded the anticipated number of children and youth to be served, there remains opportunity to improve participation in early intervention services for students in need of a higher level of intervention. In addition, culturally appropriate program evaluation efforts has been identified as an opportunity to enhance the program.

Solutions in Progress

RPIAAC staff are proactive in their outreach activities to promote the program and provide information on what the program offers. Staff continue to work with participants in gathering consistent program and demographic data to ensure accurate outcomes and statistical program information is reported. Staff also realize it takes time to build a trusting relationship with students and their family and staff remain consistent in providing services to help build that trust. Staff are working to establish an appropriate infrastructure for gathering and reporting outcome data.

Fiscal Year 2013/14 Program Demographics

The following represents the ethnicity and gender of program participants over the course of the fiscal year.



Projections for Next Fiscal Year

The Resilience Promotion in African American Children program is projected to serve over **2,000** children and youth in Fiscal Year 2015/16. The program is comprised of prevention and early intervention activities with estimated percentage of services distributed amongst categories as follows:

Service Type	Percentage
Prevention	94%
Early Intervention	6%

Community Based Initiative

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



The Promotores de Salud/Community Health Workers program is designed to increase awareness and access to community-based prevention and mental health services without stigma or fear of discrimination. This program promotes mental health awareness, education and available resources for the members of various culturally-specific populations throughout the county in a culturally and linguistically appropriate manner. Services are specifically targeted at underserved and unserved groups including Latino and Spanish-speaking communities, African-American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities.

MHSA Legislative Goals and Related Key Outcomes

- Reducing Prolonged Suffering
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness/increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning.
- Reducing Stigma and Discrimination Associated with Mental Illness
 - ◇ Increased accurate knowledge about mental illness.
 - ◇ Increased intent to seek services if needed.

Target Populations

- Children
- TAY
- Adults
- Older Adult

Projected Number to be Served FY 2015/16

- **1,000** Children
- **3,700** TAY
- **21,000** Adults
- **5,600** Older Adult

Community Based Initiative

Positive Results

The Promotores de Salud/Community Health Workers program provides a multitude of services including recruitment and training of individuals interested in becoming Community Health Workers. These individuals provide regular outreach presentations to church groups, community and school groups. They also provide modular presentations to smaller groups, families or individuals for the purpose of facilitating a discussion on specific behavioral health topics. The curriculum they use includes general mental health topics along with specific modules for post-partum depression, domestic violence, and suicide prevention. They participate in events and community fairs that are culturally and linguistically relevant to provide and disseminate information to underserved and unserved populations in concentrated neighborhoods.

A total of **38,000** unduplicated participants were served in FY 2013/2014. All participants receive a pre and post test. Overall, **99%** of participants stated presentations increased their knowledge on mental health and mental illness.

Collaborative Partners

- El Sol Neighborhood Educational Center.
- Desert Mountain Children's Center.
- African American Mental Health Coalition.
- Asian American Resource Center.
- Rainbow Pride Youth Alliance.
- Riverside-San Bernardino County Indian Health, Inc.

Success Story

"Sonia" participated in a one-hour presentation given by an existing Promotor de Salud. She received valuable information which helped her understand her daughter's mental health condition. After the presentation, the Promotor de Salud helped her find prevention and early intervention services in her community. After having received assistance for her and her family, she wanted to help others in her community understand more about mental health and wellness. She decided to become a Promotor de Salud herself and promote mental health education in her community. She is set to begin training next quarter and become the newest addition to the Promotor de Salud program.



Artwork by Erica Porteous

Challenges

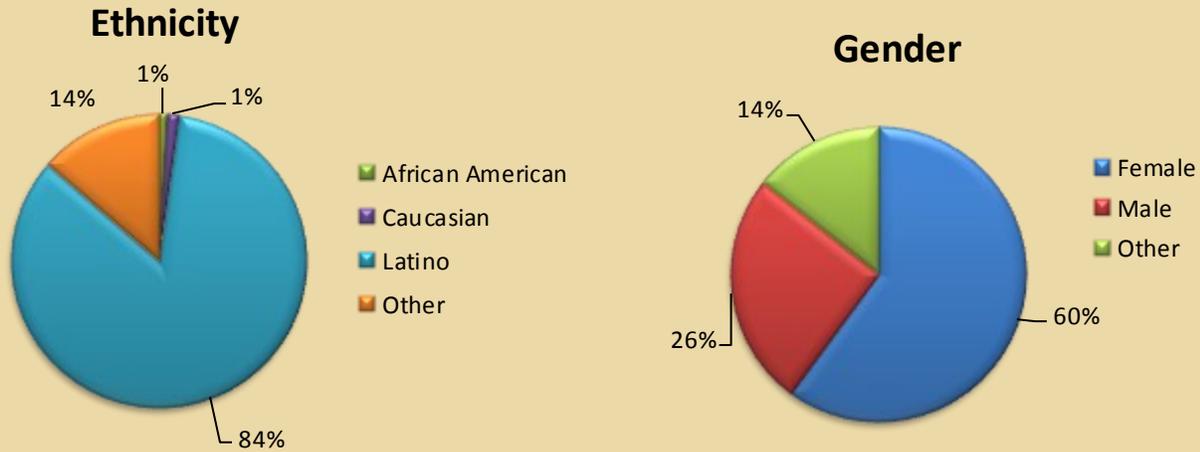
Some of the challenges include collecting resources and materials that are culturally and linguistically appropriate for the diverse populations we serve. For example, there are several different languages and dialects in the Asian/Pacific Islander population. Development of appropriate training materials in the various languages can be challenging. In addition, some of the populations are located in remote geographic areas of the county. While the services are provided countywide, consistent travel to remote areas can be challenging.

Solutions in Progress

Strategies to augment recruitment efforts and increase staff in remote areas of the county are underway. In addition, there are plans to offer additional train-the-trainer workshops in remote areas. Cultural workgroups are developing culturally and linguistically appropriate materials. Contracted providers are working with DBH and stakeholders to explore ways to create culturally appropriate evaluation methodologies and establish more consistent data collection and outcome reporting.

Community Based Initiative

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The Promotores de Salud program consists of Prevention activities that fall entirely within the Prevention service type.

Service Type	Percentage
Prevention	100%

Program Expansion

The future service description for the Promotores de Salud/Community Health Worker programs will be expanded to include peer counseling services as part of the scope of work .

This strategy was found to be very effective in the Holistic Campus service design in meeting the needs of the Latino community. In FY 2013/14, **27,391** people were served in the Holistic Campus. **52%** of those served were Latino. We will continue to monitor the effectiveness of the approach for consideration in other programs or parts of the entire system of care.

Family Resource Centers (PEI CI-2)

Family Resource Centers (FRC) offer various culturally and linguistically competent services tailored to meet the identified needs of the communities they serve. This program serves all ages and includes the following: personal development activities; parent/caregiver support and education; behavioral health education workshops; after school programs for children/youth/transitional age youth; health education workshops; adult skill-based education (e.g. education and employment assistance); counseling and therapy for all ages. Services are delivered in the local FRCs and are also deployed into the communities they serve, increasing the likelihood that community members will use the services while reducing stigmatizing attitudes associated with behavioral health services. FRCs utilize various science or research based curriculum, programs and practices for their education programs. Evidence-based curriculum such as The Strengthening Families program, NCTI® Crossroads Education, Family Strengthening Approach, Social Work Model, Communities that Care Model, Guiding Good Choices and Nurturing Parenting Program.

Community Based Initiative



Artwork by Gary Bustin

MHSA Legislative Goals and Related Key Outcomes

- Reduce Stigma and Discrimination Associated with Mental Illness.
 - ◇ Increased accurate knowledge about mental illness.
 - ◇ Increased intent to seek services if needed.
- Reduce Unemployment Among Consumers.
 - ◇ Lower rates of unemployment.
 - ◇ Increased employment-related skills/vocational strengths.
- Reduce Prolonged Suffering.
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness/increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning.

Positive Results

The FRCs served **31,425** unduplicated participants in FY 2013-2014. The goal for FRCs was to serve **22,000** unduplicated participants in FY 2013-2014. This goal was exceeded by **9,425** participants, which is **42.8%** more participants than originally anticipated.

FRCs are using the Life Skills Progression (LSP) assessment which is an outcome measurement instrument designed for use by programs serving low income parents of children ages 0-3 years, but it can extend to age 5. There are **43** parent and child scales which describe a spectrum of skills and abilities over six major categories of functioning. The LSP is used to collect outcomes data, to monitor family strengths and needs, plan clinical interventions, and provide data for research purposes.

FRCs report a **16%** average improvement in the areas of self-esteem, reduction of substance use/abuse, depression, mental illness, family planning, prenatal care, personal sick care, relationships with family, and relationships with peers. Improvement in these areas demonstrates improved resiliency and may reduce the risk factors that can contribute to the development of behavioral health concerns.

Target Population

- Children
- TAY
- Adults
- Older Adult

Projected Number to be Served in FY 2015/16

- **10,000** Children
- **2,700** TAY
- **8,000** Adults
- **1,300** Older Adult

Community Based Initiative

Positive Results, continued

FRC providers also utilize the Global Assessment of Functioning (GAF) scale as a tool to monitor clinical outcomes. Providers tracked GAF scores of early intervention participants. GAF scores measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Participant's scores were noted at case opening and case closing, and results showed a **14%** overall improvement, as illustrated below.

Average GAF Scores for FRC Providers in FY 2013-2014		
At Case Intake	At Case Discharge	Improvement
57	64.9	14%



Collaborative Partners

- Building a Generation
- Ontario-Montclair School District
- Pacific Clinics
- Rim Family Services
- Riverside-San Bernardino County Indian Health, Inc.
- Valley Star Children and Family Services, Inc.
- Victor Community Support Services, Inc.

Success Story

Middle school student "Ricky" was referred to the FRC for counseling due to exhibiting anger and behaviors at school which adversely impacted his learning. Initially, Ricky's father was resistant to counseling for his son, but after meeting with the counselor for an assessment he agreed that his son could benefit from the sessions.

When mental health intern, Christine, met with Ricky he was extremely agitated--his anger apparent from his clenched fists. He refused to talk. Over time, Christine remained supportive and worked hard at developing a therapeutic relationship with Ricky.

The break-through session occurred when Ricky refused to talk to Christine, so she suggested that he instead write how he was feeling. Ricky wrote something on a sheet of paper, but then crumpled it up. He then unfolded the paper and agreed to share its contents with Christine. In the letter, Ricky wrote that he had no one in his life to talk to. He felt unimportant to the world and as if he didn't matter. He went on to write that "the person who makes me feel important and that I have value is Christine." Ricky wrote that this was the first time in his life where he has felt "safe talking about my stuff." He went on to share that the sessions were helping him to "feel better" about himself. Ricky has continued to show progress in handling his anger and acting appropriately at school.

Community Based Initiative

Challenges

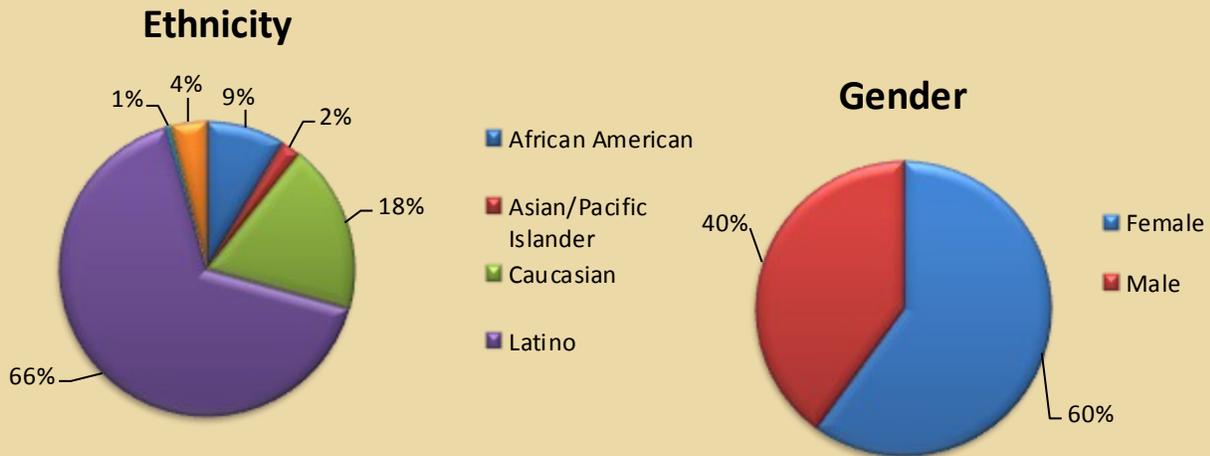
The identification of appropriate measurement tools for curriculum-based groups has been identified as an obstacle for the program. Finding solutions to increase staff retention and reduce staff turnover is a challenge. Ensuring that there is sufficient quality program monitoring to adequately serve all participants, can be difficult. In addition, the demand for mental health services and classes has increased greatly.

“The person who makes me feel important and that I have value is Christine (Therapist).”
-FRC client

Solutions in Progress

As part of DBHs System-wide Program Outcomes Committee (SPOC), measurement tools are being identified. The availability of instruments that establish structure and make the collection and assessment of outcomes consistent across the program and amongst providers will support the evaluation framework established by the department. Plans to enhance staff training are in development. Establishing methods to track community mental health needs will ensure FRCs will meet the needs of the communities they are serving, for example establishing relapse prevention groups or support for maternal mental health. Continue outreach activities.

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The Family Resource Center program includes a variety of Prevention and Early Intervention activities. The figure below illustrates the distribution of activities for the next fiscal year.

Service Type	Percentage
Prevention	94%
Early Intervention	6%

Community Based Initiative

Program Expansion

Based on the input from stakeholders and needs, the scope of work for the FRCs will be expanded to include targeted relapse prevention groups for individuals living with serious mental illness and screening, identification, and supports for at-risk groups such as moms experiencing postpartum depression or challenges. These added interventions and supports will be available at FRCs across the county.

This change is expected to take place during the next Request For Proposal (RFP) cycle, the process the county utilizes to procure for services with community-based organizations. The estimated time frame for the release of the RFP is FY 2015/2016.

Native American Resource Center (PEI CI-3)

The Native American Resource Center functions as a one-stop center offering several prevention and early intervention resources for Native American populations of all ages. The center provides services that use strength-based traditional Native-American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development and education assistance. All behavioral health prevention and early intervention services and family supportive services are provided in a culturally relevant context.

Target Population

- Children
- TAY
- Adults
- Older Adult

Projected Number to be Served in FY 2015/16

- **500** Children
- **1,000** TAY
- **500** Adults
- **200** Older Adult

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness / increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Reduce Stigma & Discrimination Associated with Mental Illness.
 - ◇ Increased accurate knowledge about mental illness.
 - ◇ Increased intent to seek services if needed.

Positive Results

The Native American Resource Center utilizes the *White Bison Education Programs* as part of their holistic approach to servicing the Native American population. They also make cultural adaptations to traditional counseling and treatment approaches. This practice reduces stigmatizing attitudes about mental illness and/or use of services and enhances wellness and resilience efforts.

The Native American Resource Center served a total of **9,165** participants in FY 2013/14 . On average, **16%** of participants are children (ages 0-15), **45%** are TAY (ages 16-25), **27%** are adults (ages 26-59), and **12%** are older adults (ages 60+).

Community Based Initiative

Positive Results, continued

The Center uses a community-defined practice pre/post test survey to monitor program outcomes. A total of **135** participants were surveyed last year. The end results indicated that **60%** of participants are aware of mental health services available in the community. When asked about the "Intent to Seek Services", **70%** of the participants answered "yes" to willingness to participate in services.

Category	Survey Question Indicator	Post Survey Results
Intent to Seek Services	Willingness to Participate in Services	70%
Mental Health Knowledge	Aware of Services Available in the Community	60%

Collaborative Partners

- Riverside-San Bernardino County Indian Health, Inc.
- Native American Awareness Sub-Committee.



Success Story

Here at the Native American Resource Center we offer various classes that promote mental health, substance use/abuse awareness and cultural awareness. During one of our holistic-centered groups that focus on Physical, Spiritual, Emotional and Mental wellness, some of our elders made Native American regalia for themselves. The regalia was used as part of local cultural awareness activities. The regalia was also showcased as part of our larger annual Pow-Wow gathering. This was reported as a powerful process for the elders in the community. It offered them opportunity to reaffirm their identity and make a valuable contribution to their community while participating in an activity that promotes mental health wellness in a culturally appropriate manner.

Challenges

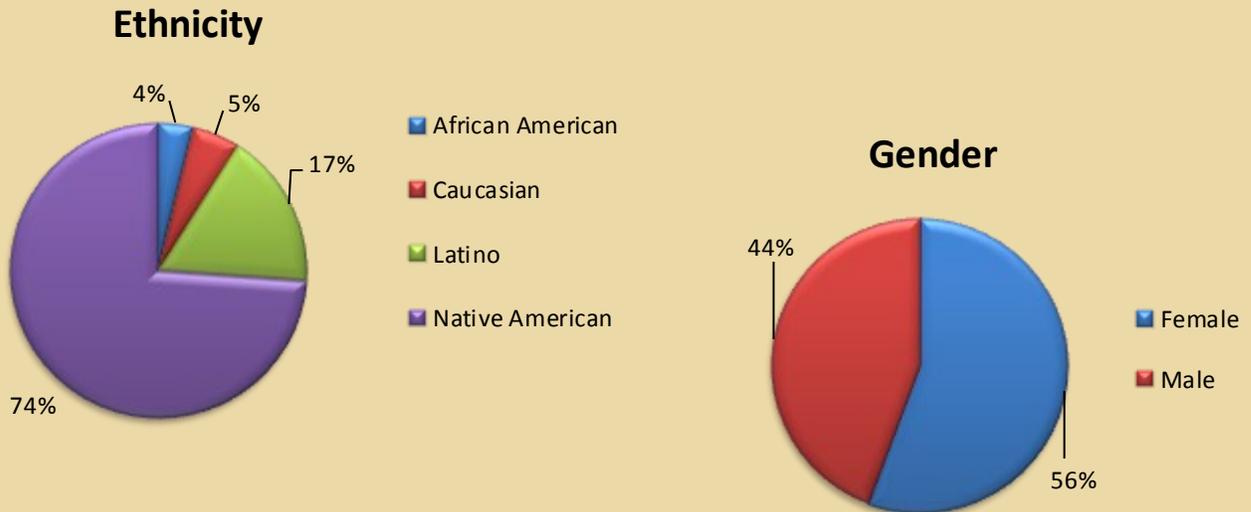
The increase in Native American Resource Center participation has posed a challenge in providing case management to participants. As a result, the program is not able to provide as much individualized attention as they have in the past. In addition, the sustained presence of historical trauma and stigmatizing attitudes about mental health services has made it difficult to collect consistent demographic information from participants.

Solutions in Progress

Offer additional resources to participants through networking and collaborations with local partners. Establish structured outcome assessment and collecting outcomes more consistently across the program

Community Based Initiative

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The Native American Resource Center program includes a variety of Prevention and Early Intervention activities. The figure below illustrates the distribution of activities for the next fiscal year.

Service Type	Percentage
Prevention	50%
Early Intervention	50%

National Curriculum and Training Institute® Crossroads Education© (PEI CI-4)

The National Curriculum and Training Institute (NCTI) Crossroads® Education program is a curriculum-based education strategy that fosters positive, pro-social behavior in children (ages 10-15) and transitional age youth (TAY) (ages 16-25). In FY 2015/16 the program served **7,633** unduplicated participants. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process.

Providers utilize the NCTI® Crossroads© curricula and the Real Colors Personality Instrument to focus on the relationship between values, attitudes, behaviors, as they relate to the decision making process. Class topics include: anger management; life skills; parent education; substance abuse prevention; gang involvement; truancy intervention; and graffiti prevention. Parenting classes are offered to the families of those participating in the program.

Community Based Initiative

MHSA Legislative Goals and Related Key Outcomes

- Reduce School Failure/Dropout Rates related to behavioral health concerns.
 - ◊ Increased school attendance.
 - ◊ Increased subjective school connectedness.
 - ◊ Lower rate of school dropouts related to behavioral health concerns.
 - ◊ Lower rate of failing students.
 - ◊ Decreased school behavioral problems.
 - ◊ Decreased school achievement problems.
- Reduce Incarcerations.
 - ◊ Lower rate of incarcerations.
 - ◊ Decreased delinquency behaviors which increase likelihood of juvenile detention.

Target Populations

- Children
- TAY

Projected Number to be Served FY 2015/16

- **500** Children
- **4,000** TAY

Positive Results

Crossroads© has built pre and post tests into the curriculum. These tests measure the level of knowledge obtained by participants and the fidelity

of the program implementation, but cannot measure behavioral change. The test data indicates that Crossroads Education© participants are gaining the pro-social skills and assets needed to make positive changes in their lives.

Crossroads Skills Progression		
Class Title	Class Learning Objectives	Students' Increased Understanding of Course Content
Truancy	Understanding how success in school translates to success in work and in life.	55%
Youth Anger Management Level 1	Understanding the influence that strong emotions have on behavior and gaining better control.	56%
Youth Drugs & Alcohol Level 1	Identity skills & resources that help develop a healthy, positive lifestyle.	30%
Shoplifting	Identify and take positive steps to change present behavior.	89%

The adjacent table explains the learning objectives for each Crossroads course offered, and the increased rate of understanding students gained after completing each course in FY 2013-14.

The test data indicates that Crossroads© participants are gaining the pro-social skills and assets needed to make positive changes in their lives.

Collaborative Partners

- Family Service Agency of San Bernardino
- Inland Valley Drug and Alcohol and Recovery Services
- Reach Out West End
- Rim Family Services

Success Story

"I am a graduate of Pride Platoon Boot Camp Class 008. When my parents told me they were putting me in boot camp I wasn't too happy about it, but the thing I was actually looking forward to the most were the anger management classes."

Community Based Initiative



Artwork by Garth Pezant

Success Story, continued

"After my first session with Mr. Don, right away I knew I could be open and talk about things. I think Mr. Don is more understanding with us and heard what we had to say about things. He taught me more about my anger and where it comes from. He even helped me to talk to my parents and be open with them. Mr. Don is someone to go to not only for help but advice. I am very thankful for what Mr. Don has done for me; he has changed my life for the better. He has even opened my eyes to pursue a career that helps others like Mr. Don does."

Challenges

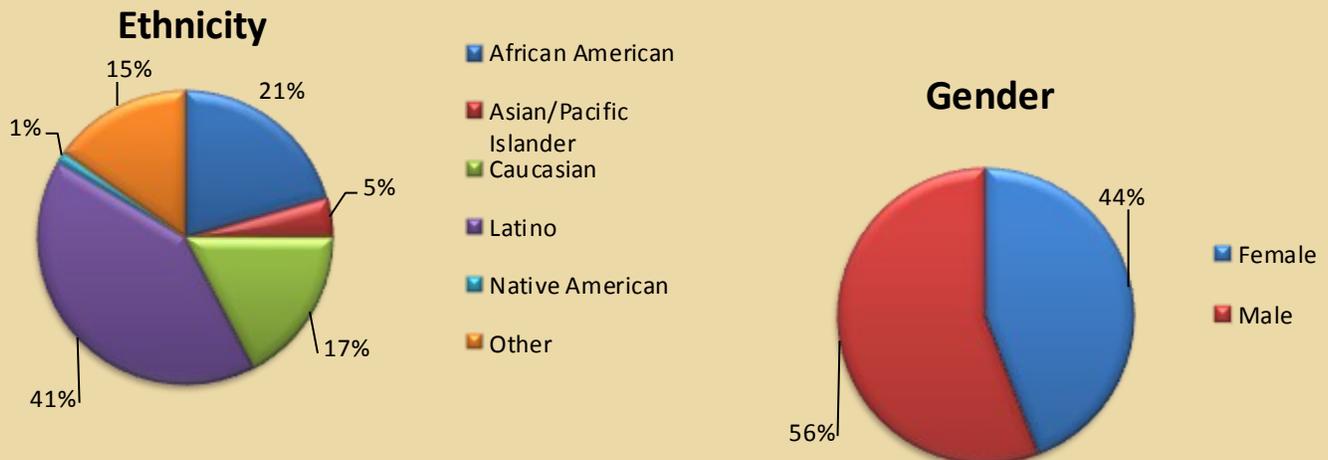
Consistent student participation throughout entirety of program and sustainable parental support and involvement have been identified as a challenge. Transportation for after school sessions in remote areas is difficult. Limited number of certified staff available to deliver services.

Limited space to expand services and offer more classes at various times to meet the needs of the community.

Solutions in Progress

Capture data to determine specific reasons for participation attrition and develop solutions. Improve current strategies that address transportation and expansion issues. Review and make changes to staffing patterns that will increase retention and maximize effectiveness in the program. Increase service locations though increased program collaborations and networking.

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The NCTI® program consists of solely prevention activities with distribution of funding as follows:

Service Type	Percentage
Prevention	100%

System Enhancement Initiative

Older Adult Community Services (PEI SE-1)



The Older Adult Community Services (OACS) program is designed to promote a healthy aging process for older adults (ages 60+) by providing prevention and early intervention services to assist in maintaining positive mental health. Services provided focus on assisting older adults before mental health issues develop and/or require a greater level of treatment. The OACS program helps to promote healthy aging, prevention of suicide in seniors, early intervention techniques and overall senior wellness. In order to ensure the program is available for a larger number of seniors, the program is available via a mobile unit, in senior centers, and in their own homes.

The OACS Program continues to work on reducing the stigma associated with mental illness and behavioral health problems in the older adult community by providing services in natural, community based settings. This program increases knowledge about mental health and access to free and confidential mental health services which allows older adults to seek services, if needed. This program also addresses the specific causes and factors that lead to suicide in seniors by

targeting those who are exposed to trauma and bereavement and those who are experiencing the onset of serious psychiatric illness. Education, support, screening for suicidal ideation and follow up clinical interventions are provided to the older adult community.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness/increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Reduce Suicide.
 - ◇ Decreased suicidal ideation.
 - ◇ Increased knowledge of suicide risk factors.
 - ◇ Increased knowledge of suicide prevention resources.
 - ◇ Decreased suicide risk, as measured by assessments/outcome measures.
- Reduce Stigma & Discrimination Associated with Mental Illness.
 - ◇ Increased accurate knowledge about mental illness.
 - ◇ Increased intent to seek services if needed.

The Older Adult Community Services will be expanded to include peer counseling as part of the primary services. This strategy was found to be very effective in as a service design in assisting older adults in the Agewise Program. The scope of work for providers will be modified to include the peer counseling component for contracts awarded in fiscal year 2015-2016.

Target Population

- Older Adults

Projected Number to be Served FY 2015/16

- 6,000 Older Adults

System Enhancement Initiative

Positive Results

OACS subprograms provide access to services for older adults. The Mobile Resource program provides bilingual and senior appropriate mental health and suicide prevention screenings as well as substance abuse screenings to older adults who are in geographically and/or economically isolated areas. The Older Adult Wellness Service is the most utilized service of the target population, delivering and/or coordinating comprehensive activities and support services, while decreasing older adult hospitalizations. The Home Safety program assists older adults in maintaining a level of appropriate personal and home safety. This includes providing services and education that increases personal and home safety, fall prevention, and medication management.

A total of **5,453** unduplicated participants were provided with services and linkages to resources within their communities during FY 2013/14, thereby reducing risk by increasing resiliency, coping skills and social support networks.

Program participants were administered a survey to measure their level of satisfaction with the services they were provided. Of those surveyed, **90%** indicated an overall satisfaction with services received.

For FY 2013/14, participants receiving Early Intervention services demonstrated average improvement in GAF scores of **8%** after receiving clinical interventions, as illustrated in the table below. GAF scores measure the progress of participants receiving early intervention services and measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Participants' scores were noted at case opening and case closing.

Average GAF Scores for OACS Providers in FY 2013/14		
At Case Intake	At Case Discharge	Improvement
52	56	8%

Success Story

"Gabriela" participated in early intervention services through the OACS program for one year. Upon entering treatment, she presented with symptoms of depressed mood, feelings of hopelessness, tearfulness, not being able to concentrate at work, fatigue and discord in her interpersonal relationships with her daughters. As treatment progressed, Gabriela began to share about deeper issues, and it became clear that Gabriela had an issue with hoarding. The therapist educated Gabriela about hoarding in order to help her understand the behavior and reduce stigma associated with it. Gabriela realized that this problem was impacting several areas of her life including her interpersonal relationships and her ability to carry out daily tasks. By clearly identifying the problem, Gabriela was able to take steps to improve her life. The therapist facilitated a session with Gabriela and her grown children in an effort to build communication between them. With the help of her children, Gabriela has been able to make changes in her home life. She has completed home repairs and started the process of cleaning out her home. Gabriela expressed her appreciation of the OACS program.

System Enhancement Initiative

Collaborative Partners

- Family Service Association.
- Lutheran Social Services.
- Rim Family Services.
- West End Family Counseling.



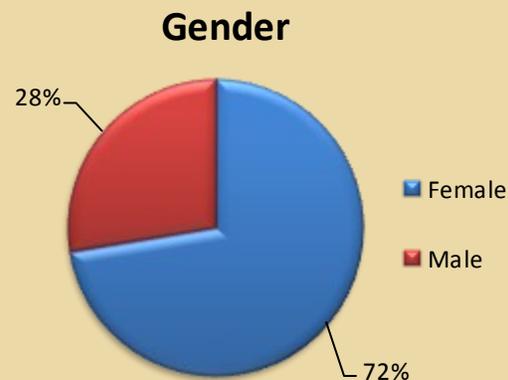
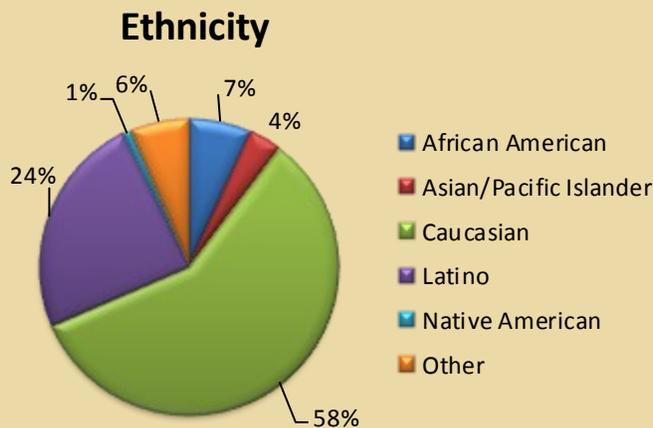
Challenges

Challenges facing the OACS program are the stigma related to seeking and receiving mental health services as well as finding available and adequate space at community locations.

Solutions in Progress

OACS providers are engaging and educating participants via wellness presentations and through screenings related to physical health. This strategy creates the pathway for discussion and connection to available behavioral/mental health services. Providers are continuing outreach efforts to promote attendance and reduce stigma associated with seeking behavioral health services. Providers are also coordinating with other programs at community locations to ensure there is available time and space to administer the older adult program.

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The OACS program consists of prevention and early intervention activities with allocation of services indicated by the illustration on the right.

Service Type	Percentage
Prevention	76%
Early Intervention	24%

System Enhancement Initiative

Child and Youth Connection (PEI SE-2)

The Child and Youth Connection (CYC) program provides prevention and early intervention services to children and transitional age youth involved in the foster care and juvenile justice systems. Services include mental health screenings, drug assessments, and therapeutic interventions. In addition, consultations are coordinated to identify appropriate experts who facilitate changes in the treatment plan or changes to the minors' placement. A Mentoring Resource Network is maintained where various agencies and stakeholders meet to conduct needs assessments and create mentoring opportunities for system involved youth.

The CYC includes a special component intended to improve social, developmental, cognitive, emotional, and behavioral functioning of young children. This component consists of Screening, Assessment, Referral and Treatment (SART) and Early Identification and Intervention Services (EIS). SART is a collaboration between DBH, Child and Family Services (CFS), Department of Public Health, First 5, and Children's Network. It is intended to identify young children at risk of developmental and behavioral health problems. SART provides comprehensive treatment services, including assessment, individual therapy, family therapy, rehabilitative services, and intensive care coordination. EIS provides services exclusively to children through the age of six (6), with concentration on children aged 0-5, who are not displaying appropriate interactions and attachment. Services include comprehensive treatment services, assessment, individual therapy, family therapy, rehabilitative services, and intensive care coordination.

Target Population

- Children
- TAY
- Adults

Projected Number to be Served FY 2015/16

- 4,300 Children
- 4,000 TAY
- 200 Adults

MHSA Legislative Goals and Related Key Outcomes

- Reduce Incarcerations.
 - ◇ Lower rate of incarcerations.
 - ◇ Decreased delinquency behaviors which increase likelihood of juvenile detainment.
- Reduce Prolonged Suffering.
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness / increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing occupation/education, legal, managing money, interpersonal, social).
- Reduce Number of Minor Consumers Removed from Their Home.
 - ◇ Increased family management skills.
 - ◇ Increase in ratio of minors maintained in the least restrictive environment necessary to meet their goals.
 - ◇ Increased residential stability for family.
 - ◇ Increase parental /caregiver knowledge of child's mental health condition and available services.
 - ◇ Increase relationship permanence for children at risk of removal.

System Enhancement Initiative

Positive Results

One of the tools the CYC program uses for program monitoring and outcome measurement is the Child and Adolescent Needs and Strengths Assessment–San Bernardino (CANS-SB). The CANS-SB provides information regarding the impact services have on children participating in the SART and EIIS component of the CYC program. Typically, children participating in SART/EIIS present with specific difficulties or needs. These needs can be categorized in various domains such as life functioning, behavioral and emotional problems, risk behaviors or issues specific to the zero to five (0-5) population. CANS-SB data allows analysis of individual scores for each domain to determine if significant changes have been made. An indication that a client’s need is resolved in a domain is considered significant. CANS-SB data collected for the CYC SART program in FY 2013/14 provides positive results in relation to MHSA Legislated Goals and Key Outcomes. One of the MHSA Goals for CYC is to “Reduce Incarcerations.” Key outcome indicators would include a decrease in behaviors often as a risk for future delinquency behaviors. The CANS-SB data shows the following positive results:

Collaborative Partners

- Juvenile Public Defender’s Office.
- Children’s Network.
- Child and Family Services.
- Christian Counseling Service.
- Desert Mountain Children’s Center.
- Loma Linda Medical Center.
- Victor Community Support Services.
- West End Family Counseling.

CANS-SB Domain Item	Participants Needing Assistance with Domain Item at Intake	Participants Needing Assistance with Domain Item at Discharge
Anger Control	34.21%	17.97%
Oppositional Behavior	31.39%	21.09%

A second MHSA Goal for CYC is to “Reduce Prolonged Suffering.” Key outcome indicators include a decreased impairment in general areas of life functioning. The CANS-SB data shows the following positive results:

CANS-SB Domain Item	Participants Needing Assistance with Domain Item at Intake	Participants Needing Assistance with Domain Item at Discharge
Communication	43.19%	23.33%
Regulatory Problems	42.22%	22.50%
Affect Dysregulation	47.18%	21.09%
Adaptability	30.35%	12.50%

System Enhancement Initiative

Another MHSA Goal for CYC is to, “Reduce the Number of Minor Consumers Removed from their Home.” Key outcome indicators include increased relationship permanence for children at risk of removal. CANS-SB data for the CYC SART program provided data on “Maternal Availability.” This domain addresses the physical and emotional availability of a child’s caretaker which affects the emotional and physical well being of a child. The CANS-SB data indicates that **34.11%** of participants needed assistance at intake with “Maternal Availability.” At discharge, **31.67%** of participants needed assistance with this problem.

The projected number of participants to be served each fiscal year is **5,418**. In FY 2013/14 the total number of unduplicated children and transitional aged youth served was **8,983**.

Success Story

A four year old male, “Matthew”, receiving services through the EISS component has shown great improvement through CYC services. Matthew and his grandmother had recently moved from another state. He was previously receiving therapy and his grandmother wanted him to continue services. During the initial clinical assessment, Matthew presented as anxious and fearful and had difficulty expressing his feelings. He was not open to participating in therapy, as evidenced by his refusal to talk to the clinician. Matthew’s symptoms included sensory problems, difficulty expressing his feelings, defiance, aggressiveness, and anxiety related to any physical separation from his grandmother. He also had difficulty playing with other children due to his limited social skills. During the initial therapy sessions, he often cried, exhibited tantrums, and demanded his grandmother accompany him in the session. Matthew received therapeutic intervention services to improve his social, cognitive, emotional, behavioral and developmental functioning. Through consistent attendance, team work, and various techniques Matthew has made significant progress since starting therapy. He is able to attend therapy sessions and Sunday school without his grandmother’s presence. Furthermore, he is able to express his feelings rather than shutting down or becoming aggressive, and does not hit others as often. He hugs, gives high fives, and will occasionally hold someone else’s hand. Matthew’s tantrums have decreased, and he has been willing to explore different foods. He is doing well accepting the consequences of his actions (e.g., being placed in time out when he misbehaves or exhibits a tantrum). He has also slept in his own bed on one occasion. Matthew’s social skills have improved by attending a social skills group where he plays and interacts with the other clients in attendance. He stated he was excited about starting school and he is happy and proud of himself. Matthew’s grandmother has expressed happiness with her grandson’s progress, as well as with CYC EISS services.



Challenges

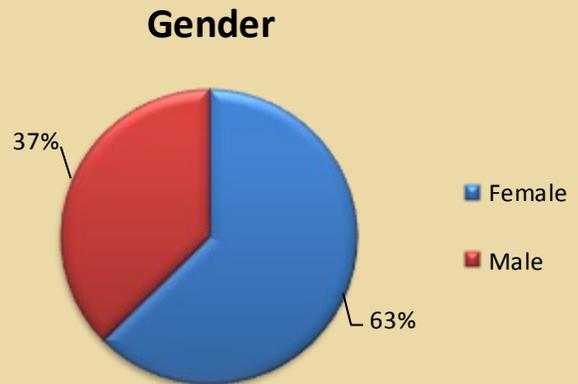
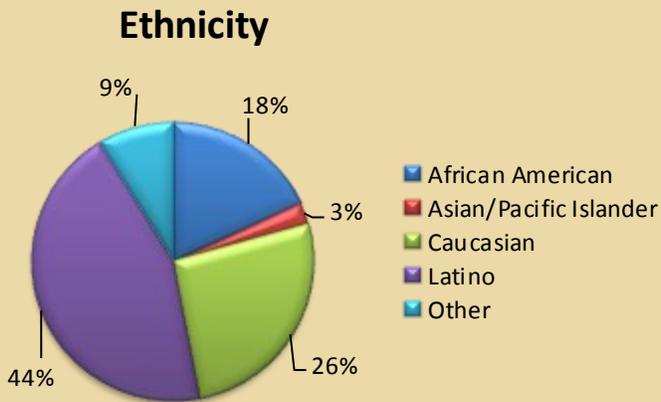
Outside of EISS, a challenge CYC providers face is the collection of pertinent demographic for universal services. Identifying instruments to collect appropriate program data to accurately report outcomes for prevention services is a challenge.

Solutions in Progress

The System-wide Performance Outcomes Committee is engaged in identifying and recommended appropriate tools for all service activities.

System Enhancement Initiative

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The CYC program consists of prevention and early intervention activities with the allocation indicated below:

Service Type	Percentage
Prevention	3%
Early Intervention	97%



System Enhancement Initiative

Community Wholeness and Enrichment (PEI SE-3)

The Community Wholeness and Enrichment (CWE) program serves transitional age youth (TAY) (ages 16-25) and adults (ages 26-59) who are experiencing the initial onset of a mental or emotional illness and/or substance use problem. Services include risk/depression/substance abuse screenings, community mental health support and education; support groups (including bereavement and loss groups), and short-term mental health services. The primary level of early intervention services is delivered through a network of community-based organizations and via a minimum of two integrated primary health clinics.



In fiscal year 2013/14, the CWE program was projected to serve **2,200** participants. Providers served **6,800** unduplicated participants which is **209.25%** more participants than expected.

Target Population

- TAY
- Adults

Projected Number to be Served FY 2015/16

- **1,300** TAY
- **3,700** Adults

MHSA Legislative Goals and Related Key Outcomes

- Reduce Suicide.
 - ◇ Decreased suicidal ideation.
 - ◇ Increased knowledge of suicide risk factors.
 - ◇ Increased knowledge of suicide prevention resources.
 - ◇ Decreased suicide risk, as measured by assessments and outcome measures.
- Reduce Prolonged Suffering.
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness/increased hope.
 - ◇ Increased resiliency.
 - ◇ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).
- Reduce Homelessness Among Consumers.
 - ◇ Decreased rate of homelessness.
 - ◇ Increased residence stability.
- Reduce Stigma and Discrimination Associated with Mental Illness.
 - ◇ Increased accurate knowledge about mental illness.
 - ◇ Increased intent to seek services if needed.

System Enhancement Initiative

Positive Results

CWE programs utilize a variety of evidence-based and promising practices such as Seeking Safety, Choosing Not to Use, Grieving, Sharing and Healing, Strengthening Relationships with Family and Friends, Living with Feelings and Handling Stress, and Nurtured Heart Parenting. Current providers are using various evidence-based clinical interventions such as Trauma-Focused Cognitive Behavioral Therapy, Motivational Interviewing, Dialectical Behavior Therapy (DBT), Solution Focused Family Therapy Techniques, and Cognitive Life Skills in Behavioral Therapy.

CWE uses the Patient Health Questionnaire 9 (PHQ-9) instrument to screen, diagnose, monitor and measure a client's severity of depression. It is a brief self-report tool that the client completes at intake and is scored by the provider. It includes a question that screens for the presence and duration of suicidal ideations. It is administered repeatedly to reflect the improvement or worsening of depression in response to treatment.

Also used is the Generalized Anxiety Disorder 7 (GAD-7). The GAD-7 is a self-reported questionnaire for screening and measuring the severity of generalized anxiety disorder. Below are the results for the PHQ-9 and GAD-7 Test Scores. Both show an improvement in their post scores.

The GAD-7 has seven items, which measure severity of various signs of generalized anxiety disorder according to reported response categories of "not at all," "several days," "more than half the days," and "nearly every day." The assessment is indicated by a total score. The total score is calculated by assigning a value from 0-1 to each response and adding the responses together for a total score of all seven items.

Both of the test scores below show an improvement in their post scores.

➤ PHQ-9 Test Scores

Pre Score	Post Score
22	10

55% Average Improvement

➤ GAD-7 Test Scores

Pre Score	Post Score
11	10

9% Average Improvement

Collaborative Partners

- Bilingual Family Counseling Services, Inc.
- RIM Family Services, Inc.
- South Coast Community Services.
- Victor Community Support Services, Inc.
- McKee Family Health Center.
- Westside Family Health Center.



System Enhancement Initiative

Success Story

“Michelle”, a 24-year-old female, came to our program severely depressed. She grew up in a hostile environment which included domestic violence and alcohol addiction. She currently lives with her boyfriend and their 2-year and 5-year old sons. Michelle was exhibiting excessive isolation, sadness, and lack of motivation. She was isolating herself in her room away from family and friends. Michelle had difficulty connecting with her 5-year old and would not hold him or show any affection towards him. She had strong resentment towards her boyfriend who reminded her of her father and past negative events. Treatment focused on increased socialization with family and friends, processing past experiences through identifying feelings and distorted thoughts, writing in an awareness log, putting into practice new healthy coping skills, and acknowledging current negative beliefs and thoughts to help her develop insight and change her patterns of thought and behavior. In the final phase of treatment, she was able to identify the triggers, beliefs, distortions, feelings and behaviors that lead her to depression. She was able to improve her relationship with her 5-year old son by holding him and comforting him without feeling uncomfortable. Michelle started helping in his classroom twice a week, began praising him for desired behaviors, and became emotionally available to him. She was able to improve her relationship with her boyfriend by learning and practicing assertiveness and communication skills. She is able to attend family gatherings and no longer isolates herself in her room. She expressed feeling significant emotional relief and shared about future plans which include going back to college.

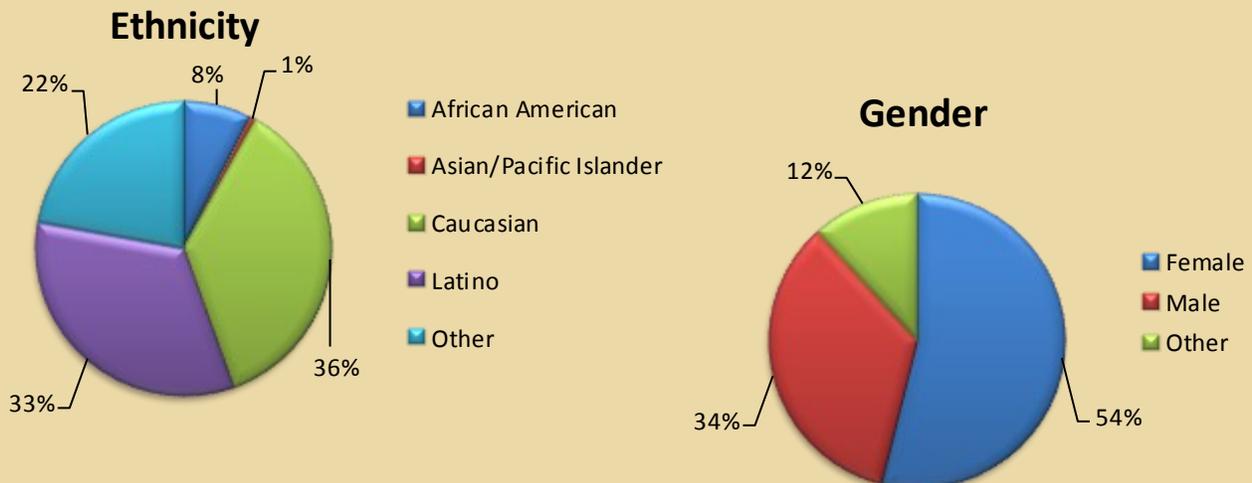
Challenges

Tracking outcomes across all program strategies is a challenge faced by providers. Another challenge facing providers is staffing changes and shortages which have created a hardship in delivering services to the community.

Solutions in Progress

CWE providers are training and educating staff to consistently track all client contact and demographic information to ensure the integrity of data needed to measure outcomes. Providers to structure an outcome assessment tool and collect data on a consistent basis across the program. With proper staffing levels providers have been able to re-enter communities and provide services.

Fiscal Year 2013/14 Program Demographics



System Enhancement Initiative

Projections for Next Fiscal Year

The CWE program consists of prevention and early intervention activities as indicated below.

Service Type	Percentage
Prevention	36%
Early Intervention	64%

Military Services & Family Support Program (PEI SE-4)

The Military Services and Family Support Program (MSFS) is a PEI program intended for military families in San Bernardino County. All veterans, active duty or retired military personnel, reservists, or National Guard who have served on or after September 11, 2001, and their families are eligible. Diverse children in these families face adjustment difficulties and vulnerabilities, as they may live with the anxiety of having a parent serving in a time of war. These children and youth need support in coping with well-founded fears. In addition, the men and women returning from active duty carry the emotional scars of prolonged battle fatigue and possibly Post-Traumatic Stress Disorder (PTSD). This program provides in-home thorough psychosocial assessments, family interventions, and rehabilitative support for military families who have been identified with needing these services.

The MSFS program includes two main components for military families. The first is the prevention component which provides screenings and assessment for individuals and their families. It also provides support groups which are designed to meet the unique needs of military families. Intervention is the second component and its services include case management and referrals for individuals and families identified as needing long-term, intensive mental health services. This component also provides for individual, couples, and/or family counseling and therapy as well as short-term mental health services for participants experiencing the onset of a mental illness.



Portions of this program are offered in collaboration with the County Department of Veterans Affairs. Offering multiple access options increases the likelihood military personnel will utilize services, while also reducing the occurrence of stigma and discrimination associated with obtaining behavioral health services.

System Enhancement Initiative

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
 - ◊ Improved life satisfaction.
 - ◊ Decreased hopelessness/increased hope.
 - ◊ Increased Resiliency.
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing occupation/education, legal, managing money, interpersonal, social).
- Reduce Suicide.
 - ◊ Decreased suicidal ideation.
 - ◊ Increased knowledge of suicide risk factors.
 - ◊ Increased knowledge of suicide prevention resources.
 - ◊ Decreased suicide risk, as measured by assessment/outcome measures.
- Reduce Stigma & Discrimination Associated with Mental Illness.
 - ◊ Increased accurate knowledge about mental illness.
 - ◊ Increased intent to seek services, if needed.

Target Population

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2015/16

- 400 Children
- 500 TAY
- 2,400 Adults
- 200 Older Adult

Positive Results

The MSFS program utilizes the Beck Depression Inventory, the Beck Anxiety Inventory, the Global Assessment of Functioning (GAF), and Adult Needs and Strengths Assessment (ANSA) to measure outcomes and ensure goals are being met.

Results from the Beck Depression Inventory and the Beck Anxiety Inventory indicate that participants rate of depression and anxiety is being reduced after receiving services through the MSFS program.

➤ Beck Depression Inventory - Average

Pre Score	Post Score
24.8	20.2

19% Average Improvement

➤ Beck Anxiety Inventory - Average

Pre Score	Post Score
44.2	20.5

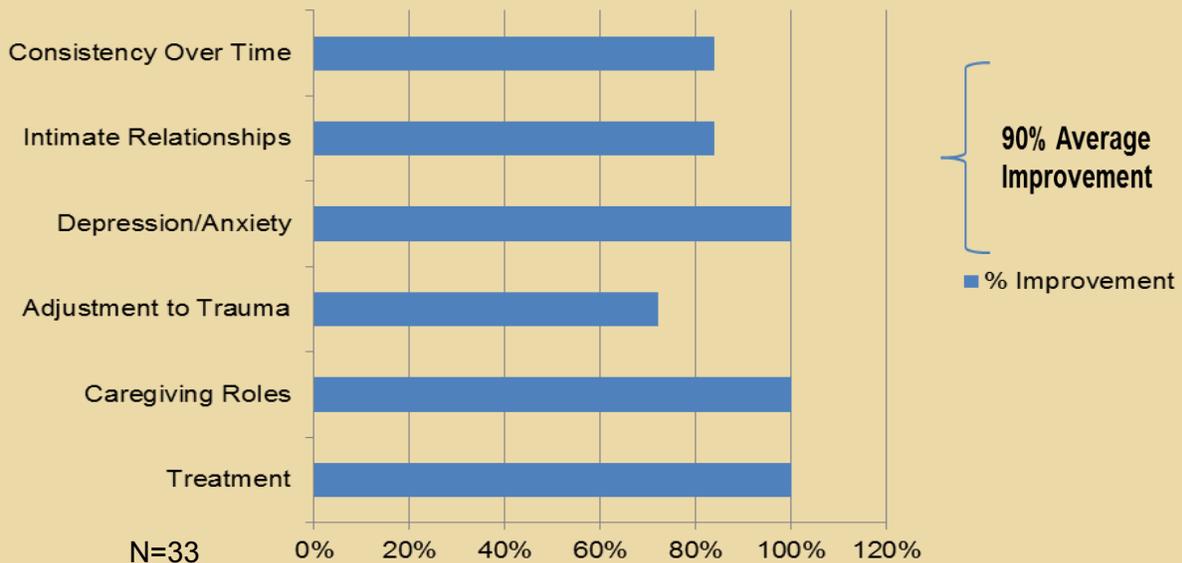
54% Average Improvement

N=79

System Enhancement Initiative

The ANSA is an assessment tool used in adult individual treatment plans to measure functioning in several important life domains. Data indicates that participants are improving in several domains after receiving services through the MSFS program.

ANSA Score Improvement



For FY 2013/14, participants receiving Early Intervention services demonstrated average improvement in GAF scores of **3.98%** after receiving clinical interventions, as illustrated in the table below. GAF scores were tracked to measure the progress of participants receiving early intervention services. GAF scores measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Participants' scores were noted at case opening and case closing.

Average GAF Scores for Military Services & Family Support		
At Case Intake	At Case Discharge	Improvement
47.7	49.6	3.98%



Collaborative Partners

- Pacific Clinics.
- Christian Counseling Service of East Valley, Inc.
- Victor Community Support Services, Inc.
- Department of Veteran Affairs.

System Enhancement Initiative

Success Story

Through the course of therapeutic services, a MSFS client, "Cheryl", was taught to use Trauma Resiliency Model (TRM) skills to assist with self-regulation and reducing symptoms related to Post-Traumatic Stress Disorder. Cheryl reported that her anxiety was greatly reduced and she had several personal victories since learning these skills. She was able to do many activities that she was not comfortable doing previously. She reported being able to shop in a crowded store with less elevated anxiety than usual, sit in a restaurant with her back to the wall, as well as spending time socializing with friends and family. Cheryl reports that using TRM skills have reduced her anxiety attacks and she has had a noticeable decrease in agitated thoughts and anger. MSFS services have helped Cheryl to make great strides in her recovery and in daily functioning.

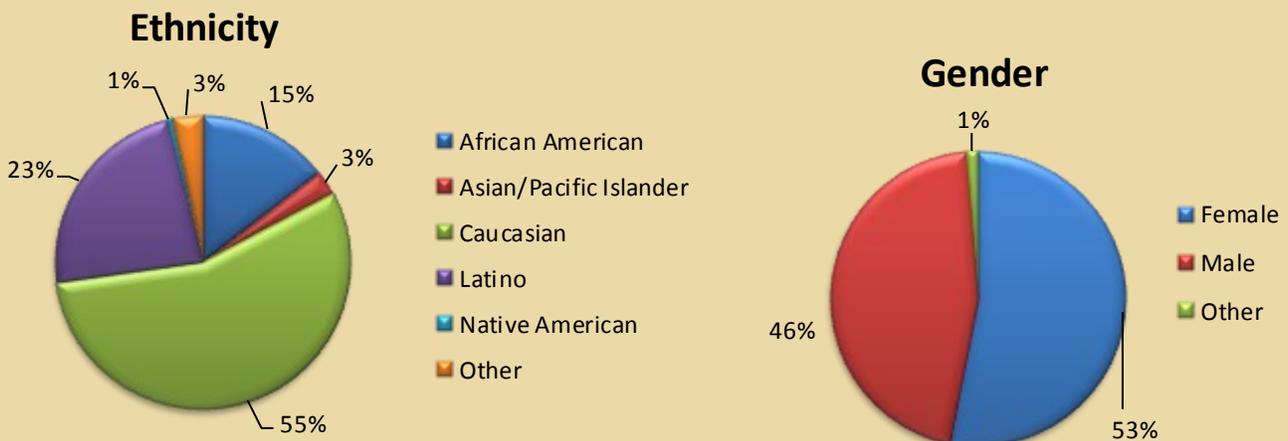
Challenges

The MSFS program has experienced high turnover of their staff which has made it challenging to manage referrals. Also, due to the nature of the military, there is a constant rotation and change in staff due to reassignments.

Solutions in Progress

The MSFS staff continue to work in collaboration with school and military site personnel to build trust and strengthen relationships between staff and participants. The providers will continue accurate and consistent gathering of data to ensure accurate outcomes and program information are reported.

Fiscal Year 2013/14 Program Demographics



Projections for Next Fiscal Year

The MSFS program consists of prevention and early intervention activities as identified in the illustration on the right.

Service Type	Percentage
Prevention	64%
Early Intervention	36%

System Enhancement Initiative

LIFT Program (PEI SE-5)

The LIFT program seeks to improve the health, well-being and self-sufficiency of low-income mothers and their children. Services are delivered in the home by nurses who provide educational information that promotes the physical and emotional care of children by their mothers, family members and caretakers. Program nurses link family members with needed physical and mental health services. Services include:



- Prenatal screenings.
- Postpartum depression screenings.
- Maternal attachment support.
- Substance use/abuse screenings and support.
- Parenting education/support.
- Life and employment skills development.
- Case management.
- Assistance with developmental milestones for the child.

These services last for the duration of the mother's pregnancy up until the child is two years old.

The LIFT program is a home visitation model that utilizes the research based *Partners for a Healthy Baby Curriculum*. Science and research based assessment and evaluation tools are used including the Maternal Fetal Attachment Scale, Fagerstrom Test for Nicotine Dependence, the Edinburgh Postnatal Depression Scale and the Life Skills Progression (LSP) tool.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
 - ◊ Improved life satisfaction.
 - ◊ Decreased hopelessness/increased hope.
 - ◊ Increased resiliency.
 - ◊ Decreased impairment in general areas of life functioning.
- Reduce Stigma and Discrimination Associated with Mental Illness.
 - ◊ Increased accurate knowledge about mental illness.
 - ◊ Increased intent to seek services if needed.
- Reduce School/Failure and Dropout Rates.
 - ◊ Increased school attendance.
 - ◊ Increased subjective school connectedness.
 - ◊ Lower rate of school dropouts.
 - ◊ Lower rate of failing students.
 - ◊ Decreased school behavioral problems.
 - ◊ Decreased school achievement problems.
- Reduce Unemployment Among Consumers.
 - ◊ Lower rate of unemployment.
 - ◊ Increased employment-related skills/vocational strengths.

Target Population

- TAY

Projected Number to be Served FY 2015/16

- 100 TAY

System Enhancement Initiative

Positive Results

The LIFT program served **58** unduplicated mothers in FY 2013/14. Every six (6) months participants complete the Life Skills Progression (LSP) assessment tool and data from FY 2013/14 indicates participants are gaining employment, receiving support in obtaining their educational goals, obtaining access to the health care system, receiving education on family planning methods, and experiencing reduced signs of depression.

Pregnant and post-partum mothers participating in the LIFT program have expressed appreciation for the support the Registered Nurse (RN) was providing and was most receptive to personal support.

Success Story

PSD LIFT enrolled a pregnant mother, "Denise", that was starting to show unexplained signs of "sadness" as her delivery date approached. The RN had been discussing Denise's need to complete high school and seek out a stable job. Up to this point, she was resistant and although she was resistant. The RN was eventually able to discuss Denise's unexplained sadness. She confided that she was worried about being able to provide for her newborn. PSD has a component that provides job coaching and help identifying current employment opportunities. Denise decided to participate in this program and shortly after delivery got a stable entry level job and returned to complete her high school diploma.



Artwork by Greg Vander-Haeghen

Challenges

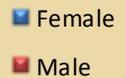
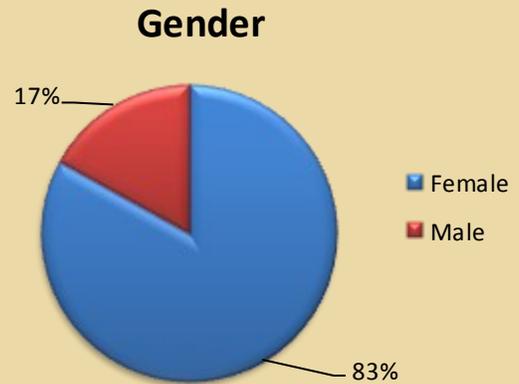
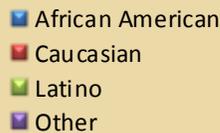
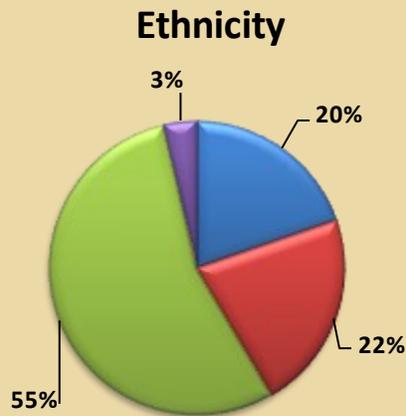
The success of LIFT identified a need to provide services to all pregnant mothers not to only first-time mothers. LIFT challenges include nursing staff retention/turnover, having to coordinate with other agencies/entities to provide simultaneous services, and consistent gathering and reporting of data.

Solutions in Progress

LIFT has implemented recruitment strategies to fully staff nursing positions. In an effort to expand services, LIFT, will partner with *Easter Seals* to provide services to the West Valley. Another expansion of the program is to include all low-income mothers, not just first-time mothers. The expanded definition of the target population is intended to support the provider in reaching the expected number of families to be served. Lastly, LIFT is identifying ways to collect accurate and thorough program and demographic data in order to provide necessary program reports and outcomes.

System Enhancement Initiative

Fiscal Year 2013/14 Program Demographics



Service Type	Percentage
Prevention	100%

Projection for Next Fiscal Year

LIFT consists exclusively of prevention activities as indicated in the illustration on the left.

Coalition Against Sexual Exploitation (PEI SE-6)

The Coalition Against Sexual Exploitation (CASE) program is a collaborative approach between ten (10) public agencies that serve sexually exploited children (ages 12-15), TAY (ages 16-25), and those at risk for sexual exploitation through a centralized referral mechanism managed by the CASE Coordinator and Multi-Disciplinary Team (MDT). The program coordinates community outreach and education as well as direct services. Services include mental health assessments, crisis intervention, case management, school enrollment assistance, therapeutic interventions, transportation, placement, and linkage/referral to community resources. In FY 2014/15, 3717 individuals have participated in either CASE education or therapeutic services.

The Coalition Against Sexual Exploitation (CASE) program was originally an Innovation project, introduced in 2010, through the approved MHSA Innovation component plan. The County conducted an extensive Community Program Planning (CPP) process involving a variety of community stakeholders. Based on stakeholder input and review of the CASE program, CASE was identified as a project necessary to address the need of this population and to continue as a PEI program.

The initial intent of the program was to develop a model of identification, facilitate rehabilitation for a specific group of children/youth who have been sexually exploited, and develop approaches to mental health education to assist in the prevention of future exploitation. The long-term goal of the project is to make use of an innovative collaboration to strengthen systems that serve sexually exploited children/youth, by developing creative strategies and combining best practices in trauma care with local-collaborative expertise.

With stakeholder support, CASE was transitioned into a PEI program in July 2014 to continue to provide effective elements of the project. Since that date, the CASE program has been collecting data consistent with the other PEI programs. Progress will be reported in next year's annual update.

System Enhancement Initiative

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
 - ◊ Improved life satisfaction.
 - ◊ Decreased hopelessness/increased hope.
 - ◊ Increased resiliency.
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).

Positive Results

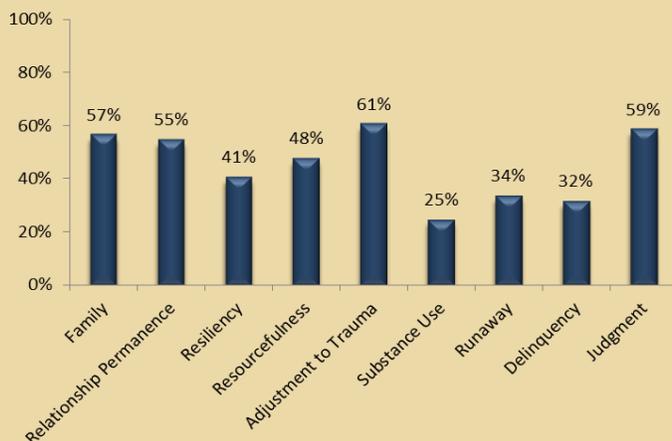
CASE had specific objectives when it was created. One of them was to develop an effective means of identifying diverse children who are vulnerable to exploitation. The graph below shows some predictive indicators which were extracted from CANS (Child and Adolescent Needs and Strength Assessment) data.

The data on the chart indicates specific indicators that have helped CASE staff in developing effective strategies to help participants of the CASE program.

CASE continues its efforts to raise awareness about human trafficking in San Bernardino County. In January, 2015, the Annual CASE Anti-Human Trafficking Awareness Walk was held at the Children's Network on Hospitality Lane. The walk was attended by over **450** community members.

Additionally, CASE continues to provide on-going education to the community organizations and stakeholders. Over the past year, the CASE presentation, Identification & Assessment of Victims of Trafficking and Commercial Sexual Exploitation, has been offered to law enforcement, probation officers, social workers, therapists, intake specialists, childcare workers, teachers, guidance counselors, school resource officers, first responders and community members.

The program data for this time period can be found in the Innovations section of the annual update. Up until 6/30/2014, CASE was an Innovation project that, with stakeholder support, transitioned to PEI.



Target Population

- Children
- TAY
- Adults

Projected Number to be Served FY 2015/16

- 25 Children
- 25 TAY
- 3000 Adults

Collaborative Partners

- San Bernardino County Superintendent of Schools.
- Superior Court of California-Juvenile Court Division.
- County Department of Behavioral Health.
- Department of Public Health.
- Children and Family Services.
- Children's Network .
- District Attorney's Office.
- Probation Department.
- Public Defender.

System Enhancement Initiative

Success Story

“Janet”, a 16-year-old female, who has a two year history of being a victim of commercial sexual exploitation started participating in the CASE program. Previous to starting the program, she was detained by law enforcement in numerous counties and is currently on probation. As part of the CASE program, she attends school and therapy. Her experience has been so positive that she has requested to use her “victims of crime” funds to allow her to meet with the therapist on a more regular basis. Janet has also secured a job working part-time at a fast food restaurant. All of this has been facilitated by the CASE social worker who provides ongoing case management services and support to Janet who has taken positive actions for herself. She has not run away from home and is complying with all terms and conditions of her probation. She has not re-engaged in “the life” and is working, in concert with the CASE social worker, to ensure that she does not return.



Artwork by Gary Bustin

Challenges

The implementation of the CASE program identified a few challenges such as the CANS Assessment taking longer than anticipated to implement, frequent changes in staff on the CASE team made it difficult to ensure staff were adequately trained, and analyzing data to obtain accurate outcomes information. Providers have noted that many of the youth in the CASE program do not stay in one place long enough to build trust and relationships with case managers and social workers. Also, frequent transitions in living arrangements and episodes of running away can make the delivery of behavioral health services a challenge.

Solutions in Progress

The CASE program progress completed during the first quarter of fiscal year 2014-2015 centered on the transition of the CASE program from being funded through MHSA Innovations (INN) to Prevention and Early Intervention (PEI) as of July 1, 2014. In order to facilitate this transition, staff from INN and PEI worked closely together to identify goals, data collection, and the reporting process relative to PEI. Solutions to ensure the program is successful include establishing a structured outcome assessment and consistent data collection across the program. It is imperative to the success of the program to continue building the CASE network of providers, for those in need of services.

Projections for Next Fiscal Year

The CASE program consists of prevention and early intervention activities as detailed below.

Service Type	Percentage
Prevention	100%



Artwork by Cordero Carruthers

Community Services and Supports (CSS)

Community Services and Supports

Introduction

The Mental Health Services Act (MHSA) requires that services are “consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

- To promote concepts key to the recovery for individuals who have mental illness; hope, personal empowerment, respect, social connections, responsibility, and self-determination.
- To promote consumer operated services as a way to support recovery.
- To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- To plan for consumer’s individual needs.

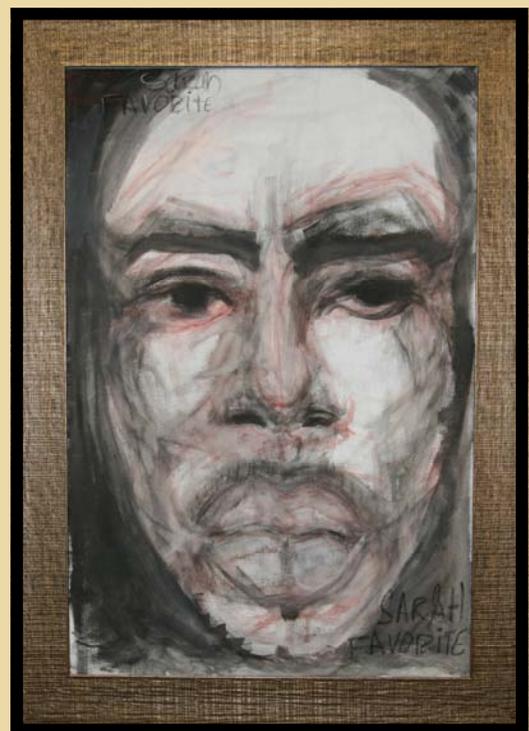
The majority of MHSA funding (**80%**) is mandated to be directed toward the Community Services and Supports (CSS) component. CSS provides access to mental health services through our previously approved programs and targets: Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill populations. Seriously Emotionally Disturbed refers to children and youth with difficulty functioning in multiple life domains such as school, home, and/or community.

Serious Mental Illness (SMI) is a term defined by Federal regulations that describe mental disorders that significantly interfere with some area of functioning.

The CSS services component provides access to Full Service Partnerships (FSP). FSP’s provide all necessary services and supports to help clients achieve their mental health goals and treatment plan. FSP services comprehensively address client and family needs and “do whatever it takes” to meet those needs, including intensive services and supports and strong connections to community resources with a focus on resilience and recovery.

MHSA Legislative Goals

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



Artwork by Sarah Favorite

Community Services and Supports

Community Services and Support

This component has greatly contributed to the ongoing transformation of the public mental health system by:

- Augmenting existing services.
- Establishing a system of care for crisis services.
- Developing programming to address the needs of Transitional Age Youth (TAY).
- Developing supportive housing and maximizing MHSA funds for housing opportunities.
- Enhancing and expanding wraparound services to children.
- Expansion of adult FSP.

There are currently fourteen CSS programs designed to serve all age groups. The programs are as follows:

- 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-1: Clubhouse Expansion Program
- A-2: Forensic Integrated Mental Health Services (FACT, STAR and CIT)
- A-3: Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)
- A-4: Crisis Walk-in Centers (CWIC)
- A-5: Psychiatric Triage Diversion Program
- A-6: Community Crisis Response Team (CCRT)
- A-7: Homeless Intensive Case Management and Outreach Services/Housing and Employment/Homeless Outreach Service Teams
- A-8: Big Bear Full Service Partnership
- A-9: Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services
- OA-1: AgeWise-Circle of Care
- OA-2: AgeWise-Mobile Response



Artwork by David Pacheco

Community Services and Supports Programs

Comprehensive Children and Family Support Services (C-1)

Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for Full Service Partnerships (FSP) to provide wraparound services to diverse children and youth with emotional disturbances and co-occurring disorders.

Wraparound has proven to be an effective means by which children and youth receive assistance and avoid out-of-home placements or loss of current placements. Additionally participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community. For Fiscal Year 2013/14, there were **1,227** participants in the program, of which **1,205** were unduplicated, meaning they began receiving services during the reporting period and had not been included in previous counts.

Wraparound is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes. Services are "wrapped around" the child and family in their natural environments. Wraparound is community-based (using a balance of formal and informal supports), culturally relevant, flexible, and coordinated across agencies; it is outcome driven, and provides unconditional care (SAMHSA, 2008).

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
 - ◊ Decreased suffering from serious emotional difficulties.
 - ◊ Decreased hopelessness/increased hope
 - ◊ Increased resiliency.
- Reduce homelessness and increase safe and permanent housing:
 - ◊ Increased residential stability.
- Reduction in criminal and juvenile justice involvement:
 - ◊ Reduced delinquent behaviors which increase likelihood of juvenile justice involvement.

Target Population

- Children

Projected Number to Be Served FY 2015/16

- 882 Children

***"Wrap has helped me so, so much!"
- Wraparound Participant***

Positive Results

The Child and Adolescent Needs and Strengths (CANS) is an assessment tool utilized within all CCFSS programs; however, the infrastructure to provide consistent utilization of the CANS within any one agency was not fully available until the end of FY2013/14. These infrastructures ensure supervisors are attending to the accuracy of the CANS. Reviewing data prior to FY2014/15 there is a consistent under-reporting of difficulties across all programs. For example, according to the CANS data in FY2013/14 approximately **10%** of children and youth served through CCFSS programs were not experiencing any significant needs in regards to their general ability to function or their experience of mental health issues. When specific CANS are examined in detail (i.e., compared to clinical records), it is

Community Services and Supports Programs

clear that the CANS data is under-reporting the child's suffering and corresponding needs. This global under-reporting of needs results in a limited ability to report on improvements. This should be taken into consideration when reviewing the results.

