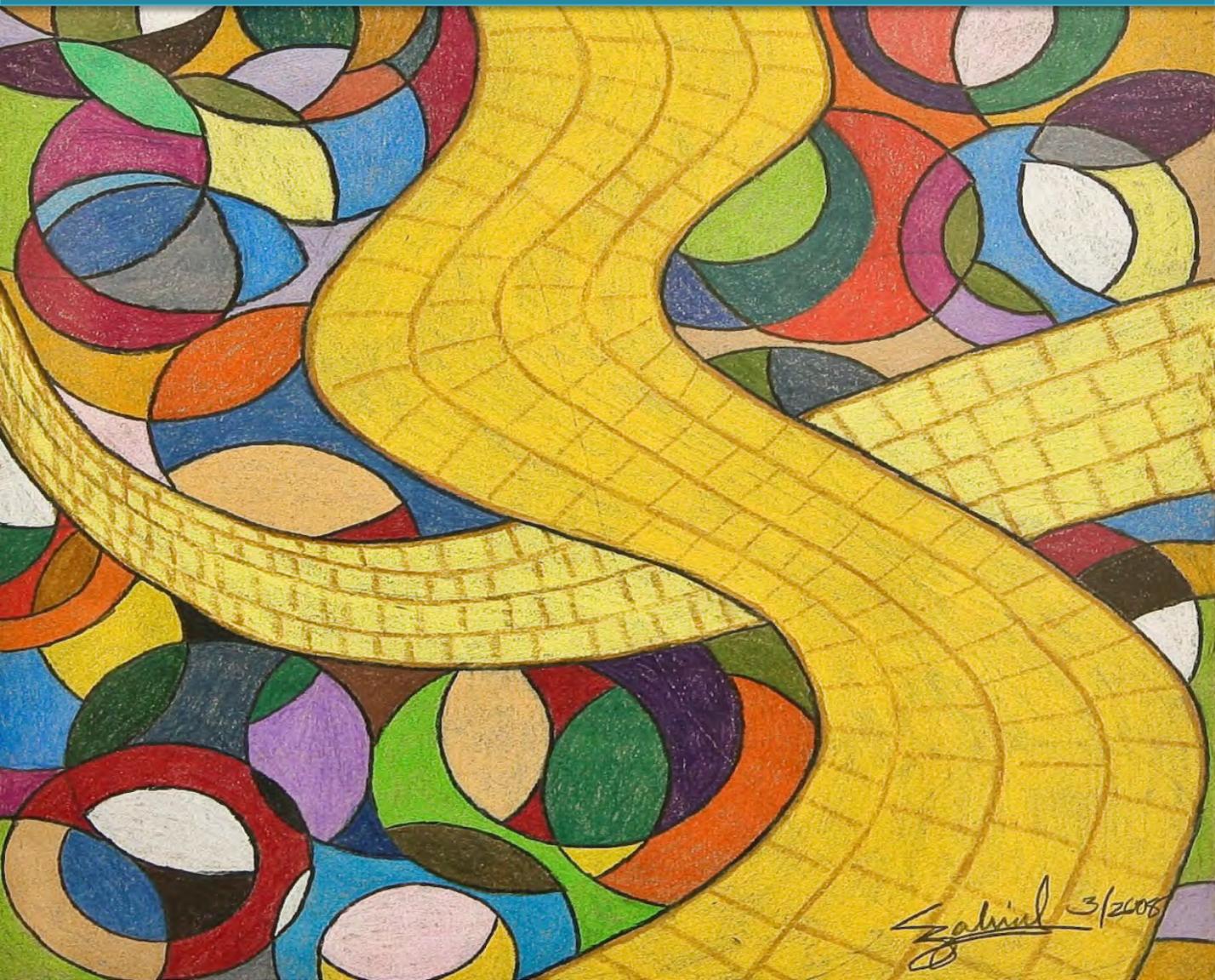


County of San Bernardino
Department of Behavioral Health
Mental Health Services Act
Integrated Plan
Fiscal Years 2014/15 Through 2016/17



July 1, 2014

Artwork Provided By and In Memory of:

GABRIEL GONZALEZ



Message from the Director

**MENTAL HEALTH
SERVICES ACT**

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

Welcome to the County of San Bernardino, Department of Behavioral Health’s (DBH) Mental Health Services Act (MHSa) Integrated Plan celebrating the accomplishments of the implementation of MHSa. This is the first year that counties across the state of California are completing an MHSa Three-Year Integrated Plan focusing on Fiscal Years 2014/15 through 2016/17. The MHSa Integrated Plan allows the opportunity to reflect upon what has transpired across the County since the inception of MHSa in 2005, and how the planning and implementation of MHSa has and continues to change the face of public mental health.

We would like to take this opportunity to thank the Board of Supervisors and the County Administrative Office for their continued support of DBH as we strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities.

It is my hope that you find the MHSa Integrated Plan informative and a reflection of DBH’s efforts to achieve the goal of recovery focused and wellness driven services, while at the same time developing relationships with consumers, family members and community partners to create and expand culturally relevant services to members of our community.

The progress made in the past nine years has been achieved through the extraordinary collaborative relationships between DBH and contract agency staff, the Behavioral Health Commission and our many community partners. There has been concerted effort and dedication to support both the transformative tenants of MHSa and the Wellness Component in the Countywide Vision. I hope you find this Plan both informative and a true celebration of the impact MHSa has had in the development of prevention programs and superior behavioral health services in the County of San Bernardino.

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

Sincerely,

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



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience



ACTUALIZACIÓN ANUAL DE
LA LEY DE SERVICIOS DE
SALUD MENTAL
(SIGLAS MHSa EN INGLÉS)

Mensaje de la Directora

PLAN INTEGRADO MHSa

AÑO FISCAL 14/15 - 16/17

Bienvenido al Plan de Integración de la Ley de Servicios de Salud Mental (MHSa por sus siglas en inglés) del Condado de San Bernardino, Departamento de Salud Mental (DBH por sus siglas en inglés) celebrando los logros de la implementación del MHSa. Este es el primer año que los condados en el estado de California están completando un plan trienal Integrado MHSa centrado en los años fiscales 2014/15, 2015/16 y 2016/17. El Plan integral de MHSa permite la oportunidad de reflexionar sobre lo que ha sucedido en todo el condado desde la creación del MHSa en 2005, y cómo la planificación y ejecución del MHSa ha cambiado y sigue cambiando el imagen de la salud mental pública.

Nos gustaría tomar esta oportunidad para agradecer a la Junta de Supervisores y a la Oficina Administrativa del Condado por su continuo apoyo a DBH ya que estamos esforzándonos para ser reconocidos como un sistema progresista de servicios fluidos, accesibles y efectivos que promuevan la prevención, intervención, recuperación y resiliencia de los individuos, familias y comunidades.

Espero que el Plan Integral de MHSa le resulte informativo y que lo considere como un reflejo de los esfuerzos de DBH para lograr la meta de servicios enfocados a la recuperación y al bienestar, mientras que al mismo tiempo desarrollamos relaciones con los consumidores, familiares y socios de la comunidad para crear y expandir servicios culturalmente relevantes para los miembros de nuestra comunidad.

Los progresos realizados en los últimos nueve años se han logrado a través de las relaciones de colaboración extraordinarias entre DBH y personal de las agencias contratadas, la Comisión de Salud Mental y muchos de nuestros socios comunitarios. Ha habido esfuerzos conjuntos y dedicación para apoyar tanto los inquilinos transformadores del MHSa y el componente de bienestar en la Visión del Condado. Espero que este Plan le sea informativo y también sea una verdadera celebración del impacto que MHSa ha tenido en el desarrollo de programas de prevención y servicios superiores de salud mental en el Condado de San Bernardino. Gracias por tomarse el tiempo para revisar y hacer sus comentarios sobre este plan. La Oficina de Planificación Programáticas de MHSa de DBH esperara sus comentarios por correo electrónico a través de: MHSa@dbh.sbcounty.gov.

Sinceramente,

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



County of San Bernardino - Department of Behavioral Health





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SERVICES ACT**

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County of San Bernardino - Department of Behavioral Health





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County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience



MENTAL HEALTH SERVICES ACT

Mental Health Services Act Integrated Plan FY 2014/15-2016/17

Background

Welfare and Institutions Code Section (WIC §) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

The County of San Bernardino is pleased to present our Mental Health Services Act (MHSA) Integrated Plan for Fiscal Years (FY) 2014/15– 2016/17.

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 veterans 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.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Introduction to the Integrated Plan

The County of San Bernardino Mental Health Services Act (MHSA) Three-Year Integrated Plan (Plan) 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 service trends, program goals and outcomes of Behavioral Health programs, and provides a roadmap to a unified system of care dedicated to continuous improvement of programs and services.

Specifically, the Integrated Plan focuses on a collaborative continuum approach in which consumers, family members, providers, staff, and faith and community-based organizations can work together to systematically improve the public mental health system. The emphasis of the Integrated Plan is to link MHSA components, programs and funding with Medi-Cal and other behavioral health programs to create an integrated service experience for clients. The Plan is an example of the Department of Behavioral Health's (DBH) efforts 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. While the Plan is expected to continue to change and evolve over the next three (3) years, as will be reflected in Annual Updates to the Plan, this draft is intended to set the framework for meaningful integration at the local department, program and policy level.

The Plan incorporates program successes and demonstrates areas of opportunity, such as improving evaluation of programs across multiple domains, enhancing the department's use of technology in clinical care, the need to build capacity of providers as we meet the changing landscape of healthcare reform and successful client engagement strategies that activate clients fully into their own healthcare in meaningful ways. Key to the Integrated Plan, is recognizing that thoughtful analysis offers opportunity for action and the integration of rapid cycle decision making processes into department operations to improve, change or modify programs to the benefit of clients, our community and stakeholders. In short, the purpose of this Plan is to inform community stakeholders, leadership and policy makers in the administration and management of Behavioral Health Programs, as well as meet the regulatory requirements of the MHSA.

Integration at the MHSA level is not the only level of integration this plan seeks to achieve. Over the last several years, the County of San Bernardino has engaged in processes aimed at creating a county vision statement that encompasses the needs of our diverse residents. The vision contains ten inter-related elements that DBH, as a health related county department, directly impacts, including the element of wellness. The element of wellness in the County Vision states:

"In support of a healthy county, we value both prevention programs and superior healthcare services. We should reduce chronic disease and socio-economic disparities through health education, promotion of healthy lifestyles and healthy city initiatives, development of outcome-based health services, and increasing the collaboration between and among providers and community-based organizations."

Introduction to the Integrated Plan

The interplay of the six (6) MHSa components works similarly; each component is designed to meet a specific purpose but all are interrelated, building upon each other, as well as other health services in the community. The MHSa Integrated Plan should be considered to be the treatment plan for the behavioral health system, setting goals for improvement, recognizing and documenting strengths and facilitating wellness for the residents and community in the County of San Bernardino.



As you read through this plan, the linkages between the various components should come to mind as well as the concept of integration through technology and appropriate information sharing, working with other programs and health professions to treat the whole person, and improving behavioral health programs so they are easy to navigate, understand, access and demonstrate outcomes.

If you have questions or would like to provide additional input on the integrated plan, please contact the office of MHSa Program Planning at MHSa@dbh.sbcounty.gov or at (909) 252-4046 to be included on our distribution lists, provide feedback to this posted plan, or get involved in ongoing stakeholder meetings.

Similar to the artwork provided by artist Gabriel Gonzalez on the cover of this Integrated Plan, MHSa and other services must connect to create a pathway to recovery. Over the next several years, DBH along with our stakeholders, community partners, consumers, family members, other county departments and health partners will focus intently on creating a path to recovery that is sustainable, easy to travel and most of all, inspiring wellness for those who travel it.



Overview of the 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 veterans 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.

The County of San Bernardino's Department of Behavioral Health (DBH) has been highly committed to including diverse consumers and stakeholders from throughout the county and within all levels of Mental Health Services Act (MHSA) planning, implementation, evaluation, and program improvement since the inception of MHSA in 2005. As the stakeholder process evolved over the last nine (9) years, DBH has incorporated several best practices into our planning process that has allowed stakeholders to remain connected to the department and engaged in meaningful discussions about critical behavioral health issues.

In lieu of one-time annual stakeholder engagement meetings and processes, the County of San Bernardino has committed to integrating ongoing stakeholder engagement as part of standard business operations. While this has been a practice for the last several years, as a specific example, since July 2013, over **280** regular, ongoing meetings with diverse stakeholders have been hosted by DBH to discuss a variety of topics related to mental health policy, pending legislation, program planning and implementation, and financial resources affiliated with Behavioral Health programs. This integration has allowed DBH to utilize a participatory framework to:

- Educate diverse stakeholders and consumers about the MHSA and the public mental health system as a whole;
- Be responsive to the changing environment of public mental health; and
- Identify and incorporate any course corrections in a timely manner.

Overview of the Stakeholder Process

Schedules for these ongoing meetings are available to stakeholders and distributed widely with interpreter services available to participating community members. 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) separate monthly meetings, one held in each of the five (5) supervisorial districts within the county and led by the Behavioral Health Commissioners in that district.
- Community Advisory Policy 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).
- MHSA Executive Committee.
- Association of Community Based Organizations (ACBO).
- Room and Board Advisory Coalition.
- SART Collaborative.
- System-wide Program Outcomes Committee (SPOC).

Additional stakeholder engagement and education meetings include:

- Bimonthly 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 employees.
- Older Adult Peer Counselor Support and Outreach System.
- Transitional Age Youth (TAY) Network.

Stakeholder attendance, as documented on meeting sign-in sheets and consumer feedback forms, indicate the representation of those community members outlined in Welfare and Institutions Code (WIC) 5848 and include underserved, unserved, and inappropriately served populations. Significant focus on outreach to diverse stakeholders that represent the demographics of the county included clients with severe mental illness as well as other community groups. Over the 2012/13 fiscal year DBH staff attended 81 health fairs and community education events in an effort to provide community education, offer information and connect individuals with the Department of Behavioral Health. Outreach efforts also served to build internal list serves, email lists and contact lists that are used to distribute information about the Integrated Plan, community forums and regularly scheduled stakeholder meetings.

Stakeholder input is always considered when making system decisions within the Department. Policy, program planning and implementation issues are regularly discussed at all of the monthly meetings listed in this report. Monitoring, evaluation and quality improvement is the focus of the Department's Quality Management Action Committee (QMAC) meetings and often leads to quality of care improvements for MHSA programs. Budget allocations are discussed regularly at the CPAC and MHSA Executive meetings, as well as others as needed.

Overview of the 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.

When a need for training is identified, arrangements are made to deploy culturally and clinically competent trainings to providers of MHSA services that enhance the quality of care for consumers and their families. Consumers, family members, service providers and peer staff are among the membership of all committees allowing for consistent feedback and interaction to occur between department staff and community stakeholders regarding MHSA programs. Documentation of these activities are included in minutes recorded at each meeting and are frequently provided to Department of Health Care Services (DHCS) staff and California External Quality Review Organization (CAEQRO), APS staff and are reviewed by meeting participants monthly.

Training specific to participation in stakeholder meetings has also been provided to those attending stakeholder meetings. Training materials are entitled, "How to Get the Most from Today's Meeting and Make Your Voice Heard," and include information as follows:

- Start from a place of learning—We are all here to learn together and from one another.
- Keep an open mind and engage fully in the process.
- Listen with curiosity to understand the projects and how they can better serve people in your community.
- Share your opinions in a respectful and constructive way.
- Help keep an atmosphere of professionalism and considerate discussion—Some ways you can do this:
 - ◆ Give thoughtful, kind and constructive feedback.
 - ◆ Share information when appropriate.
 - ◆ Stay focused on the topic at hand.
 - ◆ Respect the moderator and timekeeper.
 - ◆ Treat any personal information that others share with respect and confidentiality.

Another opportunity to receive and learn from stakeholder input regarding MHSA was a Mental Health Services Oversight and Accountability Commission (MHSOAC) forum hosted by the County of San Bernardino on March 14, 2013 and attended by nearly 200 participants (MHSA Annual Update FY 2013/14, page 8). As a result of the forum and a subsequent independent evaluation of Community Program Planning (CPP) standards, the MHSOAC has identified the County of San Bernardino Department of Behavioral Health as a contributor to Community Program Planning (CPP) promising practices. DBH has been invited to represent the county in a statewide CPP Promising Practices Summit. The outcomes of the summit will include the development of CPP Promising Practice curriculum, training, and technical assistance for Counties and statewide MHSA stakeholders.

Stakeholder Process Standards

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

As evidenced by the extensive schedule of community oriented meetings, the Department embeds collaboration with the community into ongoing operations at multiple levels. DBH has a commitment to cultural competence with twelve (12) cultural subcommittees and coalitions that meet monthly, in addition to the Cultural Competency Advisory Committee. Cultural competency is woven in to everything we do at DBH, including planning, implementing and evaluating programs. The Office of Cultural Competence and Ethnic Services (OCCES) reports to the DBH Director and is an essential part of all aspects 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 MHSa program lead to ensure the delivery of culturally competent and appropriate services, including providing feedback and input into all programs. The CCO or members of OCCES regularly sit on boards or committees where they can provide input or effect change regarding program planning or implementation. OCCES provides support by translating documents for the Department and arranging for translation services whenever requests for services, training, outreach, and/or stakeholder meetings are received. Additionally, language regarding cultural competence is included in all Department contracts with organizational, and individual providers and is included as a category in every DBH employee's Work Performance Evaluation.

The County of San Bernardino, Department of Behavioral Health 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 active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs is elevated, reporting at the executive level, 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 nine (9) consumer clubhouses to encourage regular participation in MHSa 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 MHSa 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.

Stakeholder Process Standards

The Peer-Driven Room and Board Advisory Coalition, initiated and facilitated by the Patient's Rights Office, is an innovative, ground-breaking collaboration of behavioral health consumers, providers, Room & Board Operators and other community stakeholders. Conceptualized in response to the long-standing concerns regarding unlicensed Room & Boards in the community, the Coalition has established as its mission to "empower and educate" consumers, "promote self-advocacy" and identify "safe and supportive housing" that facilitates consumer wellness and recovery efforts for members in MHSA funded programs. This is one of the training grounds in which consumer and stakeholders are coached on how to strategically address issues that impact them personally.

Additionally, DBH has committed to the funding of **205** Full Time Equivalent (FTE) Peer and Family Advocates or equivalent positions through MHSA to assist in system transformation and valued contributions to the stakeholder process. These positions have increasing levels of responsibility and provide peer counseling, and linkages to services and supports. These positions are dispersed throughout the Department providing consumer advocacy and assistance, as well as providing input on systems issues major program areas:

- Consumer Clubhouses.
- Forensic Services.
- Assertive Community Treatment.
- Crisis Walk In Centers.
- Hospital Triage Diversion.
- Homeless Intensive Case Management.
- Community Crisis Response Services.
- Wraparound Services.
- AgeWise.
- Transitional Age Youth.
- Department Administration.

It is through the integration of consumers at all levels of our department structure that we are able to ensure wide-spread consumer representation in MHSA stakeholder meetings and activities. Also, this inclusion occurs regularly as their participation is embedded in Department operations every day, not just during stakeholder meetings. Consumers participate in regularly occurring meetings as well as stakeholder meetings and meaningfully contribute to all levels of MHSA program planning activities.

This participation and integration in to all aspects of programming makes for a seamless culturally competent system. The OCCES highlights efforts made by staff, contract staff, consumers or members of the community who demonstrate a level of cultural competence that the committee feels deserves recognition. The Cultural Competency Excellence Award is awarded every month at our Behavioral Health Commission meeting.

Stakeholder Process Standards

In preparation of the development of this MHSa Three-Year Integrated Plan, the Department also wanted to ensure plan specific meetings were hosted in multiple venues in each region of the County, in addition to regularly occurring stakeholder meetings. A schedule of those meetings with dates, time and locations are provided in this document.

As listed in the schedule, five special sessions of the Behavioral Health Commissions, District Advisory Committee (DAC) meetings were provided in each geographic region of the county. This ensured representation from all areas of San Bernardino's geographically large region and provided an opportunity for the uniqueness of each area needs to be discussed. Each DAC meeting included an opportunity for DBH leadership staff to host a dialogue with community, consumer, and family member attendees about the history and successes of MHSa since implementation, discuss program implementation and evaluation, and elicit opportunities for input and feedback on the MHSa Integrated Plan. To ensure that stakeholders could fully benefit from the community meetings, Cultural Competence staff arranged for Spanish interpretation, American Sign Language and Vietnamese interpretation upon request at each meeting.

To further support this Community Planning Process (CPP) effort, a special session of the Community Policy Advisory Committee was hosted by the DBH Director on March 20, 2014 to ensure the community had continued direct access to executive leadership during the stakeholder process. 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 to interact with decision-making staff as well.

Attendees at all special sessions 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 in the stakeholder process standards section of the MHSa Integrated Plan.

Outreach to Stakeholders

To meet the requirements of the MHSa, extensive outreach to promote the plan specific stakeholder process was done using a variety of methods at multiple levels, to invite stakeholders to have their voice heard and their feedback included. Information regarding the stakeholder process was disseminated through the use of press releases to all local media outlets, email and flyer (available in English and Spanish) distribution to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions, and regularly scheduled stakeholder meetings, including the County of San Bernardino Behavioral Health Commission, to reach representatives of our diverse population. Social media sites such as Facebook were also used to promote the MHSa Integrated Planning process and extended 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 MHSa Coordinator and Component Leads, in conjunction with the Community OutReach and Education (CORE) services unit assumed responsibility for coordination and management of the CPP process, building upon existing stakeholder engagement components, mechanisms and collaborative networks within the mental health system and evolving out of the original CPP initiated in 2005.

Stakeholder Process Standards

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 serving organizations.
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

During the stakeholder meetings for the MHSA Integrated Plan, several community members voiced their support and approval of the plan, as well as the methodology the County of San Bernardino has used to implement the various MHSA components over the last nine (9) years. Statements included in the meetings are as follows:

“San Bernardino has been on the cutting edge of integrating MHSA into our services”

~ Service provider.

“My first experience with MHSA was in the INFO program. The collaboration between DBH and Probation was great”

~ DBH staff member.

“There has been such a big change in collaboration and communication since the beginning of MHSA. Having meetings like this is much more effective”

~ Justice System Partner.

“San Bernardino is a leader in the state”

~ Family Member.

“The best thing about FSP’s and Pathways is that they are always there for us”

~ Consumer.

The CPP meetings provided the venue to capture the transformational spirit of MHSA, including the opportunity for stakeholders to ask for additional information and for the Department to respond. For example, one stakeholder requested information related to the end of a contracted employment position approved and funded under time-limited Prevention and Early Intervention (PEI) Training, Technical Assistance, and Capacity Building funding; stating that the role of the position was important. The Department was able to respond that the function of the position would remain the same and would be transitioned from a time-limited contracted position to a regular status county position.

Stakeholder Process Standards

An additional question was asked about the percentage of PEI funding that is awarded to community-based organizations. The response to this inquiry is as follows, *“Percentage of Prevention and Early Intervention (PEI) program funding awarded to Community Based Organizations is 80%. For more information on PEI funding please contact the DBH Office of Prevention and Early Intervention at (909) 252-4009.”*

Additionally, several stakeholders requested copies of the presentation materials which were provided individually to stakeholders and made accessible via the DBH website. 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.

The screenshot shows a web browser window displaying the website for the County of San Bernardino Department of Behavioral Health. The page title is "Mental Health Services Act (MHSa)". The main content area features a list of "MHSa Three-Year Plan and Annual Plan Updates in Chronological Order" with 12 numbered links. A large red arrow points to the link for "MHSa Annual Update". Below this list, there are sections for "MHSa Annual Update FY 2013-2014", "MHSa Integrated Plan:", "MHSa Integrated Three-Year Plan FY 14/15 - 16/17 - Community Program Planning Presentation", "Processes", "MHSa Issue Resolution Process", and "Latest State Notices". A left-hand navigation menu lists various services and information.

Screenshot taken 03/28/14 from <http://www.sbcounty.gov/dbh/mhsa/mhsa.asp#>

Stakeholder Process Standards

County of San Bernardino Department of Behavioral Health
March 21

Special Stakeholder Engagement Meetings!

Come and learn more about how the Mental Health Services Act has been integrated into current DBH services and future planning.

Join us on the Pathway to Integration!
District Advisory Committee Meetings

These community stakeholder engagement will focus on the MHSA Integrated Plan. Special focus will be placed on sharing how the Mental Health Service Act has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

First District Wednesday, March 19, 2014 11:00 a.m. – 12:30 p.m. Victor Community Health Campus 13400 Chulavita Rd. Vista, CA 92382 Hosted by Andy Gruchy Contact: Chris Contreras (951) 955-7287	Second District Thursday, March 20, 2014 8:00 – 9:00 p.m. Rancho Cucamonga Family Resource Center 8793 Arroyo Pk. Rancho Cucamonga, CA 91750 Hosted by Sarah Oberhardt-Rose and Mikha Scheraga Contact: April Guzman (909) 854-8440	Third District Tuesday, March 18, 2014 11:00 a.m. – 12:00 p.m. Phoenix Community Counseling Center 820 E. Gilbert St. San Bernardino, CA 92415 Hosted by Sharon Naeve and Tanya Bortner Contact: Debi Garcia (909) 387-7218
Fourth District Thursday, March 20, 2014 9:00 – 9:00 a.m. Rancho Cucamonga Family Resource Center 8793 Arroyo Pk. Rancho Cucamonga, CA 91750 Hosted by Sarah Oberhardt-Rose and Mikha Scheraga Contact: April Guzman (909) 854-8440	Fifth District Monday, March 24, 2014 8:30 – 7:30 p.m. New Hope Family Life Center Auditorium 1505 W. Highland Ave. San Bernardino, CA 92411 Hosted by Dr. Francois and Andy Gruchy Contact: Chris Contreras (909) 421-8400	

For questions, interpretation services for individuals with disabilities, accommodations please contact: Aditya Menaria (909)212-4069 or 7-1-1 for TTY users
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 2% tax surcharge on personal income over \$1 million per year.
County of San Bernardino | Department of Behavioral Health

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County of San Bernardino Department of Behavioral Health
March 17

Special Stakeholder Engagement Meetings!

Come and learn more about how the Mental Health Services Act has been integrated into current DBH services and future planning.

Join us on the Pathway to Integration!
Thursday, March 20, 2014
for the
Community Policy Advisory Committee (CPAC) meeting OR **Cultural Competency Advisory Committee (CCAC) meeting**

9:00 – 11:00 a.m.
CSBHS - Auditorium
850 E. Foothill Blvd., Rialto, CA 92376

1:00 – 3:00 p.m.
CSBHS - Auditorium
850 E. Foothill Blvd., Rialto, CA 92376

These special 2-hour community stakeholder engagement meetings will focus on the MHSA Integrated Plan. The CPAC meeting will be hosted by Department of Behavioral Health Director, Catherine Thomas and the CCAC meeting will be hosted by Department of Behavioral Health Assistant Director, Veronica Kelley.

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County of San Bernardino Department of Behavioral Health
March 13

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Fourth District Thursday, March 20, 2014 9:00 – 9:00 a.m. Rancho Cucamonga	Fifth District Monday, March 24, 2014 8:30 – 7:30 p.m. New Hope Family Life Center	

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2 people like this.

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Boost

County of San Bernardino Department of Behavioral Health
March 5

Special Stakeholder Engagement Meetings!

Come and learn more about how the Mental Health Services Act has been integrated into current DBH services and future planning.

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for the
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850 E. Foothill Blvd., Rialto, CA 92376

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Karen Cervantes likes this.

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Boost

Stakeholder Process Standards

Departamento de Salud Mental, Condado de San Bernardino
March 21

Reuniones Especiales de las partes interesadas

Venga y aprenda más sobre cómo la Ley de Servicios de Salud Mental se ha integrado en los servicios del Departamento de Salud Mental actuales y planificación para el futuro.

¡Acompañenos en el camino a la integración!

Juntas del Comité Consultivo del Distrito

Estas sesiones especiales de participación de los interesados de la comunidad se concentrarán en la Ley de Servicios de Salud Mental Plan Integrado. Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

Primer Distrito Miércoles, 19 de marzo del 2014 11:00 a.m. – 12:30 p.m. Victor Community Health Campus 15400 Chalmers Rd. Victorville, CA 92392 Conducido por Andy Grubly Contacte: Chris Corrales (760) 955-7287	Segundo Distrito Jueves, 20 de marzo del 2014 9:00 – 3:00 p.m. Rancho Cucamonga Family Resource Center 8793 Arroyo Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Misha Schertel Contacte: April Guzman (909) 854-5440	Tercer Distrito Martes, 18 de marzo del 2014 11:00 a.m. – 12:00 p.m. Phoenix Community Counseling Center 822 S. Gilbert St. San Bernardino, CA 92415 Conducido por Sharon Heavins y Tanya Braithorn Contacte: Debbi Coates (909) 387-7219
Cuarto Distrito Jueves, 13 de marzo del 2014 9:00 – 3:00 p.m. Rancho Conejillo Family Resource Center 9791 Arroyo Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Misha Schertel Contacte: April Guzman (909) 854-5440	Quinto Distrito Lunes, 24 de marzo del 2014 8:30 – 7:30 p.m. New Hope Family Life Center Buellville 1509 W. Highland Ave. San Bernardino, CA 92412 Conducido por Dr. Franklin y Andy Grubly Contacte: Crina Vranesworth (909) 422-4804	

Para preguntas, servicios de interpretación o petición de acomodaciones relacionadas con alguna discapacidad, por favor llame al: Aldery Hernandez (909) 512-4099 o 7-1-1 para usuarios de TTY.

La Ley de Servicios de Salud Mental (MHSCL, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más de un millón de dólares al año.

Condado de San Bernardino | Departamento de Salud Mental

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Rebecca Coronado likes this.

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Departamento de Salud Mental, Condado de San Bernardino
March 17

Reuniones Especiales de las partes interesadas

Venga y aprenda más sobre cómo la Ley de Servicios de Salud Mental se ha integrado en los servicios del Departamento de Salud Mental actuales y planificación para el futuro.

¡Acompañenos en el Camino a la Integración!

Jueves, 20 de marzo de 2014

para la

Junta de Comité Asesor de Políticas Comunitaria (CPAC por sus siglas en inglés)
9:00 – 11:00 a.m.
CSBHS - Auditorio
850 E. Foothill Blvd., Rialto, CA 92376

Junta de Comité Asesor de Competencia Cultural (CCAC por sus siglas en inglés)
1:00 – 3:00 p.m.
CSBHS - Auditorio
850 E. Foothill Blvd., Rialto, CA 92376

Estas sesiones especiales de participación de los interesados de la comunidad de 2 horas se concentrarán en el Plan Integrado de la Ley de Servicios de Salud Mental. La Junta de Comité Asesor de Políticas Comunitaria (CPAC por sus siglas en inglés) será organizada por la Directora de el Departamento de Salud Mental, Calyona Thomas y la Junta de Comité Asesor de Competencia Cultural (CCAC por sus siglas en inglés) será organizada por la Directora asistente de departamento el Departamento de Salud Mental, Veronica Kellay.

¡Acompañenos en el camino a la integración!

Juntas del Comité Consultivo del Distrito

Estas sesiones especiales de participación de los interesados de la comunidad se concentrarán en la Ley de Servicios de Salud Mental Plan Integrado. Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

Primer Distrito Miércoles, 19 de marzo del 2014 11:00 a.m. – 12:30 p.m. Victor Community Health Campus 15400 Chalmers Rd. Victorville, CA 92392 Conducido por Andy Grubly Contacte: Chris Corrales (760) 955-7287	Segundo Distrito Jueves, 13 de marzo del 2014 9:00 – 3:00 p.m. Rancho Cucamonga Family Resource Center 8793 Arroyo Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Misha Schertel Contacte: April Guzman (909) 854-5440	Tercer Distrito Martes, 18 de marzo del 2014 11:00 a.m. – 12:00 p.m. Phoenix Community Counseling Center 822 S. Gilbert St. San Bernardino, CA 92415 Conducido por Sharon Heavins y Tanya Braithorn Contacte: Debbi Coates (909) 387-7219
Cuarto Distrito Jueves, 13 de marzo del 2014 9:00 – 3:00 p.m. Rancho Conejillo Family Resource Center 9791 Arroyo Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Misha Schertel Contacte: April Guzman (909) 854-5440	Quinto Distrito Lunes, 24 de marzo del 2014 8:30 – 7:30 p.m. New Hope Family Life Center Buellville 1509 W. Highland Ave. San Bernardino, CA 92412 Conducido por Dr. Franklin y Andy Grubly Contacte: Crina Vranesworth (909) 422-4804	

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Departamento de Salud Mental, Condado de San Bernardino
March 5

Reuniones Especiales de las partes interesadas

Venga y aprenda más sobre cómo la Ley de Servicios de Salud Mental se ha integrado en los servicios del Departamento de Salud Mental actuales y planificación para el futuro.

¡Acompañenos en el Camino a la Integración!

Jueves, 20 de marzo de 2014

para la

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9:00 – 11:00 a.m.
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850 E. Foothill Blvd., Rialto, CA 92376

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¡Acompañenos en el camino a la integración!

Juntas del Comité Consultivo del Distrito

Estas sesiones especiales de participación de los interesados de la comunidad se concentrarán en la Ley de Servicios de Salud Mental Plan Integrado. Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

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Cuarto Distrito Jueves, 13 de marzo del 2014 9:00 – 3:00 p.m. Rancho Conejillo Family Resource Center 9791 Arroyo Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Misha Schertel Contacte: April Guzman (909) 854-5440	Quinto Distrito Lunes, 24 de marzo del 2014 8:30 – 7:30 p.m. New Hope Family Life Center Buellville 1509 W. Highland Ave. San Bernardino, CA 92412 Conducido por Dr. Franklin y Andy Grubly Contacte: Crina Vranesworth (909) 422-4804	

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Departamento de Salud Mental, Condado de San Bernardino
March 10

Reuniones Especiales de las partes interesadas

Venga y aprenda más sobre cómo la Ley de Servicios de Salud Mental se ha integrado en los servicios del Departamento de Salud Mental actuales y planificación para el futuro.

¡Acompañenos en el Camino a la Integración!

Jueves, 20 de marzo de 2014

para la

Junta de Comité Asesor de Políticas Comunitaria (CPAC por sus siglas en inglés)
9:00 – 11:00 a.m.
CSBHS - Auditorio
850 E. Foothill Blvd., Rialto, CA 92376

Junta de Comité Asesor de Competencia Cultural (CCAC por sus siglas en inglés)
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850 E. Foothill Blvd., Rialto, CA 92376

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Juntas del Comité Consultivo del Distrito

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Rebecca Coronado likes this.

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Stakeholder Process Standards

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 9:00 – 11:00 a.m. 1:00 – 3:00 p.m.
 CSBHS - Auditorium CSBHS - Auditorium
 850 E. Foothill Blvd., Rialto, CA 92376 850 E. Foothill Blvd., Rialto, CA 92376

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For questions, interpretation services or requests for disability-related accommodations please contact: Aidery Hernandez (909)252-4069 or 7-1-1 for TTY users

The MHS (Prop 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.

County of San Bernardino | Department of Behavioral Health

MHSA Annual Integrated Plan Fiscal Years 2014/15-16/17 Community Planning Meeting Schedule

English

Full sized
Stakeholder Community Meeting Schedules
 in English and Spanish
 are available in the Attachments
 section of this Update.

Seven (7) community meetings
 were held for the
 MHSA Integrated Plan process.

Join us on the Pathway to Integration!
District Advisory Committee Meetings

These community stakeholder engagement will focus on the MHSA Integrated Plan. Special focus will be placed on sharing how the Mental Health Service Act has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

<p>First District Wednesday, March 19, 2014 11:00 a.m. – 12:30 p.m. Victor Community Holistic Campus 15400 Cholame Rd. Victorville, CA 92392 Hosted by Andy Gruchy Contact: Chris Croteau (760) 955-7287</p>	<p>Second District Thursday, March 13, 2014 3:00 – 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Hosted by Sarah Eberhardt-Rios and Mike Schertell Contact: April Guzman (909) 854-3440</p>	<p>Third District Tuesday, March 18, 2014 11:00 a.m. – 12:00 p.m. Phoenix Community Counseling Center 820 E. Gilbert St. San Bernardino, CA 92415 Hosted by Sharon Nevins and Tanya Bratton Contact: Debbi Cazarez (909) 387-7219</p>
<p>Fourth District Thursday, March 13, 2014 3:00 – 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Hosted by Sarah Eberhardt-Rios and Mike Schertell Contact: April Guzman (909) 854-3440</p>	<p>Fifth District Monday, March 24, 2014 5:30 – 7:30 p.m. New Hope Family Life Center Auditorium 1505 W. Highland Ave. San Bernardino, CA 92411 Hosted by Dr. Frausto and Andy Gruchy Contact: Crista Wentworth (909) 421-4606</p>	

For questions, interpretation services or requests for disability-related accommodations please contact: Aidery Hernandez (909)252-4069 or 7-1-1 for TTY users

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County of San Bernardino | Department of Behavioral Health

Stakeholder Process Standards

¡Acompáñenos en el Camino a la Integración!
Jueves, 20 de marzo de 2014

para la

Junta de Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés) **o** **Junta de Comité Asesor de Competencia Cultural** (CCAC por sus siglas en inglés)

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 CSBHS - Auditorio CSBHS - Auditorio
 850 E. Foothill Blvd., Rialto, CA 92376 850 E. Foothill Blvd., Rialto, CA 92376

Estos sesiones especiales de participación de los interesados de la comunidad de 2 horas se concentrarán en el Plan Integrado de la Ley de Servicios de Salud Mental. La Junta de Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés) será organizada por la Directora de el Departamento de Salud Mental, CaSonya Thomas y la Junta de Comité Asesor de Competencia Cultural (CCAC por sus siglas en inglés) será organizada por la Director asistente de departamento el Departamento de Salud Mental, Veronica Kelley.

Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

Para preguntas, servicios de interpretación o petición de acomodos relacionados con alguna incapacidad, por favor llame al: Aiderly Hernandez (909)252-4069 o 7-1-1 para usuarios de TTY.

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más a un millón de dólares al año.

Condado de San Bernardino | Departamento de Salud Mental

MHSA Integrated Plan Fiscal Years 2014/15-16/17 Community Planning Meeting Schedule

Spanish

Full sized
**Stakeholder Community
 Meeting Schedules**
 in English and Spanish
 are available in the Attachments
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Juntas del Comité Consultivo del Distrito

Estas sesiones especiales de participación de los interesados de la comunidad se concentrarán en la Ley de Servicios de Salud Mental Plan Integrado. Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

<p>Primer Distrito Miércoles, 19 de marzo del 2014 11:00 a.m. — 12:30 p.m. Victor Community Holistic Campus 15400 Cholame Rd. Victorville, CA 92392 Conducido por Andy Gruchy Contacte: Chris Croteau (760) 955-7287</p>	<p>Segundo Distrito Jueves, 13 de marzo del 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Mike Schertell Contacte: April Guzman (909) 854-3440</p>	<p>Tercer Distrito Martes, 18 de marzo del 2014 11:00 a.m. — 12:00 p.m. Phoenix Community Counseling Center 820 E. Gilbert St. San Bernardino, CA 92415 Conducido por Sharon Nevins y Tanya Bratton Contacte: Debbi Cazarez (909) 387-7219</p>
<p>Cuarto Distrito Jueves, 13 de marzo del 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Conducido por Sarah Eberhardt-Rios y Mike Schertell Contacte: April Guzman (909) 854-3440</p>	<p>Quinto Distrito Lunes, 24 de marzo del 2014 5:30 — 7:30 p.m. New Hope Family Life Center Auditorio 1505 W. Highland Ave. San Bernardino, CA 92411 Conducido por Dr. Frausto y Andy Gruchy Contacte: Crista Wentworth (909) 421-4606</p>	

Para preguntas, servicios de interpretación o petición de acomodos relacionados con alguna incapacidad, por favor llame al: Aiderly Hernandez (909)252-4069 o 7-1-1 para usuarios de TTY.

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más a un millón de dólares al año.

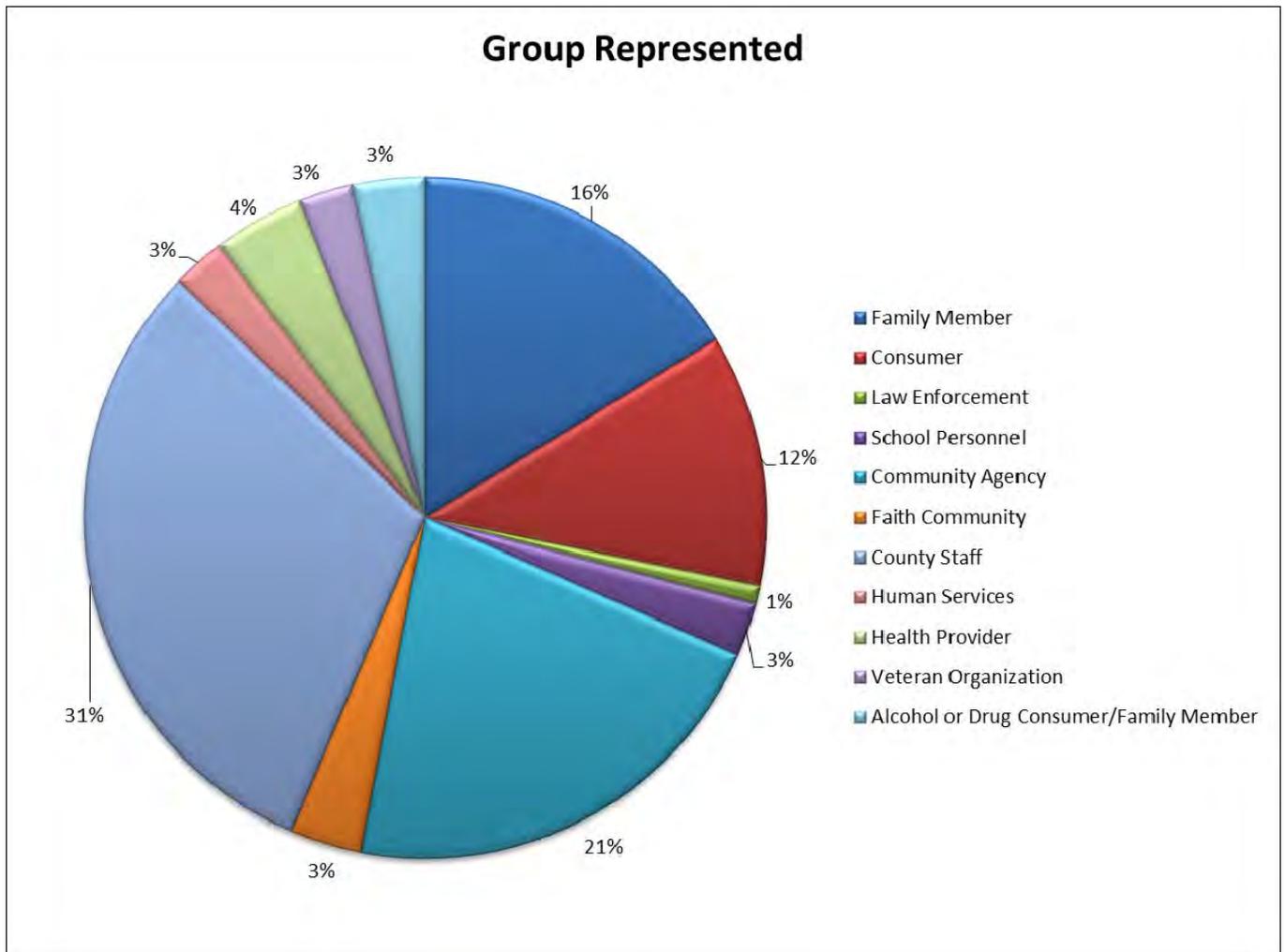
Condado de San Bernardino | Departamento de Salud Mental

Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

Approximately **100 stakeholders** completed a stakeholder comment form in the MHS Integrated Plan special community planning sessions held throughout March of 2014, with **138 individuals attending the meetings** as documented by sign-in sheets. 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 who 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.

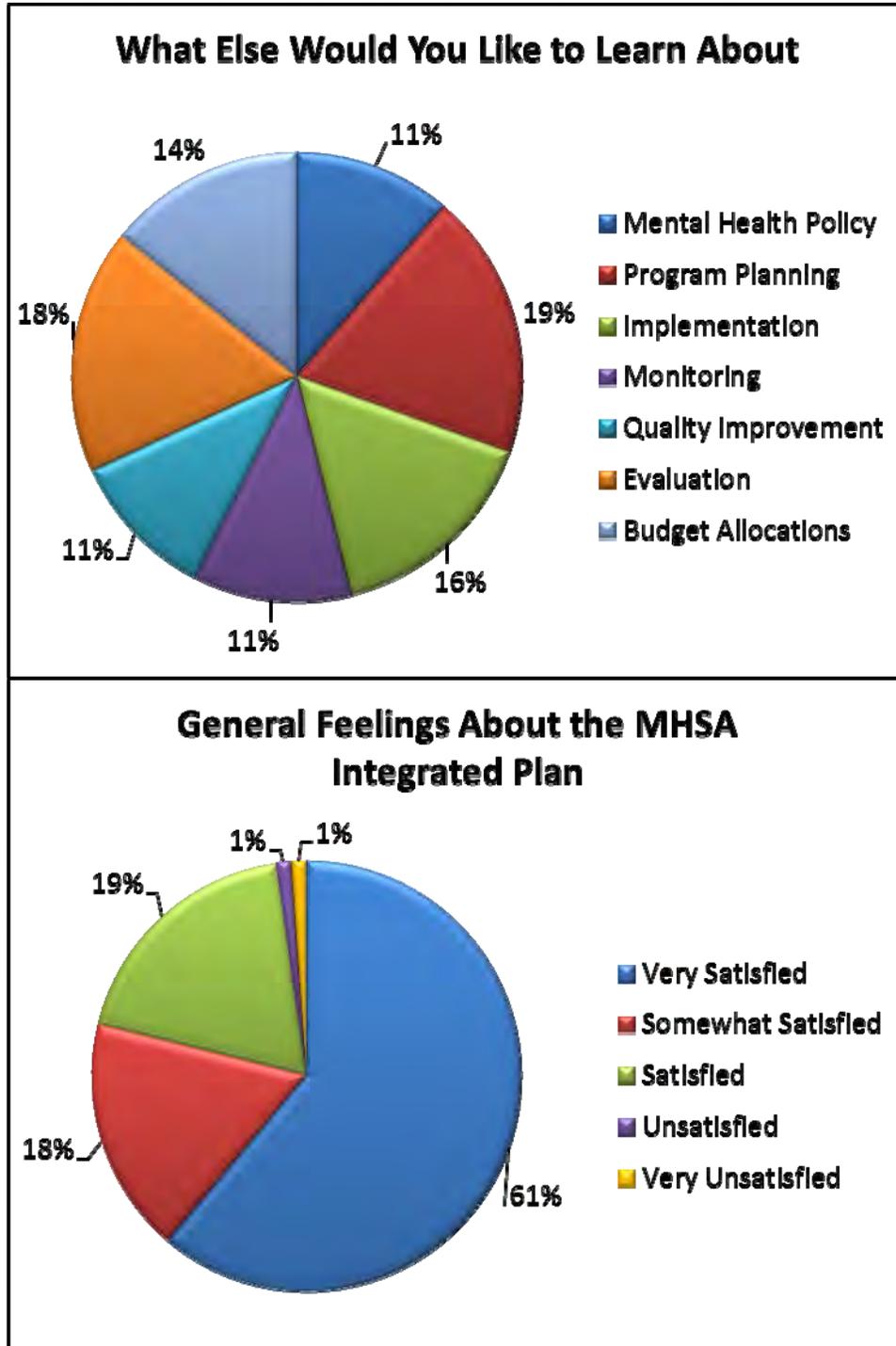
The following demographic information was collected from the stakeholder meetings:

MHS Integrated Plan Community Planning Meeting Stakeholder Demographics



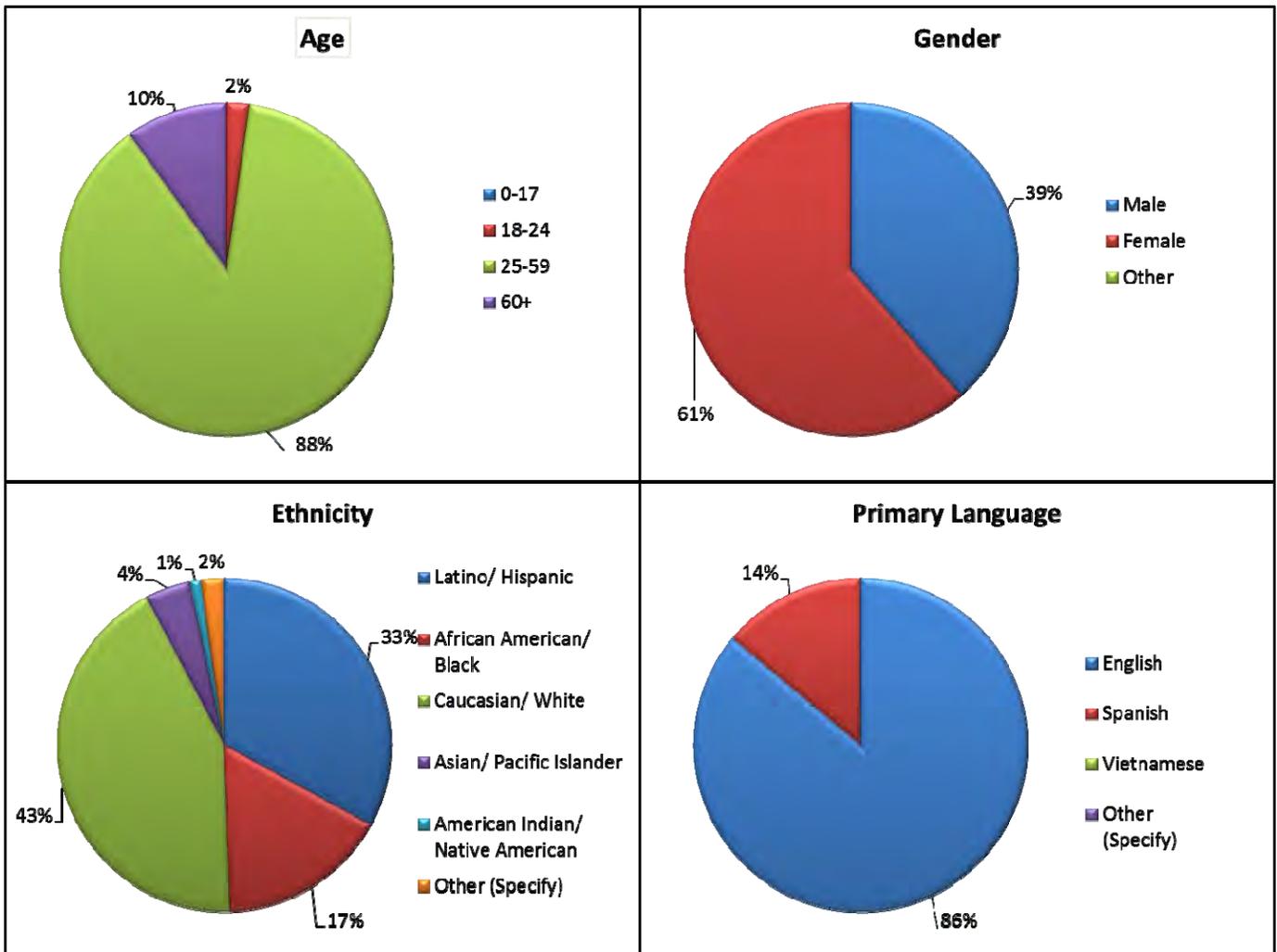
Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

MHSA Integrated Plan Community Planning Meeting Stakeholder Demographics



Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

MHSA Integrated Plan Community Planning Meeting Stakeholder Demographics



Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA Integrated Plan community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA INTEGRATED PLAN?
1	First time happening. Plan for 3 years. Funding not planned to increase but possible.
2	History of MHSA. Current MHSA funding. Plan for next 3 years.
3	How money has been used. How the programs are working.
4	Timeframes. Programs developed/supported. Very interesting to learn multiple layers in which MHSA funds are distributed.
5	All of the components, processes and next steps. It really helped me provide a framework of reference to contextualize what I knew about MHSA.
6	Six components.
7	I'm glad to hear that CASE & IVRT will continue to get funding. Success First has multiple funding streams.
8	About all the wonderful programs.
9	I learned that I know very little about DBH.
10	There's a lot of help out there like program, but we don't know.
11	I learn about people behavior health problems.
12	It was really important to learn the plans, now I know that it exists and that I benefit from it.
13	They have different program I didn't know about.
14	People in need of mental health have a place to go.
15	About the mobile response team.
16	The new RBEST program seems helpful.
17	Looking to integrate programs and take them to underserved areas.
18	Willingness to bring in Nurse Practitioners and Physician Assistants.
19	All current mental health programs.
20	Everything was well covered.
21	The variety of services.
22	The diversity of services provided and accessible.
23	More clear on where we have been. Looking forward to posting.
24	Some more details.
25	A PEI program I had not heard of - LIFT.
26	Number surreal!
27	That MHSA has made a tremendous impact on the community through services and support.
28	I learned about the significant impact of MHSA funding before and after it went into effect.
29	There is progress and hope.
30	A lot of programs/projects across "target" population and focus.
31	Certain programs have been successful, especially housing. Surprisingly high numbers of consumers are being housed. What are the costs per client?
32	Lots of new programs. Increased collaboration. Increased focus on wellness/recovery model.

Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA Integrated Plan community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA INTEGRATED PLAN?
33	Progress that has been made since its inception.
34	Vast array of services provided.
35	Did not realize how much money S.B. county has received in MHSA funding for all programs.
36	Too much to list, but the various programs and received details of them.
37	Programs created and will be created through MHSA fund.
38	I learned about several programs and Plan to attend the DBH Expo.
39	Each of the programs are very well supported and needed in the county.
40	DAC
41	Different components in a continuum of care
42	Research
43	That they have a lot of funding.
44	There were few details that I picked up...misc. stuff (nothing major). Hearing from the clubhouse people added a nice perspective.
45	All the various services and programs.
46	I didn't realize we have so many fantastic programs! Very impressive.
47	How many services that these funds provide.
48	Funding source
49	All the health services for people with mental health.
50	How they help others around the county and region.
51	Good overview of plan.
52	The resources.
53	A lot about a diversity of programs.
54	That there are a lot of services provided.
55	Lots of improvements.
56	About RBEST program and ARMC diversion unit.
57	How they are dealing with crisis and mental health in hospital and jail setting.
58	Need copy of the PPT.
59	All of the programs that have been made available by MHSA to serve of residents.
60	The benefits of the funding on the community.
61	Some Innovation are interesting.
62	RBEST
63	There are more programs through-out the county.

Integrated Plan Fiscal Years 2014/15-2016/17 Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA Integrated Plan community planning meeting comment forms.

In Their Own Words

#	DO YOU HAVE OTHER CONCERNS NOT ADDRESSED IN THIS DISCUSSION?
1	Employment for disable person program
2	No business bosses would like to hire mental or behavior people
3	We feel discrimination
4	They didn't discuss about the goals
5	It is a lot of information and would like to have it in writing since it is important
6	More programs about anxiety
7	We (DBH) are losing CT1 and other experienced clinicians to other agencies as our salaries and benefit package is not as competitive.
8	Clinics out of space and unable to have more needed staff added
9	How does the county plan to address caregiving/parenting of children? We can provide services to children forever (!) but when we send them home to caregivers who haven't changed it difficult to make a significant impact.
10	Not clear on how INN programs ended /continued/etc.
11	Perhaps more on residential beds/ treatment programs (adults)?
12	Dollar amount given to CBO (PEI, WET. Technology)
13	None. Outstanding presentation.
14	Provide breakdown of funding to CBOs - nonprofits per year
15	Would have liked to have a back and forth discussion instead of individual reports. More client and family member involvement in this report.
16	Future funding opportunities and expansion of the services that are being provided.
17	Community Liaison position
18	There is a huge need for emergency shelters. They are disappearing because of funding/turning into transitional facilities. The most underserved population is single men.
19	Homeless shelters. Crisis interim home
20	Making sure MHSA helps traditional clinics, too.
21	What effect will ACA have on us?
22	TAY who do not have Medi-Cal or who are a former foster child have no access to TAY services. I have tried for year to no avail. There is a high percentage of young people in Redlands. Can you provide services to that community?
23	Need more information on dual diagnosis and accessibility. How are individuals with multiple disabilities served?
24	Some of the programs funded, I've never heard of them. As a worker in the field, if I've not heard of it, is the general community hearing about them?
25	Need more information on the RFP process.
26	I would like to see program funding for long term programs that are working.

Review of Stakeholder Feedback Since 2005

Since the inception of MHSA, the Department of Behavioral Health has consistently surveyed for community mental health needs in the County of San Bernardino. Beginning in 2005 and through 2014, the department has accumulated significant amounts of data, information and input on programming as a result of MHSA, which has been used to guide decision-making and improve services to consumers and families. As part of this year's MHSA Integrated Plan efforts, the department looked back to the early efforts of MHSA and community stakeholder feedback, beginning with the documented feedback of **1,072** individuals in an overview of needs tabulated November 14, 2005.

A listing of questions and the top solutions identified by respondents in 2005 are as follows:

How to Improve Access?

- Increase information in the community about mental health and mental illness.
- Help other agencies understand and respond to mental health issues before a crisis occurs.
- Offer services during crisis situations.
- Offer mental health services in schools.
- Offer mental health consultations and services in other locations.

How to Increase Involvement?

- Offer classes about mental illness for family members.
- Increase education about improving family relationships.
- Develop/implement parenting classes.
- Develop/implement peer support groups.
- Offer support groups for care providers.

How to Improve Outcomes?

- Maintain a stable living environment.
- Staying out of trouble with the law, or out of jail.
- Staying in school or vocational training program.
- Positive social activity and recreation with friends or peers.
- Being able to work in spite of mental illness.

How Should Various Agencies Collaborate?

- Assistance obtaining needed benefits, supportive services.
- Transportation to services.
- Consultation to teachers on early signs of emotional distress and possible treatments.
- Early involvement by other agencies.

Review of Stakeholder Feedback Since 2005

How to Assure Culturally Competent Services?

- Offer educational classes for clients and family members on high risk groups and offer support groups.
- Create more support groups that can be run by consumer/family or special needs group.
- Make sure staff understand how to work with clients of all cultural groups.
- Make sure staff know how to find resources for all cultural groups in our county.
- Expand mental health services for my culture and/or language.

Where are the Biggest Barriers?

- Lack of awareness of what resources are available.
- Too much “red tape,” forms, waiting lists.
- Transportation.
- Embarrassment or stigma.
- Fear of losing children.

How Can Recovery be Promoted?

- Education for families who want to help their mentally ill family member.
- Programs that help build skills in problem solving and conflict resolution.
- Counseling on further education and finding employment.
- Services where kids meet after schools.
- Services in my own community where I worship or network.

What Are the Most Pressing Community Mental Health Issues?

- Drug or Alcohol Abuse.
- Violence in the Community.
- Homelessness/Runaways.
- Violence in the Home.
- Unable to Work.

Review of Stakeholder Feedback Since 2005

As we look back to the beginning of MHSA and review the successes of the last nine (9) years, we see that DBH and our community partners have completed a tremendous amount of programming aimed at the needs first identified in 2005. Evidence of this progress is detailed in this MHSA Integrated Plan report, and the many submitted before this. In reading program component reports this year, you will clearly see the breadth and depth of programs developed to meet the needs included in the 2005 summary. While the pages are numerous, a highlight of some of the accomplishments over the past nine (9) years include:

- Significant support includes the development of supportive housing and employment services that leverage multiple funding sources and work across all programs and components.
- Increased collaboration with community partners and local agencies across all six components of MHSA.
- The Full Service Partnerships (FSP) greatly enhanced the clinics ability to provide recovery oriented services to the most severely mentally ill populations that had been underserved.
- Twelve (12) PEI programs have been developed and implemented through an extensive community planning process, expanding DBH services to include prevention and early intervention as part of the continuum of care.
- The ability to test new approaches to treatment and recovery and apply those approaches the mental health system for improved outcomes.
- Since MHSA was implemented in 2005, the County of San Bernardino has received approximately **\$453** million and provided services to between **150,000** to **195,000** individuals annually.

These achievements and others were discussed in the stakeholder meetings affiliated with the MHSA Integrated Plan and detailed in a PowerPoint, which describes several elements of DBH's system transformation and integration efforts over the last nine (9) years.

The information included in the PowerPoint and within this MHSA Integrated Plan highlights DBH's multi-year efforts to increase the numbers of diverse populations served, create more access to behavioral health services, and provide client-driven and recovery-focused services dedicated to reducing inappropriate hospitalizations, incarcerations and homelessness.

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Community Services and Supports

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 MSHA funds for housing opportunities
- Enhancing and expanding wraparound services to children
- Approximately \$315 million has been received

Programs created since MSHA implementation

Community Services and Supports

- Comprehensive Children and Family Support Services (CCFSS)
- Integrated New Family Opportunities (INFO)
- Transitional Age Youth (TAY) One Stop Centers
- Clubhouse Expansion Program
- Forensic Integrated Mental Health Services (STAR, FACT)
- Members Assertive Positive Solutions (MAPS)/ Assertive Community Treatment Team (ACT)
- Crisis Walk-in Centers (CWIC)
- Psychiatric Triage Diversion Team

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Programs created since MSHA implementation

Community Services and Supports (cont.)

- Community Crisis Response Teams (CCRT)
- Homeless Intensive Case Management and Outreach
- Big Bear Full Service Partnership (FSP)
- Agewise Older Adult Services
- Agewise Mobile Response
- Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services

Prevention and Early Intervention

- PEI is intended to reduce risk factors, increase protective factors, and intervene early in the progression of an illness.
- The component works to build resiliency across the target populations and prevent mental illness from becoming severe and disabling.
- Twelve PEI programs have been developed and implemented.
- Approximately \$81 million has been received.

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Programs created since MSHA implementation

Prevention and Early Intervention

- Child and Youth Connection
- Community Wholeness and Enrichment
- Family Resource Centers
- Lift – Home Nurse Visitation Program
- Military Services and Family Support
- National Curriculum and Training Institute Crossroads Education (NCTI)
- Native American Resource Center
- Older Adult Community Services
- PEI Preschool Program
- Promotores de Salud/CHW
- Resiliency Promotion in African American Children
- Student Assistance Program

PEI Statewide Initiatives

In 2010 DBH assigned \$8.6 million to support implementation of PEI statewide projects via the California Mental Health Services Authority (CalMHSA); joining with other California counties to make a statewide impact.

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

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Innovation Projects

- Innovation projects must contribute to learning and be developed within the community through a process that is inclusive and representative especially of unserved, underserved and inappropriately served populations.
- The intent of this component is to implement novel, creative, ingenious mental health approaches that are expected to contribute to learning transformation and integration of the mental health system.
- Approximately \$22 million has been received.

Programs created since MSHA implementation

Innovation

- | | |
|--|--|
| ○ Interagency Youth Resiliency Team (IYRT) | ○ Community Resiliency Model (CRM) |
| ○ Online Diverse Community Experiences (ODCE) | ○ Holistic Campus |
| ○ Coalition Against Sexual Exploitation (CASE) | ○ Transitional Age Youth Behavioral Health Hostel (The STAY) |

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Coming Soon via Innovation...

Recovery Based Engagement Support Teams (RBEST)

- Recently approved by the BOS
- Set to go before the MHSOAC on March 27, 2014
- Implementation and evaluation design of the project is in progress

Workforce Education & Training

- Effective in developing highly educated and culturally competent workforce
- Continued support for the peer support certification
- Successful in implementing and expanding internship programs for:
 - Marriage and Family Therapy
 - Master in Social Work
 - Psychology
- Approximately \$11 million has been received.

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Programs created since MSHA implementation

Workforce Education and Training

- Expand Existing Training Program
- Training to Support Fundamental Concepts of MSHA
- Development of Core Competencies
- Outreach to High School, Adult Education, Community College and ROP Students
- Leadership development Program
- Peer and Family Advocate Workforce Support Initiatives
- Expand Existing Internship Program
- Medical Education Program
- Scholarship Program
- Increase Eligibility of Federal Workforce Funding

Capital Facilities and Technological Needs

- Over the past several years MSHA has allowed for time limited funding to be utilized to purchase or rehabilitate County owned buildings.
 - Rehabilitation of Building H - The new One Stop TAY Center opened in April 2012, and started providing services that same month.
 - Crisis residential services are also provided at the same location (The STAY)
- Procurement, development and implementation of the Electronic Health Record (EHR)
 - The San Bernardino Accessible Billing and Electronic Records (SABER) is set to go live July 1, 2015.
- Looking for more opportunities to utilize funding and add resources to the community
- Approximately \$24 million has been received.

Overview of System Transformation and Integration Efforts

This and other information was shared in DBH's MSHA Integrated Plan stakeholder meetings and included information as follows:

Our Ongoing Commitment

- Opportunities for diverse stakeholder engagement (CPAC, BHC, DAC, etc.)
- Continued integration between systems of care to better serve diverse county residents, no matter what their insurance program
- Utilization of technology to create access to services and care
- Developing a diverse pool of behavioral health professionals
- Improved communications with other healthcare providers to ensure integrated treatment plans and treat the whole person
- Continuous outreach and engagement with diverse county residents via community events, trainings, and cultural celebrations

Celebrate Actualization

MHSA

Development of Core Competencies
CHILDREN'S WILKINSON SERVICES
Interagency Youth Resiliency Team
Child and Youth Connection
Age-wise Older Adult Services
Community Resiliency Model
PEI Preschool Program
Integrated New Family Opportunities
Family Resource Center
Community Crisis Response Teams
Consumer-Operated Peer-Support Services and Outpatient Expansion
Training to Support Fundamental Concepts of MHSA
National Crossroads Educational Institute Training
Homeless Intensive Case Management and Outreach
Peer and Family Advocate Workforce Support Initiatives
Increase Eligibility of Federal Workforce-Funding
Military Services and Family Support
Forensic Integrated Mental Health Services
Online Diverse Community Experiences
TAY Behavioral Health Hostel

Assertive Community Treatment Team
Psychiatric Triage/Diversion Team
Home Nurse Visitation Program
CLIMATE TO STUDENTS
Full Service Partnership
Crisis Walk In Centers
Internship Program
TAY One Stop Centers
Promotora de Salud
Scholarship Program
Coalition Against Sexual Exploitation
Psychiatric Residency Program
Community Wholeness and Enrichment
Student Assistance Program
Holistic Campus
Lift
Older Adult Community Services
Leadership Development Program
Resiliency in African American Children
Alliance for Behavioral and Emotional Treatment
MHSA Housing
Native American Resource Center
Expanding Evidence Based Program

Public Review

WIC § 5848 states that a draft Plan shall be prepared and circulated for review and comment for at least 30 days to representatives 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 Plan at the close of the 30 day comment period.

The DBH MHSA Integrated Plan was posted on the Department's website from **April 7, 2014 through May 7, 2014**, at www.sbcounty.gov/dbh. The Public Hearing to affirm the stakeholder process occurred at the regularly scheduled Behavioral Health Commission Meeting on **June 5, 2014** which is held from **12:00 p.m. until 2:00 p.m.**

During the public posting period, the following information appeared in the DBH MHSA Integrated Plan to ensure stakeholders had access to relevant Department and MHSA information.

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

During the stakeholder meetings for this MHSA Integrated Plan several 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 stakeholder meetings it was noted that community members would like information about how to access funds related to 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.

RFPs may be accessed at the county website per the following link <http://www.sbcounty.gov/purchasing/RFP/Default.aspx>. More information on the department's RFP process will be provided over the course of the next year at the Regional District Advisory Committee meetings. District Advisory meeting dates may be requested at the following link <http://www.sbcounty.gov/dbh/mhcommission/CommentForm.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 Integrated Plan report as well as MHSA funding information related to programs.

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 in the Overview of Stakeholder process section is encouraged. The Community Policy and Advisory Committee (CPAC) specifically

Public Review

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.

Once the plan is written and posted, feedback is regularly solicited on the content of plans/ programs 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 plan/ MHSA Integrated Plan 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/purchasing/RFP/Default.aspx>.

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 in general or programs as detailed in this MHSA Integrated Plan, 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.

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.org, to find resources nearby.

Reduction of Discrimination and Stigma:

Prevention and Early Intervention (PEI) Programs focus to reduce 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 and leadership programs for children, youth, transitional age youth, adults and older adults, mental health education workshops, community

Public Review

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 Holistic Campuses focus on community driven and culturally informed practices in order to provide cultural specific healing techniques that increase access to underserved groups. The time-limited project creates a setting in which participants and partners can frame cultural differences as learning sources for each other and the behavioral health system. Service emphases are designed specifically for diverse ethnic and cultural groups, LGBTQ, military, veterans and their families.

Several of the classes offered by the Holistic Campuses are designed to help parents/ caregivers, as well as those they care for, flourish in their surroundings. Additional information regarding holistic campus services can be obtained by calling **1-800-772-9866**.

The Family Resource Centers (FRC)s 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 time-limited Innovation Projects and those that have ended are discussed in detail in the Innovation Component Section of this report. To date, two Innovation projects have ended and have final reports included which detail program outcomes, successes and what practices will be continued based on learning during the projects. Several additional Innovation projects have not ended but, in accordance with regulations, these time-limited projects are scheduled to end next year. Updates on those projects is also included in the Innovation Component Section of this report. Additional information regarding Innovation Projects can be obtained at **1-800-772-9866**.

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.org, to find resources nearby.

Public Review

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 the County of San Bernardino 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 or 711 for EBY users.**

Community Education and Resources:

Community Outreach and Education (CORE) provides outreach and education through the County of San Bernardino. 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 over **81** community events throughout the year. Additional information about CORE activities and obtaining information about department program and services can be obtained by calling **(909) 382-3180.**

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 the County of San Bernardino, as well as the opportunity to provide you this feedback on your requests for more information during the MHSA Integrated Plan stakeholder meetings.

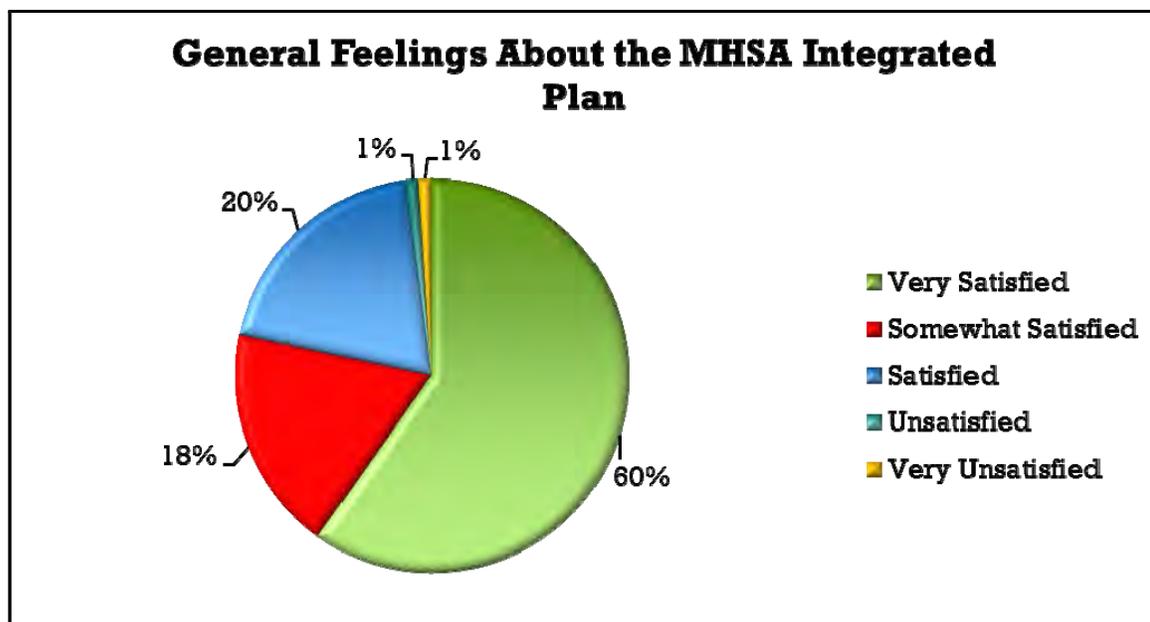
Response to Substantive Comments/Recommendations

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 Integrated Plan, DBH continued to promote the thirty (30) day posting and provided overviews and information related to the MHSA Integrated Plan. Every County of San Bernardino Public Library 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 sixty five (65) 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, and were included on all DBH sponsored social media sites.

The MHSA Coordinator made printed copies of the plan, made them available at every meeting and distributed six (6) hard copies to community and agency members, upon their request. As a result, one hundred forty-eight (148) comments were received. One hundred forty-one (141) of the comments were received on the English or Spanish Stakeholder Comment Form that was provided to all stakeholders, six (6) were in an email format, and one (1) was a phone call requesting additional information about the implementation timeline for the Electronic Health Record, SABER.

Of importance to note, is that one hundred thirty-seven (137) of the comment forms were received as the result of a coordinated effort by one (1) contracted provider agency in response to the planned end date for an innovation project. The forms were accompanied by a letter, available as an attachment in this document.

In addition to the response coordinated by the one (1) provider, DBH received eleven (11) additional comments from various stakeholders, one utilizing the Spanish version of the form. All eleven (11) indicated they were satisfied to very satisfied with the MHSA Integrated Plan and affiliated stakeholder process. The graph below illustrates the reported general feelings about the MHSA Integrated Plan from stakeholders that participated in Community Program Planning and provided feedback during the 30-Day Public Comment period.



Substantive Comments/Recommendations

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

Summary and Analysis of Substantive Comments

Comments received on the MHSA Integrated Plan and stakeholder process, were supportive of the MHSA Integrated Plan and the Department's Community Program Planning process. Comments received included opportunities to correct typographical errors; support of DBH's intention of support training, technical assistance, and capacity building for community-based organizations; and a question concerning the perceived discontinuance of a staff position, the Community Liaison.

DBH Response

The following are direct questions or concerns regarding the MHSA Integrated Plan posed within the written feedback that was received, along with appropriate responses, with the exception of suggested corrections to typographical errors.

Question: What happened to the Community Liaisons?

Response: The Community Liaisons were hired as contract staff positions and paid for under time-limited Prevention and Early Intervention Training, Technical Assistance, and Capacity Building (TTACB) funding. The TTACB funding has ended, therefore, the contract positions will end. Due to the value associated with the role and function of the Community Liaison, two classified permanent county positions, Mental Health Education Consultants, will be requested and included in the DBH Office of Cultural Competency and Ethnic Services (OCCES) to ensure the continuation of duties performed by Community Liaisons. Once these positions are approved via County operations, OCCES will begin recruitment for this important position and the duties will be continued.

Question: Will the Elevate Program continue to be around (i.e, capacity building activities)?

Response: The MHSA Integrated Plan, in the Summary of Program Changes, Community Education and Provider Training subsection, contains information concerning coordination of community education and capacity building activities. Capacity building activities, such as those included in the Elevate program, will continue as part of this plan.

In addition to the questions, DBH received the following written comments:

Comment: "Please put Bear Valley Unified School District as part of the Mental Health Alliance."

Response: All requested corrections have been made in the final MHSA Integrated Plan.

Comment: "I am concerned that the decisions about DBH Programs are not including enough community stakeholders that can significantly discuss how to market to cultural effectively before a DBH agenda is established. I am concern that DBH has lost their "We are Family" identity in exchange for a business as usual mentality. I am concerned that front line staff are not fully aware and do not know the significance of the coming electronic health records project, and will have major resistance to the heavy training as they cross over to SABER and having a negative impact on MHSA work load."

Substantive Comments/Recommendations

- Response:** Thank you for your comment. The Department of Behavioral Health is dedicated to the Community Program Planning process and considers all stakeholder feedback, including that of DBH employees, in the collaborative decision making process. We will continue to improve our staff and community education efforts and appreciate any suggestions for improvement you may have. The implementation of the electronic health record, SABER, as required by law, is a major change in business process. The department recognizes the significance of this project and has developed a collaborative team, communication plan, and extensive training plan to manage and navigate this transition. Please continue to provide feedback to your supervisor on how improvements in communication can be made and track DBH's communication efforts on the SABER Project intranet website at <http://countyline/dbh/ehr/>.
- Comment:** "I would like to express my whole hearted support for this Capacity Building project. There are many, many new contractors in San Bernardino County and the coordination and information re: the myriad of services available currently remains obscured even for those who are long established contractors. This results in a lack of knowledge that can and must be disseminated to the public. To offer trainings and education to the contracted providers will only serve to improve knowledge and services to the public that we serve. It will support contractors, both large and small, long established and newly established to be better prepared in our handling of complex administrative, billing, and the expanded(ing) health care system. The better we are able to coordinate and understand multiple funding streams, complicated cost reports, expansion of services will only serve for a more stable contractor base and in turn an improvement in services. Thank you for hearing our voice."
- Comment:** "Please use this email as my support for the addition of a Provider Training staff position. The value to all contract providers receiving continued and consistent training will be a great advantage to all in the DBH network."
- Comment:** "I think it should not be limited to agencies that participate in "Capacity Building' Activities" but to any contracted agency."
- Comment:** "Our agency partners in several areas of the plan."
- Response:** Thank you for your collective comments and feedback. Capacity building opportunities will be open to all contracted agencies.

Substantive Comments/Recommendations

Feedback Regarding Planned Innovation Project End Date

The information below represents a summary of concerns outlined in a letter received May 5, 2014, from a contract provider agency regarding a planned end date to an Innovation Project and the Department's response.

In addition to the letter, the provider submitted one hundred thirty-seven (137) comment forms acquired from staff, community advocates, and consumers and family members. The following is an analysis of the 137 comment forms received and the Department's response.

DBH would like to thank those stakeholders that participated in providing public comment related to the end date of the time-limited, Innovation (INN) Holistic Campus project set to end in June 2015.

Of the one hundred thirty-seven (137) comment forms, **93%** were related to a single subject, a portion of one Innovation project, the Holistic Campus that is operated by the contracted provider, El Sol.

- Approximately **74%** indicated a desire to not end funding for the Innovation funded Holistic Campus project located in the City of San Bernardino.
- Approximately **15%** did not provide any comment.
- Approximately **4%** stated they learned about MHSAs programs or expressed they liked the Holistic Campus.
- Approximately **4%** provided written feedback that stated they had "no" concerns about the Integrated Plan.
- Approximately **3%** commented they learned about the contracted provider agency and/or the agencies Executive Director.
- **85%** of the forms indicated dissatisfaction with the MHSAs Integrated Plan related to the planned Innovation project end date.
- **66%** were the Spanish version of the feedback forms.

The draft MHSAs Integrated Plan contained information regarding the INN Holistic Campus project (INN-04) and planned project end date. A description of the MHSOAC approved project, the progress to date, the timeline, evaluation, and acknowledgment that the transferable learning, sustainability and funding options "have not been determined at the time of this report" (page 193, MHSAs Three Year Integrated Plan) were included in the report. In addition, the budget pages reflect the end of Innovation funding related to this time-limited project in accordance with the MHSOAC approved timeline which has been routinely communicated over the term of the Holistic Campus project.

In response, the Department arranged a meeting with El Sol (provider) Executive Director and staff members on May 9, 2014, to address concerns; offer education concerning the intent of the Innovation Component, as defined in statute; solicit suggested language to include in the final version of the MHSAs Integrated Plan to ensure community understanding; reiterate information and input gathered during the Innovation Community Program Planning (CPP) process that occurred in June and July 2013; and address parameters of contracts between DBH and the provider, El Sol. In addition, El Sol and their stakeholders were encouraged to participate in the May 15, 2014, Community Policy Advisory Committee (CPAC) Meeting, as a discussion of both CASE (INN-02) and the Holistic Campus (INN-04) were scheduled as primary agenda topics.

Substantive Comments/Recommendations

The May 15, 2014, CPAC meeting was focused on community education of the Innovation component, including the intent, guiding regulations, evaluation requirements, two (2) of the Innovation projects, and progress to date.

- DBH provided Spanish interpretation services to community participants in need of translation services.
- A comprehensive, fifty (50) slide PowerPoint was provided in both English and Spanish to all attendees. The presentation served as both an educational and discussion tool for the group.
- The educational and informational material was provided by the DBH Research and Evaluation unit and Executive Management, including two Deputy Directors, and the Director of Behavioral Health.
- The Director, based on the importance of the discussion, extended the length of the two hour meeting by one additional hour to accommodate the question and answer process and ensure a common understanding that:
 - Innovation projects are time-limited,
 - Decisions concerning the Holistic Campus had not been made,
 - The project will not end until June 2015,
 - The project outcomes are in process of being analyzed, and
 - Any changes will be addressed as part of subsequent annual updates and stakeholder process.

The opportunity to participate in the ongoing stakeholder process each month at CPAC and other community meetings was reiterated and several comments from the stakeholders for the Department's consideration are as follows:

- That DBH consider the appropriateness of implementing time-limited, service-based Innovation projects via community-based organizations and consider how this approach might impact trust within the community.
- Providers of Innovation funded services should disclose the time-limited nature of the project to service recipients right at the beginning of care, as is common practice when engaging in therapeutic services with an Intern, which is also time-limited.
- MHSA Plans and subsequent updates should be shorter in length and/or have tools that assist and support community understanding.

DBH Response

DBH appreciates the coordinated response in relation to the Holistic Campus end date. The evaluation portion of the overall project has not been completed as the Innovation project is still in the process of being tested. In compliance with Welfare and Institutions Code 5830, Part 3.2 and as approved by the MHSOAC, the project is set to end in 2015. The sustainability of the learning and how the information or strategies will be implemented into the overall system of care will be an ongoing conversation and included as part of the monthly stakeholder process. To ensure the evaluation efforts are completed and accurate, DBH may allocate additional Innovation funding to the Fiscal Year 2014/2015 budget to strengthen evaluation activities. In addition, DBH has inserted clarifying language in the Innovation Component Section of the MHSA Integrated Plan, including a timeline demonstrating the various end dates for each Innovation project and will continue to work with community partners to strengthen Innovation project communication.

Although there were no substantive recommendations for revisions to the MHSA Integrated Plan, there were many significant comments by stakeholders in relation to Innovation projects, which will be taken into consideration during the ongoing planning, implementation and evaluation process.

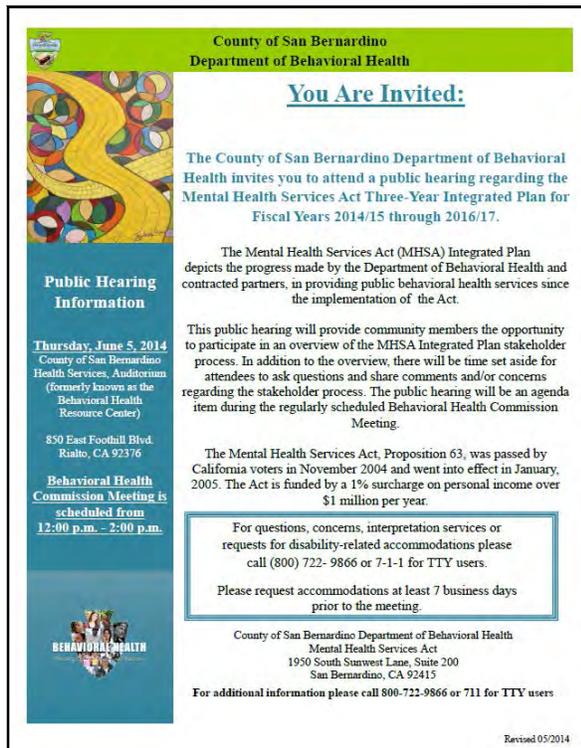
Public Hearing

Public Hearing

A Public Hearing hosted by the County of San Bernardino Behavioral Health Commission was conducted on June 5, 2014, 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, and a copy of the MHSA Public Hearing PowerPoint Presentation. As with all public meetings, interpretive services were offered, upon request, 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 serves, posted on the DBH Intranet and the Internet, included as a post on all social media sites, and distributed by MHSA Outreach Staff at a variety of venues.

In addition, a press release was created and distributed to sixty-five (65) media outlets to inform all county residents. 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.



**County of San Bernardino
Department of Behavioral Health**

You Are Invited:

The County of San Bernardino Department of Behavioral Health invites you to attend a public hearing regarding the Mental Health Services Act Three-Year Integrated Plan for Fiscal Years 2014/15 through 2016/17.

The Mental Health Services Act (MHSA) Integrated Plan depicts the progress made by the Department of Behavioral Health and contracted partners, in providing public behavioral health services since the implementation of the Act.

This public hearing will provide community members the opportunity to participate in an overview of the MHSA Integrated Plan stakeholder process. In addition to the overview, there will be time set aside for attendees to ask questions and share comments and/or concerns regarding the stakeholder process. 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.

County of San Bernardino Department of Behavioral Health
Mental Health Services Act
1950 South Swanwest Lane, Suite 200
San Bernardino, CA 92415

For additional information please call 800-722-9866 or 711 for TTY users

Revised 05/2014

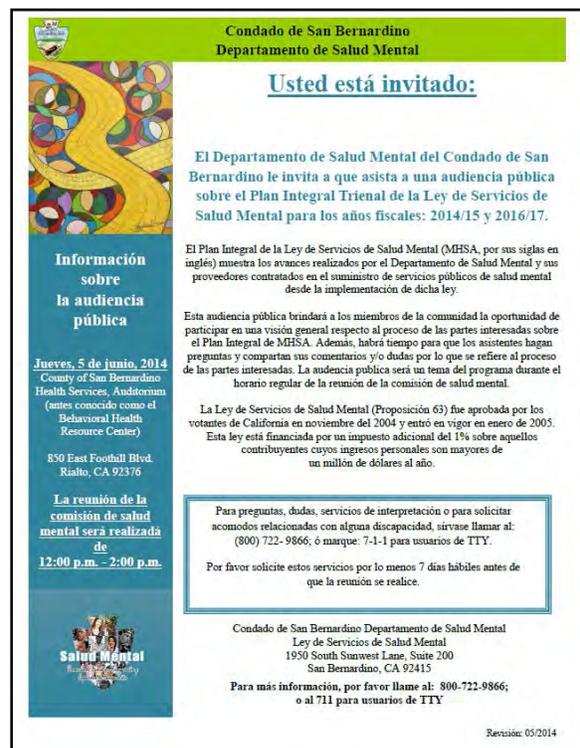
Public Hearing Information

Thursday, June 5, 2014
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.

BEHAVIORAL HEALTH



**Condado de San Bernardino
Departamento de Salud Mental**

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 Integral Trienal de la Ley de Servicios de Salud Mental para los años fiscales: 2014/15 y 2016/17.

El Plan Integral 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 desde la implementación de dicha ley.

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 Integral 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 entró en vigor en enero de 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 acomodados 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
Ley de Servicios de Salud Mental
1950 South Swanwest Lane, Suite 200
San Bernardino, CA 92415

Para más información, por favor llame al: 800-722-9866; o al 711 para usuarios de TTY

Revisión: 05/2014

Información sobre la audiencia pública

Jueves, 5 de junio, 2014
County of San Bernardino Health Services, Auditorium (antes conocido como el Behavioral Health Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

La reunión de la comisión de salud mental será realizada de 12:00 p.m. - 2:00 p.m.

Salud Mental

Public Hearing

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

COUNTY OF SAN BERNARDINO
DEPARTMENT OF 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 MHSa 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.

05/23/2014

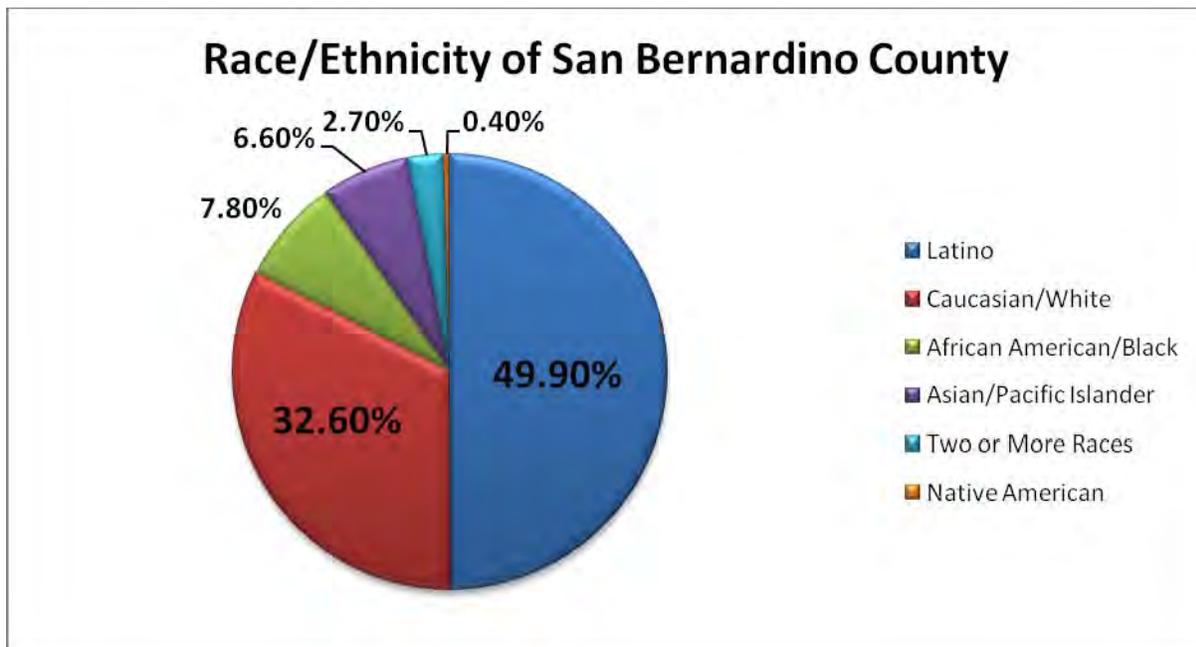
No substantive recommendations were received. The Behavioral Health Commission affirmed that the Department had adhered to the MHSa Community Program Planning process and supported the submission of the MHSa Integrated Plan to the Board of Supervisors for approval.

County Demographic Overview

The County of San Bernardino 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). The total population as of the 2010 census is **2,035,210**. 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 Twenty-nine Palms, Marine Corps Logistics Base Barstow, and Twenty-nine Palms Strategic Expeditionary Landing Field.

The County of San Bernardino 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.*

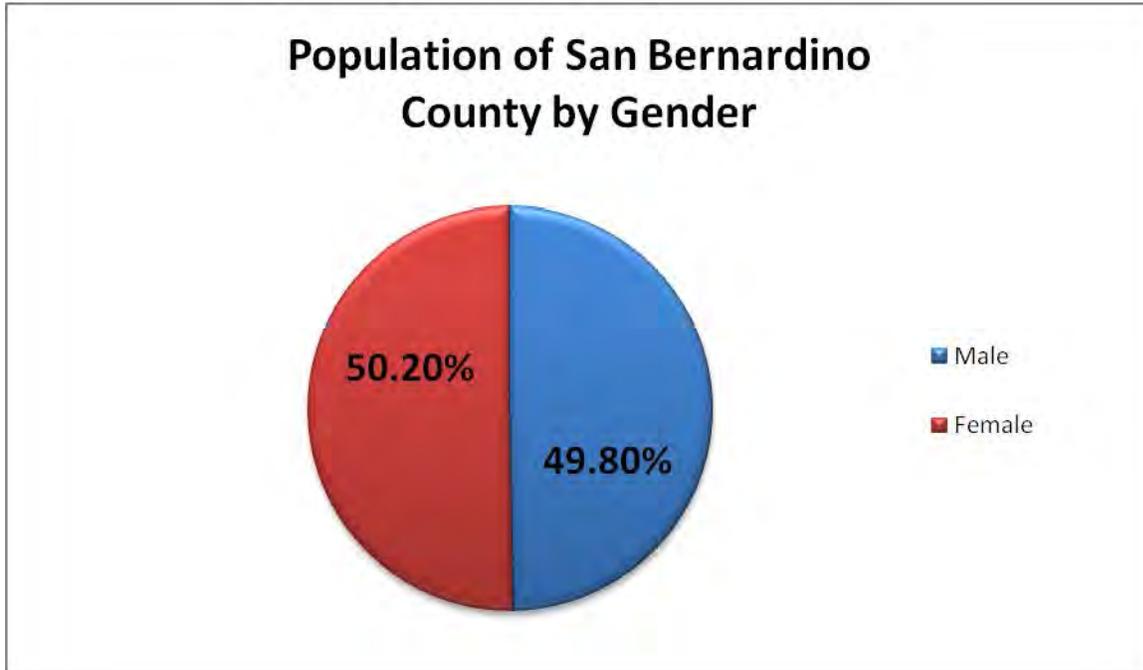


**2013 County of San Bernardino Community Indicators Report*

County Demographic Overview

The County's general population is young, with **28.2%** of residents under the age of **18** years.* The largest age group is those aged **15 to 19** years, followed by **25 to 29** years old.