CANS data is analyzed here in two ways: (1) Global Measurement and (2) Specific Area/Construct. The Global Measure analysis incorporates all the specific items in a domain (e.g., Life Functioning) and compares scores from the onset of services to the planned discharge. The Specific Area analysis considers only those children and youth who presented with a significant need for help on that item/construct and reports what percentage of those children and youth no longer needed help at the conclusion of services. It is important to understand the percentage of improvement for a single construct (e.g., Social Functioning) within the context of treatment research. Specifically, treatment studies show that most control groups (i.e., the test subjects who did not receive any intervention) fall evenly within three groups (i.e., 1/3rd of the group shows no changes, 1/3rd shows improvement, and 1/3rd show a worsening of difficulties). Since **33%** of control group members show improvement, a treatment is considered to be beneficial when significantly more than **33%** of the members show improvement.

Global Measurement of Life Functioning

- **90.49%** of children and youth entering CCFSS Programs were scored as having at least one area of impaired life functioning.
- **55.7%** of these children showed statistically significant improvements upon exiting the program.

Specific Areas of Life Functioning

- **Family Difficulties: 65%** of the children needed help with family difficulties, and of those, **54%** showed marked improvement in this area that no additional help was needed at the time of exiting the program.
- **Social Functioning: 41%** of the children needed help improving their social functioning, and of those, **68%** showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Recreational: 26%** of the children needed help with positive recreational leisure time activities, and of those, **66%** showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Sleep: 23%** of the children needed help with sleep disruption, and of those, **66%** showed substantial improvement in this area that no additional help was needed at the time of exiting the program.



Artwork by Lazaro Sanchez-Free

Global Measurement of Behavioral and Emotional Needs:

- **89.14%** of children and youth entering CCFSS Programs were scored as having at least one significant behavioral or emotional need.
- **49.4%** of these children showed statistically significant improvements upon exiting the program.

Specific Areas of Behavioral and Emotional Needs:

- **Impulsivity/Hyperactivity: 35%** of the children required treatment for difficulties related to impulsivity and/or hyperactivity, of those, **50%** of showed marked improvement in this area that no additional help was needed at the time of exiting the program.
- **Depression: 35%** of the children required treatment for difficulties related to depression, and of those, **59%** of showed marked improvement in this area that no additional help was needed at the time of exiting the program.

Community Services and Supports Programs

- **Anxiety:** 23% of the children required treatment for difficulties related to anxiety, and of those, 60% of them showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Adjustment to Trauma:** 30% of the children needed help with adjusting to trauma, and of those, 61% showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Anger Control:** 55% of the children required treatment for anger control, and of those, 60% showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Eating Disorders:** 5% of the children required treatment for eating disorders, and of those, 85% showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Affect Dysregulation:** 24% of the children required treatment for affect dysregulation, and of those, 73% showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Behavioral Regressions:** 5% of the children required treatment for regressions in behaviors, and of those, 70% showed substantial improvement in this area that no additional help was needed at the time of exiting the program.
- **Substance Abuse:** 8% of the children required treatment for substance use, and of those, 42% showed marked improvement in this area that no additional help was needed at the time of exiting the program.

The concept of residential stability is quite different for children than it is for adults. Children coming to the CCFSS programs reside in a variety of situations related to a multitude of circumstances. Some reside with biological families and do not have any Child Welfare involvement; others reside with biological families and do have Child Welfare involvement. Some children are placed into a family by Child Welfare and others are placed into group homes by Child Welfare. While the basic question of residential stability for the caregiver is relevant, the Key Outcomes likely to increase residential stability for the child are (1) being with a caregiver likely to be involved once the child has grown, (2) how well the child is functioning within the family home, and (3) how involved and knowledgeable the caregiver is with regards to the needs of the child. These last items are indicative of a level of engagement from the caregiver; more engaged caregivers are less likely to request a child removed from their home.



Artwork by Jose Luis Mendez

Community Services and Supports Programs

Specific indicators likely to increase residential stability:

- **Caregiver's Residential Stability:** While **8%** of the caregivers involved in the CCFSS Programs indicated needing help in obtaining a more stable residence, **74%** of those needing residential stability were able to obtain this by the end of services.
- **53%** of the children seen entered a CCFSS Program needing help improving their functioning within their living situation. **59%** of these children were able to significantly improve on this item, indicating a decrease in conflict within the home.
- **5%** of the caregivers were significantly uninvolved with the mental health needs of their children at the time of admission, **91%** of these caregivers were seen as appropriately involved by the end of services.
- **33%** of the caregivers showed a detrimentally low level of knowledge regarding the child's mental health needs at the start of services. **80%** of these caregivers gained enough knowledge related to the child's needs that this was of no concern by the end of the program.

Evaluating the effectiveness of CCFSS programs on reducing the likelihood of involvement in the juvenile justice system requires focusing on impacts on specific pre-cursors that could later lead to juvenile justice involvement. Specifically, **55%** of the children seen in CCFSS programs needed help with those precursors that could easily lead to criminal or juvenile justice involvement, and of those **55%** identified, **14%** had specific difficulties related to formal legal charges.

Specific indicators likely to increase juvenile justice involvement:

- **Delinquency:** **6%** of the children were engaging in delinquent type of behaviors that could result in an arrest at the start of services. **58%** of these children were no longer seen as needing help on this upon exiting the programs.
- **Danger to Others:** **10%** of the children needed help to address the possibility that they would harm someone else. **78%** of these children were no longer considered to be at risk for harming others at the end of the program.
- **Runaway:** **5%** of the children seen were engaging in runaway behaviors at the start of services. **67%** of them successfully managed to stop these behaviors by the end of services.
- **Conduct Disorder Behaviors:** **10%** of the children displayed conduct disorder behaviors requiring intervention at the start of services. **60%** of these children improved to the point of not needing help with this issue upon discharge.
- **Oppositional Behaviors:** **41%** of the children needed help with oppositional behaviors at the start of services. **48%** of these children improved to the point of not needing help with this issue upon discharge.

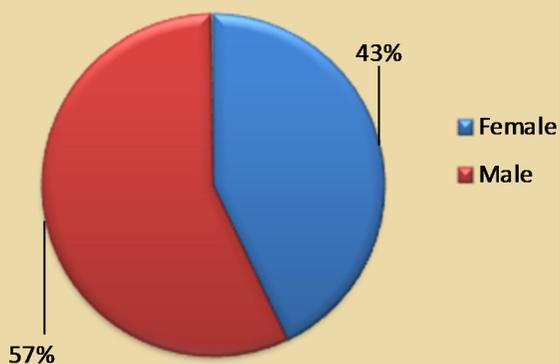


Artwork by David Pacheco

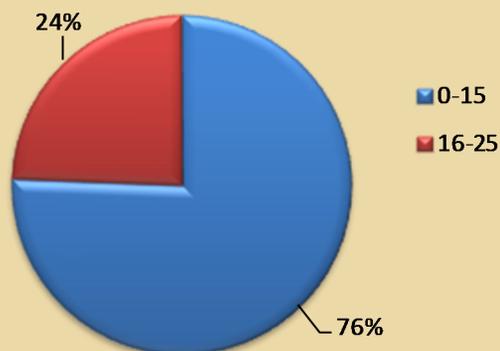
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

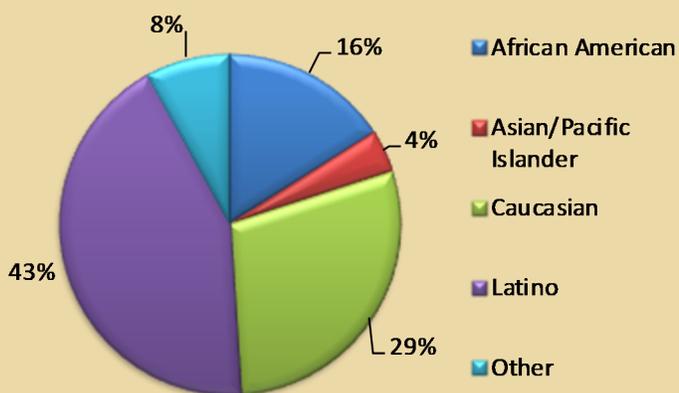
Gender



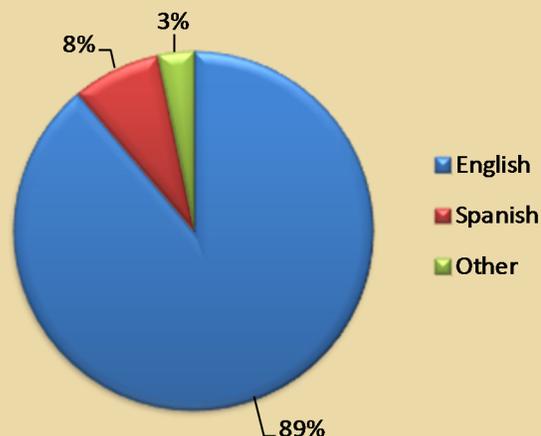
Age



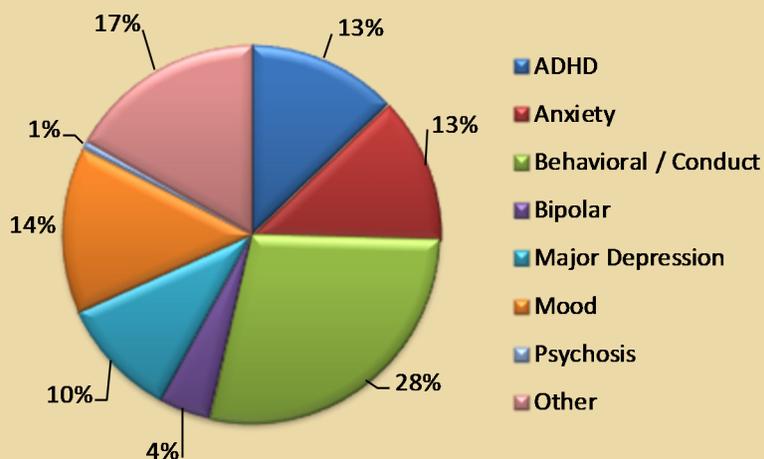
Ethnicity



Primary Language



Diagnostic Group



Community Services and Supports Programs

Success Story

At the time of referral to Wrap services, “Janet” and her siblings were living with a maternal grandmother in family foster care while the mother completed an in-patient treatment program due to a history of substance abuse. Initially, Janet presented as timid and shy, very fearful of strangers and the dark, exhibiting anxious episodes, frequent nightmares, socially withdrawn, often angry, and physically aggressive toward the care provider and siblings. After a short period of time, the mother was reunified with her children and moved in with the grandmother and family. The Wrap team began the process of building rapport by engaging family members to focus on shared strengths and visualize steps to create a healthy family future. Initial interventions focused on assertive communication with siblings, mother, and extended family members. Wrap also assisted Janet with identifying feelings and expressing needs and wants without aggression. The Wrap team demonstrated Parent Resources for Information, Development, and Education (PRIDE) skills and encouraged parents to have one-on-one interactions with the child and to practice active listening skills. As a result, Janet has formed good relationships with peers at school and family members, is no longer having nightmares, is no longer scared of the dark, is no longer socially withdrawn, or physically aggressive. Notably, Janet has built a loving and trusting relationship with the mother, father, siblings, and extended family members.

Challenges

Fiscal year FY 2013/14 was the first full year in which the Katie A. Settlement was being implemented. The CCFSS Program was chosen as one of the primary means by which the Core Practice Model (CPM) would be implemented for Dependents meeting the settlement specified subclass criteria. The CCFSS Full Services Partnerships serve dependents at home and in congregate care, all of whom potentially qualify for additional CPM services of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Existing Wrap-informed programs and CPM have strong similarities; therefore, utilizing these existing programs is appropriate. There are also strong similarities between CPM and these Wrap-informed programs, so utilizing these existing programs to implement CPM was deemed prudent. However, implementing CPM and new services (i.e., ICC & IHBS) presented a variety of challenges.

One hundred percent of the staff of the existing programs needed to be trained on the CPM, ICC, and IHBS. This was started prior to FY 2013/14, but the majority of the trainings occurred in FY 2013/14. In addition to the training, the infrastructure needed to support the provision of ICC and IHBS needed to be implemented. Although staff were all trained and appeared to implement the requirements of the CPM quickly, throughout the year additional efforts continued to be made to ensure the CPM values and practices were being maintained. Having DBH staff involved in the implementation of the Child and Family Team Meetings (CFTM) was necessary throughout the year.

While the entire CCFSS Program has implemented the CPM, in reality, the CCFSS Program is divided into three separate programs that form one continuum of care for Children’s Full Service Partnerships (FSP). Each program has faced unique challenges. The Children’s Residential Intensive Services (ChRIS) program is a conjoint effort with Children and Family Services (CFS) to serve high needs youth in congregate care. ChRIS is an expansion and continuation of the state sponsored Residentially Based Services (RBS) pilot project. Wraparound is another conjoint effort with CFS attempting to provide intensive in-home services as an alternative to residential placement. Success First/Early Wrap (SF/EW) is a Wrap-informed FSP targeting children in need of short-term intensive services, including Dependents and Wards who do not qualify for Wraparound.

FY 2013/14 was the first year of operation of ChRIS. Previously it was a smaller program under the RBS pilot project. The expansion from one agency to three agencies and from **12** beds to **36** beds was accomplished by allocating more EPSDT Medi-Cal funds and partnering with CFS for additional

Community Services and Supports Programs



Artwork by David Pacheco

funds for non-mental health services. This expansion was the primary challenge for this past year. The three agencies which were awarded the program were all solid congregate care agencies, but only one of them had experience with RBS. The primary challenge of FY 2013/14 was facilitating the modifications of congregate practices to fit with the ChRIS model. This included an introduction of new staff, new program elements (e.g. Enrichment and Bridging Activities), and further development of a trauma-informed care model.

Wraparound is a conjointly operated program by DBH and CFS and is a key program to the successful implementation of the CPM. This transition from established Wraparound program to primary CPM program was the challenge for FY 2013/14. The complexity of the challenge involves the funding of Wraparound services. Wraparound has three funding streams: (1) Aid to Families with Dependent Children – Foster Care (AFDC-FC); (2) EPSDT Medi-Cal; and, (3) MHSA. Agencies must allocate staff and activities to the different funding sources. A key element of the settlement agreement was the introduction of Intensive Care Coordination (ICC) as a new EPSDT Medi-Cal Specialty Mental Health Service. The Wraparound agencies coordinated care for children prior to the existence of ICC and this coordination was primarily funded through AFDC-FC. In order to utilize ICC and more accurately capture these activities, agencies needed to make significant programmatic adjustments.

Success First/Early Wrap (SF/EW) is a time-limited Wrap-informed FSP program whose target population has always included Dependents, but these youth are only a portion of those served. SF/EW has been designated to serve these dependents who do not qualify for Wraparound but are in need of CPM as required for subclass members. In addition to making modifications to SF/EW to fully implement the CPM, encouraging CFS Social Workers to increase utilization of SF/EW was an additional challenge.

Solutions in Progress

The implementation of the Core Practice Model (CPM) within all CCFSS Programs is a primary focus during this current fiscal year and several different efforts to facilitate this are ongoing. These efforts include, but are not limited to, the following:

- Monthly trainings coordinated by CFS on the CPM. The majority of trainees are CFS line workers, but all trainings are also attended by CCFSS Program staff.
- Quarterly meetings with each CCFSS Program to explore CPM implementation.
- Development of reports on CPM related data points. These reports prompt clinical staff to contact providers and review service plans and CPM implementation.
- Development of Child and Family Team (CFT) practice and report standards with CFS.

The group home agencies implementing ChRIS continue to participate in three different meeting practices to ensure compliance with the CPM and ChRIS model: (1) Steering Committee, (2) Oversight Meeting, and (3) Child and Family Team Meetings. The Steering Committee decided to continue to meet monthly during the second year of operations. This high level monitoring appears to help maintain consistency across the agencies. The Oversight Meeting is held quarterly for each agency and is able to focus more on the program elements specific to that agency. Lastly, CFT meetings are held monthly to quarterly, according to the child's needs which allow for a child-centered focus.

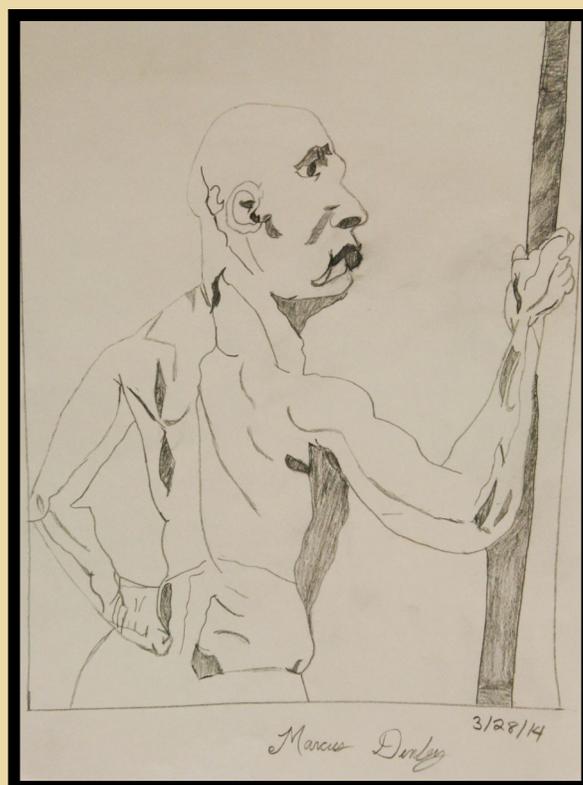
Community Services and Supports Programs

The Wraparound and Success First/Early Wrap agencies are meeting with DBH managerial staff quarterly to problem-solve any CPM implementation issues. Through these discussions and the development of data-driven reports, additional efforts are being made by DBH and CFS staff to identify children in need of Wraparound or SF/EW services. DBH staff who are co-located at CFS offices review mental health screenings with the intention of linking Dependents to appropriate CPM services which include the CCFSS Programs. Reaching out to CFS Social Workers has been, and is expected to continue to be, a successful way to increase the utilization of CCFSS Programs by Dependents.

SF/EW staff are joining CFS staff at all CPM implementation trainings. These monthly trainings, facilitated by CFS, target a small group of social workers (e.g., 20-25) and focus on the broad implementation of the CPM. SF/EW staff and social workers servicing the same area attend the same monthly trainings. This arrangement increases familiarity of the SF/EW program and allows for better connections.

Collaborative Partners

- County of San Bernardino Children and Family Services.
- County of San Bernardino Probation.
- Department of Behavioral Health Transitional Age Youth Centers.
- School Attendance Review Boards.
- School Districts.
- San Bernardino County First Five.
- Local Communities.
- David and Margaret Youth and Family Services.
- East Valley C.H.A.R.L.E.E.
- EMQ-Families First, Inc.
- Family Services Agency of San Bernardino.
- Lutheran Social Services.
- Mental Health Systems, Inc.
- South Coast Community Services.
- Victor Community Support Services.
- Victor Treatment Centers.



Artwork by Marcus Denby

“I appreciate the services. Wrap saw me every day at one point. The Family Specialist would come every morning to help make sure I got to school and that I stayed on the right track. I also appreciate the help in getting into the welding program.”

- Clubhouse Member

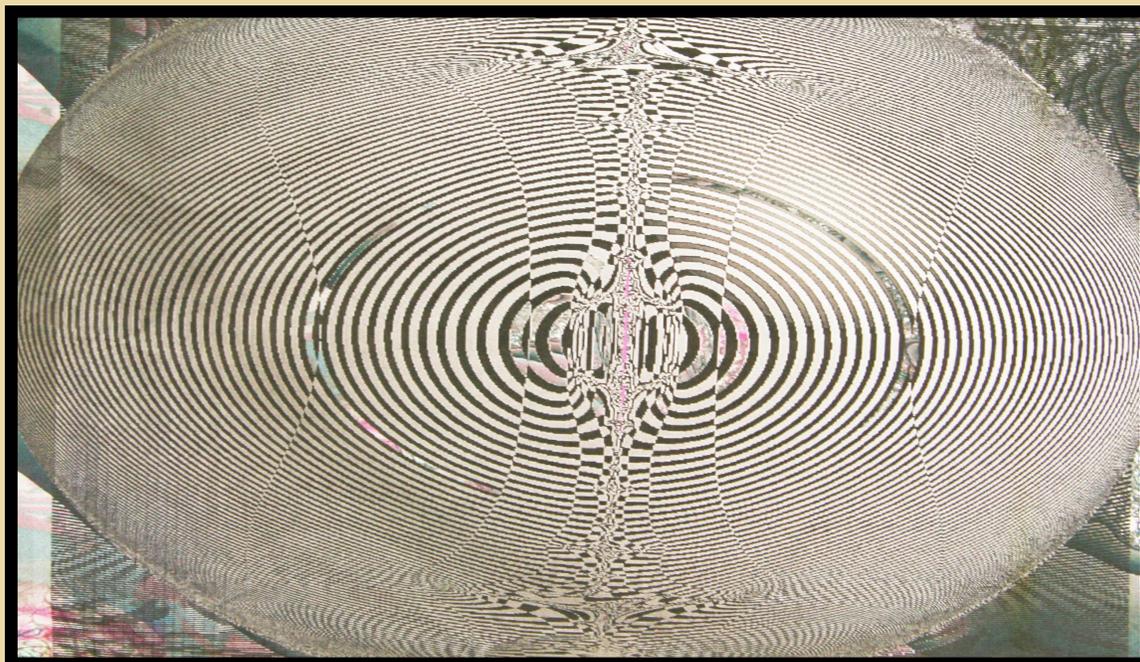
Community Services and Supports Programs

Planned Program Expansion

There will be an increase in outreach efforts to facilitate more dependents entering into the Core Practice Model. Additional staff (i.e. **5** Therapists and **1** Office Assistant) will be added to the CCFSS Program to serve Dependents in group homes. The duties of these therapists will focus on connecting Dependents to CCFSS programs through outreach efforts to CFS Social Workers and through direct services to Dependents. Based upon the current placements of CFS it is expected that these new therapists will provide EPSDT Specialty Mental Health Services to **150** Dependents and outreach and engagement activities to **250** CFS staff (e.g. **1:1** consultations, unit in-services, and presentations). Direct mental health services will include assessments, targeted case management, collateral, intensive care coordination, and occasionally brief therapy.

Expansion of CCFSS Programs to include Outreach and Engagement efforts to serve Dependents in congregate care. This will include the creation of five Clinical Therapist positions and one Office Assistant to support their efforts. This team will be supervised by the DBH Clinic Supervisor and Manager currently overseeing the implementation of CCFSS.

Clinical Therapists will be co-located at CFS regional offices in order to work closer with the CFS Social Workers caring for the children in placement. The clinical therapists will conduct mental health assessments at the group homes, provide ongoing Core Practice Model services as needed, and work toward the Dependents being served by one of the three existing CCFSS Programs. Children placed out of county and in need of an ongoing group home placement will be progressively linked to ChRIS. Children in group homes who are likely to be leaving congregate care in the next three months will be progressively linked to Wraparound or Success First/Early Wrap. These therapists will be in the field often and will require substantial support at the office. The office assistant will be responsible for ensuring compliance with all required registration and tracking of activities.



Artwork by Peter Miller

Community Services and Supports Programs

Integrated New Family Opportunities (C-2)

Integrated New Family Opportunities (INFO) is a NACo award-winning program using 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. The program is not gender or language specific; providing services to males and females in English, Spanish, or other languages as needed.

Youth in the San Bernardino County Central Juvenile Detention and Assessment Center (JDAC) receive mental health and substance abuse services through a joint effort between San Bernardino County Probation and the Department of Behavioral Health (DBH). Services provided help reduce hospitalizations, out-of-home placements, and to help children/youth remain with their families. The services provided by the INFO Program increase stabilization, help families identify community supports, and encourage recovery, wellness, and resiliency.

For Fiscal Year 2013/14, INFO provided services to **46** participants. Another **605** potential participants received information about the program as an option they can choose to best help them.

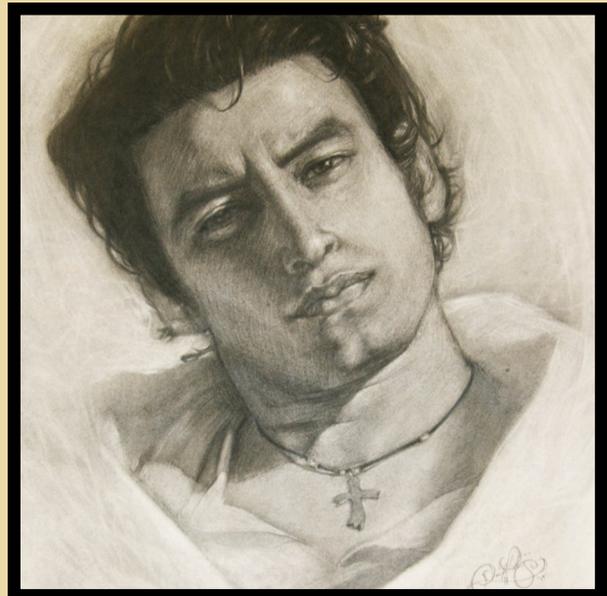
MHSA Legislative Goals and Related Key Outcomes

- Increase in self-help and consumer/family involvement:
 - ◇ Increase in number of collateral contacts, such as family members and informal supports.
- Reduction in criminal and juvenile justice involvement:
 - ◇ Decrease number of days in detention.
 - ◇ Decrease sustained allegations.
 - ◇ Reduced recidivism.

Positive Results

INFO continues to prove the system works!

- The INFO program has **100%** involvement of family members during the program.
- Contact with informal supports, such as school counselors and teachers, has increased **48%**.
- Youth that have successfully completed the program have experienced a:
 - ◇ **7%** decrease in detention days.
 - ◇ **79%** decrease in sustained allegations.
 - ◇ **50%** decrease in recidivism.



Artwork by David Pacheco

Target Population

- Juvenile Justice Youth

Projected Number to be Served in FY 2015/16

- 55 Juvenile Justice Youth

Community Services and Supports Programs

Success Stories

Bella's Story

Probation referred "Bella" to the INFO Program due to burglary and battery charges. She and her Mom had a physically volatile relationship and she was living with an aunt. Mother and daughter said that when they entered services they did not expect things to change or that their therapist would understand their lifestyle. Bella and her mother now say that the Functional Family Therapy (FFT) services allow them to talk to each other instead of cursing at each other. Bella was referred to and attended the San Bernardino Employment and Training Agency (SBETA) Educational Camp, which she completed, and reports that it has supported her in pursuing further education. She has acquired her California Driver's License and has submitted her financial aid paperwork to enter Valley College. Today Bella is no longer on probation and advocates for other girls her age explaining to them what her INFO experience did for her family.

Sam's Story

"Sam" entered the Integrated New Family Opportunities (INFO) Program in June of 2013 as a probation referral due to felony offenses. Resistant to "outsiders interference", the INFO Team supported him as he worked through family and drug issues. He came from a family where criminality and addiction were generational. As he progressed through Moral Recognition Therapy (MRT) groups and Functional Family Therapy (FFT) sessions with his grandmother he seemed empowered to change. When he found out that he was going to become a father, he expressed to staff that he never wanted his child to experience a life such as his. In preparing for his child's arrival, with support from INFO Staff, he gained employment and has worked full-time since March 2014. He has remained out of custody and was discharged from probation successfully.

"He makes his own decisions to do better, more respectful, more communication."

- INFO Graduate Parent

Challenges

- A limited referral base for continued program growth and Functional Family Therapy (FFT) certification.
- Continued provision of evidence-based substance use programs for adolescents. **73%** of youth entering the program have a substance use concern.

"I was leery at first, but open-minded, and I learned so much"

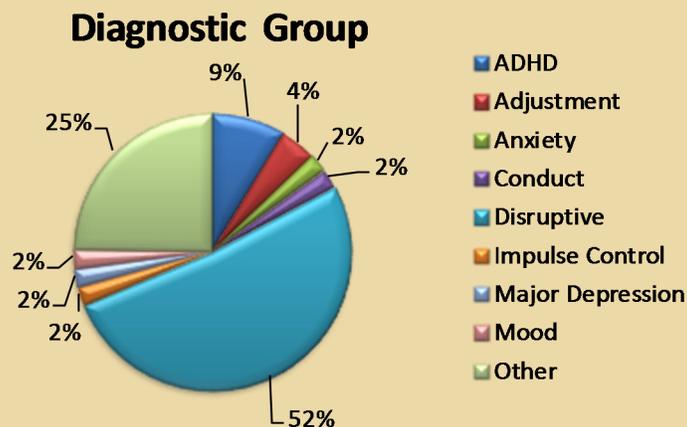
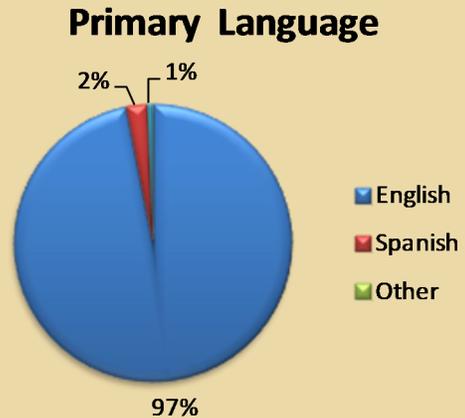
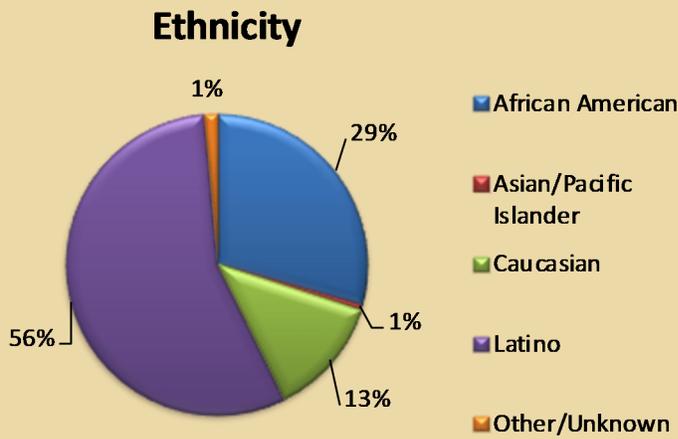
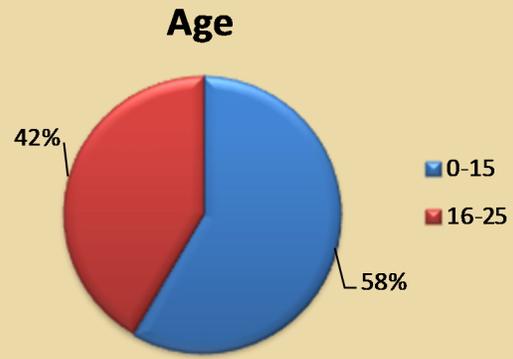
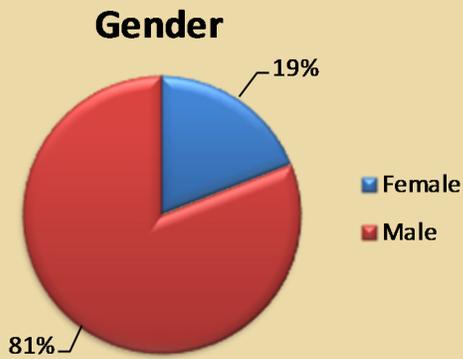
- INFO Graduate

Solutions in Progress

- Increase referrals through the expansion of the target population to include youth that are on Informal Summary Probation. The program continues to seek solutions to this challenge into FY 2015/16.
- The INFO program continues the implementation of weekly group sessions using Moral Recognition Therapy (MRT), an evidence-based substance abuse treatment strategy to address youth's substance abuse concerns.

Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics



Community Services and Supports Programs

Program Updates

In FY 2015/16, the INFO program will continue to find solutions to increase the number of referrals. Proposed program changes that will be evaluated by the INFO team Program Administration include, but are not limited to, the following:

- Make program mandatory as part of the youth's court-ordered Terms and Conditions of Probation. Currently the program is voluntary.
- Extend the program to youth that live in the High Desert region.
- Extend the program to youth in school who are at-risk of entering the juvenile justice system.

Collaborative Partners

San Bernardino County departments:

- Probation Department.
- Juvenile Court San Bernardino.
- District Attorney's Office.
- Public Defender's Office.

Community agencies:

- National Alliance on Mental Illness (NAMI).
- Native American Resource Center - Riverside San Bernardino County Indian Health Inc.
- Mary's Mercy Center.
- Catholic Charities.
- Children's Fund.
- North San Bernardino Jr. All-American Football & Cheer.
- Options for Youth.
- Fontana Unified School District.
- San Bernardino City Unified School District.
- Rialto Unified School District.
- Colton Unified School District.
- County Superintendent of Schools - Youth Services Program.
- Community Action Partnership.
- Salvation Army San Bernardino.
- Boys & Girls Club San Bernardino.



Artwork by Peter Millar

“Through the INFO Program I learned to communicate with my son and help my son stay on task.”

-INFO Graduate Parent

“I think about my family now.”

-INFO Graduate

Community Services and Supports Programs

One Stop Transitional Age Youth Centers (TAY-1)

The Department of Behavioral Health funds four (4) One Stop Transitional Age Youth (TAY) Centers, one in each region of the County. One Stop TAY Centers services are currently being provided by one County clinic, San Bernardino One Stop TAY Center and two contracted agencies. Pacific Clinics and Victor Community Support Services are both contracted to serve differing areas within the County, determined by zip code. One Stop TAY Centers administer two separate programs, allowing TAY clients to one (1), selectively utilize those services needed to maximize their individual potentials (Recovery Wellness and Resiliency Model) while already in the community; and two (2), to prepare them for re-entry into the community. The One Stop TAY Centers served a total of **868** consumers during FY 2013/14.

Centers provide Full Service Partnerships (FSP) services to seriously emotionally disturbed children, adolescents, and youth with serious mental disorders. Services for Full Service Partnerships (FSP) include but are not limited to:

- Group and individual counseling/therapy.
- Intensive case management.
- Crisis intervention and stabilization.
- Medication evaluation/management.
- Housing assistance.
- Transportation assistance.
- Childcare for TAY with infants and toddlers and community reintegration assistance.

In addition, One Stop TAY Centers provide or link participants to co-occurring substance abuse and mental health services and treatment programs. Centers also link participants to specialty mental health services and provide outreach and engagement activities to identify and engage unserved TAY. An array of services are provided to assist TAY in reaching their goal of independence. Each center provides a menu of available recovery, wellness and resilience services appropriate to the populations/regions they are serving.

Services for both FSP's and TAY include: 24/7 access to an interdisciplinary team of behavioral health professional staff and peer advocates, housing support and referrals, educational/vocational assistance, job search and coaching, skill building necessary for community life, access and referrals to recovery and co-occurring specialized programs, recreational activities, family education services, access to showers and laundry facilities, e-mail/internet access, and other necessary referrals for community integration. Services provided at the centers address the transitional domains of employment, educational opportunities, housing, and community life necessary for wellness, recovery and resilience of TAY.



Artwork by Peter Millar

Community Services and Supports Programs

Additionally, One Stop TAY Centers provide co-located County agencies and community partners to provide comprehensive services for TAY in order to reduce out-of-home and high levels of placement, incarceration, and institutionalization. This includes, but is not limited to:

- Individuals with co-occurring disorders.
- High users of acute facilities.
- Homeless or at-risk of homelessness.
- Individuals with a history of incarceration institutionalization.
- Recidivists with significant functional impairment.

The ultimate goal of One Stop TAY Centers is to assist TAY to become independent, stay out of the hospital or higher levels of care, reduce involvement in the criminal justice system, and reduce homelessness. One Stop TAY Center participants attend regular update meetings to measure progress toward their goals and develop new goals in an effort to move to lower levels of care and achieve goals towards independence. Consumers, youth, and their families are integral part in the development of age appropriate services that reflect the developmental and special needs of participants through TAY advisory groups and focus groups. TAY peers and TAY family members are also hired to provide services as peer advocates, TAY mentors, and parent partners. One Stop TAY Centers are modeled as drop-in centers, not as a mental health clinics, in order to improve TAY participation. All services are provided in a culturally competent manner that is both age and developmentally appropriate.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
 - ◊ Increased Resiliency.
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Reduce homelessness and increase safe and permanent housing:
 - ◊ Decreased rate of homelessness for clients.
 - ◊ Increased residence stability.
- Reduction in disparities in racial and ethnic populations:
 - ◊ Reduction in mental health and health care disparities.
- Increase a network of community support services:
 - ◊ Increase in number of collaborative partners.

Target Population

- Transitional Age Youth (TAY), ages 16-25

Projected Number to be Served FY 2015/16

- 1,400 TAY

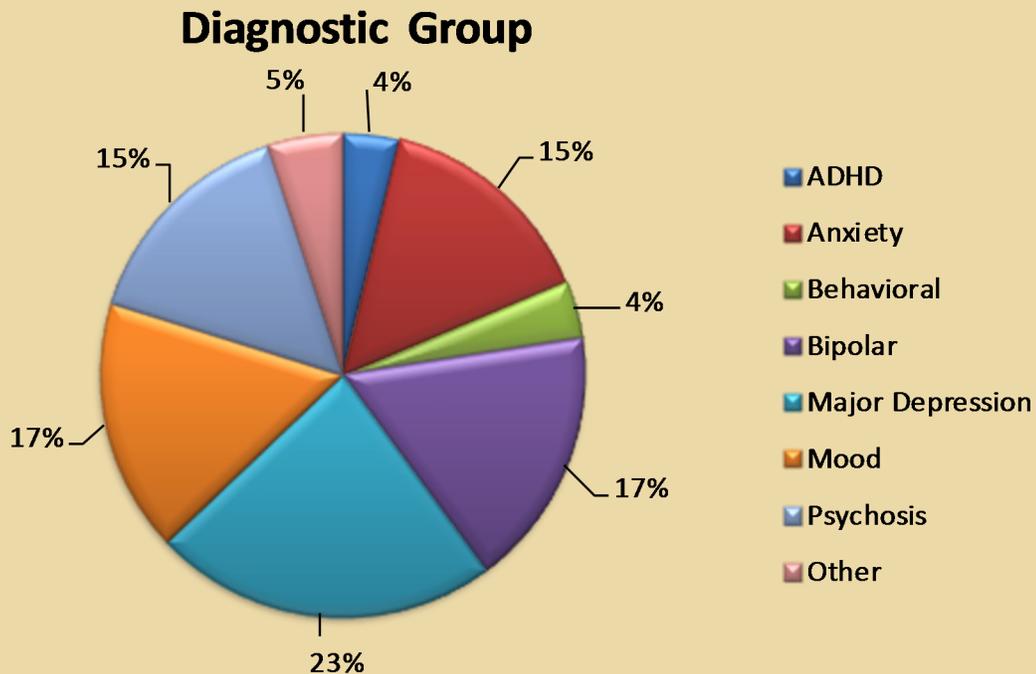
Community Services and Supports Programs

Positive Results

Increased Resiliency and decreased impairment in general areas of life functioning

Data Collection Reporting (DCR) system data reports the following information:

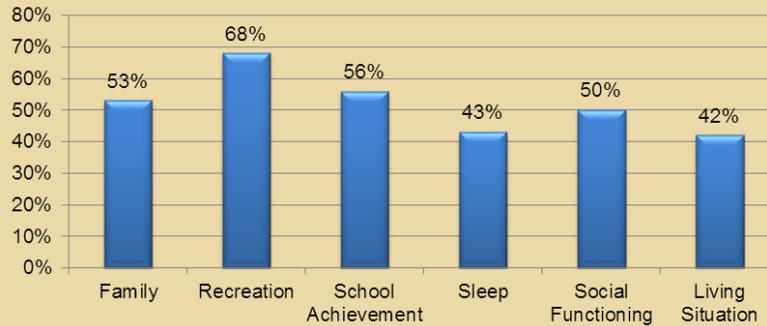
- **Hospitalization:**
 - ◇ 96% of FSP TAY did not require hospitalization services and were able to maintain their mental wellness through FSP services in FY 2013/14.
- **Emergency Mental Health**
 - ◇ 83% of FSP TAY did not receive emergency mental health interventions in FY 2013/14 .
 - ◇ 7% of FSP TAY who reported a history of emergency mental health interventions prior to entering FSP services, did not receive any emergency mental health interventions in FY 2013/14.
- **Emergency Physical Health**
 - ◇ 83% of FSP TAY did not receive emergency physical health interventions in FY13/14 .
 - ◇ 8% of FSP TAY who reported a history of emergency physical health interventions did not require any emergency physical health interventions in FY 2013/14, showing increases in accessing appropriate physical health care needs at lower levels of care.
- **Employment**
 - ◇ 4% of FSP TAY who reported no employment prior to entering FSP services in FY 2013/14, obtained employment.



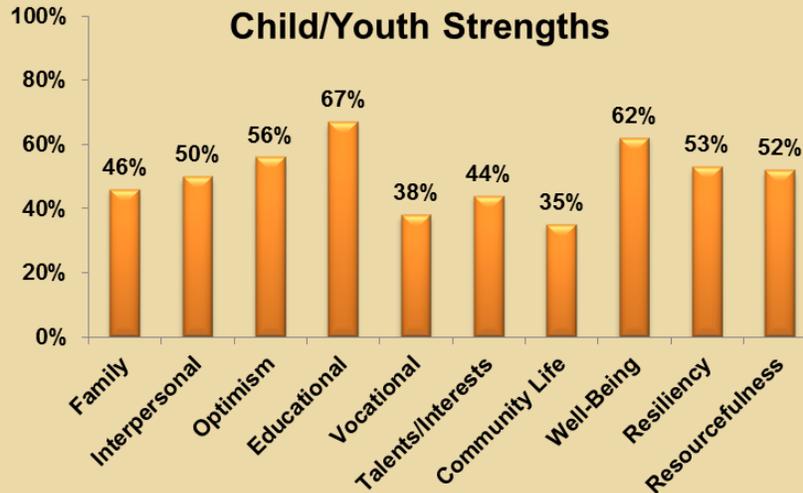
Community Services and Supports Programs

The graphs below represent the percentage of youth who presented with a significant issue on an item within the Life Functioning, Child/Youth Strengths, or Behavioral/Emotional Needs & Risk Behaviors domains, and had this issue resolved by the completion of the program.

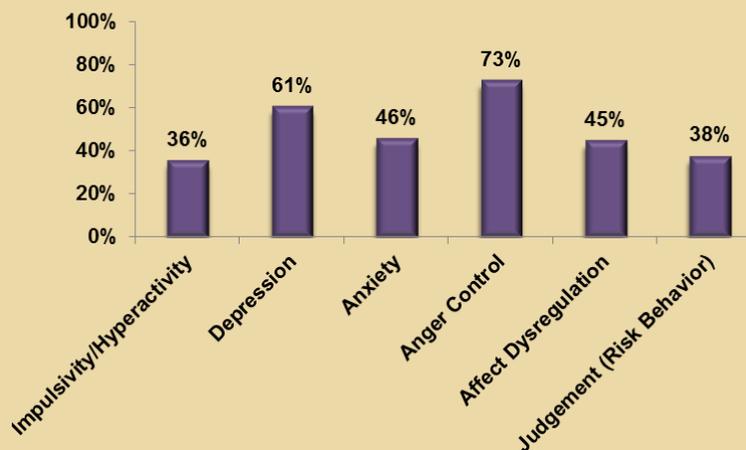
Life Functioning



Child/Youth Strengths



Child/Youth Behavioral/Emotional Needs & Risk Behavior



Community Services and Supports Programs

Positive Results, continued

Decreased rates of homelessness and increased residential stability:

DCR data for FY 2013/14 reports the following information regarding the living situation of TAY:

- **79%** percent of TAY in FSP were not homeless prior to FY 2013/14, and remained that way during FY 2013/14. This shows that the TAY maintained a stable residence during FY 2013/14.
- **17%** of FSP TAY who were homeless prior to FY2013/14 were no longer homeless in FY 2013/14. FSP TAY were able to attain and maintain stable housing during the fiscal year.
- **42%** of youth who presented with a significant issue in their living situation, had resolved this issue by the completion of the program.

Reduction in mental health and health care disparities:

- In FY 2013/14, One Stop TAY Centers provided services to **847** TAY, **402** youth received Full Service Partnership (FSP) Services, which are a priority population, and **445** youth received General System Development (GSD) services.
- FSP services were provided to **168** Latino TAY and **78** African American TAY, both are priority populations for TAY programs due to high rates of out of home placements and juvenile justice involvement.
- Of the **445** GSD service recipients, **108** identified as Latino and **106** as African American, both priority populations for TAY programs.

Increase collaborative partners:

In FY 2013/14, One Stop TAY Centers worked with **68** County and community based programs to assist TAY reintegrate back into their communities and reach their goal of independence. As a result of collaborations, TAY programs have additional resources to assist FSP partners in attaining their goals towards independence. Examples include:

- One Stop TAY centers collaborate with the San Bernardino County Workforce Development Department to refer TAY youth that may meet their Youth Workforce Investment Act (WIA) programs for employment and employment training opportunities.
- The High Desert TAY program collaborated with Apple Valley School Districts Workforce Investment Act (WIA) program in FY 2013/14 which resulted in full time and part time employment for **five (5)** youth.

Additionally, these collaborative efforts help to ensure that services are provided to TAY who do not meet FSP eligibility requirements.

***"You guys have been there when
no one else has and I greatly
appreciate it."***

- TAY client

Community Services and Supports Programs

Success Stories

Examples of TAY success stories are listed below:

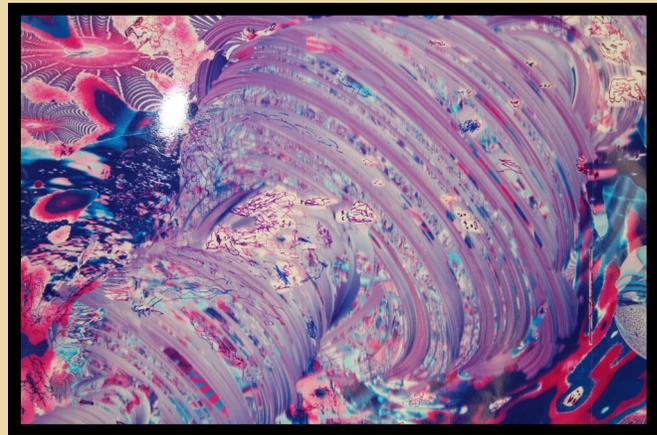
Yucca TAY Center

Many clients move on from our program and are successful in school or employment.

- “John” met and maintained his goals. He was able to move from an internship to a full-time position at his place of employment.
- “Nancy” is currently finishing her AA degree and is finally ready to transfer to a four (4) year college.
- “Frank” came into the TAY Center homeless and jobless. He obtained employment within two (2) weeks. The TAY Center assisted him with housing by placing him in transitional housing (Molding Hearts).
- “Rocky” travels to and from Yucca Valley to Cabazon, a distance of 30+ miles one way, without a vehicle utilizing local transit bus system, to go to his place of employment until a location opens in Yucca Valley.

Rancho TAY Center

“Susan” came to us as a teenager. She was very anxious around other people and had to be seen in her home initially due to extreme fear of being around others. It was impacting her ability to complete her education or interact with peers. With treatment from her clinical team, she was eventually able to work herself up to meeting with the staff outside of her home and then, eventually, at the TAY Center. With a lot of patience and hard work on her part, she started attending a school program to complete her High School diploma, attended drop-in services and was able to make some friends. Susan started to participate in groups at the center, as well as different events, and worked her way up to looking for a job. She got a job at a fast food restaurant and loved it. She was very successful in her position and promoted to manager. Susan was also able to purchase a car which she brought to the TAY Center for staff and peers to see. Her hard work and determination, along with the commitment from her treatment team, both in FSP and drop-in, have made her a Rancho TAY success Story.



Artwork by Peter Millar

San Bernardino TAY Center

“Lisa” is a TAY who is single mother and has been participating in our program since December of 2013. Lisa transferred from the High Desert TAY Center to the San Bernardino TAY Center due to access housing for pregnant and parenting TAY. She has served as the secretary of the TAY advisory board, and parents her eight month old daughter in a strength-based manner. Lisa recently became employed by San Bernardino County.

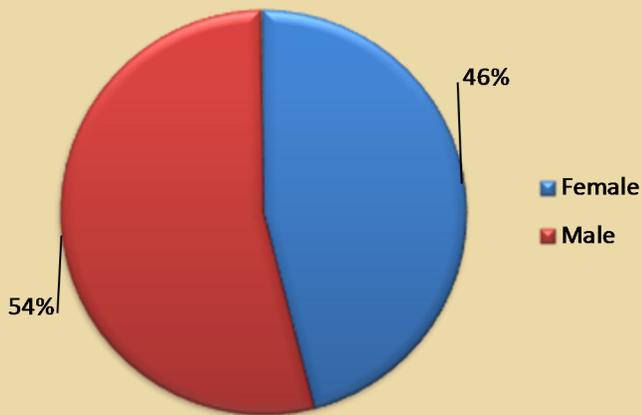
"TAY helped me believe in myself."

- TAY client

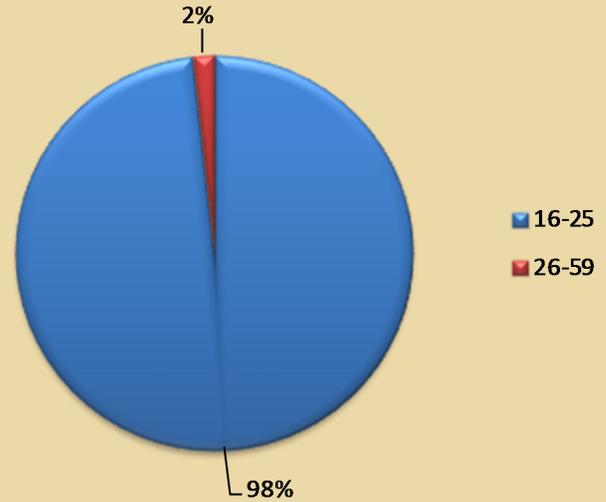
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

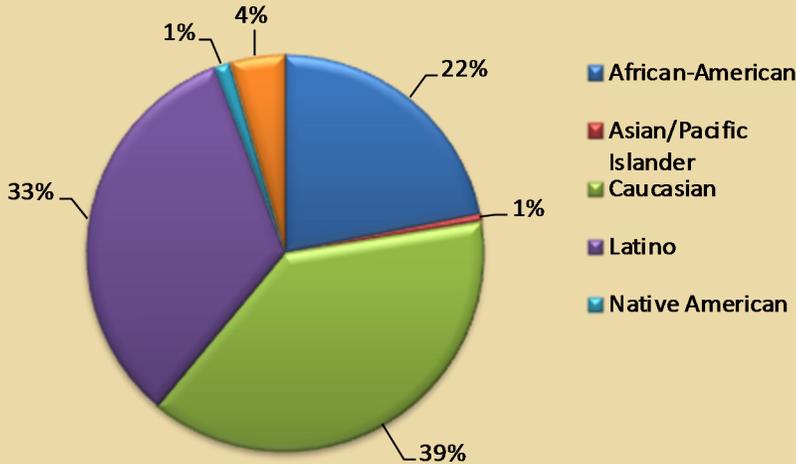
Gender



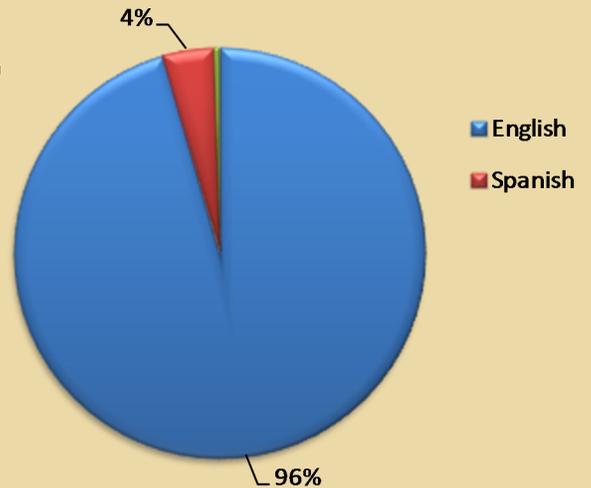
Age



Ethnicity



Preferred Language



Community Services and Supports Programs

Challenges

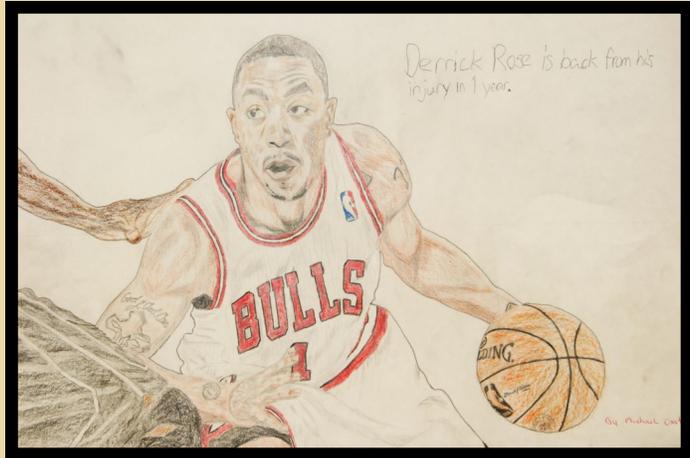
Due to the geographic size of San Bernardino County, providing services to the TAY population continues to be a challenge.

Transportation

Transportation is an ongoing challenge in the rural areas of the County, which hinders TAY consumers accessing resources in the community. Public transportation does not travel on unpaved roads and in some areas of the County, the main bus lines only run three (3) times a day, and in some remote areas, no public mass-transit transportation exists.

Employment

Employment is also a challenge for the TAY population. These challenges include, but are not limited to, limited employment sites for TAY within the city areas, limited employment opportunities in rural areas, and when the youth are able to obtain employment, some experience difficulty in maintaining stable employment.



Artwork by Michael Conte

Housing

The demand for TAY specific housing appears to be greater than the amount of housing available across the county.

Outreach and Retention

Weekly orientation to TAY services are well attended. However, retention of potential TAY clients from weekly orientations is a challenge. Also, TAY attending high school had a difficult time attending new client orientation sessions at the centers scheduled times.

Enrichment Opportunities

While collaboration with volunteer services continues, there are limited volunteer sites for TAY to in more rural areas of the county. Enrichment opportunities allow for TAY to give back to their communities and learn new skills.

***"TAY is a safe place to go."
- TAY client***

Community Services and Supports Programs

Solutions in Progress

Transportation

To assist consumers with transportation issues, consumers are provided with daily and/or monthly bus passes. Consumers are transported to the Full Service Partner (FSP) in accordance with the guidelines the TAY Center has established (e.g. 24 hour advance notice, goal directed/oriented, to support attending out of area necessary appointments). A token economy system, as a positive reinforcement, is in place for all consumers to earn TAY bucks to purchase bus passes. In Yucca Valley, TAY provides transportation to job fairs to help youth without transportation attend employment seeking activities.

Employment

To assist TAY in obtaining employment, several different solutions are being attempted. For example, in the Yucca Valley area, TAY are provided with 1-hour workshops which includes the development of resumes, completing applications, do's and don'ts of interviewing, mock interviewing, and proper attire. Several relationships have been developed with family and community businesses to speak to the youth as to what employers are looking for in a potential employee. TAY have the opportunity to obtain a Food Handlers Card that provides a better chance of obtaining employment within the food industry. They also partnered with the County of Workforce Development Department to identify local employment opportunities and upcoming job fairs where they successfully assisted **13** youth obtain full-time or part time employment in FY 13/14.

To assist TAY in the High Desert area, strengthened relationships with Apple Valley School District's Workforce Investment Act (WIA) program resulted in full-time and part-time employment for five (**5**) TAY.

To assist TAY in the San Bernardino area, staff continue to reach out and educate local employers on mental health issues and encourage them to provide work sites for TAY with mental health issues. Additionally, staff started an employment group to provide youth with job search and employment retention skills.

***"TAY stuck by my side through the
hardest of times."***

- TAY client

Housing

To address homelessness among the TAY population, the TAY shelter (Molding Hearts) has been at full capacity since its inception. One-Stop TAY Centers have partnered with a sober living home (Gabe's House) to provide FSP consumers with alternative housing. Relationships have been established with local community hotels and motels to provide temporary assistance until a more permanent solution can be established. Intensive support is offered to all current shelter bed providers by providing **24** hour access to after hours staff via phone, weekly housing meetings, and maintaining open communication.

In the High Desert, housing referrals out of the area were made, such as The STAY (Youth Hostel), and DBH's Shelter Plus Care program. In the west end of the County, the Rancho TAY worked with DBH to reach out to current and potential housing providers to get them engaged in the County's Request for Proposal (RFP) process to open homes for TAY. In the central valley area, the San Bernardino TAY continued outreach to Board and Care providers to house more TAY youth.

Community Services and Supports Programs

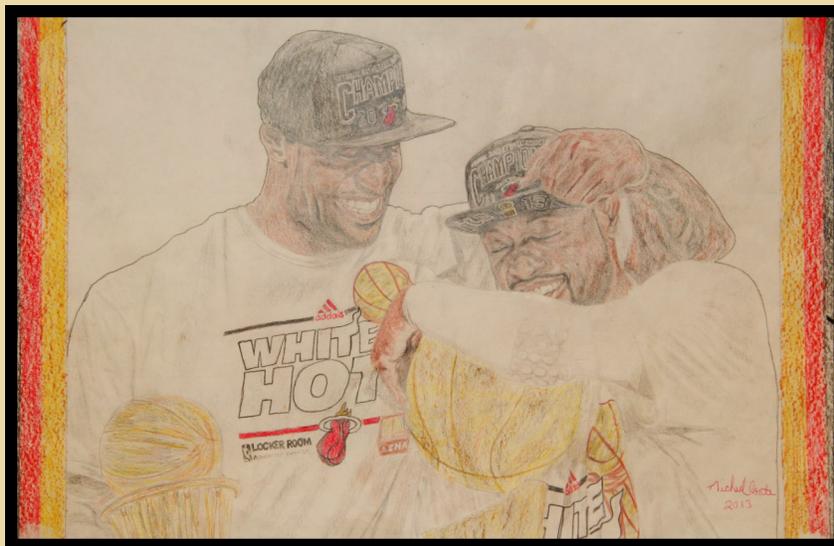
Outreach and Retention

In the High Desert area, orientation sessions were rescheduled to earlier in the week to increase new client retention by being able to do assessments and have clients begin their group the day after orientation rather than waiting until the next week. To accommodate high school students, one-on-one and evening orientations were added, as well as groups that start after school hours.

In the west end of the County, increased outreach efforts to areas where they might connect with more TAY consumers, such as street outreach and visiting local parks to make contact with homeless potential clients who may have a difficult time accessing services. The centers outreach worker continues to attend community events and provides presentations to other community programs serving TAY age youth to inform them of services.

Enrichment Opportunities

Continue to educate community members and organizations on mental health issues, encouraging them to provide opportunities for TAY to volunteer and give back to their communities. Continue to partner with DBH Volunteer Services to identify opportunities.



Artwork by Michael Conte

Community Services and Supports Programs

Collaborative Partners

- Children's Fund.
- Department of Rehabilitation.
- Workforce Development Department and Workforce Investment Board.
- Department of Public Health.
- Riverside San Bernardino Indain Health, Inc.: Native American Resource Center.
- Department of Children and Family Services.
- San Bernardino County Superintendent of Schools.
- Department of Probation.
- Salvation Army.
- Lutheran Social Services.
- Path of Life.
- Mary's Table.
- The Way Outreach.
- Valley Star Children and Family Services, Inc.: The STAY (Youth Hostel).
- Pacific Clinics.
- Victor Community Support Services: Family Resource Center, Holistic Campus and Wraparound program.
- Molding Hearts.
- Victor Unified School District.
- Snowline School District.
- Apple Valley Joint Unified School District.
- Hesperia Unified School District.
- Morongo Basin Unified School District.
- Mission City.
- Department of Behavioral Health, Crisis Walk In Clinics.
- Walden Family Services: Independent Living Program and Parenting Group.
- High Desert Homeless Shelter.
- Moses House.
- Rose of Sharon.
- Family Assistance Program.
- Goodwill.
- YES Center.
- Victor Valley Rescue Mission.
- Hughes Housing.
- Planned Parenthood.
- Reach Out Yucca Valley.
- Copper Mountain College.
- Mental Health Systems.
- Morongo Basin Haven Basin Wide Foundation.
- Boys and Girls Club.
- Soroptimist Club.
- High Desert Pregnancy Clinic.
- 29 Palms Marine Base.
- Unity Home.
- The Way Station.
- High Desert-Department of Behavioral Health.
- Morongo Basin Sexual Assault.
- High Desert Hospital.
- Tele-Care Crisis Walk In Clinic (CWIC).
- Gabe's House.
- Desert Mountain Children's Center: SART program.
- Family Service Association.
- Chaffey College.
- Project Chela.
- First Star Catering.
- Rancho Cucamonga Center.
- Mount San Antonio College.
- California State University, San Bernardino.
- New Hope.
- Chaffey Adult School.
- San Bernardino Men's Home.
- Chino Men's and Women's Home.
- Dr. Alav, MD.
- Clínica Médica.
- Head Start.
- Inland Valley Recovery Services (IVRS).
- Matrix Institute on Addictions.
- Women, Infant, and Children (WIC): West End Offices.



Artwork by Sheila Dery

Community Services and Supports Programs

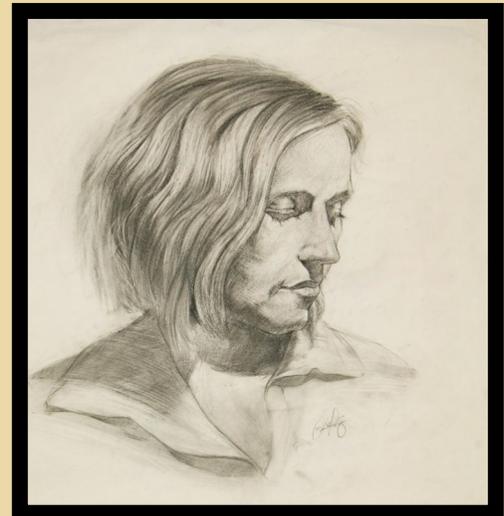
Clubhouse Expansion A-1

Clubhouses are recovery oriented centers for members, **18** years or older that operate with minimal support from department staff. They are primarily consumer operated, and members have significant opportunity for input related to program and activity choices. Each clubhouse provides Wellness, Recovery and Resilience Model programs in stigma free environments for the Seriously Mentally Ill (SMI) population in an effort to increase members' overall functioning and community integration.

Growth opportunities for members include but are not limited to: living skills, volunteerism, job skills, community integration activities, canteen and clothing closet operations, nutrition and cooking, and physical health. These various activities aid in increasing members' ability to integrate and cope within the community. Clubhouses also sponsor regularly scheduled social/recreational activities, both in the community and on site, which increase members' ability to interact and develop skills that improve their ability to function in the community. The main objectives of the Clubhouse Program include assisting consumers in making their own choices, reintegrating into the community as a contributing member, and achieving a satisfying and fulfilling life.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
 - ◊ Improved life satisfaction.
 - ◊ Decreased hopelessness/increased hope.
 - ◊ Increased resiliency.
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).
- Increase in self-help and consumer / family involvement:
 - ◊ Increase in ratio of voluntary mental health services to involuntary mental health services.
 - ◊ Increase in number of encounters with collateral contact, such as family members and informal supports.
 - ◊ Increase in program attendance and frequency per consumer.
 - ◊ Increase in self-help/support/12-step group attendance and frequency per consumer.
- Increase a network of community support services:
 - ◊ Increase in number of collaborative partners.



Artwork by David Pacheco

Target Population

- Adults

Projected Number to be Served FY 2015/16

- 8,250 Adults

Community Services and Supports Programs

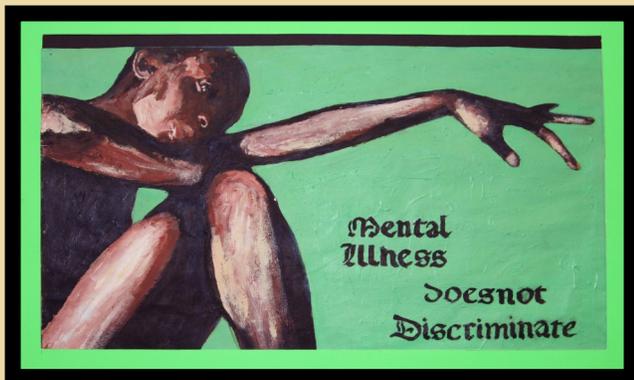
Positive Results

In FY 2013/14, the Clubhouse Program served a total of **7,500** consumers, of which **1,603** were unduplicated. Clubhouse members had over **50** opportunities to explore various collateral and family supports through community integration excursions. Clubhouses also offered **48** different groups per month for increasing self-help skills. There was a significant decrease in the amount of times emergency services were accessed for physical health challenges due to an increase in education and linkages to physical health and nutrition resources. The Clubhouse program presented at, and participated in, community forums all over San Bernardino County in partnership with the Integrated Plan presentations. Over **100** consumers participated in activities throughout the year in support and partnership with the National Alliance on Mental Illness (NAMI). Additional results include:

- Group attendance increased by over **25%** in comparison to prior years.
- Trainings were held at various sites to educate consumers on how to run and facilitate groups by the Office of Consumer and Family Affairs.
- Clubhouses participated in several collaborative functions such as the Wellness Triathlon in an effort to continue to build upon social and interpersonal skills.
- Clubhouse board members held a day-long strategic planning retreat to complete the creation of their vision, mission, and values statements. Consumers subsequently presented to the Behavioral Health Commission.

“My clubhouse family is what helped me though the holidays when I usually get very depressed.”

- Clubhouse member



Artwork by Gary Bustin

Success Story

“A Walk Toward My Goal”

Written by Edward, shared with his permission.

I will start my story in 2003. I could not handle the symptoms of my mental illness any longer. The things I was experiencing began to affect my family, friends, and job. I had a psychotic break. I was hospitalized, and soon returned to California, with nothing. I had no job, and no real friends. My mother became my only source of support. I isolated myself and slept all day, into the night.

There were also times where I did not sleep at all. One evening a friend of my mother gave her the number to Mesa clinic to seek treatment for me. I went through the intake process and began to see a doctor there. Over a long period of time of being treated by the doctor, she suggested I do therapy. I trusted her, so I said yes. During the sessions, healing, self-awareness, accountability, and goal attainment were the focus. Having my mom behind me, trusting my doctor and the intern therapist I encountered, I began to believe in myself, not just a man with bipolar with psychotic features.

Community Services and Supports Programs

Success Story, continued

The whole time I was going through this, I was the father of a grown daughter and a baby boy. My son became my main focus. I began to see when I achieved my goals that were set in therapy, it was easier to do all the duties and responsibilities a father has to his child, with great love. My doctor and my last therapist, along with a Peer and Family Advocate, began to push me to get involved. I became the treasurer of Pathways to Recovery Clubhouse. I was the facilitator for the men's and spirituality groups, and I was the canteen manager for some time. There were ups and downs the whole time but I never quit because of my son and what I wanted to achieve for us both. The day came after years of applying and interviewing, the Program Manager for the Clubhouse asked me if I wanted to work as a Peer and Family Advocate. I accepted and after a lot of training classes and attending meetings here and there, I am proud to say that I am an employee of San Bernardino County Department of Behavioral Health. I owe it all to my mom, my son, my doctor, my two intern therapists, and the interactive treatment I received. I do not just want to be an employee. I want to make my whole department better. My next goal is a college degree in psychology. I am not my diagnosis. I am viable, goal-oriented, and focused.

Challenges

- Difficulty in measuring appropriate outcomes for consumer-run programs.
- Access to transportation.
- Stigma and discrimination attached to treating and seeking help for mental illness.
- Due to an increase in demand in the Barstow area, need additional resources in that region.

“Being hired as a peer advocate changed my life.”

- Clubhouse member

Solutions in Progress

- An outcome tool has been recommended for use by the Department's Leadership Development Program. A pilot project utilizing the tool will begin in February 2015 with a goal of full implementation by FY 2015/16.
- A 15 passenger van was added to service the High Desert clubhouses. A 12 passenger van was obtained to shuttle members to the relocated Amazing Place Clubhouse in Ontario. A fiscal mechanism for the distribution of bus passes was put into place. County operated clubhouse staff have provided transportation assistance in the form of vehicles and drivers to contract operated clubhouses in order to increase their participation in engagement opportunities.
- Ongoing staff and community trainings are being conducted around anti-stigma initiatives. Examples include:
 - ◇ The formation of the "Stigma Busters Comedy Troupe" that performs at local events to continue efforts to eliminate stigma.
 - ◇ Participation in a consumer panel for Crisis Intervention Training (CIT) with law enforcement.
 - ◇ Presentations at District Advisory Committee meetings, Room and Board Coalition meetings, and community gatherings.
- Staff is currently being hired to expand the hours of service for the Barstow Desert Stars Clubhouse from one day a week to four days a week.

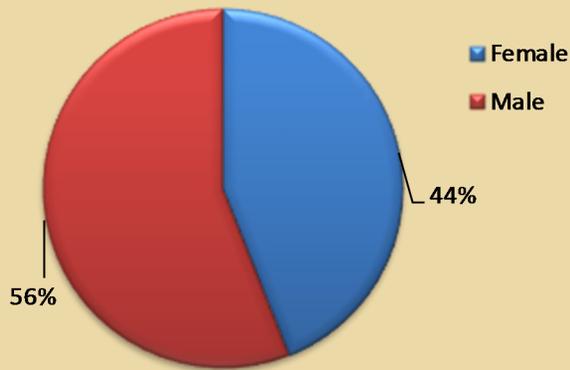
“Since I started attending groups at the clubhouse I go to the hospital less.”

- Clubhouse member

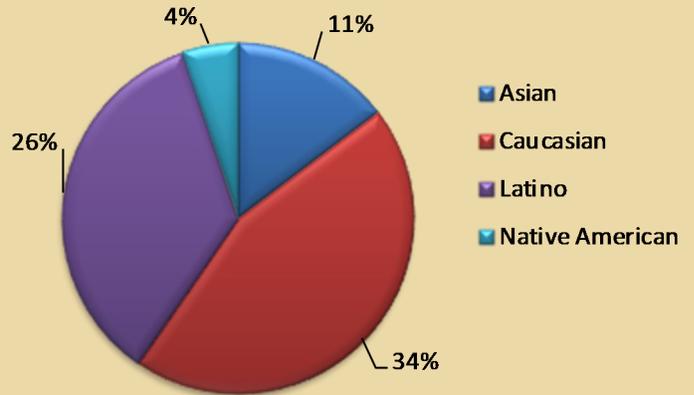
Community Services and Supports Programs

FY 2013/14 Program Demographics

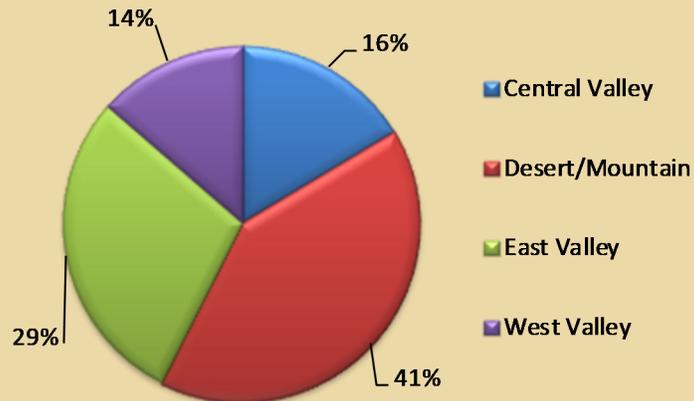
Gender



Ethnicity



Geographic Region



Community Services and Supports Programs

Outreach and Engagement

For FY 2013/14, Clubhouses organized the following outreach and engagement activities:

Activity Type	Number of Participants
Clubhouse Holiday Gatherings	650
Health Fairs	900
Community Service Activities	400
Community Presentations	575
Crisis Intervention Team Building	160
Behavioral Health Commission Presentations	150
Behavioral Health Wellness Triathlon	225
Evening with the Stars Education and Recognition Event	20
TOTAL	3,080

Program Updates

The Desert Stars Clubhouse in Barstow will be increasing their hours of operation from one day per week to four days per week by next fiscal year. As a result, a Peer and Family Advocate III position was added. Additional updates include:

- The implementation of an outcome measurement tool for all clubhouse members via the Life Satisfaction Survey.
- The establishment of the new Clubhouse Executive Board, which will be made up of board representatives from each clubhouse throughout San Bernardino County. This board will serve as both a higher level planning entity, as well as be available for consumer advocacy and representation during departmental program planning, monitoring and development.