Gender breakdown is as follows: **50.2%** of the population is female, **49.8%** is male.*



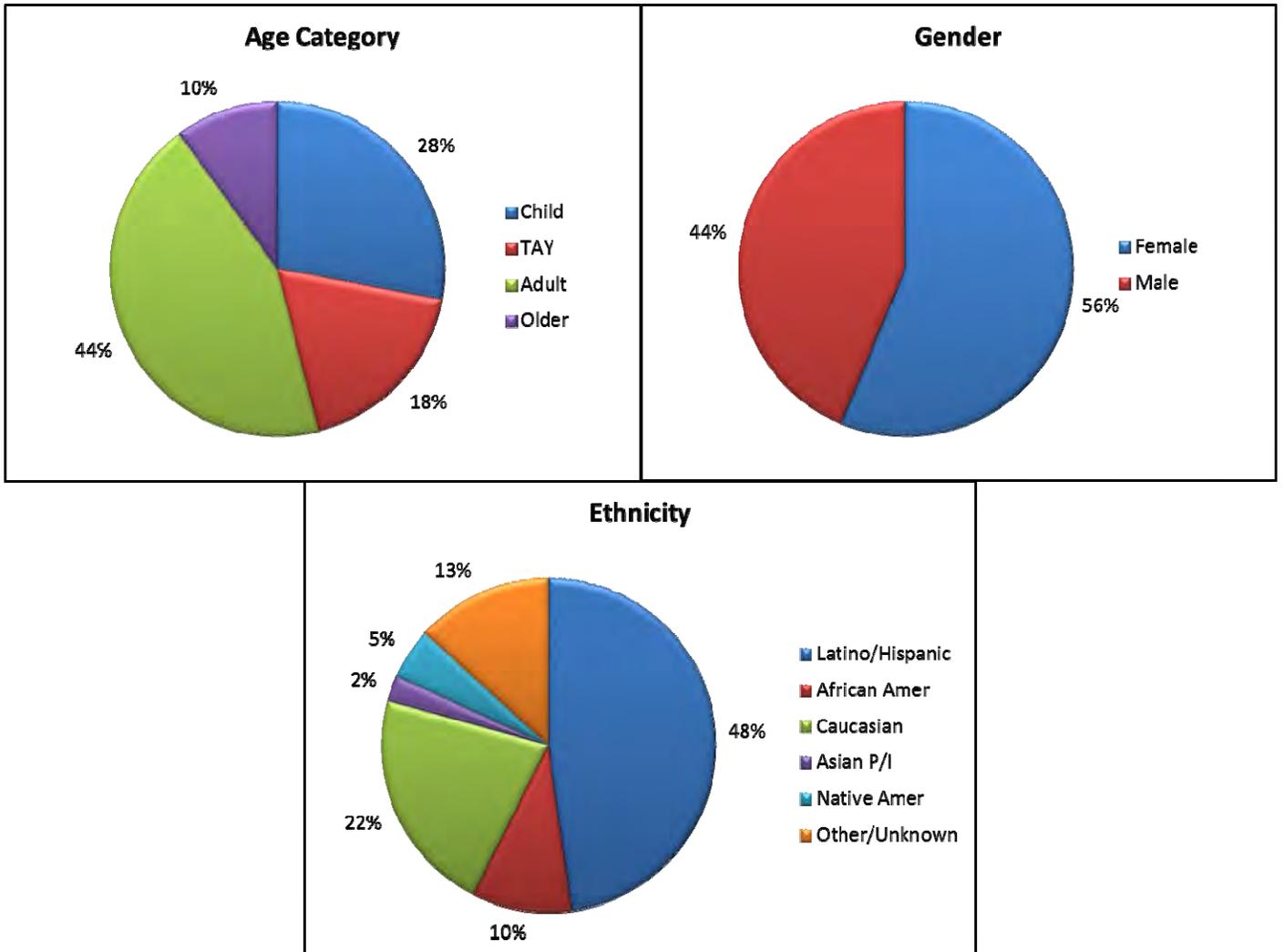
As of 2012, there are approximately **111,749** veterans residing in the County of San Bernardino, comprising approximately **5.4%** of the county's population. While the overall veteran population is declining, the number of veterans returning home from active duty is increasing.**

*Census data, 2012 Estimate, <http://quickfacts.census.gov/qfd/states/06/06071.html>

**2013 County of San Bernardino Community Indicators Report

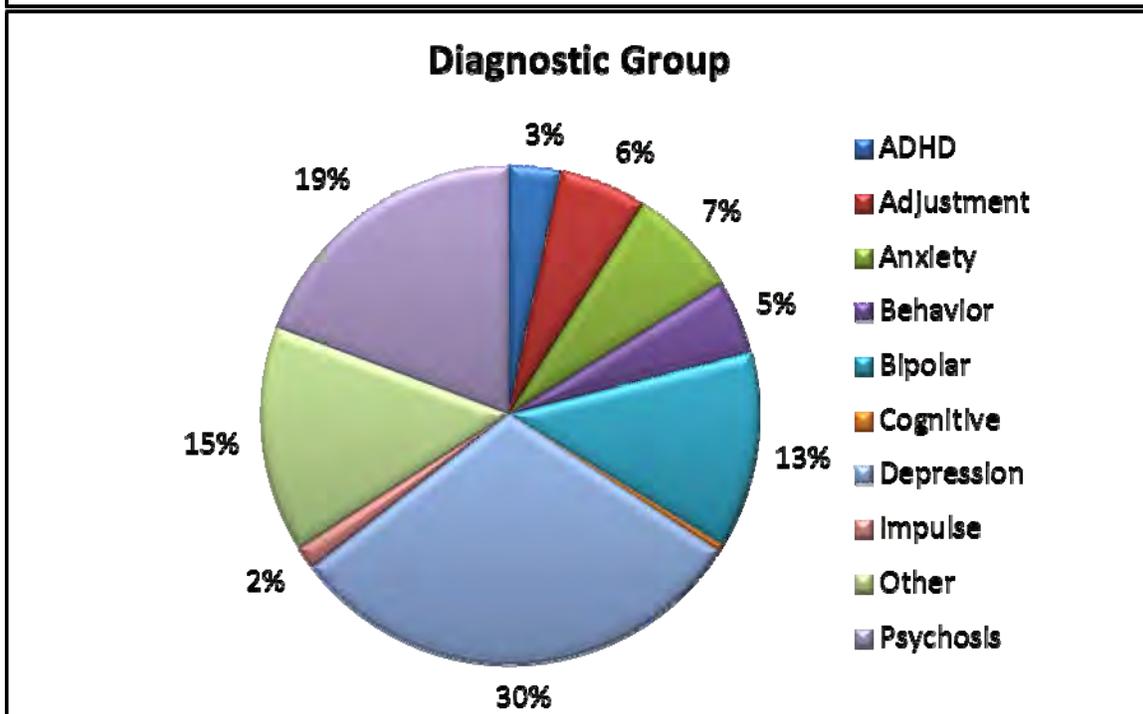
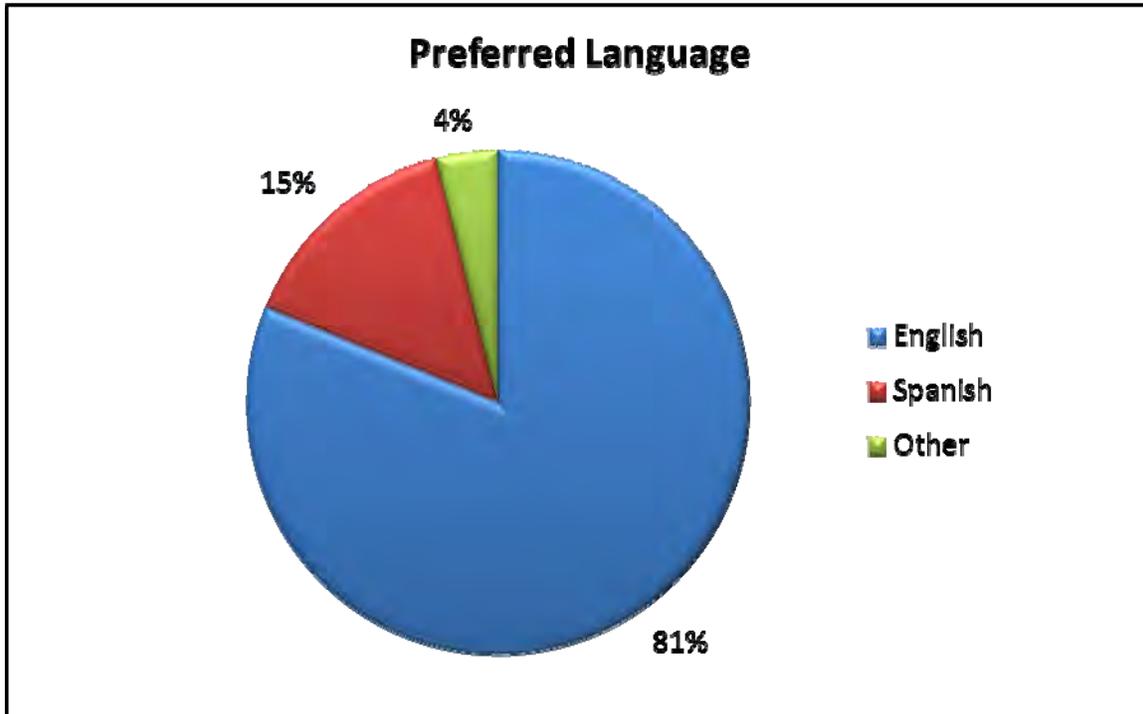
Demographic Overview of Community Members Served in MHSA Programs

Clients served in Community Services & Supports (CSS), Prevention & Early Intervention (PEI) and Innovation (INN) in Fiscal Year 2012/13 totaled **159,080**.



Demographic Overview of Community Members Served in MHSA Programs

Clients served in Community Services & Supports (CSS), Prevention & Early Intervention (PEI) and Innovation (INN) in Fiscal Year 2012/13 totaled **159,080**.



MHSA Work Plans

MHSA Component	Work Plan
Community Services & Supports (CSS)	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
	A-3: Members Assertive Positive Solutions (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
	A-8: Big Bear Full Service Partnership (FSP)
	A-9: Access, Coordination, and Enhancement (ACE)
	OA-1: AgeWise-Circle of Care
	OA-2: AgeWise-Mobile Response
Prevention and Early Intervention (PEI)	Prevention and Early Intervention (PEI)
Workforce Education and Training (WET)	Workforce Education and Training (WET)
Innovation (INN)	Coalition Against Sexual Exploitation (CASE)
	Online Diverse Community Experience (ODCE) Final Report Included.
	Community Resiliency Model (CRM) Final Report Included.
	Behavioral Health Youth Hostel
	Interagency Youth Resiliency Team (IYRT)
	Holistic Campus
Capital Facilities & Technology (CFTN)	Capital Facilities
	Technology



MENTAL HEALTH SERVICES ACT

C-1: Comprehensive Children and Family Support Services (CCFSS)

M H S A I N T E G R A T E D P L A N F I S C A L Y E A R S 1 4 / 1 5 - 1 6 / 1 7

Service Goals/Outcome Measures

The Goals of the Comprehensive Children and Family Support Services (CCFSS) are:

- **Reduce** the number of multiple **out-of-home placements** for foster care youth.
- **Reduce criminal** and juvenile **justice involvement**.
- **Increase self-help** and consumer and family involvement.

The objectives are to:

- **Provide** culturally sensitive/competent, family-centered, strength-based and needs-driven services to children and families who are underserved with complex mental health, behavioral or co-occurring needs in a family setting.
- **Decrease psychiatric hospitalizations** and prevent a higher level of mandated care.
- **Assist with formal and informal community supportive services.**
- **Utilize** flex funds fiscal assistance for immediate safety concerns such as to **prevent homelessness** or for immediate activities of daily living and assistance of clothing, food, housing and medications.
- **Coordinate services** consisting of respite options, 24/7 crisis phone and mobile crisis intervention services in cooperation with established community crisis centers as well as immediate issues over the phone.
- **Improve stability in the home.**
- **Provide outpatient services** as appropriate to the treatment needs and service goals of the child and family.
- **Improve** school advocacy, promotion and attendance by reducing expulsions, arrests, substance abuse and emergency interventions.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Comprehensive Children and Family Support Services (CCFSS) Created?

Senate Bill (SB) 163 Wraparound had proven to be an effective means by which wards and dependents could receive assistance and avoid out-of-home placements or loss of a current placements. Additionally, wards and dependents were helped in accomplishing appropriate goals and developing constructive relationships within their family and community. Despite these successes, there were still children and youth being identified by DBH, Probation, and Children and Family Services (CFS) as needing a wraparound style intervention who did not qualify for SB 163 Wraparound. As a result, the need for services was not met, and often situations worsened.

- Success First/Early Wrap was created to facilitate the success of these children and youth who do not qualify for SB 163 Wraparound services.
- Since inception, CCFSS was expanded two (2) ways: 1) The Wrap informed Full Service Partnership culture was applied to youth in high levels of placement through the Residentially Based Services (RBS) pilot program; 2) SB 163 Wraparound was incorporated into CCFSS. Combined, the three (3) programs provide a continuum of wraparound, or wrap informed services, for children and youth within placement, in a formal long term wraparound placement, and through a time limited wrap-informed program that allows for proactive efforts to help children and youth.

Program Overview

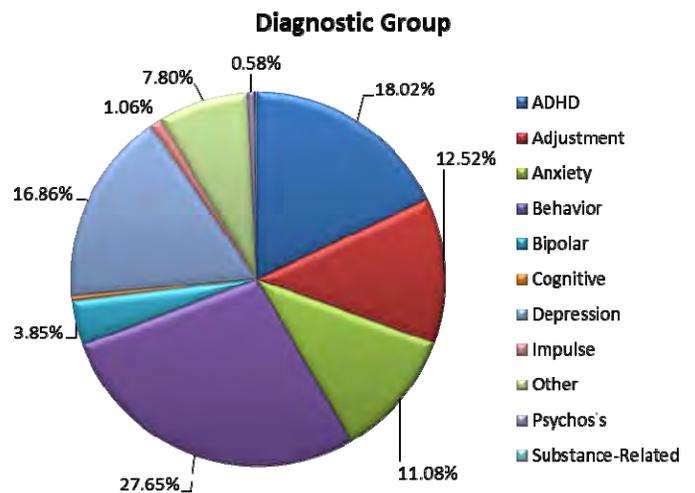
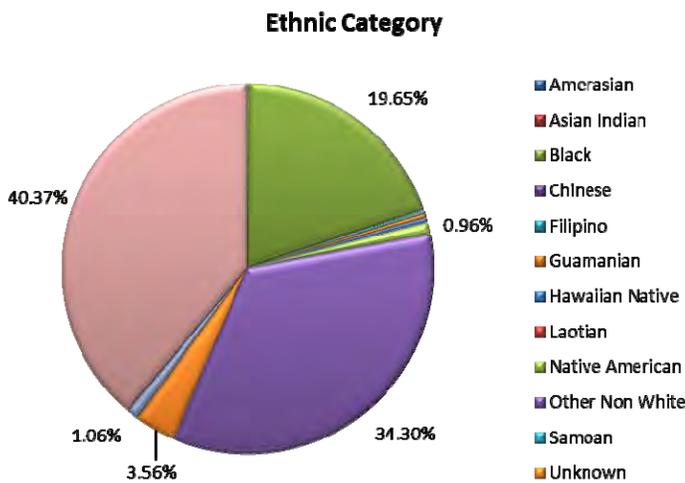
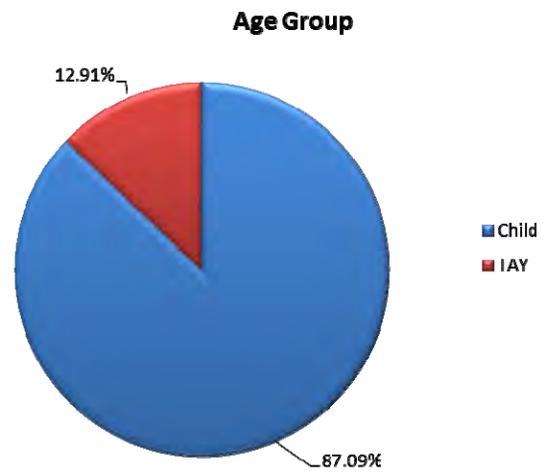
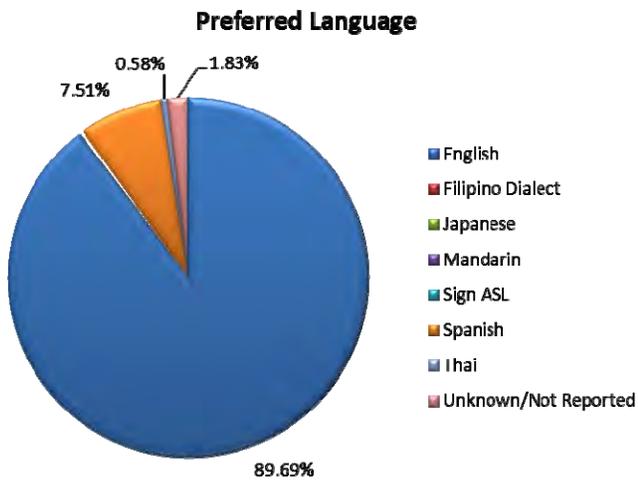
The Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for inclusion in Full Service Partnerships (FSP) to provide “Wraparound” services to diverse children and youth with emotional disturbances and co-occurring disorders. Since the start of the program, over **11,000** children and their families have been served.

Wraparound had proven to be an effective means by which children and youth can receive assistance and avoid out-of-home placements or loss of a current placements. Additionally, participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community.

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. The wraparound planning process is child- and family-centered, builds on child and family strengths, is community-based (using a balance of formal and informal supports), is culturally relevant, flexible, and coordinated across agencies; it is outcome driven, and provides unconditional care (SAMHSA, 2008).

Program Data

During Fiscal Year (FY) 2012/2013, CCFSS demographics were as follows:



470 (45%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Component	FY 2014-15	FY 2015-16	FY 2016-17
Success First/Early Wrap	400	400	400
Children's Residential Intensive Services (CHRIS)	32	32	32
SB 163 Wraparound	450	450	450
Total	882	882	882

Services

The Services provided by the Comprehensive Children and Family Support Services (CCFSS) program include:

- Case Management,
- Individual and Family Therapy,
- Crisis Intervention,
- Collateral Support,
- 24-Hour Telephone Support Services,
- Stress & Anger Management Training,
- Parent & Family Advocate,
- Parenting Support,
- Teen Support Groups, and
- Medication Support.

Non Mental Health Services provided include Parent Partner supportive meetings and flexible funds to pay for resources to meet life needs.

Positive Results

Participation in the CCFSS program has resulted in many positive outcomes including:

- Increased family connections.
- Decreased hospitalizations.
- Decreased involvement with law enforcement and the Juvenile Justice system.
- Increased services to ethnic populations overrepresented in Child Welfare and Juvenile Justice Systems.
- Increased academic success and retention in school.
- Decreased homelessness.
- Increased lower level community supportive services.
- Increased family independence through increased informal community support.
- Reduced removal from family home to a higher level of care.
- Provided evidence-based treatment that specifically addresses trauma symptoms, substance abuse, parent-child relational difficulties and attachment disorders, oppositional defiance, mood disorders, disorders of infancy and early childhood and parenting skills deficits.
- 70% of children/youth in Success First/Early Wrap reach their goals by the end of service.

Challenges

- Child psychiatrists are a severely limited resource in the County of San Bernardino and there has been difficulty linking children and youth to these resources for appropriate follow-up care. DBH, through the Medical Education Program, is actively recruiting to meet this need.
- Single parent families without extended familial support and functioning at or below poverty pose exceptional challenges, as their natural resources are very limited.
- Balancing youth's and/or family's voice and choice with the "mandatory" terms and conditions of probation and/or dependency court.
- Some family participation appears to be more motivated by avoiding other consequences (e.g., placement), this results in less robust disclosure of family issues (e.g., alcoholism, domestic violence, etc.), and these unknown obstacles create multiple difficulties to service providers.
- Accessing appropriate community resources for youth in Residentially Based Services (RBS), during the time the youth are residing at the RBS residence is highly difficult due to complications of supervision requirements when parents or foster parents are not highly involved.

Solutions in Progress

- Use of Success First/Early Wraparound to transition more long-term care cases to other specialty programs within the same Community Based Organization (CBO) ensuring smoother transitions and continuity of care.
- Continue to expand the array of services provided by SB 163 Wraparound programs to include Therapeutic Behavioral Services (TBS) (i.e., one-to-one behavioral coaching). The implementation of this within the Wraparound programs has been difficult; however, significant gains appear to have been made in the past year.
- Consistent on-site training and campaigning regarding eligibility criteria, referral processes, and hands on support for making referrals to the CCFSS program (i.e., Success First / Early Wraparound, SB 163 Wraparound, and Residentially based Services).
- Participation with Children & Family Services (CFS) at Team Decision Making (TDM) meetings to ensure consistent information about eligibility criteria and referral processes. This is being accomplished by: 1) Participation of the CBO's that implement the CCFSS programs and 2) Integration of a DBH Prevention and Early Intervention (PEI) Child and Youth Connection program designated to participate in Team Decision Making (TDM) meetings with CFS.

In Their Own Words

Success First / Early Wraparound

A 17 year-old Hispanic male resided in the home with parents and was referred to the Success First program due to his excessive problems with primary support, social, academic and occupational functioning. At the beginning of treatment he was exhibiting the following behaviors: angry outbursts (yelling, screaming, punching walls and doors, throwing items, etc.), physical aggression (pushing shoving, threatening) towards caregivers, and defiant behaviors in the home and at school. Client was receiving failing grades and displaying defiance and experiencing hallucinations at school. Client had been hospitalized between 4-6 times prior to treatment. After 3 ½ months in the program, he graduated; not only meeting, but surpassing all established goals. He and his family were extremely excited when he graduated. He repeatedly thanked the Family Services Care Coordinator and Clinician during his graduation. He stated "I learned a lot" during the program. He is no longer truant from school and is completing his assignments and on the path to graduate on time. He was not hospitalized during the program and stopped having suicidal thoughts and responding to hallucinations. He has learned coping skills to assist with reducing these negative thoughts.

- ⇒ One Mom stated during her daughter's graduation that, she had seen a significant improvement. She had been worried about her daughter's yelling and screaming and worried that her behavior would never change. She was glad a program like this existed because she was not aware of it prior.



SB 163 Wraparound

- ⇒ *"Without the encouragement of the Wrap team, my son would have gone back to smoking marijuana a long time ago. I would have probably had him arrested for beating up his brother without wraparound."*
- ⇒ *"The Wraparound team is really responsible for holding our family together through this tough time."*
- ⇒ *"Thank you for teaching us to not give up on our son by setting the example for us."*
- ⇒ *"Without the persistence and encouragement of the Wraparound team my son would have never had the motivation to complete his community services on his own."*
- ⇒ *"Without Wraparound my son would have been removed from our home. Now, he is able to self-sooth and behaves appropriately in social setting without having a tantrum."*
- ⇒ *"He's doing much better since we started working with him. I learned a lot. He used to hit me when I got him; now it's very rare. To me, that's a big step. He's working on personal stuff....taking a shower. Now he is working on taking a shower every day...or 4 days a week. He used to never shower."*

Collaborative Partners

Thank you to our partners!

County of San Bernardino Children & 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

First/Early Wraparound & SB 163 Programs



C-1: COMPREHENSIVE CHILDREN AND FAMILY SUPPORT SERVICES (CCFSS)



MENTAL HEALTH SERVICES ACT

C-2: Integrated New Family Opportunities (INFO)

M H S A I N T E G R A T E D P L A N F I S C A L Y E A R S 1 4 / 1 5 - 1 6 - / 1 7

Service Goals/Outcome Measures

The Goals of the of Integrated New Family Opportunities (INFO) are:

- **Reduction** in criminal and juvenile justice involvement
- **Increase** in self-help and consumer/family involvement

The Objectives are:

- **Reduce** recidivism
- **Decrease** juvenile detention days
- **Decrease** sustained allegations
- **Increase** consumer and family relations



County of San Bernardino - Department of Behavioral Health



BEHAVIORAL HEALTH
Promoting Wellness, Recovery, and Resilience

Promoting Wellness, Recovery and Resilience

Why Was Integrated New Family Opportunities (INFO) Created?

Juvenile arrests in the County of San Bernardino increased steadily from 2002 to 2005. In 2005, **7,482** juveniles were booked and detained in the County Juvenile Detention and Assessment Centers (JDACs). **The County had a significantly higher juvenile arrest rate than the rest of the state.**

The lack of early identification (screening, assessment and referral) of **mental health (MH) and alcohol and drug (AOD) problems in the County's juvenile justice population was evident in that only 8% of the County's detained juvenile justice population was identified with MH or AOD problems as opposed to 70% identified in the same population nationwide.**

Many youth are detained and placed in the system for relatively minor, non-violent offenses, but end up engaged in the system because of the lack of community-based mental health and AOD treatment services.

There was a need for a partnership between the Department of Behavioral Health, Probation and the Courts.

Program Overview

This program has been MHSAs funded since November, 2008. 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 un-served or underserved and who are on probation. The program was designed with the knowledge that many youth are detained and placed in the system for relatively minor, non-violent offenses, but end up engaged in the system because of the lack of community-based **mental health and Alcohol and Drug** treatment services. Through a partnership between the Department of Behavioral Health, Probation and the Courts this highly effective program has provided help to over **303** families, since inception.

Unique Qualities of Program

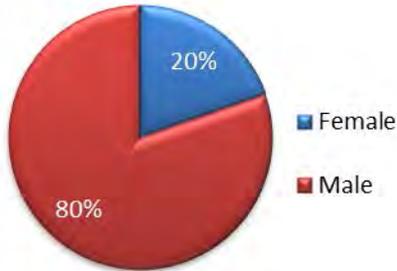
INFO is a unique and innovative program that unites the disparate philosophies of Probation and Behavioral Health to create one new, synthesized modality. Combining the strengths of two county departments is an unprecedented approach for a juvenile justice intervention program in the County of San Bernardino and the State of California. For years, researchers and advocates have recommended this collaboration for juveniles involved in the justice system so that minors and their families are provided with the right combination of governmental support to help them achieve success while keeping the community safe.

The term "voluntary participation" is not often heard in the juvenile justice system. Typically, juveniles are ordered into treatment programs, community service, and other intervention programs. INFO chose a different approach for the program. Minors and families must agree to participate voluntarily, thereby indicating motivation to make changes in their life situation.

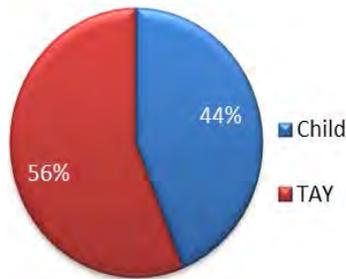
Program Data

During Fiscal Year (FY) 2012/13, INFO demographics were as follows:

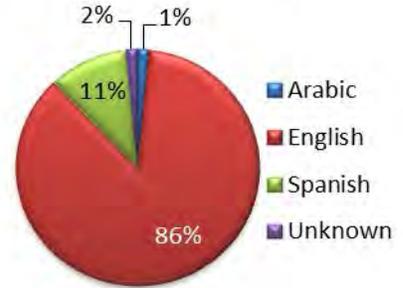
Gender



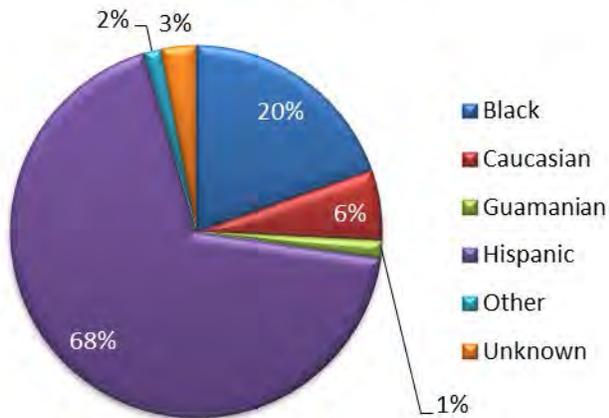
Age Group



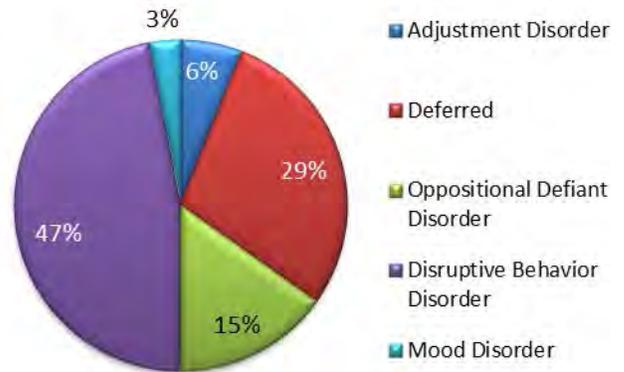
Language



Ethnic Category



Diagnostic Group



Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
INFO	60	60	60
Total	60	60	60

Services

The INFO program provides screening services using one Evidence Based Screening Instrument: MAYSI-2 (Massachusetts Youth Screening Instrument- version 2). To maximize the positive impact and outcomes for the children, youth , and families that they serve, three Evidence Based Services are provided: Functional Family Therapy (FFT), Moral Reconciliation Therapy (MRT), and Intensive Case Management.

Other program services include Mental Health Assessment , Alcohol and Drug (AOD) Services, Linkage to Community Resources and Supports, and a Multidisciplinary Treatment Team that includes Clinical Therapists, a Alcohol and Drug Counselor, a Peer and Family Advocate, Probation Officers, and a Probation Corrections Officer, provide weekly case conference meetings to discuss the progress of the minors.

Minors and families are enrolled in the program for approximately three to six months. During this time they receive FFT for approximately 12 to 14 weeks. MRT, substance abuse, and after-care services are also provided . Intensive Probation supervision is maintained during the three to six month enrollment but is gradually decreased as the minor and family become a cohesive, functional family unit, and are less dependent upon the INFO team and services. Due to the intensity of Functional Family Therapy (FFT) and Intensive Probation Supervision, small caseloads have been found to be most effective for ensuring program integrity.

Positive Results

INFO Works! Recidivism is one of the most relevant measures of success or failure in a community-based correction program. By combining the strengths of two disparate disciplines , Probation and Behavioral Health, the INFO team combines into one approach with a common goal.

Of the 245 youth that completed the program there has been a:

1. 55% overall reduction in recidivism
2. 20% decrease in juvenile detention days
3. 83% decrease in sustained allegations

Based on the pre-FFT and post-FFT self-report surveys administered through January 2013, the increase in youth and family relations was a minimum of 32.6%. The CiMH San Bernardino County Program Performance Dashboard Report states the following positive changes for the families:

Parental Figure 1	Parental Figure 2	Child/Youth
58.3% positive change	50% positive change	32.6% positive change

The program looks at data from one year prior to program entry, during the program, and one year after program completion.

Prior to entering the INFO program, minors spent 4,877 days in a Juvenile Detention and Assessment Center (JDAC) at an estimated cost of \$2,422,998. After entering the INFO program, minors spent 791 only days in a JDAC, for a total diverted cost of \$2,989,313.

C - 2: INTEGRATED NEW FAMILY OPPORTUNITIES (INFO)

Making a Difference

Joe entered the INFO program June 2013. He was transferred from Riverside County after being on formal probation for four years. He had a history of being entrenched in gang activity. Joe and his mother were able to participate and fully engage in Functional Family Therapy (FFT) sessions and Moral Recognition Therapy (MRT) group.

Joe has since completed FFT and graduated October 2013. He returned to be a Special Guest Speaker at the following INFO graduation. Joe's mother expressed "he was like a different person" because he was so respectful to the family and her. She also noted his active participation in his local church. Joe proudly shared his report card with the INFO staff and peers, which showed great improvement in his grades and attendance.

Joe continues to remain off probation and has had no negative legal contact since his completion of the program. Joe continues to attend MRT group weekly for his sustained personal growth as well as to support his peers, despite now residing in another County.



Peer and Family Advocate and Probation Corrections Officer prepare to visit an INFO family

C-2: INTEGRATED NEW FAMILY OPPORTUNITIES (INFO)

Challenges

Challenge 1: Increase evidence-based substance abuse services to minors in program. In Fiscal Year (FY) 2010/11, **55%** of the minors enrolled in the INFO program had a substance abuse concern.

Challenge 2: Nationwide the number of juveniles being detained in the juvenile detention and assessment centers (JDAC) has been on a steady decline. This is due, in part to an increase in community based programs such as INFO. The INFO program has relied primarily on the Probation department and the JDAC's as the primary referral source. A decline in population also results in a decline in minors that can be screened for the program.

Solutions in Progress

Solution 1: INFO staff implemented another Evidenced based program, Moral Recognition Therapy (MRT), an evidence-based substance abuse treatment strategy that seeks to **decrease recidivism** among juvenile offenders by increasing moral reasoning. Originally developed as a criminal justice-based drug treatment, MRT has been adapted to fit other areas of interest like mental health treatment and co-occurring disorders. An MRT-trained alcohol and drug counselor and Clinical therapist holds twice weekly group sessions where minors can enter or exit the program at any time, similar to a traditional 12-step program. The program has been a success and added benefit to INFO.

Solution 2: INFO has been in existence for over seven years, is an FFT certified site and has the staffing resources and knowledge to expand the referral network to other county departments and community agencies. This will be a program focus for the coming year.

In Their Own Words

Child: "I think about my family now"...

Parent: "He makes his own decisions to do better, more respectful, and communicates with our other kids".

Parent: "Leary at first...but open-minded, learned so much."

Child: "Thanks for helping me to change. "

Parent of child said: "I never thought it [INFO] would help me this much."

Mother: "I thought I was by myself, the only Hispanic, when my son got in trouble. This was as far as I made it. But then God put Richard Hernandez and the INFO program in my path. I knew I'm not going to be by myself. I trusted and now he has good grades, A's and B's. Before was nothing but yelling and now he tells me without yelling.."



C-2: INTEGRATED NEW FAMILY OPPORTUNITIES (INFO)

Collaborative Partners

The INFO Program would like to acknowledge the support of the following agencies:

Department of Behavioral Health Administration

County of San Bernardino Probation Department

Juvenile Court San Bernardino

County of San Bernardino District Attorney's Office

County of San Bernardino Public Defender's Office

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

San Bernardino County Museum

Community Action Partnership

Salvation Army San Bernardino

Boys & Girls Club San Bernardino

These agencies helped INFO meet the needs of our families, allowed our minors to perform community service, and assisted with resources for the basic life needs of our families.



MENTAL HEALTH
SERVICES ACT

TAY-1: Transitional Age Youth (TAY) One Stop Centers

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R S 1 4 / 1 5 - 1 6 / 1 7

Service Goals/Outcome Measures

The overall goals of the TAY center are:

- **Reduce** the subjective suffering from serious mental illness for TAY.
- **Reduce homelessness** and increase safe and permanent housing.
- **Reduction in disparities** in racial and ethnic populations.
- **Reduce** the frequency of **emergency room visits** and unnecessary hospitalizations.
- **Increase** a network of **community support services**.

The objectives of Transitional Age Youth (TAY) One Stop Centers are:

- **Increase** consumer self-help and family involvement.
- **Increase** access to treatment and services for co-occurring problems; substance abuse and health.
- **Reduce** service disparities for racial and ethnic populations.
- **Reduce** criminal and juvenile justice involvement.
- **Reduce** frequent emergency room visits and unnecessary hospitalizations.
- **Increase** a network of community support services.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Were Transitional Age Youth (TAY)

One Stop Centers Created?

Transitional Age Youth (TAY) Centers were created to provide integrated services to transitional aged youth (16-25 years-old) who are unserved, uninsured and homeless or at risk of becoming homeless.

Transitional age youth typically have been over-represented in the Justice System and out-of-home placements (foster care, group homes, institutions). The TAY Centers provide a high level of care with services that are gender specific, culturally and linguistically appropriate.

Program Overview

The Department of Behavioral Health (DBH), in partnership with the Departments of Probation, Public Health (DPH), Children and Family Services (CFS), Transitional Assistance Department (TAD), Inland Regional Center (IRC) and the San Bernardino County Superintendent of Schools (SBCSSS), are addressing the needs of Transitional Age Youth (TAY) (ages 16-25) with mental and behavioral disabilities, by providing coordinated and comprehensive support and direct services at TAY One Stop Centers.

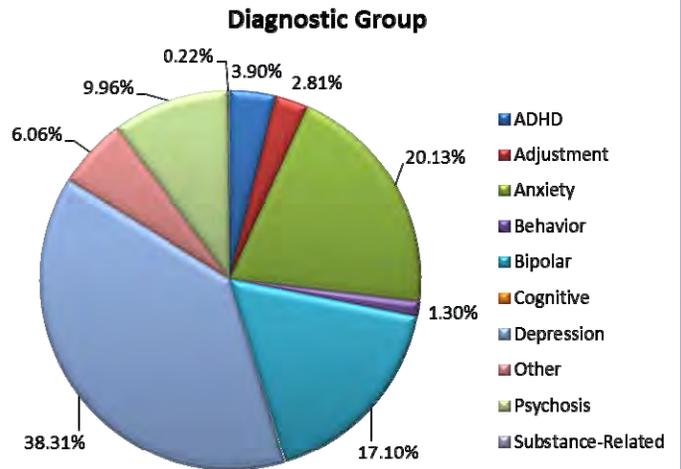
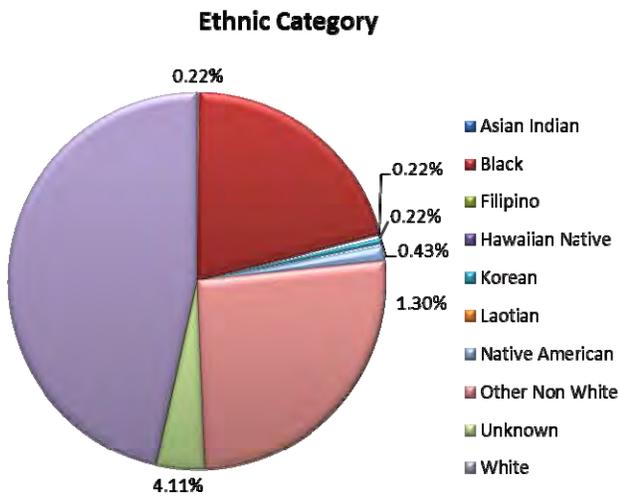
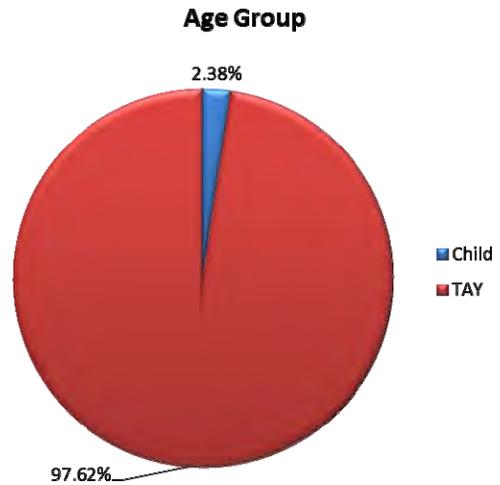
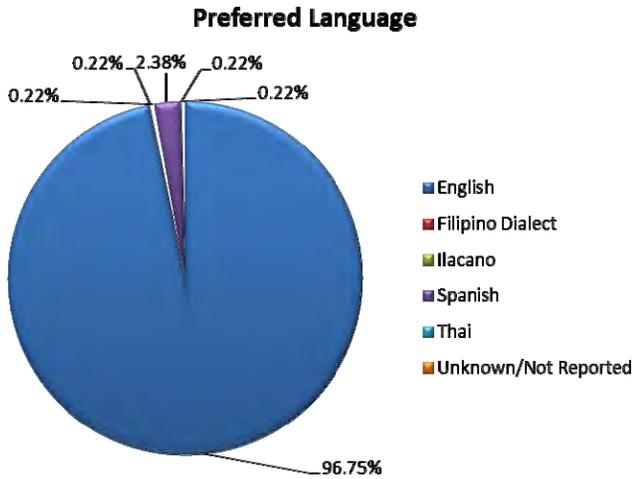
TAY One Stop Centers provide integrated mental health services to individuals age 16 to 25 with mental and/or emotional problems who may be emancipating from: foster care, group homes, the juvenile justice system, or county jail. Since the inception of the program, over **10,000** TAY have received services through the program. Of those **10,000**, over **1,600** have participated as Full Service Partners.

Services for TAY address transition domains of employment, educational opportunities, living situations, community life, medication, mental health, physical well being, drug and alcohol use, trauma, domestic violence, and physical, emotional and sexual abuse, hopefully resulting in greater independence. Services are gender specific, culturally and linguistically appropriate.

The TAY Centers provide programs that allow TAY clients to selectively utilize services needed to maximize individual potential (Recovery Model) while already in the community and to use interim services (Short-Term Residential Model) to prepare TAY for entry into the community. With multi-agency collaboration, services from each agency are co-located in the centers for easy access, and to eliminate barriers of maneuvering separate systems. A real focus is placed on providing services to TAY aging out of the foster care system.

Program Data

During Fiscal Year (FY) 2012/2013, TAY demographics were as follows:



192 (42%) of those represented, identified as being of **Hispanic Origin**.

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
TAY One Stop	1,400	1,400	1,400
Total	1,400	1,400	1,400

Services

TAY Center Services include:

- Group and Individual Therapy/Counseling.
- Homeless Assistance.
- Independent Living Skill Classes, GED/High School Diploma classes, Extended Education Assistance.
- Employment Assistance.
- Transportation Assistance.
- Community Involvement.
- Indoor/Outdoor Activities, Recreation Activities.

Positive Results

TAY Centers have contributed to savings in community costs by assisting transitional age youth in becoming independent, staying out of the juvenile justice system, and reducing hospitalizations and homelessness.

TAY that participate in housing are living on their own and doing well. They receive weekly visits from TAY program case managers to ensure they have the services and support they need to help them maintain housing and reintegrate into the community. TAY are attending college and/or seeking and maintaining employment.

Performance Outcomes

The TAY Centers served **1,697** unduplicated Full Service Partnership (FSP), **2,054** System Development and **6,299** Outreach & Engagement youth since the inception of the program for a total of **10,050**. The programs have also **increased** the amount of emergency shelter beds and board & care bed utilization and continue to outreach to **increase** the number of beds available in low-serving areas. Training records also show that consumers are increasingly participating in a number of diverse trainings across the County.

Making a Difference

A. is a client who voluntarily went to TAY's rehabilitation program after being in the STAY crisis residential center. She excelled in the rehabilitation program and was eager to share her progress with her TAY case manager each week. She worked her program and continues to work hard at her aftercare relapse prevention strategies. A. describes the TAY program as, *"Stopping me from dying on the streets."* She states she has *"learned how to be resourceful and stay clean and sober."*

Challenges

- There are limited services for system involved TAY to assist in areas of employment, educational opportunities, living situations, community life, medication, mental health, physical well-being, drug and alcohol use, trauma, domestic violence, physical, emotional and sexual abuse.
- Services are still needed to address the specific gender, culture and language of TAY.
- There is still a need for emergency shelter bed services to prepare for entry into the community, as well as a need for qualified housing providers and a lack of available housing throughout the county.
- Community collaboration for long-term employment for TAY remains a challenge.
- The number of individuals without insurance needing medical and dental treatment is still high.

Solutions in Progress

- All TAY Centers continue to work with the TAY Advisory Boards to address the needs and concerns of the TAY.
- Continued efforts are being made to reach the targeted populations of Latino and African Americans that do not have access to appropriate services and are inappropriately served or underserved.
- Continued outreach efforts are being made to establish new emergency shelter beds throughout the county. There is also increased collaboration with Board and Cares to provide housing for TAY clients.
- Continued efforts to assist clients in applying for Social Security and other medical insurance programs available through the Affordable Care Act.
- In collaboration with the Housing Authority of the County of San Bernardino and the County of San Bernardino Department of Behavioral Health Housing and Employment Program, the Phoenix Apartments were refurbished. This project offers eight (8) units to TAY in San Bernardino County with permanent, affordable housing and an array of services to help them maintain housing and reintegrate into the community.
- TAY at Phoenix are living on their own and doing well. They receive weekly visits from TAY program case managers to ensure they have the services and support they need to help them maintain housing and reintegrate into the community. TAY are attending college and/or seeking/maintain employment.
- The TAY program worked closely with DBH's Innovation Program to develop the Youth Resiliency Team (IYRT) Mentoring Program. This program provides intensive mentoring services to underserved and inappropriately served system-involved youth.
- The Innovation funded One-Stop TAY facility continues to provide collaborative services. The STAY includes a 14-bed crisis residential facility, a multipurpose room, a training kitchen, recreation room, resource center and media education room.

In Their Own Words

- ⇒ *"The TAY center has helped me learn tools I never knew existed. I am so excited to have my baby while being clean and sober. It is a new experience for me."*
- ⇒ The TAY center is, *"Stopping me from dying on the streets."*
- ⇒ *"The TAY center had helped me overcome my anxiety and feel better about myself."*



Collaborative Partners

Thank you to the ongoing partnerships that enable success for our TAY!

Pacific Clinics

Victor Community Support Services

San Bernardino County Department of Behavioral Health Innovation Program

San Bernardino County Workforce Development Department

TAY-I: TRANSITIONAL AGE YOUTH (TAY) ONE STOP CENTERS



**MENTAL HEALTH
SERVICES ACT**

A-1: Clubhouse Expansion Program

MHSA INTEGRATED PLAN FISCAL YEARS 14/15-16/17

Service Goals/Outcome Measures

The Goals of the Clubhouse are:

- **Reduce the subjective suffering** from serious mental illness for adults.
- **Increase** a network of **community support services**.
- **Increase in self-help** and consumer/family involvement.

The objectives of Clubhouse Expansion Program are:

- **Employ a Peer and Family Advocate workforce** to assist consumers to link to housing, benefits, education and employment resources.
- **Assist consumers to make their own choices**, reintegrating into the community as a contributing member and achieving a satisfying and fulfilling life.
- **Provide Wellness, Recovery and Resilience model programs** such as:
 - ◇ Employment
 - ◇ Housing
 - ◇ Life Skills
 - ◇ Entitlement Benefits
 - ◇ Recreation
 - ◇ Social Support
 - ◇ Physical Health including education and activities related to diet and exercise.
 - ◇ Promote members integration into the community and increase coping skills.
 - ◇ Provide and facilitate peer-run groups including basic education, money management and crisis management.
 - ◇ **Increase** members interactions and development of social skills by providing regularly scheduled social and recreational activities both onsite and in the community.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Clubhouse Expansion Program Created?

Priority issues identified by stakeholders through the community program planning process included:

- Stigma and Discrimination.
- Physical well-being in response to reduced life span among individuals with mental health and substance abuse issues.
- Homelessness.
- Frequent hospitalizations and emergency room visits.
- Inability to manage independence.
- Institutionalization and incarceration.
- Isolation.
- Access to care; lack of transportation.

Services

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 population to increase their overall functioning and community integration.

Clubhouses are primarily consumer staff operated and members have significant input in program and activity choices. In the clubhouses there are various work units including clerical, maintenance, food services, clothes closet, and newsletter, from which members can develop pre-vocational skills.