Collaborative Partners

- San Bernardino County Sheriffs Deputies via Crisis Intervention Training.
- Housing and Employment Specialists.
- Law Enforcement presenting on how to stay safe on the streets.
- Brulte Senior Center.
- Hillside Community Church.
- The Rock Church.
- Salvation Army.
- Goodwill.
- National Alliance on Mental Illness.
- Ontario Reign.
- Native American Resource Center.
- Family Resource Centers.
- LGBTQ cultural training.
- Cal State San Bernardino Nurses.
- Psychology Interns.
- Social Work Interns.
- Trauma Resource Institute.
- Starbucks.
- Upland Public Library.
- The Getty Museum.
- 24 Hour Fitness.
- City of Rialto Parks and Recreation Department.
- Loma Linda Behavioral Health.

Community Services and Supports Programs

Forensic Integrated Mental Health Services (A-2)

Forensic Integrated Mental Health Services is comprised of two main components: The first includes Supervised Treatment After Release (STAR) and Forensic Assertive Community Treatment (FACT) programs, both which serve consumers who voluntarily participate in the four (4) Mental Health Courts located throughout San Bernardino County. The second component is the Crisis Intervention Training (CIT) program. This program provides training to law enforcement personnel to assist them in recognizing and addressing the needs of consumers and their families who are in crisis as a result of mental illness.

Supervised Treatment After Release (STAR) Program

Beginning in the late 1990s, the establishment of Mental Health Courts throughout the United States began pursuant to federal legislation and funding. San Bernardino was one of the first counties to have such a program, beginning in 1999. With the growing community concern for more effective treatment of mentally ill offenders, the Mental Health Court system continues to thrive, both nationally and at the local level.

***"I am so grateful for FACT
for supporting me no
matter what."***

- FACT consumer

San Bernardino County currently has four (4) Mental Health Courts located in the cities of San Bernardino, Rancho Cucamonga, Victorville and Joshua Tree that offer voluntary court referred treatment programs for consumers with severe and persistent mental illness and are supervised by the criminal justice system. These individuals agree to make mental health treatment part of the terms and conditions of their probation. The STAR is also a Full Service Partnership (FSP) providing services from a multidisciplinary treatment team located at each of the courts, which consists of representatives from both the STAR and FACT programs, Probation, Sheriff, Public Defender and District Attorney Departments. The Mental Health Court in Joshua Tree also includes treatment personnel from the High Desert Medical Center (HDMC) program.

Forensic Assertive Community Treatment (FACT) Program

FACT is also an FSP, offering a variety of mental health treatment options to meet the needs of consumers with mental illness who are on formal probation. San Bernardino County modeled this program after the well-researched Assertive Community Treatment (ACT). Since the FACT program services are **75% to 80%** community based, individuals who have difficulty keeping appointments at outpatient clinics due to various barriers related to their mental illness are referred to the FACT program across all four Mental Health Courts. These consumers are seen at their homes weekly, or as necessary by the clinical team, including home visits by a psychiatrist.

***"I need you guys. I am tired
of living out of control."***

- CIT consumer

Crisis Intervention Training (CIT) Program

CIT provides extensive training to law enforcement personnel as first-line responders to crisis calls in which mental health issues are identified or suspected. CIT has been embedded for the past two years in the completion requirements for all San Bernardino County Deputies who graduate from the Sheriff's Basic Academy. This training has resulted in increased law enforcement officer

awareness on the stigma associated to mental illness, the ability to access appropriate community resources, as well as provide an increase in law enforcement officer safety, and the safety needs of consumers who are in crisis because of their mental illness.

Community Services and Supports Programs

MHSA Legislative Goals and Related Key Outcomes

- Reduce homelessness and increase safe housing:
 - ◇ Decreased rate of homelessness for consumers.
 - ◇ Increased residence stability.
- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◇ Increased encounters in specialty co-occurring and substance abuse interventions.
 - ◇ Increased encounters in integrated health clinic.
 - ◇ Increased transportation to co-occurring appointments provided.
- Reduction in criminal and juvenile justice involvement:
 - ◇ Decreased rate of incarcerations.
 - ◇ Decreased arrests.
 - ◇ Decreased jail bookings.
 - ◇ Decreased sustained allegations.
 - ◇ Reduced jail/prison recidivism.
 - ◇ Decrease in jail days.
 - ◇ Reduce delinquent behaviors which increase likelihood of juvenile justice involvement.
 - ◇ Reduce difficulties related to Conduct Disorders.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◇ Reduced number of emergency room visits for mental health concerns.
 - ◇ Reduced administrative hospital days.
 - ◇ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU).
 - ◇ Increase in number of individuals diverted from hospitalization.

Target Population

- Adults
- Individuals with severe and persistent mental illness or co-occurring disorders
- Recidivists of the criminal justice system

Projected Number to be Served FY 2015/16

- 110 STAR
- 100 FACT
- 240 CIT
- 25 HDMC

***"Even though I have been here
a while, I still get the help and
support that I need."***

- Forensics consumer



Artwork by Peter Millar

Community Services and Supports Programs

Positive Results

The Forensics Integrated Mental Health Services Program served a total of **189** consumers in FY 2013/14. The FACT program served **61** individuals with positive results showing participants had a **70%** reduction in jail days.

Participation in the STAR program is typically 1-1/2 to 2 years and after completion, homelessness decreases to nearly **0%** since the programs facilitate or provide housing for all consumers. The STAR program served **128** individuals and positive results show that in FY 2013/14, participants had a **99%** reduction in jail days. In comparison to pre-enrollment levels, consumers participating in the Mental Health Court program have shown high rates of diversion from incarceration resulting in a decrease in jail bed days each year.

The **CIT** program has increased officer awareness of available community resources throughout the county specific to addressing a crisis related to an individual's mental illness. As a result, consumers and their families are able to access immediate mental health services in the community by these CIT trained law enforcement officers. More specifically, these officers are able to work collaboratively with these individuals to obtain voluntary treatment for their mental health needs through community resources, which in turn deters incarceration and/or unnecessary hospitalization at local emergency rooms. During FY 2013/14, **186** law enforcement personnel were trained through the CIT program.

The tools used to measure the outcomes related to the goals include: Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS), Basis-24 Demographics (Behavior and Symptom Identification Scales), Homeless Management Information System (HMIS), Data Collection and Reporting (DCR), OSHPD Hospital Data, reports on admin days, rates of use of Crisis Walk-in Centers (CWIC), Community Crisis Response Teams (CCRT), CSU, and COMPAS.

Success Stories

"Robert", a 23 year old male, enrolled in the FACT Program with a history of childhood trauma and abuse. He had been in the foster care system, placed in several different foster homes, had a lengthy history of incarceration and homelessness, and had a significant history of substance use/abuse. Robert actively participated in the treatment services offered by the FACT program, focusing on his sobriety, educational/vocational goals, and reunification with family. He reconnected with his biological mother, and focused on being a parent to his young daughter. Robert successfully graduated from Mental Health Court and completed the terms and conditions of his probation in 2013. Shortly prior to graduating, he enrolled in the Center for Employment Training for vocational training in Welding Fabrication. Later he successfully completed and graduated from the program with two welding certifications. Robert moved from a sober living home into an independent living setting and has been working in landscaping, though he has been seeking entry level positions in the welding industry. He remains very motivated to obtain employment in the welding industry and has an appointment to start working with the State Department of Vocational Rehabilitation.

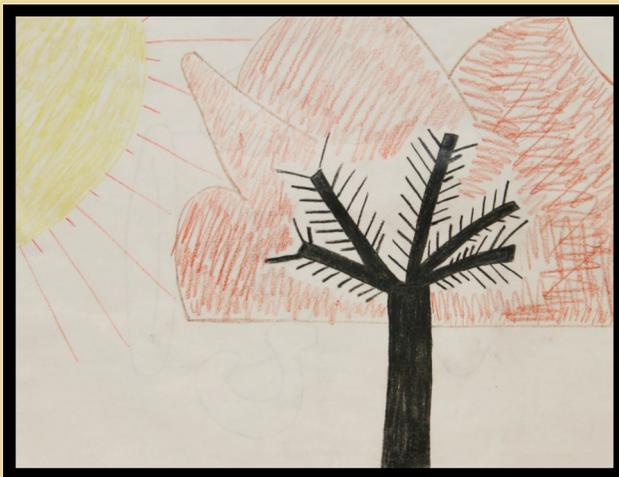


Artwork by David Pacheco

Community Services and Supports Programs

“Joseph,” a 35 year old male with a serious history of co-occurring mental illness and substance abuse, was accepted into the STAR program through Mental Health Court in 2013. He was experiencing suicidal ideations and symptoms of Schizophrenia that prevented him from maintaining a job and a strong family. Due to Joseph’s self-injurious and self-medicating behaviors, he was facing a charge that would have kept him incarcerated for over three (3) years. Joseph was accepted into STAR as a condition of probation, was stabilized on medication, educated on Adult Daily Living Skills, individual therapy, housing, therapy, groups to develop social skills, and offered a support system with other consumers enrolled in the program. He successfully completed 19 months in the program and completed the terms and conditions of his probation in 2014. During graduation, Joseph gave a speech where he thanked the STAR treatment team and the court for “believing in the program and allowing him another opportunity to live his life”. Joseph’s mother also wrote a letter the day of his graduation to the program that stated: “Just wanted to write and thank you again for all your help and support regarding my son, and to share that tomorrow is Joseph’s STAR Graduation day! Joseph has been sober now for almost two (2) years, completed his program through DBH, and is living successfully in a group home. I appreciate and am grateful for your thoughtfulness, kind words, and all the personal time you took to support my family and me through this challenging time. You are a true blessing!”

***"I really appreciate all the help
I'm getting and the housing."
- Forensics consumer***



Artwork by Alec Hill

Challenges

- Maintaining a satisfactory broad resource base of accredited facilities and approved housing options, and managing consumer’s conflicts related to residential issues and changes.
- Applying for SSI for those who qualify and finding solutions to a resistance in awarding benefits for consumers who have co-occurring conditions.
- Lack of employment opportunities for consumers with a criminal background and / or a co-occurring disorder.
- Integrating changes in sentencing as a result of Assembly Bill 109 Public Safety Realignment Act and the newly enacted Proposition 47.
- Need for additional instructors, role-players, and evaluators for the scenarios where participants apply the knowledge and skills learned through the CIT training.

Community Services and Supports Programs

Solutions in Progress

- A Request for Proposal (RFP) was issued in FY 2013/14 that resulted in contracts being signed effective 7/1/15 with eight (8) vendors who operate Room and Board facilities to secure 94 beds to provide stable housing for consumers participating in the STAR program.
- Five (5) STAR program staff attended SSI/SSDI Outreach, Access and Recovery (SOAR) training to increase their knowledge and skills in assisting consumers with completing and submitting thorough SSI/SSDI application packets.
- Four (4) consumers from the STAR program participated in the DBH Supportive Employment program and found part-time jobs to increase their job marketing skills. Consumers are encouraged and assisted with enrolling in community colleges and vocational training programs to make them more attractive in the job market. HDMC has been working in partnership with the Probation Department to specifically educate local businesses about Mental Health Courts and the respective clientele. All programs are increasing efforts to locate felon-friendly employers.
- Plans are being made to expand the STAR program to provide treatment services to include individuals affected by Assembly Bill 109 and the newly enacted Proposition 47.
- The Adult Forensic Services Program continues to work in collaboration with the Behavioral Health and Criminal Justice Consensus Committee to increase community awareness about the partnership between the behavioral health and criminal justice systems and resources available to the community at large for the adult forensic population.
- The CIT program has begun implementing a strategy of staying in contact with highly motivated and engaged participants to take part in future role-play and evaluation trainings, and is reaching out to Probation and Behavioral Health staff to assist as well.

Planned Program Expansion

Expansion of the existing STAR and FACT programs in the development of a 'Community STAR' and 'Community FACT' program. The target population will include adults with Severe and Persistent Mental Illness (SPMI) and/or co-occurring disorder who are high users of the criminal justice system and psychiatric hospitalizations, and who meet any of the following criteria:

- No oversight by Mental Health Court.
- No formal Probation Supervision.
- No Parole Supervision.
- Misdemeanors on Summary Probation (Proposition 47).
- Criteria no longer met for enrollment in the STAR, FACT or other community based treatment programs which serves the adult forensic population, yet requires an additional short period (3-6 months) for the transition process.
- Transitioning from a correctional setting (i.e. Detention Centers, State Hospitals) through a seamless process with the least disruption to existing behavioral health treatment care upon release into the community.

Outreach and Engagement Activities

- DBH Expo.
- Mental Health Court Graduation / Completion Ceremony.
- Art Contest Entry and Premier.
- Orientation for Community College .
- Completion of Culinary Arts Degree.
- CIT Community Presentations.
- Gangs and Drugs Taskforce Conference.

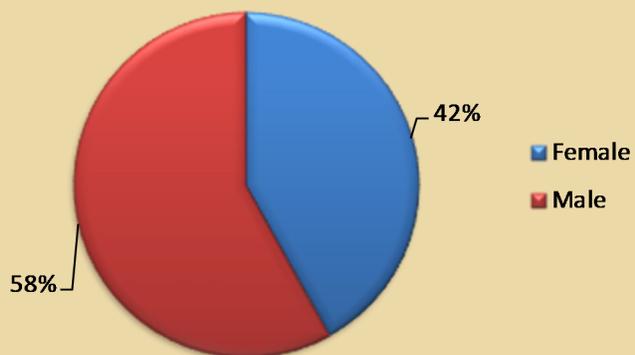
"FACT is always there for me and I can always call the program...FACT staff are like family."

- FACT consumer

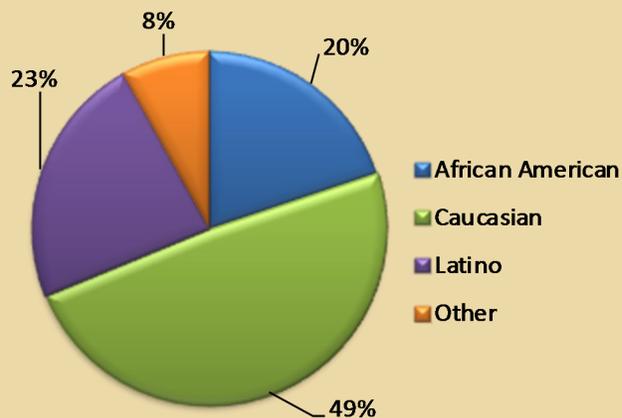
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

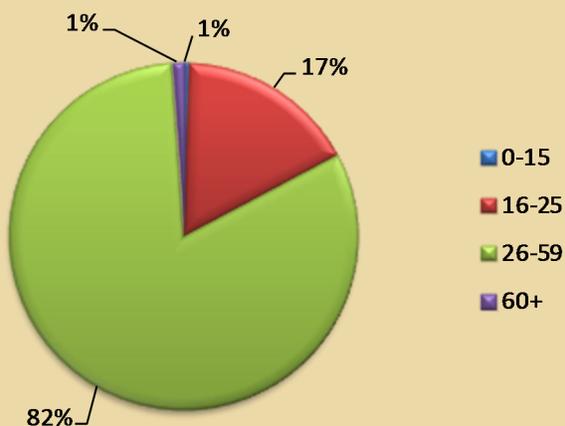
Gender



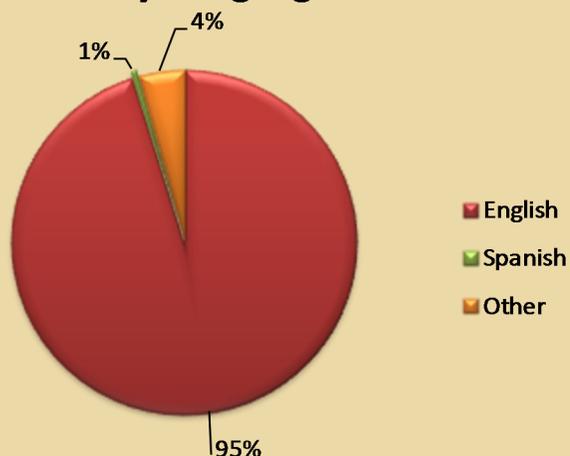
Ethnicity



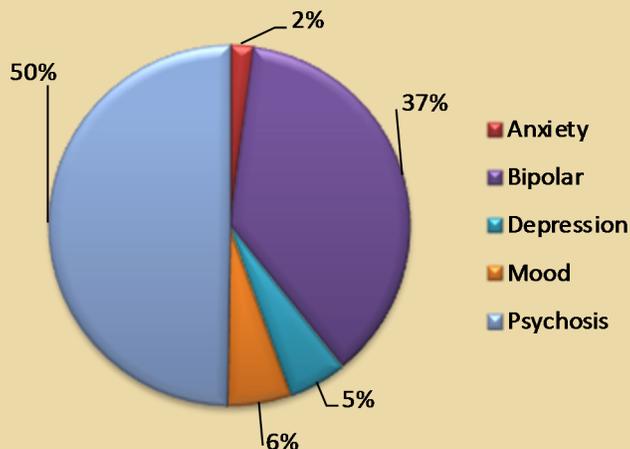
Age



Primary Language



Diagnostic Group



Community Services and Supports Programs

Collaborative Partners

- Alzheimer Association.
- Behavioral Health Commissioners.
- California State University of San Bernardino CARE Team.
- Cedar House Life Change Center.
- Coalition Against Sexual Exploitation (CASE).
- County of San Bernardino Department of Behavioral Health presenters and guest speakers.
- County of San Bernardino Probation Department.
- County of San Bernardino Sheriff Department.
- Department of Aging and Adult Services.
- Department of Behavioral Health Clubhouse Members.
- Department of Behavioral Health Community Crisis Services.
- Department of Behavioral Health Peer and Family Advocates.
- Department of the Public Defender.
- District Attorney's Office.
- Inland Empire Concerned African American Churches.
- Inland Regional Center.
- Inland Valley Recovery Services.
- Institute for Public Strategies.
- Loma Linda Veteran's Affairs Healthcare System.
- National Alliance on Mental Illness (NAMI).
- New Hope Missionary Baptist Church.
- Office of the District Attorney.
- Office of the Public Defender.
- Patton State Hospital.
- Rialto Kiwanis Club.
- San Bernardino City Police Department.
- San Bernardino County Superior Mental Health Courts.
- Shelter Services Housing Providers.
- The Counseling Team International.
- Veteran's Center of Colton.
- Westside Action Group.



Artwork by Peter Millar

Community Services and Supports Programs

Members Assertive Positive Solutions / Assertive Community Treatment (A-3)

The **Members Assertive Positive Solutions (MAPS)** and **Assertive Community Treatment (ACT)** programs are for individuals with Serious Mental Illness (SMI). These programs exist to help people live successfully in the community and achieve their personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The key differentiation between the two programs is that ACT specializes in those who may be transitioning from institutional settings such as state hospitals, institutes of mental disease (IMDs), or locked psychiatric facilities while MAPS assists those who are transitioning into society after release from incarceration. These individuals may also have a history of co-occurring substance abuse or a history of being homeless. The MAPS program served **67** unique full service partners and ACT served **102** unique full service partners in FY2013/14.

Key components of the ACT model is treatment and support services that are individualized and guided by the individual's hopes, dreams and goals. The team members share responsibility for the individuals being served. Staff-to-consumer ratio is small (approximately 1-10) and the range of services are comprehensive and flexible. Most services are provided within the community where members live, work and socialize.

The Recovery Model used for both programs builds on traditional ACT standards. The Telecare Corporation has been contracted to provide MAPS/ACT services for individuals with serious mental illness and to create a recovery-centered experience for people served. Telecare's approach is based on a belief that "recovery can happen." The program and staff strive to create an environment where a person can choose to recover. By connecting to each individual's core self and trusting it to guide the way, it is possible to awaken the desire to follow in the recovery journey. The program staff is a multidisciplinary team that include psychiatrists, nurses, Master's level prepared clinical managers, team leads, and personal service coordinators. Some staff may be consumers who are in recovery themselves.

Target Population

- Adults

Projected Number to be Served FY 2015/16

- 100 Adults: ACT
- 85 Adults : MAPS

The services and support include a comprehensive assessment and treatment, crisis intervention and immediate support 24/7. Through these programs consumers have access to:

- Psychiatric assessment and treatment.
- Medication management and support.
- Risk focused assessment and intervention.
- Physical health screening.
- Care coordination and referral.
- Substance abuse intervention.
- Counseling vocational services.
- Social skills building activities.
- Case management.
- Housing support.
- Benefits and entitlements assistance.
- Family support, education and life skills coaching.

Information and learning opportunities are provided to support individuals in their recovery. Staff support and consultation is available when members are hospitalized, and support upon discharge to aid their transition back to the community. All referrals are coordinated directly by Behavioral Health.

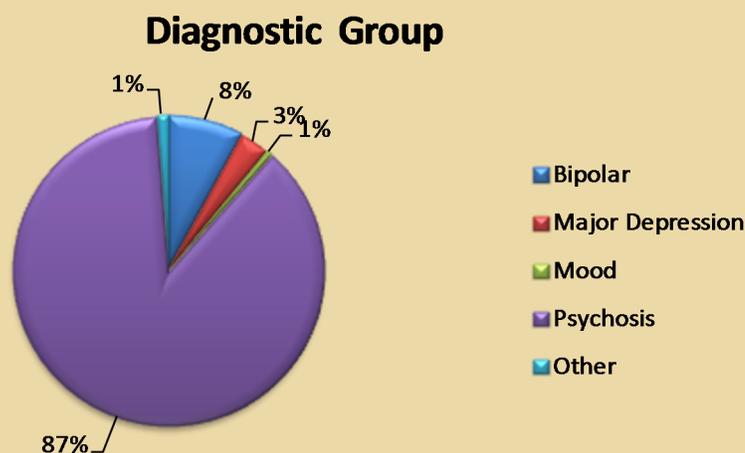
Community Services and Supports Programs

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
 - ◊ Improved life satisfaction.
 - ◊ Decreased hopelessness and increased hope.
 - ◊ Decreased impairment in general areas of life functioning.
- Reduce homelessness and increase safe and permanent housing:
 - ◊ Decreased rate of homelessness for clients related to their general living arrangement or in a supervised placement facility.
- Increase in self-help and consumer/family involvement:
 - ◊ Increased ratio of voluntary mental health services to involuntary mental health services.
 - ◊ Increased number of collaborative partners.
- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◊ Increased encounters in specialty co-occurring and substance abuse interventions.
 - ◊ Increased encounters with Primary Care Physicians.
 - ◊ Increased transportation to non-mental health services such as integrated health and substance abuse.
- Reduction in disparities in racial and ethnic populations:
 - ◊ Reduction in mental health and health care disparities.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Reduced number of emergency visits for behavioral health concerns.
- Increase a network of community support services.
 - ◊ Increased number of collaborative partners and increasing the coordination of care:

***"Put your Heart and Soul
into yourself and you will
grow strong and beautiful
in recovery."***

-MAPS/ACT consumer



Community Services and Supports Programs

Outcome Tools Used to Reach Goals

- Global Assessment of Functioning (GAF) Scores.
- Key Event Tracking System (KETS).
- ACT Database.
- Simon.
- Data Collection and Reporting Outcome Tools.
- Discharge Information.
- Telecare Database.

Positive Results

MAPS

- ◇ Three (**3**) homeless individuals living with a co-occurring disorder were placed in a permanent living situation or supervised placement.
- ◇ **52** members were diverted from psychiatric hospitalization.
- ◇ Approximately **57%** of the individuals served were from the underserved population.
- ◇ Reduced emergency room visits.
- ◇ Increased members use of community resources (i.e. club houses, enrollment in adult school and community colleges, volunteer, and use of local libraries).



Artwork by: Garth Pezant

ACT

- ◇ There were **100** clients served who showed improved life satisfaction due to being able to remain in community in the least restrictive level of care. Likewise, clients were able to attain a more hopeful attitude due to the services that aided them in recovery goal attainment. Services provided by ACT of intensive case management, **24/7** services, acute psychiatric medication support services, and assistance with daily living skills, and social and recreational activities showed a decrease in impairment in general areas of life function.
- ◇ There were seven (**7**) homeless individuals living with co-occurring disorders placed in permanent living situation or supervised placement for the FY 2013/14.
- ◇ **74%** homeless consumers received voluntary mental health services from Telecare ACT program.
- ◇ Only **28%** had involuntary hospitalizations.
- ◇ There were **15** homeless, consumers living with co-occurring disorders who participated in self-help groups such as AA, NA, and other supports.
- ◇ **12** clients were provided specialty co-occurring and substance abuse treatment services.
- ◇ Transportation to services were provided for **100%** of the clients in this program.
- ◇ There were **13** emergency room visits for psychiatric concerns for FY 2013/14 compared to **39** for FY 2012/13. This is a **26%** reduction in the number of emergency room visits in a year to year comparison.
- ◇ To prevent emergencies, the case managers, the psychiatrists, and nurses monitor side effects of the medication consumers are taking, therefore, integrating their care with mental health care in order to better serve the individual.
- ◇ FSP's receive **24/7** services with a hotline available and staff to respond to emergencies at all hours.
- ◇ ACT provides **24/7** services for individuals living with serious and persistent mental illness. They collaborate with the Public Guardians office to make placement is available for those coming out of State Hospitals.
- ◇ ACT has a network with the parents and families, and other please who the clients can work with to give back to their community through volunteer work or participation in community program.

Community Services and Supports Programs

Success Stories

MAPS

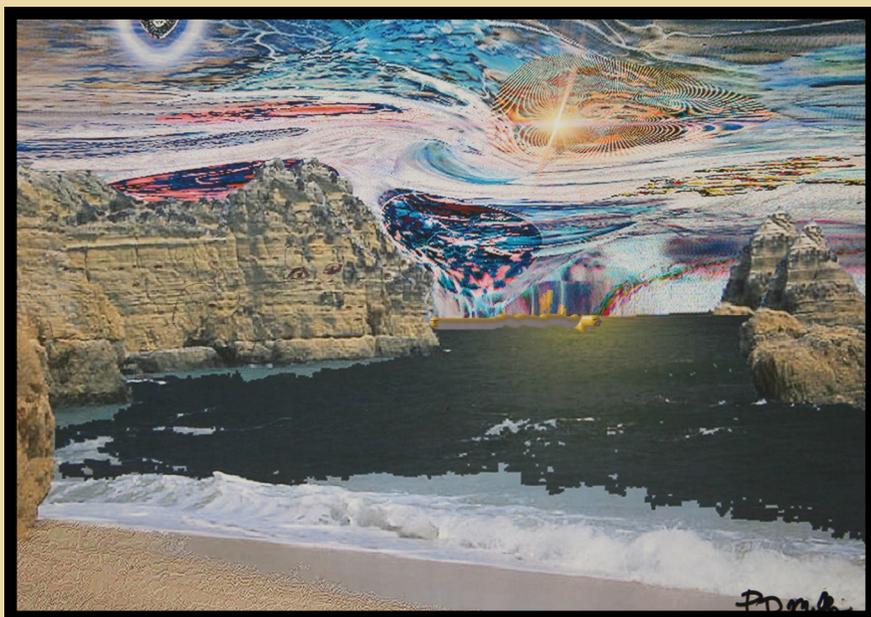
“Bobby” enrolled in the MAPS program in March 2014 when he was homeless. He had no means of financial support, no social support system, several unmet medical needs and was drinking excessively to cope with his challenges.

Since enrolling with MAPS, Bobby has now been stable in his housing for almost a year. He receives SSI benefits after being connected with an advocate service. Bobby has followed through with tending to his medical needs which included going to physical therapy to help him with his long term health problems. He is now able to get around with a walker and recently obtained an electric wheelchair. Bobby has developed friendships and a support system both with the MAPS program staff and with the people at his home who have become like family to him. He has been clean and sober since enrolling in the program and is even putting a little money aside each month in the hopes of buying a car one day soon. Bobby is truly a success story and has worked hard to achieve these accomplishments in his recovery.

ACT

“Carl”, a 49 year old male, struggled with living in structured environments due to aggressive and impulsive behaviors. Carl had difficulty maintaining his activities of daily living, including taking psychotropic medications, using substances, and not engaging socially with others, including Telecare staff.

Over the past several months, Carl has abstained from illicit drug use and has minimized his aggressive behaviors. He is living in a Board and Care currently where the staff have expressed no concerns. He is also actively engaged with Telecare staff and the services they provide. He has been taking psychotropic medication on a regular basis and has become more independent by managing his Activities of Daily Living (ADL’s) on his own.



Artwork by: Peter Millar

“Telecare helps you get back up when you are down.”

-MAPS/ACT consumer

Community Services and Supports Programs

Challenges & Solutions in Progress

MAPS

Helping our consumers become established in affordable community-based housing, a key component to sustained recovery, remains a priority. Solution: Collaborations are being developed and strengthened with various housing options throughout the County, including those programs offered through DBH. Many consumers of the program require substance abuse treatment as part of their journey to wellness. Matching the consumer to the appropriate available program is often challenging. Solution: The program has begun offering education and symptom-related groups to the consumers to meet their immediate treatment needs. Collaboration continues with the DBH alcohol and drug services programs to facilitate appropriate substance abuse treatment. The MAPS program is working to strengthen relationships with community partners who provide drug and alcohol treatment services in order to increase the capacity for treatment for the program consumers.

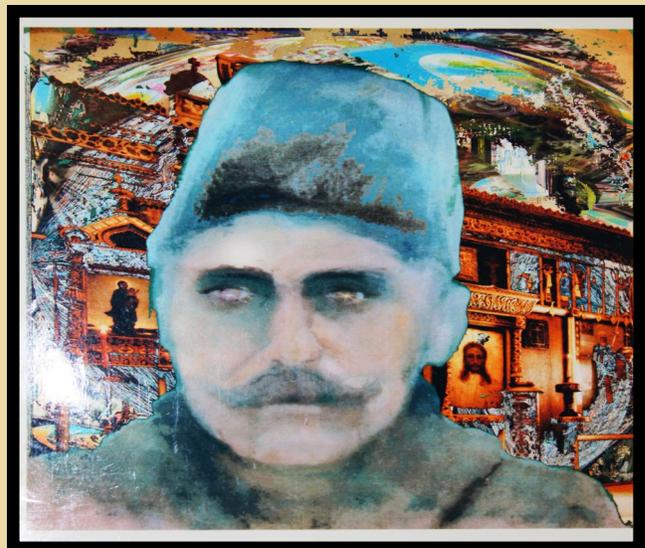
ACT

The ACT program has a caseload of **100** consumers, the majority stepped down from long term locked facilities in support of their recovery plan to place in least restrictive settings. The consumer centered care plans focus on reintegration into the community, assisting to improve the consumers skill set and improved satisfaction with quality of life. Intensive case management support is provided to strengthen the consumers skills and support prevention of a relapse.

Supporting the blending of consumer's needs and finding affordable housing that will address the recovery goals of the client who may still be working with ACT to obtain entitlements as part of their holistic resiliency plan can be a challenge. In response to this challenge, ACT conducts educational groups about resources for the consumers and creates opportunities for community involvement with potential housing operators who support the consumer's move towards independence. Another recurring theme is the opportunity to support the consumer to develop his/her intrinsic motivation to enhance their knowledge and skills in maintaining sobriety by connecting to co-occurring resources in their natural setting. ACT conducts on site educational groups on substance abuse issues to help consumers exercise their self determination to identify relapse triggers and the impact on their lives. This skill promotes consumers ability to attain desired enhanced quality of life and maintain desired change while participating in self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) available throughout San Bernardino County. ACT is expanding their in-house educational groups in FY15-16 to address consumer's individual goals.

***"They are always
available to help me."***

-MAPS/ACT consumer

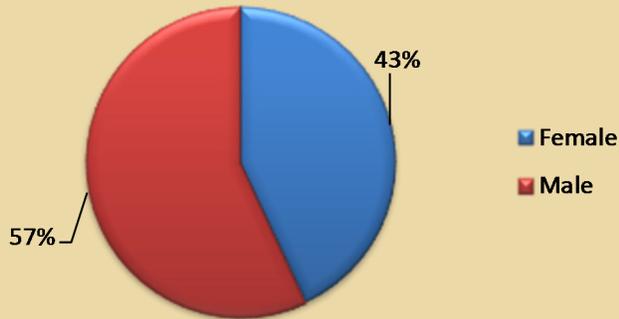


Artwork by: Peter Millar

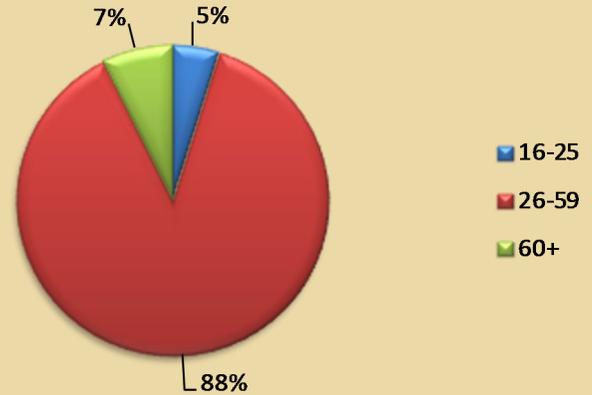
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

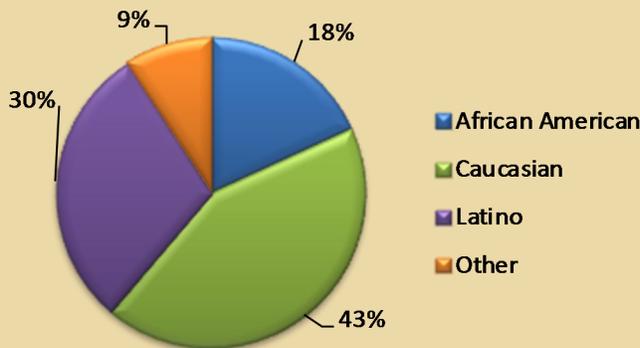
Gender



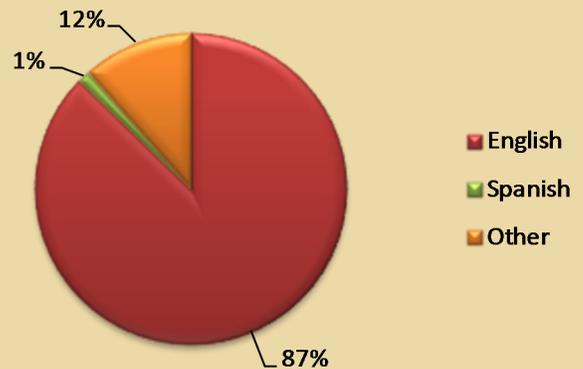
Age



Ethnicity



Primary Language



Community Services and Supports Programs

Program Expansion

MAPS

There is a planned expansion that will increase the budget for this program. It is planned to expand this program by **25** additional client spaces. This expansion will accommodate referrals from the newly formed Recovery Based Support Teams (RBEST) project. This Innovations-funded project is providing outreach and engagement for the most difficult to activate clients in the community. As this project speaks to the spirit and intent of Assisted Outpatient Treatment (Laura's Law) this high level, Full Service Partnership level of care needs to be available. In the first two months of service delivery the RBEST project has already successfully referred two (**2**) clients into the MAPS program. Additionally, as DBH moves to include residential treatment facilities in their treatment options, a community-based, Full Service Partnership needs to be available to provide a step-down component to the exit plans in order to provide a seamless, recovery based transition from the highest level of care (hospitalizations) to independent community living.

ACT

A **16** week psycho-education class about co-occurring disorders is planned for FY 2015/16 due to the lack of resources available in the community. The program changes will enhance the ability to connect and provide support for their sobriety. It will help those who have a dual diagnosis by providing a structured weekly class with **12** members and two (**2**) staff. This plan is to focus on the individual that may be ready for transition to a more independent style of living in the community.

Outreach and Engagement

MAPS

- Health Fair.
- Member Recognition.
- Community Celebrations.
- On-site Activities.
- National Alliance for the Mentally Ill (NAMI) Fundraiser.

ACT

Community Education for:

- Vicki's Place R&B.
- Susie's LBC.
- Wisdom's LBC.
- Tender Hearts Montclair Home LBC Staff.

Collaborative Partners

- Board and Care Operators.
- Substance Abuse Programs.
- Clubhouses.
- Institutes for Mental Disease.
- Substance Abuse Programs.
- Office of Homeless Services.
- Public Guardians Office.



Artwork by: Peter Millar

Community Services and Supports Programs

Crisis Walk-in Centers (A-4)

The Crisis Walk-In Centers (CWIC) provide urgent mental health services to San Bernardino County residents located in the Morongo Basin, Victorville, and the Central Valleys. These clinics conduct urgent psychiatric assessment and crisis stabilization for those clients who are in acute psychiatric distress or possibly a danger to themselves or others. All individuals regardless of age, gender, ethnicity, sexual orientation, or co-occurring disorders are served at the CWICs. The clinics are staffed by a multi-disciplinary team who focus on stabilizing those in crisis and providing linkage to resources within the community for psychiatric follow-up. In collaboration with the Community Crisis Response Teams (CCRT), the CWICs work to reduce inappropriate hospitalizations and improve the quality of life for DBH clients. Additional services include crisis intervention, crisis risk assessments, medications, education, and when necessary, evaluations for hospitalization. Consumers will be screened for appropriateness of service and will either be provided referrals or admitted in to the CWIC for assessment. Services are provided 24 hours per day, 7 days a week in Victorville and Morongo Basin. The Central Valley CWIC operates Monday through Friday from 8:00 a.m.-10:00 pm and Saturday 8:00 a.m.-5:00 p.m.

Target Population

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2015/16

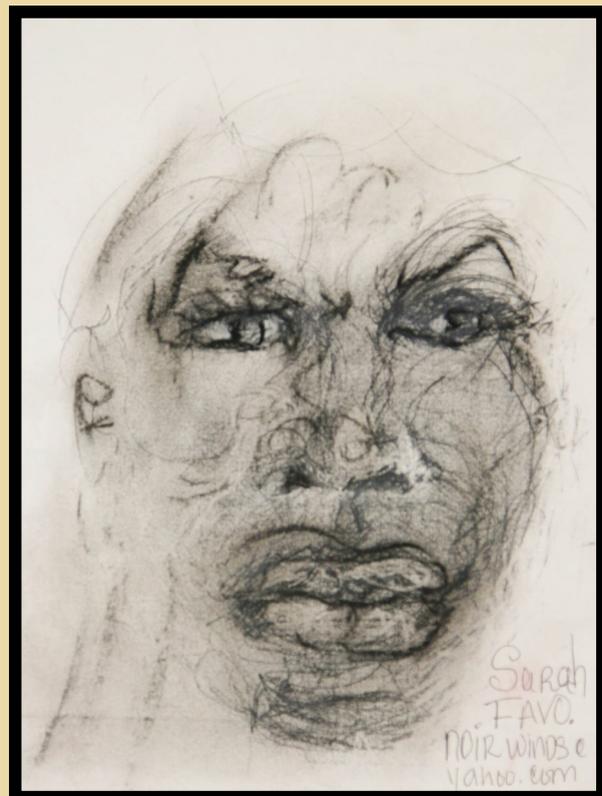
- 247 Children
- 1,710 TAY
- 5,918 Adults
- 327 Older Adults

Positive Results

CWICs bring services to the community that were not otherwise available prior to MHSA. The CWICs allow the consumer who may be experiencing a mental health emergency to receive crisis stabilization services and to stay within the community. This also allows the opportunity for families and caregivers to become involved in problem solving for their loved ones. Remote areas of the county were without local options for emergency mental health services prior to the CWICs.

MHSA Legislative Goals & Related Key Outcomes

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Increased use of alternative crisis interventions.
 - ◊ Reduce the number of emergency room visits for Behavioral Health concerns.

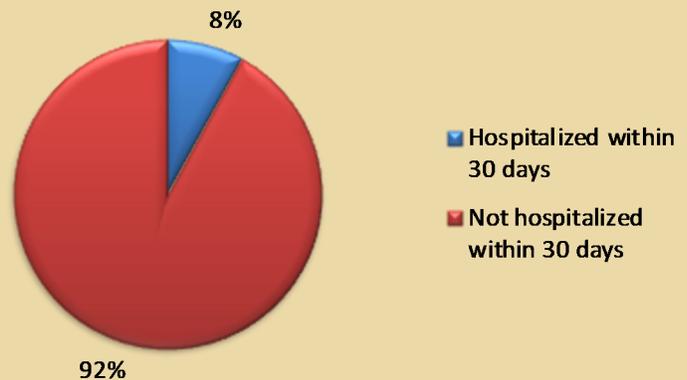


Artwork by Sarah Favorite

Community Services and Supports Programs

Each client is given a nursing evaluation to determine any medical concerns that might be preventing the clients recovery. During the FY 2013/14, crisis stabilization interventions were provided by the CWIC which included nursing, clinical, and psychiatric assessments. Needs Assessments are completed on all clients to better understand what community referrals are needed to assist with the overall goal of reducing emergency room visits and hospitalizations. Safety plans are given to assist clients with recognizing triggers related to their current crisis. **100%** of clients requesting community resources to assist with their crisis received referrals. CWIC staff assist clients in getting appointments at local clinics for medical support, and obtaining health care.

FY 2013/14 Percentage of Clients Hospitalized Within 30 Days After a CWIC Visit



As a result of services provided, **92%** of clients seen in a CWIC were not hospitalized within 30 days after their visit. Clients determined to need hospitalization are transported to an inpatient psychiatric hospital within the county.

In the FY 2013/14, a total of **8,149** consumers were served for crisis services. Of those **8,149**, **40%** received medications and **58%** received linkage to outpatient services. A total of **7,949** were diverted from hospitalization and to less restrictive services which results in a **98%** diversion rate. CWICs are a vital service in the department's efforts to reduce hospital emergency room encounter of individuals experiencing a mental health crisis. San Bernardino County Hospital Emergency Rooms report **3.58%** of all emergency room encounters are due to a primary Mental Health diagnosis, while the state average is **4.21 %**.

Challenges

- Individuals who are not experiencing a mental health crisis but are referred for medication support.
- Statewide shortage of psychiatrists, needed for medication support services.
- Homeless or at-risk individuals who are not experiencing a mental health crisis.

Solutions in Progress

- Continue to work collaboratively with community partners to provide ongoing education regarding appropriate referrals.
- Continue to work collaboratively with clinics and health plans to assist with client appointments.

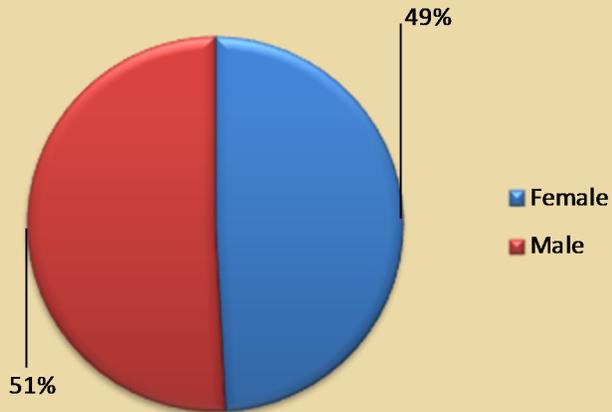
Collaborative Partners

- CCRT
- Local Schools
- Law Enforcement
- Inland Empire Health Plan-Kaiser
- Molina
- Arrowhead Regional Health Center—Behavioral Health Unit
- DBH Diversion
- Community Clinic Association of San Bernardino County
- Other designated 5150 hospitals

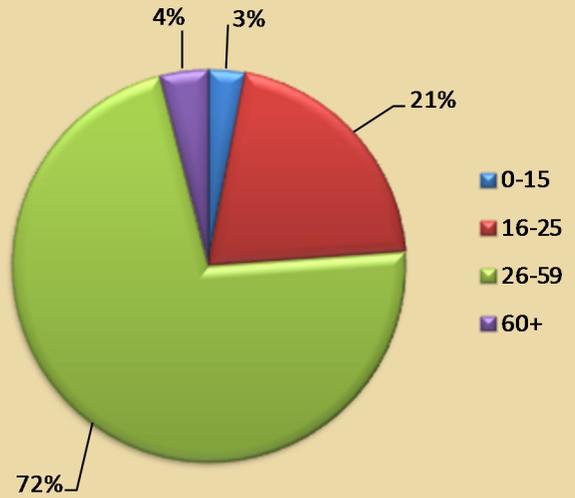
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

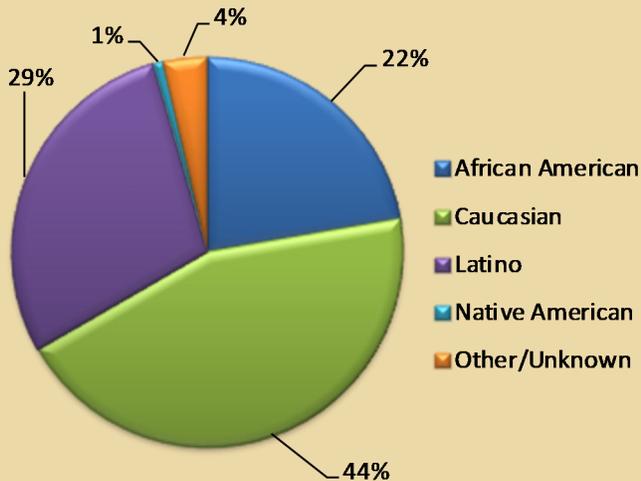
Gender



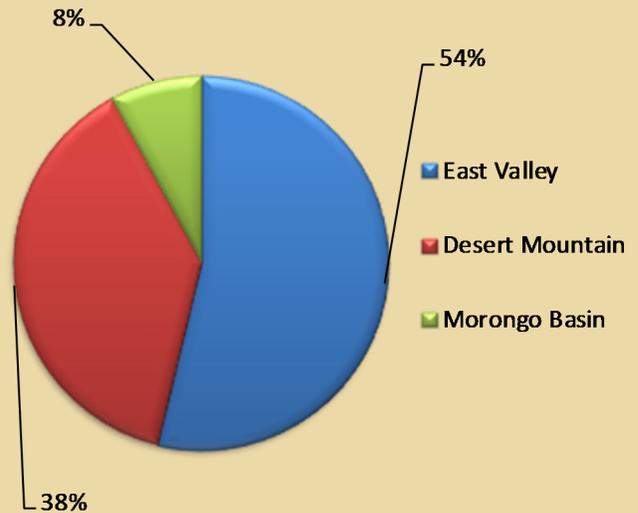
Age



Ethnicity



Geographic Region



Community Services and Supports Programs

Psychiatric Triage Diversion Program (A-5)

This program is located within the Psychiatric Emergency Room of the County hospital, Arrowhead Regional Medical Center (ARMC). Many individuals present to emergency rooms requesting mental health services that can be more effectively and efficiently met in an outpatient setting. This program was designed to screen these individuals to determine if their needs can be met in other settings outside of an inpatient treatment unit. There are many individuals who after receiving a psychiatric assessment, do not meet the criteria for inpatient psychiatric treatment. The Diversion Staff provides assessments of these individuals to determine how to best meet their needs outside of the hospital environment. Services provided include crisis assessment, crisis intervention, case management, collateral contacts, transportation assistance, housing assistance, linkage with outpatient resources and providers, referrals to medical and social service agencies, family and caretaker education, and client advocacy. The total number served by the Psychiatric Triage Diversion Program during FY 2013/14 was **4,014** consumers.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Decrease unnecessary and/or inappropriate inpatient psychiatric admissions.

Positive Results

Results show that **3,506** out of the **4,014** individuals who received services were successfully diverted from inpatient treatment to outpatient treatment options. Data collected included: demographics, insurance status, homelessness, medical conditions, co-occurring issues, recent incarcerations, outcomes of the encounters, and resources and referrals provided to the consumer.



Artwork by Marcy Grebus

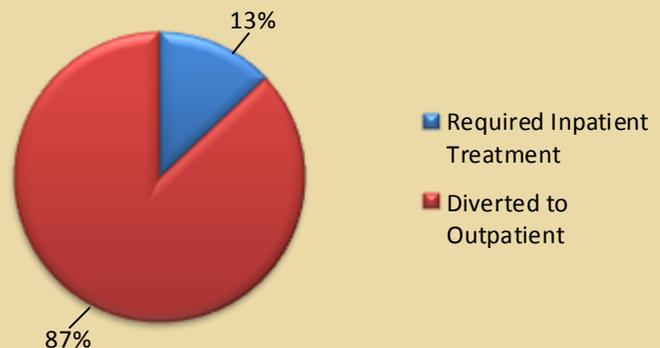
Target Population

- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2015/16

- 950 TAY
- 3,000 Adult
- 140 Older Adult

Diversion Rates



Community Services and Supports Programs

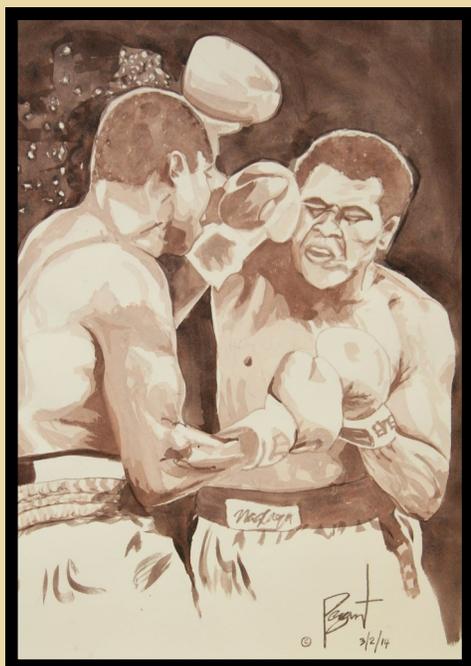
Success Story

“Matt” was a 21-year-old hearing impaired male who communicated via sign language. He was recently discharged from an inpatient unit and homeless. Not being from this area, he was not familiar with any resources or social supports in the area. He was requesting assistance in securing substance abuse treatment as he was using methamphetamines.

Matt was assessed with the help of two sign language staff members on site at the hospital. After a lengthy and comprehensive assessment, both Matt and the staff determined that a significant barrier for him was the inability to communicate effectively with non-hearing-impaired individuals. With his consent, contact was made with his family and a full needs assessment conducted.

Matt was linked and appointments were made with the Inland Empire Center on Deafness and a DBH clinic. He was linked with a homeless shelter for housing, given referrals to drug and alcohol treatment programs, and provided with full fare all day bus passes to allow him to move about the local area to go to the appointments and housing referrals.

Matt felt that these services adequately met his needs. He has not returned to an inpatient unit since this encounter.



Artwork by Garth Pezant

Challenges

As we continue with the implementation of the program and work to improve delivery of coordinated care for adults who have co-occurring physical health and behavioral health care needs, the program is challenged with seamless service delivery while diverting clients from a hospital emergency room to an outpatient clinic / service provider.

Solutions in Progress

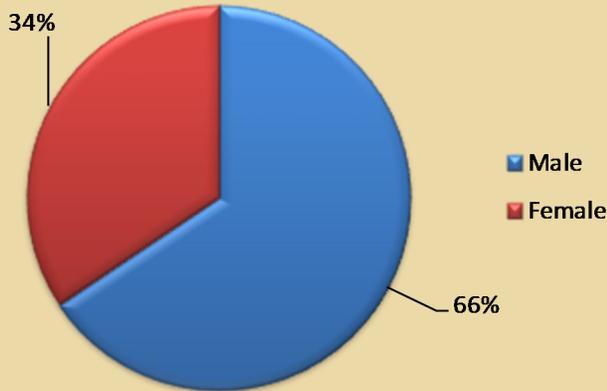
The Psychiatric Diversion team continues to work collaboratively with partner agencies, DBH outpatient clinics, and community agencies to understand all the needs of the clients served. The inclusion of scheduled regular multidisciplinary meetings between the program and partner agencies were instituted.



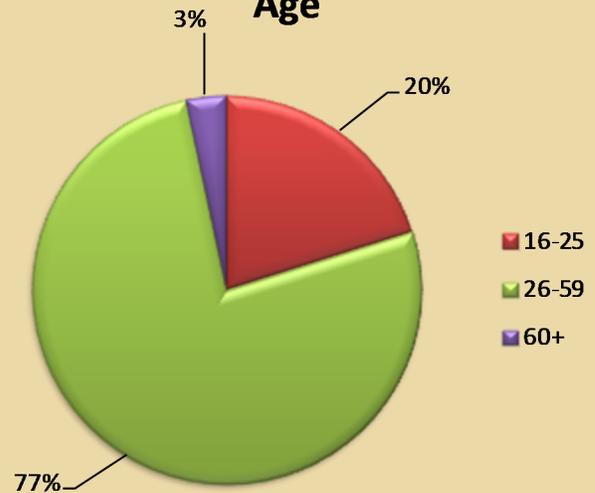
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

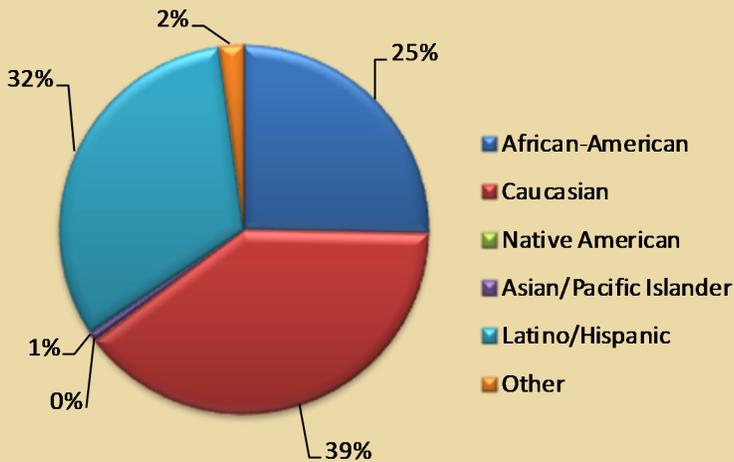
Gender



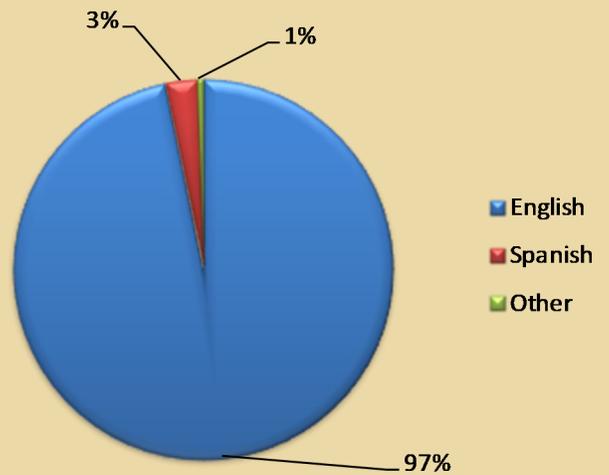
Age



Ethnicity



Primary Language



Community Services and Supports Programs

Collaborative Partners

- Arrowhead Regional Medical Center.
- San Bernardino County Law Enforcement.
- Telecare Corporation.
- County Probation.
- State Parole.
- Public Guardian's Office.
- Department of Family Services.
- Department of Aging.
- Fee for Service Private Hospitals.
- Los Angeles, Orange, and Riverside County Department of Behavioral Health.
- Contract mental health providers.

Planned Program Expansion

It is anticipated that the program will begin providing services to our partner fee-for-service hospitals on a very limited basis. A staff member may be provided with contractual hospital sites to assist with similar hospital inpatient diversion activities for individuals who present on a voluntary basis but do not require inpatient treatment.



Behavioral Health—Located at 303 E. Vanderbilt Way, San Bernardino, CA 92415



Arrowhead Regional Medical Center—Located at 400 N. Pepper Ave Colton, CA 92345

Community Services and Supports Programs

Community Crisis Response Teams (A-6)

The Crisis System of Care provides urgent mental health services to residents of San Bernardino County. The Community Crisis Response Teams (CCRT) utilize specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, medication referrals. Additional services include linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations. CCRT also provides follow-up services to Medi-Cal eligible children being discharged from psychiatric facilities, including linking those children and their families to ongoing outpatient mental health services and other community resources. The total number served by CCRT staff for the FY 2013/14 was **4,518** consumers.

MHSA Legislative Goals & Related Key Outcomes

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Reduced number of emergency room visits for behavioral health concerns.
 - ◊ Increased use of alternative crisis interventions.
 - ◊ Increase in number of individuals diverted from hospitalization.



Artwork by Jean Loi

Target Population

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2015/16

- 2,340 Children
- 761 TAY
- 2,416 Adults
- 327 Older Adults

Positive Results

In FY 2013/14, there were **4,518** crisis calls. Out of those **4,518** crisis calls, **2,204** (or **49%**) of those clients were diverted from unnecessary hospitalizations. The CCRT utilized a Record of Intervention (R.O.I.) logs to measure such program specific outcomes.

Community Services and Supports Programs

Success Stories

CCRT has many success stories from consumers and families that have been grateful for the immediate assistance provided during a psychiatric crisis.

- One such story involves a call from a high school for a student who was cutting and experiencing selective mutism. The mother did not speak English, and an interpreter was needed. The CCRT staff and a San Bernardino Police Officer researched alternatives to hospitalization, and were able to set her up for an appointment with an Indonesian speaking therapist for the next morning. Due to our collaboration with SBPD and the family, this partnership was successful in making a safety plan, and the girl was provided needed resources and avoided hospitalization.
- An elderly woman was very isolated following the death of her husband, and was experiencing psychotic symptoms and needed crisis services. The CCRT staff provided the assessment and hours of case management follow up needed to ensure she was linked to appropriate outpatient services following her hospitalization.
- The team responded to a County assistance office to evaluate a woman that had presented there with her children. She was depressed, overwhelmed and was living in her car with her children. The team provided crisis intervention counseling and assisted in getting her into a shelter immediately with the plan for longer term housing. She stated to the team that she felt they had given her hope to keep going and care for her children, she was very grateful and said she didn't feel alone in her situation anymore.
- A collaborative meeting process was established to discuss gaps in services existing in the high desert area. The goal is to effectively serve community members experiencing psychiatric crises that involve crisis services, law enforcement, and three Hospital Emergency Room representatives.

***"Thank you for the exceptional and compassionate way that CCRT staff treated my sister in crisis, I live far away and sometimes I can't sleep at night worrying about her."
- Family member***

Challenges

The primary challenge for CCRT was staffing shortages. This created a hardship for existing staff to cover all shifts of this 24/7 program. Staff worked extra hours to ensure shifts were covered.

Another challenge was an insufficient number of vehicles for all the teams. One vehicle was dedicated the Morongo Basin to assist with Sheriff, CWIC, and the Hospital in providing care to consumers in the Morongo Basin area.

Solutions in Progress

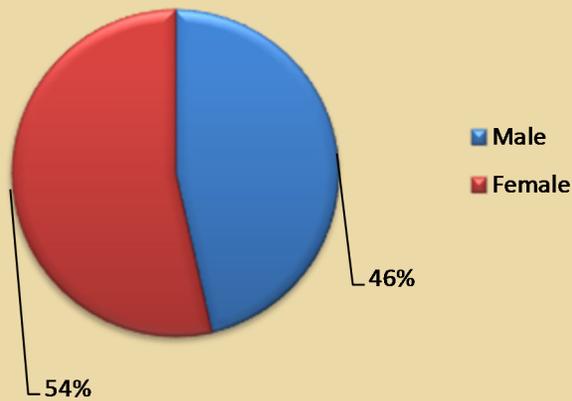
During staffing shortages, teams pulled together to ensure all shifts were covered and all calls were responded to. This teamwork fostered goodwill amongst staff and supported the development of teamwork. CCRT is in the process of recruitment, hiring 9 new staff members. The goal going forward is to maintain the positions as filled.

Two additional vehicles were approved and are now in the procurement process. This will be an asset to the program. Also, an additional vehicle was requested for the upcoming year to assist out-stationed staff in the Morongo Basin.

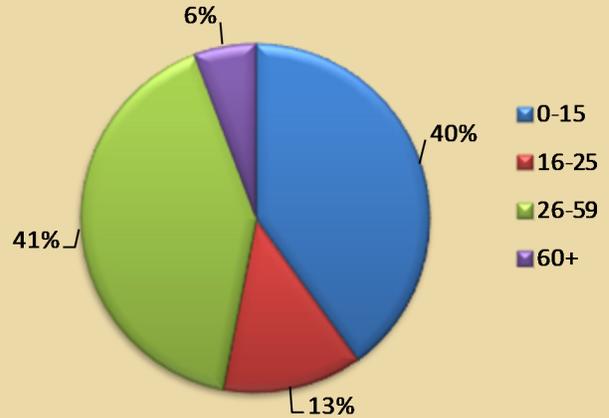
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

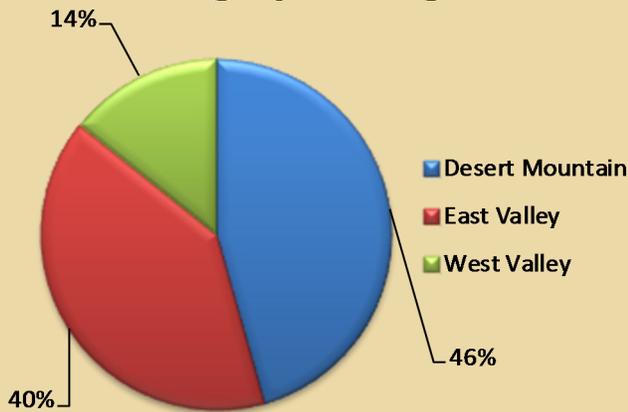
Gender



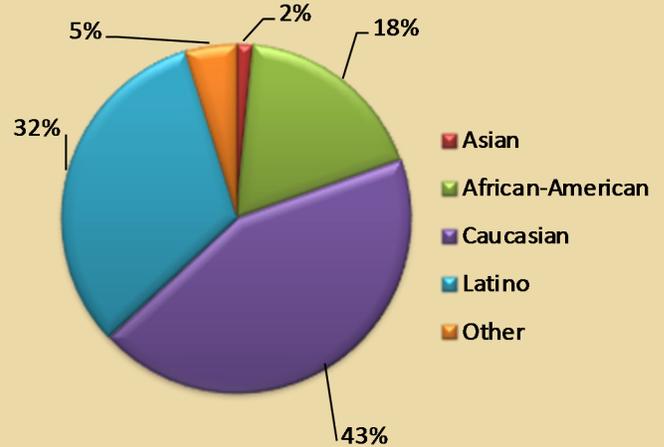
Age



Geographic Region



Ethnicity



Community Services and Supports Programs

Collaborative Partners

- San Antonio Community Hospital.
- Arrowhead Regional Medical Center.
- St. Mary's Hospital.
- Victor Valley Hospital.
- Desert Valley Hospital.
- St. Bernardines Hospital.
- Community Hospital in San Bernardino.
- Redlands Community Hospital.
- Loma Linda Medical Center.
- Canyon Ridge Hospital.
- Behavioral Medical Center, Loma Linda.
- Mountains Hospital in Arrowhead.
- Bear Valley Hospital in Big Bear.
- High Desert Hospital in Morongo Basin.
- DBH Contract Agencies.
- Children's Intensive Case Management Services.
- Code Enforcement.
- Sheriff Stations throughout San Bernardino County.
- Local Police Departments throughout San Bernardino County.
- DBH Clinics.
- TAY Center.
- Probation, Adult and Juvenile.
- Elementary, Middle, High and Nonpublic Schools.
- Board and Care Facilities.
- Juvenile Group Homes.
- Kaiser ED and Outpatient Services.
- Private Providers, Medical and Psychiatric.
- Children's Foster Services.
- CWICs in three regions.
- Family Resource Centers.
- Coalition Against Sexual Exploitation.

***"Thank you for helping me put
my family back together."
- CCRT consumer***

Outreach and Engagement

During the FY 2013/14, CCRT's participated in **143** Law Enforcement Briefings, presented at **3** hospitals, **8** conferences reaching over **6,000** participants, **14** schools, and **44** community presentations or meetings. The combined number of participants from all activities totaled **12,314**.

***"Now I feel confident enough to
advocate for my kids because you
made me feel like I can do it ."***
- CCRT consumer



Artwork by David Pacheco

Community Services and Supports Programs

Homeless Intensive Case Management and Outreach Services (A-7)

The Homeless Intensive Case Management and Outreach program is comprised of four (4) focus areas: Full Service Partnerships, Intensive Outreach and Case Management, Homeless Outreach Support Teams, and the Housing and Employment Program.

The Full Service Partnership (FSP) is a vital component in DBH's Adult System of Care. The FSP is designed serve adults in San Bernardino County who are severely and mentally ill or who have untreated co-occurring disorders and who are in many cases, recently released from state hospitals and/or institutionalized care. These adults are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization. The FSP promotes the principles of recovery, wellness, and resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Services focus on the client's strengths and possibilities in order to move toward new levels of functioning in the community.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to clients is one (1) to 15 to allow for intense support of the clients 24 hours a day/7days a week. The FSP offers a true one-stop shop of all available resources such as housing, interim assistance, medication support services and the aforementioned intensive case management. FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. This intense, interactive support from case managers and other community resources benefits FSP clientele and contributes to increased independence and reduced psychiatric hospitalization, thus enhancing the individual's quality of life.

This holistic approach meets the clients needs by providing coordination of care with mental health and substance abuse outpatient clinics as well as physical health care providers. Those who have been homeless often come into the FSP with many physical problems and are supported through linkage and transportation to community based health care providers. In addition, employment preparation and support services are provided to help the FSP clients reintegrate into the job market or obtain entitlements such as SSI (Supplemental Security Income) as each individual's needs dictate.

Overall, the program promotes the principles of recovery, wellness, and resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. The focus of the services is on the client's strengths and possibilities in order to move toward new levels of functioning in the community. These are clients who lack access to community resources, are high-end users of emergency rooms, have possibly been in a psychiatric inpatient setting, and/or may have criminal/law enforcement contacts such as jail and the court systems. These services may include short-term placement in the emergency shelter level of care for up to 30 days, and an assigned a case manager. Individuals in need of short-term placement potentially face homelessness after being released or diverted from a higher level of care such as an acute inpatient psychiatric hospital. Shelter is needed while waiting for a substance abuse treatment program bed or for income entitlements. They are provided after placement help with their adjustment back into the community, eliminating re-hospitalizations and homelessness.



Artwork by Gary Bustin

Community Services and Supports Programs

The transitional-level of care provides longer term, structured case management to assist in overcoming obstacles to employment and obtaining permanent housing. Clients at this level of care agree to engage in a partnership with DBH and participate in an array of structured activities that will enable them to move towards addressing their mental health and substance abuse issues as well as their medical, employment and housing concerns. Case management services assist with identifying and establishing consumer resources, assisting in employment services, and establishing consumer funds for related purchases.

The maintenance-level of care provides continued case management to stabilize mentally ill adults who are transitioned to housing programs. For example, Individuals living in their own apartment, living semi-independently, or in Room and Boards in the community. A major service provided at this level is relapse prevention and focus on recovery goals.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
 - ◊ Increased resiliency.
 - ◊ Decreased impairment in general areas of life functioning (e.g., health/self care/housing, occupation/education, legal, managing money, interpersonal/social).
- Reduce homelessness and increase safe and permanent housing:
 - ◊ Increased residence stability.
 - ◊ Decrease rates of homelessness for clients.
- Increase in self-help and consumer/family involvement:
 - ◊ Increase in ratio of voluntary mental health services to involuntary mental health services.
- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◊ Increased encounters in specialty co-occurring and substance abuse interventions.
 - ◊ Increased encounters with Primary Care Physician.
 - ◊ Increased transportation to non-mental health co-occurring appointments (such as substance abuse and/or primary care, etc.).
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Reduce number of emergency room visits for behavioral health concerns.
 - ◊ Reduce administrative hospital days.
- Increase a network of community support services:
 - ◊ Increased number of collaborative partners.
 - ◊ Increased coordination of care.

Target Population

- TAY
- Adults
- Older adults
- Severely and chronically mentally ill individuals or individuals who have untreated co-occurring disorders and are homeless or at risk of becoming homeless.

Projected Number to be Served FY 2015/16

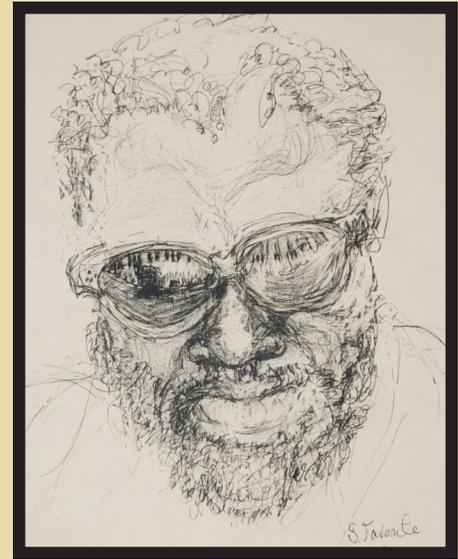
- 8 TAY
- 1,056 Adults
- 40 Older Adults

Community Services and Supports Programs

Positive Results

FSP clients are benefiting from access to psychiatry, psychotherapy and intensive case management services provided through this program. As a result, there has been an increase in life domain functioning including clients with greater levels of family involvement, greater residence stability and improved social functioning. This progress in functioning has contributed to the ability of clients to live more balanced lives. Some clients have been able to engage in meaningful volunteer service and positive recreational activities. As clients have improved social activities and interactions with a support system including family and friends, the quality of life for FSP clients has been greatly improved.

HICMOS placed **42** homeless individuals living with mentally ill/co-occurring disorders in some kind of permanent housing for the FY 2013/14. This includes DBH subsidized housing which allows them to be more independent with the support of the intensive case management services. Shelter programs are **100%** voluntary and participants are free to discontinue use of services at any time.



Artwork by Sarah Favorite

Housing project results from the Housing & Employment focus area are as follows:

- Vintage: located in the city of San Bernardino, dedicated for the senior mentally ill individuals who are **55** years of age or older. The Homeless Intensive Case Management and Outreach program is comprised of **three (3)** focus areas: Intensive Outreach and Case Management, Homeless Outreach Support Teams, and the Housing and Employment Program.
- MHSA one-bedroom units reserved for the qualified consumers. As of December 2014, this project is at full capacity.
- Magnolia: located in the city of San Bernardino dedicated for the senior mentally ill individuals who are **60** years of age or older. There are **10** MHSA one-bedroom units reserved for the qualified consumers. As of December 2014, this project is at full capacity.
- Mountain Breeze Villas: located in the city of Highland dedicated for the adult mentally ill individuals who are **18 to 59** years old. There are **20** MHSA one-bedroom units reserved to the qualified consumers. As of January 2015, this project is at **100%** capacity.
- Phoenix Apartments: located in the city of San Bernardino dedicated for the Transitional Age Youth (TAY) mentally ill individuals who are **18 to 25** years old. There are 8 MHSA units in this complex. As of December 2014, this project is at **40%** capacity.

DBH's transportation services for sheltered individuals to and from office for Job Group, conducted by Department of Rehabilitation provided bus passes for clients to meet transportation needs for outpatient substance use treatment, medical and/or other treatment plan related activities. Transportation is utilized on a daily basis by the majority of participants.

Intensive case managers work closely with participants and as a result, emergency room utilization has decreased tremendously for clients in this program because consumers are receiving an appropriate level of care and least restrictive means of support in place. All consumers currently participating are doing so on a voluntary basis. Also, diversion staff have observed a significant decrease in the usage of hospitalizations for those participating in the shelter program, and administrative hospital days have been completely eliminated.

Community Services and Supports Programs

Over the FY 2013/14 HICMOS expanded their collaborative partners to include Veterans agencies, community day treatment programs, other homeless shelters such as Salvation Army, Lutheran Mission and similar entities in the high desert areas. Coordination of care has increased with the expansion of Medi-Cal and the accessibility of homeless individuals securing coverage.

Results for HOST show that by November 2013, households leased up (placed in permanent supportive housing) between August 2013 - November 2013 totaled **172** households. All individuals leased up receive wrap-around case management services per HUD Homeless Assistant Shelter Plus Care grant service match requirements.

Success Stories

- “Stacy” has a long history of mental illness and chronic homelessness. She has moved around and lived in different areas of Southern California including homeless shelter on Skid Row in Los Angeles. During the time of being homeless, she was not able to seek appropriate mental health treatment. Stacy was not able to take her medications to reduce her symptoms. This made her mental health condition become worse. She never felt safe living in the shelters and on the street. Stacy was able to seek assistance from Phoenix Clinic, and was referred to the MHSA Housing and Employment program (Mountain Breeze Villas), and therefore, was able to move in in September 2014. She is doing much better having a stable place to live and continuing receive mental health treatment at Phoenix Clinic. She feels safe in her own place and follows through with her treatment plan. Her stress level has been reduced and she is stabilized with her medications.
- Over the course of “Erica’s” time with HOST, she engaged in therapy/counseling and learned how to maintain/manage mental health systems effectively to the point where she was able to take a job as a Certified Nurse Assistant, maintain it well for over a year and eventually earned a promotion. This has financially afforded her the opportunity to become self-sufficient. Erica gained valuable insight about her mental health condition and treatment needs, including therapy, and continues to seek services independently. She recently got married and reports the relationship is healthy and supportive. Erica has aspirations of attending Registered Nursing school as a dream to work in a hospital
- Upon contact, “Michelle” was homeless and suffering from a mental illness. HOST staff have worked extensively with her to establish medication compliance, consistent counseling, and positive life structuring. Michelle is now stable, happy with her living situation and seeking volunteer opportunities.

"I was so stressed living in the shelter and it was affecting my mental health."

-Housing Consumer



Artwork by Gary Bustin

Community Services and Supports Programs

Challenges and Solutions in Progress

FSP services in the High Desert region serve clients that are spread over a large geographic area (approximately **1,500** square miles). Providing services to clients in home settings is preferred, but due to this large service area, case managers are limited in their ability to do so. Case managers triage clients daily, giving priority to those cases most in need. To remedy, FSP plans to maximize the efficiency of staff, vehicles and program resources to meet the challenges of the service region.

Some of the challenges faced by HICMOS is finding appropriate community level placements for clients to live on a long-term basis, and the ability to help clients set and meet their goals for recovery and remain stable in the community. The positive effects of expanded Medi-cal will continue to assist clients in receiving their mental and physical health care in a coordinated manner which fosters stability in all life domains. HICMOS continues to collaborate with agencies and organizations that serve the homeless population working toward decreasing the stigma of mental illness

HOST's greatest challenge is a lack of funding and/or resources, and lack of permanent housing and emergency shelter beds. The exclusive criteria for homeless shelters at times disqualifies candidates needing homeless assistance; for example, single males lack resources for homeless shelters. Consumers continue to struggle with move-in costs and endeavors such as the ability to purchase books, attend school, etc. due to gaps in funding streams. HOST continues to collaborate with Sheriff's HOPE program to identify and engage chronically homeless individuals. Staff attended the Homeless Provider Network and Interagency Council on Homelessness to gain education best practices, as well as networking and gaining resources across the county. HOST also obtained Board approval for a petty cash checking account to assist with client move-in costs.

A challenge faced by Housing & Employment is the difficulty filling vacancies at the Transitional Age Youth Phoenix Apartment. To remedy this challenge, the program is considering opening the project to all adults instead of restricting it to the TAY population.

Outreach and Engagement

HICMOS participates in outreach and engagement activities with local agencies such as San Bernardino County Public Guardians Office leading to **five (5)** participants, Lutheran Mission leading to **10** participants, and Mary's Table leading to **three (3)** participants. Other collaborative partners with HICMOS include acute psychiatric hospitals, Community Crisis Response Team (CCRT), Diversion, outpatient clinics, Social Security Administration, and the Department of Rehabilitation.

Through collaboration with the Sheriff's HOPE program, **HOST** is able to identify and engage chronically homeless individuals and has reached a total of **325** participants.

Housing & Employment participated in the Health Fair for the TAY population at the San Bernardino One-Stop TAY Center.

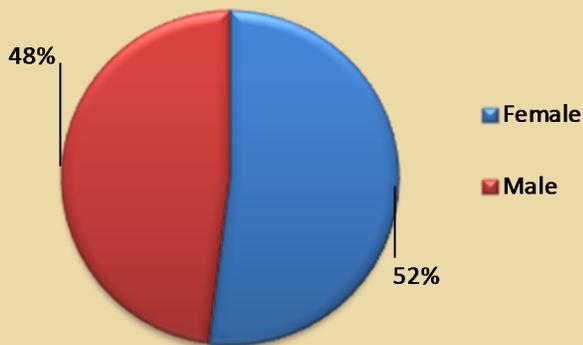


Artwork by David Pacheco

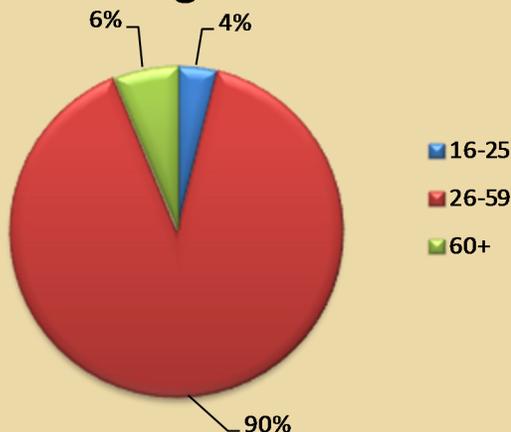
Community Services and Supports Programs

Fiscal Year 2013/14 Homeless Program Demographics

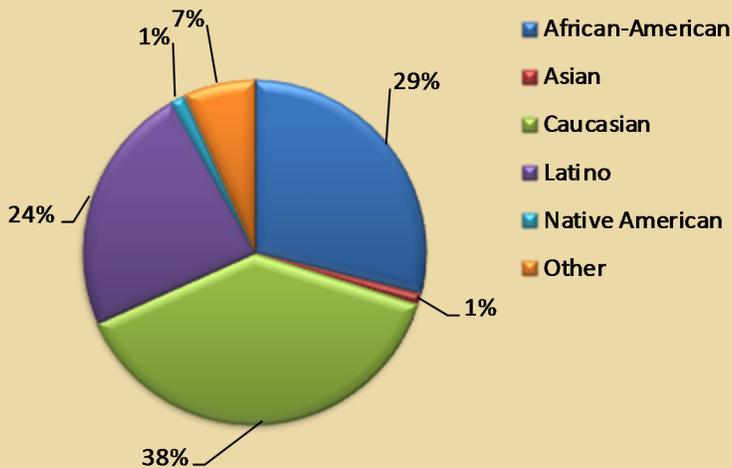
Gender



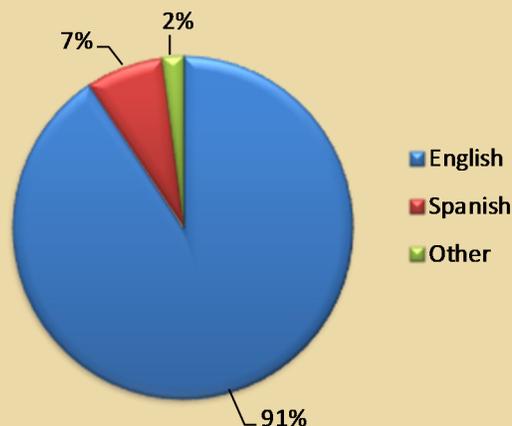
Age



Ethnicity



Primary Language



Focus Area	Total Number Served
HICMOS	777
HOST	137
Housing and Employment	265
FSP	417
Total	1596

"I really appreciate the help the homeless program staff has provided me. I have such gratitude and respect for every person I have come into contact with at the office. Without the help of the program I would not be living independently."
-HICMOS consumer

Community Services and Supports Programs

Program Expansion

A planned program change for Housing & Employment, under MHSAs-Housing-One-Time Only Funds will release a Notice of Funding Availability administered by the County of San Bernardino Department of Community Housing and Development for affordable housing countywide projects. Types of funding will be Prop. 41 Veteran Supportive Housing, MHSAs Housing, Project-Based Voucher-Housing Authority and Cap-Trade-Transitional Housing funds. The goal is to see how many eligible affordable housing projects are submitted. If more than one housing project is eligible, it will allow the Director to determine if additional funding for MHSAs Housing can be funded from other MHSAs resources.

The Phoenix Apartment under the MHSAs Housing Program will seek a change in the target population. Currently, this project is for the TAY population, since there has been minimal referrals, DBH is seeking approval from DHCS and CalHFA to modify the existing target population to include adults from the Phoenix Clinic.

Collaborative Partners

- DBH Housing & Employment.
- DBH Adult Systems of Care.
- DBH Recovery Based Engagement Support Teams (RBEST).
- Housing Authority of San Bernardino County.
- San Bernardino County Homeless Partnership.
- Vet Awareness.
- Knowledge and Education for Your Success (KEYS).
- U.S. Vets, and rehab programs throughout the county such as The Living Word and River's Edge Men's Ranch.
- The Housing Authority of San Bernardino County.
- CalHFA (California Housing Finance Agency).
- DHCS (Department of Health Care Services).
- Housing Partner I (Developer).
- Beacon Property Management (Property Management).
- John Stewart Co. (Property Management).
- Western Senior Housing (Property Management).
- USA San Bernardino 611, Inc. (Developer).
- Meta Housing Corporation (Developer).
- WCH Affordable II, LLC. c/o Western Community Housing, Inc.
- Mountain Breeze Villas, LP (Developer).
- Alliance Property Group, Inc.
- Hearthstone Housing Foundation.
- County of San Bernardino Department of Behavioral Health (DBH): Phoenix Community Counseling FSP; Mesa Community Counseling FSP; TAY FSP and Age Wise Supportive Services.

“FSP helps me keep track of my meds. My case manager helps me stay on track to take them as prescribed.”
-FSP Consumer

Community Services and Supports Programs

Big Bear Full Service Partnership (A-8)

The Big Bear Full Service Partnership (FSP) is an alliance of mental health service providers in the geographically isolated Big Bear Lake area that provides mental health services to children and adults. The partnership began in May 2009 to help a traditionally underserved area of mental health services. This Full Service Partnership allows for consumers in this geographic region to access a continuum of needed mental health services including intensive case management, co-occurring treatment, and transportation services for low income and underserved clients in the Big Bear Valley. Having these resources increases their ability to function within the community, within families, and school. The partnership provides linkage to community resources and assists uninsured clients by providing access to Medi-Cal. Other services include psychotherapy and medication services.

For Fiscal Year 2013/14, the Big Bear FSP served **90** participants, of which **82** were unduplicated, meaning the clients started services in the fiscal year.

MHSA Legislative Goals and Related Key Outcomes

- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◊ Decrease in the exacerbation of symptomology due to the reduction of substance abuse/dependence, and an increase in mood stability.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◊ Increase the number of individuals diverted from hospitalization.

Positive Results

The approach of the Big Bear FSP is to provide co-occurring services for a mental disorder and substance abuse or dependence. If the FSP program does not have a built in co-occurring treatment program, then clients are connected to outpatient or residential treatment programs if client is ready to commit to sobriety. The FSP provider coordinates services with the substance treatment program. There has been an increase in the clients' willingness to accept substance abuse/dependence treatment services because the client is aware of program supports in place during the treatment program and after the completion of the program. The Big Bear FSP has also been able to get approximately **90%** of the uninsured clients in the program enrolled in Medi-Cal or Covered California.

Crisis intervention in the Big Bear Full Service Partnership has prevented eight (**8**) hospitalizations year-to-date as the FSP helps to link people with an outpatient clinic, which decreases the cost of services and provides a more consistent use of services.

Target Population

- Adults
- Older Adults

Projected Number to be Served in FY 2015/16

- 145

Community Services and Supports Programs

Challenges

- The geographic location of the community makes accessing additional community support available in more populated areas of the county difficult.
- Finding appropriately licensed or pre-licensed staff to work in the mountain area is a challenge.
- Public transportation resources have limited availability.
- Access to additional benefits or entitlements has limited availability.
- Clients may not engage in the full continuum of services and treatment options available.
- Engaging the Latino population residing in the mountain area.

***"I would not be here if you weren't taking care of me."
- Big Bear FSP Participant***

Solutions in Progress

- Case managers are working with clients to help them sign up for Medi-Cal.
- Strategies to reach the Latino population include partnering with the school system and creating a partnership with the Community Health Worker/Promotores de Salud program to assist in relationship building and community education for the Latino population residing in the mountains.
- Case managers are also working with clients to facilitate movement to other insurance providers.
- There has been an increase in Activities of Daily Living (ADL) groups to provide increased functionality for clients who do not benefit from one-on-one therapy.

Collaborative Partners

- Bear Valley Community.
- Domestic Violence Education and Services (DOVES).
- Health Start.
- Healthcare District.

***"I am so glad I can get treatment here, I can't get off the hill."
- Big Bear FSP Participant***

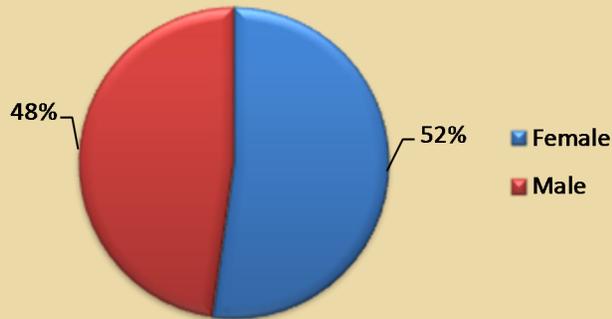


Artwork by Peter Millar

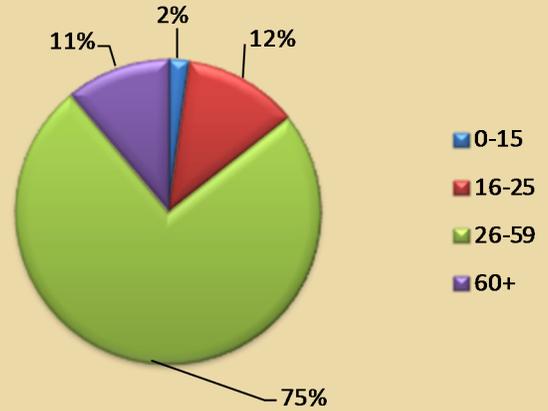
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

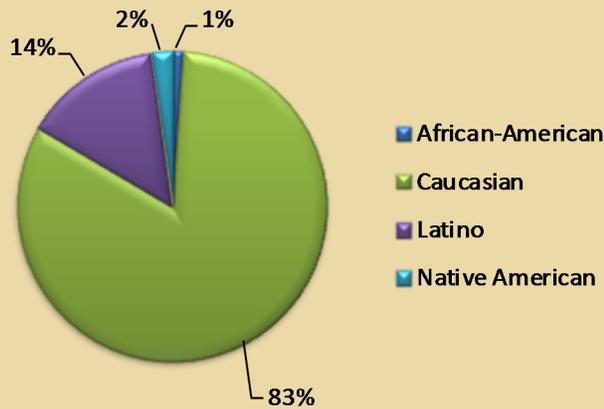
Gender



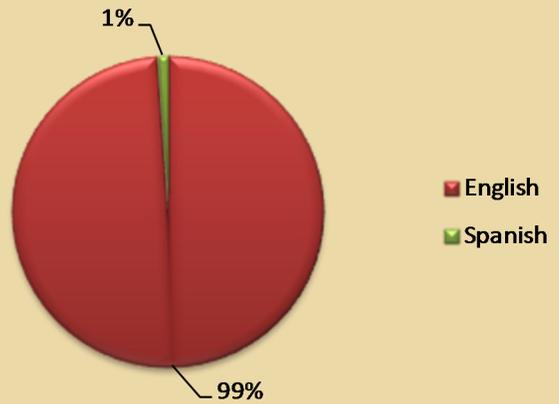
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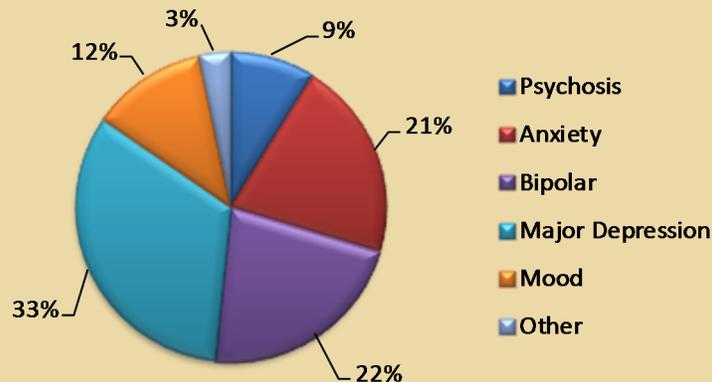
Ethnicity



Primary Language



Diagnostic Group



Community Services and Supports Programs

Access, Coordination, and Enhancement (A-9)

The Access Coordination and Enhancement (ACE) for Quality Behavioral Health Services program seeks to improve the timeliness of access to Department of Behavioral Health (DBH) outpatient services. As the population of San Bernardino County continues to grow, requests for services from clients have significantly risen over the past decade.

ACE services are focused on changing service delivery in the major DBH outpatient clinics and is the starting point for a transformational process in our Outpatient programs and services. The ACE program is seeking solutions to improve the linkage from psychiatric hospital to clinic. A centralized case management and referral workflow is being implemented. Also, greater linkage with the Recovery Based Engagement Support Teams (RBEST) program will help improve the number of consumers keeping their medical appointments.

Services provided through the ACE Program include:

- Mental Health Assessments.
- Psychiatric Evaluations.
- Substance Abuse screenings.
- Referrals and linkage.
- Access to appropriate services.



Artwork by Sarah Favorite

MHSA Legislative Goals and Related Key Outcomes

- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◇ **50%** increase in the number of assessments (referred out and opened).
 - ◇ **50%** increase in the number of complete intake assessments (opened).
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◇ **100%** of those discharged from ARMC Behavioral Health will have an assessment intake appointment within 7 days of discharge.
 - ◇ If medically necessary, an appointment with a Psychiatrist within 14 days of discharge.

Target Population

- Adults

Projected Number to be Served FY 2015/16

- 2,400 Hospital Discharges

Community Services and Supports Programs

Positive Results

The implementation of the ACE program has been a progressive process and the careful planning has spanned across fiscal years. Since its inception, the Department of Behavioral Health has worked diligently on hiring and establishing business processes for this program. Much of the fiscal year (FY) 2013/14 consisted of developing what data should be measured and which tools would be used. Although it is not from the FY 2013/14, the data provided herein covers the first two quarters of FY 2014/15 to show preliminary successes of the program thus far.

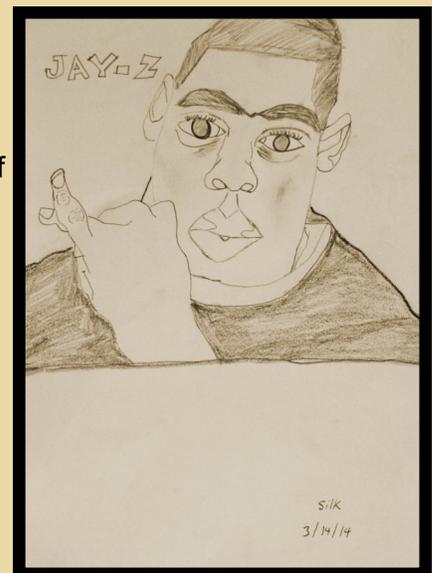
- There was an overall decrease in screenings throughout all clinics which represents a positive result, as it coincides with the expansion of Medi-Cal through the Affordable Care Act. This expansion created a new behavioral health platform for Medi-Cal beneficiaries to access managed care services by either Inland Empire Health Plan (IEHP) or Molina Health Plans.
- There was an **18%** reduction in assessments for the 1st and 2nd quarter of FY 2014/15. The ACE program averaged **775** assessments a month while the baseline average was **909** assessments a month.
- During the first (1st) and second (2nd) quarter of FY 2014/15, intake assessments increased **27%** from a baseline average of **409** per month to **520** intake assessments per month.
- For FY 2014/15, ACE expects **3,119** new cases added to the clinics, compared to **2,454** new cases for the baseline measurement of FY 2012/13. This has resulted in a **27%**



Artwork by Tim Jackson

Challenges

- The challenges ACE encountered were the recruiting and hiring of qualified staff for the ACE positions. Due to difficulties in recruitment and retention of Psychiatrists, the ACE program has not been successful in keeping the available positions filled.
- Training all partners, contractors, and DBH staff in the ACE program and Tier III criteria.
- Developing activity tracking systems for data not found in the SIMON system.
- The goal of a psychiatric appointment within 14 days does not adequately capture the intent of providing Medication Support Services to hospital discharged clients.
- For the 1st and 2nd quarter of FY 2014/15, the ACE program scheduled post-hospitalization assessment appointments for **1,106** consumers: **76%** were scheduled within 7 days of discharge and **56%** of those appointments were successfully completed. The show rate for consumers that a psychiatric evaluation is medically necessary has lowered to **45%**. These low show rates indicate a greater effort is needed to link consumers with outpatient services.



Artwork by Marcus Denby

Community Services and Supports Programs

Solutions in Progress

- As a result of working collaboratively with DBH Administration and the San Bernardino County Human Resources Department, some recruitments were initiated and processes streamlined.
- Several presentations were conducted with the local Health Plans, Hospitals, and DBH clinics to educate on the ACE program and Tier III criteria used by the program.
- A tracking system was developed for use by all ACE programs to capture additional data not entered into the SIMON database system. This system is a temporary measure until the SABER Electronic Health Record system is implemented.
- We continue to analyze the appointment show rates and research methods to improve them among the target population.

Planned Program Expansion

The ACE program is seeking to improve the linkage from hospital to clinic. A centralized case management and referral workflow has been identified as a possible solution. Also greater linkage with Innovation’s RBEST program could help improve show rates of consumers to their scheduled appointments.

Outreach and Engagement

For FY 2013/14, the table below show the outreach and engagement activities completed by ACE:

Event	Number of Events	Total Served
ACE - Tier III Criteria Partner Presentations (Health Plans, Hospitals Etc.)	4	52
ACE - Tier III Criteria DBH Clinic Presentations	15	252
ACE - Tier III Criteria Contractor Presentations	3	25
Total	22	329

Collaborative Partners

- Inland Empire Health Plan—Kaiser.
- Molina Healthcare.
- Arrowhead Regional Medical Center - Behavioral Health Unit.
- DBH Diversion and CCRT Programs.
- Community Clinic Association of San Bernardino County.
- Other Designated 5150 Hospitals.

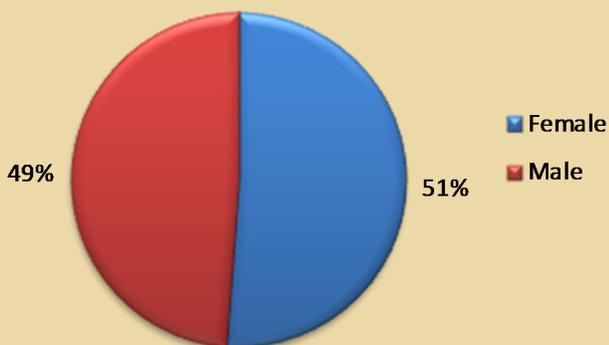


Artwork by Joe Zamudio

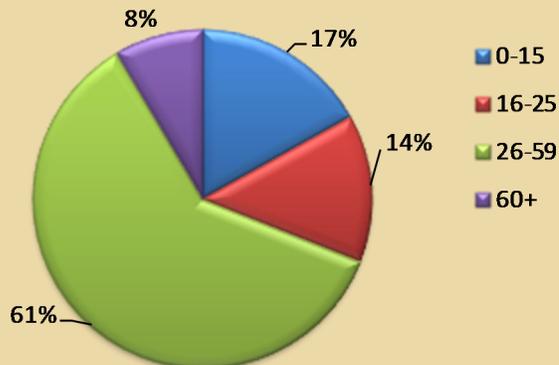
Community Services and Supports Programs

Fiscal Year 2013/14 Clinic Demographics

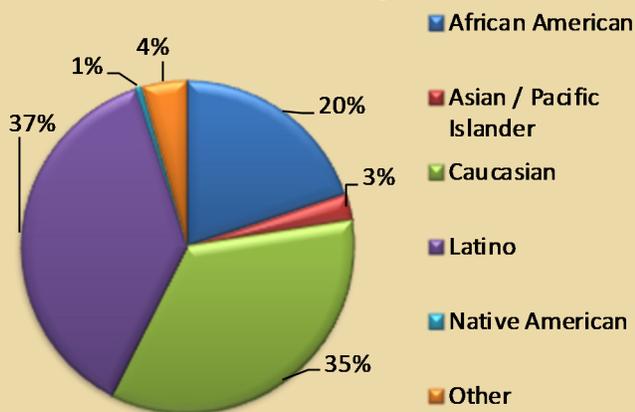
Gender



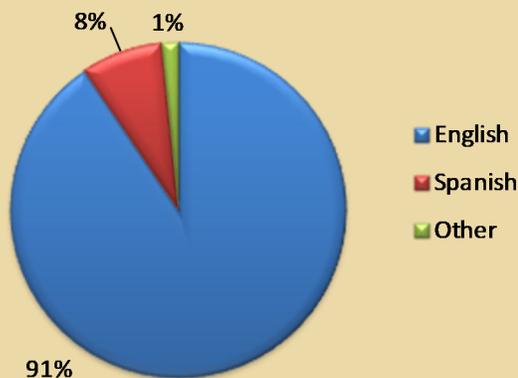
Age



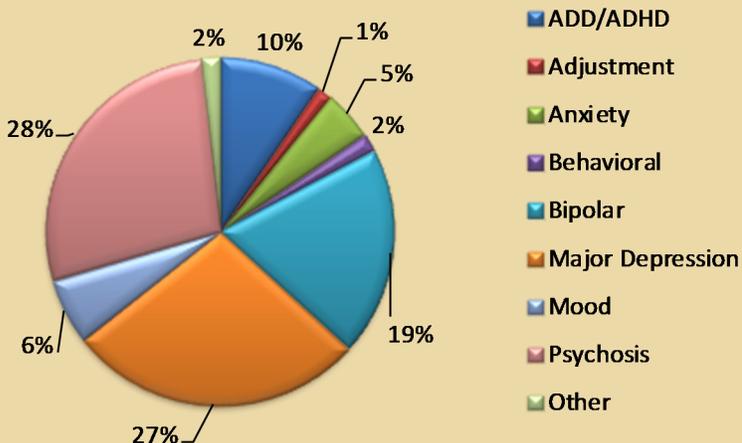
Ethnicity



Primary Language



Diagnostic Group



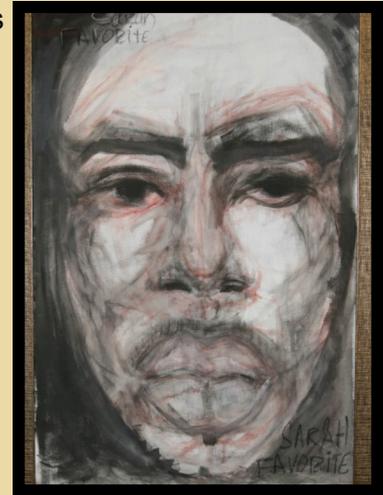
This demographic information illustrates the demographic of all clinics implementing the ACE Program.

Community Services and Supports Programs

Age Wise: Circle of Care Program (OA-1)

The Age Wise Circle of Care program provides behavioral health and case management services for older adults, age 60 and older, with a mental illness or a co-occurring disorder. The program works to increase access to services for older adults as well as decrease the stigma that is associated with mental illness in the older adult community. The program has built capacity through collaboration with the other community and government agencies that serve older adults and their caregivers. During FY 2013/14, the program **11** outreach and engagement activities were conducted where **1,334** participants received information on mental illness and programs offered.

To facilitate the goals of attaining housing and preventing homelessness of mentally ill older adults, DBH has enhanced a focus on wellness and recovery. This focus assists older adults in remaining independent and active in their communities for as long as possible. Collaborative partnerships developed between program staff and public agencies such as Adult Protective Services, Department of Adult and Aging Services and the Social Security Administration, aid clients in obtaining needed support including obtaining entitlements. The development of two DBH subsidized senior apartment complexes in FY 2013/14 provided additional access for **30** older adults to obtain low income housing. Older adults residing in these apartments can receive the mental health services provided through the program. Staff also work with the apartment management to develop program activities that keep older adult residents engaged and in a stable living environment.



Artwork by Sarah Favorite

This program is focused on helping unserved, underserved and inappropriately served older adults develop integrated care with their

physical and mental health needs. A major goal is to outreach to the primary care physician providing resources, education and services to identify and treat older adults with depression and other mental health issues. Staff have coordinated with primary care physicians in the community throughout San Bernardino County to ensure both physical health and mental health care was provided to older adults engaged in the program.

Target Population

- Older Adults (age 60+)

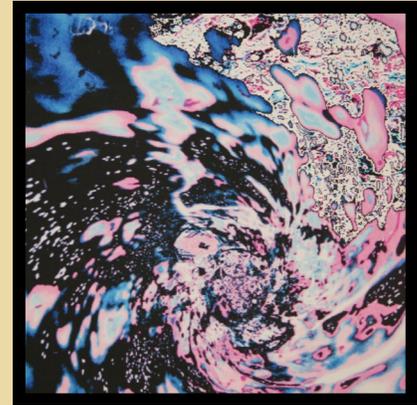
Projected Number to be Served in FY 2015/16

- 194 Older Adults

Community Services and Supports Programs

MHSA Legislative Goals and Related Key Outcomes

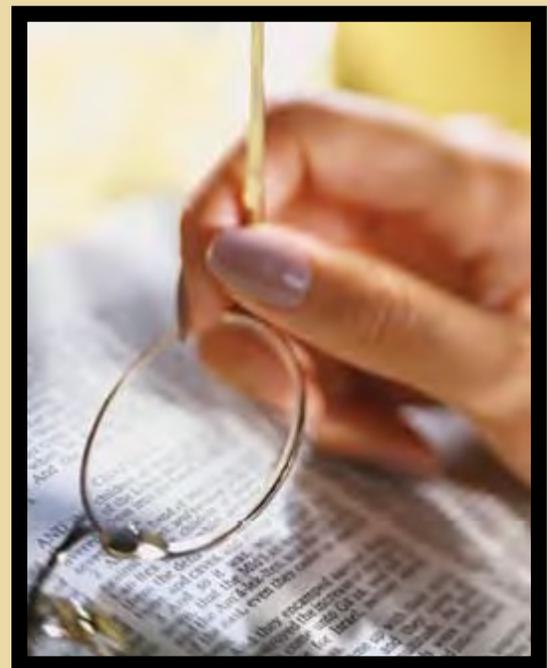
- Reduce homelessness and increase safe and permanent housing:
 - ◇ Decreased rate of homelessness.
- Increase in self-help and consumer/family involvement:
 - ◇ Increase in number of consumer volunteers/Peer and Family Advocates after participation in the program.
- Increase access to treatment and services for co-occurring problems: substance abuse and health:
 - ◇ Increased encounters in integrated health clinic and/or with primary care/health specialist providers.
- Reduction in disparities in racial and ethnic populations:
 - ◇ Reduction in mental health and health care disparities.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◇ Reduced number of emergency room visits for behavioral health concerns.
- Increase a network of community support services:
 - ◇ Increase in number of collaborative partners.



Artwork by Peter Millar

Positive Results

- **90** older adults were provided general system development services to assist them to remain in their home or were provided with appropriate referrals.
- **32** older adults were provided subsidized housing services along with ongoing case management services allowing them to remain in their own apartment.
- Senior Peer Counseling program has increased the number of volunteers by **45%**.
- Increased encounters with primary care providers by **20%**.
- **52%** of the older adults served were of underserved ethnic groups.
- Only one (**1**) older adult participating in the program was hospitalized for behavioral health concerns.
- Collaborative partners have increased by **54%**.



Picture caption

Community Services and Supports Programs

Success Story

“Heather”, a 60 year old Latina, presented with severe mental health symptoms of panic, auditory hallucinations, suicidal ideation and self-injurious cutting behaviors. At the end of her short term disability income and facing eviction due to her inability to pay rent, Age Wise Circle of Care supportive services assisted Heather. She engaged in individual mental health services and occupational therapy services; was stabilized on psychotropic medications; and was provided linkage to outpatient medication support services.

In addition to receiving mental health services, her support team helped her secure safe and affordable housing with Project Hope and Social Security Disability Insurance entitlements. Today, Heather enjoys a more active lifestyle where she is an active member of the community and church. She attends weekly Bible studies, religious support groups, and church services. Volunteering twice weekly at her local senior center serving lunches and participating in various events in her senior apartment community rounds out her active lifestyle. Most importantly, she learned through her journey in the program that she has the coping skills necessary to handle any of life’s future stressors, should they arise.

Challenges

Building a trusting relationship between program staff and the client is a challenge as older adults with a mental illness or a co-occurring disorder where they are homeless, at risk of being homeless, incarcerated or hospitalized, are often very distrusting of services provided by government agencies.

Accessing services due to many factors such as stigma associated with mental illness and lack of mental health education, limited funds and transportation; immigration issues; identity theft; retirement and pension benefit problems; and social security concerns are challenges that continue to affect the older adult population.

Solutions in Progress

Outreach and engagement activities are making an impact among older adults targeted by this program. As education expands and is provided, participants are exhibiting better attendance and involvement with community resources.

The Affordable Care Act has increased access to services for the treatment of medical and mental health issues.

By providing in-home therapy and case management services, older adults are able to access needed care. Access is further expanded through the provision of culturally competent services. For example, this program provides bilingual Spanish-speaking staff to work with the monolingual older adults and utilizes interpreter services for other language encounters.

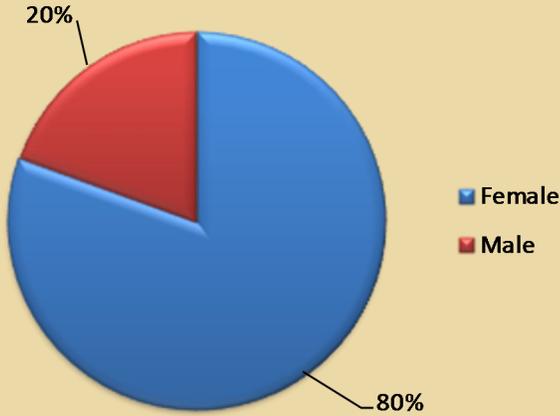


Picture caption

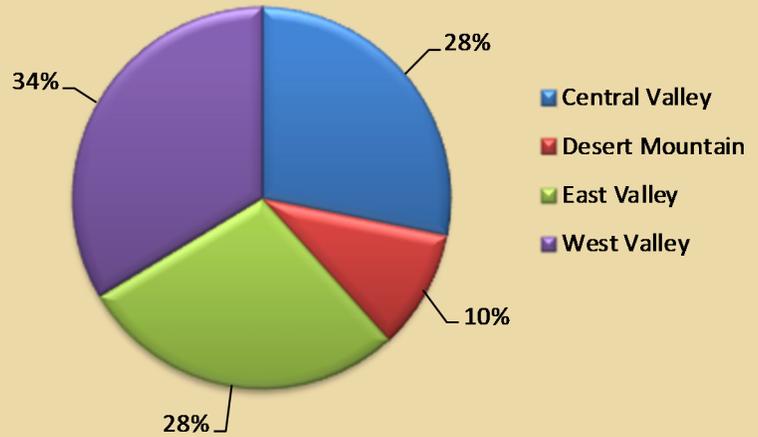
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

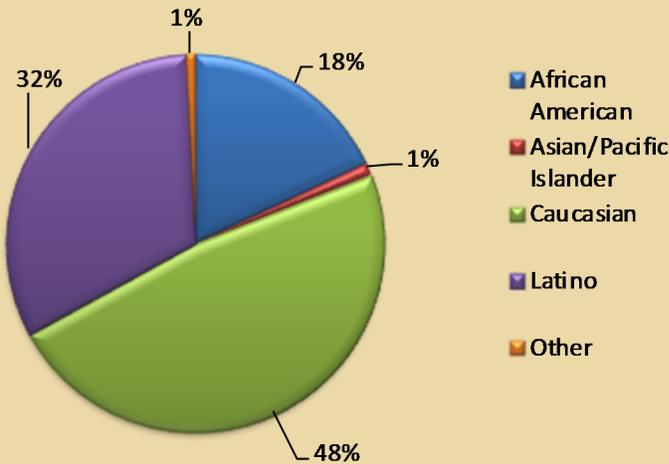
Gender



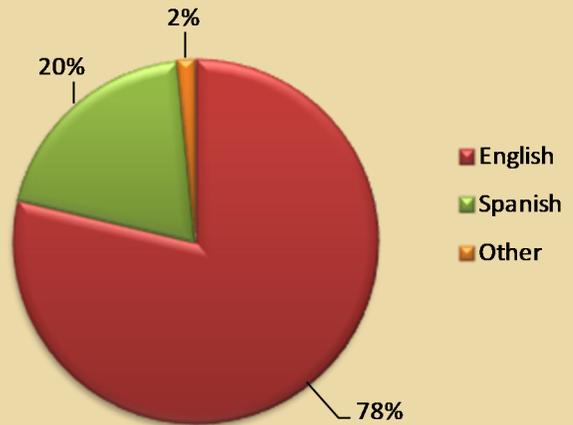
Geographic Region



Ethnicity



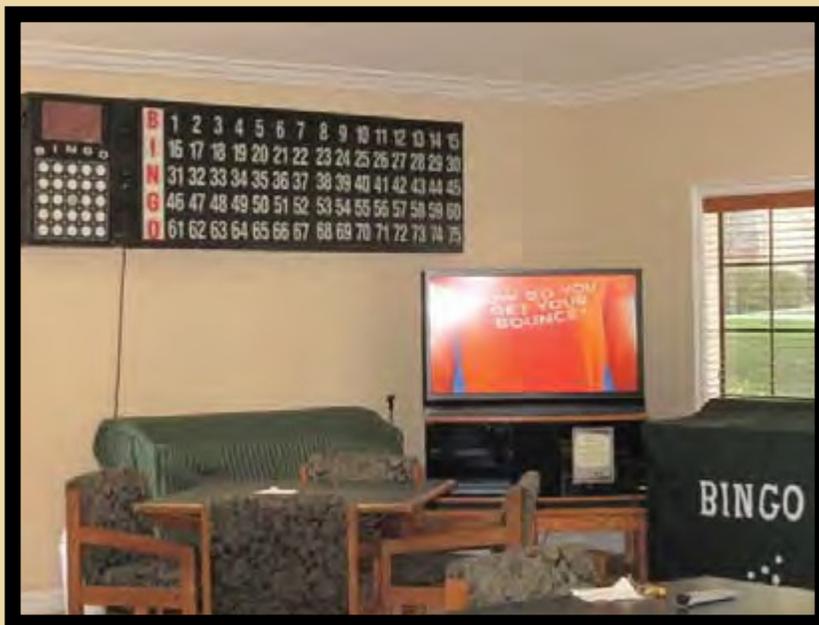
Language



Community Services and Supports Programs

Collaborative Partners

- Shield.
- Public Guardian.
- Adult Protective Services (APS).
- Senior Information and Assistance (SIA).
- Court Mental Health Counselors.
- Veterans Affairs (VA).
- Kaiser.
- Inland Empire Health Plan.
- Molina.
- Housing and Employment.
- Life Steps.
- Western Senior Housing.
- USA Properties Fund.



Community Services and Supports Programs

Mobile Outreach and Intensive Case Management (OA-2)

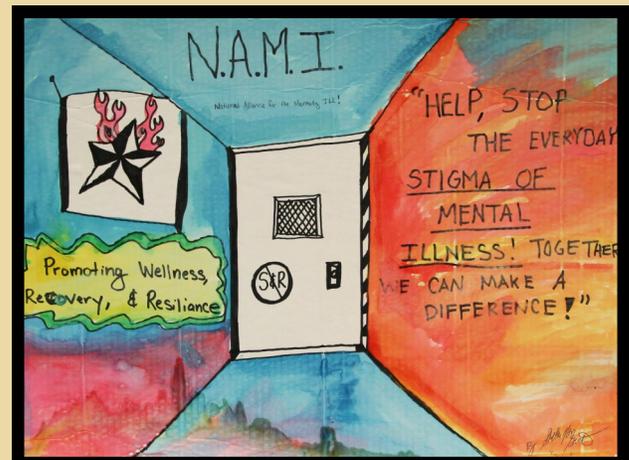
The Circle of Care program is composed of two distinct components: Mobile Outreach and Intensive Case Management.

Some of the services provided to the older adult community by Mobile Outreach are:

- Crisis response and crisis prevention.
- Comprehensive mental health and substance abuse services and referrals.
- Integrated geriatric assessment including the physical health of the older adult and its effect on their mental health.
- Assistance in acquisition of entitlements.
- Linkages and referrals for clients, their families, and caregivers.
- Transportation services to mental health, physical health, and other appointments.

The transportation service is important in helping stabilize the client in the community after a crisis situation. The older adult is often unable to drive or use public transit this causes more isolation and makes accessing DBH services difficult. These services are provided through outreach to isolated seniors in their homes, to the homeless older adults in the community, and those that are at risk of being homeless.

The multidisciplinary treatment teams go to churches, nutrition centers, senior centers and other community settings to offer services and help the community become aware of these services. The program staff provides these services to rural cities such as Barstow, Phelan, Newberry Springs, Lucerne Valley and Baker. The outreach teams participate in community multidisciplinary treatment team meetings that review older adult cases and coordinate services to assist with their needs.



Artwork by Stella Grosso

Intensive Case Management is provided through Full Service Partnerships (FSP) with clients in need of high level case management services, mental health therapy, medication support services, and senior peer counseling services. Services are designed to assist the client with their ability to manage independently in the community. Some of these services are:

- Provide 24/7 mental health services and after hours phone coverage.
- Provide Senior Peer Counseling services.
- Assist clients to develop their self-care and daily living skills.
- Coordination of mental health and medical care with primary care physicians.

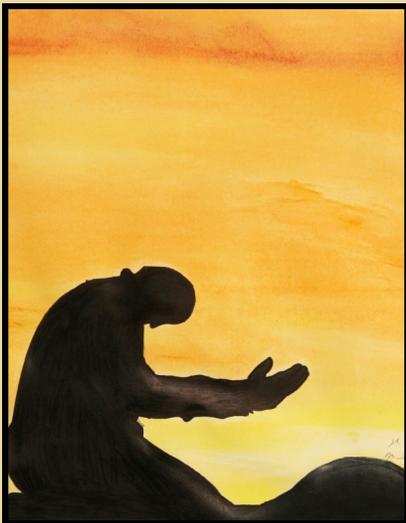
The FSP program incorporates services of the Senior Peer Counseling component where older adult volunteers go to the clients' homes and provide peer counseling, support, linkage, and referrals to needed services. They assist with form completion, appointments, visit senior centers, facilitate referrals for nutritional needs, and find resources. Peer Counselors provide outreach to the community, families, and other agencies.

All services of the Intensive Case Management/FSP program are geared toward assisting seniors to remain in their own homes, or appropriate housing, active in their communities, and pursue individualized personal goals to maintain their recovery.

Community Services and Supports Programs

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults:
 - ◇ Improved life satisfaction.
 - ◇ Decreased hopelessness / increased hope.
 - ◇ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Increase in self-help and consumer/family involvement:
 - ◇ Increase in ratio of voluntary mental health services to involuntary mental health services.
 - ◇ Increase in number of encounters with collateral contacts such as family members and informal supports.
- Increase access to treatment and services for co-occurring problems; substance abuse and health:
 - ◇ Increase in number of encounters in integrated health clinic and/or with primary care/health specialist providers.
- Reduction in disparities in racial and ethnic populations:
 - ◇ Reduction in mental health and health care disparities.
- Reduction in criminal justice involvement:
 - ◇ Decrease rate of incarcerations.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
 - ◇ Reduce number of emergency room visits for behavioral health concerns.
- Increase a network of community support services:
 - ◇ Increase in number of collaborative partners.



Artwork by Marvin Ray Toms

Target Population

- Older Adults
- Homeless or at risk of being homeless
- High users of emergency room and acute psychiatric inpatient services
- Those having difficulty accessing services due to system barriers

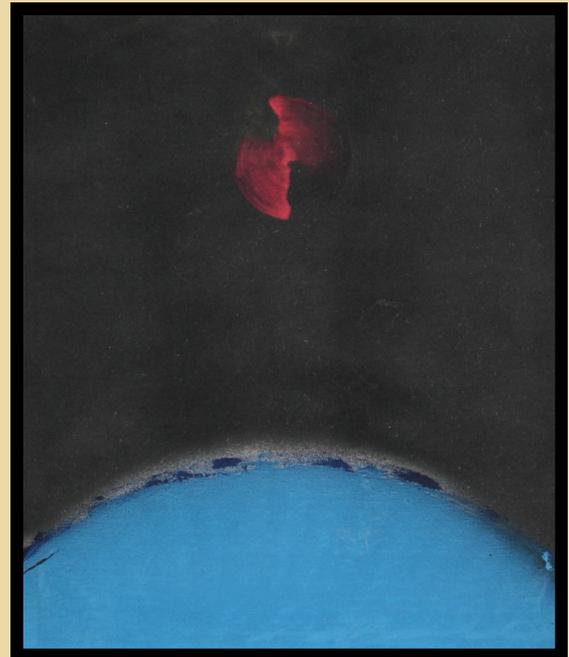
Projected Number to Be Served FY 2015/16

- 40 Older Adults

Community Services and Supports Programs

Positive Results

- Circle of Care provides full service partnership (FSP) intensive case management services and general system development to clients. During FY 2013/14, **13** full service partners were served and **23** clients were provided general system development services. With intensive case management services the older adult has support that reduces their level of distress due to their mental illness or co-occurring disorder. In addition, integrating the mental health and physical health services improves their overall functioning in general areas of life.
- Previous clients and their families account for **50%** of the referrals to the program.
- **60%** of the consumers had increased hope by the time they completed the program.
- **40%** of the consumers served were moved from temporary housing to permanent subsidized housing, decreasing their chances of homelessness.
- Collateral contacts with family members and informal supports increased by **22%**.
- Access to treatment and services for substance use and physical health concerns increased by **12%**.
- **100%** of enrolled clients were connected with a primary care physician.
- **100%** of enrolled clients with prescription substance abuse concerns have a multidisciplinary team made up of their behavioral health case manager, primary care provider(s), and family members, that provides supportive assistance for managing their prescription regimen.
- **54%** of older adults served in the program are from underserved ethnic groups.
- There were no return or new incarcerations in the Circle of Care Mobile Outreach and Intensive Case Management program.
- Only one (**1**) older adult was hospitalized for behavioral health concerns from this program. Mobile outreach and crisis staff interventions assisted in keeping older adults from utilizing emergency room and hospital services.
- Collaborative partners have increased by **54%**.



Artwork by Richard Davenport

Community Services and Supports Programs

Success Story

"Shelley" is a 65 year old immigrant from Thailand who entered the U.S. in the early 70's. Prior to receiving assistance from San Bernardino County Behavioral Health, Shelley had been homeless for 16 years. Living in and out of homeless shelters in the High Desert, working short-term jobs in exchange for shelter, and unable to maintain gainful employment since her mid 30's due to a nervous breakdown and subsequent symptoms of mental illness, the Age Wise program was there to help her. In March 2010, when her case was opened, she was homeless and jobless without any medical benefits. The Age Wise program worked closely with Shelley to update her information with U.S. Immigration Services, Social Security Administration, and other county agencies in order to apply, obtain, and maintain needed services. She was placed on Interim Assistance through San Bernardino County due to her elderly and mentally disabled status. She was temporarily placed in a Board and Care to ensure her physical safety and prevent further mental health decompensation while her Supplemental Security Income application was being processed. Without the assistance she received from the Age Wise Program, Shelley would still be homeless. Today she lives in Apple Valley in her own apartment and continues to receive services from Age Wise to help maintain her independence. Treatment goals have shifted from intensive case management and mental health stabilization to reconnecting her with her three sons and grandchildren to establish a strong support system.

Challenges

Building a trusting relationship between program staff and the client is a challenge as older adults with a mental illness or a co-occurring disorder where they are homeless, at risk of being homeless, incarcerated or hospitalized, are often very distrusting of services provided by government agencies.

Accessing services due to many factors such as stigma and lack of mental health education, limited funds and transportation; immigration issues; identity theft; retirement and pension benefit problems; and social security concerns are challenges that continue to affect

***" I was helped to get my
money situation better."
-Age Wise consumer***

Solutions in Progress

Outreach and engagement activities are making an impact among older adults targeted by this program. As education expands and is provided, participants are exhibiting better attendance and involvement with community resources.

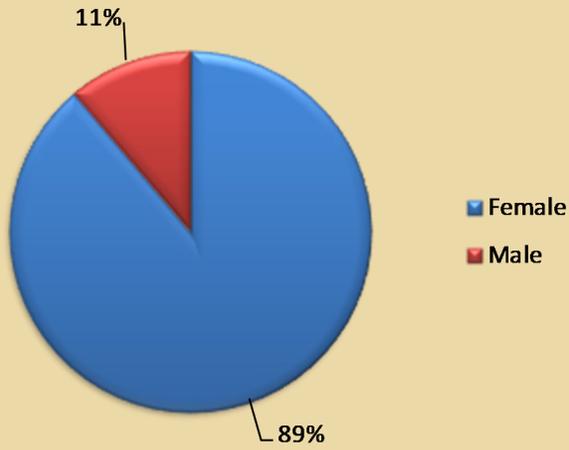
The Affordable Care Act has increased access to services for the treatment of medical and mental health issues.

Programs such as Senior Peer Counseling provide opportunities to make increased resources available to older adults in the community suffering from mental health and co-occurring disorders, who may also have physical health concerns.

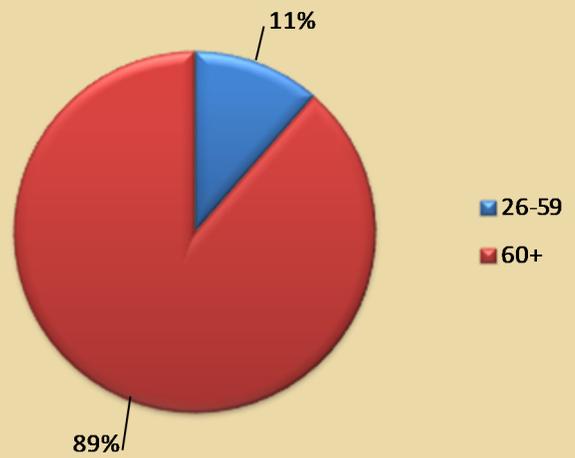
Community Services and Supports Programs

Fiscal Year 2013/14 Program Demographics

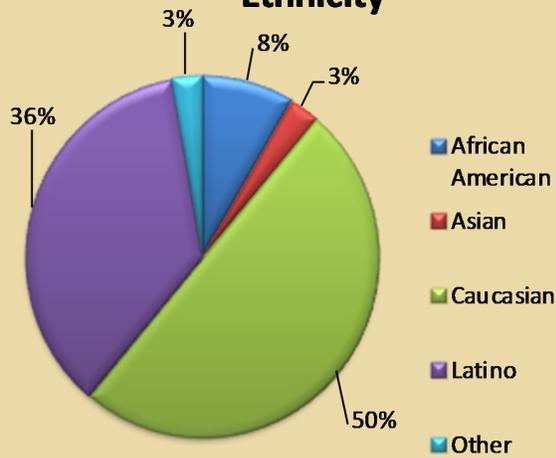
Gender



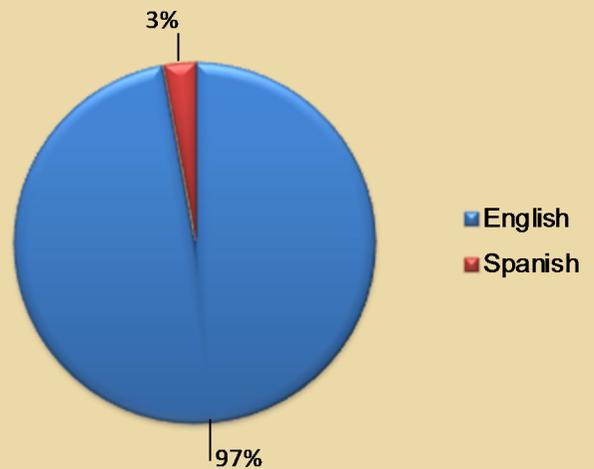
Age



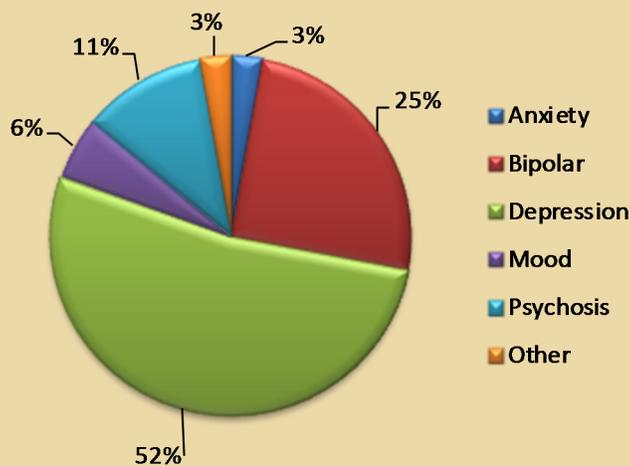
Ethnicity



Primary Language



Diagnostic Group



Community Services and Supports Programs

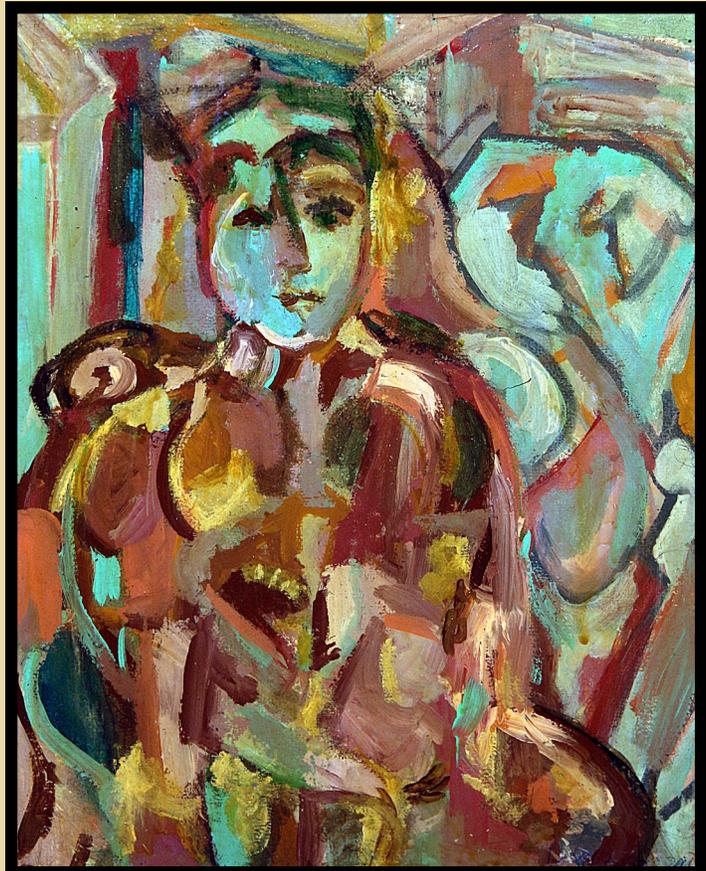
Outreach and Engagement

To identify and engage unserved individuals and communities in the mental health system and reduce disparities identified by the county, Age Wise participated in **23** community education sessions, reaching **597** potential consumers regarding early signs of potentially severe and disabling mental illness and co-occurring disorders. Age Wise made nine (**9**) contacts within the community to offer services to older adults utilizing food banks and senior centers to **233** individuals. Finally, Age Wise participated in **21** fairs and community events reaching out to **396** potential consumers in need of services.

Partners

- Shield.
- Public Guardian.
- Adult Protective Services (APS).
- Senior Information and Assistance (SIA).
- Court Mental Health Counselors.
- Veterans Affairs (VA).
- Kaiser.
- Inland Empire Health Plan.
- Molina.
- Housing and Employment.
- Life Steps.
- Western Senior Housing.
- USA Properties Fund.

*" I am not alone anymore."
-Age Wise consumer*



Artwork by Marissa Franklin



Artwork by Michael Schertell

Innovation (INN)

Introduction to Innovation

The Innovation component of the Mental Health Services Act (MHSA) is designed to test methods that adequately address the mental health needs of unserved and underserved populations by expanding or developing services and supports that produce successful outcomes. These projects are intended to be time-limited and considered to be innovative, novel, creative, and/or ingenious mental health practices that contribute to learning rather than a primary focus on providing services.

Innovation projects are designed to support and learn about new approaches to mental health care by doing one of the following:

- Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing mental health practice or approach, including, but not limited to, adaption for a new setting or community.
- Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health context or settings.



An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

- Administrative, governance, and organizational practices, processes, or procedures.
- Advocacy.
- Education and training for service providers, including nontraditional mental health practitioners.
- Outreach, capacity building, and community development.
- System development.
- Public education efforts.
- Research.
- Services and interventions, including prevention, early intervention, and treatment.

The intent of Innovation funded projects is to design, pilot, and evaluate the efficacy of new or changed mental health approaches. Thus, this component is unique, as it focuses on research and learning that can be utilized to improve the overall behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) before funding is expended.

MHSA Legislative Goals

The Innovation component seeks to implement and test time-limited, novel, creative, or ingenious mental health approaches that are expected to contribute to learning, transformation, and the integration of the mental health system.

Every Innovation project must identify one of the following primary purposes:

- **Increase** access to underserved groups
- **Increase** the quality of services, including better outcomes
- **Increase** access to services
- **Promote** interagency collaboration

Introduction to Innovation

Innovation Pending Legislative Requirements

Current Innovation Guidelines originated in 2009 from the Department of Mental Health (DMH) Info Notice #90-02. The Mental Health Services Oversight and Accountability Commission (MHSOAC) has recently proposed a revised version of the guidelines to be adopted as a replacement. The new guidelines are still pending approval before implementation begins, however some notable distinctions in the proposal that will impact the way Innovation Projects are designed and implemented include:

- A refined description of the elements necessary in any Innovation project.
- A well defined breakdown of demographic data to be collected for individuals served by the project.
- A clear distinction that Innovation Projects are to be considered time-limited pilot projects and should have an end date that is not more than four (4) years from the start date of the project.
- Successful parts of the project may continue under a different funding source or be incorporated into existing services.
- Projects may be terminated prior to planned end date.
- There is an increased focus on outcomes and evaluation.
- The inclusion of a preliminary plan regarding how it will be decided if the project will continue when Innovation funding ends.
- Defined reporting requirements.

As of the time of this report, all information is proposed and subject to change as proposed legislation goes through legislative review.



Artwork by Cindy Messer

Innovation Projects

Holistic Campus (INN - 04)

This project establishes a "Holistic Campus" that shall be at least **80%** peer run by community members and cultural brokers, including individuals representing the County's cultures, ethnic communities, the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) community and military veterans and their families in one location. This project brings together a diverse group to create their own resource networks/strategies, growing out of each of their cultural strengths. With the emphasis on peer staff running the center, in a non-behavioral health setting, and having ties to the community and resources, the holistic campus is expected to be much more accessible, culturally and linguistically competent and relevant, and community friendly. The primary purpose of the Holistic Campus project is to **increase access to underserved groups**.

In addition to having a majority of diverse peer/community member staff, the center is designed to be a hub for local and community based providers and resources. Staff is expected to establish collaborative relationships with physical health providers and community based organizations that deal with housing, employment, education and benefits issues and culturally specific healing strategies. Examples of the strategies for inclusion are cross-cultural and cross-generational opportunities such as acupressure, acupuncture, pet therapy, art therapy, music therapy, and healing circles. It is up to the Holistic Campus Advisory Board to advise the Department of Behavioral Health (DBH) which culturally specific healing strategies are needed, desired, and found to be most effective by the community. By offering services specifically requested by the community and welcoming all to the holistic campus, it is anticipated that diverse consumers will request and receive behavioral health information and services as needed without stigma.

The focus of the campus will be overall wellness, resilience and resources with traditional behavioral health entities taking a more subtle but still readily accessible role to provide behavioral health services and integrated treatment in a single setting for those consumers with identified co-occurring disorders. The total numbers served by the Holistic Campus project in FY 2013/14 is **27,391**, with **9,393** being unduplicated.

The three (**3**) contracted agencies providing holistic campus services in differing areas within the county were Victor Community Support Systems, Inc. (VCSS), Mental Health Systems, Inc. (MHS), and El Sol Neighborhood Educational Center (El Sol).

MHSA Legislative Goals and Related Key Outcomes

- To increase access to underserved groups:
 - ◊ Increased rates of underserved participating in the program in comparison to standard services.
- Promote interagency collaboration:
 - ◊ Increased collaboration by two or more agencies.
 - ◊ Improve community capacity building.

Target Populations

- Latino
- African American
- Native American
- Asian/Pacific Islander
- LGBTQ
- Veterans & Military

Innovation Projects

Project Learning Goals

The following Innovation learning goals were identified in the project description approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in February of 2010.

1. Learn about and evaluate the effectiveness of having a Holistic Campus run primarily by diverse peers/participants in cooperation with multiple community providers and resources in one centralized location.
2. Understand, define and operationalize what partnership means and what can be accomplished from a program perspective.
3. Understand how to respectfully use community resources.
4. Understand what type of support and training is needed by peer cultural brokers as well as the small percentage of clinical staff.
5. Understand what and how underrepresented cultural groups can learn from each other and how they work together.
6. Assess the benefits of joining multiple participant, stakeholder, and cultural groups into one community-driven setting to establish relevant peer support networks, resources, linkages around their distinct resources and needs.
7. Evaluate if these new approaches, in addition to the HCAB, lead to an increased access to services from those that would not normally seek traditional behavioral health services due to stigma and other cultural considerations.
8. Determine if this high percentage of culturally diverse peers, along with the availability of resources to local providers, fosters a more diverse environment and concurrently out of one location with both culturally specific and traditional healing methods.
9. Determine if our underserved, unserved and inappropriately served populations are more comfortable seeking services within a Holistic Campus setting, where the community determines the services offered, the majority of employees are peers and cultural brokers, and where DBH provides maximum flexibility.
10. Determine if this setting reduces stigma associated with behavioral health issues.



Innovation Projects

Success Stories

“The Holistic Campus team has taught me exercises that help me control myself and move on with my daily life. I feel that I can perform my daily tasks which is something that I couldn’t do previously. I am wholeheartedly grateful for the support they have given me to recover and to continue with my life. Many thanks.”

“Jaime”, a 40-year-old Veteran who was experiencing unemployment, marital problems, and expecting a new child, suffered from diminished self-esteem. He was unable to obtain the assistance he needed from the Veterans Administration and was referred to the Holistic Campus by another client. After a few months of attending equine-assisted therapy, couples therapy, seeking safety group, men’s support group, and the Ready, Set, Go group, Jaime was able to find a good-paying job, afford his own place with his wife and kids, and his marital issues were resolved.

“My road to recovery starts with the Holistic Campus. So far, after being on the streets of Ontario, California, off and on for about ten years for reasons that I am not proud of, I woke up in a jail cell realizing that I no longer wanted to live my life on the outside of society. Not knowing quite how to get back to the place that I once was before with no job, no home, and no purpose for living; I didn’t know how to go about getting to that place I was once proud of. After three months of stumbling around clean and sober, with no desire to return to a life of drugs, a fellow homeless friend suggested that I visit the Holistic Campus. I asked what they had to offer. After looking at their activity schedule, I chose the computer skills class thinking that if I knew how to use a computer it would be a good step in the right direction to obtain a job or other opportunities. Once I became more involved with the program, I found that there were more opportunities and avenues available, and I started to see hope; Not only because of the activities, but because of the staff at the Holistic Campus who allow me to participate and be a part of everyday interaction. In conclusion, I would like to

thank all the holistic Campus staff members that have helped me, encourage me and support my transformation into who I am today. I am proud to say today, I am a member of the Holistic Campus family and the chief in charge of the nutritional services here at the Holistic Campus.”



Artwork by Stella Grosso

Innovation Projects

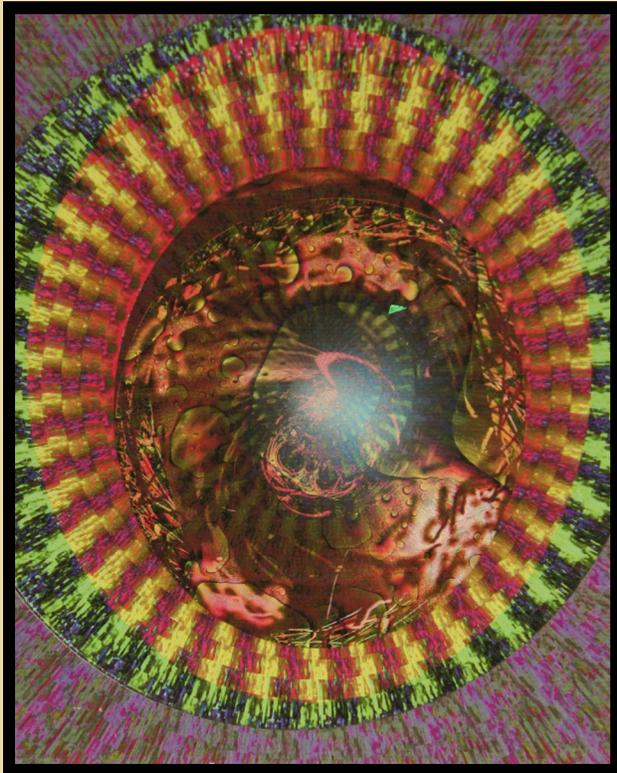
Challenges

Central Valley: There were challenges reaching out to the underserved communities in the beginning.

West Valley: The use of the holistic campus as a drop-in center, or clubhouse by homeless members was a surprising outcome as this was not the original target population, however the campus was happy to serve them. Due to the availability of resources such as access to washer/dryer use, and occasional refreshments, the homeless community became regular attendees, yet there was a reluctance to engage further in health and wellness activities.

High Desert: A particularly significant barrier to recruiting participants in the high desert is transportation. Transportation was provided for some services from the holistic campus, but participants must be able to access the holistic campus on a regular basis to ensure continuous mental health services and support.

A barrier to recruiting veterans and their families is the existing cultural belief towards mental illness. Veterans and their families who have participated at the holistic campus have been hesitant to participate in the mental health services offered.



Artwork by Peter Millar

A particularly significant barrier to recruiting participants in the high desert is geography.

-Holistic Campus staff

Innovation Projects

Solutions in Progress

Central Valley: There was success in opening doors to some Asian-American Churches, establishing a partnership with staff from the Native American Resource Center brought healing classes to the campus that were of Native American interest. Outreach conducted at events hosted by Prevention and Early Intervention (PEI) Native American Resource Center was helpful.

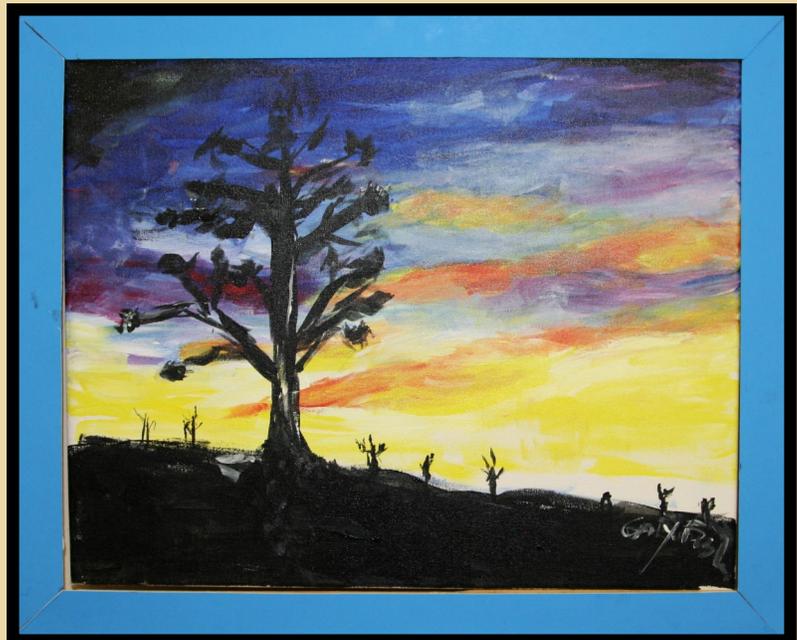
West Valley: This project is completing the evaluation phase. We have learned that we need to take appropriate measures designed to capture relevant data at the onset of the project in order to effectively measure the impact that an Innovation can make on the mental health system of care. The office of Innovation, DBH Research & Evaluation, along with the holistic campus contractors, have been collaborating on data verification and analysis for the lifetime of the project. The focus will be to evaluate the outcomes of the project and to measure “how and if” we have “increased access to underserved groups”.

High Desert: To capture the clients on a “walk-in” basis, a policy of flexibility was implemented, allowing staff to provide services on an as needed basis, schedule times to provide services, and not to cancel scheduled group services. It is crucial to address the services on demand to build trust in the community.

To address the challenge in reaching Veterans and their families, the holistic campus hosted a Veteran Resource and Employment Fair in collaboration with the Employment Development Department (EDD). This event brought in **34** new veterans. It is hypothesized that the employment portion of the fair was the most important element in recruiting veterans.

Planned Ending and Challenges

Learning from an Innovation project is experienced throughout the process. The uniqueness of having a project that has a known end date, makes implementation of an Innovation project more challenging than other programs, as planning for the transition of clients to similar services must be a consideration with service oriented projects like the holistic campus. Time must be allotted for the “ramp-down” of services and there must be a commitment from all partners to transitioning clients with a warm handoff to local comparable services. It is important to place an emphasis on the short-term aspect of the project when communicating with stakeholders. Equally important is that contracted vendors understand the research-oriented nature of an Innovation project.



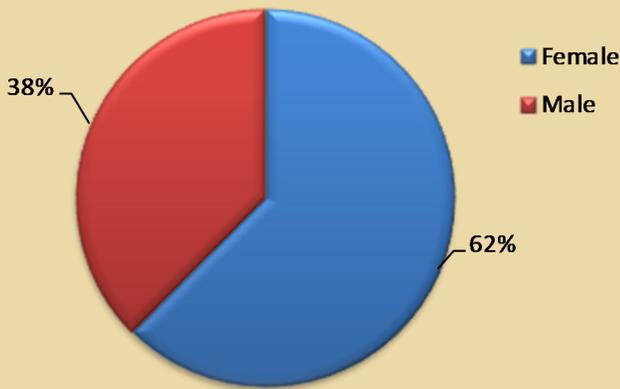
Artwork by Gary Bustin

Innovation Projects

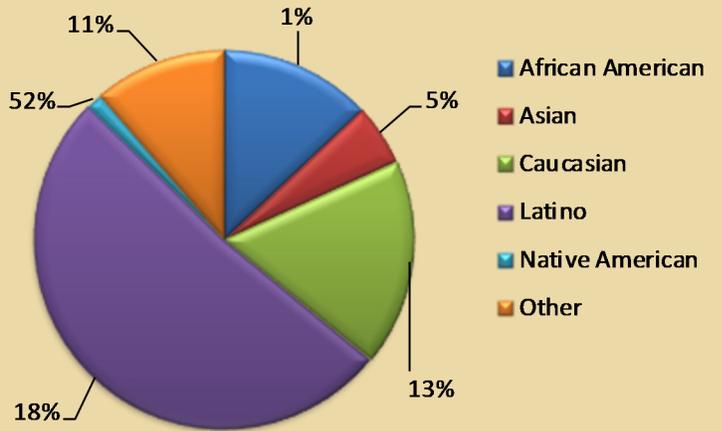
Fiscal Year 2013/14 Project Demographics

The following table is a representation of the underserved populations served by the Holistic Campus project (Central Valley, West Valley, High Desert) for FY 2013/2014.