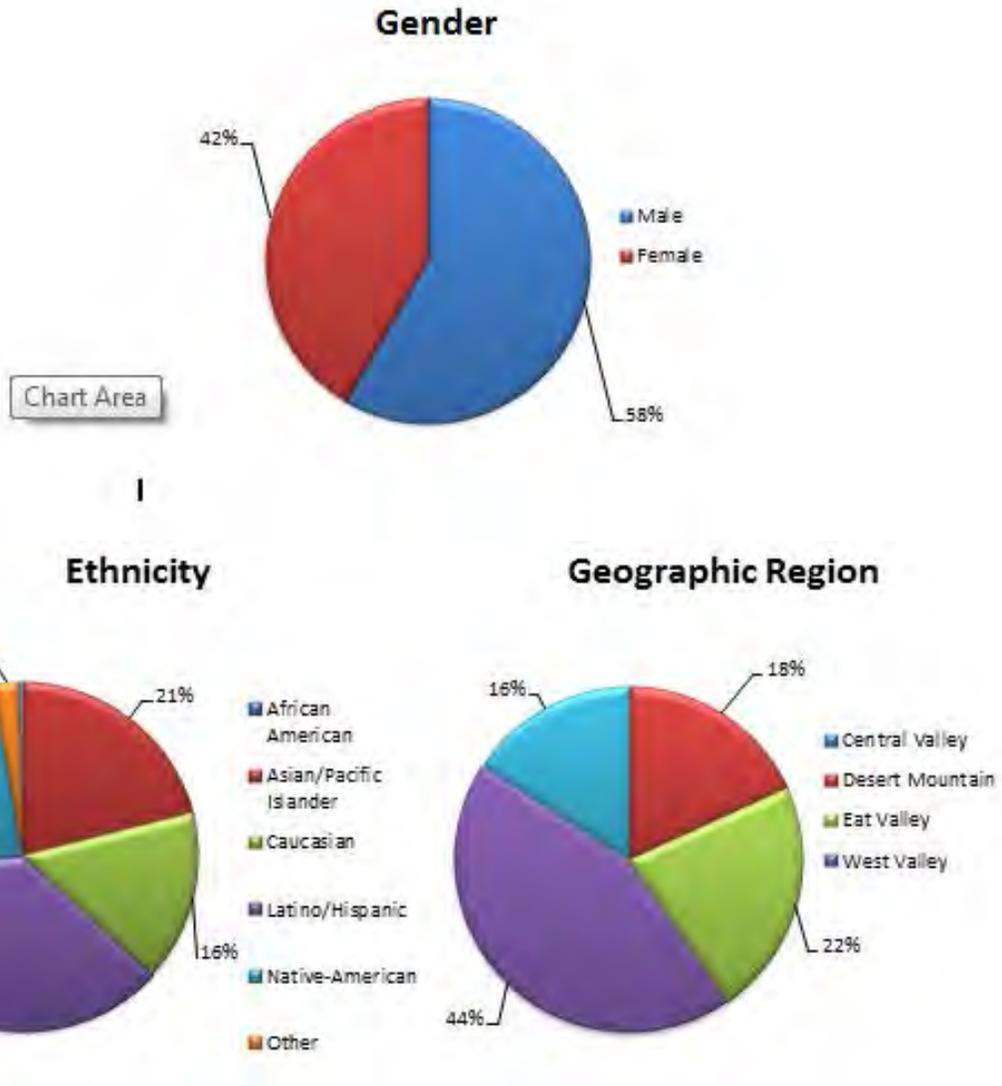
Peer and Family Advocates (PFAs) and other consumer leaders provide a variety of groups in clubhouses including:

- Basic education,
- Spirituality,
- Work training and money management,
- Activities of daily living,
- Relationships,
- Crisis management,
- Advocacy,
- Health related issues.

These increase members ability to integrate and cope in the community. The clubhouses sponsor regularly scheduled social/recreational activities, both in the community and on site, that increase members ability to interact and develop skills that improve ability to function in the community.

Program Data

Clubhouse participant demographics are broken down by gender, ethnicity and geographic region.



Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
Clubhouse	450	450	450



Artwork by Sheila Dery - Born that Way

Positive Results

- Collectively up to **26** groups are run per clubhouse per week.
- Average daily attendance ranges from **20 to 44** members per day per clubhouse.
- Addition of five (**5**) Peer and Family Advocates in this reporting period with an additional Peer and Family Advocate being increased from part-time to full-time.
- A wellness component has been added which includes nutrition, exercise, and support for health related issues e.g. smoking cessation classes and partnership with 24 Hour Fitness to offer weekly fitness classes on site.
- Focused on community integration and awareness through the implementation of annual community service projects.
- Emphasis on partnership between county and contract operated clubhouses in order to broaden the peer support network.
- Identification and education on utilization of community resources to foster independent living.
- Through clubhouse participation, consumers are provided transportation assistance with the use of program vans and distribution of bus passes to ensure they can attend doctor, legal and program appointments and participation in community events.
- The Office of Consumer and Family Affairs is operated by a consumer and a family member with the long term goal of supporting, coordinating and advocating for system wide Recovery Model planning and implementation.
- Consumers are in charge of activities including running numerous groups, staffing the reception area, operating a clothes closet, cooking and engaging peers in recreational activities.

A-1: CLUBHOUSE EXPANSION PROGRAM

Making a Difference

G. worked as a security guard for a local company when in 2003 he was diagnosed with Paranoid Schizophrenia and later in 2007 with Bipolar 1. Shortly after receiving his first diagnosis, he resigned from his job which brought about extreme feelings of isolation. In trying to deal with his mental illness, G. soon found himself homeless. G.'s family contacted a local DBH walk-in clinic and community counseling. The clinic offered behavioral health services and G. quickly enrolled.

A clinical therapist with the counseling center introduced G. to a peer support clubhouse and referred him to Full Service Partnership (FSP) program. The clubhouse offered valuable support G. needed to assist in his recovery. He actively participated. While attending the clubhouse, G. flourished and became an elected board member, facilitator of the clubhouse performances (including improve comedy and relationship performances), and co-coordinator of the National Alliance on Mental Illness' (NAMI) annual events. His contributions were publicly recognized at the 2013 "Evening with the Stars" event hosted in part by NAMI and DBH where G. was awarded "Peer Advocate of the Year." Surprised and honored, G. said he accepted the award on behalf of a lot of people who do many great things at the clubhouse.

Challenges

The Clubhouse Expansion program has faced some of the same challenges other peer run programs throughout the state have faced. Challenges include:

- Stigma and discrimination.
- Access to transportation.
- Ongoing evaluation of clubhouse programs to identify challenges and/or issues that need to be addressed and measure consumer satisfaction with clubhouse operations.
- Navigating restrictive policies when hiring consumer employees.
- Ongoing and specialized training for consumer employees.

Solutions in Progress

- Ongoing staff and community trainings are being conducted surrounding anti-stigma initiatives.
- The Clubhouse Expansion program utilizes bus passes, community transportation agencies and clubhouse vans to address transportation challenges.
- There were **144** individuals who participated in focus groups throughout the County of San Bernardino. The groups discussed important and challenging topics and individuals shared their opinions largely without reservation. **89%** of those completing a comment form identified the program to be valued and a great place to be a member and belong. Improvements were also identified and a plan was put in place to work collaboratively with consumers and staff to address those needs.
- DBH Human Resources has worked extensively to ensure that consumers are able to gain employment through the county and navigate the hiring process.

In Their Own Words

- ⇒ *“The best thing about FSP’s and Pathways is that they are always there for us.”*
- ⇒ *“We have friends and family there.”*
- ⇒ *“We all need these clubhouses. And we need them for the people after us that need help.”*
- ⇒ *“Our re-hospitalization rate is very low for the clubhouse because we support each other.”*



A-1: CLUBHOUSE EXPANSION PROGRAM

County of San Bernardino Clubhouses

A Place to Be

805 E. Mt. View
Barstow, CA 92311
(760) 256-5026

TEAM House

201 W. Mill St.
San Bernardino, CA 92408
(909) 386-5000

Santa Fe Social Club

56020 Santa Fe Trail, Suite M
Yucca Valley, CA 92284
(760) 369-4057

Amazing Place *

2940 Inland Empire Blvd.
Ontario, CA 91764
(909) 579-8157

Our Place

721 Nevada Street, Suite 205
Redlands, CA 92373
(909) 557.2145

Serenity Clubhouse

12625 Hesperia Rd., Suite B
Victorville, CA 92392
(760) 955-6224

Central Valley FUN Clubhouse

1501 S. Riverside Ave.
Rialto, CA 92376
(909) 877-4887

Someplace to Go

32770 Old Woman Springs Rd, #B
Lucerne Valley, CA 92356
(760) 248-2327

Pathways to Recovery

850 E. Foothill Blvd.
Rialto, CA 92376
(909) 421-9248

** Amazing Place is moving to the above address effective June 2014.*



MENTAL HEALTH SERVICES ACT

A-2: Forensic Integrated Mental Health Services

MHSA INTEGRATED PLAN FISCAL YEARS 14/15-16/17

Service Goals/Outcome Measures

The Goals of Forensic Integrated Mental Health Services are:

- Reduce homelessness and increase and permanent housing.
- Increase access to treatment and services for co-occurring problems.
- Reduction in criminal involvement.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.

The objectives are:

A. Supervised Treatment After Release (STAR)

- Maintain seriously mentally ill individuals in the least restrictive environment possible, consistent with their personal and community safety.
- Divert defendants with mental illness into judicially supervised, community-based treatment.

B. Forensic Assertive Community Treatment (FACT) Program

- **Reduce recidivism** (jail and psychiatric hospitalization).
- **Increase public safety** through focusing on information choice and decision making.
- **Increase community tenure** through development of independent living skills and providing appropriate array of services and support.
- **Support persons in recovering their lives** and roles by rekindling hopes and dreams and assisting with reunifying them with their families.

C. Crisis Intervention Team (CIT) Program

- **Help** law enforcement officers enhance their understanding, judgment, competence, physical safety, and the safety of others when responding to situations involving those with a mental illness.
- **Improve** positive police and mental health system collaboration and communication.



County of San Bernardino - Department of Behavioral Health



Why Was Forensic Integrated Mental Health Services Created?

Forensic Assertive Community Treatment (FACT)

In 2007, in order to provide a variety of mental health treatment options to meet the needs of probationers with mental illness, San Bernardino County introduced the treatment program based on the well-researched Assertive Community Treatment (ACT) Model to complement their existing innovative programs. Since ACT programs are community based, individuals who have trouble keeping appointments at outpatient clinics are seen at their homes weekly or whenever necessary, including home visits by a psychiatrist for those who can't make it into the office. Forensic Assertive Community Treatment (FACT) is a full service partnership. A multi-disciplinary team consisting of mental health professionals, Probation, a Psychiatrist, and the Courts collectively provide counseling, 24/7 intensive case management, Psychiatric services, and housing, financial and educational assistance as well as employment services.

Supervised Treatment After Release (STAR)

Mental Health Courts began to be established throughout the United States pursuant to federal legislation and funding in the late 1990's. 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 has greatly expanded in the last decade, both nationally and at the local level.

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, with STAR clinical staff and case managers, Superior Court of San Bernardino County, Sheriff's Department, San Bernardino County Probation, Public Defender, District Attorney, Cedar House Rehabilitation, and various DBH Housing programs. Services are delivered as part of a voluntary Mental Health Court to assist clients in recovery through day rehabilitation, co-occurring services, psychiatric services, group and individual therapy, and intensive case management with financial and housing support.

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 and culturally competent interventions, the purpose of which is to bridge the gap between the culture of Law Enforcement and Mental Health.

Services

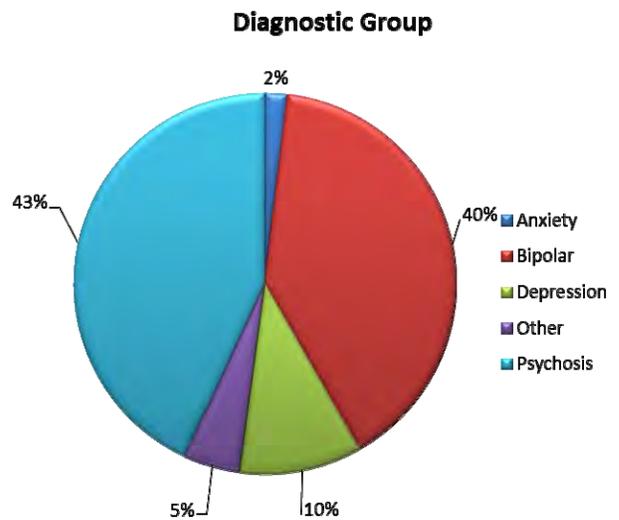
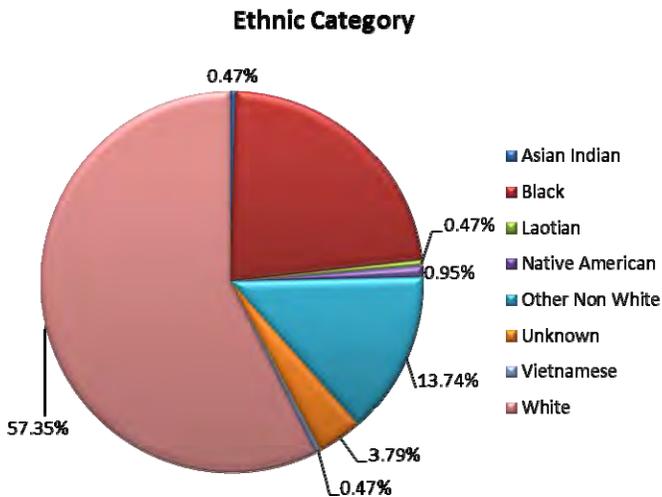
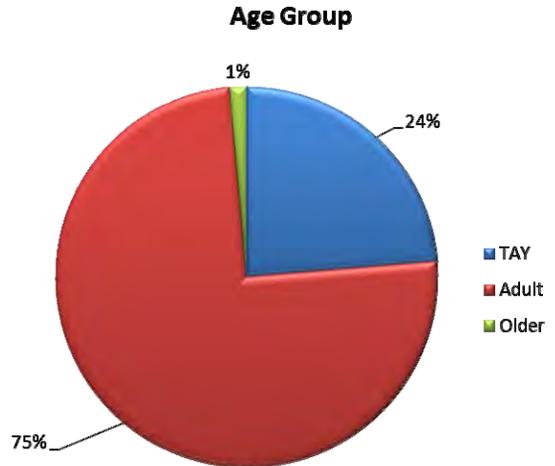
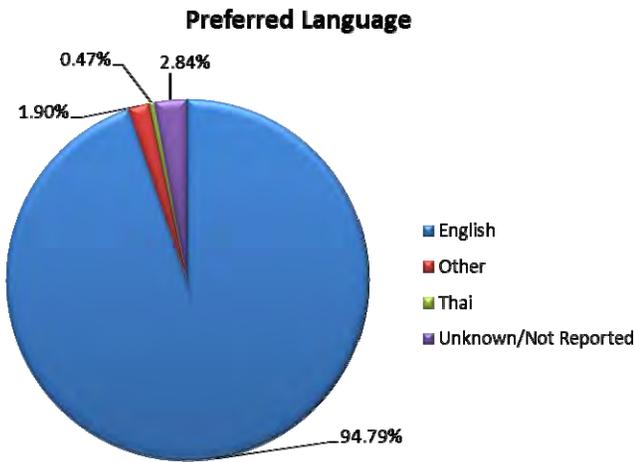
Services for **FACT** and **STAR** include but are not limited to:

- Mental Health and Alcohol and Drug Assessment and Treatment Planning.
- Medication Support.
- Intensive case management.
- Group and Individual counseling.

CIT consists of intensive training services for law enforcement partners.

Program Data

During Fiscal Year (FY) 2012/2013, Forensics demographics were as follows:



*40 (19%) of those represented, identified as being of **Hispanic Origin**.*

Projected Number to be Served

Program	FY 2014/15	FY 2015/16	FY 2016/17
FACT	50	50	50
STAR	250	250	250
Total	300	300	300

Positive Results

Since the start of the Forensic Integrated Mental Health Program has collectively served **1,662** individuals across the county with **664 in System Development** and **998 in Full Service Partnerships**.

The **FACT program** serves approximately 40-50 individuals per year and boasts that:

- Clients decreased their number of days spent in jail by **73%**.
- Clients have decreased by **80%** their number of hospital admissions.
- Since 7/1/2009, clients had an **85%** drop in homeless days.

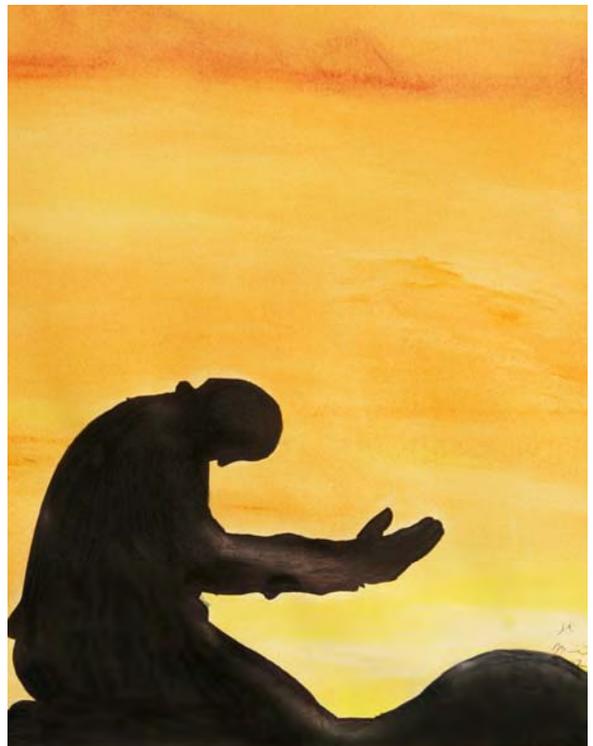
The **STAR program** continues to see success with clients moving from custody to active participation and completion of the program. The program has shown successes as evidenced below in the outcomes of clients. This is accomplished with direct supervision in cooperation with Probation, the Mental Health Treatment Team, the Drug and Alcohol Treatment Team, and the Mental Health Court.

In comparison to pre-enrollment levels, clients participating in the STAR program have shown:

- **67%** decrease per year in jail days.
- **74%** decrease per year in hospital days.
- Throughout participation in the program, (typically 1.5 to 2 years) homelessness for all participants decreases to **0%**, since the program facilitates or provides housing for all clients.
- In 2009, the STAR program received the Best Practices Award from California's Council on Mentally Ill Offenders.

CIT has been well received and demonstrated:

- Increased officer awareness of an ability to access appropriate community resources.
- Increased officer safety and safety of those in crisis.
- **90%** of those seen by CIT officers access mental health services.
- Time savings to patrol officers.
- Successful collaboration with Behavioral Health and police communities which has led to positive community relations as a whole.
- In 2013, **39 Site Coordinators** were trained.



Artwork by Marvin Ray Toms - Red Dawn

A - 2: FORENSIC INTEGRATED MENTAL HEALTH SERVICES



Making a Difference

FACT

D. is a 28 year-old motivated young man, who despite his past has leaped into his future without looking back. D. has been a member in the **FACT** program since 2010. He was able to complete his terms of probation in 2012. Soon after, he transitioned from sober living housing to independent housing. He then enrolled at San Bernardino Valley College in 2012 and received his certificate in Human Services with an emphasis in Drug & Alcohol Counseling in 2015. Since being in the program, D. has been able to maintain his sobriety, win several honors, awards, and accolades from peers, **FACT** treatment staff, and school. He is known in the program for being a leader among his peers and wants to one day help others, who took the path he did, to turn their lives around and live to their fullest potential.

STAR

S., a 37 year-old Caucasian male with serious history of mental illness and substance abuse with criminal charges was accepted in Victorville's Mental Health Court three years ago. S. attempted suicide when he was 18. A doctor told him he needed treatment but he could not afford counseling and medication. He had gone through a divorce and switched jobs **38** times. He accepted **STAR** as a condition of probation, was stabilized on medication, got stable housing and mental health treatment. He graduated **STAR** and completed Probation in 2013. S. returned to Tennessee obtained custody of his daughter; had his truck driving privilege reinstated and is in the process of getting married. "I don't know the last time I set out to do something and accomplished it," he said with a smile.

CIT

- Each new hired San Bernardino County Sheriff's Deputy must go through the **32**-Hour CIT Training as a requirement to being placed in their jail assignments to begin their career.
- New hired Deputies are immersed with mental health resources, education, engagement tactics, communication strategies, placement options, and community partnerships to assist them when in a situation that involves mental illness of an individual.
- A cultural shift within our County Law Enforcement leaders has been incrementally growing towards having focused resources and a higher appreciation for organizations that work with individuals and family members that have mental illness. This shift has allowed for across the board training for Site Coordinators, Captains, and Lieutenants to be trained on CIT protocol, reporting, and support for their personnel in the field.

A-2: FORENSIC INTEGRATED MENTAL HEALTH SERVICES

Challenges

Challenges continue to center largely on:

- **Homelessness and Appropriate Housing**
 - ◇ Maintaining a satisfactory broad resource base of accredited facilities.
 - ◇ Dealing with patient's conflicts centering on residential issues and changes.
- **Financial Assistance**
 - ◇ Obtaining SSI for those clients who qualify for it.
 - ◇ Dealing with the resistance in awarding benefits for those clients who have co-occurring conditions.
- **Employment**
 - ◇ For those who are able to work, dealing with stigmas in the community regarding those with criminal records.
 - ◇ Complications with occupational training.
- **Continuing Coordination with the Criminal Justice System**
 - ◇ Communication between law enforcement, probation, the courts and treatment facilities.
 - ◇ Training and attrition of law enforcement personnel.

Solutions in Progress

- Negotiating client housing has become a specialty for STAR case managers.
- The Mental Health Court (MHC) team has taken an active role in locating, and securing with the assistance of the mental health service, client appropriate, local area shelters that are stable and willing to be part of the treatment teams.
- Increase wellness activities for members and encourage the addition of wellness goals on treatment plans, such as developing a plan for exercise and addressing physical health issues by scheduling doctor appointments with primary care physicians.
- Also, develop a "Bicycle Scholarship: Incentive Program where members could receive financial assistance with purchasing bicycles.
- Increase promotion of employment as a recovery tool to members, either as a part or full time activity. Goal is to assist 3-5 members in developing and implementing an employment goal.
- Increase promotion of attending school, obtaining a General Educational Development (GED) certificate, or volunteer work as a recovery tool to members either as a part time or full time activity.
- Continue to assist clients with harm reduction behaviors that lead to recidivism, i.e. substance abuse, and criminal behaviors.
- Continue to find appropriate housing and provide financial assistance that will help the client in their recovery.
- Continue to locate employers that are willing to give clients an opportunity for employment.
- Both the CIT coordinator and the Program Manager II are now part of the internal Crisis Intervention Team Committee for the County of San Bernardino Sheriff's Department. The Sheriff's Department recognized the significance of CIT and integrated it into their basic academy. The basic academy is also the regional training site; **all law enforcement will have the training at the start of their careers.**

A-2: FORENSIC INTEGRATED MENTAL HEALTH SERVICES

In Their Own Words

A. STAR

STAR Program (Rancho Cucamonga, San Bernardino, Victorville, Barstow):

- ⇒ *"I get better when I follow program directions. When I do it my way it doesn't work and I get paranoid, start using, and go to jail again."*
- ⇒ *"I thought I was the only one. In the program I've found people who are like me, have some of the same experiences, and staff who care."*
- ⇒ *"I am learning better boundaries. I'm learning about my mental health symptoms and how to manage them. This makes me safer to myself and around other people."*

STAR Morongo Basin (Joshua Tree):

- ⇒ *"I don't know the last time I set out to do something and accomplished it."*
- ⇒ *"I am so grateful for the Joshua Tree Mental Health Court. It saved my life!"*
- ⇒ *"Thanks to Joshua Tree Mental Health Court I have my life back. I take my meds as prescribed and stay clean and sober. I feel good about myself."*

B. Forensic Assertive Community Treatment (FACT) Program

- ⇒ *"Telecare is a good place for me because it keeps me in a good sense of mind. It helps me to live again."*
- ⇒ *"I thank Telecare for filling me with life once again. Telecare saves. I can smile once again."*
- ⇒ *"Telecare is awesome due to all the help they are giving us and giving us a new life. I can call them morning, noon or night and they are always there; they are my family."*

C. Crisis Intervention Team (CIT) Program

- ⇒ *"I like the fact that the class also focused on the mental health issues that we as officers must deal with and giving us the resources on how to take care of ourselves and partners."*
- ⇒ *"I am thankful for the opportunity to engage openly with individuals with mental illness when they are not in crisis—my first chance to share and appreciate their personal stories."*
- ⇒ *"I never knew these resources existed. This course should be required for all law enforcement."*
- ⇒ *"As law enforcement we are exposed to so much. It's important we take care of our own mental health and I am glad this class provided resources for us too."*

Collaborative Partners

Thank you to all of our partners!

Alzheimer Association
Behavioral Health Commissioners
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 Sheriff Department
Department of Behavioral Health Clubhouse Members
Department of Behavioral Health Community Crisis Services
Department of Behavioral Health Peer & Family Advocates
Department of Probation
Inland Regional Center
Inland Valley Recovery Services
Institute for Public Strategies
Joshua Tree Department of Probation
Joshua Tree Superior Court
Loma Linda Veteran's Affairs Healthcare System
National Alliance on Mental Illness
Office of the District Attorney
Office of the Public Defender
Patton State Hospital
San Bernardino County Sheriff Department
San Bernardino County Superior Court
The Counseling Team International
Veteran's Center of Colton

Telecare San Bernardino FACT program would like to acknowledge the leadership in the Department of Behavioral Health for their support and guidance as well as for the collaboration with West Valley Detention Center, San Bernardino Superior Courts, and the treatment teams in the Mental Health Court.



MENTAL HEALTH SERVICES ACT

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

MHSA INTEGRATED PLAN

FISCAL YEARS 14/15-16/17

Service Goals/Outcome Measures

The Goals of Members Assertive Positive Solutions (MAPS)/Assertive Community Treatment (ACT) are:

- **Decrease psychiatric hospitalizations** for program consumers.
- **Reduce justice involvement** for program participants.
- **Increase access to housing.**

The Objectives of the program are:

- **Provide assertive case management and support**, 24/7 for those transitioning from locked facilities, including State Hospitals and Institutions for Medical Disease (IMD).
- **Provide intensive services** to **100** seriously and persistently mentally ill and those with co-occurring disorders.
- **Provide FSP services** to individuals from long term locked facilities.
- **Provide** a program that will place and work with those in placements (Board and Care, living with families, and in independent living) to maintain individual's recovery in the community.
- **Coordinate services** in partnership with families, probation, parole, providers of acute care and agencies that work with homeless mentally ill.
- **Include services** to support sober living, safe havens, transitional shelters, and permanent housing.
- **Preparation** for consumers to pursue further education, training, job search and employment.
- **Ensure** appropriate psychiatric services.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Members Assertive Positive Solutions (MAPS)/ Assertive Community Treatment (ACT) Created?

Historically, there have been a large number of consumers that were utilizing the emergency services and acute psychiatric hospitalization to meet their psychiatric needs. In addition, many mentally ill / co-occurring consumers were caught in the cycle of arrest and incarceration for minor crimes on a repeated basis. The Telecare ACT program was developed to provide intensive case management services 24/7 to maintain those with these issues in the community and provide a system of care to those ready to transition from a locked facility into a lower level of care. There are often minimal support systems for these individuals or continued family contacts. These consumers are often homeless or at risk of being homeless.

The need for the Assertive Community Treatment (ACT) program was developed because of the following:

- Increased number of homeless and severely and persistently mentally ill utilizing acute hospitalization as a main method of accessing treatment services.
- Increase in the number of homeless consumers not receiving treatment.
- Lack of transitional placements providing these intensive services for those being released from a locked facility (State hospital and Institutions for the Mentally Ill (IMD)).

Services

Services include:

- Mental health interventions,
- Assertive case management, and
- The full range of community-based services consistent with the Recovery Model.

Services are provided in partnership with families, Probation, private medical and psychiatric providers, and providers of acute care.

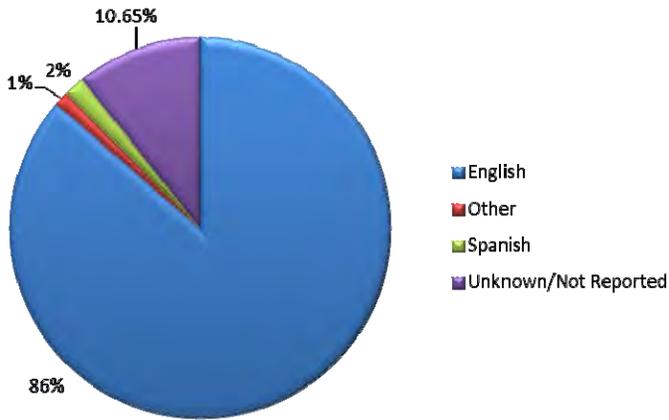
Services include education and employment preparation, training and support.

There is also support for sober living, safe havens, transitional shelter, single room occupancy and permanent housing, as appropriate. Case management services include substance abuse interventions and access to substance abuse services, including detoxification. Psychiatric services are provided by program staff. In addition, case managers provide support for transitional placements to provide intensive services for those being released from a locked facility (State hospital and Institutions for the Mentally Ill).

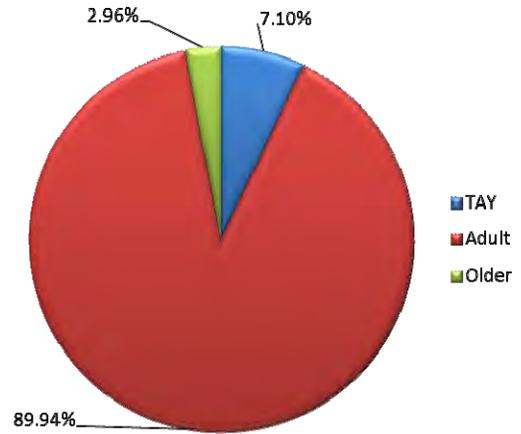
Program Data

During Fiscal Year (FY) 2012/2013, MAPS/ACT demographics were as follows:

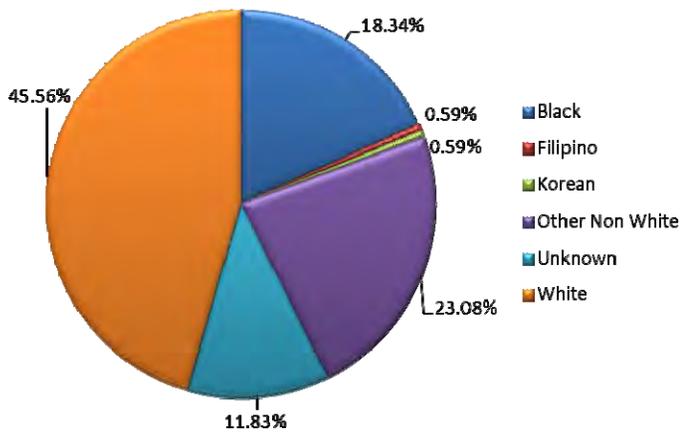
Preferred Language



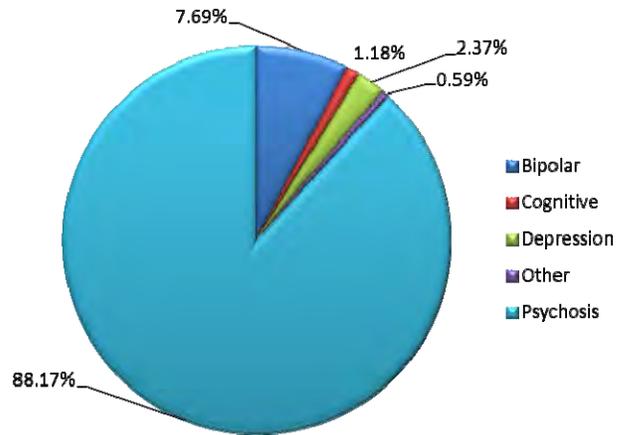
Age Group



Ethnic Category



Diagnostic Group



50 (30%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
MAPS/ACT	100	100	100
Total	100	100	100

Positive Results

- Intensive services for **100** individuals transitioning from long term locked facilities, including State Hospitals and Institutions for Medical Disease (IMD).
- Intensive services are provided 24/7 to maintain the mentally ill and those with co-occurring disorders in the community from long term locked facilities.
- Placement services for individuals transitioning from long term facilities.



Making a Difference

T. came to the ACT program while residing in an Institution for Mental Disease (IMD). His goal was to become more independent and to eventually have his own apartment. T. was discharged from the IMD to a board and care and showed difficulties following rules, anger management issues and substance abuse. The ACT team continued to work with him on his coping skills to decrease his anger and to increase his socialization skills with the support of the board and care and the ACT team, T. started a daily routine and started working on achieving his goals. He attended classes at the local adult school and utilized the public transportation system to become more independent in the community. After the member terminated from conservatorship, he moved to an apartment and is now working with the ACT team on his budget skills. He is trying to go back to school to receive his GED and has improvement in managing his mental health related issues.

A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)

Challenges

- The effects of stigma on those who need to utilize mental health services.
- Consumers often show signs of reluctance and are uncomfortable going back out into the community.
- The presence of substance abuse along with mental illness.
- The absence of enough community placements (board and care facilities) to refer the consumers coming out of the locked facilities.



Artwork by Sheila Dery

Solutions in Progress

- Coordination with state hospitals and IMD's to ensure the ACT program has sufficient information to place individuals from locked facilities in successful placements.
- Increased specialized training for staff of the Telecare ACT program to work with the severely mentally ill and those with co-occurring disorders.
- Increased hiring of master level staff to effectively provide the treatment intervention services.
- Education of consumers regarding their program and services to assist them as they transition back into the community.
- Coordination with the housing programs to help consumers be able to have a stable secure living situation.

A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)

In Their Own Words

- ⇒ *"I'm grateful for all that the ACT team has done for me."*
- ⇒ *"ACT is the reason why I'm stable in the community."*
- ⇒ *"ACT is there for me when I don't feel good."*



Collaborative Partners

Department of Behavioral Health

Telecare

State Hospital and Institution for Mental Disease Gatekeeping Team

Arrowhead Regional Medical Center

Public Guardians Office

Conservatorship Investigation Unit

State Hospital and Institution for Mental Disease Programs and Staff

A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)



MENTAL HEALTH SERVICES ACT

Community Crisis Services A-4: Crisis Walk-in Centers and A-6:Community Crisis Response Team

MHSA INTEGRATED PLAN FISCAL YEARS 14/15-16/17

Service Goals/Outcome Measures

The overall goal for Crisis Service programs are to:

- **Decrease psychiatric hospitalizations** for program consumers.

The objectives of Community Crisis Services are:

- **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.
- **Increase** consumer access to services.
- **Provide** Crisis Intervention services in the community in response to traumatic events utilizing the Trauma Resiliency Model (TRM).



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Were Crisis Walk-in Centers and Community Crisis Response Teams Created?

- Outlying areas of the largest geographic county in the contiguous United States had no alternatives for mental health crisis other than hospital emergency departments or calls to law enforcement to place a person in crisis on a psychiatric hold.
- Law Enforcement personnel would spend 4 - 8 hours on psychiatric emergencies, delaying an officer's return to the community due to transporting mental health consumers to a hospital, up to 200 miles away.
- Hospitalization occurred in psychiatric hospitals miles from family and support systems.
- Community members from all walks of life were ending up in an emergency room, because they didn't know where else to go, resulting in hospital emergency department overload.
- A person experiencing a psychiatric emergency was often in an inappropriate service location, such as, emergency rooms, law enforcement agencies, correctional facilities and homeless shelters.

Services

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. Consumers will be screened for appropriateness of service and will either be provided referrals or admitted in to CWIC for additional assessment.

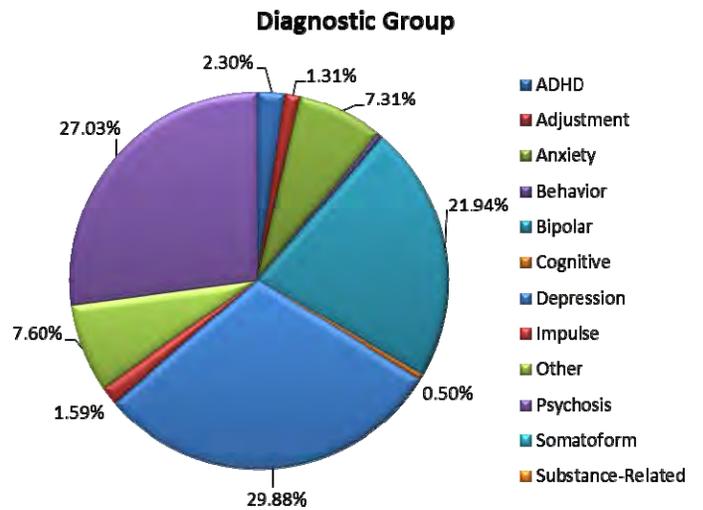
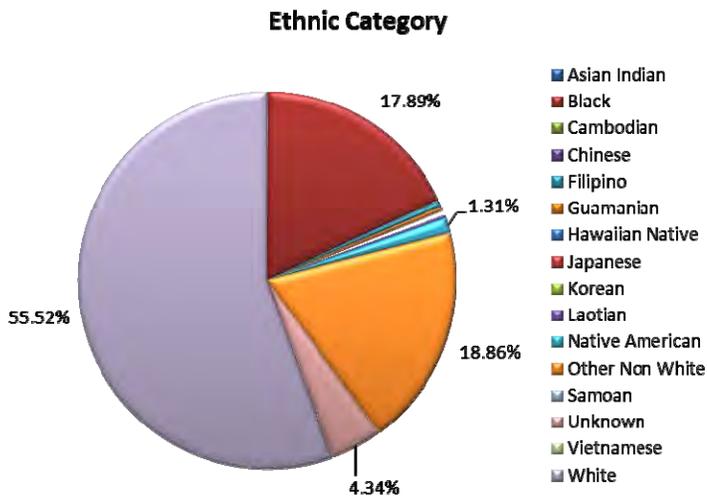
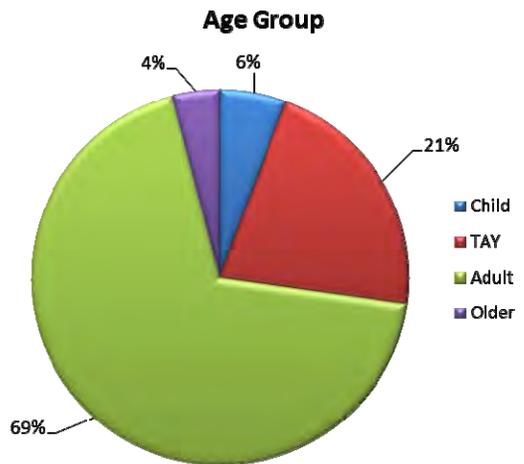
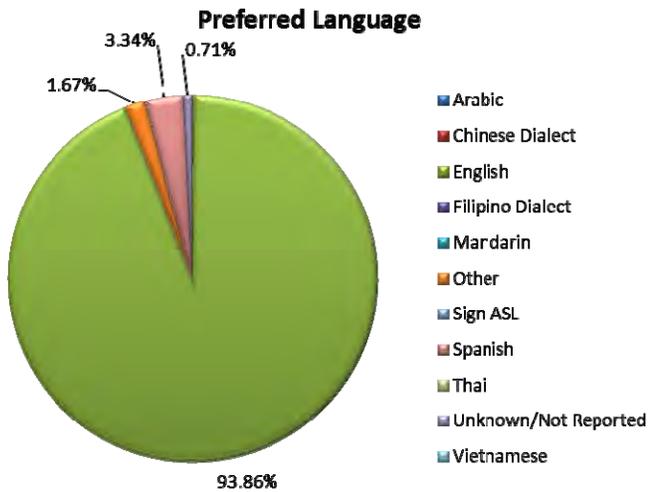
The Community Crisis Response Team (CCRT) utilizes specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, medication referrals, and linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations. CCRT also provides follow-up services to Medi-Cal eligible children being discharged from psychiatric facilities, including linking those children and their families to on-going outpatient mental health services and other community resources.

CCRT's outreach and engagement efforts included collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations. The CCRT West Valley team works closely with the DBH Integrated Health clinic. Also, CCRT's Peer & Family Advocates have started family support groups in the community to help build family and community resiliency.

Program Data

A-4: CWIC

During Fiscal Year (FY) 2012/2013, CWIC demographics were as follows:



1,016 (27%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
A-4 CWIC	8,700	8,700	8,700
A-5 CCRT	7,800	7,800	7,800
Total	16,500	16,500	16,500

Services (continued)

CCRT crisis services staff also participate in the Crisis Intervention Training (CIT) program by the DBH-Forensics unit in conjunction with the San Bernardino County Sheriff's Department. The CIT program is a 32 hour mental health course presented to law enforcement agencies to assist their officers in making appropriate choices in the field when responding to critical mental health incidents. This training is then reinforced in the field when working with CCRT staff on crisis calls.

Crisis Walk-In Clinics have been integral to the development of a Crisis System of Care (SOC) serving San Bernardino County 24 hours a day, 7 days a week. The Crisis Walk- In Centers (CWIC) bring services to the community that were not otherwise available prior to MHSA. The CWICs allow the consumer to stay in their community and provides the opportunity to involve caregivers and families in the problem solving. Remote areas of the county had no local options for emergency mental health services prior to the CWICs.

Positive Results

Community Crisis Services (CCS) has **increased availability of resources and access to services** for mentally ill community members in crisis. By providing these services individuals are helped in community settings with an appropriate level of care, thus avoiding unnecessary hospitalization. CCS has also increased collaboration among law enforcement, Department of Aging and Adult Services, Children and Family Services, and hospital emergency departments.

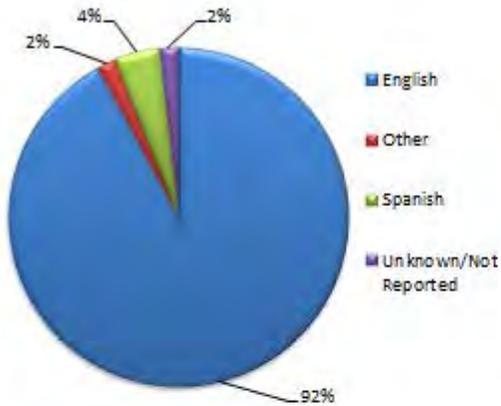
- The CCRT receives over **7,000** calls per year. Approximately **60%** of the calls received are crisis calls. Of those crisis calls, nearly **50%** of the clients were diverted from unnecessary hospitalization.
- The positive outcomes CCRT and CWIC achieved by reducing inappropriate hospitalizations, directly affects hospitalization costs in our communities. For instance, in Fiscal Year (FY) 2012/2013, approximately **11,900** individuals were diverted from hospitalization and the average daily bed rate is **\$625**.

Program Data

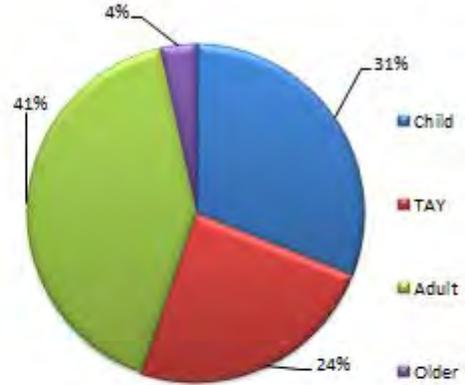
A-6: CCRT

During Fiscal Year (FY) 2012/2013, CCRT demographics were as follows:

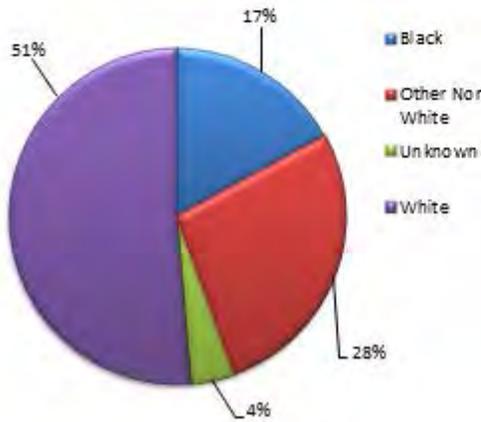
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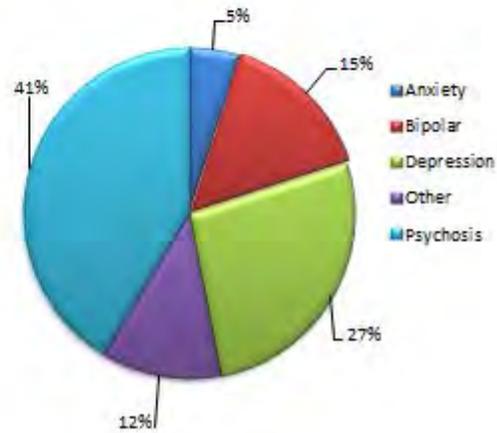
Age Group



Ethnic Category



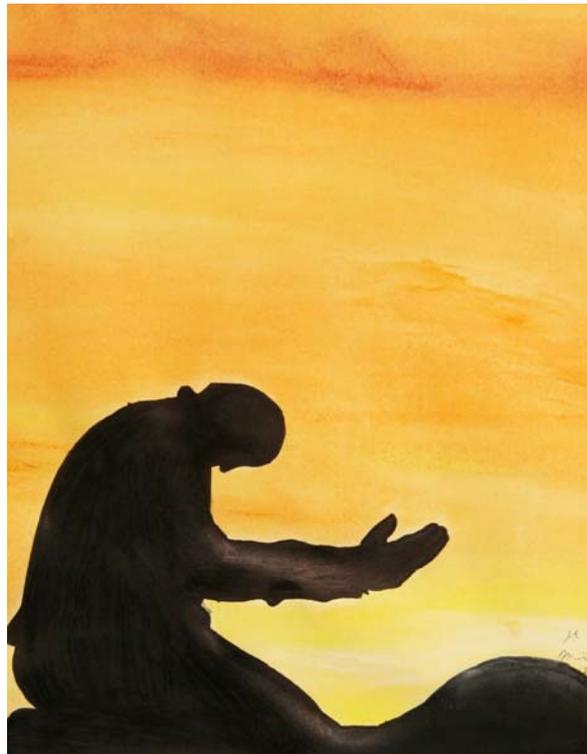
Diagnostic Group



994 (34%) of those represented, identified as being of **Hispanic Origin**.

Making a Difference

CCRT staff members responded out to a call at 1:00 AM from law enforcement regarding a female teen that was a run away and had a history of being self injurious. She did not meet criteria for hospitalization and the team went to her home and sat in the living room at 2:00 AM doing a family therapy session with the girl and her parents about the concerns that were being presented. The family had been leery of counseling but after the communication during the session, they decided to let the team help them get an appointment for outpatient counseling. They felt they had increased communication with their daughter and understood what she was going through. They followed up at a DBH clinic and stated that they were grateful for the CCRT intervention.



Artwork by
Marvin Ray Toms

Challenges

CCRT has experienced significant staffing shortages, necessitating extra shifts to continue to provide 24/7 coverage. The teams face challenges with the County of San Bernardino's large geographical size, which can make for longer response times when responding to calls. The desert region lacks psychiatric inpatient services, which necessitates long distance travel and staff time to bring consumers to psychiatric hospitals. The increased need for mental health services combined with the decreased commercial health coverage and services has led to an increase in acute psychiatric emergencies.

Solutions in Progress

CCRT are in the process of hiring new staff with the goal of maintaining fully staffed teams and easing the work load for existing staff.

CCRT East Valley is currently assisting the Big Bear Sheriff's Department during daytime hours with transporting clients to emergency services.

CCRT staff in the High Desert region work closely with Law Enforcement to coordinate transportation of consumers to appropriate services in a timely manner. This collaboration works well for both agencies and most importantly for the consumers served.

CCRT provides outreach to schools, Police/Sheriff Briefings, Public Health and Department of Family Services, Job Corps and many other entities to collaborate and build community partnerships.



In Their Own Words

- ⇒ A minor female runaway said, *"I really appreciate what you guys did for me, you are kind and patient. I didn't think anyone would want to help me get home,"* regarding CCRT services that assisted at the San Bernardino Police Department.
- ⇒ The family of an adult woman living with her parents stated, *"We didn't know there were services like this, we were worried she would be arrested and go to jail. Thank you so much, she is taking her medication now and we are very happy,"* when assisted by CCRT in obtaining her necessary medications.

Collaborative Partners

Community Crisis Services wishes to thank our partners!!

CCRT and CWIC work closely with many community partners, including law enforcement, schools, other DBH programs and clinics, hospital emergency departments, Department of Aging and Adult Services, Department of Children and Family Services, Probation, Code Enforcement, community-based organizations, and individual community members and their families.