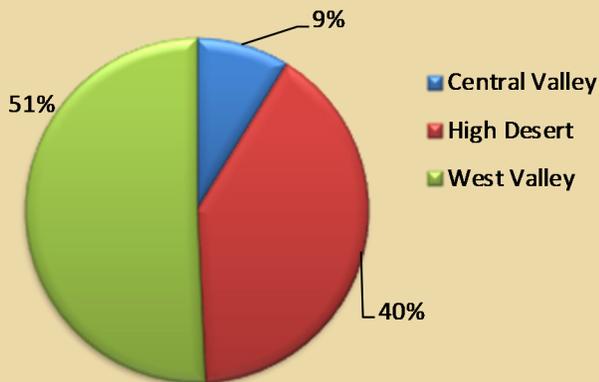
Gender



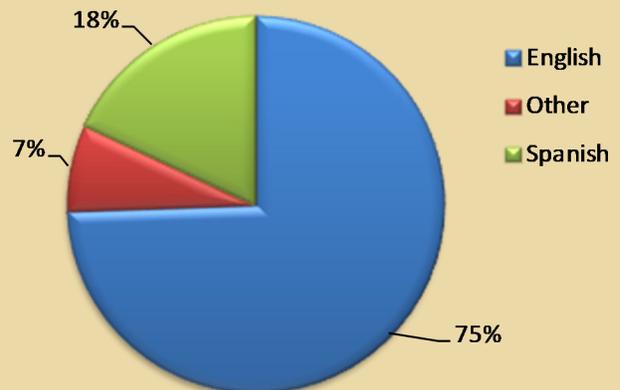
Ethnicity



Number Served By Region



Preferred Language



Innovation Projects

Other Information

As the holistic campus projects comes to completion in June 30, 2015, the Department of Behavioral Health (DBH) Office of Innovation will evaluate the overall effectiveness of the project based on final reports submitted by all three providers, data that was collected and analyzed, as well as survey data collected throughout the span of the project. The holistic campus final report will be submitted in the MHSA Annual Update Fiscal year 2016/17.

Collaborative Partners

The following agencies are the collaborative partners for the Holistic Campus project:

- Bienestar.
- Church of Second Chances.
- Leading Edge Educational Foundation.
- Ontario Wheel House, Salvation Army.
- 12 Step Community.
- Another Chance Foundation.
- Lighthouse Restoration.
- Victorville Rescue Mission.
- Family Assistance Program.
- St. John of God.
- Healthy Victorville.
- Native American Resource Center.



Holistic Campus Grand Opening Central Valley, January 2013

Innovation Projects

Interagency Youth Resiliency Team (INN - 05)

The Interagency Youth Resiliency Team (IYRT) project is an intensive trauma informed, culturally appropriate mentoring project developed to more meaningfully connect system involved youth with supportive adults and increase their ability to successfully transition to independence. The primary purpose of the IYRT project is to **increase access to underserved groups**.

IYRT assesses a youth's strengths/needs, assists them in establishing meaningful connections, and identifies individual goals, activities and experiences they need to complete prior to transitioning to adulthood. IYRT services are provided to underserved and inappropriately served system involved youth who are dependents of the Children and Family Services (CFS) foster care system, wards of the court that are being supervised by the Probation Department, and youth at risk of system involvement.

Services provided to IYRT mentees include but are not limited to: one-to-one and group mentoring, assessment, evaluation, collateral, case management, plan development, and linkage and consultation. Services target five (5) main

domain areas for youth: education, employment, enduring connections, housing, and physical health/mental health. Mentoring services are also offered to the caregivers/resource providers of the youth, provided by mentors with the lived experience of being a caregiver for at-risk youth, in an effort to increase positive outcomes. The project also provides training to child serving professionals to help increase their knowledge and understanding of system involved youths issues of grief, loss, environmental trauma, exposure to violence, gangs, child abuse, exploitation, neglect, and the dependent/ward system.

IYRT employs mentors who are former foster or probation youth, who understand the unique difficulties and dynamics inherent in being system involved through their own lived experience. By appropriately matching mentors with mentees, culturally appropriate, intensive, trauma-informed mentoring services are provided to youth and their caregivers/resource providers, involved with (or at risk of being involved with) the foster care and/or probation systems.

IYRT services are currently being delivered by three separate agencies who developed their own curriculum, while still meeting regularly to ensure a cohesive standard of services. The three (3) contracted agencies, EMQ Families First, Inc., Valley Star Children and Family Services, Inc., and Reach Out, serve differing areas within the County. Innovation funding is projected through June 30, 2015.



Artwork by Gerardo Huante

Target Populations

- Youth in foster care
- Youth on probation
- Youth at risk of involvement in either system

Innovation Projects

MHSA Legislative Goals and Related Key Outcomes

- Increase access to underserved groups:
 - ◊ Increase rates of underserved participating in the program.
- Increase quality of services, including better outcomes:
 - ◊ Regular collection, analysis, and reporting of data to improve the program.
- Promote interagency collaboration in:
 - ◊ Increase collaboration by two or more agencies.



Artwork by Sarah Favorite

Project Learning Goals

The following learning goals were identified in the INN project description approved by the Mental Health Oversight and Accountability Commission (MHSOAC):

1. To increase the understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth.
2. To learn if the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system".
3. To learn if the reality of being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief, loss, and trauma.
4. To learn if a team that includes three major county departments (DBH, CFS and Probation), and countless youth serving programs succeeds in addressing the issues of grief, loss, exposure to violence and environmental trauma experienced by these children.
5. To learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues.
6. To learn if the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project.
7. To learn if the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors.
8. To develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner.
9. To learn if Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training.
10. To learn if the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes.

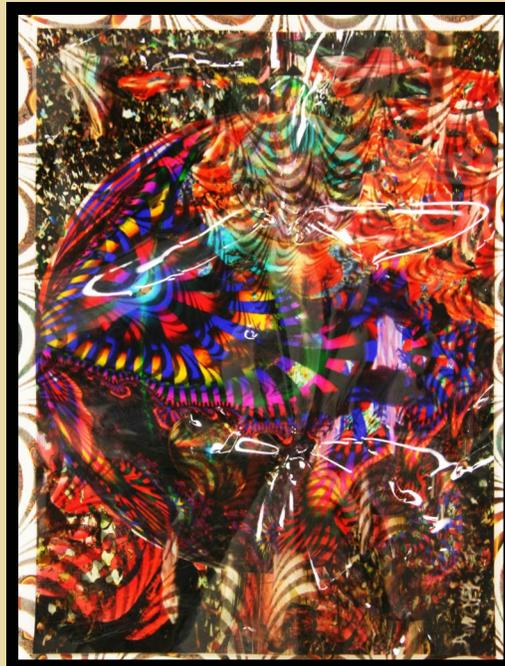
Innovation Projects

Positive Results

The IYRT project served a total of **240** unduplicated youth during FY 2013/14. This includes **136** CFS only youth, **36** Probation only youth, **22** youth who were involved with both CFS and Probation, and **46** youth who were at risk of becoming system involved.

Listed below are more results from the project.

- Effectively increased access to system-involved youth: **57%** identified as foster youth, **15%** identified as juvenile justice involved, and **9%** identified as both foster youth and juvenile justice involved.
- Effectively increased access to youth at-risk of system involvement, **19%** identified as at-risk for system involvement.
- Provided educational services to **177** caregivers and resource providers to increase positive outcomes for youth.
- **67%** of youth had an identified social functioning concern that was resolved by the time they completed the program.
- **80%** of youth increased their resiliency through the program.
- **67%** of youth had difficulty with adjustment to trauma that was resolved by the time they completed the program.
- Successfully brought together **29** youth-serving agencies from across the county to work together serving the individual needs of youth, caregivers, and resource providers in the program's five main domain areas, education, employment, enduring connections, housing, physical health/mental health, and generate appropriate referrals.
- Partnered with Wells Fargo to provide financial education where **82** IYRT participants and staff participated in money management and credit building trainings.
- Collaborated with the City of Ontario Parks and Recreation to utilize the Veterans Memorial Park Community Center for program activities. With the numerous amenities like walking trails, basketball courts, outside exercise equipment, and an indoor kitchen, the park provided a great resource for mentor-mentee sessions, and teaching youth about physical and mental health self-care.

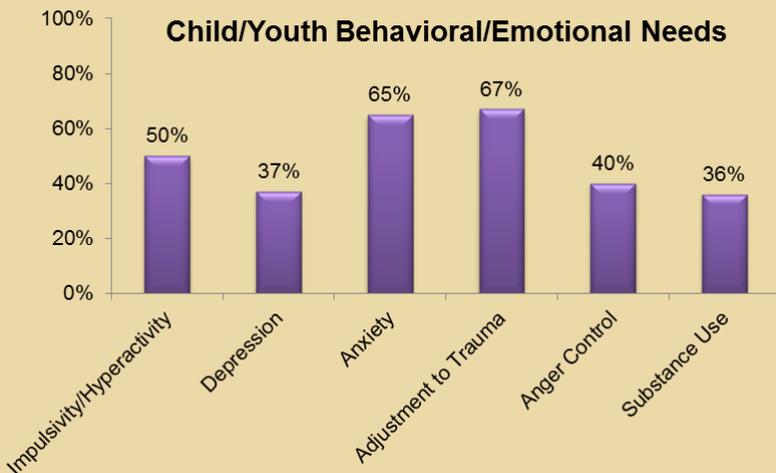
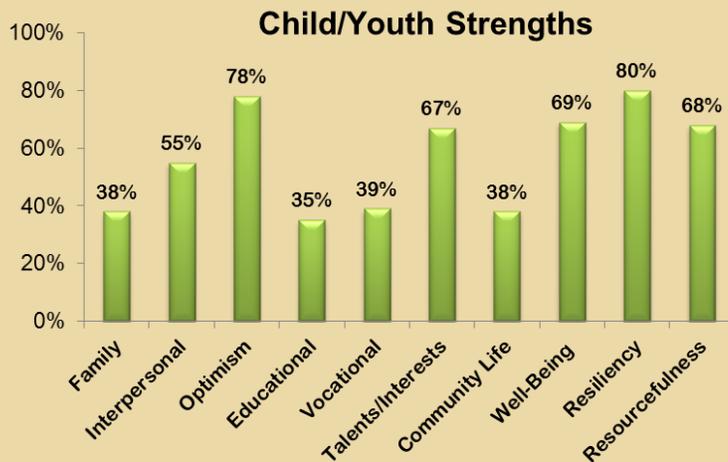


Artwork by Peter Millar

Innovation Projects

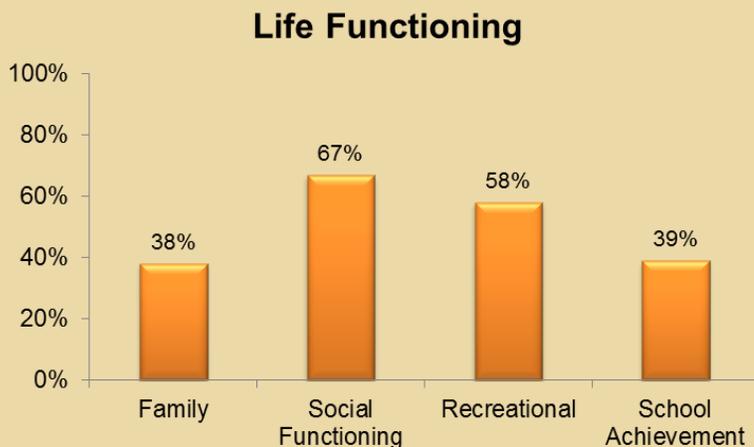
The outcomes are measured through review of client demographic, episode and service information and analysis of the Child Adolescent, Needs and Strengths Assessment-San Bernardino (CANS-SB) which are completed at designated intervals.

The graph to the right represents the percentage of youth who presented with a significant issue on an item within the Strengths domain, and had this issue resolved by the completion of the program.



The graph to the left represents the percentage of youth who presented with a significant issue on an item within the Behavioral/Emotional Needs domain, and had this issue resolved by the completion of the program.

The graph to the right represents the percentage of youth who presented with a significant issue on an item within the Life Functioning domain, and had this issue resolved by the completion of the program.



Innovation Projects

Success Stories

EMQ Families First

“Frank” has come a long way from when he first entered the program. He has been able to take a step back and take a look at the things he wants to accomplish and set a plan on how to achieve his goals. His mentor worked with him on staying positive and supported him through his highs and lows. He was also able to better the relationship with his siblings and parents through sharing his feelings and finding alternative ways to solve some of problems that they faced at home. Frank struggled with being patient while waiting for his work visa to come, and had doubts that it was even going to come. Working with his mentor helped Frank take his mind off the things that he couldn't control and helped him focus on getting ready for his visa to come. *“My mentor helped me with staying positive when I thought there was no hope.”* Frank stated when he finally got his work visa.

Frank has learned a lot from being in the program and working with his mentor. Not only has Frank attained his work visa and social security card, but he found a job and has started working. The future is full of promise for Frank. He is still working on finishing his GED, his priority now that he has a job, and he plans to get his drivers license and save money to buy a car.

We are so proud of Frank. So far he's had a rough road in life, but he has shown the motivation and dedication to want to go far in his life and now has the tools to get there.

***“My mentor helped me with
staying positive when I thought
there was no hope.”***

- IYRT mentee

Reach Out

One of our youth mentees provided the dorm room tour during the college Scavenger Hunt at California State University, San Bernardino (CSUSB). The previous year, she was given a tour of the dorms at Cal Poly Pomona and now this program year, she is the tour guide. She never imagined she could attend college but shared thanks to the TEAM program and her mentor, as she now attends the same college as her mentor!

***“I do not know where I would
be if it was not for my
mentor's kindness.”***

- IYRT mentee

Innovation Projects

Valley Star Children and Family Services

The following success story is from a caretaker mentee who has a youth participating in the IYRT project who also received mentoring services from a caretaker mentor with lived experience.

“I had a dirty secret, I did not have a high school diploma. I was in corporate America for over 20 years and when I got laid-off and I could not find a job, because I did not meet the minimum education requirements. I was too embarrassed to tell anyone or ask for help. I was behind on my bills, and was in danger of losing my home. I was afraid I would not be able to take care of my kids. Luckily, I had a great mentor who listened and did not judge me. My mentor took me down to the Adult School and supported me emotionally as I passed my GED, telling me I could do it. I am now completing my nursing program and looking forward to getting back out into the work force. I do not know where I would be if it was not for my mentor’s kindness.”

Challenges

- Difficulty conducting the IYRT project in the rural and remote areas, including the High Desert, due to the lack of mentors, transportation issues, and struggles to generate appropriate referrals.
- Conducting collaborative communication with referring agencies.



Artwork by Peter Millar

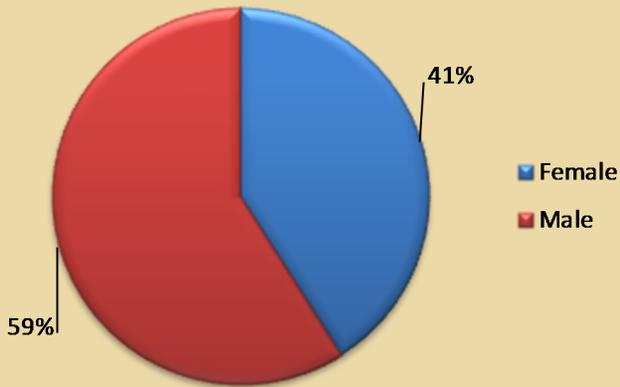
Solutions in Progress

- IYRT providers extended services to youth from the High Desert who could make transportation arrangements to participate in IYRT events in the Central Valley. No youth from the High Desert were enrolled in IYRT mentoring services.
- The IYRT contractors meeting was merged with the service providers and the community partners to form one workgroup which met on a monthly basis and included Children and Family Services (CFS) and the Probation Departments to address communication and referral related issues.

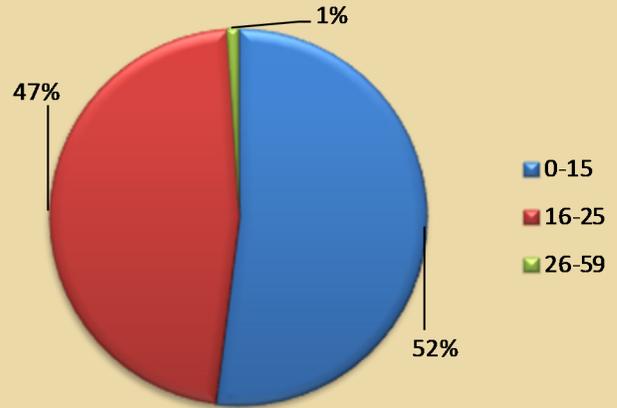
Innovation Projects

Fiscal Year 2013/14 Project Demographics

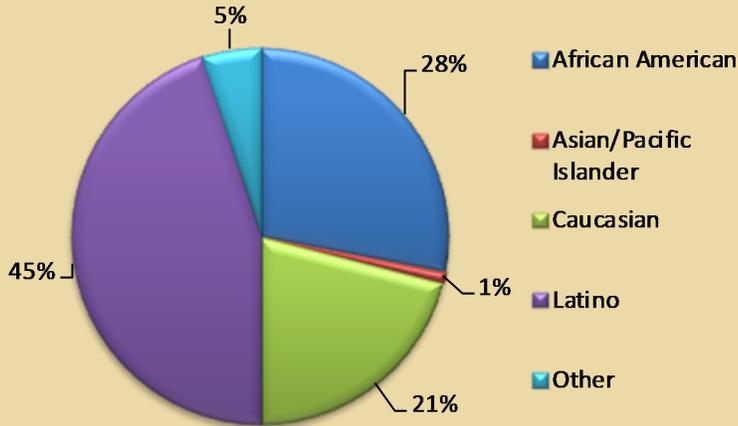
Gender



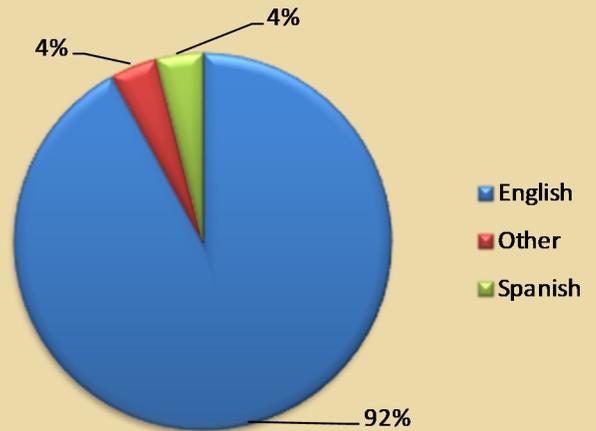
Age



Ethnicity



Language



Innovation Projects

Collaborative Partners

The following agencies are the collaborative partners for the IYRT project:

County of San Bernardino Partners:

- Department of Behavioral Health (DBH).
- Department of Children and Family Services (CFS).
- Department of Probation.
- Workforce Investment Board.
- Children's Network .

Community Partners:

- Gang Reduction Intervention Team.
- Valley Star Family Resource Center.
- Valley Star Crisis Residential Treatment Center, The STAY.
- Valley Star High School.
- Oasis Harmony Center.
- Washington High School.
- San Bernardino Police Department, Crime Intervention Partnership.
- California State University, San Bernardino.
- Young Visionaries.
- Brightest Star Inc.
- City of Colton.
- Wells Fargo.
- Rialto Unified School District.
- El Sol Neighborhood Educational Center.
- National Association of Social Workers, California Chapter.
- Victor Community Supports Services, Group Homes.
- San Bernardino County Superintendent of Schools, Foster Care Services.
- San Bernardino Valley College, EOP Program.
- CARS Mentoring Program.
- City of Ontario, Parks and Recreation.
- Cal Poly Pomona.
- Chaffey College.
- University of California, Riverside.
- West Coast University.
- East Valley Charlee.



Artwork by Chuck Ayala

Innovation Projects

Transitional Age Youth Behavioral Health Hostel (INN - 06)

The Transitional Age Youth (TAY) Behavioral Health Hostel, named The STAY by it's advisory board, is a short-term, **14-bed**, crisis residential treatment program for the Transitional Age Youth (TAY) population between the ages of **18 to 25**, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization. Services are designed to be culturally and linguistically appropriate crisis stabilization services, with particular emphasis on diverse (African American, Latino, LGBTQ youth, etc.) former system-involved youth. The STAY is designed to be **80%** peer run, by individuals representing the County's diverse ethnic communities and cultures. The program is currently contracted and services are being provided by Valley Star Children and Family Services, Inc. (Valley Star). The primary purpose of The STAY is to **increase access to underserved groups**.

Valley Star has developed a psychiatric rehabilitation program for The STAY that is a comprehensive and multidisciplinary/ interdisciplinary program designed to meet the following objectives:

- Improve residents' adaptive functioning through their acquisition of skills essential for successful independent or semi-independent living in the community (less restrictive environment).
- Prevent residents' regression to a lower level of functioning through their acquisition of skills essential for not returning to a higher level of care (acute or State hospitalization).

Services include therapeutic and psycho-educational groups and activities that include focuses on daily living skills-training, behavioral intervention/modification training, individual and group counseling, crisis intervention, medication support, drug and alcohol counseling/referrals, recreational therapy, educational assistance, and pre release and discharge preparation and planning.

The program bases itself within a structured, consistent therapeutic milieu designed to enhance the self-images of the residents and to promote health, and supportive interactions among the residents and staff. The multidisciplinary design includes diverse input from the psychiatric, nursing, social service, vocational, and recreational activity disciplines.



Artwork by Peter Millar

Target Populations

- Former system involved youth
- LGBTQ
- African American
- Latino

Projected Number to be Served FY 2015/16

- 96 youth

“It takes courage and hard work to become well.”

- STAY resident

Innovation Projects

MHSA Legislative Goals and Related Key Outcomes

- Increase access to underserved groups:
 - ◊ Increase rates of underserved participating in the program.
- Increase quality of services, including better outcomes:
 - ◊ Regular collection, analysis, and reporting of data to improve the program.
 - ◊ Improved year-over-year outcomes.
- Promote interagency collaboration:
 - ◊ Increase collaboration by two or more agencies.
- Increase access to services:
 - ◊ Increase number of clients served.

Project Learning Goals

The following learning goals were identified in the project description which was approved by the Mental Health Oversight and Accountability Commission (MHSOAC):

1. Learn about and evaluate the effectiveness of having a TAY Behavioral Health Hostel run primarily by diverse peers.
2. Learn if the innovative application of culturally specific crisis stabilization services is an effective model.
3. Learn what type of support and training is needed for diverse peer staff to effectively provide a culturally & linguistically appropriate peer run Behavioral Health Hostel.
4. Evaluate if these new approaches, in addition to the Peer Advisory Board leads to increased access to services and better outcomes with regards to crisis stabilization.
5. Determine if the high percentage of culturally diverse peers along with the availability of resources to local providers fosters a more diverse environment in which multiple cultures within the TAY population can be served appropriately and concurrently out of one location with both western and traditional healing methods.
6. Determine if our unserved, underserved, and inappropriately served TAY populations are have better outcomes while seeking crisis stabilization services in a Behavioral Health Hostel where the community determines the services offered, the majority of employees are peers, and where the County provides minimal direction.
7. Assess the benefits of joining multiple consumer, stakeholder, cultural groups into one community-driven setting to establish relevant peer support networks, resources, linkages around their distinct resources and needs.
8. Learn if the identification and implementation of models to address issues of grief, loss, identity, and environmental trauma help to facilitate crisis stabilization with former system involved youth.
9. Learn if new innovative policies and procedures around the housing of LGBTQ TAY can help facilitate the crisis stabilization process for these TAY.
10. Learn the impacts of innovative policies and procedures around the housing of LGBTQ TAY on TAY who do not identify as LGBTQ.

“Because of The STAY I am a better person today than I was yesterday and even more prepared for greatness for tomorrow!”

- STAY resident

Innovation Projects

Positive Results

Since the project's inception in FY2012/13, The STAY has successfully increased access to crisis residential treatment services to the underserved TAY population. In FY 2013/14, The STAY specifically increased services to youth who identify as LGBTQ, Latino, or African American, and youth in or at-risk of involvement in the juvenile justice or foster care systems.

The STAY project served a total of **88** unduplicated youth during FY 2013/14. This includes **30** African American youth, **30** Hispanic youth, **38** LGTBQ youth, and **40** System involved youth. Of the **40** system involved youth, there were **22** CFS, **11** Probation, and **7** who were both CFS and Probation.

10 STAY clients successfully transitioned to One Stop TAY Center Full Service Partnerships (FSP). FSP services include housing assistance.

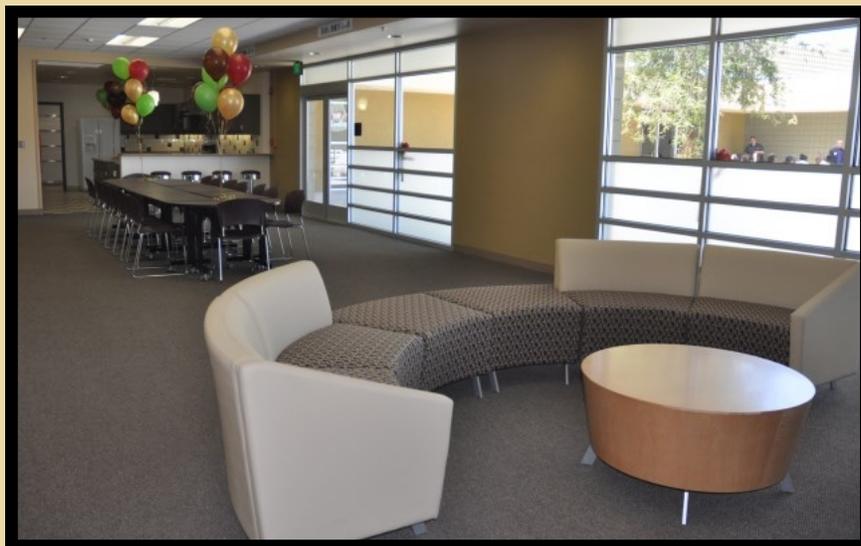
Increase Access to Services and Increase Access to Underserved Groups

The STAY is the only project of its kind as it has increased access to Crisis Residential Treatment (CRT) services to **88** underserved TAY county residents and serves as a model for future CRT's.

Promote Interagency Collaboration

The STAY worked with seven (**7**) collaborative partners during FY 2013/14 to address the needs of youth enrolled in The STAY. As a result of the collaborations, The STAY has more resources to assist their residents in transitioning to lower levels of care, appropriate care (i.e. substance abuse treatment) and reintegrating back into the community.

Example: The San Bernardino One Stop TAY center collaborates with The STAY in linking and referring residents with co-occurring disorders to Residential Substance Use Disorder Treatment Services (i.e. Cedar House, DBH contractor) ensuring clients get the most appropriate care.



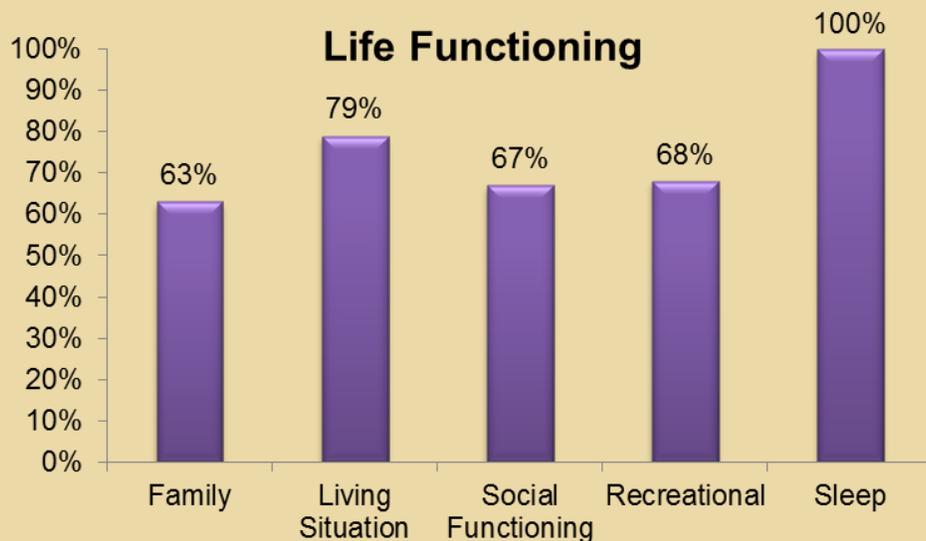
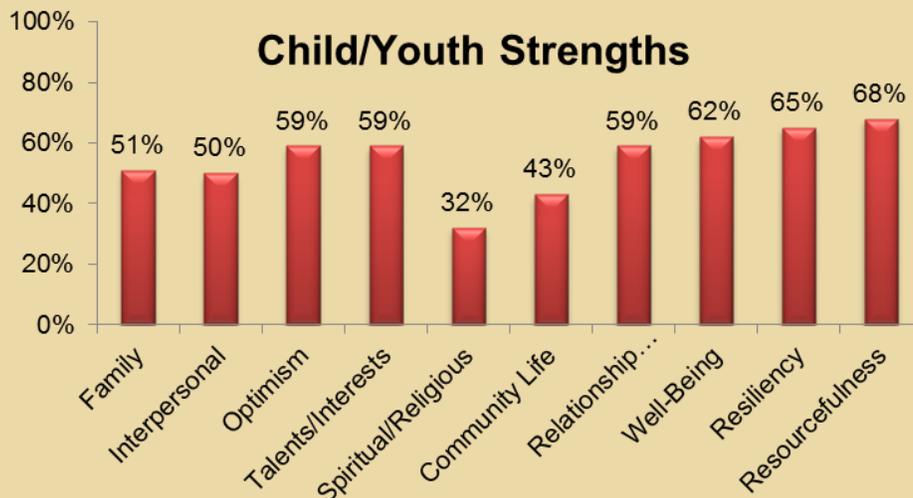
Innovation Projects

Increase Quality of Services, Including Better Outcomes

All of the residents at the STAY participate in completing a Child and Adolescent Needs and Strengths (CANS-SB) assessment at time of enrollment and discharge from the STAY. The assessment identifies the youth's difficulties, needs and strengths.

The following graphs represent the percentage of youth who presented with a significant issue on a specific item within that domain, and had the issue resolved by the completion of the program or had built resiliency in the domain.

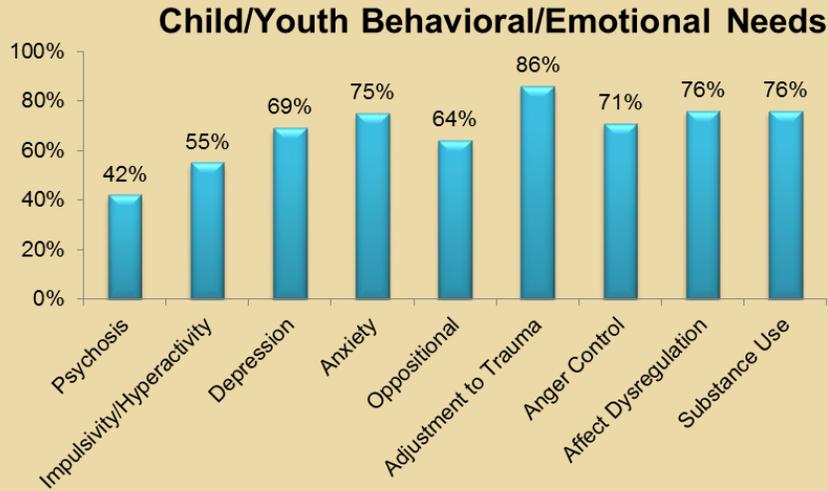
The graph to the right represents the percentage of youth who presented with a significant issue on an item within the Strengths domain, and had this issue resolved by the completion of the program.



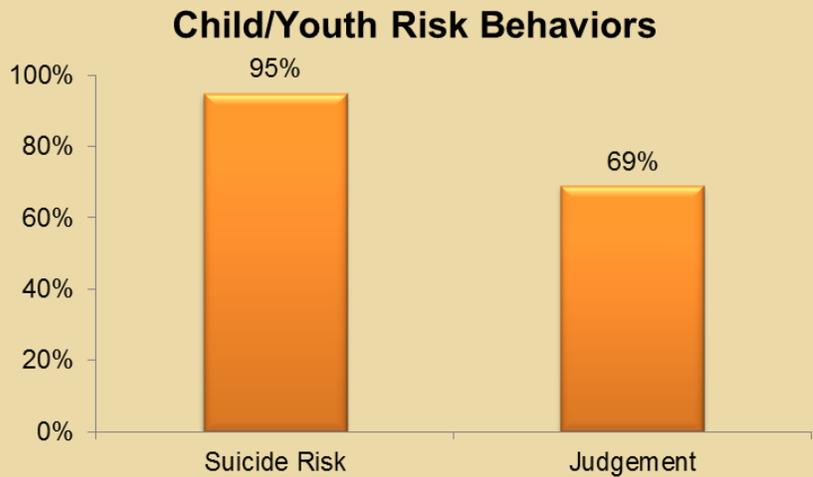
The graph to the left represents the percentage of youth who presented with a significant issue on an item within the Life Functioning domain, and had this issue resolved by the completion of the program.

Innovation Projects

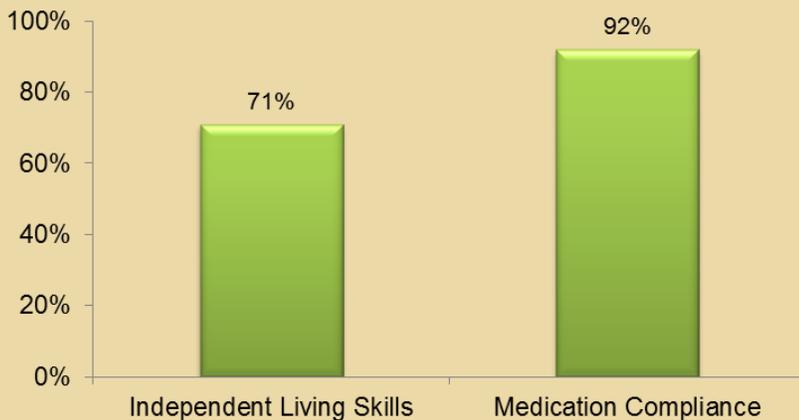
The graph below represents the percentage of youth who presented with a significant issue on an item within the Behavioral/Emotional Needs domain, and had this issue resolved by the completion of the program.



The graph to the right represents the percentage of youth who presented with a significant issue on an item within the Risk Behaviors domain, and had this issue resolved by the completion of the program.



TAY Module

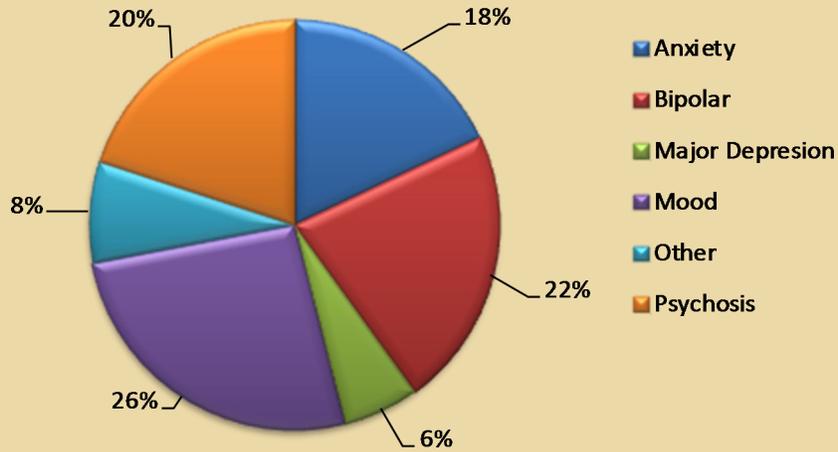


The graph to the left represents the percentage of youth who presented with a significant issue on an item within the TAY module, and had this issue resolved by the completion of the program.

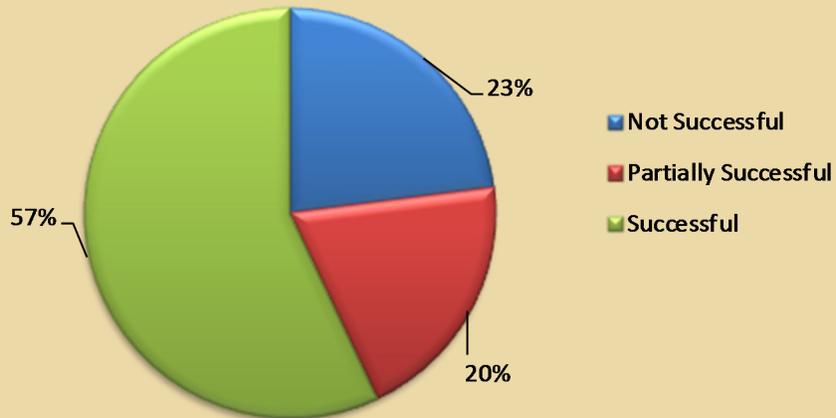
Innovation Projects

The graphs below identify the diagnosis of TAY and the treatment progress obtained by the completion of the program.

Diagnosis



Treatment Progress



Innovation Projects

Success Story

My name is “Wendy” and when I came to The STAY I had a lot of problems to solve in my life. I came from a homeless shelter and had just graduated from high school. I didn’t have many family supports who could help me accomplish my goals. I had a lot of anxiety about where my life was going to go and no one to work on it with. I always knew I needed therapy but never had the resources to get it. I felt like I had mild depression from all the trauma I experienced in my life and needed support for that.

On my first day at The STAY I was sad because it was my birthday and I didn’t know where I was going to sleep that night. When I found out I was accepted into the program I was excited and felt like it was my birthday present.

One of the things I appreciated greatly was that The STAY allowed me to continue participating in my basketball team. They encouraged me to continue focusing on basketball and were able to help transport me to basketball workouts at various community colleges. Also, The STAY provided me with transportation to my part time job that I had already had before The STAY. This allowed me to save money and plan for my future. The Recovery Counselors really encouraged me to work towards getting an even better job that pays more and where I could continue growing professionally.

Overall, I learned a lot about myself in therapy. I was able to learn how to control myself, why I do the things I do, and it helped me understand my behaviors. I was able to learn the negative pattern of my behaviors and the way I act in relationships. I learned the way I handled stress, anxiety, sadness, and anger was typically to isolate myself and refuse to do anything people told me to do. Now I am able to express my feelings more frequently by using my words and not expressing my feelings through unhealthy behaviors. I was able to learn healthy coping skills, especially in WRAP group. I learned a lot about independent life skills such as budgeting and separating “I want vs. I need.”

The Recovery Counselors really motivated and inspired me to break some of my bad habits I had before I came here; such as sleeping until noon, refusing to participate in chores, and organizing my work, school, and basketball schedule. I made a lot of growth at The STAY in a short 3 months that is really going to help me out with the rest of my life.

On my last few days at The STAY, a lot of the staff shared how much they would miss me and how much they appreciated my presence in the building. The majority of the residents also shared that they would greatly miss me and said I was a good role model and positive influence towards them. I was really excited to be moving forward towards my future, independence, and completing a stepping stone in my life. For the first time in my life I had no anxiety about where I was going next. I know I will be successful with the life skills The STAY has equipped me with; such as keeping to a routine, organizing my schedule, daily living skills, and exercise.

Something I always told myself was, “This might be the story today, but it will not be the story of my life.” The STAY helped me improve my chances to turn my dreams into reality!

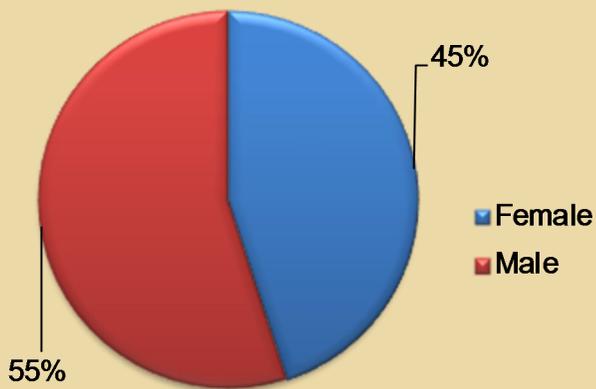


Artwork by Peter Millar

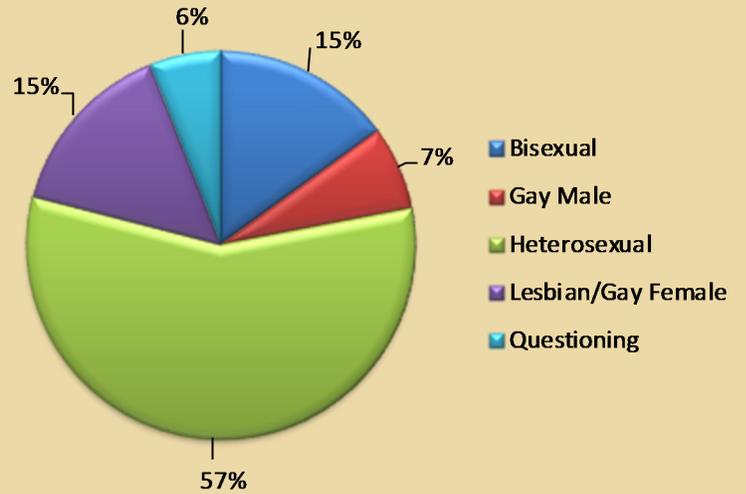
Innovation Projects

Fiscal Year 2013/14 Project Demographics

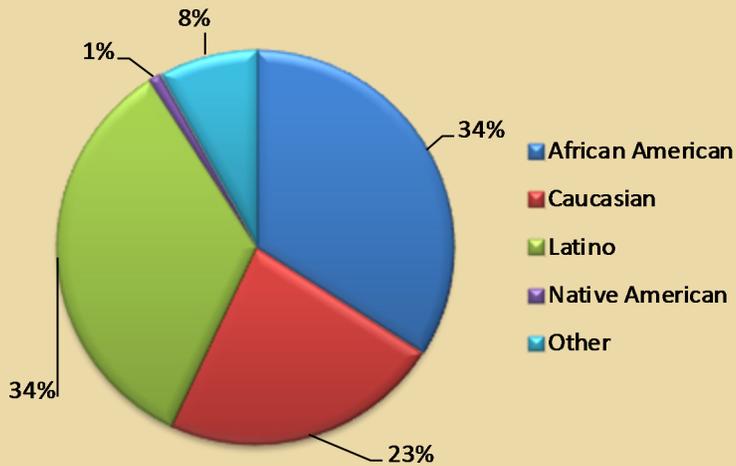
Gender



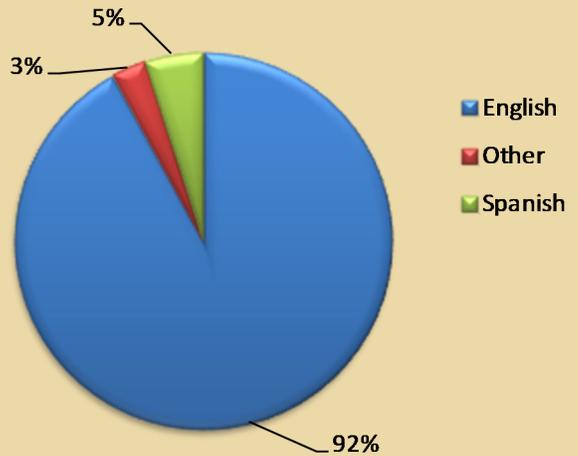
Sexual Orientation



Ethnicity



Language



Innovation Projects

Outreach and Engagement Events

Outreach and engagement events were conducted throughout San Bernardino County during FY 2013/14 to share with the community how The STAY is impacting the TAY population. Below are the events conducted:

- Four (4) Community Meetings and Presentations where **24** people attended.
- One (1) STAY Open House attended by **75** people.
- Five (5) STAY Facility Tours for **11** people.
- One (1) Community Event for HOPE Program Open House where **100** people attended.
- One (1) DBH EXPO where **150** people requested program brochures and additional information.

Challenges

- Community partners and referring agencies continue to provide referrals for youth in need of housing only and not for mental health crisis services.
- Limited availability of appropriate housing placements for residents after discharge.

Solutions in Progress

- The STAY Clinical Manager and Program Manager continue to educate referral sources on The STAY's admission process and the requirements in order to meet criteria for the program.
- The STAY Clinical Manager works closely with the San Bernardino One Stop TAY Center Clinic Supervisor to ensure discharging residents have housing resources after discharge.
 - ◊ The One Stop TAY center assists in linking and referring discharging residents to Cedar House, for co-occurring issues, and One Stop TAY Center Full Service Partnership services.
 - ◊ In FY13/14 **21** STAY clients entered Cedar House and **28** STAY clients transitioned to One Stop TAY Center Full Service Partnerships (FSP), with services including housing assistance.
- The STAY Clinical Manager also works closely with the Department of Behavioral Health's Community Crisis Response Team (CCRT) for the evaluation of potential residents who may need a higher level of care than The STAY due to their high acuity.

Collaborative Partners

The following agencies are the collaborative partners for The STAY project:

County of San Bernardino

- Department of Behavioral Health (DBH).
- San Bernardino One Stop TAY Center.
- Community Crisis Response Team (CCRT).

Community Partners

- Clinica Medica.
- Valley Star Non-Public School in Mentone.
- Job Corps.
- Cedar House.
- Unlimited Resource Network.



Innovation Projects

Recovery Based Engagement Support Teams (INN - 07)

The goal of the Recovery Based Engagement Support Teams (RBEST) project is to “activate” individuals into appropriate mental health services through field-based outreach, engagement, case management, family education, support and therapy services for the most challenging, diverse adult clients in the community who suffer from untreated mental illness. The primary purpose of the RBEST project is to ***increase the quality of services, including better outcomes.***

The team provides a holistic, multidisciplinary approach to meeting the individual needs and goals of the client and the elimination of obstacles. Services are provided to clients in the least intrusive, restrictive, and disruptive way to promote client resiliency and recovery; maintain their dignity and self-worth; and link them to appropriate mental health services.

The RBEST project serves two (2) different populations: adults who are non-compliant and/or resistant to treatment and the “invisible individual”, who are adults who have traditionally been cared for by family members with minimal outside assistance. Those family members are now unable to provide care due to age, health, or other concerns. Little is known about the service needs of these “invisible” individuals.

“I am so thankful to have someone who is really listening to me. Everyone wants to just pass us on and not really help.”
-RBEST client

Target Population

- Adults

Projected Number to be Served FY 2015/16

- 300 Adults

MHSA Legislative Goals and Related Key Outcomes

- To increase the quality of services, including better outcomes:
 - ◊ Regular collection, analysis, and reporting of data to improve the program.
 - ◊ Improved outcomes compared to standard services.
- To increase access to underserved groups:
 - ◊ Increased rates of underserved participating in the program in comparison to standard services.

Innovation Projects

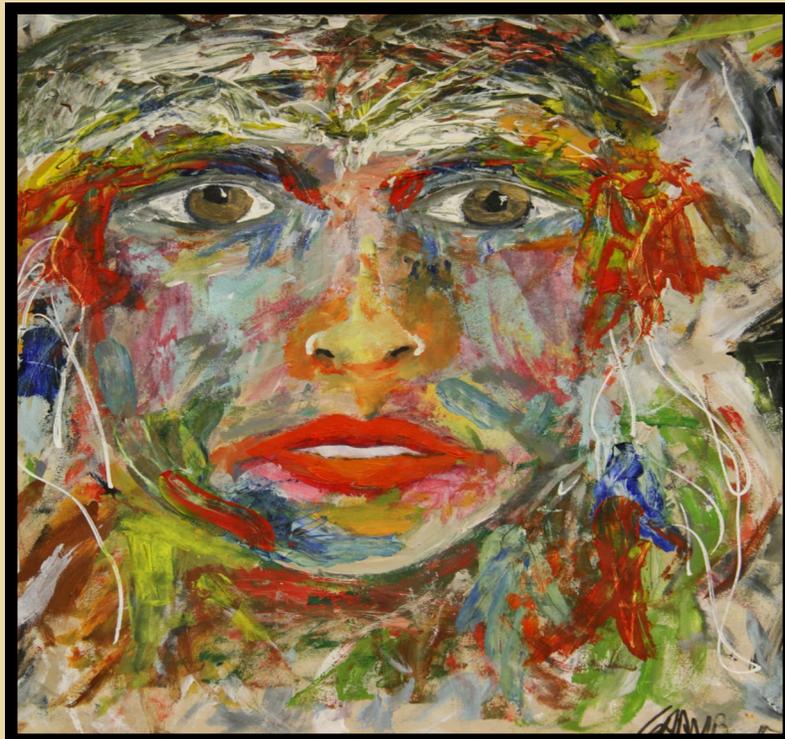
Project Learning Goals

The following learning goals were identified in the INN project description approved by the Mental Health Oversight and Accountability Commission (MHSOAC):

1. Disruption of the existing system will occur through utilizing engagement and outreach strategies that traditionally target individuals who are currently activated in psychiatric care to instead target the noncompliant and resistant to treatment individuals.
2. Identified individuals who are high users of inpatient services will have fewer inpatient admissions and/or fewer psychiatric hospital days and/or more frequent activation in psychiatric interventions following the offering of an incentive.
3. Families of individuals with a mental illness will acknowledge having increased understanding and knowledge regarding mental, as well as improved and increased strategies to care for their mentally ill loved ones as a result of care provider initiated activation strategies.

Addressing the Spirit of Laura's Law (AB 1421)

The RBEST project was designed to address the spirit and intent of Assembly Bill 1421, known as Laura's Law. Enacted in 2002, Laura's Law gives counties the option to mandate clients into outpatient treatment through an order of the court. RBEST works with individuals that are non-compliant or resistant to treatment in order to **voluntarily** engage in appropriate and necessary outpatient treatment.



Artwork by Gary Bustin

Innovation Projects

Positive Results

During FY 2013/14, implementation efforts of the RBEST project took place immediately following the MHSOAC approval of the project in March 2014. This included the development of business practices, creation of an evaluation logic model (see **ATTACHMENT**), identification of the Family Experiences Interview Schedule (FEIS) tool, identification of training, and the process of hiring staff for the project. The majority of staff were hired in FY 2014/15 and services began in October 2014.

While the project was newly approved in FY 2013/14, the RBEST project staff conducted the first outreach and educational presentation in April 2014. The project's staff will continue conducting community stakeholder meetings throughout San Bernardino County in FY 2014/15 and FY 2015/16.

The RBEST project received the first referral in October 2014 and through the first quarter of FY 2014/15, the project has received a total of **39** referrals.



Artwork by Peter Millar

Collaborative Partners

The RBEST project was planned to operate on a referral system. The identification of other agencies as to where the referrals for the RBEST project would come from was a key component. Outreach was conducted, and the following agencies are collaborating with the RBEST project to serve the consumers of San Bernardino County by providing referrals:

- Department of Behavioral Health (DBH) Administration.
- Arrowhead Regional Medical Center.
- Community Hospital of San Bernardino.
- DBH Community Crisis Response Teams.
- DBH Crisis Walk-In Clinics.
- Behavioral Health Commission.
- San Bernardino County Sheriff's Department.

More outreach sites will be identified as the project proceeds in implementation. The project is being implemented per the approved MHSO Innovation Plan 2014, which can be viewed here: http://www.sbcounty.gov/dbh/mhsa/Innovation_Plan/2014/index.html

Innovation Projects

Coalition Against Sexual Exploitation (INN - 02) FINAL REPORT

This final report is based on the instructions provided in the Department of Mental Health (DMH) Information Notice 09-02.

Each county must provide the Mental Health Services Oversight and Accountability Commission (MHSOAC) a final report upon completion of the project. The final report may be included in the County's Annual Update or the Integrated Three-Year Plan, whichever is due during the year the project is completed; the county does not have to provide a separate report according to the Department of Mental Health (DMH) Information Notice 09-02, Enclosure 1, Part III, Reporting Section.

Issue Identified

Prior to the creation and implementation of the Mental Health Services Act (MHSA), Innovation project, Coalition Against Sexual Exploitation (CASE), there were no services tailored specifically for survivors of commercial sexual exploitation in San Bernardino County. There was no training available to professionals or community members regarding these issues and there was minimal coordination of services for sexually exploited children.

In an informal survey conducted of **50** dependent girls placed by San Bernardino County Department of Children and Family Services (CFS) in group homes, **25%** identified themselves as actively engaged in prostitution and another **25%** had a sophisticated understanding of the nomenclature used and the means of becoming involved in prostitution. Almost all of the girls knew stories about someone involved in prostitution while living in a group home. Probation had identified a four-fold increase of children arrested for prostitution in San Bernardino County over the 2005-2010 time period. Children of all cultures and ethnicities are affected by this practice. The CASE project was part of a committed systemic approach to address the issue of sexual exploitation of children and youth in a comprehensive manner.

Did You Know?

- The average age of entry into prostitution is **12-14** years old.
- One in three teens will be recruited by a pimp within **48 to 72** hours of running away from home.
- The National Runaway Switchboard estimates as many as **1.6 to 2.8** million children are on the streets at any time.



The Coalition Against Sexual Exploitation (CASE) project was submitted as part of San Bernardino County's Innovation Plan in February 2010. The project was approved for Innovation funding by the MHSOAC in March 2010, and project work began shortly thereafter.

Pursuant to Welfare and Institutions Code 5830, the primary purpose of the CASE project was to **increase the quality of services, including better outcomes** for sexually abused children in San Bernardino County.

Innovation Projects

Project Description

The primary INN purpose for the CASE project has two objectives. The first, Quality of Services, is a measure of how well CASE is serving and responding to victims. This was assessed in the following two ways: 1) Participants' sense that CASE staff members are effective listeners and care about them; and, 2) The degree to which participants acquired new knowledge that they intend to use. How well participants like the project and whether or not they would recommend the project to others are also indicators of service quality. The second objective of this goal is Service Outcomes, which focuses on the degree to which the project has influenced participants' behaviors, attitudes, and perceptions.

The Coalition Against Sexual Exploitation (CASE) project identified the need for a collaborative approach to servicing sexually exploited children and youth to address the needs of this unique and inappropriately served population. Historically, law enforcement treats these children and youth like criminals rather than responding to their status as victims. Stakeholders in San Bernardino County identified this population as being highly vulnerable and in great need of appropriate interventions that address their victimization and the co-occurring disorders. Additionally, stakeholders encouraged the development of outreach and mental health education to improve understanding for those who interact with these children, and to broaden our understanding of the scope and impact of sexual crimes against children.

Utilizing an interagency approach which included partners from throughout the community (governmental agencies, community based organizations, parents, foster parents, nurses, teachers and others) a comprehensive model of interventions/services was designed, implemented and tested. This model is similar to the County's Interagency Planning Council and other child-serving multi-disciplinary teams which addressed outreach, education, interventions, outcome measurements and ongoing planning. The model was used to assist individual children with ongoing legal, health and social/educational needs as well as continuing collaborative planning for ongoing service coordination and provision.

While coordinated interventions, services and multi-disciplinary teams are not unique, this model has not been used with exploited youth, especially in an effort to bring more community resources, cultural brokers and child/youth advocates into the effort.

The CASE project developed a model of collaborative care that facilitated a safe haven and clinical rehabilitation for children who are sexually exploited and developed approaches to mental health education that assisted in the prevention of future exploitation. In addition, the CASE project also conducted extensive outreach, education, and training within the county.



Innovation Projects

Collaboration

The Coalition Against Sexual Exploitation (CASE) project is a collaborative effort bringing together nine (9) San Bernardino County departments (representing an increase from five (5) in the project's infancy) to address the Commercial Sexual Exploitation of Children (CSEC). These agencies include:

- Department of Behavioral Health (DBH).
- Children and Family Services (CFS).
- Children's Network .
- District Attorney (DA).
- Probation.
- Public Defender.
- Public Health.
- Sheriff's Department.
- Superintendent of County Schools.

Service Overview

A Steering Committee consisting of one (1) representative from each of the collaborative departments met on a monthly basis to oversee program operations, review and approve expenditures and receive reports from the Coordinator regarding program updates.

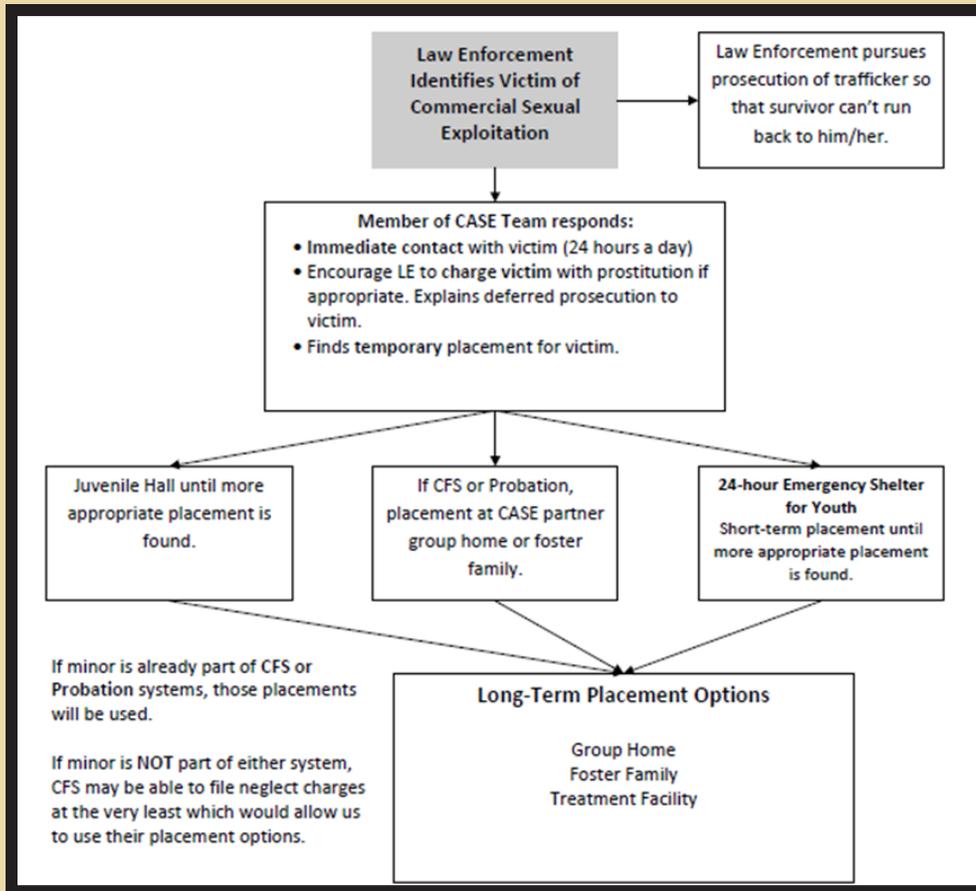
The CASE Team is overseen by a coordinator. The Coordinator's role is to oversee and coordinate the efforts of the program as well as to be the main point of contact. In addition, the Coordinator takes a lead role in delivering training, education and outreach to the community.

The establishment of the Multi-Disciplinary Team (MDT) was a major accomplishment toward increasing access to underserved groups as it has served as a single point of contact for the commercially sexually exploited clients, helping them to feel they have the support of a team. In addition, re-traumatization to clients was reduced due to improved information sharing, and it was easier for clients to access and navigate the larger social service network. Unfortunately, the clients' ages affected eligibility for certain services and/or recommendations for certain services.



Innovation Projects

The CASE team was responsible for training Law Enforcement and others in the identification and assessment of domestic minor sex trafficking victims. The flowchart below was created to determine how clients would be referred to the CASE team and ideally how that intervention would take place:



The CASE project provided the following direct and indirect services to reduce the number of diverse children and youth who are sexually exploited. The intended target population to be served by this project were youth ages **13-25** with a priority including African American, Asia/Pacific Islander, Latino, Native American, and the LGBTQ community.

Direct Services Included:

- Providing intensive case management.
- Building rapport.
- Advocating in court proceedings and making treatment recommendations to the court.
- Providing placement services.
- Working with clients and family members.
- Transportation to and from community-based services.

Indirect Services Included:

- Training on awareness and resources.
- Education and community outreach designed and conducted to give service providers the tools necessary for identifying and assessing possible victims of commercial sexual exploitation.
- Increase referrals to the project and access to services.
- Advocating for policy change to better serve the Commercial Sexual Exploitation of Children (CSEC).

Innovation Projects

The CASE project identified five (5) areas of learning and emphasis for the project to address. The five (5) areas of learning, or learning goals, the project intended to address were:

- Increase our understanding of the impact of sexual exploitation, risk factors, and the means to develop rapport, initiate effective identification and collaborative intervention and treatment.
- Develop an effective means of identifying diverse children in child welfare who are vulnerable to exploitation.
- Develop a means of identifying diverse children brought into the probation system who are exploited.
- Develop a system of comprehensive interventions and treatment models to determine which are the most effective for developing rapport, addressing the “brain washing” phenomenon related to childhood prostitution and improving the child’s survival skills.
- Develop a training and education module, effective for community-based implementation.



What was learned and identified from addressing the learning goals listed above is expanded upon in this final report.

Four-hour trainings were offered on a monthly basis to the community at large, which included social service practitioners, educators, law enforcement, probation officers and attorneys. In addition, the CASE project also collaborated with the Department of Behavioral Health Workforce Education and Training (WET) unit with the Crisis Intervention Training for law enforcement.

CASE services were provided in collaboration with its professional partners, including Juvenile Probation, Children and Family Services, Public Defender Practitioner, Department of Behavioral Health, and the San Bernardino County Sheriff’s Department. Due to CASE’s growing partnerships in the community, access to services by underserved groups has increased each year.

The majority of referrals came from the Probation Department when youth were identified as possible victims of trafficking when being arrested and detained on charges of prostitution and related offenses. The **105** participants served by CASE were primarily females, ages **13 to 18**.

The following table demonstrates the number of minors served and the number of presentations and trainings conducted throughout the project’s implementation.

Year	# of Minors Served	# of Presentations and Trainings	# of Presentation and Training Participants
2011	28	81	3,091
2012	36	96	4,079
2013 -- June 2014	41	157	7,381
Total	105	334	14,551

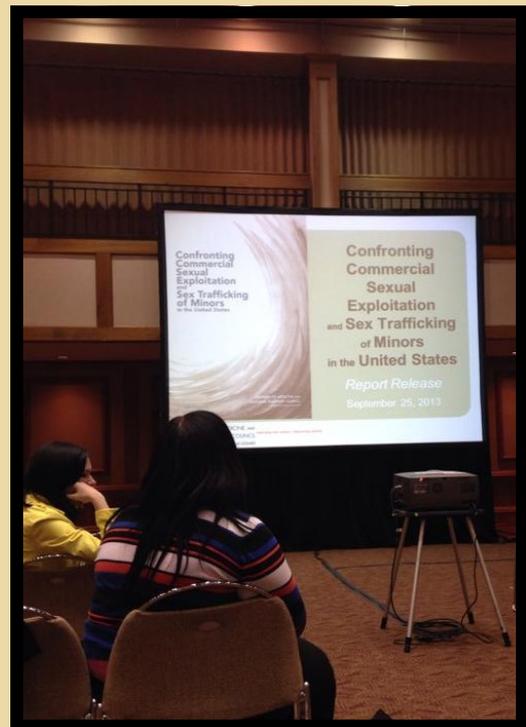
Innovation Projects

The CASE project also includes a Multi-disciplinary Team (MDT) of professionals from five (5) of the partner agencies. The MDT oversees a combined caseload of 30 children at any one time who are at-risk of or are victims of commercial sexual exploitation, including those who are “system-involved” and those who are not. In addition, the MDT provides expert guidance to others in their respective departments concerning identification, assessment, and intervention strategies relative to the commercial sexual exploitation of children. Having a team of experts who not only communicates with each other on a regular basis but also provides specialized support for survivors of Commercial Sexual Exploitation of Children (CSEC) is invaluable. In addition the project includes an Outreach and Engagement Committee which meets on a monthly basis and provides training on the subject of CSEC to build capacity within the community to better serve this population.

Outreach, Education and Training

The Coalition Against Sexual Exploitation (CASE) project was formed in part to learn about the most effective ways to address the mental health issues related to juveniles who are victimized by commercial sexual exploitation. The most common mental health presentations for victims of child sexual exploitation include substance-related disorders, dissociative disorders, impulse control, conduct disorder, ADHD, antisocial personality traits and most or all of the Axis IV psychological and environmental problems. Mood and anxiety disorders such as obsessive compulsive disorder and PTSD are also common. These mental health issues stem from the continuous physical and psychological abuse that is inflicted upon these children.

Due to the lack of training regarding the CSEC among professionals who work with young people in this county, a training committee was formed consisting of individuals from various backgrounds. The purpose was to come up with a plan to identify who would need to receive training and what information might be most relevant to them. Those identified to receive training included social workers, therapists, probation officers, law enforcement, medical professionals and others.



The table below identifies the progress made regarding the quantity of presentations and trainings conducted:

Year	# of Presentations and Trainings Conducted	# of Presentation and Training Participants
2011	81	3,091
2012	96	4,079
2013 -- June 2014	157	7,381
Total	334	14,551

Innovation Projects

As part of the learning goal related to training, the CASE team developed three (3) different presentations that focused on teaching participants about the mental health aspects of sexual exploitation involvement and how to intervene appropriately. The following **three levels** of targeted trainings and education and awareness trainings were developed:

- **Level 1:** Provides training regarding the awareness and resources (60-90 minutes), which includes basic “Human Trafficking/CSEC 101” and is offered to all groups as a starting point but particularly to Schools and Community Groups.
- **Level 2:** Provides training regarding interviewing and identifying techniques (2-3 Hours), which includes Level 1 training above along with how to effectively interview possible CSEC victims and is offered to First Responders, Law Enforcement, Emergency and Medical Personnel and Non-Governmental Service Providers.
- **Level 3:** Provides training regarding working with CSEC survivors (3-4 Hours), which includes the Level 1 and Level 2 trainings above, in addition to specific techniques (Trauma Focused) helpful in providing services for CSEC survivors, and is particularly useful for Non-Governmental Service Providers.

Level	Type of Training	Name of Training
One	Awareness & Resources (60-90 Minute)	What is CASE (Coalition Against Sexual Exploitation)?
Two	Interviewing/Identifying Techniques (2-3 Hours)	<ul style="list-style-type: none"> • Domestic Sex Trafficking: The Criminal Operations of the American Pimp • Sex Trafficking & the Exploitation of Adolescents from a Medical Professional’s Perspective • The Commercial Aspect of Sexual Exploitation Demand
Three	Working with CSEC Survivors (3-4 Hours)	<ul style="list-style-type: none"> • Identification & Assessment of Victims of Trafficking and Sexual Exploitation • Identification of Victims of Trafficking and Sexual Exploitation for First Responders (Polaris Project) • Trauma Informed Practice to Victims of Human Trafficking (SafeHouse)

Specialized trainings (Level Three) were also conducted regarding the following topics:

- Runaway Girl (2 day).
- Girls Education and Mentoring Services (GEMS) (two [2] day).
- Briere/Lanktree (200 social service providers regarding complex trauma and trauma-informed care, essential components in understanding and working more effectively with survivors of sexual exploitation).

Innovation Projects

In order to incorporate this framework of trainings to distinct groups, the following objectives were created to identify trainings to specific groups:

Objective #1

First responders (consisting of crisis response teams, children and family service personnel, “211” operators) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

Objective #2

Law Enforcement will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

Objective #3

Emergency & Other Medical Professionals (including emergency room personnel, nurses, doctors, fire departments, paramedics, etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

Objective #4

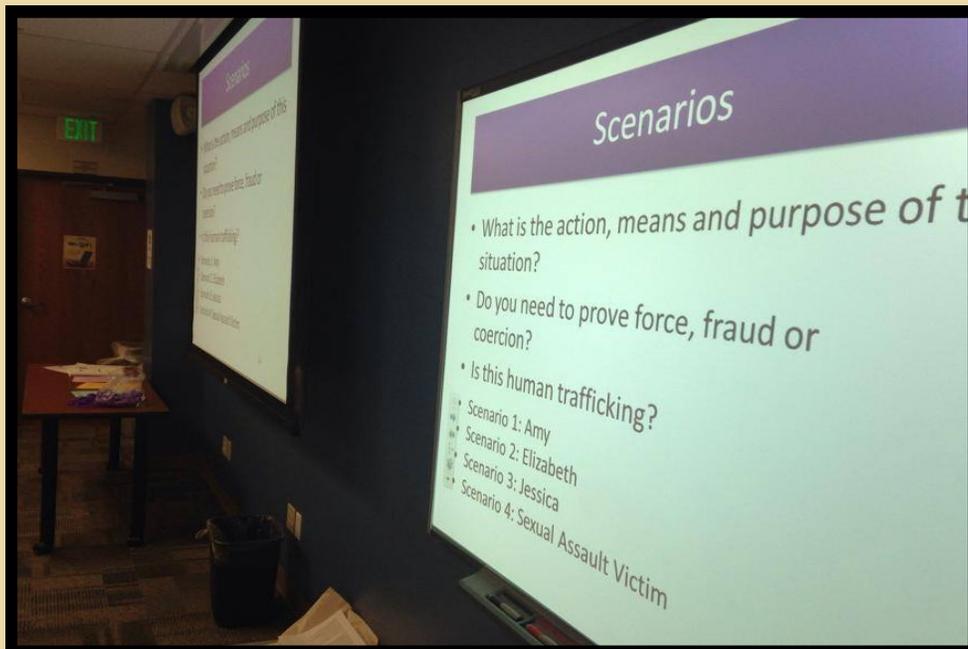
Service Providers (including local homeless shelters, counseling centers/therapists and non-governmental organizations) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

Objective #5

Schools (including teachers, parents, students, guidance counselors, school psychologists, school nurses, peer leadership groups etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

Objective #6

Service Groups/Clubs & Community at Large (including faith-based community) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.



Innovation Projects

Out of the work of this committee came a necessity for countywide training that would include those professionals who work with this population and who would benefit from a training that included information about how to identify, assess and work with the population of sexually exploited minors. The focus was providing training to anyone in the county (at large) of San Bernardino, the trainings were held at various locations throughout the county were open to the public.



The number of countywide trainings conducted for each objective including the number of individuals trained are reflected in the table below.

Objective (Groups trained or education provided)	# of Trainings	Total provided training or education
Objective #1 First responders (consisting of crisis response teams, children and family service personnel, "211" operators) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	60	1,899
Objective #2 Law Enforcement will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	45	1,585
Objective #3 Emergency & Other Medical Professionals (including emergency room personnel, nurses, doctors, fire departments, paramedics, etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	7	232
Objective #4 Service Providers (including local homeless shelters, counseling centers/therapists and non-governmental organizations) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	19	530
Objective #5 Schools (including teachers, parents, students, guidance counselors, school psychologists, school nurses, peer leadership groups etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	34	1,139
Objective #6 Service Groups/Clubs & Community at Large (including faith-based community) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	57	3,233
Grand Total	222	8,618

Innovation Projects

In addition to the formalized trainings listed previously, educational activities were provided to the community, which included Outreach, Film Screenings, etc. and are identified in the following table.

Objective (Education provided)	# of Activities	Total provided educational activities
Objective #1 First responders (consisting of crisis response teams, children and family service personnel, "211" operators) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	6	520
Objective #2 Law enforcement will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	1	25
Objective #3 Emergency and other medical professionals (including emergency room personnel, nurses, doctors, fire departments, paramedics, etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	1	10
Objective #4 Service providers (including local homeless shelters, counseling centers/therapists and non-governmental organizations) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	1	100
Objective #5 Schools (including teachers, parents, students, guidance counselors, school psychologists, school nurses, peer leadership groups etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	2	135
Objective #6 Service groups/clubs and community at large (including faith-based community) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.	17	1,893
Grand Total	28	2,683



Innovation Projects

Training Survey Results

Training participants completed an on-line survey utilizing SurveyMonkey (<https://www.surveymonkey.com/>) to test their knowledge. These responses measured how successful the training material was and if the trainee obtained an increased knowledge of the CASE project. The responses for the question, "Please respond to the following items regarding the presentation using the scale:" are provided below.

Q.1 My understanding of human trafficking and sexual exploitation was enhanced:					
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
2	2	1	56	145	206
1.0%	1.0%	0.5%	27.2%	70.4%	
			201		
			97.6%		

Q.2 My ability to identify and/or work with victims of human trafficking and sexual exploitation was improved:					
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
2	3	7	62	131	205
1.0%	1.5%	3.4%	30.2%	63.9%	
			193		
			94.1%		

Training survey comments from 21 of the CASE trainings:

Listed below are examples of comments received from the trainings conducted:

- "The instructor was engaging and passionate about the topic and really stressed the importance of the issue and helped us see it from the victim's perspective. Videos were key in hearing the victim's perspective and sustaining class engagement."
- "Great information that we as County workers and/or Parents should be aware of. This is a presentation that should be attended by everyone possible. Thank you."
- "The presenter was engaging, interesting, and entertaining, so your attention was maintained and there was multiple media methods incorporated."
- "Well-organized, personable, great personal applications of content, good pace, excellent activities, videos and interactive case studies"
- "I have been involved in MANY trainings and found this one to be in the top 3. Thank you for this free learning opportunity! Could you make it available on a Saturday when people could come who can't take off from their jobs?"
- "A sound way of alerting our society about the evil and dehumanization of any form of trafficking. Keep the education rolling."
- "It was good having two presenters, covering different areas and with different styles of presenting. I really appreciated the hand out, and the use of different teaching methods. I was also grateful to be able to get social work CEUs for this training."

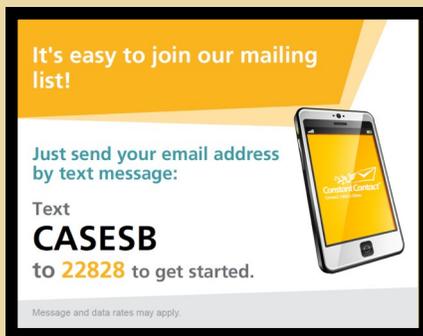
Innovation Projects

Promotion

The CASE project was promoted throughout San Bernardino County on a regular basis. Outreach and engagement regarding what the CASE project was about and providing education regarding the issues was a high priority for the Project Coordinator. Examples of how the CASE project was promoted include, but are not limited to the following:

- Departmental Web Blasts via San Bernardino County's Postmaster (e-mail).
- Posts on the Department's Social Media Sites (Facebook and Twitter).
- CASE Annual Awareness Walk.
- Flyers.

Further examples of the promotional material are provided in the Attachments section.



Innovation Projects

 **San Bernardino County Coalition Against Sexual Exploitation**
October 13, 2011 · 🌐

Don't forget to register for our next film screening on November 16th!

"Sex + Money: A National Search for Human Worth" Film Screening

Sex+Money: A National Search for Human Worth is a documentary about domestic minor sex trafficking and the modern-day abolitionist movement fighting to stop it. Since September 2009, the crew has traveled to over 30 states and conducted more than 75 interviews with federal agents, victims, politica...

 **San Bernardino County Coalition Against Sexual Exploitation**
October 18, 2011 · 🌐

Want to get more invovled with CASE in San Bernardino? Come participate in a training to become a speaker on the issue of commercial sexual exploitation of children and CASE and become part of our Speaker's Bureau.

 **CASE Speaker's Bureau Training**

One of the goals of the San Bernardino County Coalition Against Sexual Exploitation is to raise awareness of and help people identify victims of domestic minor sex trafficking. There is a need throughout the County to provide the general public,

EVENTBRITE.COM

 **San Bernardino County Coalition Against Sexual Exploitation**
January 7, 2012 · 🌐

Representing San Bernardino County at the LA Freedom Walk.



Innovation Projects

Effectiveness

Over the past three and a half (3-1/2) years of CASE's implementation, the CASE project served a total of **105** minors who survived sexual exploitation and trained/educated **14,551** professionals and community members to raise awareness and increase identification of the commercial sexual exploitation of children. Through development and implementation of its collaborative, community education and training model, CASE contributed to the County's understanding regarding each of its five (5) learning goals.

Examples of the key outcomes and learning of CASE are provided below:

- Ongoing emphasis on outreach is needed at the ground level in the communities. The training and education component of CASE is comprehensive with its strong emphasis on raising public and educational awareness of commercial sexual exploitation of children.
- The project's focus on interagency collaboration among the public safety, criminal justice, and behavioral care sectors was critical to success. The MDT enabled CASE to use the most effective trauma-informed practices available and increased the efficacy of services to trafficked youth.
- Ongoing and consistent support for the client is needed, not just during a crisis. The CASE Coordinator found that the critical factor to providing quality services was the establishment and maintenance of a relationship between a case manager/service provider and the survivor. This consistency in relationship provides a safety net for the youth so that regardless of the decisions they make, they continue to have at least one person who continues to support them and encourages steps towards recovery.
- CASE provides comprehensive care working with the family as well as with the victim. In addition, the focus of the CASE intervention is on the strength and goals of the individuals, not on trauma, disorders, or deficiency.
- Although CASE was designed to serve males as well as females, the MDT may expand outreach efforts to serve more males moving in the future. The human trafficking of males is more challenging to identify because there is even more lack of awareness in the community and less self-reporting than with females. The project would also like to expand its training and education efforts to incorporate foster parents and agencies, as well as provide a street team outreach component. However, neither of these strategies has been implemented to date.

The effectiveness of the CASE project toward achieving its purpose of increasing the quality of services, including better outcomes, is discussed below with reference to each of the project's five (5) learning goals, identified in the initial project description.

Learning Goal 1: Increase our understanding of the impact of sexual exploitation, risk factors, and the means to develop rapport, initiate effective identification and collaborative intervention and treatment.

Lack of awareness and services at the time of implementation meant that Commercially Sexually Exploited Children (CSEC) in San Bernardino County were more often seen as offenders and placed within the Juvenile Justice system. They were dealt with in a punitive fashion rather than receiving mental health services to address underlying issues, including trauma, that were contributing to their re-victimization by traffickers. Recurring victimization led to further trauma causing increased occurrence and severity of mental health issues often lasting into adulthood.

This goal was specifically meant to increase the availability and quality of services for CSEC with the hope to improve outcomes for this inappropriately served population. Prior to the implementation of this collaborative effort, there were no services specifically tailored to the unique needs of CSEC in San Bernardino County and a general lack of awareness about the issue and best practices in terms of the delivery of mental health and other services.

Innovation Projects

In order to address this goal, a Multi Disciplinary Team (MDT) was created and the core team consisted of the CASE Coordinator, a Department of Behavioral Health Clinician, a Children and Family Services (CFS) Social Worker, and a Probation Officer. During the initial stages of the project, the team attended various trainings which allowed them to better understand the dynamics and mental health effects of trafficking as well as gain knowledge relative to best practices when working with CSEC. Prior to this, there was little understanding by those in the mental health system about the issue.

The MDT began meeting on a weekly basis at the beginning of the project to discuss cases. These meetings allowed for seamless delivery of services within and amongst several child-serving county departments filling gaps and reducing overlap in the delivery of services to victims of CSEC. Through the sharing of information, the MDT meetings also allowed individual team members to recognize the overall impact of exploitation in each child's life more easily and more clearly and make adjustments to case plans as necessary. Sharing information within the MDT allowed each member of the team to work more effectively with the client as it provided a larger picture of the unique needs and strengths of each client. The MDT also allowed each member the opportunity to learn from each other's experience in working with the population and provided peer support to reduce secondary trauma of working with CSEC.



Another benefit of the MDT was that the client had a whole team supporting them instead of just one case manager/probation officer. Because of the sharing of information within the MDT, re-traumatization was reduced as fewer people had to ask the same questions of the client. The MDT acts as a “hub” or “single point of contact” for victims allowing them access to a multitude of services delivered by outside agencies instead of having to be responsible for finding the right agency with the right service. The MDT helps clients navigate the larger social service network within their community through informal partnerships with organizations and agencies who serve victims of trafficking. The MDT model proved to be very useful in the coordination and delivery of services to CSEC.

Another learning that occurred was that building rapport with CSEC victims is challenging. Because rapport is difficult to establish, the availability of one case manager/mental health professional having a network of supports was found to be important to help the victim access a multitude of services was found to be most effective. This eliminates the need to develop rapport with a multitude of professionals for different services in order to be effective.

The CASE project learned that the majority of CSEC identified through the CASE project came from referrals by Probation and were African American females. The overrepresentation of African Americans may demonstrate higher unmet mental health needs for this population, which may result in higher incidents of interaction with the justice system. In an effort to reduce disparities in this population, the Department is invested in implementing more culturally responsive prevention and early intervention programs. Some of the prevention and early intervention programs include Family Resource Centers, African American Community Health Worker Programs, and Resilience Promotion in African American Children's Services Program. DBH is also conducting outreach to the African American faith based community to provide behavioral health education and services. Other activities conducted towards reducing disparities include identifying and using evidence based practices that have been proven to be effective for the African American population.

Innovation Projects

The impact of sexual exploitation is significant to not only the victim but to his/her family and community and often takes years to recover from. The complex and reoccurring trauma inflicted through exploitation creates mental health effects that must be dealt with comprehensively and over a long period of time and must include not only the victim but their family as well.

With support from the Department of Justice's (DOJ) Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Institute of Medicine and the National Research Council formed a committee to conduct a study of the crimes of human sexual exploitation and trafficking. In a September 2013 report published by the Institute, titled *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*, the committee concluded that efforts to prevent, identify, and respond to commercial sexual exploitation and sex trafficking of minors require better collaborative approaches that build upon the capabilities of people and entities from a range of sectors. The committee based its deliberations on three fundamental principles: 1) these crimes should be understood as acts of abuse and violence, 2) minors who are commercial sexually exploited or trafficked for sexual purposes should not be considered criminals, and 3) the identification of victims and survivors, as well as interventions, should do no further harm. These mirror the tenets of the CASE team's approach.

Further, the committee, in their report, recommended increased awareness and understanding, strengthening of the law's response, strengthening of research to advance understanding and to support the development of prevention and intervention strategies, support for multi-sector and interagency collaboration. They urged leveraging existing resources whenever possible. San Bernardino County's efforts in this direction began years earlier, as this report, and this project shows. Yet there is still more work to be done. An article titled *Human Trafficking Cases Slipping Through the Cracks in Federal and State Legal Systems*, published by the Urban Institute, June 20, 2012, states that researchers from the Urban Institute's Justice Policy Center and Northeastern University's Institute on Race and Justice found that police officers, prosecutors, judges and officials from all levels of government lack awareness of human trafficking laws and don't consider such cases to be a priority. The researchers found that human trafficking victims, including minors, are being arrested at high rates. Among the numerous reasons the article cited for why local law enforcement officials have trouble identifying and investigating human trafficking, was insufficient resources for training and the lack of diversity, cultural competence, and language skills. Also cited were numerous reasons why state prosecutors have difficulty pursuing human trafficking cases. These included lack of legal precedent and state law, lack of resources, lack of institutional infrastructure, lack of awareness and training regarding human trafficking.

The recent passing of Proposition 35 in the State of California will help address many of the issues cited by the report. In November 2012, Californian voters passed Proposition 35, the Californians Against Sexual Exploitation Act. As a joint effort between California Against Slavery and the Safer California Foundation, the Act passed with over **81.3%** approval. It is the most popular ballot initiative in California election history and the first initiative to pass with over **80%** of the vote. With more than **10** million votes, it also represents the most votes cast in support of an initiative in California history. An affiliate of California Against Slavery (CAS) is the CAS Research and Education (CASRE), a human rights organization and 501(c)(3), is building on the momentum created by Prop 35, as they are committed to engaging in charitable and educational projects to combat the atrocity of human trafficking in the state and nation. CASRE is working to ensure the full and successful implementation of Prop 35. Their effort is focus on specific areas where gaps exist and where they can have the most impact.

Innovation Projects

The Act made critical enhancements to California state laws to combat human trafficking and exploitation:

- Higher prison terms for human traffickers, to hold these criminals accountable.
- Require convicted human traffickers to register as sex offenders, to prevent future crimes.
- Require all registered sex offenders to disclose their internet accounts, to stop predators online.
- Increase fines for convicted human traffickers and use these funds to pay for survivor' services, which will help repair their lives.
- Mandate human trafficking training for law enforcement.
- Protect victims in court proceedings.
- Remove the need to prove force to prosecute child sex traffickers.

The new law is already being used to prosecute traffickers. The first life sentence for a trafficker was given in San Bernardino County after the passage of this proposition!

Another significant advance, in the initial stages of implementation, is the California Preventing and Addressing Child and Trafficking Project (PACT), a grant awarded by the US Department of Health and Human Services (DHHS) Administration for Children and Families. San Bernardino County is one (1) of 10 counties selected to participate in this statewide project to develop a model approach to addressing the needs of victims of human trafficking in California. As a result of the grant, an agreement was formed between the Child and Family Policy Institute of California (CFPIC) and San Bernardino County Health and Human Services beginning Oct 1, 2014. The purpose and goal of PACT is to create and implement a state and optional county level system that will prevent the trafficking of children, and meet the needs of those identified victims. The CASE Project Coordinator will be serving as the local PACT Project Coordinator and point of contact. So far there have been multiple webinars spotlighting what counties in California are doing, and emerging promising practices.



CASE COUNTY San Bernardino County Coalition Against Sexual Exploitation shared San Bernardino County District Attorney's photo.
October 19, 2012 · 🌐

Don't miss the release of the trailer of a new documentary about human trafficking from our District Attorney's Office. The film will officially premier in January. More information to come!



San Bernardino County District Attorney

In a few days we will release our Human Trafficking trailer here on our official Facebook page. Stay tuned.



COUNTY County of San Bernardino Department of Behavioral Health
December 27, 2012 · 🌐

Attention Law Enforcement: An eight-hour POST-certified training on human trafficking will be coming to San Bernardino in February. More information can be found here: http://sdrtc.org/.../Affiliate_Cour.../HT%20Minors/HTMinors.html

POST Human Trafficking of Minors

SDRTC.ORG



Innovation Projects

Learning Goal 2: *Develop an effective means of identifying diverse children in the child welfare system who are vulnerable to exploitation. This is vital due to the deliberate targeting of children in foster care and the ever-younger age of children exploited. This will be achieved by applying the Child, Adolescent Needs and Strengths Tool (CANS) to children as they enter foster care. By building a baseline with these profiles, the project will attempt to correlate the information to profiles of children identified in the juvenile detention system as already exploited.*

The CASE project implemented the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) tool to capture data at intake to identify key areas of the youth. The Child and Adolescent Needs and Strengths (CANS) was developed by John S. Lyons, PhD, but was modified (with approval) for use by the San Bernardino County Department of Behavioral Health. The CANS is a document that organizes clinical information collected during a behavioral health assessment in a consistent manner to improve communication among those involved in planning care for a child or adolescent. It is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time.

The CANS has three (3) primary uses:

- Decision support tool.
- Quality improvement tool.
- Outcome monitoring tool.

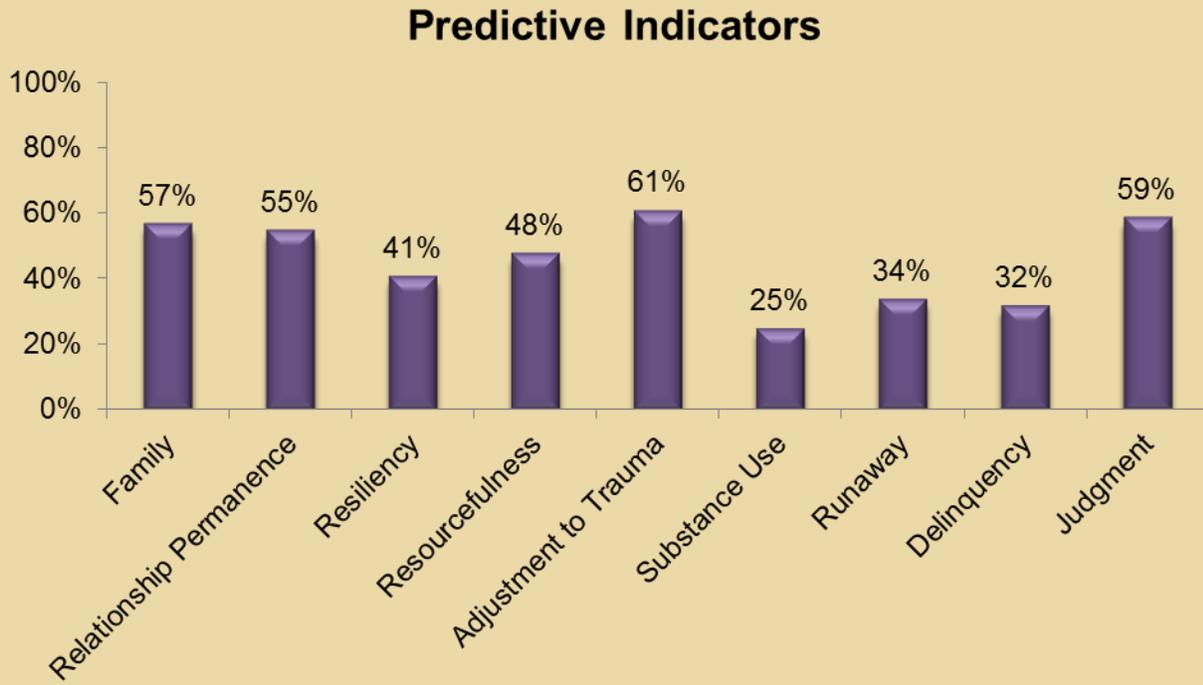
As an assessment tool, the CANS-SB can be used by child and family teams to develop a plan of care. As a quality improvement tool, the CANS-SB can be used with the Treatment Fidelity Index to determine if the strengths and needs identified are incorporated into the plan of care. As an outcome monitoring tool, the CANS-SB may be used by the larger systems of care to track aggregate improvement by children and families on the entire tool or on a particular domain of the tool.

The CANS-SB was administered by the designated CASE team member within **30** days of a client being accepted into the program and every six (6) months after that. The team member designated was determined by whomever was the lead in that case and was agreed upon amongst team members. Used as part of this project, the CANS-SB was used primarily to measure outcomes. Moving forward, the CASE Coordinator hopes to move more towards using the CANS-SB as a case planning tool, engaging the youth more in the identification of their own needs and strengths and then, subsequently, any progress they're making toward reducing their needs and increasing their strengths.



Innovation Projects

The graph below shows some predictive indicators (based on the CASE work plan and the predictive items on the MAYSI tool) extracted from the CANS tool for youth who are vulnerable to exploitation, along with the percentage entering the CASE program that presented with difficulties in these areas.



A description of each item from the CANS-SB shown in the graph, along with its respective domain is listed below:

- Family - There are two family items in separate domains. If it is in the Life Functioning domain, this item relates to Family "as defined by the child", which may not necessarily be biological family or the home in which they are living. This item measures how well the youth gets along with the family. A '0' means child/youth is doing well in relationships with family members and a '3' means child/youth is having severe problems with parents, siblings or other family members. This could include problems of domestic violence, constant arguing, etc. If the family item is in the Strengths domain, this item refers to the presence of a family identity and love and communication among family members. So a '0' in this section would mean that the Family has strong relationships and excellent communication and a '3' would mean the family needs significant assistance in developing relationships and/or communications.
- Relationship Permanence – (In Strengths domain) This rating refers to the stability of significant relationships in the child's or youth's life. '0' indicates a child/youth who has very stable relationships and '3' indicates a child/youth who does not have any stability in relationships.
- Resiliency – (In Strengths domain) This item describes the child's/youth's ability to recognize their internal strengths and use them to promote healthy development and manage their lives. '0' indicates a child/youth who is able to both identify and use internal strengths to better themselves and successfully manage difficult challenges. '3' indicates an individual who is not yet able to identify internal personal strengths.

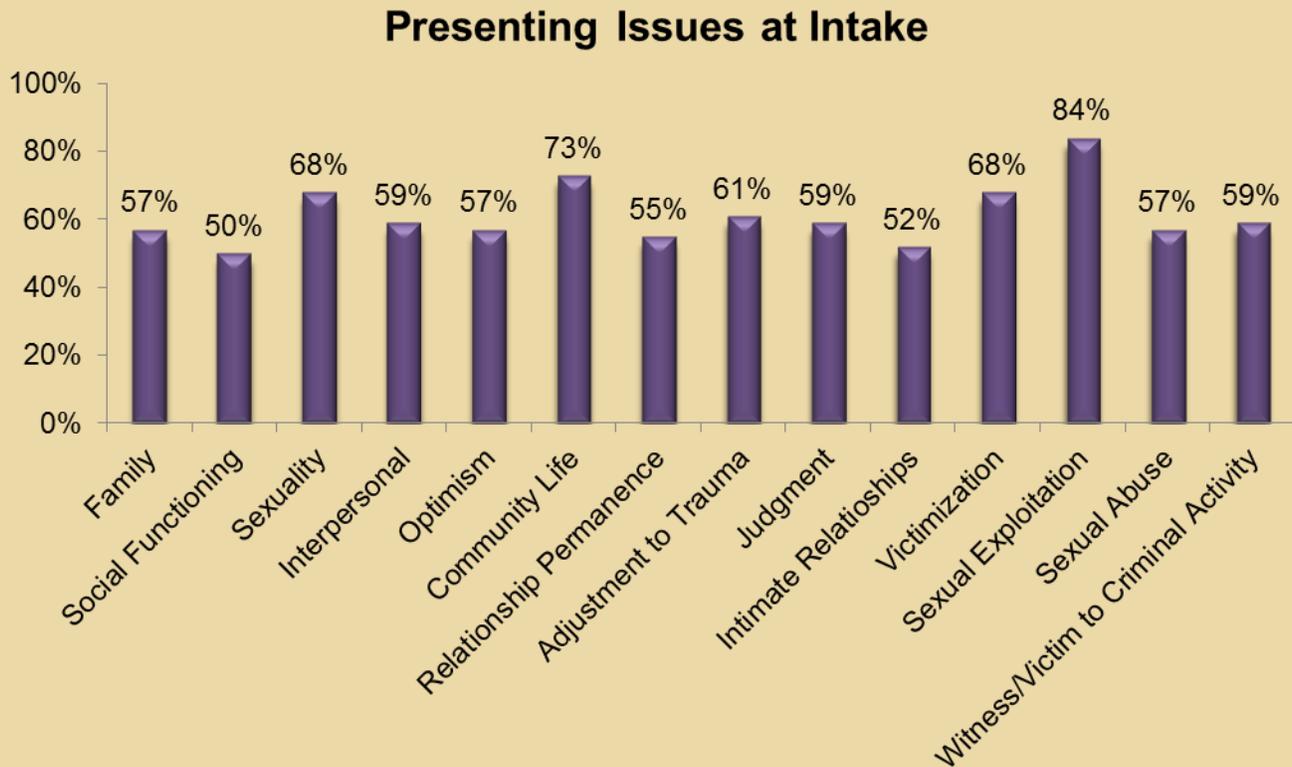
Innovation Projects

- **Resourcefulness – (In Strengths domain)**
This item describes the child's/youth's ability to recognize their external strengths and use them to promote healthy development. '0' indicates child/youth is quite skilled at finding the necessary resources required to aid in managing challenges. '3' indicates child/youth has no skills at finding the necessary resources to aid in achieving a healthy lifestyle and requires ongoing assistance with both identifying and accessing these resources.
- **Adjustment to Trauma – (In Behavioral/Emotional Needs domain)** This item covers the youth's reaction to any of a variety of traumatic experiences - such as emotional, physical, or sexual abuse, separation from family members, witnessing violence, or the victimization or murder of family members or close friends. If a child/youth has not experienced any trauma or if their traumatic experiences no longer impact their functioning, then they would be rated a '0'. A '1' indicates a child/youth who is making progress learning to adopt to a trauma or a child/youth who recently experienced a trauma where the impact on well-being is not yet known. A '2' indicates significant problems with adjustment or the presence of an acute stress reaction. A '3' indicates PTSD.
- **Substance Use – (In Behavioral/Emotional Needs domain)** These symptoms include use of alcohol and illegal drugs, the misuse of prescription medications and the inhalation of any substance for recreational purposes. '0' indicates no evidence of substance abuse and '3' indicates child requires detoxification OR is addicted to alcohol and/or drugs. Included here are youth who are intoxicated at the time of assessment (i.e. currently under the influence).
- **Runaway – (In Risk Behaviors domain)** To classify as a runaway, the child/youth is gone overnight or very late into the night. Impulsive behavior that represents an immediate threat to personal safety would also be rated here. '0' indicates no evidence of runaway behavior and '3' indicates acute threat to runaway as manifested by either recent attempts OR significant ideation about running away OR child/youth is currently a runaway.
- **Delinquency – (In Risk Behaviors domain)** This rating includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards. Sexual offenses are included as criminal behavior. '0' indicates no evidence of delinquency and '3' indicates severe acts of delinquency that places others at risk or significant loss or injury or place child/youth at risk or adult sanctions.
- **Judgment – (In Risk Behaviors domain)** This item describes the child's decision-making process and awareness of consequences. '0' indicates no evidence of problems with judgment or poor decision making that result in harm to development and/or well-being. '3' indicates problems with judgment that place the child/youth at risk or significant physical harm.



Innovation Projects

The graph below identifies key areas of presentation of the youth at intake, specifically items where a majority of the youth showed presenting issues.



A description of each item from the CANS-SB shown in the graph, along with its respective domain is listed below:

- **Social Functioning** – (Life Functioning domain) This item refers to the child's/youth's social functioning from a developmental perspective. '0' indicates child/youth is on a healthy social development pathway and '3' indicates child/youth is experiencing severe disruptions in social development.
- **Sexuality** – (Life Functioning domain) This item examines broad issues of sexual development, including sexual behavior, sexual identity, sexual concerns, and the reactions of significant others to any of these factors. '0' indicates child/youth has healthy sexual development and '3' indicates child/youth has severe problems with sexual development.
- **Interpersonal** – (Strengths domain) This item is used to identify a child/youth's social and relationship skills. This is rated independent of Social Development because a child/youth can have skills but be struggling in their relationships at a particular point in time. Thus this strength indicates long-standing relationship-making and maintaining skills. '0' indicates Child/Youth has well-developed interpersonal skills and friends and '3' indicates Child/Youth needs significant help in developing interpersonal skills and healthy friendships.
- **Optimism** – (Strengths domain) This item is based on the child/youth's sense of themselves in their own future. This is intended to rate the child's/youth's positive future orientation. '0' indicates child/youth has a strong and stable optimistic outlook on life and '3' indicates child/youth has difficulties seeing any positives about self and life.

Innovation Projects

- Community Life – (Strengths domain) This item reflects the youth's connection to their community. Youth with a sense of belonging and a stake in their community do better than those who do not have this. Youth who have moved a lot or who have been in multiple care settings may have lost this sense of connection to community life. '0' indicates child/youth is well-integrated into their community, is a member of community organizations and has positive ties to the community. '3' indicates child/youth has no identified community to which they are a member.
- Relationship Permanence – (In Strengths domain) This rating refers to the stability of significant relationships in the child's or youth's life. '0' indicates a child/youth who has very stable relationships and '3' indicates a child/youth who does not have any stability in relationships.
- Adjustment to Trauma – (In Behavioral/Emotional Needs domain) This item covers the youth's reaction to any of a variety of traumatic experiences - such as emotional, physical, or sexual abuse, separation from family members, witnessing violence, or the victimization or murder of family members or close friends. If a child/youth has not experienced any trauma or if their traumatic experiences no longer impact their functioning, then they would be rated a '0'. A '1' indicates a child/youth who is making progress learning to adapt to a trauma or a child/youth who recently experienced a trauma where the impact on well-being is not yet known. A '2' indicates significant problems with adjustment or the presence of an acute stress reaction. A '3' indicates PTSD.
- Judgment – (In Risk Behaviors domain) This item describes the child's decision-making process and awareness of consequences. '0' indicates no evidence of problems with judgment or poor decision making that result in harm to development and/or well-being. '3' indicates problems with judgment that place the child/youth at risk or significant physical harm.
- Intimate Relationships – (MODULE ITEM) Module items are only completed under certain conditions. This module is only completed when the client is aged between 16-25 and considered to be a Transitional Aged Youth (TAY). This item is in the TAY module and is used to rate the individual's current status in terms of romantic/intimate relationships. '0' indicates an adaptive partner relationship exists and the youth has a strong, positive, partner relationship with an age-appropriate peer. '3' indicates that significant difficulties exist with a partner relationship. The youth is currently involved in a negative, unhealthy relationship.
- Victimization - (MODULE ITEM) Module items are only completed under certain conditions. This module is only completed when the client is aged between **16-25** and considered to be a Transitional Aged Youth (TAY). This item is in the TAY module and is used to examine a history and level of current risk for victimization. '0' indicates a person with no evidence of recent victimization and no significant history of victimization within the past year. The person may have been robbed or burglarized on one or more occasions in the past, but no pattern of victimization exists. Person is not presently at risk for re-victimization. '3' indicates a person who has been recently victimized and is in acute risk of re-victimization. Examples include working as a prostitute and living in an abusive relationship.



Innovation Projects

- Sexual Exploitation - (MODULE ITEM) Module items are only completed under certain conditions. This module is only completed if the client has a score of 2 or 3 on the 'Sexuality' item in the Life Domain. This item is in the Sexuality module and refers to an individual's involvement or risk of involvement in sexually exploitive activities. A '0' indicates child/youth may, or may not, engage in sexual interactions; however there is no evidence of being sexually exploited or engaging in a sexual act in exchange for favors or items. Additionally, child/youth is not at risk for being groomed for this type of exploitation. A '3' indicates sexual activities are done in exchange for money or items. Activities may, or may not, be directed by a 'pimp' and child/youth may, or may not, be engaging in such acts willingly.
- Sexual Abuse - (MODULE ITEM) Module items are only completed under certain conditions. This module is only completed if the client has a score of 2 or 3 on the 'Adjustment to Trauma' item in the Behavioral/Emotional Needs Domain. This item is in the first of three separate Trauma modules and refers to if the child/youth has been sexually abused. A '0' indicates there is no evidence that the child/youth has experienced sexual abuse. A '3' indicates that the child/youth has experienced severe and repeated sexual abuse that may or may not have caused physical harm as well.
- Witness/Victim to Criminal Activity - (MODULE ITEM) Module items are only completed under certain conditions. This module is only completed if the client has a score of 2 or 3 on the 'Adjustment to Trauma' item in the Behavioral/Emotional Needs Domain. This item is in the first of three separate Trauma modules and refers to if the child/youth has been witness to or a victim of criminal activity.

As the CANS-SB was being utilized on youth already engaged in sexual exploitation, the initial indicators show that the CANS-SB tool could be useful in identifying children vulnerable to exploitation. Currently there is no evidence based tool available for identifying youth vulnerable to or currently being sexually exploited.



Survivor and Advocate, Amy Andrews shares her story at the Second Annual CASE Human Trafficking Awareness Walk on January 28, 2012.

Innovation Projects

Learning Goal 3: *Develop a means of identifying diverse children brought into the Probation system who are exploited. Currently, these children may be arrested on non-prostitution related offenses (shoplifting, giving false information to law enforcement, and drug charges). Apply the CANS and Massachusetts Youth Screening Instrument (MAYSI) to these cases.*

One of the specific objectives of the CASE project was to develop or distinguish an effective means of identifying diverse children who are vulnerable to exploitation. The CASE project team collaborated with the San Bernardino County Probation Department's Research Unit which conducted a study to determine if the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) was a better way to identify exploited youth.

The MAYSI-2 is a self-report inventory of **52** questions designed to assist juvenile justice facilities in identifying youths **12 to 17** years old who may have special mental health needs. Youths circle YES or NO concerning whether each item has been true for them "within the past few months." Youths read the items themselves (5th grade reading level) and circle the answers. Administration takes about **10-15** minutes and scoring requires approximately three (**3**) minutes. This assessment tool is used primarily in juvenile diversion programs, juvenile detentions centers, juvenile probation offices, and juvenile correctional and aftercare programs.

The instrument uses several scales to measure the following factors:

- Alcohol/Drug Use
- Angry/Irritable
- Depressed/Anxious
- Somatic Complaints
- Suicide Ideation
- Traumatic Experiences

Female minors who were booked into Juvenile Hall and administered the MAYSI between 11/2006 and 6/2013 were included in the project analysis to determine if better identification of potential CASE minors would be predicted.

Predictive analyses were conducted of the factor level as well as the question level. Question level analyses better differentiated between CASE and non-CASE minors. The results of the analysis of this project are:

- **1,461** female minors were administered the MAYSI assessment at least once during the above timeframe.
 - ◊ **36 (2.46%)** were identified as CASE youth
- **547 (37.44%)** were administered the MAYSI assessment two (**2**) or more times due to multiple bookings which resulted in:
 - ◊ **2,714** instances of the MAYSI
 - ◊ **110 (4.10%)** identified as CASE minors

Innovation Projects

Identifying CASE minors using MAYSI

Two (2) competing equations were constructed using Discriminant Function Analysis to identify potential CASE minors based on their pattern of responses to the MAYSI-2 assessment.

- Answers of “Yes” on the following items increases the probability of a minor being identified as **non-CASE** (ordered by predictive importance).
 - ◇ Question 7: *Have you though a lot about getting back at someone you have been angry at?*
 - ◇ Question 4: *Have you had a lot of problems concentrating or paying attention?*
 - ◇ Question 28: *Has your heart beat very fast?*
 - ◇ Question 23: *Have you gotten in trouble when you’ve been high or drinking?*
 - ◇ Question 8: *Have you been really jumpy or hyper?*

- Answers of “Yes” on the following items increases the probability of a minor being identified as **CASE** (ordered by predictive importance).
 - ◇ Question 25: *Have other people been able to control your brain or your thoughts?*
 - ◇ Question 49: *Have you ever been badly hurt, or been in danger of getting badly hurt or killed?*
 - ◇ Question 35: *Have you felt angry a lot?*
 - ◇ Question 50: *Have you ever been raped, or been in danger of getting raped?*
 - ◇ Question 6: *Have you been easily upset?*

Example A: If a female minor answers “yes” – indicated by a “1” in the score column on questions 8, 23, 25, 28, 35 and 49, the minor would be flagged Potential **CASE**.

“Yes” = 1, “No” = 0

Questions	Scores
Question 4	0
Question 6	0
Question 7	0
Question 8	1
Question 23	1
Question 25	1
Question 28	1
Question 35	1
Question 49	1
Question 50	0

Innovation Projects

Example B: If a female minor answers “yes” – indicated by a “1” in the score column on questions 6,7, 28 and 49, the minor would be flagged **Non-CASE**.

Questions	Scores
Question 4	0
Question 6	1
Question 7	1
Question 8	0
Question 23	0
Question 25	0
Question 28	1
Question 35	0
Question 49	1
Question 50	0

The study found that the MAYSI-2 was effective in identifying sexually exploited children brought into the probation system. While promising, these results need additional investigation to be confident in appropriate use. Since there are overrepresentations of some populations of youth in the settings where the MAYSI-2 was administered, it would be helpful to explore if this tool is the most culturally appropriate, both for describing the behavior of these youth as well as effectively and accurately generalizing the results to others not represented in this population.

One challenge, faced by the project, to using the MAYSI-2 as an identification tool is that the Probation Department does not have consistent access to administer the MAYSI-2, both at booking and **72** hours after minors have been detained, as the tool was designed. As a result, MAYSI-2 data that would be needed for regular identification purposes is not collected on a consistent basis. Therefore, the MAYSI-2 has not been implemented by the project as a screening for potential Commercial Sexually Exploited Children (CSEC)

The CASE project increased the means for effective identification of children vulnerable to sexual exploitation by raising awareness through community training, education, and outreach. Events focused on giving service providers, law enforcement, and other community members the knowledge base necessary to identify youth at risk of commercial sexual exploitation.

Events included film screenings on sexual exploitation; community panel discussions with panelists from a wide range of professional backgrounds, as well as a survivor of human trafficking; and a Speaker’s Bureau designed for community members who wanted to be able to make short informational presentations in their communities. CASE also developed an education model, which includes ongoing education with local agencies regarding sexual exploitation. Please refer to the Outreach, Education, and Training section of this report for more information.

Innovation Projects

Learning Goal 4: *Develop a system of comprehensive interventions and treatment models to determine which are the most effective for developing rapport, addressing the “brain washing” phenomenon related to childhood prostitution and improving the child’s survival skills.*

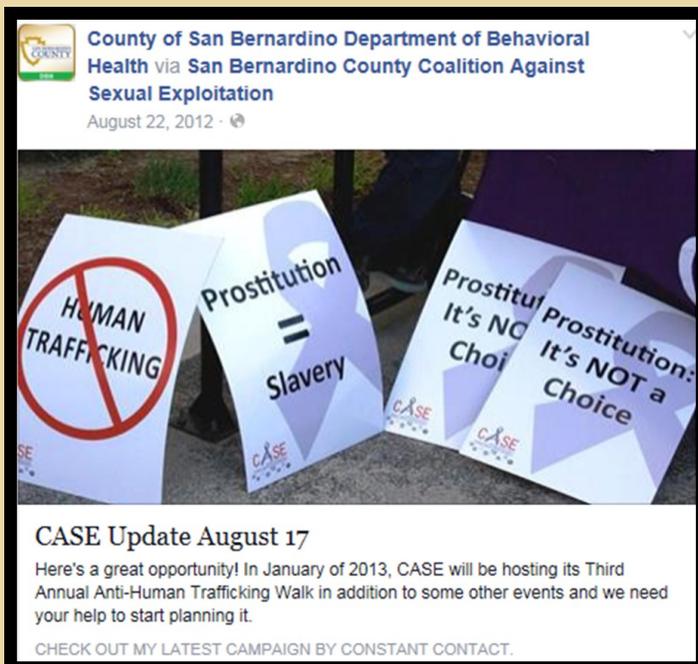
As the CASE Coordinator’s observations suggest, working with commercially sexually exploited youth has been challenging. As reported, it is sometimes difficult to even identify which girls have actually been exploited as they often will not disclose this information.

While CASE’s initial source of referrals come from Probation, it became clear that many exploited children are not on Probation for prostitution charges, some are arrested on drug charges, shoplifting, or curfew violations. Developing mechanisms for these girls to disclose took time and special training for Probation staff.

In addition, developing tools and profiles for identifying and serving clients successfully is an ongoing part of the CASE project. CASE is finding that it takes time and specialized training for therapists on trafficking to develop interview/assessment skills and mechanisms to encourage client disclosure. However, collaboration between several County and community agencies helps in the development and testing of a collaborative model of interventions and services to reduce the number of diverse children and youth that are sexually exploited.

At the same time, CASE is educating the community to recognize the widespread nature of the problem and to serve as a referral source when exploitation is suspected. CASE is struggling to change the paradigm of recognizing these sexually exploited children/youth as victims rather than criminals.

Despite these challenges, CASE places a strong emphasis on continuous improvement of its intervention and treatment models. Recognizing that it is difficult to gain its target population’s trust and establish the rapport necessary to successfully intervene, CASE recommends providing 24/7 crisis assistance, meeting youth where they live, and establishing an ongoing long-term relationship with those youth who are not ready to change their situation.



Innovation Projects

Learning Goal 5: *Develop a training and education module, effective for community-based implementation, for those who interact with these children that most effectively works for San Bernardino County's cultural and ethnic populations.*

From their report, *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*, published by the Institute of Medicine September 2013, the committee assembled with the support from the Department of Justice's (DOJ) Office of Juvenile Justice and Delinquency Prevention (OJJDP), and as discovered by the CASE team, acknowledged that numerous factors contribute to a lack of understanding and awareness of Commercial Sexual Exploitation of Children (CSEC) in the United States, including the reluctance of victims to come forward and the lack of awareness or tools for professionals who routinely interact with victims or survivors to properly identify and assist. The CASE Coordinator reported discovering that far more education and outreach was needed than originally anticipated to educate first responders on how to identify, assess, and properly refer CSEC victims. Many professionals and individuals who interact with youth, such as teachers, health care providers, child welfare workers, and law enforcement, are unaware that these crimes occur and often are ill-equipped with how to respond to victims, survivors, and those at risk. The recommendation of the committee, in their report, was for the development, implementation, and evaluation of training activities for professionals, and other individuals, who routinely engage with the CSEC population. Another recommendation was for public awareness campaigns with an increase in focus on awareness among children and adolescents to help them avoid becoming victims. The CASE project organized an annual Anti-Human Trafficking Awareness Walk, currently in its fifth (5th) year, with more participants and recognition every year.

CASE trainings on the commercial exploitation of children were provided to a total of **14,551** individuals trained or educated over the duration of the project. Professionals trained included social workers, therapists, probation officers, law enforcement, medical professionals, educators, and many other community members.

As part of the learning goal related to training, the CASE team developed three (3) different presentations that focused on teaching participants about the mental health aspects of sexual exploitation involvement and how to intervene appropriately.



Innovation Projects

The following three (3) levels of targeted trainings and education and awareness trainings were developed:

- **Level 1:** Awareness and Resources (60-90 minutes), which includes basic “Human Trafficking/ CSEC 101” and would be offered to all groups as a starting point but particularly to Schools and Community Groups.
- **Level 2:** Interviewing/Identifying Techniques (2-3 Hours), which includes not only Awareness and Resources but also how to effectively interview possible CSEC victims and would be offered to First Responders, Law Enforcement, Emergency and Medical Personnel and Non-Governmental Service Providers.
- **Level 3:** Working with CSEC Survivors (3-4 Hours), which includes the above topics in addition to specific techniques (Trauma Focused) helpful in providing services for CSEC survivors, and would be particularly useful for Non-Governmental Service Providers.

Along with the three (3) levels identified above, and in order to incorporate this framework of trainings to distinct groups, the following objectives were created to identify trainings to specific groups.

- **Objective #1**
First responders (consisting of crisis response teams, children and family service personnel, “211” operators) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.
- **Objective #2**
Law enforcement will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.
- **Objective #3**
Emergency and other medical professionals (including emergency room personnel, nurses, doctors, fire departments, paramedics, etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.
- **Objective #4**
Service providers (including local homeless shelters, counseling centers/therapists and non-governmental organizations) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.
- **Objective #5**
Schools (including teachers, parents, students, guidance counselors, school psychologists, school nurses, peer leadership groups etc.) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.
- **Objective #6**
Service groups/clubs and community at large (including faith-based community) will be aware of CSEC issues and provided with the tools to identify and respond to this population in their community.

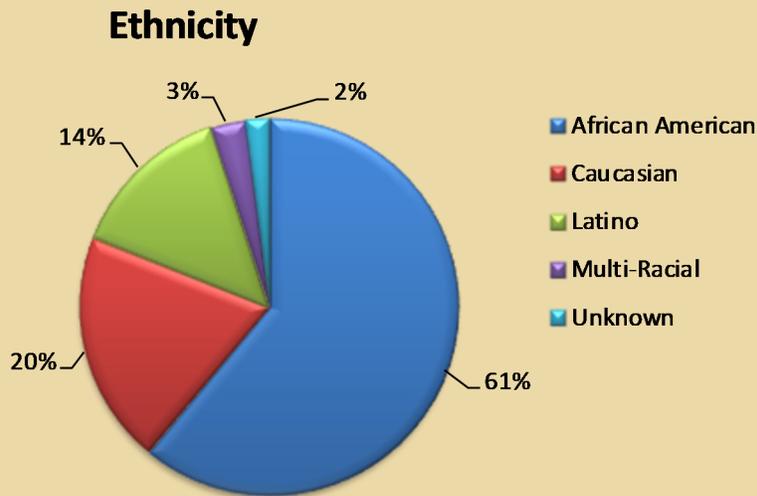
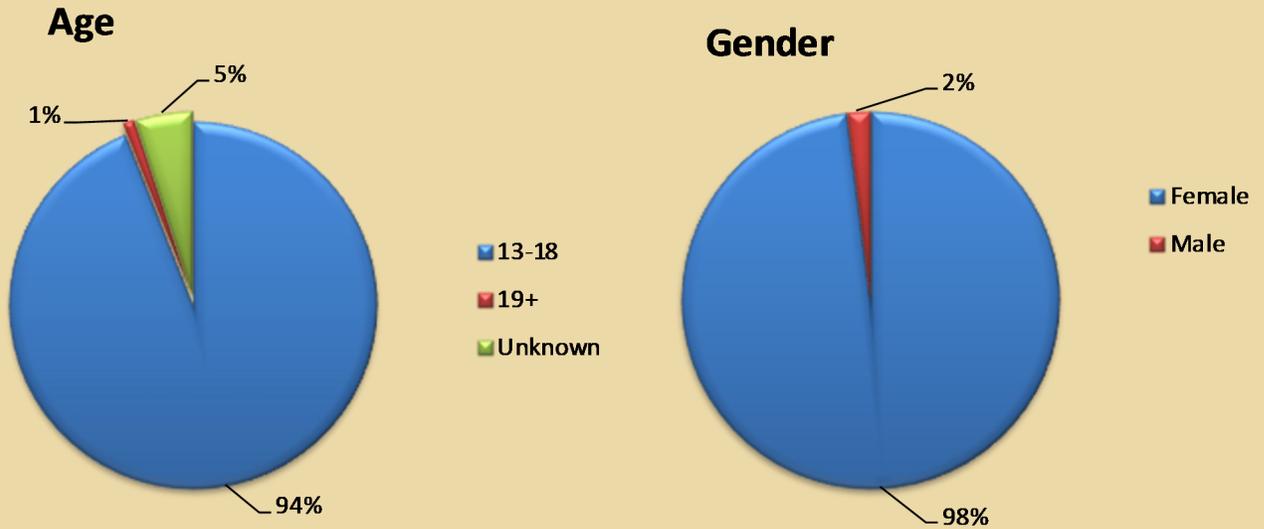
Please refer to the Outreach, Education, and Training section of this report for more information.

CASE’s Outreach and Education Committee has played a vital role in community events such as the Anti-Human Trafficking Awareness Walk, a Speaker’s Bureau to conduct informal information sessions in the community, Film Screenings of relevant films on human trafficking and sexual exploitation, and sponsorship of the Children’s Network Conference, as well as six (6) workshops on sexual exploitation of children.



Innovation Projects

The graphs below provide demographic information for ethnicity, age, and gender of the minors served through the CASE project.



Innovation Projects

Changes/Modifications

CASE's continued efforts enabled change in the communities' recognition that "trafficked youth are victims not offenders" and contributed to the success of the Multi-Disciplinary Team (MDT). The MDT gave CASE the opportunity to use the most effective trauma-informed practices available and increased the efficacy of services to trafficked youth. The multi-disciplinary/trans-disciplinary partnership is essential as is the incorporation of the perspective and direct participation of survivors. Even then, CASE discovered the importance and challenge of maintaining those relationships to minimize client set-backs. Staff turnover amongst MDT members presented challenges as the new replacement staff lacked the level of awareness, training and expertise of the staff who had been serving on the MDT. Nevertheless, the CASE Coordinator and other team members worked to overcome this challenge by spending considerable time training and working with new team members.

Additional Learning

The CASE Project Coordinator explained that their expectation at the start of the project was that there would be a basic level of understanding or awareness in the professional communities where Commercial Sexual Exploitation of Children (CSEC) victims would receive services (ex: hospitals, emergency rooms, teachers, social workers, law enforcement), however the level of awareness was far below and much more outreach, education, and training was needed than originally anticipated. In fact, more basic resources than originally planned were needed to address the lack of awareness of ways to identify victims of human trafficking and exploitation, as well as the resources available to treat them, as well as what appropriate treatment looks like. The time needed to devote to this basic information and awareness impacted the ability to identify effective interventions, which requires further research. Fortunately, with the continuation of the project under other funding sources, more outcomes are expected in this area in the future.

With respect to strengthening clinical practice, the CASE FY 2013/14 Annual Progress Report states that there are currently no known science- or evidence-based strategies or activities in regard to preventing, intervening and treating victims of commercial sexual exploitation. However, what's been shown to have brought the most success is the establishment and maintenance of a relationship between a case manager/service provider and the survivor. This consistency in relationship provides a safety net for the youth so that regardless of the decisions they make, they continue to have at least one person who continues to support them and encourages steps towards recovery.

As cited in the report *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*, published September 2013 by the Institute of Medicine, there is extremely limited evidence base related to the crime of human trafficking, particularly related to prevention and early intervention, including variance in the research. The committee submitting the report recommended against devoting a large amount of resources to refining estimates of the overall prevalence of the problem, but rather the focus should be on implementing a national research agenda that would include:

- Advancing knowledge and understanding of commercial sexual exploitation and sex trafficking of minors in the United States.



Innovation Projects

- Developing effective, youth-centered, multi-sector interventions designed to prevent minors from becoming victims or exploiters and to assist victims.
- Forming strategies and methodologies for evaluating the effectiveness of prevention and intervention laws, policies, and programs.

Through local and statewide efforts, new legislation (the passing of Prop 35), and new funding opportunities, there can be an increased focus on the areas highlighted above. The CASE team discovered the importance of public awareness as a means to increased identification and the resulting public events (movie screenings, DA involvement at public speaking events, awareness walks, conference presentations, etc) contribute to increased information sharing. The committee's recommendations regarding collaboration and coordination among numerous individuals and entities, as well as developing technological real-time information sharing platforms, are incorporated in to the ongoing focus of both the CASE team efforts and also the California Preventing and Addressing Child and Trafficking Project (PACT) grant opportunity.

In addition, the CASE FY 2013/14 Annual Report also highlighted the following outcomes based on participant characteristics:

- Outcomes were better for youth who had been trafficked for a shorter amount of time; youth who had family support; older youth who had more developed critical thinking skills and more negative experiences, which provided more internal motivation for not reengaging in prostitution and trafficking.
- Outcomes were worse for youth who had been trafficked for longer periods of time; who did not have connections to family or healthy support; who were very young (14 or younger) who may not have had many negative consequences of their involvement in prostitution, and who lacked critical thinking skills; youth who had experienced multiple or complex trauma; and youth coming from low socioeconomic status.
- Contributions to successful outcomes included the MDT model; the extensive training conducted by the MDT for other professionals working with this population; and the implementation of the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to help monitor progress towards achieving treatment goals.

CASE staff recognizes that even though awareness of the impact of sexual exploitation has increased, as has the means to develop rapport, initiate effective identification, and collaborative intervention treatment, there is still much to be learned about the delivery of mental health services to commercially sexually exploited children.



Innovation Projects

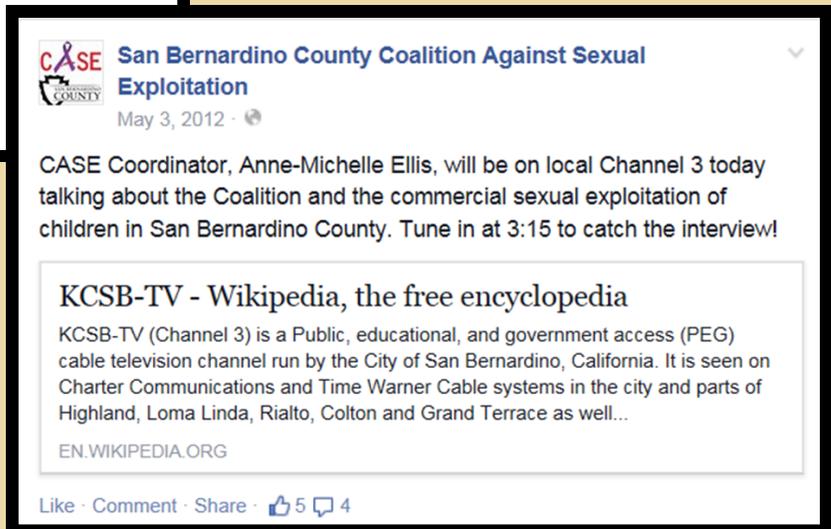
Project Recognition and Achievements

Overall, CASE has contributed to learning through increasing understanding of the impact of sexual exploitation through the development of a training and education module for social service practitioners, behavioral health professionals, and those working in the criminal justice system.

Below are additional examples of the recognition this project has received:

- National Association of Counties (NACo) award in 2011.
- In recognition of their transition and growth, CASE received an award as a promising practice from the California Mental Health Advocates for Children and Youth (CMHACY).
- The CASE project successfully worked to get the San Bernardino County Board of Supervisors to proclaim the month of January as Human Trafficking Awareness and Prevention month.
- Mentioned in over **23** newspaper articles

And it should be noted that a gradual but significant paradigm shift has occurred within the community at-large from seeing prostituted youth as criminals who need to be prosecuted to children who have been victimized and require long-term intense treatment.



Innovation Projects

Continuation of CASE

In May 2014, a presentation was conducted at the San Bernardino County Community Policy Advisory Committee (CPAC) meeting to provide stakeholders with an update on the progress the CASE project and the transitioning of the project from Innovation funding to other sources of funding.

The Department of Behavioral Health, with stakeholder insight and input, elected to continue the CASE project after funding under MHPA Innovation ended. The CASE project has been transitioned to the MHPA Prevention and Early Intervention (PEI) funding effective FY 2014/2015. The project aligns with the MHPA legislative goal of reducing prolonged suffering. The service population is a unique group with limited-targeted resources. There is inherently risk of developing a behavioral health condition in this population due to underserved cultures, exposure to trauma, and at risk of/or experience with juvenile justice involvement.

The project identified the provision of **80%** of early intervention services such as clinical assessment, mental health treatment services, and alcohol and drug counseling. Whereas **20%** selective services would be provided, such as outreach and engagement, screening, case management, multi-disciplinary collaboration, and educational services.

Ongoing funding of this project and the sustainability of services are dependent upon leveraged resources. San Bernardino County Probation and the Department of Children and Family Services (CFS) will assume funding support for staffing resulting in a reduction of the project by **55%** since the inception of the project.

The chart below highlights some of the components that are being maintained, changed, or discontinued with the transition from Innovation funding to other sources.

Topic	Maintain	Change	Discontinue
Funding for DBH, Public Defender and Children's Network positions provided by DBH.		Funding for CFS and Probation positions provided by the respective departments.	
Collaboration between Public Defender, DBH, CFS, Probation, Children's Network & District Attorney to manage caseload of CSEC youth.		Addition of Juvenile Courts (presiding judge is now Chair of Steering Committee). Now there are 10 departments or agencies involved in the MOU.	
Monthly Outreach & Education Committee Meeting	Meeting to continue on a monthly basis with location alternated between San Bernardino and Victorville.		
Use of the CANS assessment to determine client needs and outcomes.		Work with PDD to develop CSEC Protocols for CFS.	CANS tool was less useful as anticipated, no longer being used.

Innovation Projects

Materials Developed to Communicate Lessons Learned and Project Results

Throughout the project period, documents have been created to provide updates for the stakeholders of San Bernardino County and other entities regarding the CASE project. Examples of these documents include the Mental Health Services Act (MHSA) Annual Update Reports, MHSA Three-Year Integrated Plan, and Power Point presentations provided at various stakeholder meetings. Two examples include a presentation conducted by Innovation staff at the Community Policy Advisory Committee (CPAC) for San Bernardino County stakeholders in May 2014 and by the CASE Coordinator to the County Welfare Director's Association (CWDA) in November 2014.

Links to some of the documents containing updates regarding the CASE Project are provided below:

MHSA Annual Update FY 2010/2011

http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/9_CSS_FY_10-11_Plan_Update_Resubmission_II_6.11.10.pdf

MHSA Annual Update FY 2011/2012

http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/10_CSS_FY_11-12_Plan_Update_4.11.11.pdf

MHSA Annual Update FY 2012/2013

http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/11_CSS_FY_12-13_Plan_Update_6.21.12.pdf

MHSA Annual Update FY 2013/2014

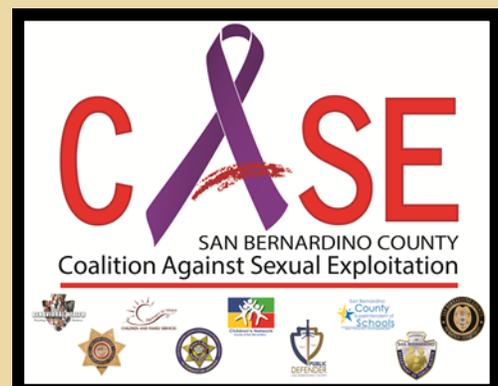
http://www.sbcounty.gov/dbh/mhsa/MHSA_Annual_Update_FY_2013-14_06072013_FINAL.pdf

MHSA Integrated Three-Year Plan FY 2014/2015 – 2016/2017

http://www.sbcounty.gov/dbh/Announcements/2014/MHSA_Integrated_Plan_070114.pdf

Please see the **ATTACHMENT** section of this report for the following CASE related attachments:

- Attachment A – CASE Logic Model
- Attachment B – CASE Brochure
- Attachment C – Referral Response Card
- Attachment D – ID and Assessment Training Flyer
- Attachment E – CASE Walk Flyer
- Attachment F – Community Policy Advisory Committee Presentation
- Attachment G – MAYSI-2 tool





Artwork by Grace Comisso

Workforce Education and Training (WET)

Workforce Education and Training

Introduction

The passage of Proposition 63, the Mental Health Services Act (MHSA), in November 2004 provided a unique opportunity to increase staffing and other resources that support public mental health programs, increase access to much-needed services, and monitor progress toward statewide goals for serving children, transition age youth, adults and older adults and their families. California's public mental health system has suffered from a shortage of public mental health workers, maldistribution of certain public mental health occupational classifications, a recognized lack of diversity in the workforce, and under-representation of professionals with consumer and family member experience, and of racial, ethnic, and cultural communities in the provision of services and support. To address the public mental health workforce issues, the MHSA included a component for Workforce Education and Training (WET) programs.

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 age groups such as infants, children, adolescents, transition age youth, and older adults.

MHSA Legislative Goals and Related Key Outcomes

- Address Workforce Shortages and Deficits Identified in the Workforce Needs Assessment:
 - ◇ Increase in number of employees hired identified as hard to fill in the needs assessment.
 - ◇ Increase in Pre-licensed to Licensed Clinical staff.
 - ◇ Increase in # of qualified applications received for clinical positions.
 - ◇ Increase in DBH pre-licensed clinicians hired (interns vs. non interns).
- Designate a WET Coordinator:
 - ◇ WET Coordinator Designated.
- Educate the Workforce on Incorporating the General Standards:
 - ◇ Trainings documented addressing these standards.
 - ◇ Training evaluations.
- Increase the Number of Clients and Family Members of Clients Employed in the Public Mental Health System:
 - ◇ Increased number of Peer and Family Advocates (PFAs) hired.
- Conduct Focused Outreach and Recruitment to Provide Equal Employment Opportunities in the Public Mental Health System for Individuals who Share the Racial/Ethnic, Cultural and/or Linguistic Characteristics of Clients, Family Members of Clients and Others in the Community Who Have Serious Mental Illness and/or Serious Emotional Disturbance:
 - ◇ Documented efforts that target the identified populations.
 - ◇ Documented Career Fairs including locations.



Artwork by Sheila Dery

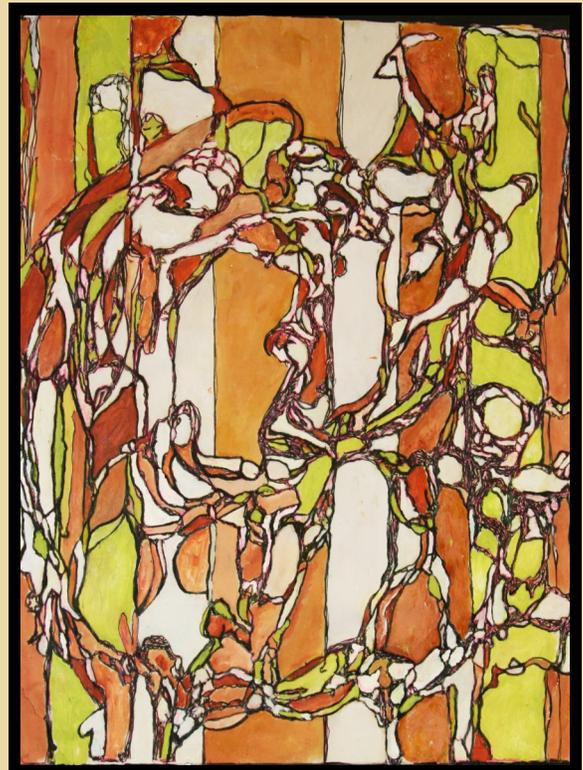
Workforce Education and Training

- Recruit, Employ and Support the Employment of Individuals in the Public Mental Health System Who are Culturally and Linguistically Competent or, at a minimum, are Educated and Trained in Cultural Competence:
 - ◊ Documented efforts that target the identified populations.
 - ◊ Adherence to cultural competency training requirement.
 - ◊ Increase in hiring of culturally competent staff.
 - ◊ Increase in # of bilingual staff, # of bilingual applicants, # of bilingual interns.
- Provide financial incentives to recruit or retain employees within the Public Mental Health System:
 - ◊ Financial incentives implemented.
 - ◊ Tracking for Employee Scholarship applicants.
 - ◊ License Exam Prep Program statistics.
- Incorporate the Input of Clients and Family Members of Clients, and When Possible Utilize Them as Trainers and Consultants in Public Mental Health WET Programs and/or Activities:
 - ◊ Documented meetings with clients and family members.
 - ◊ Documented trainings facilitated by clients and family members.
- Incorporate the Input of Diverse Racial/Ethnic Populations that Reflect California's General Population into WET Programs and/or Activities:
 - ◊ Documented meetings with diverse racial/ethnic populations.
- Establish Regional Partnerships:
 - ◊ Partnerships with other counties established.
- Coordinate WET Programs and/or Activities:
 - ◊ Coordinated WET program/activities.

Positive Results

To meet the Legislative Goal, *Address Workforce Shortages and Deficits Identified in the Workforce Needs Assessment*, a needs assessment was completed in 2008, Psychiatrists, Child Psychiatrists, licensed clinical therapists and Internists (medical doctor) were identified as hard to retain and recruit positions in the County. An updated needs assessment was completed in July 2013 which again identified Child Psychiatrists and Psychiatrists as hard-to-fill hard-to-retain positions.

Through collaboration with Human Resources, DBH was able to address many of the recruitment shortages. As seen in the table below, there has been an increase in applications for most of the occupational shortage areas first identified in the 2008 needs assessment.



Artwork by Gary Bustin

Workforce Education and Training

Number of Qualified Applications Received for DBH Positions per Fiscal Year (FY)						
Job Title	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Child Psychiatrist	N/A	N/A	N/A	N/A	N/A	N/A
Clinic Supervisor	14	10	57	N/A	N/A	30
Clinical Therapist, LCSW	N/A	3	5	12	3	6
Clinical Therapist, MFT	N/A	6	5	12	10	8
Clinical Therapist, Psychology	N/A	1	3	5	1	N/A
Clinical Therapist II	N/A	8	12	32	N/A	54
Mental Health Education Consultant	N/A	N/A	24	20	N/A	N/A
Mental Health Nurse II	2	8	4	7	N/A	29
Mental Health Specialist	72	15	13	120	N/A	90
Nurse Supervisor	4	6	N/A	10	N/A	N/A
Pre-Licensed Clinical Therapist, LCSW	37	50	65	92	81	105
Pre-Licensed Clinical Therapist, MFT	92	82	86	109	112	128
Pre-Licensed Clinical Therapist, Psychology	27	22	21	23	21	20
Pre-Licensed Clinical Therapist, LPCC	N/A	N/A	N/A	N/A	14	2
Program Manager I	75	N/A	N/A	38	N/A	20
Program Manager II	6	11	8	6	N/A	6
Psychiatric Technician I	N/A	43	54	66	59	N/A
Psychiatrist	N/A	N/A	N/A	1	6	9
Research and Planning Psychologist	N/A	N/A	N/A	3	N/A	N/A

The table above shows a significant increase in other clinical positions in DBH. The progress made in the occupational shortage areas and in other clinical positions is a credit to the various WET programs in place. However, more progress is needed as there are still occupational shortages in some key categories.

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 get licensed for their discipline.

“I am very thankful for the LEPP program. This has been a blessing, as it has enabled me to have the tools I needed to have passed the exams.”
- LEPP Participant

Workforce Education and Training

County of San Bernardino DBH WET License Exam Prep Program (LEPP) 01/15 YTD Statistics					
Program	Date Materials Received	# of Participants	# Licensed	% Licensed	
LEPP 1	July 2009	60	41	68%	
LEPP 2	Jan. 2011	38	24	63%	
LEPP 3	Jan. 2012	32	19	59%	
LEPP 4	Applicants through June 30, 2014	15	4	27%	
Totals		145	88		

As can be seen in table above, there have been **145** total participants, with approximately **63%** of the participants getting licensed in their discipline.

	Prior to LEPP (2008)	After LEPP (2009-2014)
Licensed	84	64
Pre-licensed	127	80
% Licensed	40%	44%

With the help of LEPP, DBH has been able to increase the pre-licensed to licensed ratio. Prior to the implementation of LEPP, about **40%** of Clinical Therapist I (CTI) were licensed. After the implementation of LEPP, about **44%** of CTIs are licensed. DBH expects that the percentage of pre-licensed to licensed CTIs will continue to increase with the benefit of LEPP. The LEPP program was changed in 2013 to a reimbursement program.

Participants are reimbursed for their first exam material when they pass the first exam, then are reimbursed for their second exam material when they become licensed. Additionally, there were less licensed and pre-licensed staff after the implementation of LEPP due to the economic downturn.

MHSA also helped DBH to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students enrolled in programs:

- Social Work (Bachelor's and Master's).
- Marriage and Family Therapy (Master's).
- Psychology (Doctorate).

Depending on discipline, interns are in the Internship Program **12** to **18** months. During that time, clinical interns learn to provide clinical services in a community mental health setting and policy interns learn administrative policies and procedures.

DBH is committed to hiring applicants that were previous interns. As can be seen below, the percentage of new pre-licensed Clinical Therapist I's hired increased between FY 2010/11 to FY 2012/13. There is a slight dip in FY 2013/14, however the internship year is not yet completed.

Workforce Education and Training

Pre-licensed Clinicians Hired	FY 2011/12	FY 2012/13	FY 2013/14
Total Number of Interns Hired	13	18	13
Total Number of Non-Interns Hired	11	9	16
% of Interns Hired	54%	67%	45%

To meet the Legislative Goal, *Designate a WET Coordinator*, an administrative manager position was created and continues to be funded for the Workforce Education and Training program.

To meet the Legislative Goal of *Educate the Workforce on Incorporating the General Standards*, DBH continues to incorporate them in trainings: Wellness, Recovery, and Resilience Model. The General Standards are culturally competent, support the philosophy of a client/family driven mental health system, promotes service integration and community collaboration. Among the **136** trainings provided in FY 2013/14, the following trainings are some of the trainings that incorporate the General Standards set by MHSa:

- Deaf Sensitivity Training.
- Medicine Wheel and 12 Steps-Men & Women.
- Recovery, Resiliency and Wellness: Us + Them = We.
- Working in Healthcare.
- Integration Strategies.
- Play Therapy.
- Introduction to Spirituality in Behavioral Health Treatment.
- Trauma Resiliency Model (TRM).
- Evidence Based Practice in Behavioral Health Services.
- Law and Ethics.
- Clinical Supervision.

The table below provides more information regarding trainings provided by WET.

Fiscal Year	Attendance	Classes	CEUs	Evaluation (Avg)
FY 10/11	2,723	176	696.25	4.6
FY 11/12	2,460	211	1,938.55	4.53
FY 12/13	1,948	176	1,288	3.8
FY 13/14	3,095	136	939.45	4.6

The table above also shows the overall average evaluation average of the trainings in FY 2013/14 is **4.6** out of **5**; an increase from FY 2012/13.

To meet the MHSa Legislative Goal of *Increasing the Number of Clients and Family Members of Clients Employed in the Public Mental Health System*, Peer and Family Advocates (PFA) are hired to provide various services in both county and contracted programs. PFAs are mental health consumers and/or family members who provide crisis response services, peer counseling, and linkages to services and supports for consumers of DBH services; assist with the implementation, facilitation and on-going coordination of activities of the CSS plan in compliance with MHSa requirements; and perform related duties as required.

Workforce Education and Training

There has been a significant increase in PFAs hired by DBH. As of February 19, 2015, there are **23** filled PFA positions in DBH. In comparison, in 2006, the Department only had four (**4**) PFA positions budgeted. This is significant increase. In addition, there are **11** additional newly created, vacant PFA positions that are in the process of being filled.

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The table below shows the number of DBH PFAs promoted since 2008.

	2008	2011	2013	2014
PFA's Promoted	3	1	1	4

At the time of this report, DBH contracted providers agencies employ **42** Peer and Family Advocate equivalents as part of their service delivery system. Additionally, four (**4**) PFAs or equivalents were promoted that worked for contract agencies.

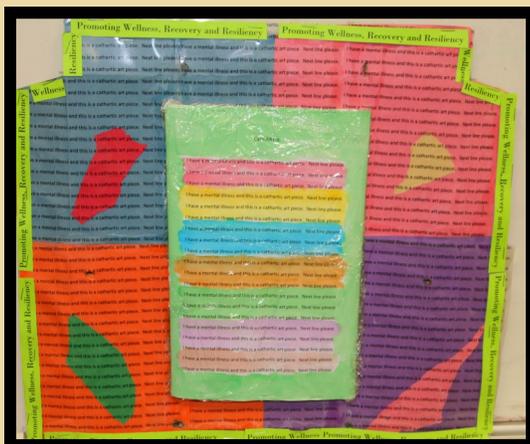
Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

To meet the Legislative Goal, *Conduct Focused Outreach and Recruitment to Provide Equal Employment Opportunities in the Public Mental Health System for Individuals who Share the Racial/Ethnic, Cultural and/or Linguistic Characteristics of Clients, Family Members of Clients and Others in the Community Who Have Serious Mental Illness and/or Serious Emotional Disturbance*, the Volunteer Services Coordinator participates in career fairs through out the County - from Barstow to San Bernardino to Morongo. As can be seen in the table below, the coordinator has doubled the number of career fairs attended since FY 2011/12.