COMMUNITY CRISIS SERVICES A-4: CRISIS WALK-IN CENTERS AND A-6: COMMUNITY CRISIS RESPONSE TEAM



MENTAL HEALTH
SERVICES ACT

A-5: Psychiatric Triage Diversion Program

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 - 1 7

The overall goal for the Psychiatric Triage Diversion program is to:

- **Decrease psychiatric hospitalizations** for program consumers.

The objectives of Psychiatric Triage Program Diversion are:

- **Screen and assess** individuals presenting to Arrowhead Regional Medical Center (ARMC) Psychiatric Triage to determine reason for Emergency Room visit.
- **Redirect clients** who need treatment to community-based services that appropriately meet their needs.
- **Help prevent** unnecessary and/or inappropriate inpatient hospitalizations.
- **Provide** crisis intervention services.
- **Provide** case management services, community-based placements, advocacy services, linkage to treatment options, education and assistance with transportation services for community members.



County of San Bernardino - Department of Behavioral Health



Why Was Psychiatric Triage Diversion Program Created?

The Psychiatric Triage Diversion Program (Diversion Team) was created to address and minimize inappropriate and/or unnecessary admissions to the inpatient unit as well as provide a service option for the needs of individuals **who do not require inpatient treatment**.

Approximately **40%** of individuals presenting to Arrowhead Regional Medical Center (ARMC) Psychiatric Triage Unit were in need of other services other than inpatient psychiatric treatment. These needs included, but are not limited to:

- Prescription refills.
- Housing assistance.
- Substance abuse assistance.
- Food assistance.
- Domestic violence issues.
- Social crisis.
- Health care services.
- Information regarding the availability of outpatient psychiatric care.



Services

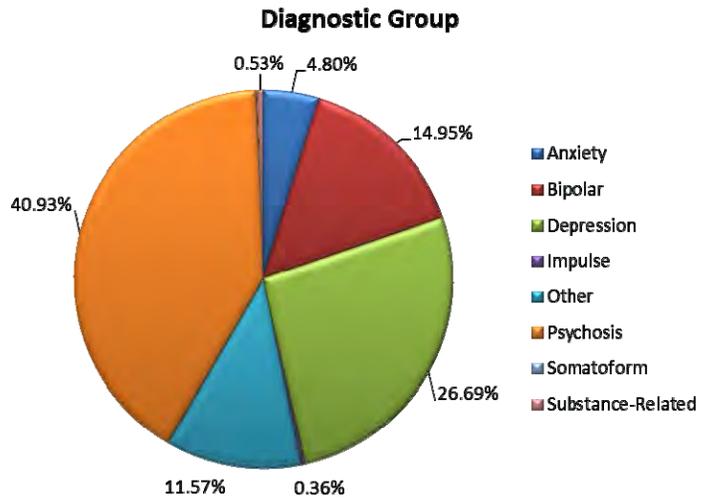
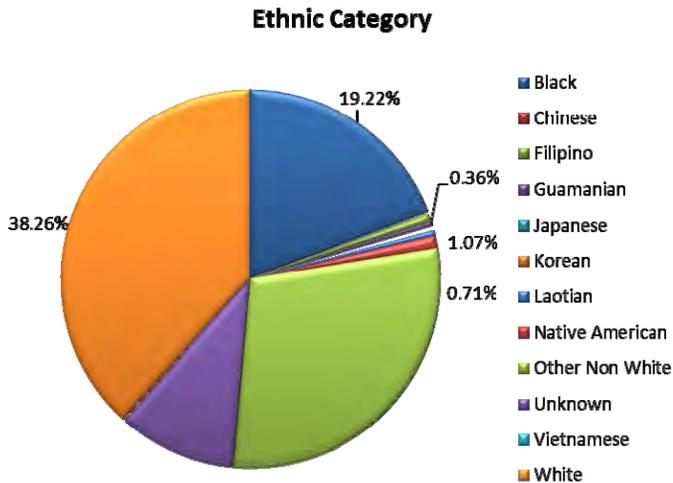
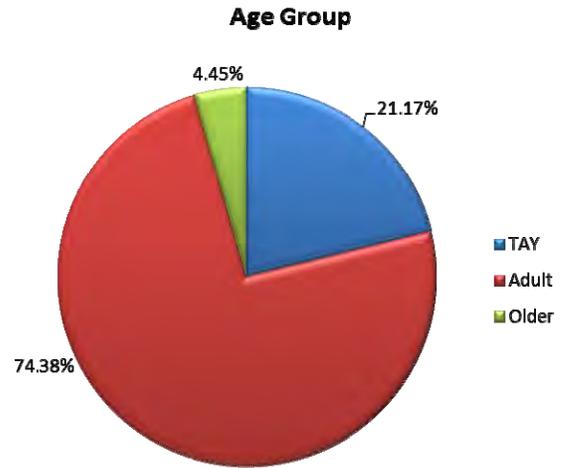
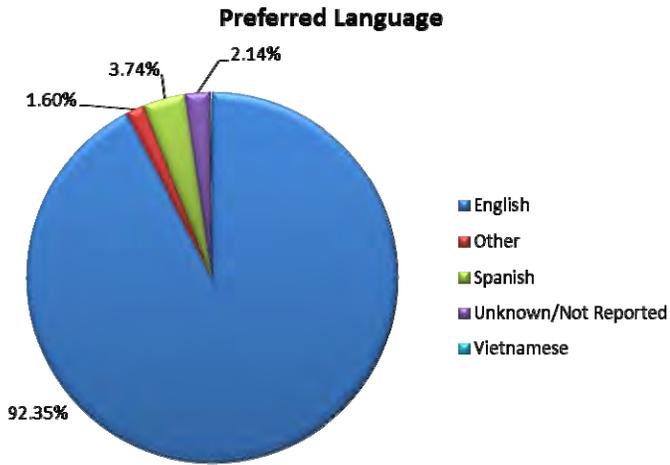
According to DBH Research and Evaluation, since the inception of the program, nearly **20,000** people have been served through the program. The Triage Diversion Unit is located at Arrowhead Regional Medical Center (ARMC). Services provided include:

- Screening and assessment.
- Crisis intervention.
- Linkage and referral.
- Placement.
- Transportation.
- Advocacy.
- Mental health education.
- Collateral contacts.
- Discharge planning.
- Conflict resolution between clients and family/caretakers.
- Consultation with admitting treatment team, including psychiatrists, nurses, and administration.

A-5: PSYCHIATRIC TRIAGE DIVERSION PROGRAM

Program Data

During Fiscal Years (FY) 2012/13, Psychiatric Triage demographics were as follows:



211 (38%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
Psychiatric Triage	3,000	3,000	3,000
Total	3,000	3,000	3,000

Positive Results

The Diversion unit was started with a target number of approximately **900** clients per year or **75** individuals per month.

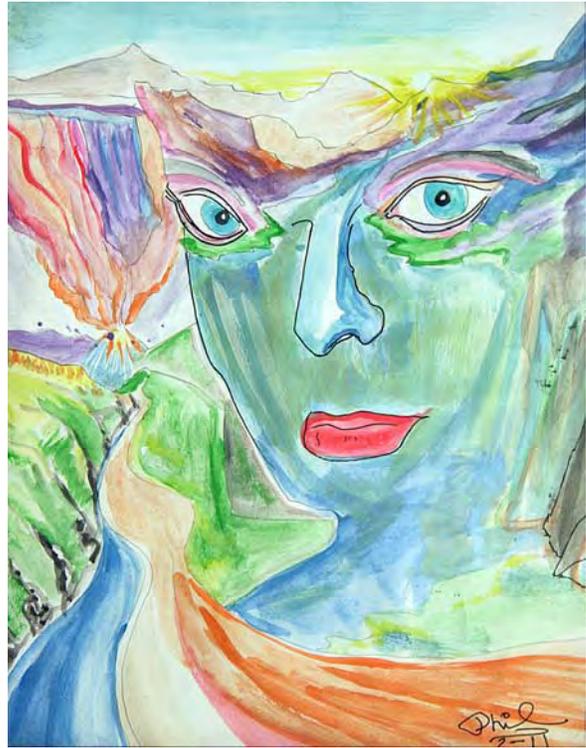
Currently, the program has seen as many as **375 clients a month**.

During Fiscal Year 2012/13, a total of **3,459** clients were served by the diversion Team.

An average of **90% of these clients (3,127) were successfully diverted to appropriate outpatient or community based services**. Reducing the number of clients on the ARMC Triage unit assists in providing a safer environment for both the community and staff and better health care for our community members who may need psychiatric services.

In addition:

- Approximately **45%** were uninsured.
- **8.9%** were recently incarcerated.
- **47.4%** had co-occurring disorders.
- **25.2%** were homeless.



Artwork by Phil Crisantiello



Artwork by Sheila Dery

A-5: PSYCHIATRIC TRIAGE DIVERSION PROGRAM

Making a Difference

M. came to ARMC Psychiatric Triage voluntarily requesting assistance for homelessness for several months. She did not require hospitalization for psychiatric reasons. She was extremely fearful about living on the street because of several incidents that had occurred, threatening her safety. The Psychiatric Triage Diversion clinician worked throughout the entire day to locate appropriate housing. She made arrangements for food for the client throughout the day and found suitable clothing for her, as she had only clothing she had was inappropriate for the weather and she had no shoes. After securing housing, the clinician made arrangements for outpatient psychiatric care for the client and the DBH transportation unit provided safe transport to her new home. An unnecessary hospitalization was avoided and the client's real needs were met in an appropriate and safe manner.

Challenges

The Triage Diversion Unit initially experienced an unexpected demand for services due to a number of community circumstances.

More of a goal rather than a challenge was the need to form a strong collaborative team with the Arrowhead Regional medical Center (ARMC) Triage staff. This new concept of blending interagency staff required an open mindedness and flexibility on the part of staff members from both agencies.

Solutions in Progress

In order to provide for the volume of services, additional staff were added to the Diversion Team. Flexible scheduling was instituted to allow for service delivery 7 days a week, 16 hours a day. This type scheduling has allowed for the inclusion of staff, interns and graduate students who require flexibility in scheduling and added critical resources to the Diversion Team. Their increased education and knowledge has strengthened the Diversion Team.

The Diversion Unit continues to consistently provide high quality services to our clients and agency partners. Outreach efforts to our fee-for-service hospital system has resulted in collaboration between the hospital staff and the Diversion Unit many times during the past year. This collaboration has allowed for a more comprehensive outpatient treatment plan for our clients, avoiding unnecessary and/or inappropriate hospitalizations. The Diversion Unit will continue to strengthen these interagency relationships in order to assist in building a comprehensive continuum of care for our clients.

In Their Own Words

- ⇒ *“We know that when our clients receive services from your program that they will be the appropriate services and their needs will be met in a way that really helps.”*
- ⇒ *“Thank you for helping me. I could not live another day on the street. I don’t know what would have happened to me. God bless you.”*



Collaborative Partners

The primary partnering program is Arrowhead Regional Medical Center (ARMC). The Diversion Unit functions within the Behavioral Health Unit. ARMC’s support and partnership has forged a collaborative team approach to caring for our clients. This partnership has been essential to the success of the Diversion Program.

ARMC’s Behavioral Health Hospital Administrator has been instrumental in strengthening the team approach between the two agencies. His support and leadership has fostered many positive outcomes through interagency taskforces, work groups, and interdisciplinary team meetings.

A-5: PSYCHIATRIC TRIAGE DIVERSION PROGRAM



MENTAL HEALTH
SERVICES ACT

A-7: Homeless Intensive Case Management and Outreach

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

Service Goals/Outcome Measures

The overall goals for the Homeless Intensive Case Management (HICMO) Services program are:

- Decrease psychiatric hospitalizations for program consumers.
- Reduce Homelessness of consumers.

The objectives of the program are:

- Provide Full Service Partnership (FSP) services of intensive case management to the severely and persistently mentally ill and those with co-occurring disorders who may be homeless or at risk of being homeless.
- Reduce the risk of becoming homelessness, hospitalized or incarcerated.
- Make available temporary housing, including emergency homeless shelter beds for these individuals in a home like environment.
- Provide ongoing housing and placement services such as referral and placement in permanent housing in the community.
- Engage in outreach activities to identify homeless individuals throughout San Bernardino County including natural gathering places, and encampments.
- Provide outreach to the underserved areas of the county.
- Develop a system of care that increases the access of Behavioral Health services for the unserved and underserved homeless in the county.
- Provide case management and support services for employment preparation.
- Assist individuals who are homeless or at risk of being homeless to receive substance abuse services to help them deal with their co-occurring issues.
- Lastly, collaborates with the Housing & Employment Program.



County of San Bernardino - Department of Behavioral Health



Why Was Homeless Intensive Case Management and

The 2013 County data on the number of homeless individuals indicate there are approximately **2,321** homeless persons in the County of San Bernardino. In addition, it indicates that the portion of mentally ill homeless adults was **21%**. This population of mentally ill homeless and those with co-occurring disorders are unserved or underserved often without linkages to medical, psychiatric, mental health and other community resources. They are at high risk of repeated psychiatric inpatient hospitalizations and incarcerations by law enforcement and the courts, and continued homelessness.

In an effort to address these issues the County of San Bernardino Department of Behavioral Health developed the Homeless Intensive Case Management and Outreach Program to provide outreach services, case management services, emergency shelter beds and supportive services for those who participate in employment preparation, and participates in the Housing and Employment Program services for those at-risk of homelessness. By identifying mentally ill individuals who are homeless or on the verge of being homeless and working with them to access services, the Homeless Program aims to reduce the number of mentally ill homeless in the county by preventing vulnerable individuals from becoming homeless; in collaboration with the Housing & Employment Program.

Program Overview

The Homeless Intensive Case Management and Outreach program is comprised of two focus areas: **Intensive Outreach and Case Management**. A new area of partnership with HICCMO is the **Housing & Employment Program** that provides referrals, case management services, and permanent supportive housing and employment related services.

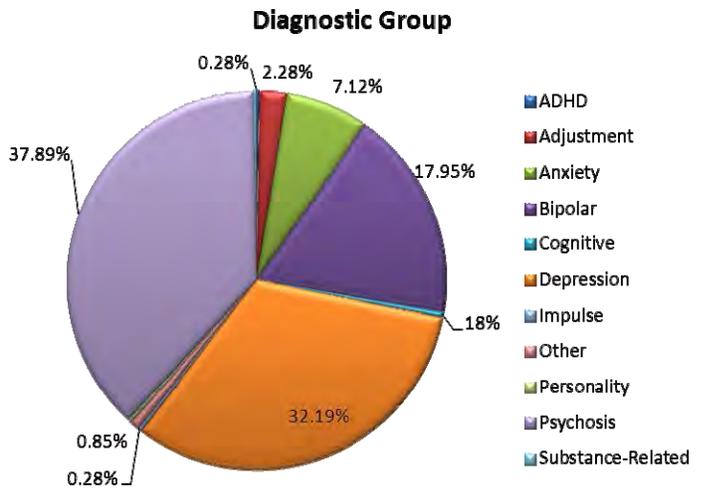
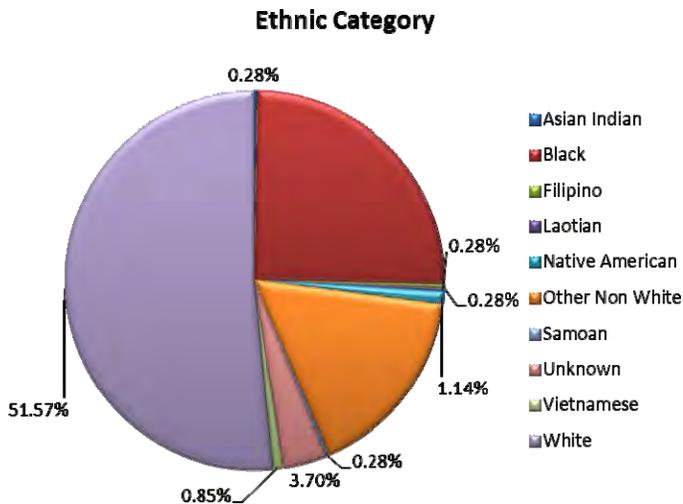
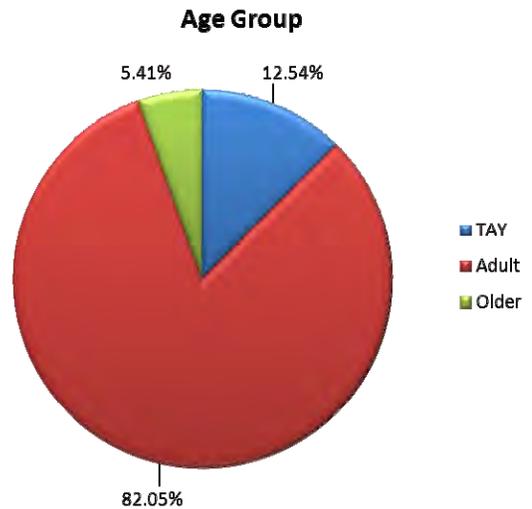
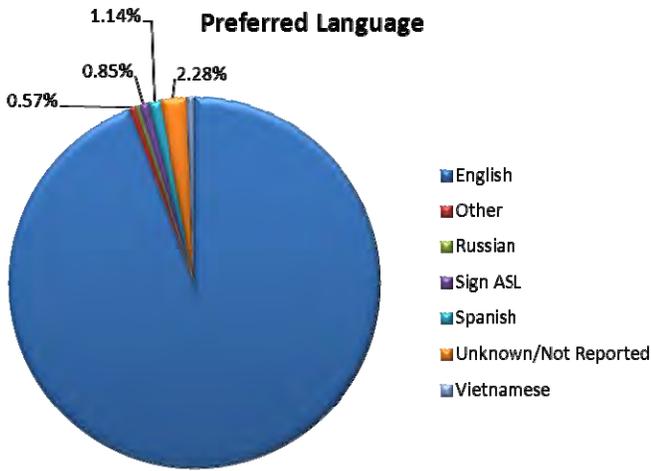
As a support for this program, and the entire system of care, the Housing & Employment Program provides assistance in obtaining educational and job related skills and ongoing support for consumers placed in housing. Furthermore, it assists consumers in establishing and maintaining a stable residency.

Consumers within the Housing and Employment Program have several choices to access housing: project-based housing consumers receive housing up to ten years in comparison to the tenant based housing, which is five years. Participants receive supportive services provided by MSHA programs, DBH's traditional Outpatient Clinics and subsidized rental assistance through the collaboration with the Housing Authority.

Services include housing and employment assistance, alcohol and drug services, annual assessments, placement, case management, medication, employment services, child care services, and transportation. Additional case management services assist with identifying and establishing consumer resources, assisting in employment services and establishing consumer funds for related purchases.

Program Data

During Fiscal Year (FY) 2012/13, HICMOS demographics were as follows:



69 (20%) of those represented, identified as being of *Hispanic Origin*.

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
Homeless Intensive Case Management	800	800	800
Housing and Employment Services	400	400	400
Total	1200	1200	1200

Services

MHSA funding has provided the opportunity for the County of San Bernardino Department of Behavioral Health to increase its outreach efforts under the guidance of the Housing & Employment Program to the mentally ill and chronically homeless population within all areas of San Bernardino County in support of the objective of assisting consumers in establishing and maintaining stable housing. The program provides a continuum of support related to housing including outreach, intensive case management services, identification and linkage to necessary supports, emergency shelter beds, and linkage to and establishment of permanent supportive housing.

The program includes Housing & Employment Program assistance as ongoing support for consumers placed in housing. Consumers can receive supportive services via other MHSA programs, DBH's traditional Outpatient Clinics and subsidized rental assistance through the Housing Authority. Services include alcohol and drug services, annual assessments, placement, case management, medication, employment services, child care services, and transportation. Case management services assist with identifying and establishing consumer resources, assisting in employment services and establishing consumer funds for related purchases. The HICMO is a collaborative outreach project which has been able to reach areas of need and provide services where the homeless individual is located.

Crisis evaluation and intervention services begin in the field, and has also been able to forge a strong collaborative effort with the San Bernardino County Sheriff's Department by having a clinical outreach team working in the field with Sheriff Deputies. This collaborative allows outreach into parks, river beds, and mountain areas where the chronically homeless have created encampments. The Outreach Teams have also been able to make referrals to the Housing & Employment Program who has placed many of these identified persons into permanent housing through a collaborative relationship with the Housing Authority of San Bernardino County and link them to behavioral health services in order to meet their mental health needs.



This approach directly ties into the Housing & Employment Program's **Master Leasing Program**. This is a six month, **Homeless Emergency Shelter** program in which "at risk of homeless" (not actually homeless) consumers can gain access to temporary emergency housing services. The program is for those who are enrolled in a Department's Full Service Partnership (FSP). The emergency shelter is the client's private selected apartment and the emergency shelter staff are the Full Service Partnership staff.

This has significantly changed the opportunity for FSP consumers to gain access to Housing and Urban Development's (HUD) **Shelter Plus Care** long term permanent and supportive housing. Shelter Plus Care housing is for solely homeless people who live on the streets or come from homeless emergency shelters. Since the Master Leasing is a homeless emergency shelter, after six months, the participants are qualified and able to transition to HUD's Shelter Plus Care program. The consumers stay in their previously selected residency and simply transfer into Shelter Plus Care long term housing. The result is that this MHSA housing allows for a smooth transition into Shelter Plus Care long term supportive housing.

A - 7 : HOMELESS INTENSIVE CASE MANAGEMENT AND OUTREACH SERVICES

Positive Results

Housing and Employment

- **97%** of Housing and Employment clients have maintained permanent housing.
- **72%** actively participate in Housing and Employment case management services.
- **13%** maintain regular employment.
- **12%** attend school.

Intensive Case Management

- **25%** of the homeless **Full Service Partners** obtained and sustained permanent housing.
- **90%** did not have repeated emergency hospital services.
- **10%** obtained and maintain regular employment.



Making a Difference

As a result of utilizing these innovative approaches to outreach services, our Outreach Team came into contact with a woman that was living in a crisis shelter. She reported that she had lost all hope and was just waiting to die. She was no longer able to maintain her doctor appointments and had not taken her medication for some time. Our Outreach Team was able to link her to crisis stabilization services, and connected her to Mesa Outpatient Clinic for ongoing mental health services. The Outreach Team invested in her and took her to many of her appointments. Our Outreach Team was successful in accessing permanent housing for this client and was able to help her find an apartment and get her on her way to being independent once again. This client is now hopeful for her future and actively participates in treatment and enrichment activities, through the dedication of our Outreach Team.

Challenges

- Engaging the homeless mentally ill to trust the system and be open to getting services.
- Overcoming the stigma of having a mental illness.
- Providing on-going appropriate housing for homeless mentally ill following a stay in the homeless shelter.
- Endeavoring to meet the medical needs of the homeless.

Solutions

- Enhanced coordination and collaboration with the County of San Bernardino's Sherriff's Department in outreach and engagement activities.
- Exploring new placement and housing opportunities including DBH subsidized housing.
- Expanding outreach services to all communities in the county to provide services or shelter.
- Collaborating and coordinating services with other county and community agencies serving the homeless such as veteran's organizations.

In Their Own Words

- ⇒ *"There is so much to say about being FSP. It's everything. The people and case managers work with me to help me attain my goals."*
- ⇒ *"I do not know where my life would be for me and my five children if not for the Outreach Team."*
- ⇒ *"I feel so much better now that I have the help and support of the Outreach Team."*

Collaborative Partners

County of San Bernardino Sherriff's Department

County of San Bernardino Housing Authority

California Housing Finance Agency

Public Guardian / Department of Aging and Adult Services

San Bernardino County Department of Public Health

Federal Housing and Urban Development

Arrowhead Regional Medical Center



MENTAL HEALTH
SERVICES ACT

A-8: Big Bear Full Service Partnership (FSP)

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

The Goals of the Big Bear Full Service Partnership are:

- **Reduction** in psychiatric hospitalizations.

The objectives of the program are:

- **Provide psychiatry** services.
- **Provide therapy** services.
- **Provide dual diagnosis** services.
- **Provide transportation** access.
- **Provide crisis management** to prevent hospitalizations.
- **Facilitate client qualification** for other benefits programs.
- **Compile** and publish a local information brochure and **resource guide** to help area residents connect with local services.



County of San Bernardino - Department of Behavioral Health



Why Was The Big Bear Full Service Partnership FSP Created?

Big Bear Valley is a geographically isolated area in the San Bernardino Mountains with very few mental health services. Those who do not qualify for government assistance and who are unable to afford medical insurance, or pay out of pocket for services, typically go unserved. Access to services is even more severely limited in the winter due to snow and poor driving conditions. The nearest accessible mental health services are 40 miles away. In addition, with the poor economy, access to services is further limited due to lack of funds for transportation.

As a result, the Big Bear Mental Health Alliance (consumers, family and community members, and community and faith based organizations etc.) came together in 2007 to address mental health issues in the community. The Alliance completed a comprehensive community needs survey, and the A-8 program was created based on prioritization of the identified needs.

Program Overview

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 Partnership began in May 2009, to help a traditionally underserved area. The Big Bear Lake area has a population of **20,000** which grows to **100,000** in peak holiday times. Access to services is severely limited in the winter due to snow and poor driving conditions. The nearest accessible mental health services are 40 miles away. The Big Bear Full Service Partnership allows for consumers in this geographic area access to a continuum of needed mental health services. Since the inception of the program, nearly **839** individuals have been served through the program.

Services

Services Provided include:

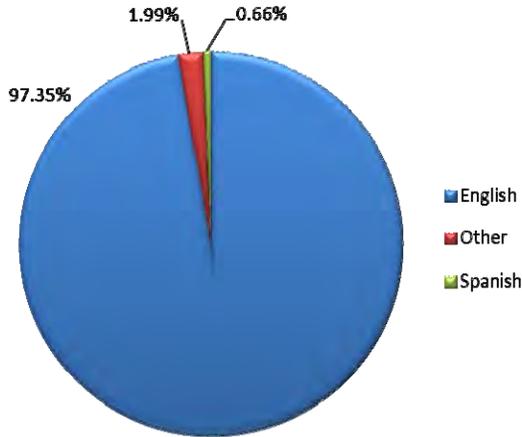
- Case management.
- Linkage to community resources.
- Crisis response services.
- Psychotherapy.
- Medication services.

A - 8 : B I G B E A R F U L L S E R V I C E P A R T N E R S H I P (F S P)

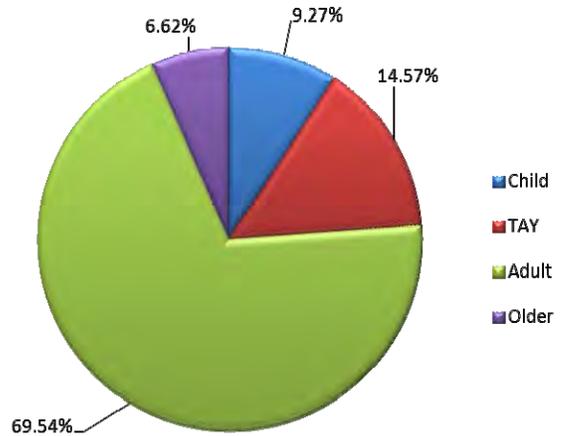
Program Data

In Fiscal Year 2012/13, Big Bear FSP demographics were as follows:

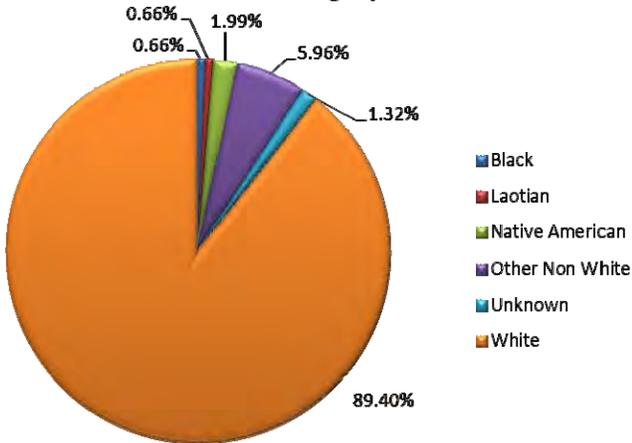
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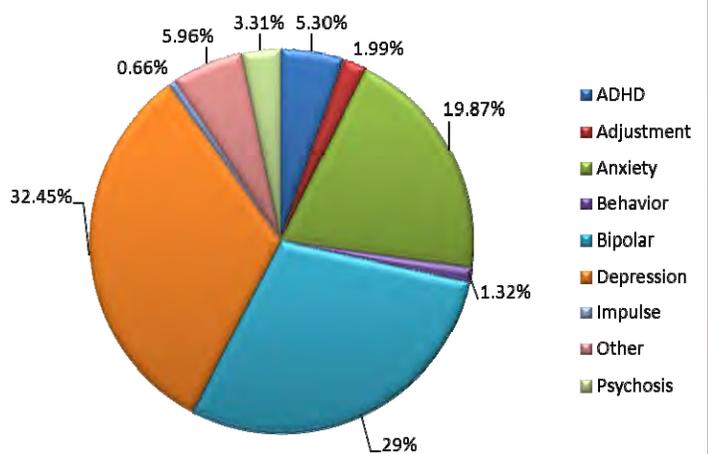
Age Group



Ethnic Category



Diagnostic Group



24 (16%) of those represented, identified as being of Hispanic Origin.

Numbers to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
Big Bear Full Service Partnership	150	150	150
Total	150	150	150

Positive Results

Over the past four (4) years:

- Services were offered to over **839** unduplicated individuals.
- **51** Clients received crisis intervention which prevented them from being hospitalized drastically reducing costs to the county/state.
- **85** Clients were assisted in obtaining psychiatric medications, which prevented the need for a higher level of care.
- **9** Clients were assisted in obtaining lab work needed to support their medication plan.
- **152** Clients benefited from dual diagnosis treatment services.
- Transportation usage (van service) increased to over **80** trips per month allowing clients to receive services which they could not otherwise access (**3,667** trips to date). This also allowed clients from the Lucerne Valley to access psychiatric care.
- **1,049** therapy/stabilization visits were facilitated.
- **1,075** psychiatric visits were conducted.
- **629** Case management visits were provided.



Making a Difference

The Big Bear FSP has served **839** clients over a 4 year, period. Since our FSP's origination, we have never had more than **1%** clients homeless at one time. Our case managers are quick to proactively respond to potential homeless situations and transition clients to alternative placements, prior to the client becoming homeless.

Challenges

- The geographic location of the community.
- Finding the appropriate level of staffing to work in the mountain area.
- Lack of transportation services.
- Access to benefit services i.e. Transitional Assistance.
- Clients not fully utilizing services and treatment options.

Western San Bernardino Mountain Communities access to services are severely limited due to the distance between these communities and the Big Bear Valley. Services are over 40 miles away and an hour drive on mountain roads.



Artwork by Sheila Dery

Solutions in Progress

The Department of Behavioral Health (DBH) contracts out a variety of behavioral health services to meet the specific needs of the County's mountain communities.

Currently, Children Intensive Services, MHSA Student Assistance Program (SAP), School-Aged Treatment Services (SATS), CalWorks (mental health services for recipients of cash aid) and Substance Abuse Services have providers that are local to the Western San Bernardino Mountains.

The Department of Behavioral Health, in future Request For Proposal's, will include a complete list of the communities the RFP is seeking services, identify the Western San Bernardino Mountains as a separate service area from Big Bear Valley and review the benefit of changing management regions for better coordination of services.

The Department of Behavioral Health will emphasize MHSA FSP services for this region in upcoming contract negotiations. In addition, general mental health contracts will also emphasize the Western San Bernardino Mountains as a distinct service area.

In Their Own Words

- ⇒ *"I needed help with my meds and Lutheran Social Services (LSS) was there!"*
- ⇒ *"My case manager helped me figure out how to get on insurance. I did not think I could get my meds because I did not have money. LSS paid for my meds."*
- ⇒ *"The ABET van lets me get to my MD appointments."*



Collaborative Partners

Alliance Members Fiscal Year 2012-13:

Lutheran Social Services

Domestic Violence Education & Services (DOVES)

Bear Valley Unified School District

MOM and DAD Project: Provides parenting, prenatal care and access to WIC

Big Bear Recovery Center

A-8: BIG BEAR FULL SERVICE PARTNERSHIP (FSP)



MENTAL HEALTH SERVICES ACT

A-9: Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services

MHSA INTEGRATED PLAN

FISCAL YEARS 14/15-16/17

Service Goals/Outcome Measures

The overall goal of the Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services program is:

- **Improve access** to outpatient mental health services for unserved, underserved and inappropriately served populations.

The objectives of the ACE program are to:

- Increased capacity in response to the demand for care.
- Provide shorter waiting times and shorter times between appointments.
- Provide same day psychiatrist evaluations when clinically appropriate.
- Provide reduced psychiatrist wait times by expediting opening of cases.
- Provide scheduled or non-scheduled appointments from inpatient referrals
- Provide increased access to individual and group therapy.
- Provide increased case management services.
- Facilitation of consumer access to additional benefits.
- Provide access to urgent psychiatric evaluation.
- Establish development of uniformed screenings and assessment tools.
- Improved coordination of care and referral within DBH's system of care.
- Improved access and better connectivity between referral and care organizations (such as homeless, primary health care and employment services).



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was the Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services Program Created?

As the population grows within the County of San Bernardino, requests for services from clients 15+ years of age (which cover TAY, adult and older adult populations) have significantly risen over the past decade.

The county population is expected to grow by **300,000** residents in the next eight (8) years and is projected to be at almost **2.6** million by 2030. With the current demand for scarce treatment resources, current population growth has already out grown availability of behavioral health treatment staff. With the implementation of the Affordable Care Act in 2014, and the increasing behavioral health needs of our current population, DBH needs to adapt ways of working to ensure a more efficient and coordinated approach, while maintaining the same high level of service quality.

Currently, service demand is exceeding DBH clinical resources. Referrals come from many sources, but the major referral sources are the Department's Access Unit, Arrowhead Regional Medical Center Behavioral Health, Fee-for-Service hospitals, emergency rooms, crisis services, law enforcement, Medi-Cal Managed Care plans such as Inland Empire Health Plan (IEHP), Molina and consumers and their families.

ACE is a fundamental tool to the resolution of inadequate staffing resources and treatment delivery processes within DBH. This program will aid in meeting the Department's goal of improving the delivery of services to unserved, underserved and inappropriately served residents residing in the County of San Bernardino.



Artwork by Sheila Dery

Services

Services provided through the ACE Program include:

- Mental Health Assessments.
- Substance Abuse screenings.
- Referrals and linkage.
- Access to appropriate services.

Program Data

DBH has been tracking current capacity in relationship to available treatment resources on a monthly, quarterly and yearly basis.

The Department’s unserved, underserved, and inappropriately served populations have increased, the acuity and risk level of clients has climbed and referrals from hospitals, Diversion Teams, Crisis Response Teams and Crisis Walk-in Centers have grown. As size and scope of the crisis response teams and crisis walk in centers grow, so do the referrals to the clinics for aftercare services once crisis services have been provided. There is an increased focus from the State Department of Health Care Services (DHCS) on ensuring adequate availability within provider networks and adequacy of access to behavioral health services. Assuming a very conservative “in-need” rate of **10%** in a given year among this population, we would expect that, across the county, about **27,000** persons in the target population of 15-years of age and above would qualify for outpatient mental health services in a given year.

This number far exceeds the number of residents in this age range who actually do receive outpatient care from general-service Department or contract sites in a 12-month period, which is approximately **14,000** TAY/Adult clients. Of the **14,000** clients age 15 and above, the age categories, diagnostic groups, and ethnicity are included below (TAY ages are 15-25, adults are 26-59, and 60 -above are older adults):

Projected Number to be Served

Program	FY 2014-15	FY 2015-16	FY 2016-17
ACE	13,628	13,628	13,628
Total	13,628	13,628	13,628



A-9: ACCESS, COORDINATION AND ENHANCEMENT (ACE) OF QUALITY BEHAVIORAL HEALTH SERVICES

Positive Results

ACE is a fundamental tool to the resolution of inadequate staffing resources and treatment delivery processes within DBH. This program will aid in meeting the Department's goal of improving the delivery of services to unserved, underserved and inappropriately served residents residing in the County of San Bernardino.



Artwork by Gary Bustin

Making a Difference

- Completion of the hiring process for positions necessary for the beginning stages of implementation.
- Establishment of a defined, tiered system of care to ensure consumers receive the most appropriate level of service to meet their needs.

Challenges

Once fully implemented, DBH will assess from the baselines measurements at current service levels in the at the four established sites to see if objectives as listed in this program were met. Measurements would include:

- The time from hospital discharge to first outpatient service.
- The time from first service to Medication Support Service.
- The time from first screening to first therapy appointment.
- Time in the waiting room once arrived to service on the same day.
- The number and focus of case management services received.
- The number of care providers included in the care plan that are internal DBH providers (i.e., employment services, housing coordinators, Substance Use Providers).
- The number of care providers that are included in the care plan that are external providers (i.e., Primary Care Providers, Health Care Specialists, physical health care coordinators, preventive health workers).
- The inpatient psychiatric recidivism rate for those served.

Solutions in Progress

Initially, ACE services have been added to the four (4) major regional clinics: Phoenix, Upland Community Counseling, Mesa Counseling, and Victor Valley Behavioral Health. Additional staff will be added to two (2) rural, desert clinics located in Barstow and Needles.

The ACE program will increase clinical staffing to perform screening and intake assessments and will increase walk-in hours from 33 per week to **120** hours per week by establishing five (5) days-a-week, 8:00 am - 5:00 pm walk-in assessment for clients.

A-9: ACCESS, COORDINATION AND ENHANCEMENT (ACE) OF QUALITY BEHAVIORAL HEALTH SERVICES



Artwork by Peter Miller

Collaborative Partners

Department of Behavioral Health

Arrowhead Regional Medical Center

State Hospital and Institution of Mental Disease Gatekeeping Team

State Hospital and Institution of Mental Disease Programs and Staff

**A-9: ACCESS, COORDINATION AND ENHANCEMENT (ACE) OF QUALITY
BEHAVIORAL HEALTH SERVICES**



MENTAL HEALTH SERVICES ACT

OA-1: Age Wise I Program

M H S A I N T E G R A T E D P L A N F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

Service Goals/Outcome Measures

The overall program Goals are:

- Reduce homelessness and increase safe and permanent housing.
- Reduction in disparities in racial and ethnic populations.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.
- Increase access to treatment and services for co-occurring problems; substance abuse and health.
- Increase in self-help and consumer/family involvement.

The objectives of Age Wise I Program are:

- **Provide** mobile mental health services to prevent premature institutionalization of older adults, inappropriate utilization of emergency rooms services, and psychiatric inpatient services.
- **Develop** a capacity building component with community partners and stakeholders serving the older adult population living with mental illness and their families.
Provide culturally competent and client centered services to older adults in all regions of the county.
- **Enhance** the Senior Peer Counseling Program and expand it county-wide.
- Assist older adults with mental illness to maintain their independence in the community.
- **Provide** mental health services to older adults on Lanterman-Petris-Short Act (LPS) conservatorship.
- **Assist** older adults to transition from long term locked facilities safely into the community.
- **Facilitate** access to acquiring entitlements, attain housing and prevent homelessness.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

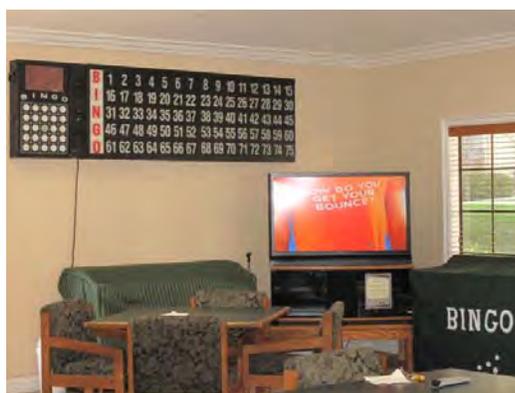
Why Was Circle of Care Created?

Older adults are especially vulnerable to the difficulties associated with accessing available services and frequently go unserved. The stigma associated with mental illness, under-identification or misidentification of mental health problems interfere in older adults accessing appropriate mental health services on a timely basis. Older adults often experience many physical problems and issues related to the aging process and losses in their lives. In addition, there are limited finances, lack of accessible and affordable transportation which creates a population that tends to be isolated and go unserved.

The Age Wise Program is a non-traditional mental health program for the high-risk and underserved older adult population. There are many different services available such as mobile case management services, counseling services, groups provided in the community, and the Senior Peer Counseling program. The Age Wise team accomplishes this through focusing on providing services, with integrity and respect for the aging process.

Some of the specific ways in which we partner with seniors include:

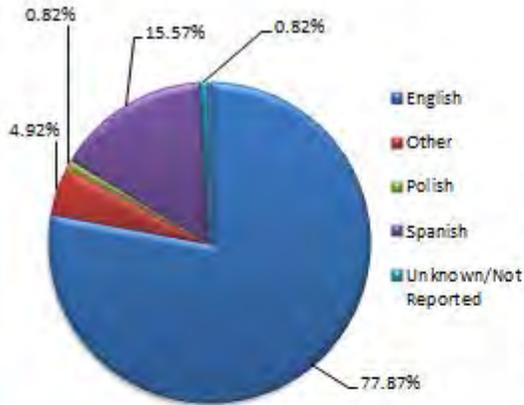
- Increased access to mental health and case management services due to in-home contacts.
- Improvement in maintaining the older adults in independent living environments such as low income housing, DBH subsidized housing, and other community living arrangements.
- Improvement in helping older adults access benefit programs such as Social Security, Medi-Cal, and Veterans services.
- Assist with transportation or access to transportation to get the Mental Health appointments, Medical appointments, or pharmacies to get their medications.
- Outreach in the community to the homeless mentally ill.
- Expansion of Senior Peer Counseling to the High Desert region of the county.



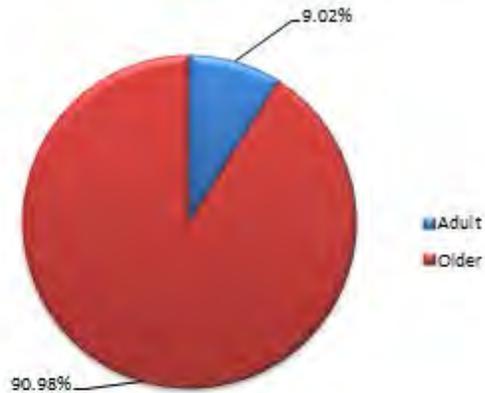
Program Data

In Fiscal Year 2012/13, AgeWise -I demographics were as follows:

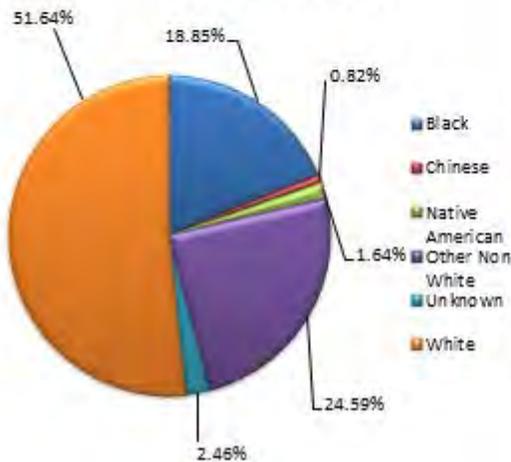
Preferred Language



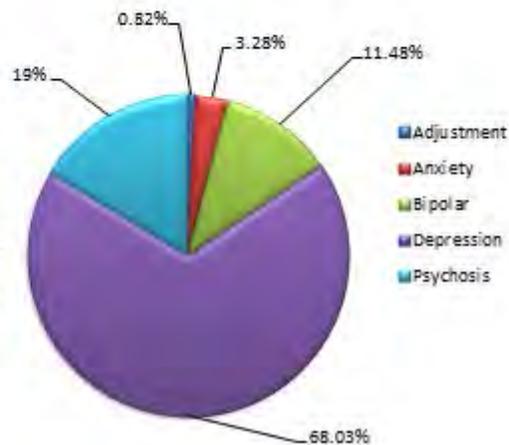
Age Group



Ethnic Category



Diagnostic Group



122 (30%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Program	FY 14-15	FY 15-16	FY 16-17
Agewise I- Circle of Care	600	600	600
Total	600	600	600

Positive Results

- Enabled older adults to remain out of psychiatric hospitals and jails.
- Decreased frequency of emergency room visits for mental health or substance abuse needs.
- Provided counseling for the grief and loss of a loved spouse or partner.
- Decreased the number of older adults who are homeless, or run the risk of becoming homeless.

Services

Services include:

- Mobile mental health services to prevent premature institutionalization of older adults, inappropriate utilization of emergency room services, and psychiatric inpatient services.
- Peer counseling services.
- Collaborating with the Crisis Intervention Training (CIT) to train law enforcement on matters pertaining to diverse older adults.
- Assisting in the placement of long term care for older adults who can no longer care for themselves.
- Providing seniors with information.
- Increasing referrals to the Elder and Family Care Clinic at the Arrowhead Regional Medical Center (ARMC) outpatient department, resulting in improved access to physical health care for older adults.
- Additionally, a network of senior peer counselors provide services to older adults county-wide and deliver presentations to senior centers, regional councils on aging and other community agencies.



Making a Difference

D. had recently been released from the hospital and was a high user of hospital psychiatric services. She had been placed in various facilities unsuccessfully. Her behavior limited facilities willing to accept her placement and was difficult on her family. Age Wise staff provided case management in a specialized Skilled Nursing Facility. At first, it was challenging to develop a working relationship with her and convince her that someone does care about her. Two years later she actively engages in therapy with Age Wise staff, participates in facility groups on a daily basis. She has earned incentives allowing purchasing in the facility canteen. As a result of her compliance with mental health medications and Age Wise services, she is now motivated to collaborate with and receive assistance with her multiple medical needs. She is no longer aggressive and assaultive towards others, she verbalizes her feelings. Her outlook on life is positive and hopeful.



Challenges

- Engaging the older adult to utilize mental health/substance abuse services because of their distrust of government systems.
- Symptoms of the aging process and medical conditions are frequently inappropriately labeled as mental health issues.
- Reducing the stigma in the community associated with being mentally ill.
- Discovering homeless mentally ill older adults in the community.

Solutions in Progress

- Helping the older adult and their families navigate the behavioral health system by reducing anxiety by providing mobile services rather than in the clinic.
- Accessing services via the Senior Peer Counseling program.
- Working with medical doctors, Department of Aging and Adult Services, Adult Protective Services, etc., to ensure that care is coordinated, collaborative and beneficial to the older adult.
- Improving housing, preventing homelessness, and employment services.
- Continuing to expand the program from the West End of the County to the high desert, the mountains and as far as Morongo, Yucca Valley, and 29 Palms region of the county.
- Developing a Recovery and Outreach team to go out into the community at parks, homeless encampments to connect with homeless older adults.

In Their Own Words

- ⇒ "Thank you for working with me."
- ⇒ "I appreciate all you do for me . . ."
- ⇒ "It feels good to know you are there when I need you."



Collaborative Partners

The Age Wise Program thanks all partners in serving older adults!

Department of Behavioral Health Clinics

Department of Behavioral Health Homeless Program

Department of Aging and Adult Services

Adult Protective Services

Lanterman-Petris-Short (LPS) Conservatorship Services

Department of Behavioral Health Housing and Employment Service



MENTAL HEALTH SERVICES ACT

OA-2: Age Wise II Circle of Care Mobile Outreach and Intensive Case Management

M H S A I N T E G R A T E D P L A N F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

Service Goals/Outcome Measures

The Overall Goals of the Circle of Care program are:

- Reduce homelessness and increase safe and permanent housing.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.