	FY 2011/12	FY 2012/13	FY 2013/14	Total
Number of Schools Visited	13	16	23	52
Number of Participants	2470	2479	1706	6655

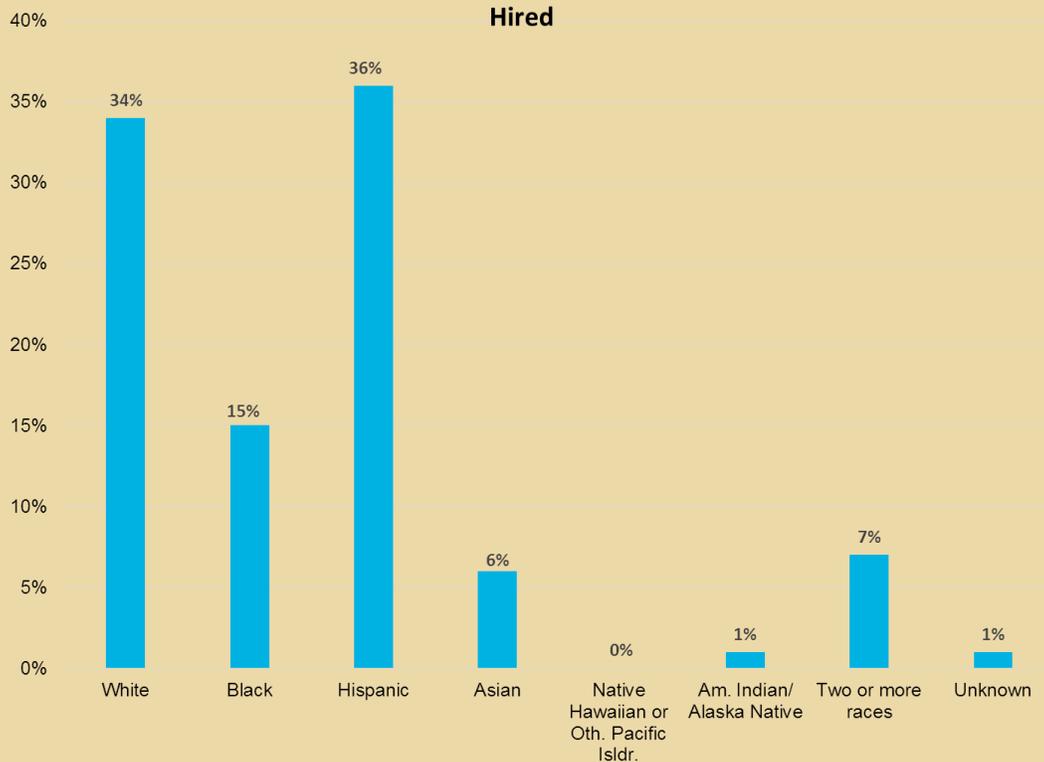
To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to share Behavioral Health career opportunities to monolingual parents so they may have a full understanding of what kind of career options there are for their children.



Artwork by Greg Vander-Haeghen

To meet the Legislative Goal, *Recruit, Employ and Support the Employment of Individuals in the Public Mental Health System Who are Culturally and Linguistically Competent or, at a minimum, are Educated and Trained in Cultural Competence*, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that, all staff are required to take either online or live cultural competency trainings (**2** hours for non-clinicians and **4** hours for clinicians, annually).

Workforce Education and Training



DBH seeks new employees that represents the diverse populations of San Bernardino County, as can be seen in the chart above (from the presentation to the Equal Opportunity Commission on September 4, 2014) to help ensure that DBH staff provides culturally and linguistically competent services.

To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants that are bilingual. In FY 2012/13, there were 150 bilingual staff. For FY 2013/14, there were 165 bilingual staff. The majority of bilingual staff speak Spanish, but other languages include:

- Tagalog
- Vietnamese
- French
- American Sign Language
- Armenian

WET has actively recruited bilingual interns to help provide services in other languages. Since FY 2008/09, on average **30%** of interns are bilingual. Of the bilingual interns, nearly **80%** are Spanish speakers.

Number of Bilingual Interns	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	Total
BSW	3	3	2	0	3	3	14
MSW	5	3	9	5	5	8	35
MFT	6	3	6	2	5	1	23
Psychology	2	1	1	1	0	2	7
Total – Bilingual	16	10	18	8	13	14	79

Workforce Education and Training

To meet the Legislative Goal, *Provide financial incentives to recruit or retain employees within the Public Mental Health System*, the Employee Scholarship Program (ESP) was piloted in 2013. Approximately, **\$25,000** is budgeted per year to be distributed among the awardees. The funding for ESP has been used 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 majority of scholarship funding is aimed at lower level employees to assist them in moving up the career ladder.

In 2013, **12** awardees were selected and another **11** awardees were selected in 2014. The table below provides a breakdown of what degrees the awardees were working on.

Degrees	2013	2014
Associates	2	0
Bachelors	5	5
Masters	5	6
Total Recipients	12	11

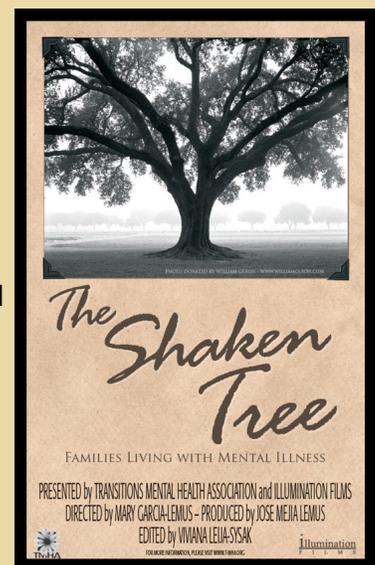
Additionally, of the 2013 awardees, **1** promoted while **2** of the 2014 awardees promoted.

To meet the Legislative Goal, *Incorporate the Input of Clients and Family Members of Clients, and When Possible Utilize Them as Trainers and Consultants in Public Mental Health WET Programs and/or Activities*, the Office of Consumer and Family Affairs are invited to the Workforce Development Discussion (WDD) meeting. The purpose of the WDD is to provide input on the implementation of the MHSWET Plan components.

Peer and Family Advocates (PFAs) train in collaboration with the Training and Development Specialists (TDS). PFAs provide an annual training titled Recovery, Resiliency and Wellness: US + THEM = We. The training is an experiential presentation that explores the Recovery Model and provides the historical background of the Medical Model.

PFAs also conduct the Shaken Tree training. The Shaken Tree is an award-winning documentary film that illuminates, through a collection of stories, the journey families experience when one of its members has chronic, persistent mental illness. Addressing their journey of pain, grief, feeling of helplessness, despair, and stigma associated with mental illness, while giving the viewer hope and ways to survive and live life fully while sharing it with someone who has a mental illness. After the documentary is viewed, the PFAs lead a discussion regarding the film and connects their own experiences with mental illness as a person in recovery of a mental illness and a family member of someone with a mental illness respectively.

PFAs are also part of the Trauma Resiliency Model (TRM) training team. TRM training is a 3-day course designed to teach skills to stabilize ones nervous system to reduce and/or prevent the symptoms of traumatic stress.



Workforce Education and Training

This model has been used successfully with adults and children and is being utilized at Juvenile Hall, triage, Community Crisis Response Team (CCRT), disaster response, Full Service Partnership (FSP), outpatient therapy, and Crisis Walk-In Clinic (CWIC). TRM is an integrative (mind-body approach), which focuses on the biological foundation of trauma and the reflexive, defensive ways the body responds to threat and fear. Although this training does not directly address alcohol and drug treatment, trauma often results in substance use/abuse. TRM promotes healing of mind and body in adults and children around the globe suffering from trauma and thereby create a healthier and safer world.

Lastly, PFAs participate in the Crisis Intervention Training (CIT) as panel members. The panel discusses their experience interacting with law enforcement. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with mental illness. Through a partnership between the County of San Bernardino Department of Behavioral Health and the San Bernardino County Sheriff's Department, the CIT Model helps reduce both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

In an effort to meet the Legislative Goal, *Incorporate the Input of Diverse Racial/Ethnic Populations that Reflect California's General Population into WET Programs and/or Activities*, DBH uses multiple methods. DBH participates in the County's Workforce Development Division (WDD) meetings and also partners with the DBH - Office of Cultural Competency and Ethnic Services (OCCES). These partnerships work towards developing a diverse workforce that is culturally competent in providing culturally and linguistically appropriate services to County residents. Some of the activities incorporated in these efforts include:

- Providing cultural competence training to all staff on an ongoing basis.
- Developing policies on the appropriate use of bilingual staff and interpreters in providing services.
- Providing guidelines on best practices when serving culture-specific groups and individuals.
- Providing interpreter training to all bilingual staff.
- Recruiting and retaining multilingual and multicultural staff at all levels of the department.
- Collaborate with community partners to identify and address the cultural needs of their communities.

Twelve Culture-Specific Awareness Subcommittees facilitated by OCCES are also used to address this Legislative Goal.

To meet the Legislative Goal, *Establish Regional Partnerships*, the Southern Counties Regional Partnership (SCRIP) was created in 2009. SCRIP 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 mental health system workforce when those programs are more easily coordinated at a regional level. The ten member counties are Kern,

Think About It...

1 in 4 are affected by Mental Illness.
On Average 3,000 people commit suicide every year.

Professions and Salary Ranges:

- Mental Health Counselor (8-11 yrs) Salary Range: \$14,100 - \$26,000
- Therapist (0-12 yrs) Salary Range: \$16,000 - \$34,000
- M.D. (D.D.) Psychiatrist (0-12 years) Salary Range: \$175,000 - \$240,000
- Ph.D. / Psy.D. Psychologist (6-9 years) Salary Range: \$80,000 - 110,000
- Counselor (5-7 years) Salary Range: \$20,000 - \$30,000
- Social Worker (4-7 years) Salary Range: \$40,000 - \$51,000
- Psychiatric Nurse, R.N. (2-4 years) Salary Range:
- Peer Support Specialist (1 year) Salary Range: \$31,000 - \$47,000
- Mental Health Specialist (2-4 years) Salary Range: \$38,000 - \$48,000
- Psychiatric Technician (1 year) Salary Range: \$35,000 - \$45,000
- Mental Health Case Manager (4-11 yrs) Salary Range: \$45,000 - \$55,000

The Inland Empire suffers from Behavioral Health Workforce Shortages and there is a high demand for careers like these.

Which Will You Choose?

Workforce Education and Training

Imperial, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tri Cities and Ventura.

San Bernardino County was the fiscal agent of SCRCP until June 30, 2014. Santa Barbara County is the new the fiscal agent for SCRCP.

Some upcoming projects include:

- Trainings for bilingual staff
- Conference with best practices for how to engage consumers
- JobsinSoCal.com marketing plan



To meet the Legislative Goal, *Coordinate WET programs and/or Activities*, the WET staff continues to coordinate all WET programs/activities.

Another aspect of WET to highlight is the Leadership Development Program (LDP). DBH contracted with Loma Linda University – School of Behavioral Health (LLUSBH) to develop the program. Under this agreement Loma Linda University has worked with DBH WET staff to evaluate and implement Evidence Based Leadership practices as part of the LDP curriculum.

Through this program, DBH will develop leaders from existing staff, begin succession planning for future leadership, begin to make leadership based assignments, and build leadership into supervisory training.

As can be seen in the table below, since LDP started in 2011, on average nearly **40%** of the participants have promoted into supervisory or managerial positions.

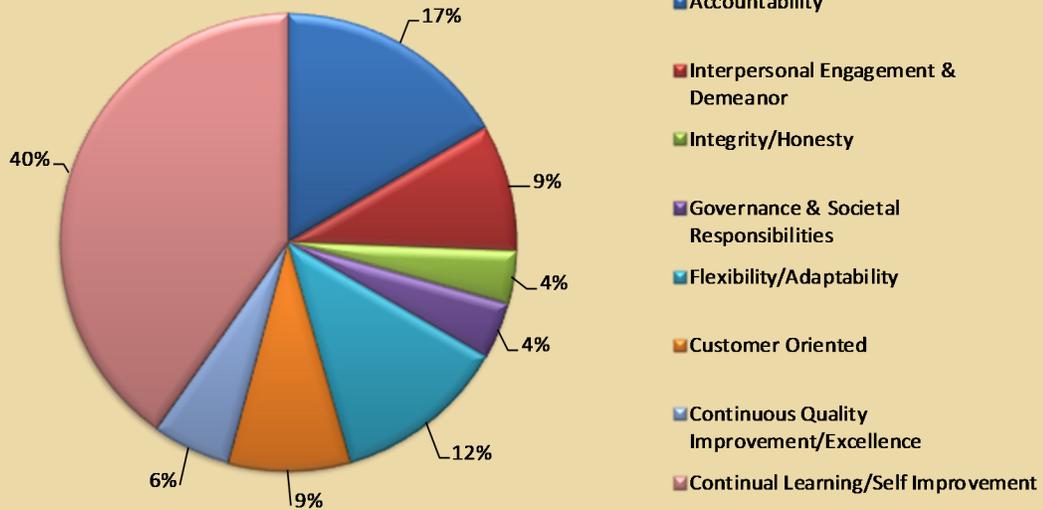
Year	Number of Participants	Number of Promotions	Percentage of Promotions
2011	11	7	64%
2012	15	6	40%
2013	15	7	47%
2014	16	1	6%
Total	57	21	Ave. 39%

LLUSBH completed an outcomes summary on LDP. Data was collected from the participants to self report which Attitudes and Behaviors, Knowledge and Perspectives, and Advanced Skills best accurately described them before and after completing the LDP program. The charts below show the summarized data collected for 2011, 2012, and 2013 from participants after completing LDP.

For Attitudes and Behaviors, the top 3 choices that were important to the participants were Continual Learning/Self Improvement, Accountability, and Interpersonal Engagement and Demeanor.

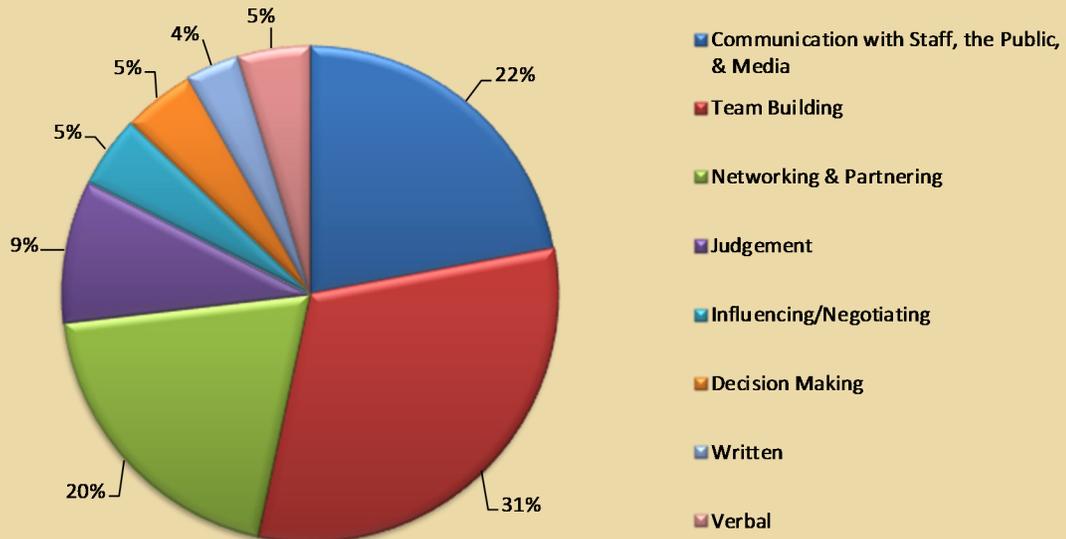
Workforce Education and Training

2011, 2012, & 2013 - Attitudes & Behaviors - Code Frequency



For Advanced Skills, in the chart below, the top 3 choices that were important to the participants were Team Building, Communicating with Staff, the Public, and Media, and Networking and Partnering.

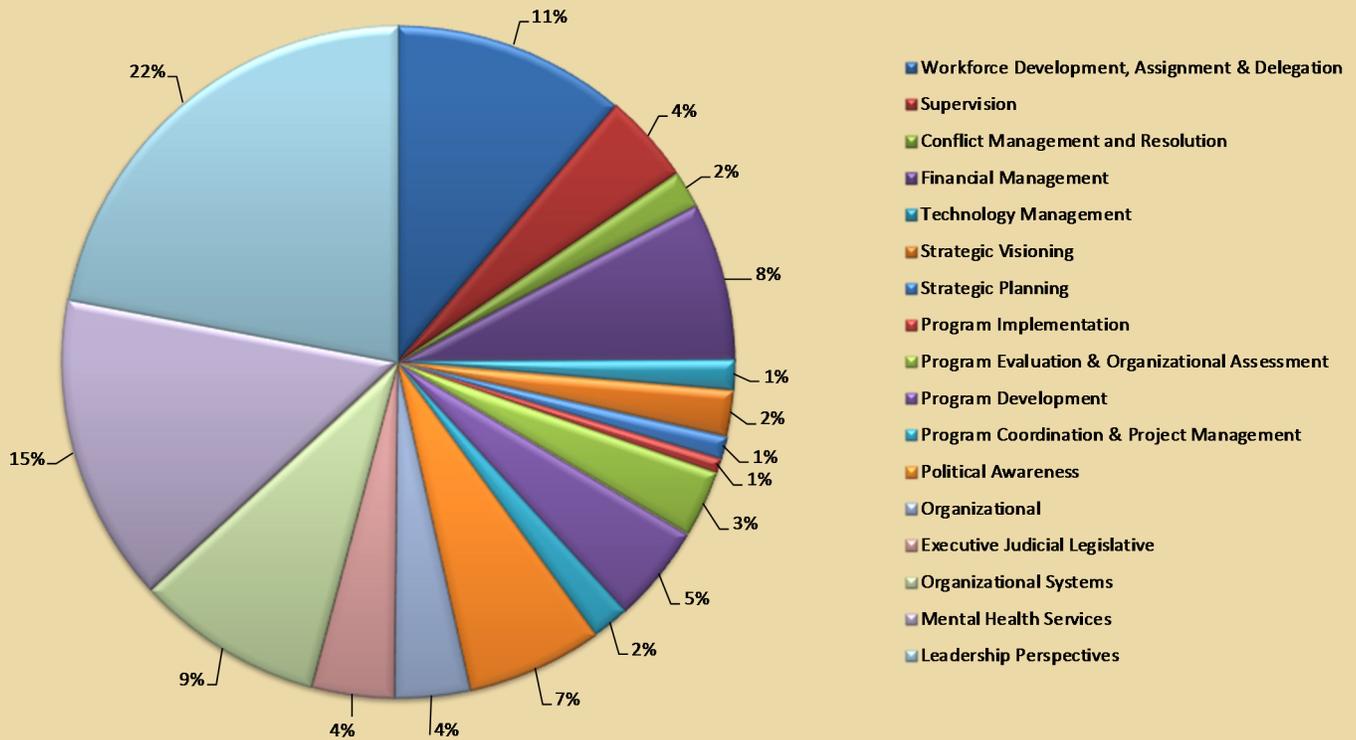
2011, 2012, & 2013 - Advanced Skills - Code Frequency



Workforce Education and Training

For Knowledge and Perspectives, in the chart below, the top 3 choices that were important to the participants were Leadership Perspectives, Mental Health Services, and Workforce Development (Assignment and Delegation).

2011, 2012, & 2013 - Knowledge & Perspectives - Code Frequency



“I would like to thank you for the opportunity to go through LDP program. I enjoyed the whole experience, well not so much the end but I am proud I got through it. I enjoyed hearing leadership in our meetings and their philosophies and meeting new people that I have grown to admire.”

- LDP Participant

Success Story

Yvonne, Peer and Family Advocate III—Employee Intern

I started my educational trajectory many years ago and life happened. There were many obstacles that I encountered on the journey to attaining my Master’s Degree in Social Work (MSW). For example, personal, medical, and educational adversities. I had been diagnosed with a learning disability during my childhood. I had been told by professional social workers and career counselors that this goal was impossible and that I would never be able to attain such a high goal and that I needed to choose a simple trade and be happy doing that job. However, attaining a higher level of education was extremely important to me. I had come from an impoverished background and attaining an education was not a top priority while growing up. But I was determined not to let anyone or anything hinder the goal that was burning upon my heart to complete my education and help others. Consequently, my educational journey was literally a merry-go-round trip over a 20 year

Workforce Education and Training

period of time, talking about needing and praying for the patience of Job's to complete my career goals.



Artwork by Sarah Favorite

In 1994, I endured a major crisis and was disabled for a period of four years. I gave up on me and my dream during the course of my crisis. When I was released to return to work, I was hired by the Department of Behavioral Health as a Peer Family Advocate III and my educational dream came alive again. I knew I had to complete the goal that I had started years ago. So I began inquiring about the MSW Internship Program. I was directed to Arelis Martinez, Social Work Internship Supervisor, who began his magical collaboration with different universities. The magic had begun and discussions among Workforce Educational Training (WET) Supervisors and Loma Linda Universities (LLU) was happening. While details were being worked out among administrators, I attended the yearly internship orientation presentation and began the application process. After all professional details were completed, Arelis and LLU proposed a four year part time curriculum program to me. I was not happy with that proposal, but I accepted it and begun my program. It has been hard work, time consuming, and challenging but it has been one of the best decisions of my life story. The DBH internship program has been a great part of my success. The Internship administrators, supervisors,

teachers, and co-workers have all been a wonderful support team as I embraced the challenge of returning to school after years. There is simply no way I would have been able to complete my educational goals without the internship program. The program allowed me the opportunity to maintain full-time employee status with benefits; time to attend school; two separate internship experiences; and tons of supervision while learning.

I will be graduating in June 2015; I have now become a professional asset to the mental health field, the Department of Behavioral Health, and to the clients that I will continue to assist with services. Thanks for believing in me and for me.

To all the Peer Family Advocates who have felt stigmatized, battled with feelings of defeat and told that their diagnosis will not allow them to achieve the goals that are burning in the heart, I say this persevere with determination and don't let fear of past failures determine your future. Empower yourself and take control of your life. It will be hard; it will be challenging, and you will want to give up but the challenge is to stay empowered and stay focused and watch yourself succeed. I am nobody special; I simply empowered myself with determination, positive support, the will to succeed, and went for what God was burning in my heart. As George S. Patton said: "Accept the challenges so that you can feel the exhilaration of victory."

Challenges

- Staff hiring challenges. The average length of time from when a position becomes open to the first day at their new job can take up to 20 weeks (4 months). Such a delay hinders a program's ability to proceed with projects.

Workforce Education and Training

- Loss of Psychiatrists. DBH continues to lose Psychiatrists to retirement or to other employers that can offer higher wages or better benefits.

Solutions in Progress

- WET is continuing to work with Human Resources to implement strategies that expedite staff hires.
- WET is going to increase the number of Psychiatric Residents in the next fiscal year.

Program Expansion

For FY 2015/16, WET is expanding the Psychiatry Residency Program by adding additional residents from Loma Linda University Medical Center and Arrowhead Regional Medical Center to help address the Psychiatrist shortage in the County.



Artwork by Peter Millar

DBH is also expanding the MFT Internship Program by adding a doctoral MFT intern. Currently, all intern positions are filled with clinical interns. There is a need for a succession plan for health informatics and research to support outcomes driven programming that adding a doctoral MFT intern would address.

The expansion of the Employee Internship is the final planned program expansion for FY 2015/16. Specifically, the addition of Bachelor in Social Work (BSW) and Alcohol and Drug Counselor employee interns.

Collaborative Partners

- Alder School of Professional Psychology.
- American Career College.
- Argosy University.
- Arrowhead Regional Medical Center (ARMC).
- Azusa Pacific University.
- Brandman University.
- California Baptist University.
- California State Polytechnic University – Pomona.
- California State University – Fullerton.
- California State University – Long Beach.
- California State University – Northridge.
- California State University – San Bernardino.
- Center for Information Systems and Technology – Claremont Graduate University.
- Chapman University.
- Chicago School of Professional Psychology.
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY-ROP).
- Hope International University.
- Inland Coalition.
- Intercoast College.
- ITT Technical Institute.
- La Sierra University.
- Loma Linda University – School of Behavioral Health (LLUSBH).
- Loma Linda University Medical Center (LLUMC).
- Loma Linda University School of Medicine (LLUSM).
- Mount St. Mary's.
- National University.
- Pacifica Graduate University.
- Pomona Valley Hospital Medical Center (PVHMC).
- San Bernardino County Superintendent of Schools Regional Occupational Program.
- Summit Career College.
- Touro University College of Osteopathic Medicine (TUCOM).
- UEI College.
- University of California – Riverside.
- University of La Verne.
- University of Redlands.
- University of Southern California.
- Western University of Health (WUH).



Department of Behavioral Health One Stop Transitional Age Youth (TAY) Center

Capital Facilities and Technological Needs (CFTN)

Capital Facilities and Technological Needs

Introduction

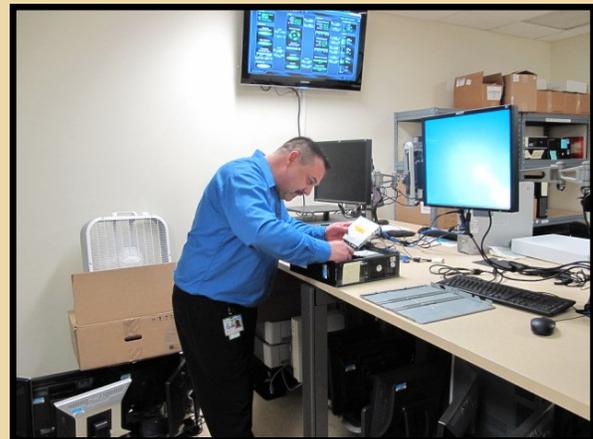
Each County's Capital Facilities and Technological Needs Component Proposal and the Capital Facilities and/or Technological Needs Project Proposals must support the goals of the MHPA and the provision of MHPA services. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

These efforts include development of a variety of technology uses and strategies and/or of community-based facilities which 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 a technological infrastructure for the mental health system to facilitate the highest quality, cost-effective services and supports for clients and their families.

The San Bernardino County Department of Behavioral Health (DBH) has embraced the transformational concepts inherent to MHPA to develop a community driven, cultural competent, wellness focused Capital Facilities Project that targets individuals and families, with special attention to underserved and unserved communities county wide.



DBH Administrative Building



Information Technology at Work

Capital Facilities and Technological Needs

MHSA Legislative Goals and Related Key Outcomes

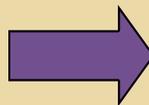
- Expansion of the capacity/access of existing services or the provision of new services:
 - ◊ Increased capacity.
 - ◊ Increased access to services.
 - ◊ Increased provision of new services.
- Increase the county mental health infrastructure on a permanent basis:
 - ◊ Permanent capital asset obtained.
- Modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency, and cost effectiveness:
 - ◊ Implement, maintain, and improve the Electronic Health Records.

Behavioral Health Management Information Systems (BHMIS) Replacement– Electronic Health Record (EHR)

Replacement of the 22-year old information system used to track clients as they progress through treatment by implementing a new BHMIS incorporating an integrated EHR system to improve technological efficiencies and meet changing state requirements, DBH is currently implementing the San Bernardino Accessible Billing and Electronic Records (SABER) System. SABER is an integrated information systems infrastructure, which would allow information to be securely accessed and exchanged. SABER, which includes an EHR, will enable DBH to more efficiently and accurately capture and retrieve consumer information.

The team has successfully accomplished the following:

- Implemented e-prescribing (Dr. First) solution - Phase I.
- Evaluated and selected a solution and selected a vendor.
- Negotiated and signed a contract.
- Designed and procured required infrastructure hardware.
- Implemented supporting infrastructure.
- Conducted support and system administration staff training.



Capital Facilities and Technological Needs

Challenges

Technological Needs

DBH continues to move forward with updating the department's technology in regards to the EHR system. Some of the challenges encountered include:

- Time constraints.
- Staffing.

Solutions

Technological Needs

Solutions identified by the implementation team include :

- Conducting e-prescribing (Dr. First) Phase II solution.
- Conducting business process group session.
- Conducting "Super-User"/Subject Matter Expert training.
- Conducting User Acceptance Testing of contracted modifications.
- Conducting data integrity and data preparation for data conversion.
- Scheduling end-user training for in-house staff and contract providers.
- Implementation of full production billing system (ShareCare) environment.

Collaborative Partners

The following agencies are collaborative partners for the CFTN component:

County of San Bernardino Partners:

- Information Services Department (ISD).
- Arrowhead Regional Medical Center (ARMC).
- Department of Behavioral Health staff
- County Counsel.
- Purchasing Department.
- County Administrative Office (CAO).

Community Partners:

- Contracted Service Providers.
- Contracted Vendor.

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Check out the latest SABER Times!

Submit all those DEAR SABER questions!

Suggest someone for the SABER Spotlight!

Visit <http://countyline/dbh/ehr/>

Dear SABER

SABER TIMES
San Bernardino Accessible Billing & Electronic Records
February 2015

Volume 2, Issue 2

Expecting SABER

By Jane C. Smith LMFT, LPCC, MCA, Clinic Supervisor

Without realizing it people constantly reassess how they are doing in life relative to their expectations and the expectations of others. There is no such thing as "objective" performance; instead, we regularly engage in a social comparison process that weighs our performance relative to benchmarks. Our going expectations also sway how much we enjoy movies and books, how we evaluate the quality of products, even how we evaluate how well our workplace adapts to change. Many times I have been hyped up for a movie only to see it and wonder what the fuss was about. On occasion I've actually been angry after the fact about the stellar reviews that preceded my viewing. In those cases, I was an even harsher critic of the film than if I had gone in without preconceptions.

Some of the most successful people and organizations in the world are those that embrace surprise. Embracing, rather than fearing, the unexpected is a key to really getting ahead, as well as being more adaptable. People have a remarkable ability to become accustomed to whatever becomes the norm in their lives. We move to a new house, we're thrilled beyond belief for a time, but then inexorably we fall into our routine, which includes going home to the same place day after day. Happiness researchers have noticed this.... *Continued on page 2*

"SABER Spotlight" — Our Behind the Screen Heroes

This month, SABER Times is featuring the contributions of the staff at West Valley Region. Supervising Office Specialist, Julie Phillips gave these ladies the task of cleaning up a variety of client data from the Vista, Ontario and Upland Clinics, in the Mental Health Services, CalWORKs, and Alcohol and Drug Services programs. Although they were allocated one week to finish this task, they worked together to complete it in just one day! Thank you for your hard work and contribution to the success of SABER!

Do you know of a person or team that's going above and beyond to make SABER a success? Let us know and they could be our next "SABER Spotlight!" Simply send an email explaining why they should be recognized to DearSABER@dbh.sbcounty.gov

West Valley team; left to right: Robie Valdez, SOA, Norma Lopez, CA IV, Yolanda Romero, CA IV, and bottom row: Casadine Carrero, CA IV. Not pictured but assisted with Data Clean Up: Brice Flores, CA III CalWORKs and Renee Tring, CA III ADS.

<http://countyline/dbh/ehr/>
SABER Times

Capital Facilities and Technological Needs

Future Project: Obtain Permanent Capital Asset– Capital Facilities

DBH has a planned project to build a new facility on existing County owned property that will house a new Crisis Residential Treatment (CRT) program. Construction of the new facility will occur during the 2015/16 fiscal year (FY) and will be modeled after DBH's previous Capital Facilities project, the Transitional Age Youth One Stop Center/Crisis Residential.

The proposed project will demolish two uninhabitable buildings, which will be replaced with a newly designed structure that will meet the needs for the new CRT facility. The CRT will contain 16 beds, specializing in providing crisis intervention for individuals diagnosed with co-occurring substance use and mental health disorders. Services will include, but will not be limited to:

- Assessments,
- Treatment plan development,
- Collateral services,
- Crisis intervention,
- Medication support services, and
- Individual and group therapy.

The goal of the program is to improve the appropriateness of care, increase access to community based mental health crisis services, reduce recidivism and mitigate the burden on hospital and law enforcement resources. The new CRT program services, which will be MHSA funded, are projected to begin in FY 2016/17. This new project is part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA) for capital funding for construction of a crisis residential treatment facility for the expansion of crisis residential treatment services.



Before Building Rehabilitation



After Building Rehabilitation



Fiscal

Estimated Cost Per Client Fiscal Year 2015-2016

County of San Bernardino

Department of Behavioral Health

Mental Health Services Act (MHSA)

MHSA Annual Update FY 2015/2016

PREVENTION AND EARLY INTERVENTION

PEI Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Cost Per Client
				Children (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
PEI SI-1	Student Assistance Program	SAP	\$ 3,152,746	24,500	2,100	6,500	0	33,100	\$ 95
PEI SI-2	Preschool PEI Program	PPP	\$ 425,000	650	0	250	0	900	\$ 472
PEI SI-3	Resilience Promotion in African American Children	RPIAAC	\$ 672,477	2,000	0	0	0	2,000	\$ 336
PEI CI-1	Promotores de Salud	PdS	\$ 1,148,630	1,100	3,700	21,000	5,600	31,400	\$ 37
PEI CI-2	Family Resource Centers	FRC	\$ 3,348,583	10,000	2,700	8,000	1,300	22,000	\$ 152
PEI CI-3	Native American Resource Center	NARC	\$ 500,000	500	1,000	500	200	2,200	\$ 227
PEI CI-4	National Crossroads Education Institute Training	NCTI	\$ 532,900	500	4,000	0	0	4,500	\$ 118
PEI SE-1	Older Adult Community Services	OACS	\$ 900,000	0	0	0	6,000	6,000	\$ 150
PEI SE-2	Child and Youth Connection	CYC	\$ 13,709,450	4,300	4,000	200	0	8,500	\$ 1,613
PEI SE-3	Community Wholeness and Enrichment	CWE	\$ 1,442,553	0	1,300	3,700	0	5,000	\$ 289
PEI SE-4	Military Services and Family Support	MSFS	\$ 725,000	400	500	2,400	200	3,500	\$ 207
PEI-SE-5	Lift - Home Nurse Visitation Program	Lift	\$ 396,000	0	100	0	0	100	\$ 3,960
PEI SE-6	Coalition Against Sexual Exploitation	CASE	\$ 436,356	25	25	3,000	0	3,050	\$ 143
Total Program Costs			\$ 27,389,695	\$ 43,975	\$ 19,425	\$ 45,550	\$ 13,300	122,250	\$ 224
PEI Administration			\$ 3,828,408						
PEI Assigned Funds			\$ 561,894						
PEI Program Total			\$ 31,779,997						

Total Client Served = 120,700 or \$224 per client.

Estimated Cost Per Client Fiscal Year 2015-2016

County of San Bernardino

Department of Behavioral Health

Mental Health Services Act (MHSA)

MHSA Annual Update FY 2015-2016

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client	
			Children /Youth	TAY	Adult	Older Adult			
			(0-15)	(16-25)	(26-59)	(60+)			
A-1	Clubhouse Expansion Program	\$2,919,505	0	0	8,250	0	8,250	\$354	
A-2	Forensic Integrated Mental Health Services	CIT/HDMC/FACT/STAR	\$7,021,959	0	0	475	0	475	\$14,783
A-3	Hospital High User Act Team	ACT/MAPS	\$3,761,391	0	0	185	0	185	\$20,332
A-4	Crisis Walk-in Center/Crisis Stabilization Unit	CWIC	\$5,002,958	420	1,500	5,982	300	8,202	\$610
A-5	Psychiatric Triage Diversion Program		\$2,580,726	0	950	3,000	140	4,090	\$631
A-6	Community Crisis Response Team	CCRT	\$7,123,127	2,340	761	2,416	327	5,844	\$1,219
A-7	Management and Outreach Services	HICMOS	\$9,486,215	0	8	1,056	40	1,104	\$8,593
A-8	Alliance for Behavioral and Emotional Health		\$370,000	0	0	145		145	\$2,552
A-9	Access, Coordination and Service Enhancement of Quality Behavioral Health Services	ACE	\$3,750,280	0	0	2,400	0	2,400	\$1,563
C-1	Comprehensive Children and Family Support Services	CCFSS	\$13,702,352	882	0	0	0	882	\$15,536
C-2	Integrated New Family Opportunities	INFO	\$1,337,187	30	25	0	0	55	\$24,312
OA-1	Agewise - Circle of Care: General System Development		\$2,625,177	0	0	0	194	194	\$13,532
OA-2	Agewise - Circle of Care: Mobile Outreach and Intensive Case Management		\$873,926	0	0	0	150	150	\$5,826
TAY-1	Transitional Age Youth One Stop Centers	TAY	\$5,795,799	0	1,400	0	0	1,400	\$4,140
	Total Program Costs		\$66,350,602					33,376	\$1,988
	CSS Administration		\$14,295,714						
	CSS Total		\$80,646,316						

Total Clients Served = 33,376 or \$1,988 per person

Estimated Cost Per Client Fiscal Year 2015-2016

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Annual Update FY 2015-16

INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
			Children /Youth	TAY	Adult	Older Adult		
			(0-15)	(16-25)	(26-59)	(60+)		
Transitional Age Youth Behavioral Health Hostel	The STAY	\$ 2,500,000		96			96	\$ 26,042
Recovery Based Engagement Support Teams	RBEST	\$ 1,786,064			300		300	\$ 5,954
Total Program Costs		\$ 4,286,064					396	\$ 10,823
INN Administration		\$ 817,768						
INN Total		\$ 5,103,832						

Total Clients Served = 396 or \$10,823 per person

**FY 2015-16 Mental Health Services Act Expenditure Plan
Funding Summary**

County: San Bernardino

Date: 6/15/15

	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 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	52,735,290	18,273,648	2,895,894	1,320,603	2,635,060	
2. Estimated New FY2015/16 Funding	58,875,054	14,681,456	3,113,776			
3. Transfer in FY2015/16 ^{a/}	(5,210,536)			1,645,833	3,564,703	
4. Access Local Prudent Reserve in FY2015/16	0	0				0
5. Estimated Available Funding for FY2015/16	106,399,808	32,955,104	6,009,670	2,966,436	6,199,763	
B. Estimated FY2015/16 MHSA Expenditures	53,484,191	21,261,670	3,986,088	2,966,436	4,169,797	
G. Estimated FY2016/17 Unspent Fund Balance	52,915,617	11,693,434	2,023,582	0	2,029,966	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	22,152,363
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

**FY 2015-16 Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: San Bernardino

Date: 6/16/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. SI-1 Student Assistance Prgm	3,152,746	3,152,746				
2. SI-2 Preschool Program	425,000	425,000				
3. SI-3 Resilience in African-Amr Children	672,477	672,477				
4. CI-1 Promotores de Salud/Comm Health Worker	1,148,630	1,148,630				
5. CI-4 National Crossroads Education Institute Training	532,900	532,900				
6. SE-1 Older Adult Community Services	900,000	900,000				
7. SE-4 Military Services & Family Support	725,000	725,000				
8. SE-5 LIFT	396,000	396,000				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. CI-2 Family Resource Centers	3,348,583	3,348,583				
12. CI-3 Native American Resource Centers	500,000	500,000				
13. SE-2 Child and Youth Connection	13,709,450	3,191,123	3,115,421		2,977,398	4,425,508
14. SE-3 Community Wholeness and Enrichment	1,442,553	1,442,553				
15. SE-6 Coalition Against Sexual Exploitation (CASE)	436,356	436,356				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	3,828,408	3,828,408				
PEI Assigned Funds	561,894	561,894				
Total PEI Program Estimated Expenditures	31,779,997	21,261,670	3,115,421	0	2,977,398	4,425,508

**FY 2015-16 Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: San Bernardino

Date: 3/17/15

	Fiscal Year 2015/16					
	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. Youth Hostel	2,500,000	1,382,256	810,000		294,030	13,714
2. Recovery Based Engagement Supp Team	1,786,064	1,786,064				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	817,768	817,768				
Total INN Program Estimated Expenditures	5,103,832	3,986,088	810,000	0	294,030	13,714

**FY 2015-16 Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: San Bernardino

Date: 3/17/15

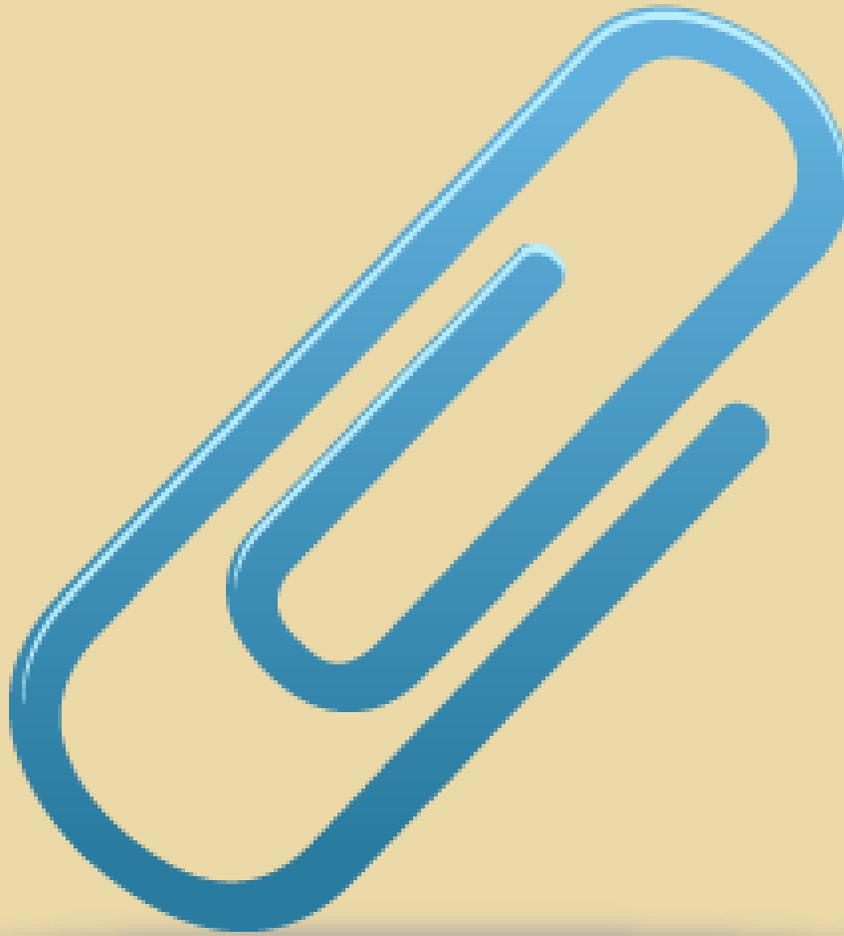
	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing and Support	985,924	985,924				
2. Training and Technical Assistance	283,219	283,219				
3. Mental Health Career Pathways Program	25,000	25,000				
4. Residency and Internship Program	1,748,892	1,489,560	259,332			
5. Financial Incentive Program	75,000	75,000				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	107,733	107,733				
Total WET Program Estimated Expenditures	3,225,768	2,966,436	259,332	0	0	0

**FY 2015-16 Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: San Bernardino

Date: 3/17/15

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Data Warehouse Continuation Project	726,621	721,273				5,348
12. Empowered Communication/Sharepoint Proj	7,877	7,877				
13. Virtual Infrastructure Project	35,000	35,000				
14. Electronic Health Record Project	1,191,614	1,191,614				
15. BHMIS Replacement Proj	2,067,691	2,067,691				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	146,342	146,342				
Total CFTN Program Estimated Expenditures	4,175,145	4,169,797	0	0	0	5,348



Attachments

Behavioral Health

January 27, 2015

Michelle Dusick
Acting MHSA Coordinator
(909) 252-4021
mdusick@dbh.sbcounty.gov

Make a difference! Attend a Mental Health Services Act Annual Update Stakeholder Meeting!



WHO: All residents living in San Bernardino County who are interested in the public mental health service delivery system, learning about the Mental Health Services Act (MHSA) and participating in the Annual Update for Fiscal Year 2015/16.

WHAT: A series of public meetings will take place throughout the county to promote community conversation and participation regarding the Annual Update for Fiscal Year 2015/16 and to discuss topics for the future of mental health policy and program planning.

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

WHY: To provide information and promote community conversation about the MHSA Annual Update for Fiscal Year 2015/16, and how it will affect the residents of San Bernardino County. Also, we will be facilitating a discussion to obtain ideas, topics, and suggestions for the future of local mental health policy and program planning.

WHEN & WHERE:

Join the Department of Behavioral Health (DBH) at the upcoming Community Policy Advisory Committee (CPAC) meeting, the Cultural Competency Advisory Committee and Sub-Committee meetings (CCAC), or one of the local District Advisory Committee (DAC) meetings. A special presentation will also be held at the Consulate of Mexico in San Bernardino (in Spanish) in addition to an on-line after-hours event.

CONTACT: Please see contact information for each meeting. For all numbers, TTY users please dial 711.

**Community Policy Advisory Committee (CPAC) and
Cultural Competency Advisory Committee (CCAC) Meetings**

<p align="center"><i>CPAC Meeting</i> Thursday, March 19, 2015 9:00 a.m. – 12:00 p.m. CSBHS - Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact: Cheryl McAdam (909) 252-4021</p>	<p align="center"><i>CCAC Meeting</i> Thursday, March 19, 2015 1:00 – 3:00 p.m. CSBHS - Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact: Aidery Hernandez (909) 386-8223</p>
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District Advisory Committees (DAC) Meetings

<p align="center"><i>First District DAC</i> Wednesday, February 18, 2015 11:00 a.m. - 12:30 p.m. Victor Community Holistic Campus 15400 Cholame Rd. Victorville, CA 92392 Contact: Chris Croteau (760) 955-7287</p>	<p align="center"><i>Second District DAC</i> Thursday, February 12, 2015 3:00 - 5:00 p.m. Mariposa Community Counseling 2940 Inland Empire Blvd. Ontario, CA 91764 Contact: April Guzman (909) 458-1381</p>
<p align="center"><i>Third District DAC</i> Tuesday, February 17, 2015 11:00 a.m. - 12:00 p.m. Our Place – Clubhouse 721 Nevada Street, Ste. 205 Redlands, CA 92373 Contact: Debbi Cazarez (909) 387-7219</p>	<p align="center"><i>Fourth District DAC</i> Thursday, February 12, 2015 3:00 - 5:00 p.m. Mariposa Community Counseling 2940 Inland Empire Blvd., Ontario, CA 91764 Contact: April Guzman (909) 458-1381</p>
<p align="center"><i>Fifth District DAC</i> Monday, February 23, 2015 5:30 - 7:30 p.m. New Hope Family Life Center - Auditorium 1505 W. Highland Ave. San Bernardino, CA 92411 Contact: Crista Wentworth (909) 421-4606</p>	

Special Meetings

<p align="center"><i>Consulate of Mexico in San Bernardino Spanish Meeting</i> Tuesday, March 3, 2015 9:00 – 11:00 a.m. Consulate of Mexico in San Bernardino–Lobby 293 North D Street San Bernardino, CA 92401 Contact: Aidery Hernandez (909) 386-8223</p>	<p align="center"><i>Online After Hours Session</i> Thursday, March 12, 2015 5:30 - 7:30 p.m. Online Adobe Connect Event Conference Number 1-877-820-7831 Passcode: 947294 To join the meeting please use the link below: https://sbcdbh.adobeconnect.com/r3sildf57pa/ Contact: Cheryl McAdam (909) 252-4021</p>
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CCAC Sub-Committee Meetings

Contact: Aidery Hernandez (909) 386-8223

<p><i>Asian Pacific Islander Awareness Sub-Committee</i> February 10, 2015 DBH Administration — Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.</p>	<p><i>Spirituality Awareness Sub-Committee</i> February 10, 2015 DBH Administration — Room 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>
<p><i>Native American Awareness Sub-Committee</i> February 17, 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.</p>	<p><i>Disabilities Awareness Sub-Committee</i> February 18, 2015 DBH Administration — Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30 - 9:30 a.m.</p>
<p><i>Transitional Age Youth Awareness Sub-Committee</i> February 18, 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.</p>	<p><i>Transitional Age Youth Awareness Sub-Committee</i> February 19, 2015 Pacific Clinics — Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.</p>
<p><i>Co-Occurring and Substance Abuse Sub-Committee</i> February 19, 2015 County of San Bernardino Health Services Auditorium 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.</p>	<p><i>Consumer & Family Member Awareness Sub-Committee</i> February 23, 2015 DBH Administration — Rm 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.</p>
<p><i>LGBTQ Awareness Sub-Committee</i> February 24, 2015 DBH Administration — Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.</p>	<p><i>Women's Awareness Sub-Committee</i> February 25, 2015 DBH Administration — Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>
<p><i>Veteran's Awareness Sub-Committee</i> March 2, 2015 DBH Administration — Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.</p>	<p><i>Latino Health Awareness Sub-Committee</i> March 3, 2015 Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.</p>
<p><i>African American Awareness Sub-Committee</i> March 9, 2015 Young Visionaries, 1580 N. Waterman Ave. San Bernardino, CA 92408 2:00 - 3:00 p.m.</p>	

Behavioral Health

Michelle Dusick
Coordinadora Temporal de MHSA
(909) 252-4021
mdusick@dbh.sbcounty.gov

27 de enero del 2015

¡Haga la diferencia! ¡Asista una reunión comunitaria sobre la Actualización Anual de la Ley de Servicios de Salud Mental!



¿QUIEN?: Todos los residentes del Condado de San Bernardino que estén interesados en el sistema de prestación de servicios de salud mental, que quieran aprender sobre la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés), que quieran participar en la Actualización de la Ley De Servicios de Salud Mental para el año fiscal 2015/16.

¿QUE?: Una serie de reuniones públicas, se llevarán a cabo en todo el condado para promover la conversación comunitaria y participación en cuanto a la Actualización Anual de la Ley de Servicios de Salud Mental, correspondiente al año fiscal 2015/16, y para conversar sobre el futuro de la política de salud mental y planificación de programas.

La Ley de Servicios de Salud Mental (también conocida como Proposición 63) fue aprobada por los electores de California en noviembre del 2004 para ampliar los servicios de salud mental para niños y adultos. La Ley es financiada por un impuesto adicional de 1% para aquellos cuyos ingresos personales son más de un millón de dólares al año.

¿POR QUE?: Para proporcionar información y promover conversaciones comunitarias sobre la Actualización Anual de la MHSA para el año fiscal 2015/16 y explicar cómo esto afectará a los residentes del Condado de San Bernardino. También, vamos a llevar a cabo una conversación para obtener ideas, temas y sugerencias para futuros proyectos de la política de salud mental y planificación de programas.

¿DONDE Y CUANDO?:

Únase con nosotros en la próxima reunión del Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés), las reuniones del Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés) y los varios subcomités o una de las reuniones locales de los Comités Consultivos de Distrito (DAC por sus siglas en inglés). Además, se llevarán a cabo presentaciones especiales en el Consulado de México en San Bernardino en español y un evento nocturno adicional estará disponible en línea.

CONTACTO: Favor de ver la información de contacto para cada reunión. Para todos los números, usuarios de TTY por favor marque 7-11.

**Reunión del Comité Asesor de Política Comunitaria (CPAC) y
Comité Consultivo de Competencia Cultural (CCAC)**

<p align="center">Reunión del CPAC Jueves, 19 de marzo del 2015 9:00 a.m. – 12:00 p.m. CSBHS - Auditorio 850 E. Foothill Blvd., Rialto, CA 92376 Contacto: Cheryl McAdam (909) 252-4021</p>	<p align="center">Reunión del CCAC Jueves, 19 de marzo del 2015 1:00 – 3:00 p.m. CSBHS - Auditorio 850 E. Foothill Blvd., Rialto, CA 92376 Contacto: Aidery Hernandez (909) 386-8223</p>
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Reunión de Comités Consultivos de Distrito (DAC)

<p align="center">Primer Distrito DAC Miércoles, 18 de febrero del 2015 11:00 a.m. - 12:00 p.m. Victor Community Holistic Campus 1540 Cholame Road Victorville, CA 92392 Contacto: Chris Croteau (760) 955-7287</p>	<p align="center">Segundo Distrito DAC Jueves, 12 de febrero del 2015 3:00 - 5:00 p.m. Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contacto: April Guzman (909) 758-1381</p>
<p align="center">Tercer Distrito DAC Martes, 17 de febrero del 2015 11:00 a.m. - 12:00 p.m. Our Place—Clubhouse 721 Nevada Street, Ste. 205 Redlands, CA 92373 Contacto: Debbie Cazarez (909) 387-7219</p>	<p align="center">Cuarto Distrito DAC Jueves, 12 de febrero del 2015 3:00 - 5:00 p.m. Mariposa Community Counseling 2940 Inland Empire Boulevard Ontario, CA 91764 Contacto: April Guzman (909) 758-1381</p>
<p align="center">Quinto Distrito DAC Lunes, 23 de febrero del 2015 5:30 - 7:30 p.m. New Hope Family Life Center Auditorium 1505 W. Highland Avenue San Bernardino, CA 92411 Contacto: Crista Wentworth (909) 421-4606</p>	

Reuniones Especiales

<p align="center">Reunión en Español Martes, 3 de marzo del 2015 9:00 – 11:00 a.m. Consulado de México en San Bernardino Sala de Espera 293 North D Street San Bernardino, CA 92401 Contacto: Aidery Hernandez (909) 386-8223</p>	<p align="center">Sesión en línea por la tarde Jueves, 12 de marzo del 2015 5:30 - 7:30 p.m. Por medio de Adobe Connect Numero de conferencia: 1-877-820-7831 Código personal: 947294 Para atender este evento use este enlace: https://sbcdbh.adobeconnect.com/r3sildf57pa/ Contacto: Cheryl McAdam (909) 252-4021</p>
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Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural (CCAC)

Contacto: Aidery Hernandez (909) 386-8223

<p><i>Subcomité de Concientización de Asiáticos/Isleños del Pacífico</i> 10 de febrero del 2015 Administración de DBH—Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.</p>	<p><i>Subcomité de Concientización de Espiritualidad</i> 10 de febrero del 2015 Administración de DBH—Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>
<p><i>Subcomité de Concientización de Nativos Americanos</i> 17 de febrero del 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.</p>	<p><i>Subcomité de Concientización de Discapacidades</i> 18 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30 - 9:30 a.m.</p>
<p><i>Subcomité de Concientización de Jóvenes en Edad de Transición</i> 18 de febrero del 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.</p>	<p><i>Subcomité de Concientización de Jóvenes en Edad de Transición</i> 19 de febrero del 2015 Pacific Clinics—Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.</p>
<p><i>Subcomité de Concientización de Diagnostico Dual y Drogadicción</i> 19 de febrero del 2015 County of San Bernardino Health Services-Auditorio 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.</p>	<p><i>Subcomité de Concientización de Consumidores y Miembros de Familias</i> 23 de febrero del 2015 Administración de DBH—Cuarto 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.</p>
<p><i>Subcomité de Concientización de LGBTQ</i> 24 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.</p>	<p><i>Subcomité de Concientización de Mujeres</i> 25 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>
<p><i>Subcomité de Concientización de Veteranos</i> 2 de marzo del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.</p>	<p><i>Subcomité de Concientización Latino</i> 3 de marzo del 2015 Consulado de México en San Bernardino Sala de Espera 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.</p>
<p><i>Subcomité de Concientización de Afroamericanos</i> 9 de marzo del 2015 Young Visionaries 1580 N. Waterman Ave., San Bernardino, CA 92408 2:00 - 3:00 p.m.</p>	



**Please join the Department of Behavioral Health for a
Mental Health Services Act Stakeholder Engagement!
Cultural Competency Advisory Committee
Sub-Committee Meetings**



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

<p>Asian Pacific Islander Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.</p>	<p>Spirituality Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>	<p>Native American Awareness Sub-Committee February 17, 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.</p>
<p>Disabilities Awareness Sub-Committee February 18, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30 - 9:30 a.m.</p>	<p>Transitional Age Youth Awareness Sub-Committee February 18, 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.</p>	<p>Transitional Age Youth Awareness Sub-Committee February 19, 2015 Pacific Clinics — Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.</p>
<p>Co-Occurring and Substance Abuse Sub-Committee February 19, 2015 County of San Bernardino Health Services - Auditorium 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.</p>	<p>Consumer & Family Member Awareness Sub-Committee February 23, 2015 Department of Behavioral Health Administration, Rm 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.</p>	<p>LGBTQ Awareness Sub-Committee February 24, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.</p>
<p>Women's Awareness Sub-Committee February 25, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>	<p>Veteran's Awareness Sub-Committee March 2, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.</p>	<p>Latino Health Awareness Sub-Committee March 3, 2015 Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.</p>
<p>African American Awareness Sub-Committee March 9, 2015 Young Visionaries, 1580 N. Waterman Ave., San Bernardino, CA 92408, 2:00 - 3:00 p.m.</p>		

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

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



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



Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural

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

<p>Subcomité de Concientización de Asiáticos/Isleños del Pacífico 10 de febrero del 2015 Administración de DBH—Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.</p>	<p>Subcomité de Concientización de Espiritualidad 10 de febrero del 2015 Administración de DBH— Cuarto 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>	<p>Subcomité de Concientización de Nativos Americanos 17 de febrero del 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.</p>
<p>Subcomité de Concientización de Discapacidades 18 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30am - 9:30 a.m.</p>	<p>Subcomité de Concientización de Jóvenes en Edad de Transición 18 de febrero del 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.</p>	<p>Subcomité de Concientización de Jóvenes en Edad de Transición 19 de febrero del 2015 Pacific Clinics— Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.</p>
<p>Subcomité de Concientización de Diagnóstico Dual y Drogadicción 19 de febrero del 2015 County of San Bernardino Health Services—Auditorio 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.</p>	<p>Subcomité de Concientización de Consumidores y Miembros de Familias 23 de febrero del 2015 Administración de DBH—Cuarto 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.</p>	<p>Subcomité de Concientización de LGBTQ 24 de febrero del 2015 Administración de DBH —Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.</p>
<p>Subcomité de Concientización de Mujeres 25 de febrero del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.</p>	<p>Subcomité de Concientización de Veteranos 2 de marzo del 2015 Administración de DBH—Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.</p>	<p>Subcomité de Concientización Latino 3 de marzo del 2015 Consulado de México en San Bernardino—Sala de Espera 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.</p>
<p>Subcomité de Concientización de Afroamericanos 9 de marzo del 2015 Young Visionaries, 1580 N. Waterman Ave., San Bernardino, CA 92408, 2:00 - 3:00 p.m.</p>		

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

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



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



District Advisory Committee Meetings

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

First District

Wednesday, February 18, 2015
11:00 a.m. - 12:00 p.m.
Victor Community Holistic Campus
1540 Cholame Road
Victorville, CA 92392
Contact: Chris Croteau (760) 955-7287

Second District

Thursday, February 12, 2015
3:00 - 5:00 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contact: April Guzman (909) 458-1381

Third District

Tuesday, February 17, 2015
11:00 a.m. - 12:00 p.m.
Our Place—Clubhouse
721 Nevada Street, Ste. 205
Redlands, CA 92373
Contact: Debbie Cazarez (909) 387-7219

Fourth District

Thursday, February 12, 2015
3:00 - 5:00 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contact: April Guzman (909) 458-1381

Fifth District

Monday, February 23, 2015
5:30 - 7:30 p.m.
New Hope Family Life Center Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contact: Crista Wentworth (909) 421-4606

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:

Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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



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



Reunión de Comité Consultiva de Distrito

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

Primer Distrito

Miércoles, 18 de febrero del 2015
11:00 a.m. - 12:00 p.m.
Victor Community Holistic Campus
 1540 Cholame Road
 Victorville, CA 92392
Contacto: Chris Croteau 760-955-7287

Segundo Distrito

Jueves, 12 de febrero del 2015
3:00 - 5:00 p.m.
Mariposa Community Counseling
 2940 Inland Empire Boulevard
 Ontario, CA 91764
Contacto: April Guzman 909-758-1381

Tercer Distrito

Martes, 17 de febrero del 2015
11:00 a.m. - 12:00 p.m.
Our Place—Clubhouse
 721 Nevada Street, Ste. 205
 Redlands, CA 92373
Contacto: Debbie Cazarez 909-387-7219

Cuarto Distrito

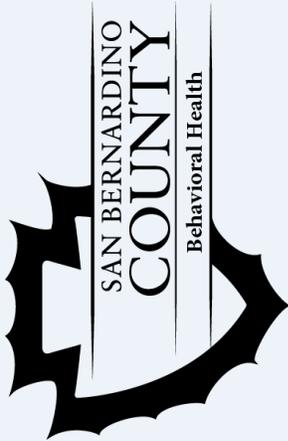
Jueves, 12 de febrero del 2015
3:00 - 5:00 p.m.
Mariposa Community Counseling
 2940 Inland Empire Boulevard
 Ontario, CA 91764
Contacto: April Guzman 909-758-1381

Quinto Distrito

Lunes, 23 de febrero del 2015
5:30 - 7:30 p.m.
New Hope Family Life Center Auditorium
 1505 W. Highland Avenue
 San Bernardino, CA 92411
Contacto: Crista Wentworth 909-421-4606

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

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



*Please join the Department of Behavioral Health
for a special presentation in Spanish at the
Mental Health Services Act Stakeholder Engagement!*



Consulate of Mexico in San Bernardino

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

Tuesday, March 3, 2015

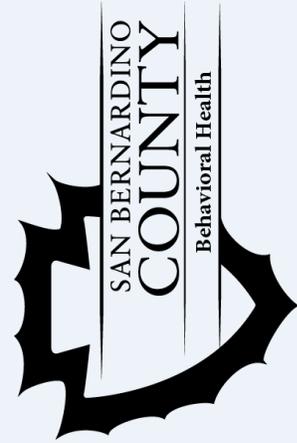
Consulate of Mexico in San Bernardino — Lobby

**293 North D Street
San Bernardino, CA 92401
9:00 - 11:00 a.m.**

*For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Aiderly Hernandez at (909) 386-8223 or 7-1-1 for TTY users or aiderly.hernandez@dbh.sbcounty.gov.*

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

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



**Únase al Departamento de Salud Mental
para una presentación en Español. . .**

***¡Reunión comunitaria para partes interesadas sobre la
Ley de Servicios de Salud Mental!***



Consulado de México en San Bernardino

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

Fecha: 3 de marzo del 2015

Localización: Consulado de México en San Bernardino

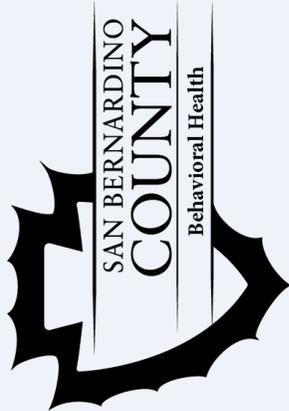
293 North D Street, San Bernardino, CA 92401

Horario: 9:00 - 11:00 a.m.

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodados especiales por razones de incapacidad, por favor comuníquese con Aiderly Hernandez al (909) 386-8223; marque el 7-1-1 si usted es TTY; también puede ir a: aiderly.hernandez@dbh.sbcounty.gov.

Por favor solicite estos acomodados por lo menos 7 días laborales previos al evento.

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



**Please join the Department of Behavioral Health for a
Mental Health Services Act Stakeholder Engagement!
Special Online After-Hours Event**



Participate from the comfort of your own home!

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

When: Thursday, March 12, 2015

Where: Online Adobe Connect Event

Time: 5:30 - 7:30 p.m.

Conference Number: US/CAN Toll Free: 1-877-820-7831

Passcode: 947294

To join the meeting please use the link below:

<https://sbcdbh.adobeconnect.com/r3sildf57pa/>

*Please note: This will be an English language session. For questions or concerns, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.*

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



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



Sesión en Línea por la Tarde

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

Fecha: Jueves, 12 de marzo del 2015

Localización: En línea evento “Adobe Connect”

Horario: 5:30 - 7:30 p.m.

Numero de Conferencia: US/CAN Toll Free: 1-877-820-7831
Contraseña: 947294

Para unirse a la reunión por favor utilice el siguiente enlace:
<https://sbcdbh.adobeconnect.com/r3sildf57pa/>

Por favor note: esta será una sesión solamente en inglés. Para preguntas o dudas, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov.

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



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

Thursday, March 19, 2015



**Community Policy Advisory
Committee (CPAC) Meeting**

9:00 a.m. - 12:00 p.m.

County of San Bernardino
Health Services—Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Facilitated by Director, CaSonya Thomas

**Cultural Competency Advisory
Committee (CCAC) Meeting**

1:00 - 3:00 p.m.

County of San Bernardino
Health Services—Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Facilitated by Assistant Director, Veronica Kelley

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

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

*For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.
Please request accommodations at least 7 business days prior to the event.*



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

Jueves, 19 de marzo del 2015



Comité Asesor de Política

Comunitaria (CPAC)

9:00 a.m. - 12:00 p.m.

County of San Bernardino
Health Services—Auditorio

850 E. Foothill Blvd.

Rialto, CA 92376

Reunión facilitada por

Directora, CaSonya Thomas

**Comité Consultivo de
Competencia Cultural (CCAC)**

1:00 - 3:00 p.m.

County of San Bernardino
Health Services—Auditorio

850 E. Foothill Blvd.,

Rialto, CA 92376

Reunión facilitada por

Subdirectora, Veronica Kelley

Estas reuniones comunitarias, para partes interesadas, se centrarán en el impacto de

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) sobre el sistema de cuidado.

Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

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

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Mental Health Services Act (MHSA)

Fiscal Year 2015/16 Annual Update

Stakeholder Comment Form

What is your age? <input type="checkbox"/> 0-15 yrs <input type="checkbox"/> 26-59 yrs <input type="checkbox"/> 16-25 yrs <input type="checkbox"/> 60+ yrs	What is your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____																
What region do you live in? <input type="checkbox"/> Central Valley Region <input type="checkbox"/> Desert/Mountain Region <input type="checkbox"/> East Valley Region <input type="checkbox"/> West Valley Region																	
What group(s) do you represent? <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Family member of consumer</td> <td style="width:50%; border:none;"><input type="checkbox"/> Social Services Agency</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Consumer of Mental Health Services</td> <td style="border:none;"><input type="checkbox"/> Health Care Provider</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Consumer of Alcohol and Drug Services</td> <td style="border:none;"><input type="checkbox"/> Community Member</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Law Enforcement</td> <td style="border:none;"><input type="checkbox"/> Active Military</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Education</td> <td style="border:none;"><input type="checkbox"/> Veteran</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Community Agency</td> <td style="border:none;"><input type="checkbox"/> Representative from Veterans Organization</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Faith Community</td> <td style="border:none;"><input type="checkbox"/> Provider of Mental Health Services</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> County Staff</td> <td style="border:none;"><input type="checkbox"/> Provider of Alcohol and Drug Services</td> </tr> </table>		<input type="checkbox"/> Family member of consumer	<input type="checkbox"/> Social Services Agency	<input type="checkbox"/> Consumer of Mental Health Services	<input type="checkbox"/> Health Care Provider	<input type="checkbox"/> Consumer of Alcohol and Drug Services	<input type="checkbox"/> Community Member	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Active Military	<input type="checkbox"/> Education	<input type="checkbox"/> Veteran	<input type="checkbox"/> Community Agency	<input type="checkbox"/> Representative from Veterans Organization	<input type="checkbox"/> Faith Community	<input type="checkbox"/> Provider of Mental Health Services	<input type="checkbox"/> County Staff	<input type="checkbox"/> Provider of Alcohol and Drug Services
<input type="checkbox"/> Family member of consumer	<input type="checkbox"/> Social Services Agency																
<input type="checkbox"/> Consumer of Mental Health Services	<input type="checkbox"/> Health Care Provider																
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<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Active Military																
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<input type="checkbox"/> Faith Community	<input type="checkbox"/> Provider of Mental Health Services																
<input type="checkbox"/> County Staff	<input type="checkbox"/> Provider of Alcohol and Drug Services																
What is your Ethnicity? <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> American Indian/Native American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Other: _____																	
What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____																	
What is your general feeling about the MHSA Annual Update in the County of San Bernardino? <input type="checkbox"/> Very Satisfied <input type="checkbox"/> Somewhat Satisfied <input type="checkbox"/> Satisfied <input type="checkbox"/> Unsatisfied <input type="checkbox"/> Very Unsatisfied																	
What is your highest priority regarding the MHSA Annual Update? <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;"><input type="checkbox"/> Basic Needs-Transportation</td> <td style="width:50%; border:none;"><input type="checkbox"/> Increased Access/Availability of Treatment/Recovery</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Emergency Preparedness</td> <td style="border:none;"><input type="checkbox"/> Family and Youth Support</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Administrative Support</td> <td></td> </tr> </table>		<input type="checkbox"/> Basic Needs-Transportation	<input type="checkbox"/> Increased Access/Availability of Treatment/Recovery	<input type="checkbox"/> Emergency Preparedness	<input type="checkbox"/> Family and Youth Support	<input type="checkbox"/> Administrative Support											
<input type="checkbox"/> Basic Needs-Transportation	<input type="checkbox"/> Increased Access/Availability of Treatment/Recovery																
<input type="checkbox"/> Emergency Preparedness	<input type="checkbox"/> Family and Youth Support																
<input type="checkbox"/> Administrative Support																	

Do you have other concerns not addressed in this discussion?

What did you learn about the MHSA Annual Update?

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

Thank you again for taking the time to review and provide input on the MHSA Annual Update in the County of San Bernardino.



Ley de Servicios de Salud Mental
 (MHSA por sus siglas en inglés)
Actualización Anual del Año Fiscal 2015/16
Formulario de Comentarios para
Personas Interesadas

¿Cuál es su edad? <input type="checkbox"/> 0-15 años <input type="checkbox"/> 26-59 años <input type="checkbox"/> 16-25 años <input type="checkbox"/> 60 + años	¿Cuál es su género? <input type="checkbox"/> Femenino <input type="checkbox"/> Masculino <input type="checkbox"/> Otro: _____
¿En cuál región vive usted? <input type="checkbox"/> Región de Valle Central <input type="checkbox"/> Región de Desierto/Montañas <input type="checkbox"/> Región al este del Valle <input type="checkbox"/> Región al oeste del Valle	
¿Qué grupo(s) representa usted? <input type="checkbox"/> Familiar del consumidor <input type="checkbox"/> Agencia de Servicios Sociales <input type="checkbox"/> Consumidor de Servicios de Salud Mental <input type="checkbox"/> Proveedor de Atención Médica <input type="checkbox"/> Consumidor de Servicios de Alcohol y Drogas <input type="checkbox"/> Miembro de la Comunidad <input type="checkbox"/> Autoridad Policial <input type="checkbox"/> En el Servicio Militar Activo <input type="checkbox"/> Educación <input type="checkbox"/> Veterano del Servicio Militar <input type="checkbox"/> Agencia Comunitaria <input type="checkbox"/> Representante de Organización de Veteranos <input type="checkbox"/> Comunidad Religiosa <input type="checkbox"/> Proveedor de Servicios de Salud Mental <input type="checkbox"/> Personal del Condado <input type="checkbox"/> Proveedor de Servicios de Alcohol y Drogas	
¿Cuál es su Grupo Étnico? <input type="checkbox"/> Afroamericano <input type="checkbox"/> Asiático/Islas del Pacífico <input type="checkbox"/> Latino/Hispano <input type="checkbox"/> Amerindio/Nativo Americano <input type="checkbox"/> Caucásico/Blanco <input type="checkbox"/> Otro: _____	
¿Cuál es su idioma principal? <input type="checkbox"/> Inglés <input type="checkbox"/> Español <input type="checkbox"/> Vietnamita <input type="checkbox"/> Otro: _____	
¿Cuál es su opinión general sobre la Actualización Anual del MHSA en el Condado de San Bernardino? <input type="checkbox"/> Muy Satisfecho <input type="checkbox"/> Algo Satisfecho <input type="checkbox"/> Satisfecho <input type="checkbox"/> Insatisfecho <input type="checkbox"/> Muy insatisfecho	
¿Cuál es su mayor prioridad con respecto a la Actualización Anual de la MHSA? <input type="checkbox"/> Necesidades básicas-transportación <input type="checkbox"/> Aumento en el acceso/disponibilidad de <input type="checkbox"/> Preparación de emergencias tratamiento/recuperación <input type="checkbox"/> Apoyo administrativo <input type="checkbox"/> Apoyo familiar y para juventud	

¿Tiene alguna otra duda que no haya sido hablada en esta junta?

¿Qué aprendió sobre la Actualización Anual de la MHSA?

¿Qué más le gustaría aprender sobre el proceso de la MHSA?

Gracias de nuevo por tomar el tiempo de revisar y proveer su opinión en el proceso de la Actualización Anual de la MHSA en el Condado de San Bernardino.



NEWS RELEASE

Behavioral Health

CONTACT:

Aimara Freeman

Media Specialist

(909) 383-3952

Aimara.Freeman@dbh.sbcounty.gov

March 20, 2015

Public input sought for Behavioral Health report

A report illustrating the recent progress made by the San Bernardino County Department of Behavioral Health and its contracted partners in addressing the needs of the community is available for public review and comment.