The objectives are:

- **Provide** mobile crisis response and crisis prevention services to the older adult population in the High Desert.
- **Partner with** hospitals and primary care providers in the High Desert to serve older adults living with mental illness.
- **Increase access** to mental health services by outreach and services in the homes of older adults.
- **Provide** intensive case management services to assist the older adult to remain in independent living.
- **Provide** Full Service Partnerships (FSP) 24/7 to the older adult population in the High Desert.
- **Provide** FSP services for those older adults living with mental illness at risk of emergency or inpatient services or those having the most difficulty accessing care due to system barriers.
- **Expand** Senior Peer Counseling program to the desert area.
- **Reduce** and prevent episodic institutionalization and incidents of relapse.
- **Utilize** mobile response to facilitate team mobility and reach geographically isolated older adults in large rural area of the High Desert.
- **Identify** appropriate housing for older adults who are homeless or at risk of being homeless.



County of San Bernardino - Department of Behavioral Health



Why Was Age Wise II Circle of Care Mobile Outreach and Intensive Case Management Created?

The older adult population with mental illness in the rural areas of the high desert have had limited services and coordinated resources. Due to limitations of ability to access transportation, support systems to assist them and financial resources many older adults are isolated in their homes while some have been abandoned by their families. The Age Wise II program was created to address these and other important issues such as **crisis response and prevention**.



Artwork by Sheila Dery

Program Overview

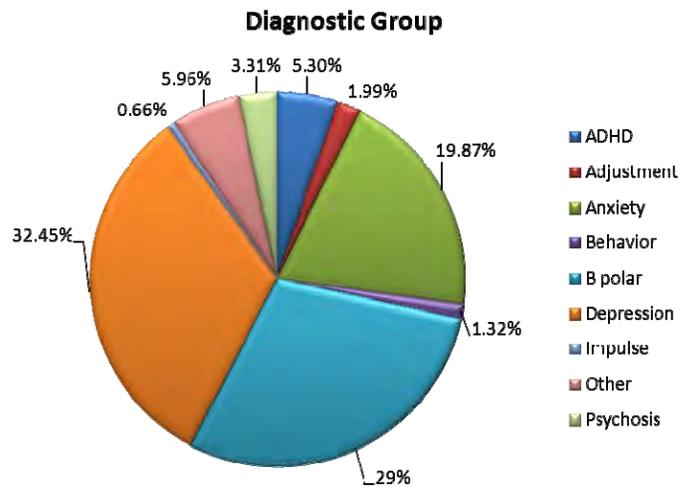
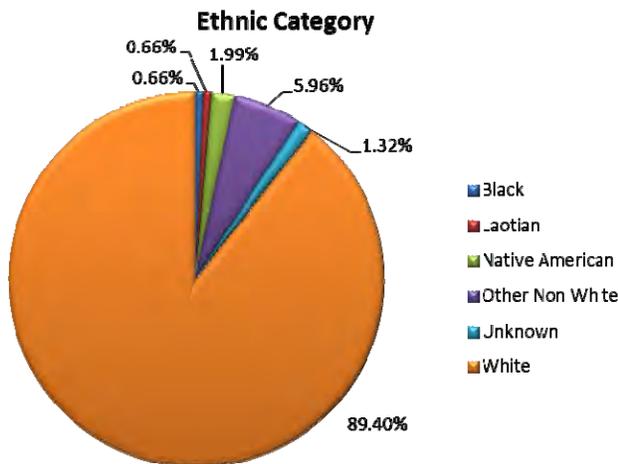
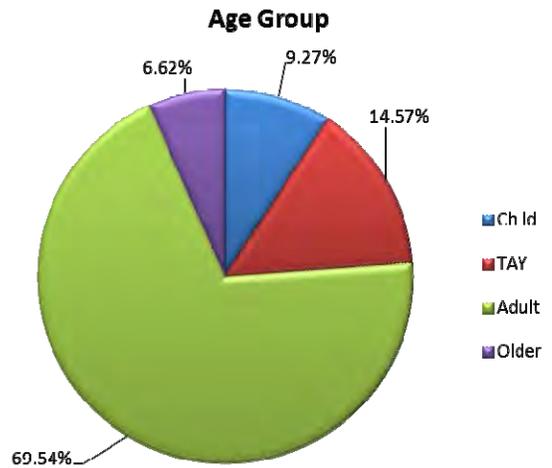
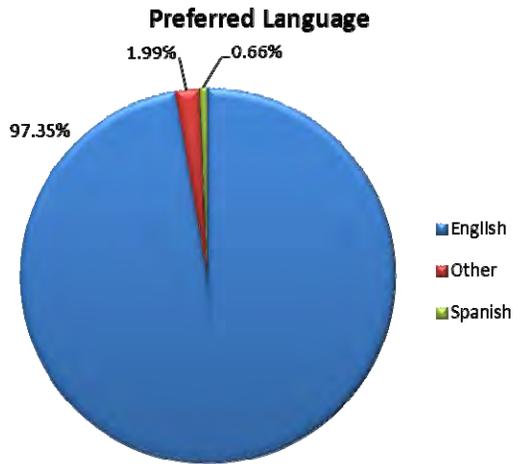
The program is located in the high desert and provides crisis intervention and mobile response services to prevent hospitalizations and homelessness for older adults in that area. In the community, the Age Wise II program works with other County departments such as the Department of Aging and Adult Service, Adult Protective Services and hospitals in coordinating resources for the older adult. 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.

Services include in home mental health counseling and Intensive case management, assessments and 5150 evaluations and mobile crisis response, facilitated transportation for medical and judicial appointments and other issues of daily living matters. Because of this program, Older Adult consumers are not utilizing costly psychiatric hospitalizations as their primary resource for management of their mental illness or other issues related to the aging process. There has been a decreased number of calls to law enforcement agencies relating to older adult and mental health issues.

Program staff also deliver outreach and engagement services, referrals and resources for the senior population including food, placements, shelters, clothing and other primary and basic needs.

Program Data

In Fiscal Year 2012/13, AgeWise II demographics were as follows:



12 (23%) of those represented, identified as being of Hispanic Origin.

Projected Number to be Served

Program	FY 14-15	FY 15-16	FY 16-17
Agewise II— Circle of Care	720	720	720
Total	720	720	720

Services

Services include in home mental health counseling and Intensive case management, assessments and 5150 evaluations and mobile crisis response, facilitated transportation for medical and judicial appointments and other issues of daily living matters.

Because of this program, Older Adult consumers are not utilizing costly psychiatric hospitalizations as their primary resource for management of their mental illness or other issues related to the aging process. There has been a decreased number of calls to law enforcement agencies relating to older adult and mental health issues.

Program staff also deliver outreach and engagement services, referrals and resources for the senior population including food, placements, shelters, clothing and other primary and basic needs.

Positive Results

- **Established** mobile, field capable multidisciplinary outreach teams providing crisis response and prevention.
- **Served a 10% increase** of older adults in Fiscal Year 2011/12 and a **20% increase** in Fiscal Year 2012/13.
- **Decreased use of emergency room visits** for mental health and substance abuse needs.
- **Assisted older adults to access social security** and other federal and state benefits.
- **Increased** the number of older adults being able to receive appropriate medical and mental health services.
- **Increased** services to prevent homeless older adults and those at risk of being homeless.
- **Educated** families about the aging process and mental illness issues of older adults.
- **Increased** number of older adults being able to receive appropriate medical and mental health services.
- **Developed** partnerships with law enforcement, other county and community agencies, and primary care providers serving the older adult to improve services either directly or through multidisciplinary teams.

Challenges

- Discovering available and affordable housing for older adults on fixed incomes.
- Engaging the older adult to accept mental health and co-occurring treatment due to their distrust of government entities.
- Addressing the stigma of mental health services in the community for the older adult.
- Ensuring the program continues to be recognized by the community and older adult.
- Outreach to seniors to recruit additional Senior Peer Counselors.
- Counseling to address substance abuse issues in the older adult population due to general denial of the problems in their life.
- Accessing and reaching homeless older adults through outreach at parks, river washes and various other locations that they gather.



Solutions in Progress

- Presentations to community organizations and participation in the community activities (health fairs, etc.) to educate the community about the need for older adult services with mental illness and substance abuse needs.
- Crisis response services to increase access of services for the older adult through quick mobile response teams.
- In-home services to the isolated older adult rather than clinic services.
- Full Service Partnerships to provide intensive case management 24/7 to ensure support for the older adult and prevent admissions to inpatient services, use of emergency rooms to meet mental health needs.
- Housing services established and developed to provide more suitable and affordable, safe housing for older adults.
- Emergency shelters for the mentally ill homeless and at-risk of being homeless older adults.
- Anti-stigma services to reduce the stigma associated with mental health services.

Making a Difference

K was homeless for five years with mental illness and substance abuse issues and had no family support. As a user of the hospital behavioral health psychiatric services she was referred to a 90-day social rehabilitation program where she received co-occurring services. When she completed rehabilitation, the Age Wise program assumed the case. K had previously worked sporadically in the blue collar field. Acquiring her entitlements was challenging due to her limited work experience, loss of access to required documents for exploration of any entitlements. Due to her homelessness and addiction her personal and health care were in serious neglect. She was linked with medical support to address her multiple medical, dental and vision issues.

After approximately 5 years of intense work with this older adult she was able to access independent housing. She was able to qualify for MHSA subsidized housing using her benefits to pay her way. She no longer needed a payee, maintained appointments and activities to support her mental health need. She initiated her efforts to re-engage a relationship with her only adult son. The Age Wise staff team continues to assist her to support her major goals in life: Maintain sobriety, Live independently and restore her family ties.



In Their Own Words

- ⇒ *"I feel blessed and I attribute my new calm attitude to the peaceful nature of the placement Age Wise II placed me in."*
- ⇒ *"I appreciate all you do for me . . ."*
- ⇒ *I feel less stuck and more hopeful about the future."*

Collaborative Partners

The Age Wise Program thanks all partners in serving older adults!

Law Enforcement

Hospitals

Department of Behavioral Health Community Crisis Response Team

Department of Behavioral Health Crisis Walk-in Clinics

Department of Aging and Adult Services

Community Churches

Agencies Dealing with the Homeless

County Adult Protective Services





MENTAL HEALTH
SERVICES ACT

County of San Bernardino Department of Behavioral Health

M H S A I N T E G R A T E D P L A N F I S C A L Y E A R 1 4 / 1 5 - 1 6 / 1 7

Prevention and Early Intervention



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

INTRODUCTION TO PREVENTION & EARLY INTERVENTION



Prevention and Early Intervention (PEI) programs are intended to implement strategies at the early end of the continuum of behavioral health care, to deter the onset of mental health conditions and/or improve a mental health problem in the early stages of its development. Inherent in its intent, PEI services contribute to changing community conditions and risk factors that are proven to increase the likelihood of developing a mental health condition.

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
- 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 of activities that emphasize individual and community wellness, recovery 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; *Prevention* 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

The County of San Bernardino's PEI Plan

In 2008, the County of San Bernardino (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. Currently, thirteen programs, including a program created under the Innovation Component, are organized into three initiatives:

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

Overview of PEI Initiatives

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)

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 (NARC)
- 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)



School-Based Initiatives

Student Assistance Program

The Student Assistance Program (SAP) serves diverse students and their families through a systemic process using techniques to mobilize resources to remove barriers to learning. This school-based approach provides focused services to students needing interventions for substance abuse, mental health, mental health related academic issues, emotional, and/or social issues. SAP connects education, programs, and services within and across school and community systems to create a network of supports to help students. 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(s) and the parent(s), 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 assist the parent and student so they may access services within the community.



Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of or experiencing juvenile justice involvement

MHSA Legislated Goals

The SAP addresses the following MHSA legislated goal:

- Reducing School Failure and Dropout Rates

When the student's problem areas are beyond the scope of the SAP, the SAP team will assist the parent and student access additional community resources. SAP 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 minimizes barriers to learning and includes early intervention, counseling, and alcohol and drug education services.

Services include identification and referral of students requiring individual and/or small group counseling, education, parent participation, and/or short-term treatment for those first experiencing the onset of a mental health condition.

In addition, SAP services include the ongoing training of education staff in the use of positive behavior interventions for the classroom and identification and referral into services.

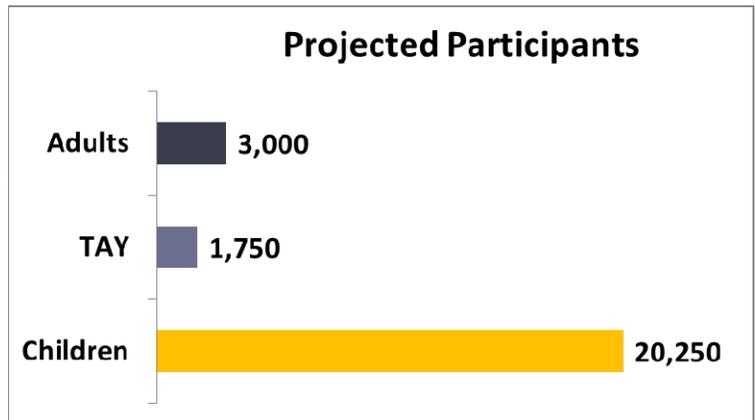
School-Based Initiatives

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 the Positive Behavioral Interventions and Supports model are 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.

SAP will serve approximately 25,000 unduplicated participants each fiscal year. On average, 81% of SAP participants are children (age 0-15), 7% are Transitional Aged Youth (TAY, ages 16-25), and 12% are adults (age 26-59). It is projected that this program will serve approximately 20,250 children, 1,750 TAY, and 3,000 adults.



SAP is primarily a prevention program, but does include early intervention activities. Services have been integrated into the larger continuum of care for school-aged children and youth. Most early intervention services are provided through other sources such as EPSDT managed care networks or the Community Support Services (CSS) Component of MHSA.

Funding is projected to be allocated as indicated below:

Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$2,652,274	89%
<i>Early Intervention</i>	\$325,410	11%

Overview of Success and/or Outcomes for FY 2012-2013

In FY 2011-2012, the SAP provided services to 26,022 unduplicated participants. In FY 2012-2013, 21,404 unduplicated participants were served. This represents services reaching an average of 23,713 individuals annually over a two year period. With increased funding in FY 2013-2014, it is anticipated that the number of participants served will also increase.

School-Based Initiatives

SAP providers also tracked Global Assessment of Functioning (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. Participants' scores were noted at case opening and case closing. The GAF scores indicate participants had 17.5% improvement in functioning after participating in SAP services, as illustrated in the table below.

Average Student GAF Scores for SAP Providers in FY 2012-2013		
At Case Intake	At Case Discharge	Improvement
52.3	61.5	17.5%

Preschool PEI Program

The Preschool PEI Program (PPP) provides support for preschool children and education for their parents and teachers. The goal 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. This program serves students enrolled in the County's Head Start program and is managed by the Preschool Services Department.

In order to accomplish goals, 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 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 in conjunction with teacher/parent training; this allows the teacher and parent to use learned intervention techniques in response to the child's individual needs and the developed support plan.

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.

Science and research based assessment and evaluation tools are used including the Desired Results Development Profiles (DRDP), Ages & Stages Questionnaire and the Life Skills Progression tool.



Target Population

- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of or experiencing juvenile justice involvement

MHSA Legislated Goals

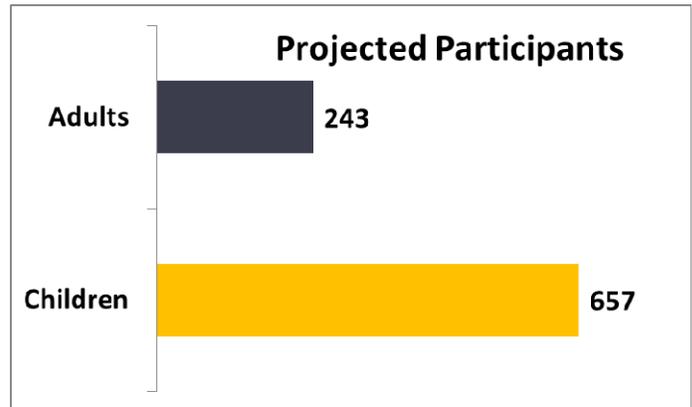
The PPP addresses the following MHSA legislated goal:

- Reducing School Failure and Dropout Rates

School-Based Initiatives

The PPP will serve approximately 900 unduplicated participants each fiscal year. On average, 73% participants are preschool children and 27% of participants are adults (ages 26-59). It is projected that this program will serve 657 children and 243 adults.

The PPP is a prevention program, therefore 100% of the projected funding is associated with prevention activities, as illustrate in the table below.



Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$425,000	100%
<i>Early Intervention</i>	\$0	0%

Overview of Success and/or Outcomes for FY 2011/2012

The PPP was developed, in part, to address the needs of preschool students with aggressive behaviors. A variety of research studies have found significant links between aggressive behavior in young children and negative "health and psychosocial outcomes" in adolescence and adulthood. ¹

In FY 2011-2012, PPP served 321 unduplicated participants. In FY 2012-2013, participants served increased by 106% with 661 unduplicated participants being served.

In FY 2011-2012, the results of pre and post DRDP assessments were analyzed for all children enrolled in the Head Start program. According to reports from the Preschool Services Department, the children receiving PEI services were enrolled in the "same classrooms, during the same time period, receiving the same basic educational services" as the larger group of children.

Children demonstrating aggressive behavior in Head Start classrooms received additional PEI support services. The data obtained indicated that these services had a very positive impact on behavior.



Three times per year, every child enrolled in the Head Start program (about 4,000 children total) received an assessment using the DRDP assessment tool.

¹ (Van Lier, P.A. and Crijnen, A.A. (2005). Trajectories of Peer-Nominated Aggression: Risk Status, Predictors and Outcomes. *Journal of Abnormal Child Psychology*, Vol. 33, No. 1, 99-112. Retrieved December 5, 2012 from <http://link.springer.com/article/10.1007%2Fs10802-005-0938-8>)

School-Based Initiatives

The DRDP measured a range of development in preschoolers. Each student received a rating on their progress within the continuum of developmental levels. These ratings ranged from "Exploring" at the lowest point to "Integrating" at the highest point.

In the six developmental domains measured, children receiving PPP services were *more likely* than their peers to be "integrating" positive behaviors. 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	35.48%	Student consistently uses a variety of socially acceptable strategies to stop self from acting impulsively.
	All Other Students	11.91%	
Taking Turns	PEI Students	22.58%	Student routinely proposes taking turns as a solution to conflicts over materials and equipment
	All Other Students	9.68%	
Relationships with Adults	PEI Students	35.48%	Student works cooperatively with an adult to plan and organize activities and to solve problems.
	All Other Students	12.08%	
Cooperative Play with Peers	PEI Students	22.81%	Student leads or participates in planning cooperative play with other children
	All Other Students	10.43%	
Conflict Negotiation	PEI Students	9.68%	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	5.47%	
Shared Use of Space and Materials	PEI Students	22.58%	Without adult prompting, the student invites others to share materials or space he or she is using
	All Other Students	10.36%	

Currently, the PPP is working with a research consultant to thoroughly evaluate FY 2012-13 data. The data analysis is expected to reveal outcomes for social-emotional gains, as well as cognitive development gains in participants. Findings will be included in the next plan update.

School-Based Initiatives



Resilience Promotion in African American Children

The Resilience Promotion in African American Children (RPAAC) 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.

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

The RPAAC program will serve approximately 2,000 unduplicated participants each fiscal year. On average, 95% or 1,900 of participants will be children (ages 0-15), 4% or 80 participants will be adults (ages 26-59) and 1% or 20 will be TAY (ages 16-25).

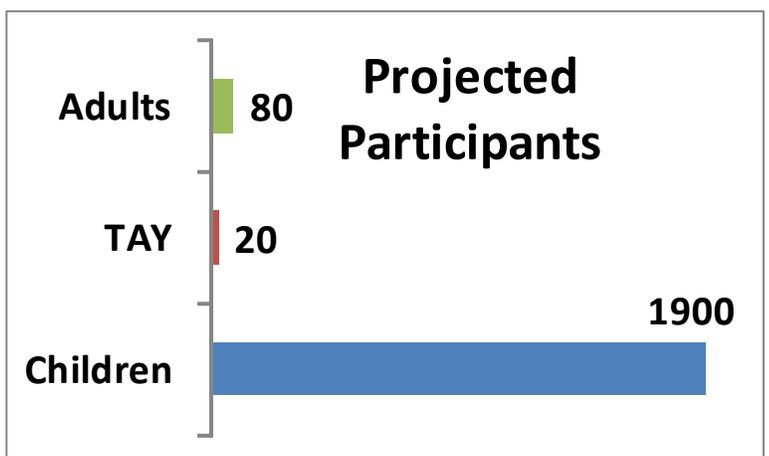
Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of or experiencing juvenile justice involvement

MHSA Legislated Goals

The RPAAC program addresses the following MHSA legislated goals:

- Reducing School Failure and Dropout Rates
- Reducing Incarcerations



School-Based Initiatives

The RPiAAC program is primarily a prevention program but does include some early intervention activities. 94% of the projected funding is associated with prevention activities and 6% is associated with early intervention funding.



Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$650,853	94%
<i>Early Intervention</i>	\$36,624	6%

Overview of Success and/or Outcomes for FY 2011-2012

In FY 2010-2011 the RPiAAC program served 3,625 participants. During this year the number of participants receiving Early Intervention and Selective services was lower than original projections, however the number of participants receiving Universal services exceeded projections. In FY 2011-2012 the program served 3,928 participants. Again, during this year the number of participants receiving Early Intervention and Selective services was lower than original projections, and the number of participants receiving Universal services exceeded projections. The RPiAAC program was not provided during FY 2012-2013 due to required termination of contracted services, however the program continued in FY 2013-2014 and it is anticipated that the number of participants in FY 2013-2014 will exceed the previous service levels.

As PEI enhances program evaluation efforts, it is anticipated that the RPiAAC program will make programmatic adjustments to improve services and meet the needs of African American children, TAY and their families.

Community-Based Initiatives



Family Resource Centers

The Family Resource Centers (FRCs) offer various programs that are tailored to be culturally and linguistically competent and meet the identified needs of the communities they serve. 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.

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 stigma associated with behavioral health services. FRCs include the following services:

Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families

MHSA Legislated Goals

The FRCs address the following MHSA legislated goals:

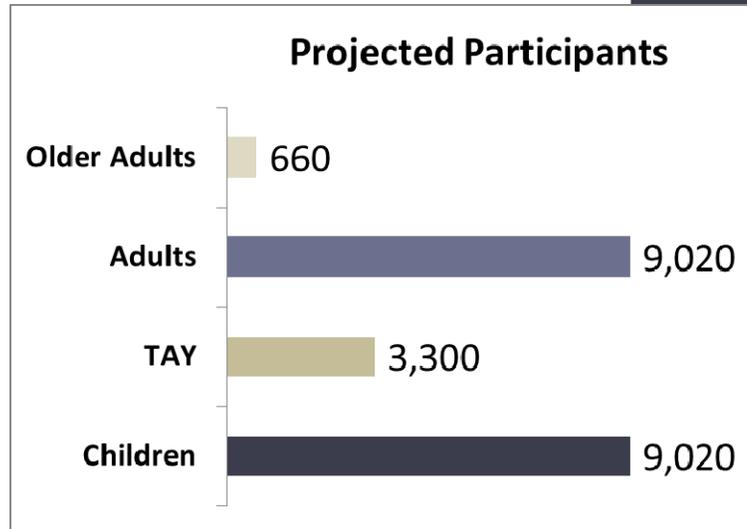
- Reducing Stigma and Discrimination Associated with Mental Illness
- Reducing Unemployment Among Consumers
- Reducing Prolonged Suffering

- Personal development activities
- Parent/caregiver support and education
- Monthly behavioral health education workshops for community members, agencies, and institutions
- After school youth projects/activities that offer opportunities for children to build positive skills and socialize with positive support
- Adult skills-based education programs
- Community counseling services offered to all age groups

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 Initiatives

The FRCs will serve approximately 22,000 unduplicated participants each fiscal year. On average, 41% of SAP participants are children (ages 0-15), 15% are TAY (ages 16-25) 41% are adults (ages 26-59) and 3% are older adults (ages 60+). It is projected that this program will serve 9,020 children, 3,300 TAY, 9,020 adults and 660 older adults.



This program is primarily a prevention program, but does include early intervention activities. Approximately 81% of the projected funding is associated with prevention activities and 19% is associated with early intervention activities, as shown in the table below.

Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$2,706,799	81%
<i>Early Intervention</i>	\$642,816	19%

Overview of Success and/or Outcomes for FY 2012-2013

In FY 2012-2013 the FRCs provided 79,773 total services. The projected number of unduplicated participants to be served was 4,441, and this goal was exceeded by over 200%, with an actual total unduplicated participant served count of 14,509.

FRC providers also 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 20.7% overall improvement, as illustrated below.

Average GAF Scores for FRC Providers in FY 2012-2013		
At Case Intake	At Case Discharge	Improvement
61	73.7	20.7%

Community-Based Initiatives



In addition to GAF scores, some FRC providers tracked additional outcome measures. One provider serving a high rate of children utilized the Child and Adolescent Functional Assessment Scale (CAFAS) to assess the level of functioning in children ages 5-19 and measure improvement.

The CAFAS scores obtained indicate that children receiving PEI services from this FRC provider improved daily functioning and learned important social-emotional skills, as illustrated in the table below.

CAFAS Scores for Children (Ages 5-19)	
Area of Concern	Reduction in Problem after FRC Services
Thinking Problems	-67.1%
Substance Use	-75.5%
Possible Self-Harmful/ Severe Moods	-57.7%
Behavioral Problems with Moderate Mood	-43.7%
Behavioral Problems without Moderate Mood	-56.6%
Moderate Mood Problems	-54.5%
Mild Problems Only	-73.9%

Community-Based Initiatives

Native American Resource Center

The Native American Resource Center (NARC) functions as a one-stop center offering several prevention and early intervention resources for American Indian and Alaskan Native children, youth, TAY, adults and older adults, and families. The center provides culturally-based services utilizing strength-based traditional Native- American programs including: outreach and education, family support, parenting, youth empowerment, workforce development and education assistance. It has similarities to the Family Resource Center as it provides mental illness and drug and alcohol prevention and early intervention services and family supportive services.

The NARC utilizes the White Bison Education Programs as part of their holistic approach to serving the Native American population. They also use traditional counseling and treatment approaches and make cultural adaptations.

The NARC will serve at least 1,700 unduplicated participants each fiscal year. On average, 16% of SAP 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+). It is projected that this program will serve 272 children, 765 TAY, 459 adults and 204 older adults.



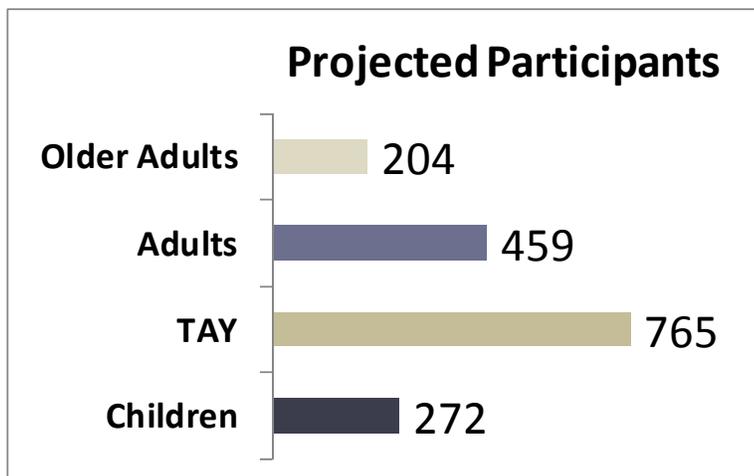
Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed individuals

MHSA Legislated Goals

The NARC program addresses the following MHSA legislated goals:

- Reducing Stigma and Discrimination Associated with Mental Illness
- Reducing Prolonged Suffering



Community-Based Initiatives

The NARC program consists of prevention and early intervention activities. Approximately 50% of the projected funding is associated with prevention activities and 50% is associated with early intervention activities, as indicated in the table below.

Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$250,000	50%
<i>Early Intervention</i>	\$250,000	50%

Overview of Success/Outcomes FY 2011-2012 and FY 2012-2013

The NARC program has remained steady in serving an average of over 8,000 participants over the two year period of FY 2011-2012 and FY 2012-2013.

The progress of participants receiving clinical services during FY 2011-2012 showed some promising results. In order to measure the progress of participants receiving early interventions services, GAF scores were tracked. 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. The table below illustrates improvement results of 9.84% overall.

Average GAF Scores for Native American Resource Center FY 2011-2012		
At Case Intake	At Case Discharge	Improvement
61	67	9.84%

Participant data was collected for FY 2012-2013 and is continuing to be collected; however, reporting mechanisms for the NARC program defer from traditional methods and therefore have delayed the attainment of results. Findings will be provided in the next plan update.

Community-Based Initiatives



NCTI Crossroads® Education

The National Curriculum and Training Institute (NCTI) Crossroads® Education program is a curriculum-based education strategy that fosters positive, pro-social behavior in children and transitional age youth with emphasis on prior offenders. Parenting classes are offered to the families of those participating in the program.

The NCTI Education program employs a Cognitive Behavioral Change model to teach pro-social behaviors through an interactive learning process. NCTI curriculum focuses on the relationship between values, attitudes and behaviors as they relate to the decision making process. The NCTI Crossroads Education providers utilize various modules of the curriculum depending on the training needs of their communities.

The evidence based curriculum used for this program is the NCTI Crossroads® Education Curricula and the Real Colors Personality Instrument.

The NCTI Crossroads Education program will serve approximately 4,000 unduplicated participants each fiscal year. On average, 50% of participants are children (ages 0-15) and 50% are TAY (ages 16-25). Crossroads Education is solely a prevention program, therefore 100% of the projected funding is associated with prevention activities.

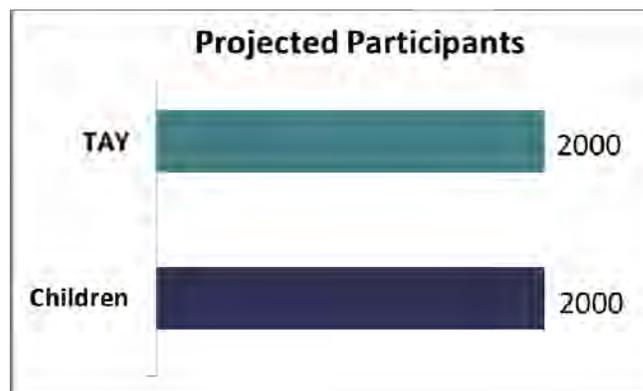
Target Population

- Underserved cultural populations
- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of or experiencing juvenile justice involvement

MHSA Legislated Goals

The NCTI Crossroads Education program addresses the following MHSA legislated goals:

- Reducing School Failure/ Dropout Rates
- Reducing Incarcerations



Community-Based Initiatives

Overview of Success and/or Outcomes for FY 2012-2013

The NCTI Crossroads Education program has increased the numbers of unduplicated participants served each year. In FY 2011-2012, the program served 7,305 unduplicated participants, and that increased 38% to 10,101 participants in FY 2012-13.

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.

The table below shows the learning objectives for each Crossroads course offered, and the increased rate of understanding students gained after completing each course in FY 2012-13. The test data indicates that Crossroads 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 Understanding of Course Content Increased
Truancy	Understanding how success in school translates to success in work and in life	44%
Youth Anger Management Level 1	Understanding the influence that strong emotions have on behavior and gaining better control	25%
Youth Anger Management Level 2	Coping with stress Problem solving & Conflict Management Understanding Consequences	51%
Youth Drugs & Alcohol Level 1	Identity skills & resources that help develop a healthy, positive lifestyle	61%
Youth Drugs & Alcohol Level 2	Setting goals for the future Choosing new, positive activities to replace old, negative activities	4%
Youth Cognitive Skills	Discover how attitude affects behavior Practice and gain new life skills	65%

Community-Based Initiatives

Promotores de Salud/ Community Health Workers

Promotores de Salud/Community Health Workers (PdS/CHW) is a prevention program designed to address the needs of the County's culturally diverse communities. The objective of this program is to improve access to and reduce the stigma of mental health services by educating community members and promoting behavioral health and wellness, as well as community resources. PdS/CHW promote behavioral health awareness, education and available resources for the members of targeted underserved and unserved groups including Latino and Spanish speaking communities, African-American communities and LGBTQ communities. Outreach services and activities are culturally and linguistically appropriate for each community served. The services provided by this program include:

- Recruitment and training of individuals interested in becoming Community Health Workers for the community.
- Regularly scheduled outreach presentations to church groups, community groups, and school groups, such as the Parent Teacher Association (PTA), etc.
- Modular presentations to smaller groups, families or individuals for the purpose of facilitating a discussion on specific behavioral health topics covered in the outreach presentation.
- Planning culturally and linguistically competent events that provide and distribute information in a concentrated area of a community or neighborhood.
- Local organized culturally relevant community fairs, cultural events or other gatherings where several agencies and/or vendors are scheduled to participate.
- Additional modules for post partum depression, domestic violence, and suicide prevention are in various stages of development and are anticipated to be implemented in the near future.

The program utilizes the Promotores de Salud or Community Health Worker Curriculum and is estimated to educate approximately 30,000 unduplicated participants each fiscal year. On average, 2% of participants are children (ages 0-15), 7% are TAY (ages 16-25), 85% are adults (ages 26-59) and 6% are older adults (ages 60+).



Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed individuals

MHSA Legislated Goals

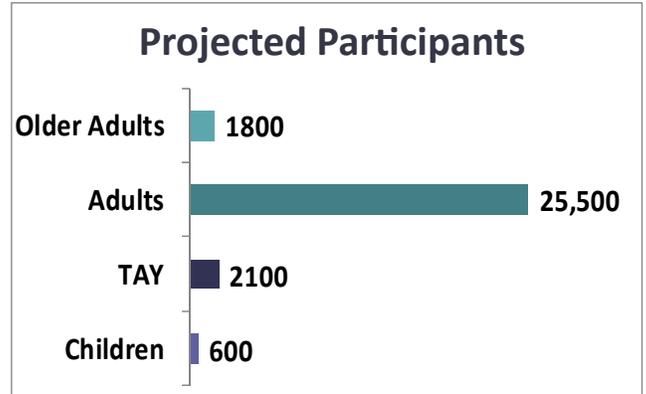
The PdS/CHW program addresses the following MHSA legislated goals:

- Reducing Prolonged Suffering
- Reducing Stigma and Discrimination Associated with Mental Illness
- Reducing School Failure/Dropout Rates

Community-Based Initiatives

It is projected that this program will serve 600 children, 2,100 TAY, 25,500 adults and 18,000 older adults.

The total funding for this program is \$1,148,630. PdS/CHW is exclusively a prevention program with 100% of funding associated with prevention activities.



Overview of Success and/or Outcomes for FY 2012-2013

All participants in the PdS/CHW program receive a pre and post test. Overall, participants surveyed showed gains in knowledge about mental health issues and appear likely to use mental health prevention and early intervention services if needed. Survey results are illustrated in the table below.

Promotores de Salud Pre and Post Test Data		
Reported Participant Outcomes		Preliminary Conclusions
98%	Scored a 90% on a mental health knowledge post-test	Participating individuals are gaining knowledge about mental health issues
92%	Scored at least a 4(on a scale from 1to 6) in the Positive Attitude Towards Mental Health Prevention Services Scale	Participating individuals are gaining a positive view of mental health
90%	Indicated an intention to use mental health prevention services on the Intention Scale	Participants that receive educational services are likely to use mental health prevention services

System Enhancement Initiatives

Older Adults Community Services



The Older Adult Community Services (OACS) Program is designed to facilitate a healthy aging process for older adults by implementing prevention and early intervention techniques that 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 includes four major sub-programs developed to promote healthy aging, prevention of suicide in seniors, early intervention techniques and overall senior wellness:

- The **Older Adult Mobile Resources** subprogram provides bilingual and senior appropriate mental health and suicide prevention screenings and substance abuse screenings to older adults who are in geographically and/or economically isolated. The program is expected to increase access to prevention and early intervention screening and support services, while decreasing older adult hospitalizations. Referrals are received from various older adult system service providers.
- The **Older Adult Wellness Services** subprogram is the most utilized service of the target population, delivering and/or coordinating comprehensive activities and support services (i.e., medical appointments, for everyday living needs, and for activity needs) to older adults.
- The **Older Adult Home Safety** subprogram assists older adults to maintain a level of appropriate personal and home safety. This includes providing services and education that increases personal safety, home safety, fall prevention and medication management.

MHSA Legislated Goals

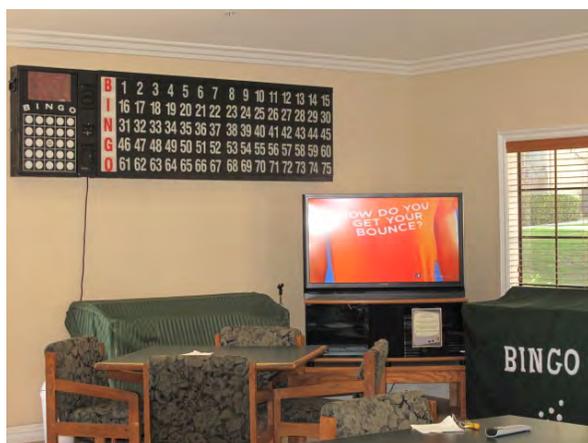
The OACS program works to reduce the stigma associated with mental illness and behavioral health problems in the older adult community by providing services in natural, community based settings. This program increases knowledge about mental illness, and access to free and confidential mental health services which allows older adults to seek services if needed. These program strategies align with the MHSA legislated goals of reducing stigma and discrimination associated with mental illness, reducing suicide risks, and reducing prolonged suffering.

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.

System Enhancement Initiatives

The OACS program will serve approximately 7,000 unduplicated older adults each year. This program is primarily a prevention program, but does include early intervention activities. Approximately 76% of the projected funding is associated with prevention activities and 24% is associated with early intervention activities, as indicated in the table below.

Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$688,250	76%
<i>Early Intervention</i>	\$211,750	24%



Evidence-Based Curriculums, Programs and/or Practices

OACS services may utilize science or research based curriculum, programs and clinical practices such as Cognitive Behavioral Therapy and the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS). Culturally appropriate and promising programs such as Feel Good Bingo and the U.S. Department of Health and Human Services' toolkit for Promoting Emotional Health and Preventing Suicide may also be utilized.

Screening and assessment tools may include the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory and Geriatric Depression Scale to assess the severity of depression, the Perceived Stress Scale to measure stress levels, and the Beck Scale for Suicide Ideation.

Target Population

- Individuals Experiencing the Onset of Serious Psychiatric Illness
- Trauma-Exposed Individuals

MHSA Legislated Goals

The OACS program addresses the following MHSA legislated goals:

- Reducing prolonged suffering
- Reducing stigma and discrimination associated with mental illness

System Enhancement Initiatives

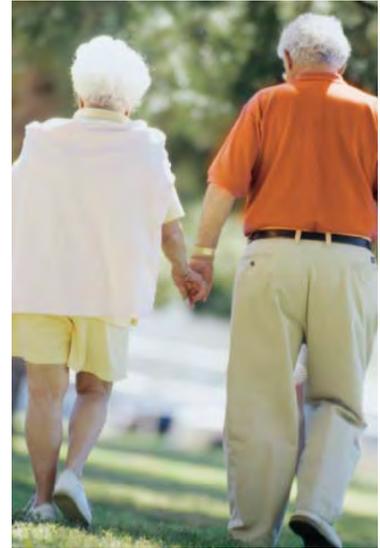
Overview of Success and/or Outcomes for FY 2012-2013

In FY 2011-2012, the OACS Program provided services to 3,902 unduplicated participants. In FY 2012-2013, 7,828 unduplicated participants were served, representing over a 100% increase in participants served.

Satisfaction surveys indicate that participants are satisfied with the services provided and OACS providers are also reporting anecdotal improvement in participant functioning, improvement in outlook on life, and a positive response to wellness and socialization activities.

For FY 2012-2013, participants receiving early intervention services demonstrated average improvement in GAF scores of 16.7% 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 of Older Adult Community Services Participants		
At Case Intake	At Case Discharge	Improvement
55.1	64.3	16.7%

As program evaluation efforts are enhanced, it is anticipated that the OACS program will implement programmatic changes in response to the needs of the older adult population, including enhancing activities that show positive results and participant demand, and scaling back activities that are not as effective and/or receive less interest of the target population.

System Enhancement Initiatives

Child Youth Connection

The Child and Youth Connection (CYC) program provides prevention services to children and transitional age youth involved in the foster care and juvenile justice systems. This program is a collaboration between DBH, the Juvenile Public Defender's Office, Children's Network, Child and Family Services (CFS) and local contract providers.

This program screens, refers and links system involved children and youth to needed mental health services, and prevention and early intervention services, by performing in-home screenings in order to identify, assess and refer clients and their families to appropriate early intervention services. Psychosocial assessments are conducted on high risk clients displaying signs or symptoms of mental health problems as identified by the court, probation and attorney in circumstances where the client does not have a label on their mental health problem or concern. Drug assessments are conducted and appropriate service recommendations are made. Consultation services are provided regarding the mental health needs of minors.

Additionally, Social Service Practitioners also consult with attorneys or service providers regarding client mental health or education issues and make referrals to mental health liaisons with resources that provide services to minors with mental health and/or special education needs. In addition, this program also includes the 0-5 Comprehensive Treatment Services Program. This program is intended to improve the social, developmental, cognitive, emotional and behavioral functioning of children ages 0-5. This program consists of the Screening, Assessment, Referral and Treatment (SART) and the Early Identification and Intervention Services (EIS). SART is a collaborative between the DBH, CFS, Public Health, First 5 and Children's Network, to identify children at risk of developmental and mental health problems. SART provides assessment, individual therapy, family therapy, rehabilitative services and intensive care coordination.

The EIS provides services to children under the age of six who are not displaying age appropriate interactions and attachment. Children may or may not have a history of trauma. Many referrals come from SART Centers, after a child has been screened for more severe concerns. EIS provides assessment, individual therapy, family therapy, rehabilitative services and intensive coordination.



Target Population

- Children/youth in stressed families
- Trauma-exposed individuals
- Children/youth at risk of or experiencing juvenile justice involvement

MHSA Legislated Goals

The CYC program addresses the following MHSA legislated goals:

- Reducing Prolonged Suffering
- Reducing the number of minor consumers removed from their homes
- Reducing homelessness among consumers
- Reducing incarcerations

System Enhancement Initiatives

Projected Number Participants to be Served

The estimated number of unduplicated participants to be served each fiscal year is 5,418, which represents a combination of the total SART/EIIS, Children’s Network, Juvenile Public Defender Office and DBH program services (shown in the table below).

Department/ Program	Estimated Unduplicated Participants to be served
SART/EIIS	4,428
Children’s Network	240
Juvenile Justice Public Defender	400
DBH	350

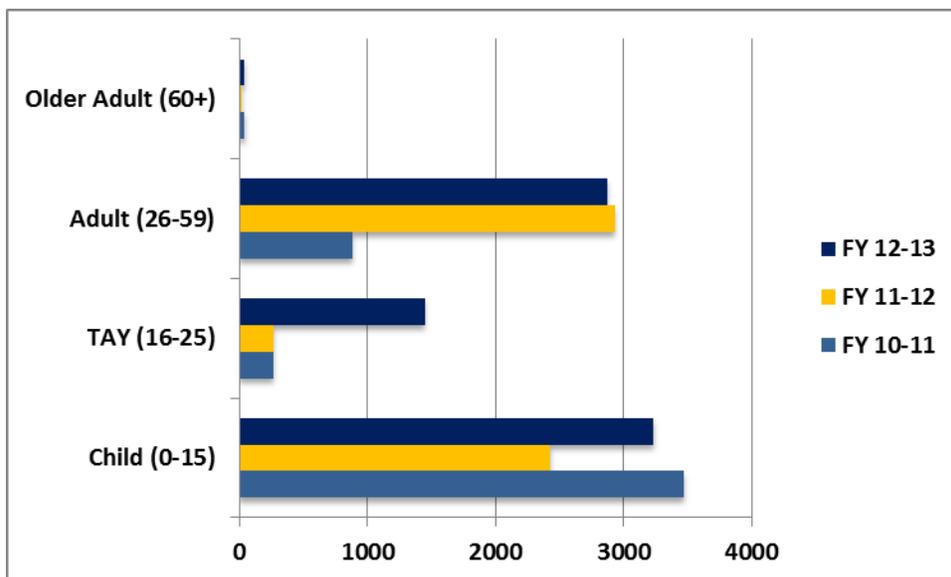
The total funding for all four components [SART/EIIS, The Mentoring Resource Network (Children's Network), Juvenile Public Defender and DBH] is \$2,702,839. Of the total funding, 3% represents prevention services and 97% is early intervention services .



Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$88,000	3%
<i>Early Intervention</i>	\$2,614,389	97%

System Enhancement Initiatives

Demographics



Evidence-Based Curriculums, Programs and/or Practices Currently in Use

The 0-5 Comprehensive Treatment Services Program utilizes the Core Practice Model. In addition, all CYC programs that provide ongoing early intervention services utilize the Child and Adolescents Needs and Strengths (CANS) tool to assist in developing a treatment plan, gauge progress, and measure outcomes.

Overview of Success and/or Outcomes for FY 2012-2013

In FY 2011-2012, the CYC program served 5,764 participants, exceeding the projected number of participants to be served of 4,680 by 23%. In FY 2012-2013 the CYC program served 7,997 participants exceeding the estimated number of participants to be served of 5,175 by 54%.

In FY 2012-2013, the program was expanded mid-year to include the 0-5 Comprehensive Children's Treatment Services Program. This allowed for additional treatment services for children that were no longer eligible for services under other funding streams.

As program evaluation efforts are being enhanced moving forward, it is anticipated that the CYC program will make programmatic adjustments to improve services and meet the needs of children and TAY and their families.

System Enhancement Initiatives

LIFT Program



The LIFT Program seeks to improve the health, well-being and self-sufficiency of first-time mothers and their children. The services are delivered in the individual's home where nurses provide a comprehensive educational program designed to promote the physical and emotional care of children by their mothers, as well as other family members and caretakers. Program nurses link family members with needed physical and mental health services. Providers encourage the involvement of family members, caretakers and friends.

Services include regular and systematic screening and assessment for both the family and child including, but not limited to, screenings for:

- Post Natal Depression,
- Maternal Attachment,
- Substance Use/Abuse
- Developmental Milestones (for the child)

Parents develop a positive relationship with the nurse home visitors and are provided linkage and access to needed services and supports in a timely manner.

LIFT Program Outcomes			
Outcome Measurement	At Initial Assessment	At Six-Month Assessment	Preliminary Conclusions
Full Time or Occasional Employment	27%	33%	Participants are gaining employment
High School Diploma/GED	41%	52%	Participants are receiving support in obtaining their educational goals
Access to Health Care	74%	100%	All participants are obtaining access to healthcare
Keeping Healthcare Appointments	78%	89%	Participants are becoming familiar with the healthcare system
Use of Family Planning Methods	23%	83%	Participants are being educated on family planning methods
Signs of Depression	59%	38%	Depression is being reduced among participants

System Enhancement Initiatives

Target Population

- Children and youth in stressed families
- Children and youth at risk of school failure

MHSA Legislated Goals

The LIFT program addresses the following MHSA legislated goals:

- Reducing prolonged suffering
- Reducing stigma and discrimination associated with mental illness
- Reducing school/failure and dropout rates
- Reducing unemployment among consumers

The LIFT program will serve approximately 120 unduplicated families each fiscal year. On average, 45% of LIFT participants are TAY (ages 16-25) and 55% of participants are adults (ages 26-59).

LIFT is a prevention program, with 100% of the projected funding (\$396,000) associated with prevention activities. The projected cost per unduplicated participant for is \$3,300.

Evidence-Based Curriculums, Programs and/or Practices Currently in Use

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 tool.

Overview of Success and/or Outcomes for FY 2012-2013

The LIFT program conducts a survey of participants every six months using the Life Skills Progression evaluation tool. Data from FY 2012-2013 indicates that after the first six months of services, participants were gaining employment, receiving support in obtaining educational goals, obtaining access to the health care system, receiving education on family planning methods and experiencing reduced signs of depression.

Anecdotally, as demonstrated in the “LIFT Program Outcomes” table on the previous page, participants are demonstrating increased employment and employment-related skills, independence and family stability, and have expressed appreciation for the ongoing support provided through the program.

System Enhancement Initiatives



Military Services & Family Support

The Military Services and Family Support (MSFS) project 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 Posttraumatic Stress Disorder (PTSD). Data analysis has shown that military personnel returning from active duty have a higher risk of suicide than that of the general population. This program provides in-home thorough psycho-social assessments, family interventions, and rehabilitative support for military families who are determined to have these needs.

This program is delivered in participants' homes, when desired, or within the community, increasing the likelihood that military personnel will utilize services, while also reducing the occurrence of stigma and discrimination associated with behavioral health. The MSFS program includes two main components for military families:

1. Prevention Component:
 - Screening and assessments for individuals and their families
 - Support groups designed to meet the unique needs of military families
2. Intervention Component:
 - Case management and referrals for individuals and their families identified as needing long term, intensive mental health services
 - Individual, couples, and family counseling and therapy
 - Short term mental health services for individuals experiencing the onset of a mental illness

Additionally, the program includes collaboration with the County Department of Veterans Affairs. Linkage is provided to standard resources offered through the Department of Veterans Affairs, as well as interventions formally tested such as, the Community Resiliency Model (CRM). Military families (active duty, national guard, and recently retired) with children and TAY will benefit from PEI services.

Additional evidence-based and effective methodologies are utilized to support positive outcomes for program participants, which may include Equine Assisted Therapy and Learning, to enhance treatment to individuals exhibiting signs of depression, PTSD and substance abuse.

System Enhancement Initiatives

Target Population

- Trauma Exposed Individuals
- Children and Youth in Stressed Families.

MHSA Legislated Goals

The MSFS program addresses the following MHSA legislated goals:

- Reducing Prolonged Suffering
- Reducing Stigma and Discrimination Associated with Mental Illness
- Reducing Suicide

Evidence-Based Curriculums, Programs and/or Practices Currently in Use

MSFS providers may use evidence based clinical interventions such as Brief Strategic Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy (PCIT) and Eye Movement Desensitization and Reprocessing (EMDR). Population specific assessment tools and interventions, such as the PTSD Checklist and Emotionally Focused Therapy (EFT) for couples, could also be used.

Additionally, promising practices such as the Trauma Resiliency Model (TRM), CRM, Equine Therapy and Equine Assisted Learning could be incorporated into the program model.

To measure the progress of participants receiving early interventions services, GAF scores were tracked. 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.



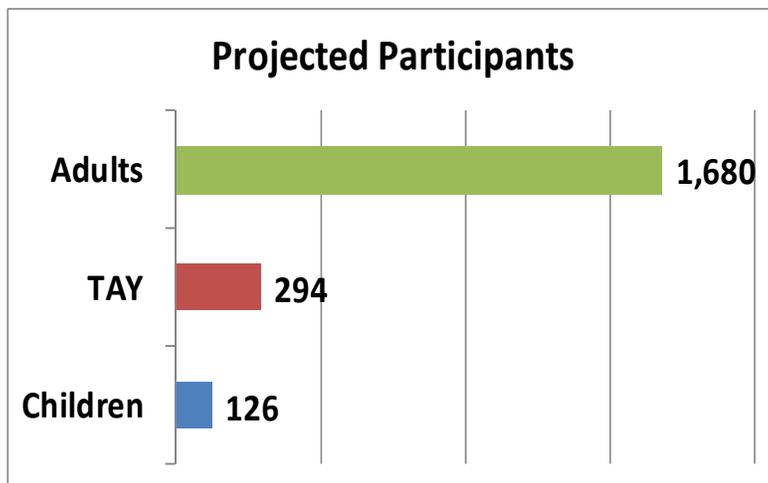
In FY 2012-13, average GAF scores for one provider (Provider A) indicate participants showed 13.3% improvement in functioning after receiving services, as shown in the table below.

Average GAF Scores for Military Services & Family Support—Provider A		
At Case Intake	At Case Discharge	Improvement
52.5	59.5	13.3%

System Enhancement Initiatives

The MSFS Program will serve approximately 2,100 unduplicated participants each fiscal year. On average, 6% of participants are children (ages 0-15), 14% are TAY (ages 16-25), and 80% are adults (ages 26-59). It is projected that this program will serve 126 children, 294 TAY, and 1,680 adults.

The MSFS Program is a prevention program that includes a significant amount of early intervention activities. Approximately 64% of the projected funding is associated with prevention activities and 36% is associated with early intervention activities. Average cost per participant for prevention activities are \$278 and \$622 for early intervention activities.



Overview of Success and/or Outcomes for FY 2012-2013

In FY 2011-2012, the MSFS Program provided services to 495 unduplicated participants. In FY 2012-2013, services were provided to 1,067 unduplicated participants, representing a 116% increase in the number of participants served. With increased funding in FY 2013-2014, it is projected that the number of participants will continue to increase.

For FY 2012-2013, participants receiving early intervention services demonstrated average improvement in GAF scores of 13.3%, as shown in the below table. Providers are also reporting anecdotal improvements in marital and family relationships and life functioning.

Average GAF Scores for Military Services & Family Support—Provider A		
At Case Intake	At Case Discharge	Improvement
52.5	59.5	13.3%

Community Wholeness & Enrichment

The Community Wholeness and Enrichment (CWE) program is designed to primarily serve TAY (ages 16-25) and adults (ages 26-59) who are experiencing the initial onset of a mental or emotional illness and/or substance abuse problems. The CWE program offers the following main components:

- Risk Screenings and community mental health education. Education is aimed at “de-stigmatizing” mental health issues and normalizing the entire mental health process in an effort to *increase the likelihood* of individuals accessing services. Education is provided via an integrated healthcare model and/or utilizing an evidence-based education model (such as, but not limited to, Mental Health First Aid, ASIST, SafeTALK, or other appropriate EBP).
- Depression and substance abuse screenings for individuals experiencing mild to moderate psychological issues followed by a link to the appropriate level of services.

System Enhancement Initiatives

Target Population

- Individuals experiencing onset of serious psychiatric illness

MHSA Legislated Goals

The CWE program addresses the following MHSA legislated goals:

- Reducing Suicide
- Reducing Stigma and Discrimination Associated with Mental Illness
- Reducing prolonged suffering

- Support groups those “at-risk” of developing a behavioral health condition. These groups are offered with the intention of increasing life/coping skills, building resilience and providing education about mental health.
- Suicide Bereavement Support groups directed at family members who have lost a loved one to suicide in community settings.
- Short-term mental health services (up to one year) to individuals who have had little or no contact with traditional mental health services, but have started experiencing/exhibiting mental health symptoms.
- Medications, if necessary at this level, may be managed via Primary Care physicians.



The primary level of early intervention services will be delivered through a network of community-based organizations and via a minimum of two integrated primary health clinics.

A First Break Clinic will be implemented to work with TAY and adults experiencing the onset of a serious mental illness with psychotic features (within the last 12 months), intended to reduce the duration of untreated psychosis. Referrals to the clinic will be received from the DBH hospital diversion team, DBH clinics, other hospital emergency rooms, primary care facilities, integrated clinics, other CWE providers, Community Crisis Response Team (CCRT), individuals from other service systems, and family members. Consumers and their family will be engaged in intensive therapeutic intervention for a maximum of five years (per PEI guidelines). During the engagement and first treatment phases, three to five services per week will be provided and can include comprehensive assessment, individual and group therapy grounded in evidence-based theory and practice, medication services, and multifamily psycho-education groups.

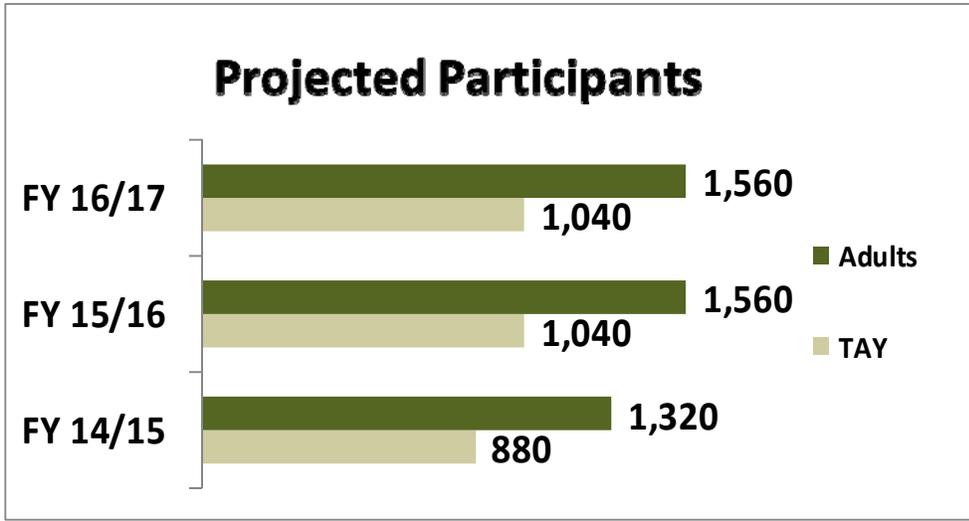
CWE programs utilize a variety of evidence-based and promising practices such as Seeking Safety, Choosing Not to Use, Grieving, Sharing and Healing, Strengthening Relationships with Family and Friends, Living with Feelings and Handling Stress and Nurtured Heart Parenting.

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. The First Break Clinic will also use assessment tools such as the Behavior and Symptom Identification Scale (Basis-24), Daily Living Activities (DLA-20), Structured Interview of Prodromal Syndromes (SIPS) and the Scale of Prodromal Symptoms (SOPS).

System Enhancement Initiatives

The CWE program will serve approximately 2,200 unduplicated participants in FY 2014-2015 and 2,600 unduplicated participants annually for FY 2015-2016 and FY 2016-2017. On average, 60% of participants are TAY (ages 16-25) and 40% are adults (ages 26-59).

As funding for the CWE program will increase to support the First Break clinic in FY 2015-2016, it is projected that the First Break program will serve an additional 400 unduplicated participants, therefore increasing the annual projections in FY 2014-2015 and FY 2015-2016.



The CWE program provides both prevention and early intervention activities. For FY 2014-2015 approximately 36% of the projected funding is associated with prevention activities and 64% of the projected funding is associated with early intervention activities, as illustrated in the table below.

As a result of the implementation of the First Break component in FY 2015-2016, it is projected that funding associated with prevention activities will reduce to 23% and funding associated with early intervention activities will increase to 77% in FY 2015-2016 and FY 2016-2017.

FY 2014-2015		
Service Type	Projected Funding	Percentage
<i>Prevention</i>	\$738,006	36%
<i>Early Intervention</i>	\$1,312,010	64%

System Enhancement Initiatives

Overview of Success and/or Outcomes for FY 2012-2013

CWE providers tracked GAF scores of participants that received 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. For FY 2012/2013, participants receiving early intervention services demonstrated average improvement in GAF scores of 21.5% after receiving clinical interventions.

Average GAF Scores of CWE Participants		
At Case Intake	At Case Discharge	Improvement
48	58.3	21.5%



Providers utilizing participant surveys are reporting improvement in client behavior, functioning, emotional health and in participants' ability to parent effectively. Providers also report improved mood, as well as positive goal development in many participants.

Between FY 2011-2012 and FY 2012-2013, services were provided to an annual average of 10,867 unduplicated participants. Moving forward, the number of projected participants is expected to decrease; however, the services provided to each individual participant are expected to increase. The increase in services, versus unduplicated participant count will occur due to the increase in intensive early intervention services being provided through the First Break component.

System Enhancement Initiatives

Coalition Against Sexual Exploitation

The Coalition Against Sexual Exploitation (CASE) program was originally a time-limited 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. After careful review of the Innovation component intent, principles and priorities, Innovations dedicated efforts on building from prior stakeholder input received during the CPP process for Community Services and Supports (CSS) and PEI, as well as solicited new input specifically for Innovation projects. Through the CPP process, CASE was identified as a project necessary to address the need in “specialty” communities.

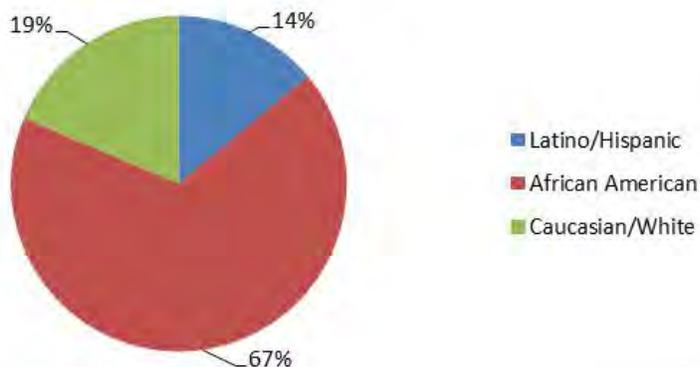
The initial intent was to develop a model of collaborative care that facilitated clinical rehabilitation for a specific group of children/youth who have been sexually exploited, and to develop approaches to mental health education that assist in the prevention of future exploitation. The long-term goal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

Since its inception, the CASE project has been successful in strengthening collaborative efforts between nine child/youth-serving agencies, including the County’s DBH, Children and Family Services, Children’s Network, District Attorney’s Office, Public Defender, Probation Department, Sheriff’s Department, Department of Public Health and the San Bernardino County Superintendent of Schools. A CASE Steering Committee comprised of agency representatives formed a multi-disciplinary team (MDT) and appointed a CASE Coordinator to oversee and coordinate program efforts.

The CASE Coordinator and MDT are charged with serving children/youth through a centralized referral mechanism, maintaining a well-coordinated system of care and increasing outreach and education regarding sexual exploitation of children/youth. The project has been successful in coordinating direct services, including: assessments, crisis intervention, case management, school enrollment assistance, transportation, placement, and referrals to community based resources. Additionally, it has reached various community-based organizations, non-profits and faith-based organizations, as well as public and private agencies, through outreach/education.

Because individuals served through CASE are inherently at risk of developing a behavioral health condition and a disparate portion are from underserved cultural populations, the project is being restructured as a PEI System Enhancement Initiative program. In FY 2012-2013 the participants served included 29 African American (67%), 8 Caucasian (19%) and 6 Latino (14%), as illustrated in the adjacent graph.

Ethnicity of Participants Served



System Enhancement Initiatives

Coalition Against Sexual Exploitation

Target Population

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness,
- Trauma exposed Individuals
- Children/Youth at risk of/or experiencing involvement in the juvenile justice system

MHSA Legislated Goals

The CASE program addresses the following MHSA legislated goal:

- Reducing prolonged suffering



Overview of Success and/or Outcomes for FY 2010-11 — FY 2012-2013

Qualitative successes include the strengthened collaboration of the CASE Steering Committee and formation of the Multi-Disciplinary Team and Case Coordinator position, which have been integral in making progress and assisting in the learning goals of the original Innovation Plan.

Quantitative successes have included services (i.e., assessments, crisis intervention, case management, school enrollment assistance, transportation, placement, and referrals to community-based resources) being delivered to an average of 42 individuals on an annual basis from FY 2010-2011 through FY 2012-2013. Additionally, the CASE program has reached out to various community-based organizations, non-profits and faith-based organizations, as well as public and private agencies, providing outreach and education to an estimated 4,000 individuals annually from FY 2010-2011 through FY 2012-2013.

The CASE Program will serve approximately 50 unduplicated participants each fiscal year. It is projected this program will serve 12 children (ages 0-15) and 38 TAY (ages 16-25).

The CASE Program is an early intervention program which also includes prevention activities. Approximately 80% of the projected funding is associated with early intervention activities and 20% is associated with prevention activities.

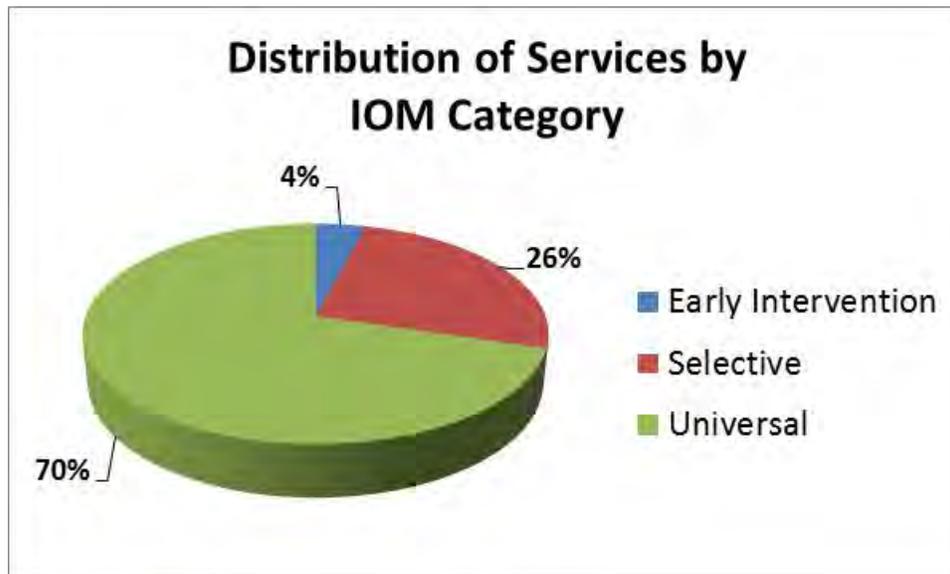
Overall Program Data



Distribution of Services

For FY 2012-2013, PEI projected to serve 58,885 unduplicated participants. Actual service counts exceeded projections by 45%, as the total number of actual unduplicated participants served was 85,229. Additionally, PEI provided over 200,000 services throughout all programs FY 2012-2013.

The distribution of services by IOM category, provided to unduplicated participants throughout all PEI programs, includes 59,945 Universal services, 21,804 Selective services, and 3,480 Early Intervention services. The respective percentages are illustrated in the graph below.



Demographics

In FY 2012-2013, over 200,000 culturally and linguistically appropriate services were provided using PEI funds. DBH PEI is dedicated to providing culturally competent services to diverse ethnic and cultural populations throughout San Bernardino County. Services are adherent to the County Cultural Competency Plan, including requiring cultural competency training on an annual basis for direct staff and contract providers. Additionally, PEI requires contract providers to assess the demographic make-up of the area being served to ensure an equitable representation of ethnicities and cultures reflected in the respective communities. This includes providing linguistically appropriate services to individuals, including bilingual and/or in need of translation services, etc.

Overall Program Data

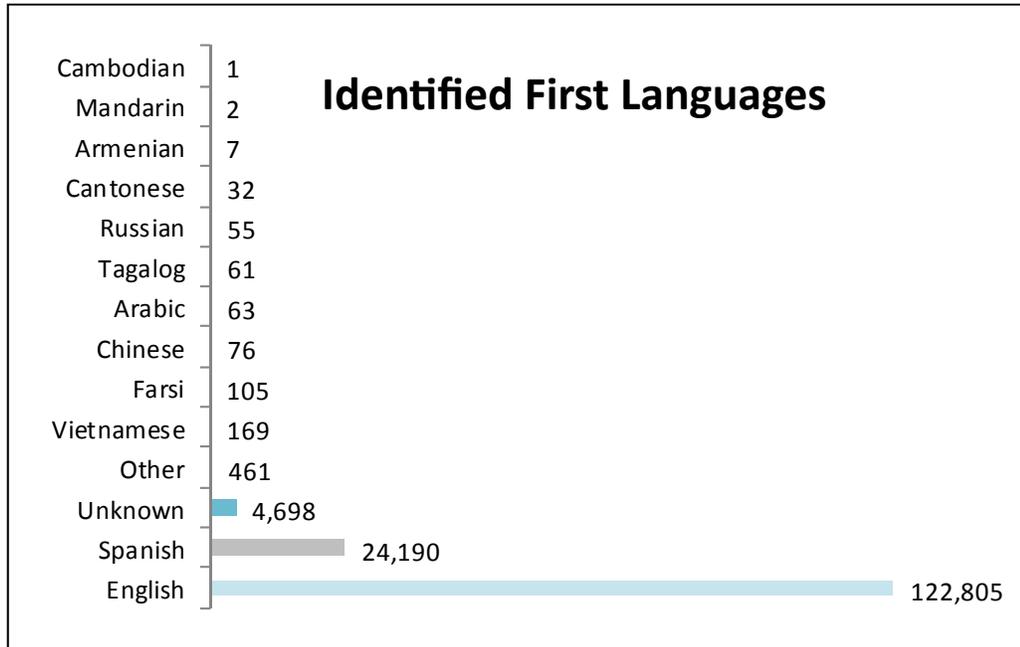
The graph below details the number of services provided to participants from various ethnic and cultural groups in FY 2012-2013.

PEI services were provided to individuals that identified languages other than English as their first language. Second to English, Spanish was the predominant language identified (15%).

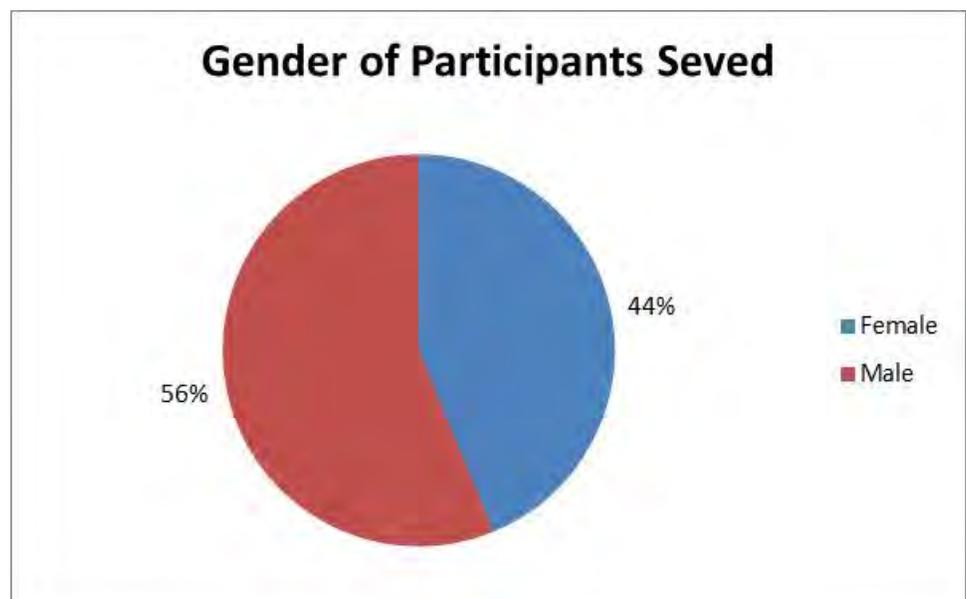


Overall Program Data

The graph below details the various languages identified by participants served. English was dominant at 122,805 (85%), followed by the threshold language, Spanish, at 24,190 (15%).



In addition to ethnic, cultural and linguistic data, information is collected on participant gender, including those who identify their gender as "Other". The majority of participants receiving PEI services are female (44%), as illustrated in the graph below.



Challenges & Outcomes



In an effort to assess the available data for all PEI programs, the following challenges were identified:

- Some programs lack standard outcome measures and tools that can be utilized across providers.
- A small percentage of providers did not have sufficient data to adequately evaluate their progress.
- A small percentage of providers were found to be providing services that require more fidelity to the program models.

Despite these challenges, the outcomes analyzed indicate that PEI programs in the County are valuable and are improving the lives of individuals and families throughout our communities.

- Underserved, Spanish speaking residents are gaining knowledge about mental health and are likely to use or refer others for services when needed, thus reducing the stigma and discrimination related to mental illness .
- Students are gaining important social and emotional skills and assets which are the building blocks of resiliency and wellness.
- Preschool students dealing with aggression and bereavement are outperforming their peers in social and emotional development after receiving PEI services.
- African American children/youth are receiving PEI services that strengthen resiliency and promote mental health wellness in diverse communities.
- Diverse populations, such as LGBTQ, are receiving PEI services in non-traditional natural settings, thus increasing access and reducing the stigma and discrimination related to mental illness .
- At risk new mothers are gaining maternal skills and life development opportunities that help reduce stress, increase resiliency and increase their ability to raise healthy and appropriately developed children.
- Adults have measurably reduced levels of depression and anxiety after receiving early intervention services.
- Older adults are satisfied with PEI activities and have reported improvements on their outlook on life.
- GAF (Global Assessment of Functioning) scores from several programs show participants have improved daily functioning after receiving PEI services.
- A variety of suicide prevention strategies are being implemented across programs, thus improving awareness of suicide prevalence and impacting risk factors.
- Culturally competent services are being provided to a variety of ethnic and cultural groups.

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 initiating 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



The total contributed from counties statewide was approximately \$136 million. This funding will expire in June 30, 2014.

During community planning meetings, DBH posed the question of continued support for these projects. Stakeholders overwhelmingly expressed to continue support, as long as local operations are not negatively impacted by the contribution. The requested contribution for larger counties, such as San Bernardino, is between 4% and 7%. The County DBH plans to make an annual contribution of approximately 4% of the PEI allocation to support the ongoing implementation of Statewide PEI Projects. Upon approval, DBH intends to assign local funding among the three initiatives 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: 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



Student Mental Health 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

Suicide Prevention 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 "warmlines")



PEI Statewide Projects

Statewide Impact : January – December 2013

<i>Individuals</i>	<i>Program/Activity</i>
124,774	Trained and/or educated on prevention strategies
819,881	Reached through crisis and early intervention services, etc.
1,475,713	Reached through informational resources
265,764,543	Views of social marketing campaign materials

Local Support of Training, Education, and Media Investments

Stigma and Discrimination Reduction Partners offered local training in the following areas:

- Provided technical assistance on integrated behavioral health implementation and SDR strategies to county staff.
- Trained **38** participants on stigma reduction strategies and **5** participants on language translation in mental health settings.
- Trained **19** *Parents and Teachers as Allies* (NAMI), and employees at local businesses on wellness in the workplace.
- Speakers Bureau Grants: The Brightest Star trained **28** speakers and reached **1,970** individuals to date. El Sol trained **34** speakers and reached **830** individuals to date.
- Community education activities included the Behavioral Health Symposium, where participants learned about such topics as the prevalence of mental illness, recovery for mental health, challenges and substance abuse issues.

Student Mental Health Partners offered local training in the following areas:

- Pre-K-12 (January–December 2013): Trained **2,439** individuals on topics such as Positive Behavioral Intervention Skills (PBIS)
- CSU San Bernardino (March-December 2013): Reached **1,400** students at Health & Wellness Workshops on mental health topics.
- San Bernardino Valley Community College: To date, trained over **1,600** individuals in crisis response and peer strategies.

Suicide Prevention Partners offered local training/media in the following areas:

- Know the Signs Suicide Prevention campaign: County residents received information through local billboards (**15.9** million views), TV (e.g. cable, Univision; **2.5** million views), online (e.g. Facebook, Hulu; **18.8** million views), magazines (**600,000** views), resulting in **37.8** million total views of the campaign materials. During the first **4** months, over **19,000** residents visited the campaign websites to seek information.
- In collaboration with the Asian American Resource Center in San Bernardino County, culturally responsive materials have been developed, such as adaptations of suicide prevention social marketing materials for the Hmong community. Know the Signs materials have also been customized for diverse populations, such as African American and Latinos, and have or will be distributed throughout the county.
- Suicide Prevention Crisis Call Centers: Received **2,612** calls in 2012 and **2,674** calls in 2013 from San Bernardino County residents.
- Suicide Prevention Training: To date, CALMHSA funded trainers have provided ASIST suicide prevention and intervention skills workshops to **127** county participants and safeTALK workshops to 36 county participants.

Solutions in Progress

Next Steps

In FY 2014-2015, the DBH will provide training and technical assistance to providers and community partners to improve their knowledge on PEI strategies and encourage enhancement of skills required to deliver impactful and appropriate PEI services. Additionally, enhancements in program monitoring and evaluation will be implemented to ensure program effectiveness and fidelity, as well as improve the ability to access outcomes measures.

Currently, PEI programs are being evaluated utilizing survey tools developed by *Evalcorp*, an evaluation consultant, to measure progress in the Family Resource Center program, Student Assistance Program and Military Services and Family Support program. Moving forward, additional evaluation tools and logic models will be developed to incorporate into all other PEI programs. Existing social-developmental assessments and/or tools will be evaluated for effectiveness in measuring legislated MHSA goals and to determine outcomes and successful progress in future years.

Overall, the information detailed in this report reveals progress and success of PEI programs. The County DBH looks forward to continuing to refine and improve methods for implementing the most effective and appropriate PEI services, promoting wellness, recovery and resiliency for participants and their families throughout our County.





MENTAL HEALTH SERVICES ACT



WET: Workforce Education and Training (WET)

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 - 1 7

Service Goals/Outcome Measures

The Goal of the Workforce Education and Training Component is:

- Develop and maintain a culturally competent behavioral health workforce.

The objectives of Workforce Education and Training are:

- **Expand** existing Department of Behavioral Health (DBH) training program.
- **Provide** training to support the fundamental concepts of the Mental Health Services Act.
- **Continue to develop** standardized core competencies for all DBH positions, including clinical, clerical and administrative positions.
- **Continue** outreach to high school, community college, adult education and Regional Occupational Program (ROP) students.
- **Continue** the existing Leadership Development Program (LDP) and create and implement an Executive LDP track.
- **Continue** to develop Peer and Family Advocate (PFA) workforce support initiatives.
- **Continue** the existing DBH Internship Program, including the Employee Internship Program.
- **Continue to** implement a short term Psychiatric Residency Program and Medical Student Training Program with local medical schools and institutions.
- **Award** Employee Scholarships and evaluate the program for possible expansion to contract agency employees.
- **Continue** to expand eligibility for federal workforce funding.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Workforce Education and Training

The Workforce Education and Training (WET) component of the Mental Health Services Act (MHSA) was created to address identified shortages in occupations, skill sets, and individuals with unique cultural and linguistic competence whom provide services in the public mental health system and to provide education and training for all individuals who provide or support services in the public mental health system, including fostering leadership skills.

All actions proposed in WET Plans had to meet the following criteria:

- Develop and maintain a culturally competent workforce.
- Include clients and family members, who are capable of providing client and family- driven services that promote:
 - * Wellness,
 - * Recovery, and
 - * Resilience
- Lead to measurable, values-driven outcomes.

DBH chose to create actions in all five (5) categories recommended for consideration of WET plan actions:

- Workforce Staffing Support.
- Training and Technical Assistance.
- Mental Health Career Pathways Programs.
- Residency, Internship Programs.
- Financial Incentive Programs.



The Workforce Education and Training (WET) component of the Three-Year Integrated Plan continues to address the County of San Bernardino's Public Mental Health System shortage of qualified individuals to provide behavioral health services. This includes community-based organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise our county's Public Mental Health System workforce. Actions funded by the Workforce Education and Training component supplement state administered workforce programs to make a local impact and are outlined below.

OVERVIEW

WET Program

The DBH Workforce Education and Training Program is charged with responsibility for developing staff equipped to provide treatment services that are culturally appropriate, mindful of the interaction between substance abuse and psychological problems and based in recovery principles. The program develops existing staff as well as works with local educational institutions and other partners of all levels to develop a pipeline for the future workforce.

WET: WORKFORCE EDUCATION AND TRAINING (WET)

Training to Support the Fundamental Concepts of the Mental Health Services Act

Over the last several years, DBH continued to identify the need for training in areas that empower DBH and contract agency staff to provide services that are based in the wellness, recovery and resilience model, that are culturally competent, that support the philosophy of a client/family driven mental health system, integrate services and includes community collaboration. The continuation and expansion of the Training Unit provides consumers and family members, all levels of our diverse workforce, and contract agencies, as needed and requested, with the education and training needed to advance the vision and business strategies adopted by DBH as well as the fundamental concepts of MHSA, placing emphasis on supporting employees with lived experience. DBH will continue to provide training relevant to these subjects, ensuring training is available to department and contract agency staff as well as consumer and family members. In addition, extensive training and support will be provided across the entire public mental health system as the department begins implementation of an Electronic Health Record system and implementation of Medi-Cal Expansion.

Development of Core Competencies

Core competencies represent the core knowledge and skills that public mental health staff should have based upon their job classification. Beginning with a master template that lists all courses that direct services, supervisory and clerical staff must have, DBH has developed training maps listing all training that has been requested and discussed by the internal workforce development workgroup. Additionally, DBH is working on developing career ladders for all groupings of job classifications within DBH and continues to work to identify pathways leading from one classification group (e.g. clerical) to another classification group (e.g. unlicensed direct service staff). Courses included in the core competency areas are mindful of the fundamental concepts of MHSA. DBH will continue to develop this action as we expand or include additional classifications into our system of care.

Outreach to High School, Adult Education, Community College and Regional Occupational Program (ROP) Students

To increase awareness of the opportunities for employment in behavioral health services, DBH has entered into collaborative relationships with local universities, community colleges, adult education entities, educational coalitions, and regional occupation programs to develop activities and programs for high school and community college students to interest them in careers in the public behavioral health system. This strategy serves as a model for expansion across the remote areas of the County. In addition, DBH networks with local high schools that provide Health Training Academies to ensure mental health professions are included.

Leadership Development Program

During community planning, a need to implement a leadership development program for staff and contract agencies was identified. DBH has implemented a successful Leadership Development Program that develops leaders from existing staff, begins succession planning for future leadership of DBH, begins to make leadership based assignments, and builds leadership into supervisory training. Traditionally, clinicians have experienced difficulty in moving from direct service provision to supervision, administrative positions and management. Participation in the leadership program gives these valuable leaders an opportunity to gain additional leadership training. Over the next several years, DBH will be developing another level of the program to assist in the development of Executive staff.

Peer and Family Advocate Workforce Support Initiatives

Peer and Family Advocates are mental health consumers and/or their 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 MHS Integrated plan in compliance with MHS requirements, and perform related duties as required. DBH provides training for consumers and their family members, as well as volunteers who want to become Peer and Family Advocates, and training for newly hired Peer and Family Advocates to assist them in making the transition from consumer to provider of behavioral health supports. All training provided to Peer and Family Advocate staff is designed to promote the inclusion of mental health consumers and family members in the mental health system. Future work related to this action includes training and support of statewide activities related to Peer and Family Advocate certification.

Expand Existing Internship Program

The county's initial Workforce Needs Assessment indicated the need to identify ways of increasing the numbers of direct service staff members in Social Work, Marriage and Family Therapy, and Clinical Psychology. Over the last several years, the expansion of the internship program has proven successful and continues to grow providing internship opportunities as an excellent way to increase the number of people working at DBH and in contract agencies in the behavioral health professions. Future action includes expansion of the internship program to additional qualified direct service classifications.

Medical Education Program

As previously identified in the Workforce Needs Assessment, the County of San Bernardino has challenges attracting and employing qualified psychiatrists in the public behavioral health system. The development of a psychiatric residency program and a medical student training program helps fill the existing gap in the provision of care so that quality behavioral health services can be provided to the residents of the county within their appropriate scopes of practice. Experience in teaching hospitals has shown that the majority of residents who train in an area eventually remain in the region upon completion of training.

The DBH Medical Director, with support staff, will continue to lead the county's initiative to establish a psychiatric residency training program and medical student training program within DBH to develop specialties in child or geriatric psychiatry, public mental health or multidisciplinary psychiatry and work one or two years in county and/or community public agency settings, such as psychiatric emergency clinics, urgent care centers, or community out-patient clinics once training is complete.

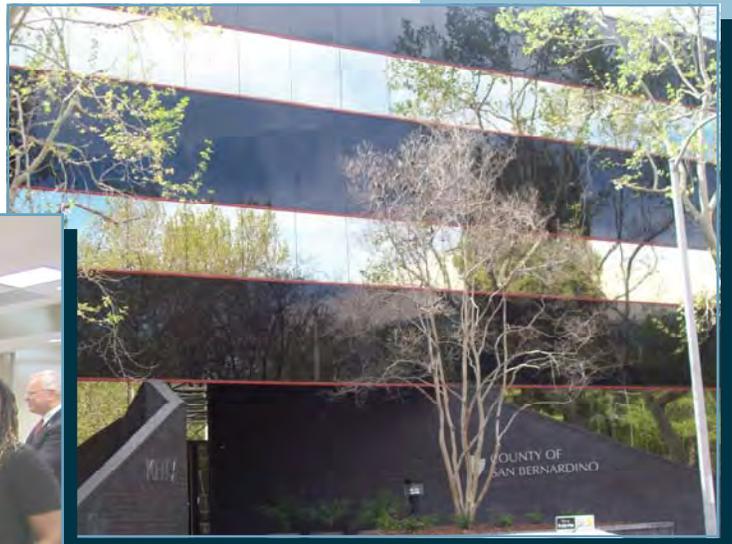
Scholarship Program

DBH will continue to implement an Employee Scholarship Program to help current DBH and contract agency employees continue their education and to advance their careers in the mental/behavioral health professions. Candidates for the Employee Scholarship Program must show proof of enrollment in a certificate, Associate of Arts, Bachelors, Masters or Doctoral degree program for consideration. Scholarships are not available to candidates for the employee internship program. The funds provided by the scholarship program supplement funding for education that is offered to county employees through the various negotiated Memoranda of Understanding and statewide WET projects. The Employee Scholarship Program is one way of addressing the issue of bilingual staff members in non-direct service positions by helping them continue their education and move to direct service staff.

Increase Eligibility of Federal Workforce Funding

A Mental Health Professional Shortage Area is a federal designation and is defined as an area having a shortage of professional mental health providers based on the availability of psychiatrist and mental health professionals. While San Bernardino County has ten MHPSAs, six are relevant to DBH: **(1)** Big Bear Lake/Running Springs, **(2)** Argus/Trona; **(3)** Baker/Newberry Springs; **(4)** Lytle Creek/Wrightwood; **(5)** Big/River/Needles; and **(6)** Joshua Tree/Landers/Morongo/Rimrock/Yucca Valley.

The benefits of an MHPSA include loan repayment for mental health service providers, with criteria varying by profession, and includes, Medicare incentives paid directly to the physician, enhanced federal grant eligibility for DBH, and improved recruitment possibilities through the National Health Service Corps Scholar placement program. The County of San Bernardino will continue to use the MHPSA designations and National Health Service Corps Site Certifications to recruit and employ professional mental health providers in the remote areas of the county.



WET: WORKFORCE EDUCATION AND TRAINING (WET)

Making a Difference

WET has **changed/improved the delivery of mental health services in the County of San Bernardino since its implementation** by:

- Increasing the number of qualified staff to serve consumers through multiple WET programs such as the Intern Program, the License Exam Prep Program, the Medical Student Program, Psychiatric Residency Program, the Employee Scholarship Program and Student Career Pathways Programs.
- Training future leaders with the Leadership Development Program.

In Their Own Words

Summarized quotes from two of our prior interns that are now working as Pre-licensed Clinicians in the Public Behavioral Health field:

"I can't say enough about much my internship year prepared me for this job. I'm working very long hours but it doesn't really feel like work because I love it! Thank you again for all that you have given me – I use it all every day!"

"The Intern program helped me tremendously. I consider myself lucky to have had such an internship where a vast amount of workshops were available to me. My field instructor was an LCSW and could explain concepts and theories and how they could be implemented in my practice. I was able to see my strengths and more importantly my weakness and given guidance on how to improve."

Summarized quote from an Employee Scholarship Recipient:

"Thank you so much for the tuition scholarship. I am enrolled in the Studies in Human Behaviors Master's program and this award has lightened my financial burden and allowed me to focus more on school."

Summarized quote from a Mental Health Loan Assumption Program recipient:

"I'd like to thank WET for the opportunity to have my loans forgiven. As an employee of DBH and previously with contract agencies it was a long term goal to one day become a clinician. This goal was realized through the opportunities I have received here at DBH. I am grateful and humbled by being a recipient of the same level of care and interest we aspire to provide those we provide service for."

Summarized quote from a Leadership Development Program (LDP) participant:

"LDP gave me an improved understanding of the DBH Executive Team and their history, experience and leadership philosophies, also DBH goals and improved knowledge of various programs. I also got exposure to external offices and hands-on experience with high-profile projects. I was shown how to improve group work and time management skills. Through LDP I gained confidence in my abilities."

Summarized quotes about our Medical Student Program and Psychiatric Residency Program (from a Resident later hired as a DBH Psychiatrist):

"As the 1st cycle for the medical student rotations come to a close, I would like to think everyone involved for participating in this newly revised WET program to provide these young student physicians with the learning experience of a lifetime. The success would not have been possible without everyone's collaboration, enthusiasm, dedication and hard work."

"Thank you for the employment opportunity. I have been passionate about working with the underserved community and am confident in my abilities as a clinician with specific experience and education through my residency training in chemical dependency, outpatient medication management and psychotherapy."

Collaborative Partners

The WET program would like to acknowledge and thank our various collaborative partners that helped to connect with the community.

WET has accepted interns for the Social Work, Marriage and Family Therapist, and Psychology Internships from numerous schools. Among them are Alder School of Professional Psychology, Argosy University, Azusa Pacific University, Chapman (Brandman) University, California Baptist University, California State Polytechnic University Pomona, California State University San Bernardino, Fuller Theological Seminary, Loma Linda University, La Sierra University, and Rosemead School of Psychology (Biola University).

The following schools that have worked in partnership with WET: American Career College, California State University (CSU) Long Beach, Intercoast College, Mt. Saint Mary's College, ITT Technical Institute, University of Phoenix, Pacifica Graduate Institute, Summit Career College, Touro University, UEI college, and University of La Verne.

WET has also worked with the San Bernardino Regional Occupational Program (ROP) and Colton, Redlands, and Yucaipa ROP to immerse their teachers in various DBH programs to help develop curricula for their students.

Loma Linda University provided assistance with the current Leadership Development Program (LDP), including helping to develop curriculum and evaluating outcomes and will also provide assistance for the proposed LDP Executive Track.

WET has also collaborated with various national, state, and local organizations and agencies: American Association for Marriage and Family Therapy (AAMFT), California Institute for Mental Health (CiMH), California Social Work Education Center (CalSWEC), Children Family Services (CFS) Countywide Training Committee, Inland Coalition, Inland Empire Clinical Education Collaborative (IECEC), Inland Psychological Association, Marriage and Family Therapy Consortium of the Inland Empire, Office of Statewide Health Planning and Development (OSHPD), Performance, Education, & Resource Centers (PERC), Trauma Resource Institute (TRI), Workforce Development Department (WDD), and Working Well Together (WWT).

Positive Outcomes

Having qualified and licensed staff is an important activity of behavioral health workforce development. After supporting three (3) cohorts of License Exam Preparation Program (LEPP) trainings, DBH saw a **12.9%** increase in the percentage of Licensed staff compared to Pre-licensed staff. We envision that the implementation of the Revised LEPP will show an even greater success.

The continued expansion of the intern program has proven to be fruitful in the recruitment of qualified staff into the public mental health system. The chart below demonstrates an increase in the percentage of interns who transition to permanent county employment as measured by the DBH pre-licensed clinicians hired interns vs. non-interns and the number of qualified applications received.

Fiscal Year	% of interns hired
FY 2010/11	32%
FY 2011/12	54%
FY 2012/13	67%
FY 2013/14	60%

WET: WORKFORCE EDUCATION AND TRAINING (WET)



MENTAL HEALTH SERVICES ACT

INN: Innovation

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 - / 1 7

Service Goals

The goal of Innovation is to:

Implement and test time-limited, novel, creative, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.



The purposes of Innovation are to:

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

The Innovation component is provided 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 will 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.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Introduction to Innovation

Innovation projects are designed to support and learn about new approaches to mental health care 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.

An Innovation project is defined as one that contributes to learning rather than a primary focus on providing a service. The purpose 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 public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

The County of San Bernardino currently has seven (7) Innovation projects in various stages of implementation. Each project was designed via an extensive Community Program Planning process. The table below illustrates the multiple projects, the timeline associated with each project, the contract end dates (if applicable), and the project end dates. All Innovation projects are time-limited. Successful parts of each project may be continued under a different funding source or implemented into existing services for improvement.

Project Title	Contract End Date (Applied Research Ends)	Analysis & Evaluation (Reviewing Findings)	Project End Date (Analysis Complete)
Online Diverse Community Experience	N/A	July 2013—Dec 2013	July 2014
Coalition Against Sexual Exploitation	MOU ends June 2014	July 2014—Dec 2014	December 2015
Community Resiliency Model	December 2013	Jan 2014– March 2014	July 2014
Holistic Campus	June 2015	July 2015 - Dec 2015	Dec 2016
Interagency Youth Resiliency Team	June 2015	July 2015 - Dec 2015	Dec 2016
Behavioral Health Youth Hostel (The STAY)	Contract extension to March 2017 to align with approved timeline	April 2017 - Sept 2017	Sept 2018
Recovery Based Engagement Support Teams	N/A	Nov 2017 - Oct 2018	Oct 2019

Challenges

A challenge inherent in the Mental Health Services Act (MHSA) Innovation component is to implement ideas that challenge previous ways of providing traditional mental health services, such as:

- Identifying client information databases that fit the diverse program structure and needs of each Innovation project.
- Identifying appropriate evaluation strategies to gauge performance outcomes for unique and innovative projects where logic models and evaluation tools do not currently exist.
- Maintaining high levels of community interest and education surrounding on-going Innovation projects.
- Implementing programs within multiple organizational partners and complex relationships.
- Quantifying and applying knowledge learned in realistic cost effective ways that actually improve quality of services.

Solutions in Progress

To implement solutions and overcome challenges, the Innovation unit is working on the following identified actions by:

- Consulting with professional evaluators, familiar with the administration of other MHSA components, in order to trouble-shoot and utilize existing resources to develop data tracking systems, and for purposes of reporting outcomes and sharing information.
- Working on evaluation activities to obtain statistical information, and assisting with data analysis needed to evaluate the effectiveness of programs and other learning objectives for the purposes of future program planning.
- Maintaining on-going contact with the Mental Health Services Oversight and Accountability Commission (MHSOAC) for guidance and direction with regard to all aspects of the administration of Innovation projects.
- Initiating the Innovation stakeholder meetings to encourage and promote community involvement around all phases of the Innovation projects.
- Working to make connections with existing DBH programs so lessons learned can be applied in real time in the most appropriate areas of the service delivery system.