The County's Draft Mental Health Services Act (MHSA, Prop. 63) Annual Update will be posted for public comment from March 20, 2015 through April 20, 2015. The public is invited to review the draft report and provide feedback on the comment forms, posted in English and Spanish. The report and comment forms are located at www.sbcounty.gov/dbh. "I encourage all interested parties to participate in this community planning process," stated CaSonya Thomas, the County's Behavioral Health Director. "The annual update process is something that occurs every year and we are always trying to improve the services provided and the way we work with community partners."

County Behavioral Health, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery and resilience in the community. Information on the Countywide Vision and the Department of Behavioral Health can be found at www.sbcounty.gov.

County Behavioral Health has leveraged resources provided through the MHSA to expand existing behavioral health services. The services are geared to target the unserved, underserved and inappropriately served members of our community. Programs provided through MHSA are approved annually by the Board of Supervisors after a comprehensive stakeholder process and public review and approval by the San Bernardino County Behavioral Health Commission.

There are several components of the MHSA including Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities, Technology and Innovation.

The Annual Update provides an overview of the outcomes related to each MHSA program and goes over the proposed changes for these components in the upcoming fiscal year.

The MHSA was passed by the California voters in November, 2004, and went into effect January, 2005. The Act is funded by a 1percent tax surcharge on personal income over \$1 million per year.

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NEWS RELEASE

Behavioral Health

CONTACT:

Aimara Freeman

Media Specialist

(909) 383.3952

aimara.freeman@dbh.sbcounty.gov

20 de marzo de 2015

Participación del público solicitada para Informe de Salud Mental

Un informe que ilustra el progreso reciente hecho por el Departamento de Salud Mental del Condado de San Bernardino y sus compañeros contratados en atender las necesidades de la comunidad está disponible para revisión pública y comentario.

El borrador del informe de la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés, también conocido como la Proposición 63) será publicado para comentarios del público desde el 20 de marzo de 2015 hasta el 20 de abril de 2015. El público es invitado a revisar el borrador del informe y proporcionar realimentación sobre las formas de comentario, publicadas en inglés y español. El borrador del informe y formas de comentario se encuentran en www.sbcounty.gov/dbh. "Animo a todas las partes interesadas a participar en este proceso de planificación comunitaria," declaró CaSonya Thomas, Directora del Departamento de Salud Mental. "El proceso de actualización anual es algo que ocurre cada año y siempre estamos tratando de mejorar los servicios prestados y la forma en que trabajamos con socios de la comunidad."

El Departamento de Salud Mental del Condado, a través de la MHSA, está apoyando la visión del Condado proporcionando servicios de salud mental y asegurando que los residentes cuentan con los recursos que necesitan para promover el bienestar, la recuperación y la resiliencia en la comunidad. Información sobre la visión del Condado y el Departamento de Salud Mental puede encontrarse en www.sbcounty.gov.

El Departamento de Salud Mental del Condado ha aprovechado los recursos proporcionados a través de la MHSA para ampliar los servicios de salud mental existentes. Los servicios están orientados a aquellos miembros de la comunidad que carecen de servicios, que reciben servicios insuficientemente o que los reciben de manera inapropiada. Programas ofrecidos a través de la MHSA son aprobados anualmente por la Junta de Supervisores después de un proceso integral de las partes interesadas y la revisión pública y aprobación por la Comisión de Salud Mental del Condado de San Bernardino.

Hay varios componentes de la MHSA que incluyen servicios y apoyos comunitarios, prevención e intervención temprana, capacitación laboral y educativa, servicios y mantenimiento de instalaciones, tecnología e innovación.

La Actualización Anual proporciona una descripción de los resultados relacionados con cada programa de MHSA y revisa los cambios propuestos para estos componentes en el próximo año fiscal.

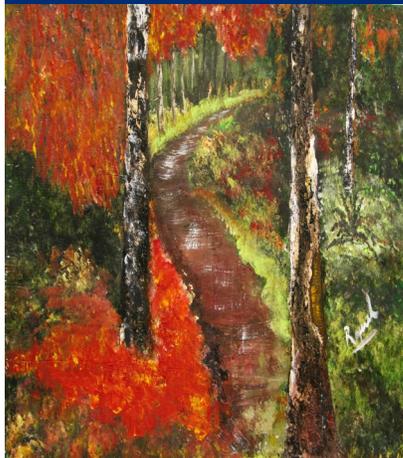


MHSA fue aprobada por los votantes de California en noviembre del 2004 y entró en vigor en enero del 2005. Esta ley es financiada por un impuesto adicional del 1% sobre aquellos contribuyentes cuyos ingresos personales son mayores a un millón de dólares al año.

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Behavioral Health



Public Hearing Information

Thursday,
May 7, 2015

County of San Bernardino
Health Services,
Auditorium (formerly
known as the Behavioral
Health Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

Behavioral Health
Commission Meeting
is scheduled from
12:00 p.m. - 2:00 p.m.

www.SBCounty.gov/dbh

Rev. 4/2015

You Are Invited:

San Bernardino County Behavioral Health invites you to attend a public hearing regarding the Mental Health Services Act Annual Update for Fiscal Year 2015/16.

The Mental Health Services Act (MHSA) Annual Update depicts the progress made by the Department of Behavioral Health and contracted partners, in providing public behavioral health services.

This public hearing will provide community members the opportunity to participate in an overview of the MHSA Annual Update stakeholder process. In addition to the overview, there will be time set aside for attendees to ask questions and share comments regarding the MHSA Annual Update for fiscal year 2015/16. The public hearing will be an agenda item during the regularly scheduled Behavioral Health Commission Meeting.

The Mental Health Services Act, Proposition 63, was passed by California voters in November 2004 and went into effect in January 2005. The Act is funded by a 1% surcharge on personal income over \$1 million per year.

For questions, concerns, interpretation services or requests for disability-related accommodations please call (800) 722- 9866 or 7-1-1 for TTY users.

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

San Bernardino County Behavioral Health
Office of Program Planning and Development
1950 South Sunwest Lane, Suite 200
San Bernardino, CA 92415

For additional information please call 800-722-9866 or 711 for TTY users.



Información sobre la audiencia pública

Jueves,
7 de mayo, 2015

County of San Bernardino
Health Services,
Auditorium (antes conocido
como el Behavioral Health
Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

La reunion de la
comisión de salud
mental será realizad
de
12:00 - 2:00 p.m.

www.SBCounty.gov/dbh

Usted está invitado:

El Departamento de Salud Mental del Condado de San Bernardino le invita a que asista a una audiencia pública sobre el Plan de Actualización Anual de la Ley de Servicios de Salud Mental para el año fiscal 2015/16.

El Plan de Actualización Anual de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) muestra los avances realizados por el Departamento de Salud Mental y sus proveedores contratados en el suministro de servicios públicos de salud mental.

Esta audiencia pública brindará a los miembros de la comunidad la oportunidad de participar en una visión general respecto al proceso de las partes interesadas sobre el Plan de Actualización de MHSA.

Además, habrá tiempo para que los asistentes hagan preguntas y compartan sus comentarios y/o dudas por lo que se refiere al proceso de las partes interesadas. La audiencia pública será un tema del programa durante el horario regular de la reunión de la comisión de salud mental.

La Ley de Servicios de Salud Mental (Proposición 63) fue aprobada por los votantes de California en noviembre del 2004 y tomo efecto en enero del 2005. Esta ley está financiada por un impuesto adicional del 1% sobre aquellos contribuyentes cuyos ingresos personales son mayores de un millón de dólares al año.

Para preguntas, dudas, servicios de interpretación o para solicitar acomodaciones relacionadas con alguna discapacidad, sírvase llamar al: (800) 722- 9866; ó marque: 7-1-1 para usuarios de TTY.

Por favor solicite estos servicios por lo menos 7 días hábiles antes de que la reunión se realice.

Condado de San Bernardino Departamento de Salud Mental
Oficina de Planificación y Desarrollo de Programas
1950 South Sunwest Lane, Suite 200
San Bernardino, CA 92415

**Para más información, por favor llame al: 800-722-9866;
o al 711 para usuarios de TTY**

Behavioral Health

Aimara Freeman
Media Specialist
(909) 383-3952

April 23, 2015

Aimara.Freeman@dbh.sbcounty.gov

(Contact information for media use only, not for publication)

Public Invited to Mental Health Services Update

The San Bernardino County Department of Behavioral Health (DBH) invites members of the community to attend the upcoming public hearing on the draft Mental Health Services Act (MHSA) Annual Update Report, which continues the comprehensive stakeholder process administered by DBH.

The public hearing, held as an agenda item during the regularly scheduled Behavioral Health Commission Meeting, will provide an overview of the MHSA Annual Update Community Program planning process, in addition to giving attendees the opportunity to provide public comment on the MHSA Annual Update for fiscal year 2015/16.

The hearing will be held on Thursday, May 7, 2015 from 12 p.m. to 2 p.m. at County of San Bernardino Health Services Auditorium, 850 E. Foothill Blvd. Rialto, CA 92376.

“Participation in the public hearing process is important because it gives residents both the opportunity to learn more about their public services and the ability to influence those services,” stated James Ramos, Chairman of the Board of Supervisors. “The programs supported by MHSA funding are based on the belief that recovery can happen. I encourage community members to attend.”

The draft Annual Update report illustrates the progress made by DBH and its contracted partners in providing behavioral health services over the last fiscal year. The report was posted for public review and comment from March 20, 2015 through April 20, 2015, with feedback to be incorporated into the final version of the MHSA Annual Update for fiscal year 2015/16.

For more information on the public hearing, interpretation services or requests for disability-related accommodations, please call (800) 722-9866 or 7-1-1 for TTY users.

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health and alcohol and drug services that promote wellness, recovery and resiliency in the community. Information on the Countywide Vision and the Department of Behavioral Health can be found at www.sbcounty.gov.

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Behavioral Health

Aimara Freeman
Especialista de Medios

(909) 383-3952

Aimara.Freeman@dbh.sbcounty.gov

(Para información de medios de comunicación, no para publicación)

23 abril del 2015

Público Invitado a la Actualización de Servicios de Salud Mental

El Departamento de Salud Mental (DBH, por sus siglas en inglés) del Condado de San Bernardino invita a los miembros de la comunidad a asistir la audiencia pública sobre el reporte de la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés), que continua el proceso compresivo de las partes interesadas administrado por DBH.

La audiencia pública, será un tema del programa durante el horario regular de la reunión de la Comisión de Salud Mental y proveerá una revista general del proceso de planificación de la Actualización Anual de MHSA, además de dar a los participantes la oportunidad de proporcionar comentarios públicos sobre la Actualización Anual de MHSA para el año fiscal 2015/16.

La audiencia se llevara a cabo el jueves, 7 de mayo del 2015 de 12 p.m. a 2 p.m. en *County of San Bernardino Health Services*, Auditorio, 850 E. Foothill Blvd., Rialto, CA, 92376.

“La participación en el proceso de la audiencia pública es importante porque da a los residentes tanto la oportunidad de aprender más acerca de sus servicios públicos y la capacidad de influir en los servicios,” declaro James Ramos, Presidente de la Junta de Supervisores. “Los programas apoyados por fondos MHSA se basan en la creencia que la recuperación puede suceder. Animo a los miembros de la comunidad a asistir.”

El borrador del informe de la Actualización Anual de la Ley de Servicios de Salud Mental ilustra los progresos realizados por DBH y sus asociados contratados en la prestación de servicios de salud mental en el último año fiscal. El reporte fue publicado para revisión y comentarios públicos el 20 marzo del 2015 hasta el 20 abril del 2015, con opiniones incorporadas en la versión final de la actualización anual de MHSA para el año fiscal 2015/16.

Para información adicional sobre la audiencia pública, servicios de interpretación o petición de acomodos relacionados con alguna incapacidad, por favor llame al: (800) 722-9866; o marque 7-1-1 si usted es usuarios de TTY.

DBH, a través de la MHSA, está apoyando *Countywide Vision* en la prestación de servicios de salud mental, y alcohol y drogas que promueven el bienestar, la recuperación y resiliencia en la comunidad. Información sobre la *Countywide Vision* y el Departamento de Salud Mental se puede encontrar en www.sbcounty.gov.

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Behavioral Health Commission

CaSonya Thomas
Director

GENERAL SESSION

THURSDAY, MAY 7, 2015

County of San Bernardino Health Services
850 E. Foothill Blvd, AUDITORIUM, Rialto, CA 92376

*If you require ADA accommodations (ASL Interpreter, other communication devices, or other interpreter services), please contact Aidery Hernandez at (909) 386-8223 prior to the meeting.

ALL MEETINGS OPEN TO THE PUBLIC

12:00 p.m. – 2:00 p.m.

PLEASE POST IN CLINIC

District 1

Michael Grabhorn
Ed O'Brien
VACANT

12:00 – 12:15 p.m.

CALL TO ORDER
PLEDGE OF ALLEGIANCE
INTRODUCTIONS

Susan McGee-Stehsel, Chair

District 2

May Farr, *Secretary*
David Miller
VACANT

12:15 – 12:20 p.m.

Tab 5: Review this Agenda
Tab 6: Review Minutes of April 2, 2015

Members of the Commission

District 3

Christopher Massa
Troy Mondragon
Catherine Inscore

12:20 – 12:35

"Finding My Path"

André Bossieux, PMII DBH,
Landon Sharp, Stars BH Group,
Selvaughn Keagan

12:35 - 12:45 p.m.

PUBLIC COMMENTS (3-minute time limit)

District 4

Akin Merino
Monica Wilson, *Vice Chair*
Jennifer Spence Carpenter

12:45 – 12:50 p.m.

CHAIRPERSON'S REPORT

Susan McGee-Stehsel, Chair

12:50 – 1:00 p.m.

COMMISSIONERS' REPORTS

Members of the Commission

District 5

Jane Ann Godager
Veatrice Jews, *Treasurer*
Susan McGee-Stehsel, *Chair*

1:00 - 1:30 p.m.

PUBLIC HEARING

Tab 7: MHSA Annual Update FY 2015-16

Michelle Dusick, MHSA
Administrative Manager, DBH

Board of Supervisors

Chairman James Ramos

1:30 – 1:35 p.m.

NEW BUSINESS – ACTION ITEM(S)

Affirm the Process of the MHSA Annual Update FY 2015-16

Members of the Commission

Clerk of the Commission

Debi Pasco
303 E. Vanderbilt Way
San Bernardino, CA 92415
909-388-0820

1:35 – 1:50 p.m.

DIRECTOR'S REPORT

CaSonya Thomas, Director DBH

1:50 - 2:00 p.m.

OUTSIDE AGENCY AND OTHER REPORTS

2:00 p.m.

ADJOURNMENT

Susan McGee-Stehsel, Chair

Written material for this meeting is available by request or at <http://www.sbcounty.gov/bhccommission>



COMISIÓN DE SALUD MENTAL

CaSonya Thomas
Directora

SESIÓN GENERAL

jueves 7 de mayo del 2015

Servicios de Salud del Condado de San Bernardino

AUDITORIO en 850 E. Foothill Blvd, Rialto, CA 92376

*Si usted requiere adaptaciones de acuerdo a ADA (Intérpretes ASL, dispositivos de comunicación u otros servicios de interpretación), por favor comuníquese con Aidery Hernández al (909) 386-8223 antes de que la reunión se realice.

TODAS LAS REUNIONES ESTAN ABIERTAS AL PÚBLICO

12:00 p.m. – 2:00 p.m.

POR FAVOR PUBLIQUE EN LA CLÍNICA

Primer Distrito

Michael Grabhorn
Ed O'Brien
VACANTE

12:00 – 12:15 p.m.

APERTURA DE LA SESIÓN
JURAMENTO A LA BANDERA
PRESENTACIONES

Susan McGee-Stehsel, Chair

Segundo Distrito

May Farr, *Secretaria*
David Miller
VACANTE

12:15 – 12:20 p.m.

Ficha 5: APROBACIÓN DE LA PRESENTE ORDEN DEL DÍA
Ficha 6: APROBACIÓN DEL ACTA DEL 2 DE ABRIL DEL 2015

Miembros de la Comisión

Tercer Distrito

Christopher Massa
Troy Mondragón
Catherine Inscore

12:20 – 12:35

PRESENTACIÓN EDUCACIONAL
"Encontrando Mi Camino"

André Bossieux, PMII DBH,
Landon Sharp, Stars BH Group,
Selvaughn Keagan

Cuarto Distrito

Akin Merino
Mónica Wilson, *Vicepresidenta*
Jennifer Spence Carpenter

12:45 – 12:50 p.m.

INFORME DE LA PRESIDENTA

Susan McGee-Stehsel, Presidenta

Quinto Distrito

Jane Ann Godager
Veatrice Jews, *Tesorera*
Susan McGee-Stehsel, *Presidenta*

12:50 – 1:00 p.m.

INFORMES DE LOS COMISIONADOS

Miembros de la Comisión

Junta de Supervisores

Presidente en Funciones de la Junta de Supervisores James Ramos

1:00 - 1:30 p.m.

Audiencia Pública

Ficha 7: Actualización Anual MHSA Año Fiscal 2015-16

Michelle Dusick, MHSA
Gerente Administrativo, DBH

Secretaria de la Comisión

Debi Pasco
303 E. Vanderbilt Way
San Bernardino, CA 92415
909-388-0820

1:30 – 1:35 p.m.

NUEVOS ASUNTOS – ACCIONES A TOMAR

Afirmar el proceso de la Actualización Anual MHSA
Años Fiscales 2015-16

Miembros de la Comisión

1:35 – 1:50 p.m.

INFORME DE LA DIRECTORA

CaSonya Thomas, Directora, DBH

1:50 - 2:00 p.m.

AGENCIAS EXTERNAS Y OTROS INFORMES

Susan McGee-Stehsel, Chair

2:00 p.m.

CIERRE DE LA SESIÓN

El material escrito de esta reunión está disponible mediante solicitud o en <http://www.sbcounty.gov/bhcommission>



Behavioral Health

Public Hearing Guidelines

1. **THE PUBLIC HEARING** will start and end on time.
2. **COURTESY AND RESPECT** for the time and opinions of others is required.
3. **EACH SPEAKER** must address a specific program in the MHSIA Integrated Plan. Every speaker may be allowed a maximum of 3 minutes; however, the time may be decreased to allow input from all speakers.
4. **COMMENTS ARE LIMITED** to expressions of support, opposition, suggested changes, additions, or deletions that pertain to specific sections, heading, and page number items.
5. **FOCUSED, CONSTRUCTIVE CRITICISM** will be accepted; unfocused, negative personal or professional comments or opinions will not be allowed.
6. **OFF-TOPIC STATEMENTS** will not be given time; the Chair will stop the speaker in the event of inappropriate comments.
7. **ANY SPEAKER** providing a written record of his/her verbal comments made during the hearing should provide a copy to assure that the information is recorded accurately. This copy will not be returned.
8. **DISCUSSION** about the planning process will not be considered. Proposed legislative changes or advocacy for proposed legislation will not be accepted, nor will general concerns about California's mental health system. Those comments must be addressed to the appropriate state legislative bodies or departments.
9. **IN ORDER TO BE CONSIDERED, WRITTEN TESTIMONY**, in lieu of personal presentation at the hearing, will be accepted until the close of the meeting. Additional comments can be written on the back of the comment form and placed in the designated area at the back of the room.



Behavioral Health

Behavioral Health Commission Public Hearing

Mental Health Services Act (MHSA)
FY 2015/16 Annual Update

Michelle Dusick, MHSA Admin Manager
MAY 7, 2015



Artwork by Raquel Acosta

www.SBCounty.gov

MHSA Annual Update FY 2015/16

Page 2

California Welfare and Institutions Code **(WIC) § 5847** and California Code of Regulations **(CCR) § 3310** state that a Three-Year Program and Expenditure Plan (Plan) and subsequent updates shall address each Mental Health Service Act (MHSA) component:

- Community Services and Supports (CSS) for children, youth, transition age youth, adults, and older adults **(WIC §5800 and §5850)**;
- Capital Facilities and Technological Needs (CFTN) **(WIC §5847)**;
- Workforce Education and Training (WET) **(WIC §5820)**;
- Prevention and Early Intervention (PEI) **(WIC §5840)**; and
- Innovation (INN) **(WIC §5830)**.



Behavioral Health

www.SBCounty.gov

MHSA Annual Update FY 2015/16

Page 3

Further, CCR §3310 states:

- The county shall update the Plan annually;
- Updates address elements that have changed; and
- Updates includes estimated expenditure projections for each Component per fiscal year.



Behavioral Health

www.SBCounty.gov

Why Are We Having a Public Hearing?

Page 4

The MHSA Plan/Update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests. The mental health board shall conduct a public hearing on the draft Three-Year Plan and/or Annual Update at the close of the 30 day comment period.

(WIC §5848)



Behavioral Health

www.SBCounty.gov

Who Should be Included in the Stakeholder Process?

Page 5

Each Three-Year Plan and Annual Update shall be developed with local stakeholders including consumers, families, service providers, veterans, and representatives from law enforcement, education, social services, veterans, alcohol and drug and health care organizations.

(WIC § 5848)



Behavioral Health

www.SBCounty.gov

Who Else is Included?

Page 6

Additionally, the stakeholder process should include:

- Representatives of unserved and/or underserved populations and family members.
- Stakeholders that represent the diversity of the demographics of the county (i.e. Location, age, gender, race/ethnicity).
- Clients with serious mental illness and/or serious emotional disturbance and their family members.

(CCR Title 9 Section 3300)



Behavioral Health

www.SBCounty.gov

What Should be Included in the Stakeholder Process?

Page 7

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

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

CCR Title 9 Section 3300 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.



Behavioral Health

www.SBCounty.gov

Are there Standards?

Page 8

Counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration
- Cultural competence
- Client driven
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families

(CCR Title 9 Section 3320)



Behavioral Health

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How We Reach Out

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Throughout the year, regular stakeholder meetings include:

- Behavioral Health Commission (BHC)
- District Advisory Committee (DAC)
- Community Policy Advisory Committee (CPAC)
- Cultural Competency Advisory Committee (CCAC), along with 12 cultural competency subcommittees
- Transition Age Youth (TAY) Center Advisory Boards
- Consumer Clubhouse Advisory Boards
- Quality Management Action Committee (QMAC)
- MHSA Executive Committee
- Association of Community Based Organizations (ACBO)
- Room and Board Advisory Coalition
- Workforce Development Committee
- Screening, Assessment, Referral, & Treatment (SART) Collaborative
- PEI Provider Network Meeting
- Parent Partners Network
- Older Adult Peer Counselor Support and Outreach System
- System-wide Program Outcomes Committee (SPOC)



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

Special sessions included:

- First District Advisory Committee Meeting - **02/18/2015**
- Second District Advisory Committee Meeting – **02/12/2015**
- Third District Advisory Committee Meeting – **02/17/2015**
- Fourth District Advisory Committee Meeting – **02/12/2015**
- Fifth District Advisory Committee Meeting – **02/23/2015**
- Community Policy Advisory Committee – **03/19/2015**
- Cultural Competency Advisory Committee – **03/19/2015**



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Special sessions, continued:

- Asian Pacific Islander Awareness Sub-Committee – **02/10/2015**
- Spirituality Awareness Sub-Committee – **02/10/2015**
- Native American Awareness Sub-Committee – **02/17/2015**
- Disabilities Awareness Sub-Committee – **02/18/2015**
- Transitional Age Youth Awareness Sub-Committee – **02/18/2015 & 02/19/2015**
- Co-Occurring and Substance Abuse Sub-Committee – **02/19/2015**
- Consumer & Family Member Awareness Sub-Committee – **02/23/2015**
- LGBTQ Awareness Sub-Committee – **02/24/2015**
- Women's Awareness Sub-Committee – **02/25/2015**
- Veteran's Awareness Sub-Committee – **03/02/2015**
- Latino Health Awareness Sub-Committee – **03/03/2015**
- African American Awareness Sub-Committee – **03/09/2015**



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Asian Pacific Islander Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 10:00 - 11:00 a.m.	Spirituality Awareness Sub-Committee February 10, 2015 Department of Behavioral Health Administration, Rm 109 B 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Native American Awareness Sub-Committee February 17, 2015 Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:00 p.m.
Disabilities Awareness Sub-Committee February 18, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 8:30 - 9:30 a.m.	Transitional Age Youth Awareness Sub-Committee February 18, 2015 One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.	Transitional Age Youth Awareness Sub-Committee February 19, 2015 Pacific Clinics — Suite 170 9047 Arrow Route, Rancho Cucamonga, CA 92404 3:00 - 4:00 p.m.
Co-Occurring and Substance Abuse Sub-Committee February 19, 2015 County of San Bernardino Health Services - Auditorium 850 E. Foothill Blvd., Rialto, CA 92373 2:30 - 3:30 p.m.	Consumer & Family Member Awareness Sub-Committee February 23, 2015 Department of Behavioral Health Administration, Rm 116 303 E. Vanderbilt Way, San Bernardino, CA 92415 2:00 - 3:00 p.m.	LGBTQ Awareness Sub-Committee February 24, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 1:30 p.m.
Women's Awareness Sub-Committee February 25, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:00 p.m.	Veteran's Awareness Sub-Committee March 2, 2015 Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	Latino Health Awareness Sub-Committee March 3, 2015 Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 9:00 - 11:00 a.m.
African American Awareness Sub-Committee March 9, 2015 Young Visionaries, 1580 N. Waterman Ave., San Bernardino, CA 92408. 2:00 - 3:00 p.m.		



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A special session was held in Spanish in collaboration with the Mexican Consulate on February 3, 2015.



Únase al Departamento de Salud Mental para una presentación en Español...

¡Reunión comunitaria para partes interesadas sobre la Ley de Servicios de Salud Mental!

Consulado de México en San Bernardino

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

Fecha: 3 de marzo del 2015

Localización: Consulado de México en San Bernardino
293 North D Street, San Bernardino, CA 92401

Horario: 9:00 - 11:00 a.m.

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodaciones especiales por razones de discapacidad, por favor comuníquese con Aubrey McAdams al (909) 386-8223, marcado al 7-1-1 si usted es TTY, también puede ir al sitio web: sbcounty.gov. Por favor reducir estas necesidades por lo menos 7 días laborables previos al evento.

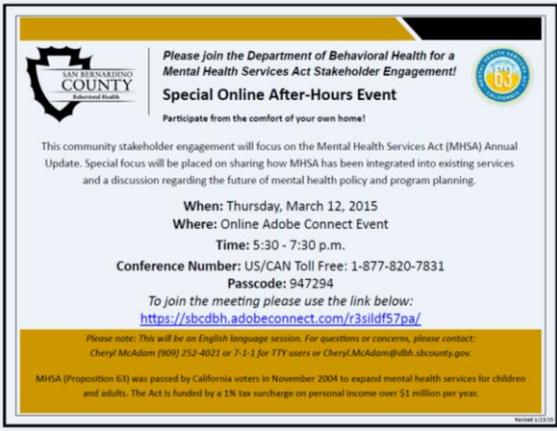
La Ley de Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños y adultos. La Ley es financiada por un pago de impuesto del 1% en ingresos personal que sobrepasa un millón de dólares por año.



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

Special Online After-Hours Event

Participate from the comfort of your own home!

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

When: Thursday, March 12, 2015
Where: Online Adobe Connect Event
Time: 5:30 - 7:30 p.m.

Conference Number: US/CAN Toll Free: 1-877-820-7831
Passcode: 947294

To join the meeting please use the link below:
<https://sbcdbh.adobeconnect.com/r3sildf57pa/>

Please note: This will be an English language session. For questions or concerns, please contact: Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.

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

An after business hours, online session using Adobe Connect was hosted on March 12, 2015.



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How We Reach Out

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DBH conducted outreach to promote the Annual Update Stakeholder Process.

Information was disseminated through:

- Press releases to **51** media outlets,
- Email and flyer distribution (English and Spanish) to:
 - Community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions, and regularly scheduled stakeholder meetings, to reach populations representative of the descriptions provided.
- Posted on County and DBH website and DBH social media sites such as Facebook and Instagram.
- Regularly announced in meetings.

(WIC § 5848 and CCR Title 9 Section 3300)



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Public Review Period

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The 30-day Public Posting March 20, 2015 through April 20, 2015

Copies of the draft MHSA Annual Update for FY 2015/16 were:

- Available online for electronic viewing.
- Physical copies were made available at clubhouses, clinics, and distributed at meetings upon request.
- Copies were available for viewing at county public libraries.
- Comment Forms were available in English and Spanish.



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What did we Learn from the Stakeholder Process?

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241 stakeholders completed a stakeholder comment form as a result of attending the special sessions or responding to the 30-day public posting. 97% indicated they were satisfied with the overall MHSA Integrated Plan and the stakeholder process.

Satisfaction Level	Percentage
Very Satisfied	53%
Satisfied	33%
Somewhat Satisfied	11%
Unsatisfied	2%
Very Unsatisfied	1%



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MHSA Annual Update Stakeholder Demographics

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Age and Gender of Respondents

Age

Age Group	Percentage
16-25 yrs	9%
26-59 yrs	76%
60+ yrs	14%
Unidentified	1%

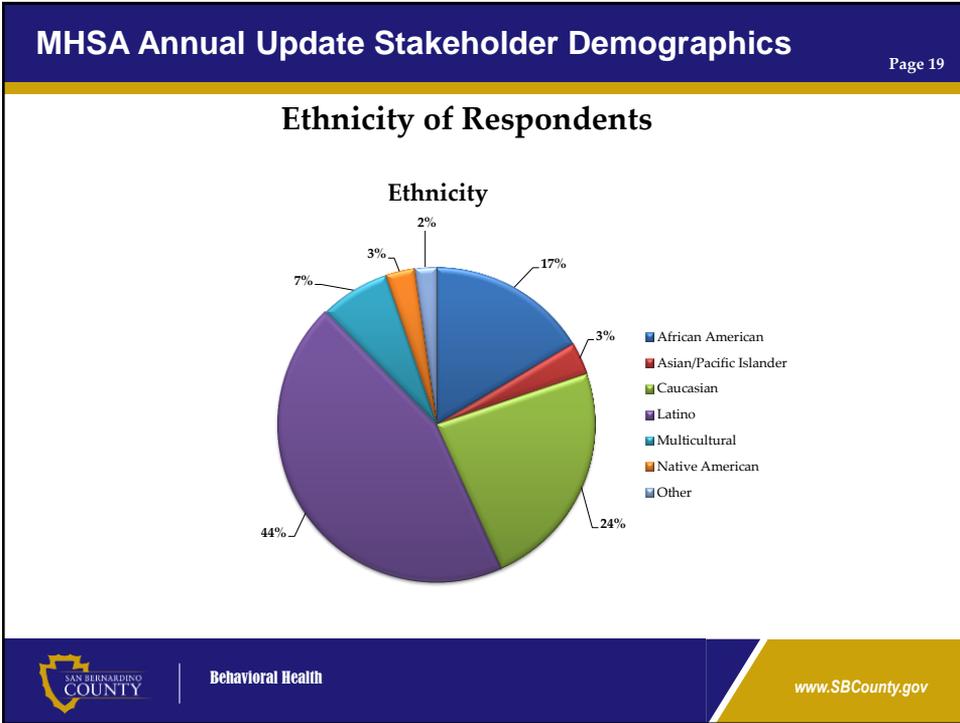
Gender

Gender	Percentage
Female	70%
Male	29%
Other	1%



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MHSА Annual Update Stakeholder Demographics

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WIC § 5848 Group Represented

Group Represented	%	Group Represented	%
Active Military/Veteran Representation	3%	Family Member	13%
Community Agency	14%	Health Care Provider	2%
Community Member	9%	Law Enforcement	1%
Consumer (MH/AOD)	12%	Provider (MH/AOD)	13%
County Staff	18%	Faith Community	4%
Education	3%	Social Service Agency	4%
Unidentified	4%		

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Comments Received

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Nine (9) comment forms were received during the public posting period of the draft MHSA Annual Update for FY 2015/16. A summary of the comments includes:

- Support for the MHSA Annual Update and Community Planning Process.
- Praise for the focus on cultural specific programs and services.
- Acknowledgment of the success of the Workforce Education and Training component programs.
- Support for Prevention and Early Intervention programs.
- Positive Feedback about MHSA programs, in general.



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Response to Substantive Comments Received

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A summary and analysis of stakeholder feedback and comments received and the department response has been included in the MHSA Annual Update for FY 2015/16.

No substantive changes were made.



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Next Steps

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The next step is to ask the Commission to affirm that the stakeholder process was conducted to meet the regulations.

The MHSA Annual Update is scheduled to be presented to the Board of Supervisors (BOS) on June 02, 2015, for approval.

The MHSA Annual Update will be submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days of BOS approval.



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Questions

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For additional questions,
please contact:

Michelle Dusick
MHSA Administrative Manager
800-722-9866
mhsa@dbh.sbcounty.gov



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Press Release Media Outlet List

ABC News	San Bernardino American News
Associated Press	San Bernardino City News
Big Bear Grizzly	San Bernardino Sun
Black Voice News	SoCal News
Bloomberg BNA	The Alpenhorn News
CBS News	Univision
CBS Radio	Victorville Daily Press
Chino Champion	Westside Story Newspaper
City News Group	Yucaipa/Calimesa News Mirror
City Newsgroup	
Daily Journal	
Desert Dispatch	
Desert Trail News	
Fontana Herald	
Fox 11 News	
Hi-Desert Star	
High Desert Daily	
Highland Community News	
Highland News	
Homeless Times	
Inland Empire Business Journal	
Inland Empire Community Newspaper	
Inland Empire Hispanic News	
Inland Empire Magazine	
Inland Newspaper	
KBHR 93.3 FM	
KCAL9 News	
KCDZ 107.7 FM	
KESQ News	
KFRG 95.1FM and 92.9 FM	
KPCC 89.3 AM	
La Prensa	
Los Angeles Times	
Mountain News	
NBC News	
Needles Desert Star	
Needles Desert Star	
News Line	
News Mirror	
News Radio	
Precinct Reporter	
Press Enterprise	



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Measurement and Assessment Tools

Adult Needs & Strengths Assessment (ANSA): A comprehensive assessment of psychological and social factors for use in treatment planning. ANSA is an assessment strategy and communication process with the consumer and family, in addition to a multi-purpose tool developed for adult services to: support decision making (level of care, service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that optimally effective treatment should include both efforts to reduce symptomatology and efforts to use and build upon strengths.

Alcohol Use Disorders Identification Test (AUDIT): A 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization, the test correctly classifies 95% of people into either alcoholics or non-alcoholics.

Beck Anxiety Inventory (BAI): A 21 item self-report questionnaire that assesses anxiety severity. It was specifically designed to reduce the overlap between depression and anxiety scales by measuring anxiety symptoms shared minimally with those of depression. Both physiological and cognitive components of anxiety are addressed in this scale.

Beck Depression Inventory (BDI): A 21 item self-report questionnaire that assesses severity of depression.

Beck Suicide Scale: A brief assessment to help identify individuals at risk for suicide. There are 5 screening items and 21 assessment items. Items on this measure assess the respondents' suicidal plans, deterrents to suicide, and the level of openness to revealing suicidal thoughts.

Behavior and Symptom Identification Scales (BASIS-24): A 24 item self-report measure that identifies a wide range of symptoms that occur across the diagnostic spectrum. It gives an overall score and scores for six subscales for the following domains of psychiatric and substance abuse symptoms and functioning including: Depression and Functioning, Relationships, Self-Harm, Emotional Liability, Psychosis, and Substance Abuse.

Brief Symptom Inventory – 18 (BSI-18): A brief inventory of participants' depression, anxiety, and somatization symptoms. This short version of the BSI questionnaire is composed of 18 Likert-type items, which are rated on the basis of distress over the last 7 days on a 5-point scale from 0 (not at all) to 4 (extremely).

Burns Depression Checklist: A 25 item tool used in evaluating symptoms of depression, and in providing an assessment of depression severity.

Center for Epidemiologic Studies Depression Scale (CES-D): A 20-item measure that asks caregivers to rate how often over the past week they experienced symptoms associated with depression, such as restless sleep, poor appetite, and feeling lonely.

Child & Adolescent Needs & Strengths Assessment (CANS): A comprehensive assessment of psychological and social factors for use in treatment planning. CANS is an assessment strategy and communication process with the youth and family, in addition to a multi-purpose tool developed for children's services to: support decision making (level of care, service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build upon strengths.

Client Service Information (CSI): A collection of client information on all mental health services provided through DBH and contract agencies. Timely and accurate reporting of this data to the State is mandated. The California Department of Health Care Services requires that CSI data be collected for all services (MHSA and non-MHSA) and for all consumers. CSI data is collected from client registration information, episode, periodic, and service entry documentation.

Promotores Community Pre/Post Survey: A survey developed by the Latino Health Collaborative, Loma Linda University, and the Department of Public Health to capture knowledge gained through mental health presentations, attitudes toward mental health services and intention to use mental health services among community members. Surveys are given to participants both before and after mental health presentations to measure the level of change in knowledge, attitude, and intention.

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS): A system used within juvenile justice settings and is an automated risk and needs assessment and unified case planning system. This actuarial risk assessment system contains offender information specifically designed to determine their risk and needs and inform dynamic case plans that will guide them throughout his or her lifecycle in the criminal justice system.

National Curriculum and Training Institute (NCTI) Crossroads Education Pre/Post Test: A set of pre- and post-tests which are used to measure the participant's increase in learning for each course and allow program managers to ensure facilitator effectiveness, as well as measure program fidelity.

Data Collection and Reporting Repository (DCR): A data collection system maintained by the California Department of Health Care Services, containing Full Service Partnership data elements across counties, regions, and the state. Use of the system is required for Full Service Partnerships.

DBH Clinic Assessment: A tool used to assess an individual's level of impaired functioning related to a mental health disorder in the five global areas: health/self-care, occupation/academic, legal/community, financial, and interpersonal/family.

It includes an assessment of the individual's presenting problems, level of risk (danger to himself or others), substance abuse, and medication history.

Desired Results Developmental Profile (DRDP): The primary objective of the desired results system and measures is to measure and encourage child development programs' progress toward the achievement of desired results by providing information and technical assistance to improve program quality.

Developmental Assets Survey: A tool for youth that measures internal strengths and external supports and their growth in these key areas over time.

Family Experiences Interview Schedule (FEIS): A semi-structured interview for family members of consumers to assess their experiences with their loved one and behavioral health treatment. This interview includes the family members' understanding of mental illness, ability to provide support for their loved one, and satisfaction with behavioral health treatment. MAYSI 2 Massachusetts Youth Screening Instrument is a brief screening instrument designed to identify potential mental health needs of adolescents involved in the juvenile justice system. It uses 7 scales to assess the youth including alcohol and drug use, mood disturbances (angry, irritable; depressed, anxious), somatic complaints, suicide ideation, thought disturbance and traumatic experiences.

Generalized Anxiety Disorder Screener (GAD-7): A brief 7-item measure that assesses generalized anxiety disorder. It is a self-report questionnaire for screening and severity measuring of generalized anxiety disorder.

Geriatric Depression Scale (GDS): A 30-item self-report assessment used to identify depression in older adults (Age 60+).

Global Assessment of Functioning (GAF): A scale from the Diagnostic and Statistical Manual of Mental Disorders that provides a measure of a consumer's overall functioning.

Homeless Information Management System (HMIS): An information technology system mandated by the federal government used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Housing Authority of the County of San Bernardino Monthly Report: Tracks increase in permanent supportive housing vouchers in San Bernardino County as well as stability in the program/length of stay.

INSPIRE – Psychological Empowerment Scale (INSPIRE-PES): A tool designed to assess subscales of psychological empowerment: sociopolitical skills, motivation to influence, participatory behavior, and perceived control specifically with regard to the INSPIRE Holistic Campus, a potential initial setting for empowerment practice. No psychometric data yet exists for this version.

Key Event Tracking System (KETS): Database used by DBH provider, Telecare, to track client demographics, as well as information related to emergency room visits, hospitalizations, incarcerations, disenrollment, change of address, and any report of the client being unaccounted for or missing.

Life Skills Progression (LSP): For use with at-risk families of children from birth to 3 years of age, this tool generates a broad, accurate portrait of the behaviors, attitudes, and skills of both parents and children and helps professional establish baseline client profiles, identify strengths and needs, plan interventions, and monitor outcomes to determine if interventions are working.

Massachusetts Youth Screening Instrument (MAYSI): A brief screening instrument designed to identify potential mental health needs of adolescents involved in the juvenile justice system. It uses 7 scales to assess the youth including alcohol and drug use, mood disturbances (angry, irritable; depressed, anxious), somatic complaints, suicide ideation, thought disturbance and traumatic experiences.

Outcomes Questionnaire (OQ – Adult & Youth): A 45 item self-report scale used to evaluate behavioral health problems at the outset and over the course of treatment. It measures symptomatic distress, quality of life, and interpersonal relationships.

Patient Health Questionnaire for Depression (PHQ9): A multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. The tool incorporates depression diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders into a brief self-report tool.

Point in Time Count: A count of homeless persons both in shelter and non-sheltered at a certain point in time. This count is done biannually by the County.

Psychological Empowerment Scale – Revised (PES-R): A 25 item scale designed to assess subscales of psychological empowerment: sociopolitical skills, motivation to influence, participatory behavior, and perceived control in youth.

San Bernardino Information Management Online Network - SIMON: DBH's billing system, which maintains a variety of data elements required for billing and some reporting.

Satisfaction Survey: This Survey is for the participants to evaluate the satisfaction with their experience at INSPIRE Multicultural Holistic Campus. These evaluations help Inspire know how to improve the service and the professional development of the staff.

Severity measure for Generalized Anxiety Disorder (GAD): A 10 item measure that assesses the severity of generalized anxiety disorder in individuals age 18 or older. Each item on the measure is rated on a 5-point scale.

Social Support Inventory (SSI): An 18 item measure of participants' degree of social support.

World Health Organization Quality of Life (WHOQOL): A 26 item subset of the World Health Organization Quality of Life measure. This assessment asks how a person feels about their quality of life, health, or other areas of their life. The WHOQOL makes use of different five-point Likert type scales based on the way the questions are worded.

CASE Logic Model							
Domains	Goals	Objectives	Strategies	Interim Outcomes (IO)	IO Measurement	Key Outcomes (KO)	KO Measurement
Mental Health Domains	Funding-Source-Specific Goal	<p>Specific Objective that Theoretically Supports Goal INN Learning Goals</p> <p>Develop an effective means of identifying diverse children who are vulnerable to exploitation. This is vital due to the deliberate targeting of children in foster care and the ever-younger age of children exploited. This can be achieved by applying the Child, Adolescent Needs and Strengths Tool (CANS) to children as they enter foster care. By building a baseline with these profiles, the project will attempt to correlate the information to profiles of children identified in the juvenile detention system as already exploited</p>	<p>EBPs, Treatment Approaches, Interventions</p> <ul style="list-style-type: none"> • Collaborative multi-disciplinary team • Case management of sexually exploited youth 	<p>As Relates to Objective(s)</p> <ul style="list-style-type: none"> • Provider developed means for identifying diverse youth vulnerable to exploitation • Number of diverse children identified 	<p>Measurement Method or Tool and Frequency of Administration</p> <ul style="list-style-type: none"> • Provider Survey (both quantitative endorsement of objective met and qualitative responses) • CANS-SB • MAYSI II 	<p>As Relates to Goal(s)</p> <p>Increased rates of Underserved participating in the program in comparison to standard services</p>	<p>Measurement Method or Tool and Frequency of Administration</p>
	Access	Increase Access to Underserved Groups		<p>Develop a means of identifying diverse children brought into the probation system who are exploited. Currently, these children may be arrested on non-prostitution related offenses (shoplifting, giving false information to law enforcement, and drug charges).</p>	<p>As Relates to Objective(s)</p> <ul style="list-style-type: none"> • Provider developed means of identifying diverse children brought into the probation system who are exploited • Number of children identified from the probation system 		
Service Effectiveness	Increase Quality of Services, Including Better Outcomes (Primary Goal)	<p>Develop a system of comprehensive interventions and treatment models to determine which are the most effective for developing rapport, addressing the "brain washing" phenomenon related to childhood prostitution and improving the child's life skills</p>	<ul style="list-style-type: none"> • Collaborative multi-disciplinary team • Case management of sexually exploited youth 	<p>As Relates to Objective(s)</p> <ul style="list-style-type: none"> • Provider developed systems of comprehensive interventions and treatment models • Participants decreased symptoms of behavioral and emotional problems, decreased drug and alcohol use, increased resilience 	<p>Measurement Method or Tool and Frequency of Administration</p> <ul style="list-style-type: none"> • Provider Survey (both quantitative endorsement of objective met and qualitative responses) • CANS-SB • Participant Survey 	<p>As Relates to Goal(s)</p> <p>Improved year-over-year outcomes Improved outcomes compared to standard services</p>	<p>Measurement Method or Tool and Frequency of Administration</p> <ul style="list-style-type: none"> • CANS-SB (intake, 6 mo, and/or post) • Participant Survey (post only)

<p>Linkages</p>	<p>Promote Interagency Collaboration</p>	<p>Increase our understanding of the impact of sexual exploitation, risk factors, and the means to develop rapport, initiate effective identification and collaborative intervention and treatment</p>	<ul style="list-style-type: none"> • Collaborative multi-disciplinary team • Case management of sexually exploited youth 	<ul style="list-style-type: none"> • Provider observation of the impact of sexual exploitation and the means to develop rapport, initiate effective identification and collaborative intervention and treatment • Training participants increased knowledge of training content • Provider reported interagency collaboration occurring 	<ul style="list-style-type: none"> • Provider Survey (both quantitative endorsement of objective met and qualitative responses) • Training Participant Survey; Collaboration Survey 	<p>Increased collaboration by county or community agencies</p>	<p>Provider Collaboration Survey (End of fiscal year)</p>
<p></p>	<p></p>	<p>Develop a training and education model, effective for community-based implementation, for those who interact with these children that most effectively work for San Bernardino County's cultural and ethnic populations</p>	<ul style="list-style-type: none"> • Promote training to other agencies • Provide trainings regarding sexually exploited youth 	<ul style="list-style-type: none"> • Provider developed training and education model effective for community-based implementation • Number of trainings conducted • Number of trainees • Training participants increased knowledge of training content 	<ul style="list-style-type: none"> • Program tracking data • Provider Survey (both quantitative endorsement of objective met and qualitative responses) • Training Participant Survey 	<p></p>	<p></p>
<p></p>	<p></p>	<p>The long-term learning goal is to make use of an innovative collaboration to strengthen clinical practice for those serving sexually exploited children. The model created by this project will develop creative clinical strategies, combine existing best practices in trauma care with local clinical expertise and utilize ongoing outcome measures.</p>	<ul style="list-style-type: none"> • Collaborative multi-disciplinary team • Case management of sexually exploited youth 	<ul style="list-style-type: none"> • Provider observation that an innovative collaboration has developed and is used to strengthen clinical practice for those serving sexually exploited children. • Provider observation that the model for this program develops creative clinical strategies, combines existing best practices in trauma care with local expertise, and utilizes outcome measures. • Participants decreased symptoms of behavioral and emotional problems, decreased drug and alcohol use, increased resilience • Training participants increased knowledge of training content • Provider reported interagency collaboration occurring 	<ul style="list-style-type: none"> • Provider Survey (both quantitative endorsement of objective met and qualitative responses) • CANS-SB • Training Participant Survey • Collaboration Survey 	<p></p>	<p></p>

Other Resources

CASE Training & Events
<http://sbcase.eventbrite.com>

CASE YouTube
www.youtube.com/sanbernardinocase

San Bernardino "211"
Information and referrals
for health and social services.

Polaris Project

National Human Trafficking Hotline
Washington, DC 888-3737-888
www.polarisproject.org

Shared Hope International
Vancouver, WA (866) 437-5433
www.sharedhope.org

National Center for

Missing and Exploited Children
24-Hour Hotline (800) 843-5678
www.missingkids.com

Families Against Sex Trafficking (FAST)
<http://families4fast.org>

Girls Education & Mentoring Services (GEMS)
New York, NY (212) 926-8089
www.gems-girls.org

Sowers Education Group
<http://sowerseducationgroup.com>

Runaway Girl
<http://runawaygirl.org>

Anne-Michelle Ellis, Coordinator
Children's Network
825 E. Hospitality Lane, 2nd Floor
San Bernardino, CA 92415-0049

Phone: 909-383-9677
Fax: 909-383-9688
anne-michelle.ellis@hss.sbcounty.gov
facebook.com/sanbernardinocase
or 7-1-1 for TTY users.

Did You Know?

The average age when a young person is first trafficked is 12-13.

One in three teens will be recruited by a trafficker within 48 to 72 hours of running from home.

The National Runaway Switchboard estimates as many as 1.6 to 2.8 million children are on the streets at any time.

Partners

County of San Bernardino:

Children & Family Services

Children's Network

Department of Behavioral Health

District Attorney

Probation

Public Defender

Public Health

Sheriff

Superintendent of Schools

Superior Court of California, Juvenile Division

Local non-profits and
faith-based groups.

Services provided in collaboration with the County of San Bernardino,
Department of Behavioral Health and funded by the Mental Health
Services Act (Proposition 63).



Coalition Against Sexual Exploitation

A

Multi-Disciplinary Response to the Commercial Sexual Exploitation of Children



San Bernardino County Coalition Against Sexual Exploitation



Overview

The commercial sexual exploitation of youth is a serious and pervasive issue affecting individuals, families and communities around the world. Exploiting children is a form of child abuse and those being exploited are victims of this serious crime. It is a complicated issue and in response, the County of San Bernardino has formed a coalition made up of law enforcement and social service agencies at a local level to coordinate their activities to capture adult offenders and best connect exploited youth to needed services.

Our Approach

- Multi-disciplinary
- Centralized referral mechanism
- Identification of a point person: The CASE Coordinator
- CASE-dedicated staff from Probation, Department of Behavioral Health, Children & Family Services, Public Defender, District Attorney and the Children's Network.
- Ability to respond quickly
- Coordinated communication among providers
- Provider accountability
- Outreach & Education
- Countywide training and technical assistance on the Commercial Sexual Exploitation of Children (CSEC) issues
- Tracking of referrals and outcomes

Goals

The Coalition Against Sexual Exploitation includes partnerships between the District Attorney, Public Defender, Public Health, Probation Department, Sheriff's Department, Children & Family Services, Behavioral Health, County Schools, Superior Court of California—Juvenile Division and Children's Network and aims to:

- Empower victims to leave their exploiter and utilize opportunities to regain control of their life and future.
- Ensure victims' physical and psychological safety.
- Ensure victims' access to resources and services, including: medical care, mental health care, substance abuse treatment, educational opportunities, job skills training, mentors/advocates and more.
- Address the larger social issues impacting at-risk youth.

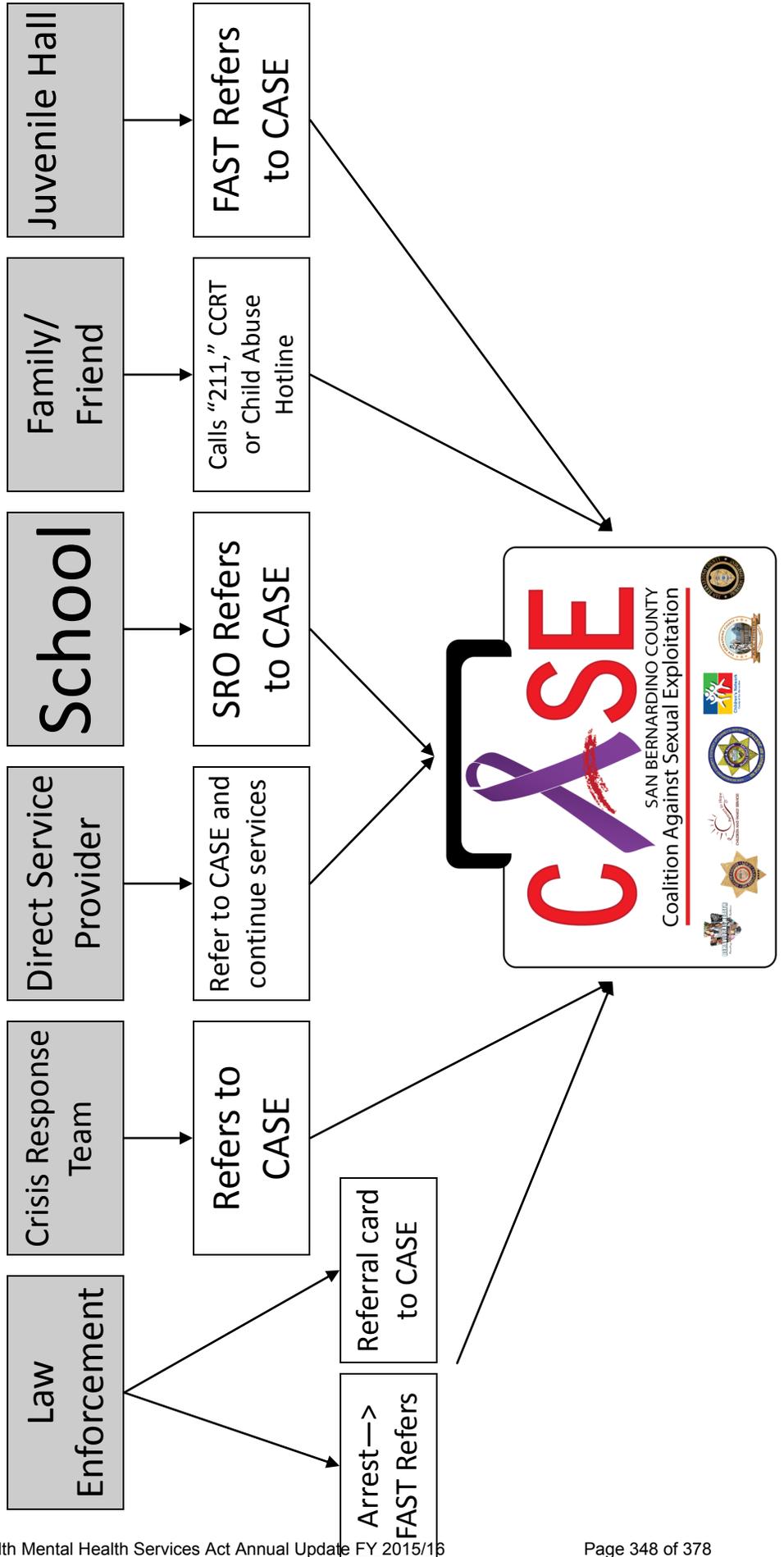
What are potential indicators of trafficking and exploitation?

- Multiple reports of running away with no explanation as to whereabouts or running out of state
- History of emotional, sexual or other physical abuse
- Signs of current physical abuse and/or sexually transmitted diseases
- Inexplicable appearance of expensive gifts, clothing, or other costly items
- Presence of an older boy-/girlfriend
- Drug addiction
- Withdrawal or lack of interest in previous activities
- Gang involvement
- Tattoos or branding that indicate ownership



Coalition Against Sexual Exploitation Referral Response Chart

Possible Victim Identified By:



The Coalition Against Sexual Exploitation presents:

**FREE
Training!!**

Scheduled Dates:

Children's Network
825 E. Hospitality Lane
Conference Room B/C
San Bernardino, CA 92415

January 8, 2015
8:30 AM-12:30 PM

February 18, 2015
12:30 PM-4:30 PM

March 19, 2015
8:30 AM-12:30 PM

April 17, 2015
8:30 AM-12:30 PM

May 6, 2015
12:30 PM-4:30 PM

June 17, 2015
12:30 PM-4:30 PM



**Identification &
Assessment of
Victims of
Trafficking and
Commercial Sexual
Exploitation**

Topics that will be covered include:

- An overview of types of sex and labor trafficking cases likely to be encountered
- How to identify and assess potential cases of sex and labor trafficking
- The business aspect of commercial sexual exploitation

Who Should Attend?

- Law Enforcement & Probation
- Social Workers & Therapists
- Intake Specialists & Childcare Workers
- Nurses & Doctors
- Teachers, Guidance Counselors & School Resource Officers
- Other first responders

BBS:

San Bernardino County Department of Behavioral Health, Provider #3766. This course meets the qualifications for 3.75 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.

Sponsored by :



CBRN CE Credits:

Provider, San Bernardino County, Department of Behavioral Health, approved by the California Board of Registered Nursing, Provider # CEP-15400, for 4 contact hours.

Note: Participation for the entire class period is required to qualify for continuing education credit; no partial credit will be awarded.

For more information or any questions regarding CE credit, please contact Sherrie Alexander at 909-252-4012.



For more information or to register, please go to <http://sbcase.eventbrite.com>

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact Anne-Michelle, CASE Coordinator, at (909) 383-9677 or 7-1-1 for TTY users.

Take a Stand Against Exploitation by Participating in a **Walk Against Human Trafficking**

*It's closer than **YOU** think!*



JOIN US IN RAISING AWARENESS ABOUT
HUMAN TRAFFICKING IN OUR COMMUNITY!

SATURDAY, JANUARY 11, 2014

JANUARY IS HUMAN TRAFFICKING AWARENESS MONTH —
GET INVOLVED!!!

LOCATION

Children's Network
825 East Hospitality Lane
San Bernardino, CA 92415

TIME

- 9:00 a.m. — Registration
- 10:00 a.m. — Speakers
- 11:00a.m. — 1.3 Mile Walk

SPECIAL GUEST SPEAKERS

- Human Trafficking Survivor
- San Bernardino County District Attorney
Mike Ramos
- Other Guest Speakers

HOSTED BY

CASE
SAN BERNARDINO COUNTY
Coalition Against Sexual Exploitation



**Free giveaway for the first
100 people who register by
going to:**

<https://2014casewalk.eventbrite.com>

Please register at <https://2014casewalk.eventbrite.com> or
call CASE Coordinator, Anne-Michelle Ellis at (909) 383-9677 or 7-1-1 for TTY users

INNOVATION:

Pathway to Learning

Community Policy Advisory Committee
(CPAC)
May 15, 2014



Presentation Objectives

- Review Innovation (INN) legislative requirements
- Overview of Evaluation Approach
- Review of current INN projects
 - CASE



INN LEGISLATIVE REQUIREMENTS WIC 5830, Part 3.2



Address one of the following learning purposes as its primary purpose:

- (1) To increase access to underserved groups.
- (2) To increase the quality of services, including better outcomes.
- (3) To promote interagency collaboration.
- (4) To increase access to services.

INN LEGISLATIVE REQUIREMENTS

WIC 5830, Part 3.2



Support innovative approaches by doing one of the following:

- (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
- (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

INN LEGISLATIVE REQUIREMENTS WIC 5830, Part 3.2



- An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service.
- County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

EVALUATION APPROACH

Mental Health Services Oversight and Accountability Commission (MHSOAC)



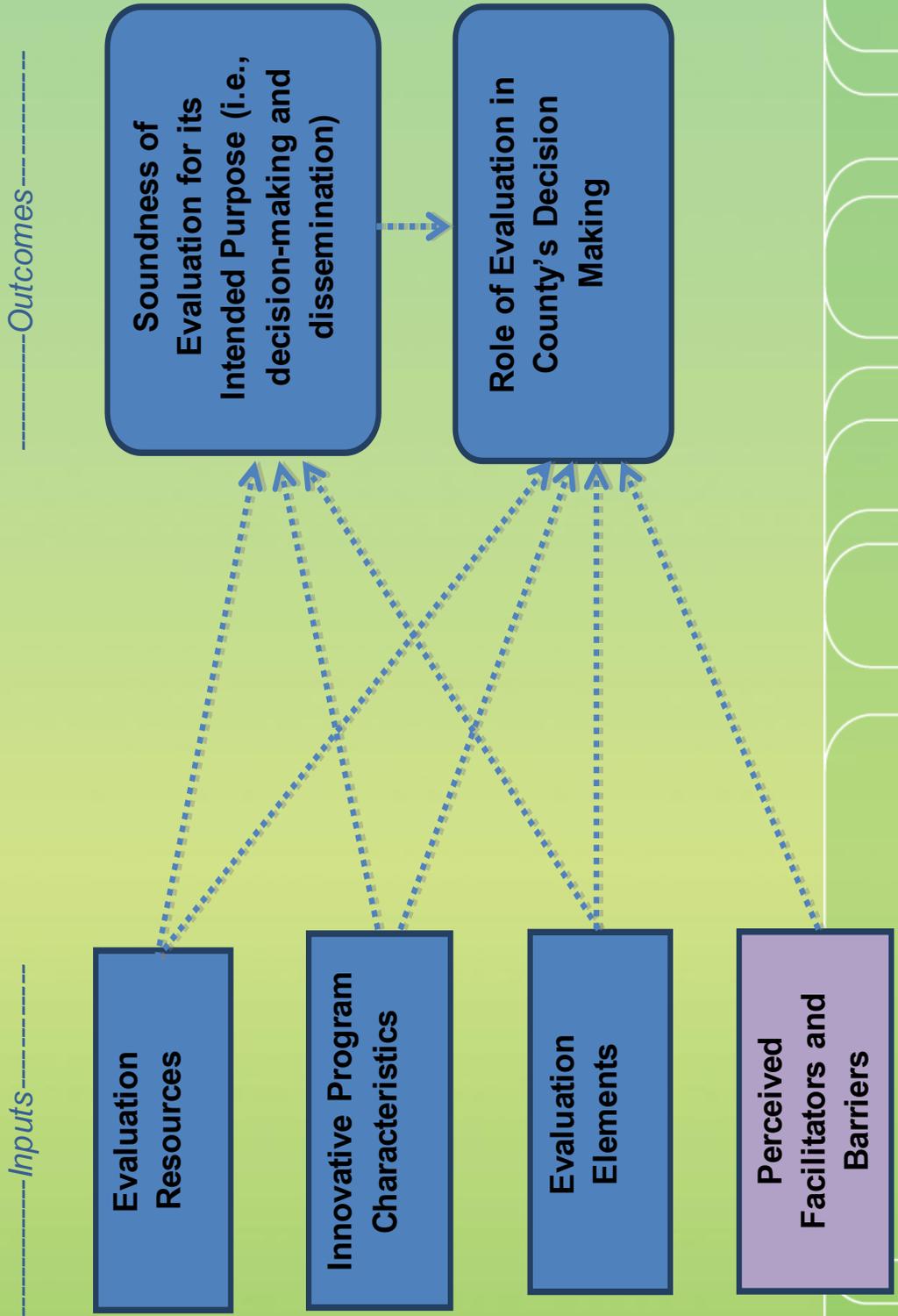
- From Innovation Evaluation RFP:
 - Purpose is “designing, piloting, and evaluating the efficacy of new or changed mental health approaches”
 - Evaluation is at the core of all Innovative Projects

EVALUATION APPROACH MHSOAC



- Overall trend of increased oversight, especially with regard to evaluation activities
- CiMH contract: Evaluation of Innovation Evaluation
 - Inventory of evaluation approaches
 - Evaluation of the efficacy of the evaluation approaches

Figure 1: OVERALL RESEARCH FRAMEWORK



EVALUATION APPROACH

Pending Regulations



- MHSOAC is preparing proposed regulations for Innovation, per AB 82
- Regulations will be outcomes-focused
 - Emphasis on research, testing, and learning
- Language moving from “program” to “project”

• All information on this slide is proposed and subject to change as proposed legislation goes through legislative review.

EVALUATION APPROACH

Pending Regulations



Time-limited Pilot Project

- Maximum of 4 years from the start date of the project
- Successful parts of the project may continue under a different funding source or be incorporated into existing services
- Projects may be terminated prior to planned end date

*All information on this slide is proposed and subject to change as proposed legislation goes through legislative review.



INN 02 – Coalition Against Sexual Exploitation (CASE)

**Michael Schertell, Deputy Director
Department of Behavioral Health
County of San Bernardino**



Overview

- Background/History/Learning Goals
- CASE Steering Committee
- CASE Project
- Specialty/Unique Population
- Successes and Outcomes
- Transition to Prevention and Early Intervention



Background/History/Learning Goals



- Inspired by District Attorney and Board of Supervisors during CASE Summit of 2009
- Originally a project of the 2010 MHSA Innovation Component Plan
- Broad Goals:
 - Develop model of collaborative care for this unique, **unserved** population
 - Strengthen practices for systems that serve sexually exploited children/youth
 - Combine best practices in trauma care with local-collaborative expertise

Learning Goals, cont'd.

- Increase understanding of impact of sexual exploitation, risk factors and a means of effective identification, intervention and treatment.
- Develop a means for identifying diverse children/youth entering juvenile justice system on non-sexual exploitation charges.
- Develop a training and education module for effective interaction with this unique population.
- Develop psychometric tools for identifying and monitoring this unique population.



CASE Steering committee

A collaborative effort made up of ten child/youth-serving agencies:

- Department of Behavioral Health
- Children and Family Services
- Children's Network
- District Attorney's Office
- Public Defender
- Probation Department
- Sheriff's Department
- Department of Public Health
- San Bernardino County Superintendent of Schools
- San Bernardino County Superior Court – Juvenile Dependency Division



CASE Project



Prior to the creation of the CASE:

- There were no services tailored specifically for survivors of commercial sexual exploitation in San Bernardino County.
- There was no training available to professionals or community members regarding these issues.
- Coordination of services for commercially sexually exploited children was minimal in most cases.
- There were no performance outcomes or statistical tools for this unique population.

Specialty/Unique Population



- Commercially Sexually Exploited Children (CSEC) often have many levels of trauma—interpersonal violence, family violence, systemic violence, societal violence, racism, sexism, etc.
- Many CSEC are involved in multiple child-serving departments/agencies. These entities have not always communicated with each other in coordination of services/case planning.
- Resulting in many youth “falling through the cracks” and not being identified as victims.

Successes and Outcomes



- Strengthened collaborative efforts between all child/youth serving agencies.
- Formation of a Multi-Disciplinary Team.
- Development of a centralized referral mechanism.
- Appointment of a CASE Coordinator to oversee and coordinate program efforts.
- Training, outreach and education to 3,000-4,400 individuals per year from FY 2010/11 – FY 2012/13

Successes and Outcomes, cont'd.



- Standardized use of the Child and Adolescent Needs and Strengths (CANS) as a tool to develop a comprehensive treatment plan that can be utilized across multiple systems.
- Utilization of the CANS to track progress, gains in functionality, increased resiliency, and reduction in symptoms.
- Development of a unique CSEC module for monitoring impact of services provided.

Successes and Outcomes, cont'd.



Utilization of the Massachusetts Youth Screening Instrument - Second Version (MAYSI-II)

- Development of a means of identifying juvenile justice youth as possible victims of sexual exploitation.

Transition to Prevention and Early Intervention



- MHSAs legislative goal: Reducing Prolonged Suffering
- Service population is a unique group with limited-targeted resources
- Inherently at risk of developing a behavioral health condition
 - Underserved cultural populations
 - Trauma exposed
 - At risk of/or experiencing juvenile justice involvement
- Disparate proportion are from underserved cultural populations

Transition to Prevention and Early Intervention, cont'd.

- 80% Early Intervention services
 - Clinical assessment
 - Mental health treatment services
 - Alcohol and drug counseling
- 20% Selective services
 - Outreach and engagement
 - Screening, case management, multi-disciplinary collaboration
 - Educational services



Transition to Prevention and Early Intervention, cont'd.



- The annual budgeted cost under Innovation was approximately \$900,000.
- Sustainability of services are dependent on leveraged resources.
 - Probation and CFS will assume funding support for staffing commitments to this effort.
 - Budget has been reduced by 55% since the inception of the project, which includes the reduction of MOU pool funds for all partners for auxiliary services/supplies.
- The annual budgeted cost now, under PEI, is approximately \$400,000.



Questions....

MAYSI-2 Screening Report

Demographic Information:

MAYSIWARE ID: 4037

Name:	JOHN DOE	Gender:	Male
Facility ID:	000000	Ethnicity:	Non Hispanic
DOB:	01/01/2001	Race:	Other
Age:	14	Administration:	2/18/2015
Admission:	2/18/2015		

MAYSI-2 ITEMS (listed by scale):

Depressed Anxious Score=0

- 3. Have nervous or worried feelings kept you from doing things you want to do? (N)
- 14. Have you had nightmares that are bad enough to make you afraid to go to sleep? (N)
- 17. Have you felt lonely too much of the time? (N)
- 21. Has it seemed like some part of your body always hurts you? (N)
- 34. Have you felt that you don't have fun with your friends anymore? (N)
- 35. Have you felt angry a lot? (N)
- 41. Has it been hard for you to feel close to people outside your family? (N)
- 47. Have you given up hope for your life? (N)
- 51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you? (N)

Suicide Ideation Score=0

- 11. Have you wished you were dead? (N)
- 16. Have you felt like life was not worth living? (N)
- 18. Have you felt like hurting yourself? (N)
- 22. Have you felt like killing yourself? (N)
- 47. Have you given up hope for your life? (N)

Alcohol/DrugUse Score=0

- 10. Have you done anything you wish you hadn't, when you were drunk or high? (N)
- 19. Have your parents or friends thought you drink too much? (N)
- 23. Have you gotten in trouble when you've been high or have been drinking? (N)
- 33. Have you used alcohol or drugs to help you feel better? (N)
- 37. Have you been drunk or high at school? (N)
- 40. Have you used alcohol and drugs at the same time? (N)
- 45. Have you been so drunk or high that you couldn't remember what happened? (N)
- 24. If yes, is this fighting? (?)

Somatic Complaints Score=0

- 27. When you have felt nervous or anxious: have you felt shaky? (N)
- 28. When you have felt nervous or anxious: has your heart beat very fast? (N)
- 29. When you have felt nervous or anxious: have you felt short of breath? (N)
- 30. When you have felt nervous or anxious: have your hands felt clammy? (N)
- 31. When you have felt nervous or anxious: has your stomach been upset? (N)
- 43. Have you had bad headaches? (N)

Angry-Irritable Score=0

- 2. Have you lost your temper easily, or had a "short fuse?" (N)
- 6. Have you been easily upset? (N)
- 7. Have you thought a lot about getting back at someone you have been angry at? (N)
- 8. Have you been really jumpy or hyper? (N)
- 13. Have you had too many bad moods? (N)
- 35. Have you felt angry a lot? (N)
- 39. Have you gotten frustrated a lot? (N)
- 42. When you have been mad, have you stayed mad for a long time? (N)
- 44. Have you hurt or broken something on purpose, just because you were mad? (N)

Thought Disturbance Score=0

- 9. Have you seen things other people say are not really there? (N)
- 20. Have you heard voices other people can't hear? (N)
- 25. Have other people been able to control your brain or your thoughts? (N)
- 26. Have you had a bad feeling that things don't seem real, like you're in a dream? (N)
- 32. Have you been able to make other people do things just by thinking about it? (N)

Traumatic Experience Score=0

- 46. Have people talked about you a lot when you're not there? (N)
- 48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you? (N)
- 49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed? (N)
- 51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you? (N)
- 52. Have you ever seen someone severely injured or killed (in person - not in movies or on TV)? (N)

Items not Contained in Scales

- 48. Have you EVER IN YOUR WHOLE LIFE had something very bad or terrifying happen to you? (N)
- 49. Have you ever been badly hurt, or been in danger of getting badly hurt or killed? (N)
- 50. Have you ever been raped, or been in danger of getting raped? (N)
- 51. Have you had a lot of bad thoughts or dreams about a bad or scary event that happened to you? (N)
- 52. Have you ever seen someone severely injured or killed (in person - not in movies or on TV)? (N)

JOHN DOE's MAYSI-2 Scores

	CAUTION					WARNING				INV	
AD ALCOHOL/DRUG USE	0	1	2	3	4	5	6	7	8		
AI ANGRY IRRITABLE	0	1	2	3	4	5	6	7	8	9	
DA DEPRESSED-ANXIOUS	0	1	2	3	4	5	6	7	8	9	
SC SOMATIC COMPLAINTS	0	1	2	3	4	5	6				
SI SUICIDE IDEATION	0	1	2	3	4	5					
TD THOUGHT DISTURBANCE (BOYS)	0	1	2	3	4	5					
TE TRAUMATIC EXPERIENCES	0	1	2	3	4	5					



Behavioral Health