In Their Own Words

⇒ A CRM trainer reported, *"... approached me about presenting CRM to all four campuses of our church. We have a lot of PTSD sufferers and their families who need these skills. Veterans with PTSD and others who suffer with PTSD are always on his heart."*

⇒ *"I can tell my mentor anything and look up to her...I learned that school is important and that there are programs at college to help foster youth....my life would be so different without IYRT because I wouldn't have experienced so many things...I used to have a problem trusting people but I can trust my mentor to give me good advice."* (IYRT Mentee, 14 years old)

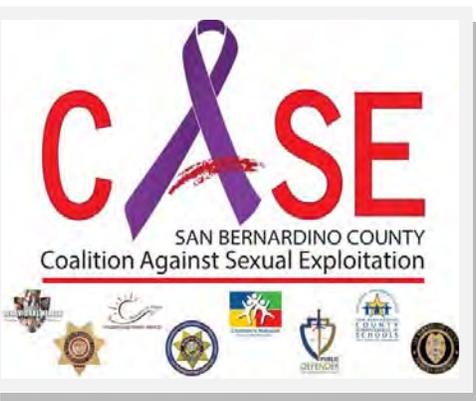
Coalition Against Sexual Exploitation (CASE)

The Coalition Against Sexual Exploitation (CASE) project is a collaborative partnership among nine (9) separate child-serving agencies within the County of San Bernardino, including many of our community partners. CASE works to provide a model of interventions and services with a common goal of reducing the number of children being exploited and drawn in to a life of prostitution. CASE seeks to develop resources to educate, prevent, intervene, and treat those affected by sexual exploitation. In addition to providing treatment and services by a specialized multi-disciplinary team of experts, CASE also provides extensive outreach and education for anyone who may interact, or come in contact with, victims of sexual exploitation. Direct services include; intensive case management, building of rapport, advocating in court proceedings, and making treatment recommendations to the court, provision of therapy, placement, and working with family members of the clients. To meet the terms outlined in WIC 5830, the primary purpose identified for this change to an existing mental health practice/approach is to **increase the quality of services** provided to achieve greater outcomes. However, it is evident that interagency collaboration is the cornerstone of this project.

CASE strives to develop a model of collaborative care that facilitates a safe haven and clinical rehabilitation for children who are sexually exploited, and to develop approaches to mental health education that assists in the prevention of future exploitation. This Innovation **increases the quality of services, including better outcomes** for sexually abused children in the County of San Bernardino.

The approved Innovation Work Plan for this project, submitted as part of the County's Innovation Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in February 2010, outlined five (5) goals that will contribute to learning. The Innovation funding for CASE expires June 30, 2014. Discussions have been underway regarding future funding and program sustainability. At the time of this report, our county partners are considering funding a portion of the project so that services being provided by the multi-disciplinary team can continue. Prevention and Early Intervention (PEI) funding will sustain the program following the conclusion of Innovation funding. A final report for this project, which will include complete funding and sustainability information, and comprehensive evaluation/outcomes information, will be developed in compliance with the regulations set forth for Innovation reporting.

In January 2014, CASE held its fourth annual Anti-Human Trafficking Awareness Walk. Over **450** people were in attendance including speakers from each of the Departments involved in CASE. There was also a male survivor who courageously shared his story. In 2013, the County of San Bernardino District Attorney released a film



entitled "Teenage \$ex 4 \$ale," which his office continues to screen throughout the County of San Bernardino. Attendees gain a broader knowledge of sex trafficking and what role they play in combatting this situation from occurring in their own communities. CASE continues to provide regular trainings on the Identification and Assessment of Victims of Trafficking and Sexual Exploitation, making great strides in working toward their goal of having a training and education module for those who interact with children who are victims, and that works effectively for the San Bernardino County's cultural and ethnic populations.

<Note: There is no forecast for clients served because the INN funding on this project ends June 2014 and will be integrated with Prevention and Early Intervention (PEI) and is represented in PEI>

Recovery Based Engagement Support Team (RBEST)

On March 27, 2014, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the MHSA Innovation Plan 2014. The Plan contained a proposal to expend Innovation funding on one (1) new Innovation project. DBH is proposing the establishment of Recovery Based Engagement Support Teams (RBEST) in each of the four (4) regions within the County, which is a new and innovative strategy, as there are no other current programs with this specific aim. These teams will provide community (field-based) services in the form of outreach, engagement, case management services, family education, support and therapy, for the most challenging diverse adult clients in the community, who suffer from untreated mental illness, in an effort to “activate” the individual into the mental health system to receive appropriate services. Included in this effort are the “invisible individuals” (identified during the stakeholder process) who have been cared for in private residences by families and loved ones without the assistance of effective behavioral health supports.

The RBEST project was designed to address the spirit and intent of AB 1421, enacted in 2002, which allows for court-ordered assisted outpatient treatment, should a county chose to do so. The RBEST project addresses AB 1421, also known as Laura’s Law, by working to engage non-compliant and/or resistant to treatment individuals into appropriate and necessary psychiatric care voluntarily.

This is a unique opportunity to present and introduce an innovative project designed to increase **the quality of services, which includes better outcomes**, by upsetting the status quo and providing field-based mobile outreach and engagement in the community, to foster and develop trust with those individuals within the County of San Bernardino. This includes individuals who have been inappropriately served, underserved, or unserved, and suffer from untreated, severe chronic and persistent mental illness. The RBEST project seeks to assist 300 individuals per year.

The project is expected to last four and a half (4 ½) years and will consist of three (3) phases:

- **Phase 1:** Policies and procedures will be created for the delivery of services: offices, staffing, equipment and supplies, and vehicles will be secured. Hiring and training will take place to ensure properly trained teams are deployed. This phase will also be devoted to building the collaborations and partnerships with community-based agencies, our Cultural Competency Advisory Subcommittees, and the Community Health Workers program.
- **Phase 2:** The middle phase of the project which is expected to be three (3) years in duration, will be devoted to full implementation of the services outlined in this project description. The teams will be deployed in the four (4) established regions of the Department and will provide field-based services. Modifications will be made to the project as learning occurs.
- **Phase 3:** During the last twelve (12) months of the project, designated staff will evaluate all of the data collected and make a determination of the project’s success. To allow for evaluation of the project, services will be reduced to providing continued assistance to consumers established during the tenure of the project.

Recovery Based Engagement Support Team (RBEST)

The project identifies the following as its learning goals:

- **Learning Goal 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 non-compliant and resistant to treatment individuals.
- **Learning Goal 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.
- **Learning Goal 3:** Families of individuals with a mental illness will acknowledge having increased understanding and knowledge regarding mental illness, as well as improved and increased strategies to care for their mentally ill loved ones as a result of care provider initiated activation strategies.

Please see the Department's MHS Innovation Plan 2014 for a detailed description of this project. Due to the timeframes associated with obtaining Plan approval, Phase I has not yet begun, as of the writing of this report. An update on the project timeline will be provided in the MHS Annual Update FY 2015/16.



Artwork contributed by Cindy Messer

Interagency Youth Resiliency Team (IYRT)

The County of San Bernardino Department of Behavioral Health (DBH), in collaboration with the Department of Children and Family Services (CFS), the Department of Probation, County Schools, local child-serving agencies and other stakeholders, wanted to find a way to more meaningfully connect youths with supportive adults, in order to increase the chances for youths to effectively transition to self-sufficiency. As a result, the Interagency Youth Resiliency Team (IYRT) mentoring project was developed. This project provides intensive mentoring services to underserved and inappropriately served system-involved youth. Mentors are former foster or probation youth, who understand the unique difficulties and dynamics inherent in being system-involved through their own lived experience. Mentoring services are also provided to the youths caregiver(s) or resource provider(s). By appropriately matching mentors with mentees, culturally appropriate, intensive, trauma-informed mentoring services are provided to youths and their caregivers, residing in the County of San Bernardino, involved with (or at risk of being involved with) the foster care and/or probation systems, to increase the youth's ability to successfully transition to independence.

The IYRT project contributes to learning by making a change to the existing mental health practice that is current procedure, but not in a comprehensive, collaborative manner. This innovative approach brings together the knowledge, expertise and experiences of diverse professionals from the mental health system, the child welfare system, the Probation Department, the courts, foster youth agencies, local faith-based organizations, resource providers and former dependents and wards. The IYRT project draws upon the experiences of former foster and probation youth to create a training/mentoring program that serves the specific needs of that youth population. Historically, aged out youth have not been sufficiently involved in the planning, implementation and evaluation of services for youth in the County of San Bernardino. Reaching out to these diverse youth to get their perspective, one not strategically sought before, in the development and realization of a program will enhance an environment of innovation. To meet the terms outlined in WIC 5830, the primary purpose identified for this change in approach to mental health services is to **increase access to underserved groups.**

This project resulted in three (3) contracts with separate agencies to provide IYRT services. Each agency developed their own curriculum and performed implementation planning, while still meeting regularly to ensure a cohesive standard of services. The programs all target five (5) main domain areas: education, employment, enduring connections, housing, physical health/mental health. The three (3) agencies, EMQ Families First, Inc., Valley Star Children and Family Services, and Reach Out, serve differing areas within the County, determined by zip code. Innovation funding is projected through June 30, 2015. Discussions have already begun regarding the future sustainability of IYRT services. Suggestions and ideas were collected during a series of Innovation focused stakeholder meetings during the Summer of 2013. Efforts are being made to identify and inform stakeholders, including county partners, who may have a vested interest in



Interagency Youth Resiliency Team (IYRT)

the target population being served by the IYRT project. It is the department's intention to provide outcome data to these entities, showing progression in changing the lives and behaviors of the youths being mentored.

The approved Innovation Work Plan for this project, submitted as part of the County's MHSOAC Annual Update FY 2010/11 to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in June 2010, outlined ten (10) goals that will contribute to learning. Each of the three (3) contracted agencies are collecting data surrounding the mentors, mentoring activities, and outreach efforts for each of their programs. Adjustments are regularly made to the individual programs as areas of improvement are identified. All programs report preliminary findings that support the contention that the mentored youth are showing improvement in their symptoms and life goals, using follow-up surveys, training evaluations, self-report, and Child and Adolescent Needs and Strengths (CANS) assessments. An increase in motivation to develop independent living skills and job skills from the youth being served has also been noticed in early outcome efforts. A final report for this project, with comprehensive evaluation and outcomes information, will be developed in compliance with the regulations set forth for Innovation reporting by the MHSOAC.

The following information is the projection for FY 2014/15:

Agency	Fiscal Year 2014/15				
	0-15	16-25	26-59	60+	Total
EMQ	29	51	20	20	120
Reach Out	14	46	15	15	90
Valley Star	14	46	15	15	90

Age breakdown amounts are estimates based on percentages of demographic breakdown from FY 2012/13 reporting.



Youth Hostel (The STAY)

The Behavioral Health 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 designed to be culturally and linguistically appropriate crisis stabilization services, with particular emphasis on diverse former system-involved youth (African American, Latino, LGBTQ youth, etc.). The hostel was designed to be **80%** peer run, by individuals representing the County's diverse ethnic communities and cultures.

Preceding the development of this project, a lengthy and inclusive stakeholder process was conducted. Stakeholders identified the diverse TAY population is vulnerable and at risk of law enforcement involvement, homelessness, hospitalization, sexual exploitation, and violence. Stakeholders identified the need for greater access for this underserved group. Further, stakeholders identified that the "basic needs" of TAY must be met in order to effectively provide any other collaborative services. An increased focus on providing TAY with resources was desperately needed to support the transition from foster youth to adulthood. To meet the terms outlined in WIC 5830, the primary purpose identified for this change to an existing mental health practice is **increasing access to underserved groups**.



The approved Innovation Work Plan for this project, submitted as part of the County's MHSOAC Annual Update FY 2011/12 to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in April 2011, outlined ten (10) goals that will contribute to learning. The hostel, which was named The STAY by the advisory board, opened its doors for services in March 2013. Preliminary assessments show that residents have had positive reaction to the services provided at The STAY, and have taken measures to improve their transition into adulthood by taking college classes, applying for and obtaining jobs, getting a drivers license, registering with the Job Corp, and finding housing. A final report for this project, with comprehensive evaluation and outcomes information, will be developed in compliance with the regulations set forth for Innovation reporting by the MHSOAC.

As described in the approved plan, this project was designed to take place over five (5) years. The plan outlined the first year to consist of a ramp-up phase and development of essential "in-house" components, in order to help a project of this size be successful. Further, it designated that "Years two (2) through five (5) will be dedicated to serving the clients in the areas described in the innovation plan." The initial planning phase involved "in-house" planning, followed by an intense Request for Proposal (RFP) process, which eventually led to a contract being awarded to Valley Star Children and Family Services Inc., in July 2012. The contractor worked diligently to establish policies, furnish and prepare the site, hire and train staff, and obtain the proper certifications to provide services. A few unexpected delays in obtaining licensure resulted in a short delay in opening their doors to the community. In order to meet the designated service time of four (4) years, the original timeline from the work plan has been amended to reflect the correct service start date, as well as incorporate a six (6) month evaluation period for staff to adequately prepare comprehensive reporting of the project outcomes. As noted in Section 3 of Exhibit F4 of the Annual Update FY 2011/12, the timeline can be longer than the period for which Innovation funding is being requested.



Youth Hostel (The STAY)

Services funded by INN through TAY Behavioral Health Hostel	3/2013-3/2017
Develop, implement, and adjust measurement/evaluation tools as needed	Ongoing
Gather data and information toward achieving learning goals	Ongoing
Conduct ongoing evaluation to share with stakeholders and drive decision making regarding future sustainability of the project	Ongoing
Evaluate, analyze, and document outcomes for overall effectiveness, learning goals, and recommendations	4/2017-9/2017

Discussions for future sustainability of this project are set to begin in the near future, however, stakeholder feedback collected during the Innovation stakeholder meetings during the summer of 2013, already shows the community's desire for continued supportive crisis services for the TAY population.

The following information is the projection for FY 2014/15, FY 2015/16, and FY 2016/17:

Youth Hostel - STAY	FY 2014/15, FY 2015/16, and FY 2016/17				
	0-15	16-25	26-59	60+	Total
Valley Star	N/A	156	N/A	N/A	156



Holistic Campus

This project brings together a diverse group of individuals, family members, and community providers to create their own individual-focused resources, networks, and strategies, growing out of cultural strengths. The holistic campus is established in an easily accessible, neutral, non-clinical setting. It is 80% peer run by community members, cultural brokers, and individuals representing the County's cultures and ethnic communities, in a single location, that is more tied to the community and its resources than a traditional behavioral health setting. The center is a hub for local and community based providers and resources, establishing collaborative relationships with behavioral and physical health providers, and community based organizations that typically assist with housing, employment, education and benefits issues, and provide therapy and culturally specific health strategies. This project creates a setting where individuals and partners can frame cultural differences as learning sources for each other and for the behavioral health system. To meet the terms outlined in WIC 5830, the primary purpose identified for this new approach to mental health services, including prevention and early intervention, is **increasing access to underserved groups**.

The focus of the Holistic Campus project is overall wellness, resiliency, recovery and linkage to resources, with traditional behavioral health methodologies taking a more subtle, yet readily accessible role in order to provide integrated treatment approaches in a single location. The Holistic Campuses utilize the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight (8) Dimensions of Wellness (emotional, social, physical, environmental, spiritual, occupational, financial, and intellectual) as a method to integrate treatment of the whole person. The project is contracted to three (3) vendors to provide services in three (3) separate, distinct regions of the County. To ensure that peer and community input drives the direction and the learning process of the campus, each campus has an Advisory Board of Directors to oversee the operations of the campus, as well as to attract new and culturally specific providers and resources.

Two (2) of the campuses, STRIVE (contracted to Mental Health Systems, MHS), and WISE (contracted to Victor Community Support Services, VCSS) are in the final phase of their contracts, ending on September 30, 2014. The Department has been in discussions with the respective agencies, interested parties, and stakeholders, regarding the sustainability of services and identifying alternative funding sources.

Options for funding are varied and have not been determined at the time of this report, however, stakeholder feedback has shown the services being offered through this project to be of value to the community. The Holistic Campus project will continue through June 2015, with the third holistic campus INSPIRE (contracted to El Sol Neighborhood Educational Center) providing services. A final report for this project, with comprehensive evaluation and outcomes information, will be developed in compliance with the regulations set forth for Innovation reporting by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Holistic Campus

The approved Innovation Work Plan for this project, submitted as part of the County's Innovation Plan to the MHSOAC in February 2010, outlined ten (10) goals that will contribute to learning. Each campus collects data surrounding the activities, services, and referrals offered to participants in the programs. Adjustments are regularly made to the individual programs as areas of improvement are identified. The WISE Campus has identified the need for additional and regular trainings for staff as a key component for success. Although peer-run services have proven to be effective in this environment, staff has encountered crisis situations necessitating specialty intervention, such as when a person presents as being a danger to self/others. They have also encountered cultural barriers when working with Veterans or the LGBTQ community. As a result, VCSS has made ongoing staff training a necessary component of their project.

The campuses seek to provide services to at least **2,400** clients annually. Please see the table below regarding forecasted number of clients served FY in 2014/15:

Campus	FY 14/15				
	0-15	16-25	26-59	60+	total
STRIVE	42	126	354	78	600
WISE	42	126	354	78	600
INSPIRE	168	504	1416	312	2400

Note: Age breakdown amounts are estimates based on percentages of demographic breakdown from FY 2012/13



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Final Report

This final report is based on the instructions provided in the Department of Mental Health Information Notice 09-02.

Each county must provide the 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.

Issue Addressed

The Online Diverse Community Experiences (ODCE) project established a departmental presence on social networking sites, such as Facebook (in both English and Spanish) and Twitter, as a model to disseminate varied behavioral health information and resources, and upcoming events.

The project sought to reach consumers, family members, community members and professionals in order to provide ongoing resources to increase access to services, reduce the stigma associated with mental health and drug/alcohol services, transform the understanding of mental health, and promote wellness, recovery, and resilience. The Department of Behavioral Health (DBH) maintained this project.

Project Description

Pursuant to Welfare and Institutions Code 5830, the primary purpose of the Online Diverse Community Experiences (ODCE) project was to **increase access to underserved groups**.

The ODCE project was submitted as part of the County of San Bernardino Innovation Plan in February 2010. The project was approved for Innovation funding by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in March 2010. preparation work began shortly thereafter. Computers were purchased and installed in the clubhouses. Focus groups were held to determine the level of training needed. Training materials were created and training sessions were scheduled. The process to create the Facebook pages was finalized on October 18, 2010 for the English page and November 29, 2010 for the Spanish page. The initial post was made to both the English and Spanish pages on December 10, 2010. Once the pages were up and running, information was posted on a regular basis to provide consumers and stakeholders general information on mental health services, resources, and events occurring within the County of San Bernardino. Innovation funding continued through June 30, 2013.

Social networking sites bring an awareness of services to internet users. Social media in general has revolutionized the manner in which individuals obtain information and the manner in which they obtain services. The Department of Behavioral Health (DBH) established two (2) Facebook pages (English and Spanish) and a Twitter account for individuals to utilize as a gateway to expand available tools and resources for the development of self-help systems and networks. Information regarding upcoming events, newsletters, and various mental health and alcohol and drug abuse topics were posted to the Facebook pages for consumers to access.

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A social networking service is a platform to build social networks or social relations among people who, for example, share interests, activities, backgrounds or real-life connections. A social network service consists of a representation of each user (often called a profile) their social links, and a variety of additional services. Social networking is a web-based service that allows individuals to create a public profile, to create a list of users with whom to share connection, and view and cross the connections within the system.^[1] Facebook is a social networking service launched in February 2004 and by September 2006 was available for use by anyone **13** years or older. By 2008, Facebook was setting up International headquarters, and by October 2012, Facebook reached one billion active users.^[2] On February 4, 2014 Facebook celebrated its 10th year anniversary, or as some would say “birthday”. Throughout the timeline of their ten-year existence, this social networking site has undergone numerous changes and expansions. A recent notable change took place February 13, 2014, when Facebook created over **50** new Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) gender identity and pronoun options.

The Department created a “profile” on Facebook to begin the construction of its social network. Both English and Spanish pages are linked to the profile, and are what is termed a “Community Page”. Community pages are differentiated from business pages by the nature and type of posts made. The posts on the Department’s pages are not “boosted” by paying for its appearance on newsfeeds outside of our “fans”. The Department relies on its fans, those who have “Liked” our page and thereafter see the posts made by the Department. The fans “Share” our posts, and in that way, further disseminate our information to a wider audience. A “fan” is differentiated from a “friend” on Facebook, by the type of page that is being followed; the Department has a Community page, and any person who likes the page will become a fan. The same is true if the Department likes another Community page, we will become a fan of theirs. When one of the Department’s posts is shared by a fan, the specific post is seen by all the friends of that fan, exponentially increasing the “reach” of that post. The “reach” of a post is measured by how many fans, and friends of fans – when a fan shares a post – have seen the post. Every user with a personal profile, or administrators of pages, is also able to “Check In” at locations, which is another way to expand a network and add connections.

Twitter is an online social networking and micro-blogging service that enables users to send and read “tweets”, which are text messages limited to **140** characters. Registered users can read and post tweets, but unregistered users can only read them. Twitter was incorporated in April 2007 and has rapidly gained worldwide popularity, with **241** million active users in 2014, who post **500** million tweets per day. The service also handles millions of search queries per day. Twitter is now one of the ten **(10)** most-visited websites.^[3]



The image shows a Facebook search results page. At the top left is the Facebook logo. To its right, the text reads "Find us on Facebook". In the top right corner, there is a small logo for "BEHAVIORAL HEALTH". Below this, the search results are displayed for "County of San Bernardino Department of Behavioral Health". The results are organized into two columns: "Behavioral Health Information" and "Services and Resources". Under "Behavioral Health Information", it says "Offered in English and Spanish". Under "Services and Resources", it says "Links to help everyone stay connected and share". At the bottom of the search results, there is a tagline: "Promoting wellness, recovery, and resiliency through social networking". Below the tagline, there is a small logo for the County of San Bernardino and text stating: "Services provided in collaboration with the County of San Bernardino, Department of Behavioral Health and funded by the Mental Health Services Act (Proposition 63)". In the bottom right corner, there is a "Like us on Facebook" button with a thumbs-up icon. At the very bottom right, the text "Rev.2/14" is visible.

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The Department's Twitter account is linked to its Facebook page. This allows the "posts" made on Facebook to be viewed by the "followers" of the Department's Twitter feed. "Tweets" that are posted separately from the Facebook posts allow for "#s" (hashtags). Hashtags are used as keywords for searches through Twitter, and are also used on other social networking services, making the task of finding "tweets" on specific topics, such as mental health, more efficient. Hashtags also became available as a feature in Facebook on June 12, 2013 according to Facebook's official site. A follower on Twitter is much like a fan on Facebook; the major difference being the limitation on characters for each "tweet." The reverse of having followers is following another twitter feed; unlike Facebook, there is no differentiation between following a personal Twitter account and following a Community Twitter account. This allows for mutual sharing and dissemination of messages, again widening the Department's social network and allowing for broader connections.

The ODCE project introduced a new application to the mental health system of a promising community driven practice/approach that has been successful in non-mental health contexts or settings. The prevalence of social networking sites on the internet (i.e. Facebook and Twitter) and their widespread use by individuals of all cultures, ages, ethnicities, and orientations made these sites a logical place for providing information on a wide range of mental health topics and resources.

Information provided via the internet is available to individuals who are socially isolated, those who are isolated due to the stigma that is inherent in the current behavioral health system, as well as those who are geographically isolated. The internet and social networking sites are places some consumers already access to find and meet friends, and to give and receive information. Becoming part of a social networking site is socially acceptable to many groups due to the focus on information gathering and networking, as well as the inherent confidentiality and anonymity which, in turn, can help reduce stigma. One of the triggers of depression is the feeling of isolation. Facebook, and other social networking sites, provide a way for individuals to interact with others facing similar challenges from the comfort of one's own home, or anywhere a computer and internet connection is available.



@sdbbh

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Focus Groups

During the early stages of implementation of the Online Diverse Community Experiences (ODCE) project, focus groups were conducted with consumers at several of the Department of Behavioral Health (DBH) Clubhouses. These focus groups were conducted to learn and gain an understanding from the target population of the project as to their thoughts on social networking, stigma, content they would like to see, and to assess their level of computer literacy.

Focus groups were conducted at five (5) Clubhouse locations during the month of November 2010.

- **122** people participated in the focus groups.
- **66** participants, or **54%**, indicated they have access to a computer, either at home or in a different location.
- **22**, or **18%**, had an existing Facebook page.

Training

DBH initiated a pilot training program with the Clubhouses and Transitional Age Youth (TAY) One Stop Centers, which are located in both the urban and rural regions of the County and provide services to the targeted populations of the County. Both the TAY Centers and the Clubhouses are designed to be culturally competent and responsive to the cultural needs of their communities because of their community-driven models.

Training was made available to Clubhouse members and consumers regarding the use of the internet and social networking sites. This training occurred in the Department's computer lab so each person could have a "hands on" learning environment. A Peer and Family Advocate (PFA) assisted with preparing the training curriculum, along with providing technical assistance during the training. The following topics were covered in the training:

- Policies regarding use of county computers.
- How to create an e-mail account.
- How to create and use a Facebook account.
- How to create and use a Twitter account.
- Internet safety, including potential risks when accessing social media sites.
- How to protect confidentiality.
- Appropriate resources and referrals, if needed.

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The table below shows the breakdown of attendees, by affiliation, for a total of 36 stakeholders trained:

Date	Affiliation	# of Attendees
2/15/2011	Seeking Others Attaining Recovery (SOAR) Clubhouse	1
2/16/2011	Victorville Clubhouse	7
2/17/2011	Amazing Place Clubhouse	5
2/18/2011	TEAM House Clubhouse	5
2/28/2011	Transitional Age Youth (TAY) Center	11
2/28/2011	Pathways to Recovery Clubhouse	7
	TOTAL	36

A second round of training was conducted by the Department in May 2013. This training was conducted at the Department's computer lab, as well as in the San Bernardino and Rancho TAY Centers. The training curriculum was updated to reflect changes in social media and to provide more of an emphasis on internet safety.

This updated curriculum included the following topics:

- Internet safety and security tips, including potential risks when accessing social media sites.
- Fraud and theft on the internet.
- Cyber stalking.
- Internet predators.
- Password protection and safety.
- How to create and use a Facebook account.
- How to create and use a Twitter account.
- How to protect confidentiality.

Upon request, the above training was also conducted to a Marriage and Family Therapist (MFT) intern group. The MFT interns can not only use the social media sites themselves, but also can share the information with their consumers.

The table below shows the breakdown of attendees, by affiliation, for a total of 26 stakeholders trained during the second round of training offered:

Date	Affiliation	# of Attendees
5/1/2013	San Bernardino TAY Center	10
5/15/2013	MFT intern class	6
5/16/2013	Rancho TAY Center	10
	TOTAL	26

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Promotion

Once the social networking accounts were created, promotional materials, such as posters, flyers, announcements, and web blasts via the County intra- and internet sites, were disseminated to inform stakeholders of the Department’s new Facebook and Twitter pages. The posters provided information regarding the Department’s social networking sites, including computer use policies and internet safety tips, and were provided to the Clubhouses to be posted in their locations. This was used to “get the word out” about obtaining information from the Department’s Facebook and/or Twitter pages.

In an effort to extend our reach and gain more users to our Spanish Facebook page, the Department collaborated with the Loma Linda University School of Public Health (LLU-SPH), who had a presence at the Mexican Consulate through an existing Memorandum of Understanding. LLU-SPH agreed to provide instruction on the use and operation of social networking sites, (i.e. DBH’s Spanish Facebook page), for community members awaiting services at the Consulate. The focus was Latino community members, however all members were welcome to use the site. LLU-SPH provided bilingual staff interns to interact with and instruct community members on the use of the site, and provide instruction on creating their own Facebook page. LLU-SPH staff also distributed flyers promoting the Spanish Facebook page at health fairs and events. The goal of the collaboration was to increase the number of users of the Department’s Spanish Facebook page, and in that sense it was successful as the number of stakeholders who viewed the Department’s Facebook page did increase. When this project began there were a total of **19** “Likes” and at the end there were a total of **54** “Likes” on the Spanish Facebook page.

Although there was success in increasing the number of viewers of the sites, there were challenges that arose. Suggestions were received on improving the attractiveness of the page, to appear more appealing to teens and adolescents. The collaboration was beneficial for the Department as lessons were learned and an increase in users was gained.



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Effectiveness

All the data gathered was provided through the Facebook Administrative pages. Please note that the information is self-reported by the users when they create their profile; demographic details are optional and not required as part of the profile. Additionally, an individual's privacy settings on Facebook may affect the ability to collect specific data. It is also important to note that throughout the timeframe of the project, and including the time that elapsed from conception, to planning, to implementation, the way in which Facebook collects and manages data has changed multiple times.

The project's learning goals were identified in the initial project description and include the following:

- 1) *The County will learn how individuals and groups use the social networking sites and what materials they will develop and post on the sites.*

This learning goal was an attempt to identify how individuals and/or groups would use social networking sites and what materials the Department would develop and post. In early implementation, the Department had to cautiously navigate County concerns with security issues associated with hosting a Facebook page. Content posted would need to be mental health information that users would respond to, but such that the risk to the Department could be managed.

The Department created and "posted" documents to the sites for users to view and increase awareness of mental health services. Posts include:

- Flyers for upcoming events, such as mental health awareness events, workshops, and trainings.
- Links to articles on mental health or alcohol/drug services, from recognized sites such as the National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration (SAMHSA), and Department of Health Care Services (DHCS).
- Promotion of stakeholder meetings, such as local District Advisory Meetings of the Behavioral Health Commission, Office of Cultural Competence and Ethnic Services (OCCES) subcommittee meetings, community program planning meetings associated with the MHSA Annual update, and Innovation stakeholder meetings.

The following are examples of "posts" which were made to the DBH Facebook page regarding upcoming events, links to mental health articles, and stakeholder meetings.

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County of San Bernardino Department of Behavioral Health
October 24, 2012

2012 Behavioral Health Wellness Triathlon

NAMI Walk
What's this "NAMI Walk" I hear about?
How do I join or create a team?
How do I earn extra points?

Diamond Valley Lake, Hemet, CA

Event Information:

- Begins at 8:00 a.m.
- Visit www.namiwalks.org or iversidesanbernardino to create and/or register your team today!
- There is no charge to participate in the NAMI Walk.
- Learn how you can earn extra points for your team today!

Saturday, October 27, 2012
Diamond Valley Lake
2615 Angler Avenue
Hemet, CA 92543

Last year the County of San Bernardino had over 100 team members participate in the triathlon... Join us in doubling that amount for 2012!!!
Please contact Victoria Hill 909.382.3167 with any questions or 7-1-1 for TTY

Like · Comment · Share

1 1 4

Departamento de Salud Mental, Condado de San Bernardino
August 10, 2012

Evaluación del Programa de Clubhouse
¡¡Que SU voz sea escuchada!!

El Departamento de Salud Mental le invita a que nos acompañe en uno de los foros comunitarios para Evaluación del Programa de Clubhouse. Asistir a cualquier programa y concentrarnos en el desarrollo de nuestros consumidores!

26 de agosto de 2012 9:00-11:00 a.m. Tara, Huerta 201 W. Main St. San Bernardino, CA 92408	1:00-3:00 p.m. Our Place 727 Avenida St. Ste. 200 Arcadia, CA 91709	¿Cómo le parecen nuestros servicios?
28 de agosto de 2012 10:00-12:00 p.m. Central Valley FSNH Clubhouse 1712 E. Diamond Blvd. Hemet, CA 92519	1:00-3:00 p.m. Victor Torres Clubhouse 1023 Estero del Rio St. # Victorville, CA 92390	¿Cómo beneficia usted al clubhouse?
29 de agosto de 2012 10:00 a.m.-12:00 p.m. Santa Fe Social Club 30021 Santa Fe Plaza, Ste. 14 Santa Ynez, CA 92084	1:00-3:00 p.m. A Place for Our Clubhouses 1779 Oak Mountain Blvd., Ste. 10 Lodi, CA 93268	¿Qué cambios sabemos de hacer?
30 de agosto de 2012 10:00-12:00 p.m. Archivos, Salud 154 N. Main St., Ste. 10 Lodi, CA 93278	12:00-2:00 p.m. FARMACIA LA ESCUELA 850 E. Foothill Blvd. Hemet, CA 92519	¿Cómo calificaria su satisfacción?
31 de agosto de 2012 12:00-2:00 p.m. A Place for Us 805 E. 34th View Banning, CA 92311		

Para información adicional comuníquese con:
Victoria Hill al (909) 382-3167 o al 7-1-1 en español o en español de TTY.
Este servicio es voluntario y gratuito. Los eventos se celebran con apoyo financiero por favor agradecer al patrocinador responsable por su apoyo y sus esfuerzos en la reunión.

Like · Comment · Share

Andres Escalante likes this.

Andres Escalante en particular los comentario y los avisos preventivos son buenos y oportunos
August 11, 2012 at 3:25pm · Like

Write a comment...

County of San Bernardino Department of Behavioral Health
May 29, 2013

GET A JUMP START ON THE COLLEGE SEARCH BY ATTENDING THE

TRANSITIONAL AGE YOUTH COLLEGE AND CAREER OPTIONS FAIR

MEET WITH REPRESENTATIVES FROM UNIVERSITIES, COMMUNITY COLLEGES AND VOCATIONAL SCHOOLS

**FRIDAY, JUNE 28, 2013
11:00 A.M. - 3:00 P.M.**

**COUNTY OF SAN BERNARDINO HEALTH SERVICES AUDITORIUM
850 EAST FOOTHILL BLVD.
RIALTO, CA 92376**

ATTEND WORKSHOPS ON:
• PREPARING COLLEGE APPLICATIONS
• PAYING FOR COLLEGE
• DEVELOPING INTERVIEW SKILLS

Para preguntas, traslados, interpretaciones, servicios, o materiales de accesibilidad, contactar al departamento de salud mental al (909) 382-4052 o 7-1-1. Para TTY, llamar al (909) 382-4052 o al 7-1-1. Este servicio es voluntario y gratuito. Los eventos se celebran con apoyo financiero por favor agradecer al patrocinador responsable por su apoyo y sus esfuerzos en la reunión.

Like · Comment · Share

419 people saw this post

Departamento de Salud Mental, Condado de San Bernardino
June 25, 2013

LANZATE A LA BÚSQUEDA DE INSTITUCIONES EDUCATIVAS PROFESIONALES ASISTIENDO A:

FERIA DE OPCIONES EDUCATIVAS DE NIVEL SUPERIOR PARA JOVENES EN EDAD DE TRANSICION

CONOCE A: REPRESENTANTES DE INSTITUCIONES EDUCATIVAS DE NIVEL SUPERIOR, UNIVERSIDADES Y ESCUELAS VOCACIONALES

**VIERNES, 28 DE JUNIO DE 2013
11:00 A.M. - 3:00 P.M.**

**CONDADO DE SAN BERNARDINO SERVICIOS DE SALUD AUDITORIUM
850 EAST FOOTHILL BLVD.**

ASISTE A TALLERES SOBRE:
• CÓMO PREPARAR SOLICITUDES PARA INGRESAR A LA UNIVERSIDAD
• CÓMO PAGAR POR TU EDUCACIÓN
• CÓMO DESARROLLAR TÉCNICAS PARA ENTREVISTAS

Para preguntas, servicios de interpretación o solicitudes de acomodaciones especiales por alguna discapacidad, por favor llamar al: (909) 382-4052 o marcar 7-1-1 si usted es usuario de TTY. Este servicio es voluntario y gratuito. Los eventos se celebran con apoyo financiero al día del evento.

Like · Comment · Share

12 people saw this post

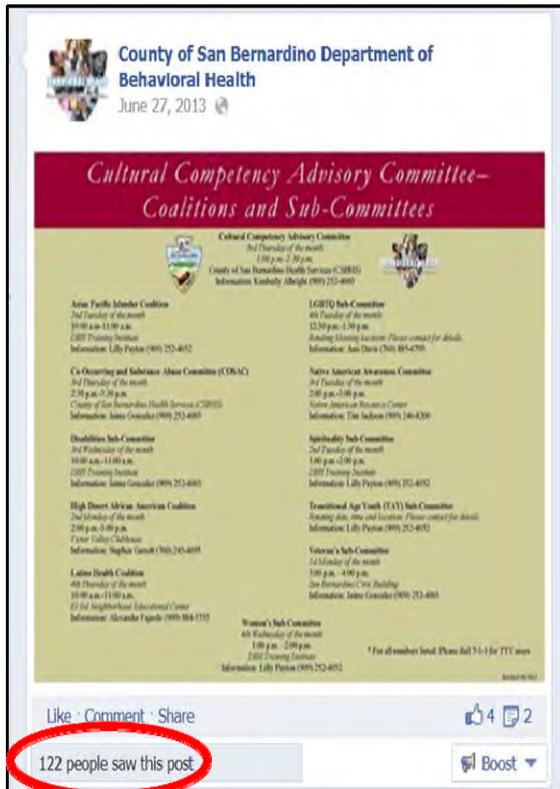
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Monitoring and evaluation of the site identified that users utilized the Department's pages in the same manner as their personal Facebook page. Users "Shared" this information with friends and family, "Liked" the page, and were able to obtain information regarding resources and upcoming events occurring within the County of San Bernardino. During this project, the information gathered from both the English and Spanish Facebook pages identified a total of:

- **205** items "Posted" to the Department's Facebook pages.
- **398** unique users "Liked" the Department's Facebook pages.
- **1,109** "Shares" of the Department's Facebook page posts.
- **369** "Check In's" to the Department's Facebook pages.

Data gathered from Facebook allows us to identify the impact of flyers, links, and articles/other information "Posted" to the page. Based on the data gathered, the majority of the "Likes" and "Shares" were from Flyers being "Posted" to the page. This is most likely due to the flyers containing pictures and images along with information, which was pleasing to the individual.

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The table below identifies the number of “Likes”, “Shares” and comments made based on the type of “Post.”

Item “Posted”	# of “Posts”	# of “Likes”	# of “Shares”	# of Comments
Flyer	65	117	58	13
Link	91	81	14	7
Article/Other	45	30	0	4

- 2) *The County will learn what groups will be organized as a result of the sites.*

This learning goal was an attempt to identify if additional groups would be organized/created among those who visited the Department’s social media sites. Consumers who attended training were taught how to create a “Group” on Facebook, based on a common interest. It is known that social media is a platform for group interaction; therefore it was suspected that individuals would create common interest groups to further interact with one another. Based on data received from an online survey, users reported they did not organize additional groups as a result of obtaining information from the Department’s social media sites.

- 3) *As a result of the establishment of the social networking sites, we will learn how the interaction on the sites will transform the understanding of mental health challenges and promote wellness and recovery.*

This learning goal was an attempt to try to understand if the Department’s Facebook pages and Twitter account would help consumers in their understanding of mental health challenges and would promote wellness and recovery. The Department evaluated the user’s self-reporting that they have benefitted.

Based on data received from an online survey, users indicated they had an increased understanding of mental health challenges that was either beneficial or at minimum remained the same when promoting wellness and recovery as a result of obtaining information from the Department’s social media sites.

Examples of information “Posted” on the Department’s Facebook pages include information regarding events being held within the County of San Bernardino, links to other sites with mental health information, along with information from the Department as shown here:

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- 4) *County will determine if diverse consumers will utilize social networking sites to access information, resources and support on Department of Behavioral Health programs and services.*

This learning goal was to identify if diverse consumers will utilize the Department’s social networking sites. As administrators of a Community Page that seeks to inform underserved and unserved populations, it is helpful to know demographic information about the fan-base, including the groups with which they identify. Information on age, gender, and place of residence is readily available data for the administrators of a Community Page to access.

Data provided by Facebook captured during this project indicated a successful attempt to reach multiple age groups of both men and women on Facebook. Of the **398** unique users who “Liked” the Department’s Facebook page, approximately **72%** were women and **27%** were men. Facebook does not require that a gender be identified, which means 1.1% of our fans did not identify their gender.

The breakdown of age group is listed below:

Age Group*	Men	Women
13-17	0.5%	0%
18-24	1.6%	4.8%
25-34	5.8%	24.5%
35-44	7.6%	20.1%
45-54	6.7%	13.9%
55-64	3.7%	6.5%
65+	0.7%	2.5%

*Age groups as defined and reported by Facebook.

The table below identifies the range of users who self-reported their city of residence and who “Liked” the Department’s Facebook page.

Hometown of Residence*	Number of Users
Kern County	1
Los Angeles County	38
Orange County	3
Riverside County	37
Sacramento County	1
San Bernardino County	274
San Diego County	3
Out of State	23
Out of Country	11
Undeclared	7

* Hometown as defined and reported by Facebook.

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- 5) *Once information has been accessed, the County will identify if diverse consumers follow up and request additional information, attend peer support group meetings, or seek help to address issues such as stress, depression or anxiety as a result of use of the social networking site.*

This learning goal was to identify if diverse consumers sought further assistance in following up and requesting additional information, attended support group meetings, or sought assistance to help with issues such as stress, depression, or anxiety as a result of the social networking sites. Survey results received indicated users reported they did seek out or request additional information to further their knowledge as a result of obtaining information from the Department's social media sites. However, specific information regarding which support groups or what additional information was requested was not indicated with the survey responses.

- 6) *The project will identify if social networking sites allow the community a new way to provide input and feedback on programs and services.*

This learning goal was to identify if social networking sites will allow stakeholders to provide input in a new way. The Department hosts several regular monthly stakeholder meetings at which information is disseminated and the community has the opportunity to provide input. Prior to the existence of the Department's Facebook page and Twitter account, there was no mechanism to disseminate information via social media. The Department now has the ability to disseminate mental health and alcohol and drug related information with a much further reach and allow the Department to capture input electronically, regardless of a person's location.

The Department's Facebook site was used to provide information, resources, and updates on upcoming events being held. Users have the opportunity to provide us with feedback in the form of comments on a post, or via private message. In this way, the project did, in fact, identify a new way for our community to provide input and feedback. Additionally, the Facebook page and Twitter account allowed another method to invite consumers and stakeholders to attend stakeholder meetings.

The information "Posted" on the Department's Facebook page was well received by the stakeholders. There were 398 "Likes" to the Facebook page by users and the information was "Shared" by those users to their friend network through Facebook. This allowed the information "Posted" to be disseminated throughout social networks.

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- 7) *The project will identify if the provision of resources on social networking sites helps reach historically underserved/inappropriately served populations and if people are more likely to seek help via this resource than through traditional outreach strategies.*

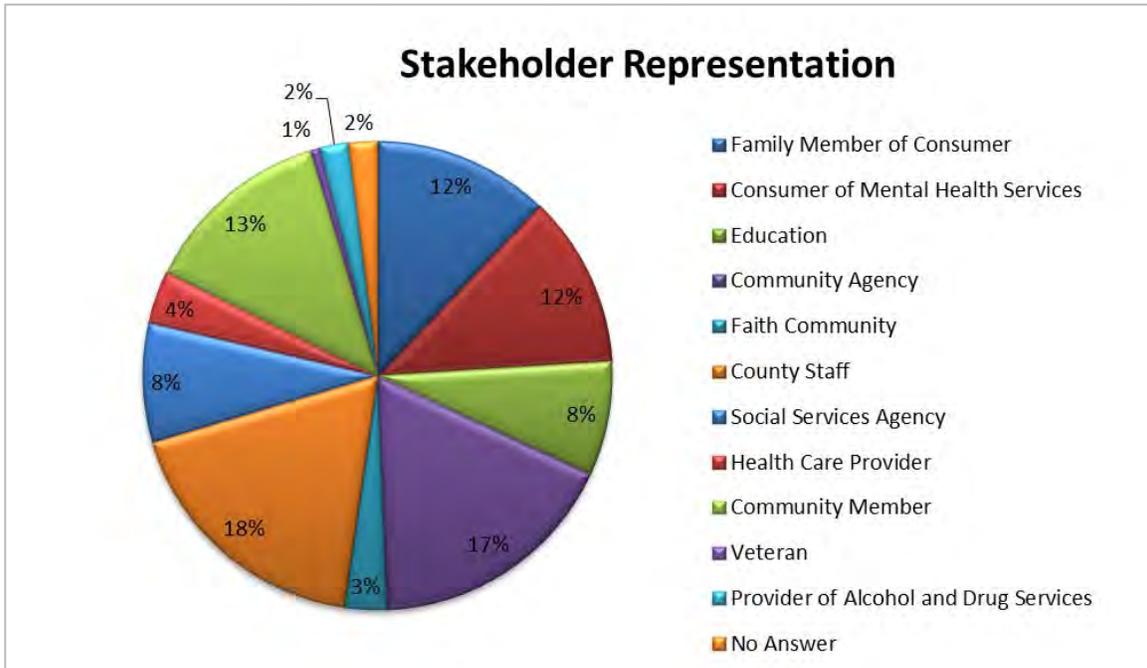
This learning goal was to identify if the resources provided on the social media sites helps reach the underserved/inappropriately served populations. DBH did not inquire if users/fans of the Facebook page were consumers of behavioral health services. The Department had concerns that self-disclosure may perpetuate stigma in in the social media environment, rather than reduce it. There was also a need to minimize the risk for the Department if a post from someone in crisis was received and not responded to in a timely manner.

However, the Department was successful in engaging underserved and inappropriately served populations as indicated by the attendance at stakeholder meetings. These community planning meetings were heavily promoted on the Facebook pages. It is believed that social media positively affected engagement of stakeholders at these meetings.

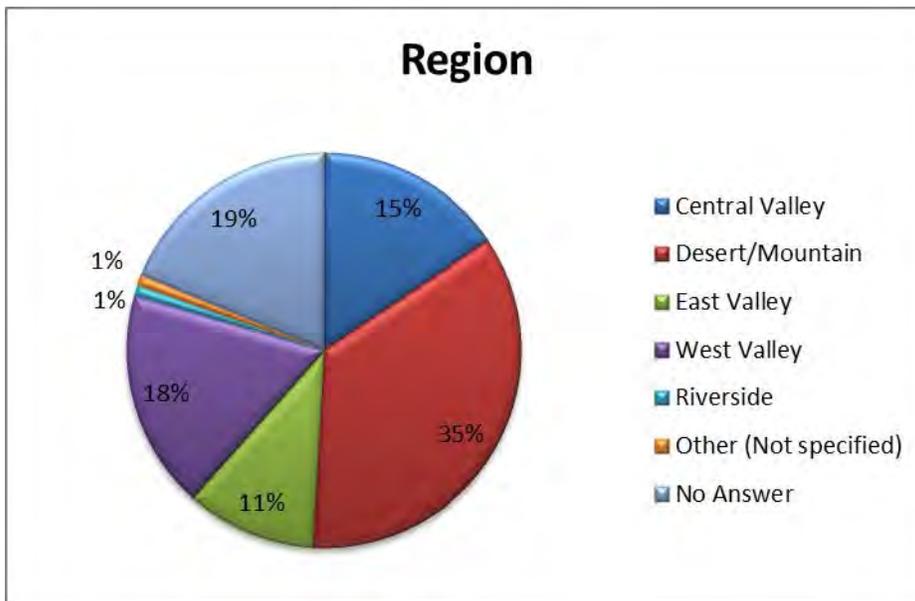
The demographic information shown below was obtained from the Community Program Planning (CPP) process in which eighteen (**18**) stakeholder meetings were conducted for the Department's MHS Annual Update FY 2013/2014 throughout April 2013. The charts below show the stakeholder representation, region, and ethnicity of the County via comment forms which were provided in English and Spanish at each stakeholder meeting.

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*Data obtained from MHSA Annual Update FY 2013/2014.

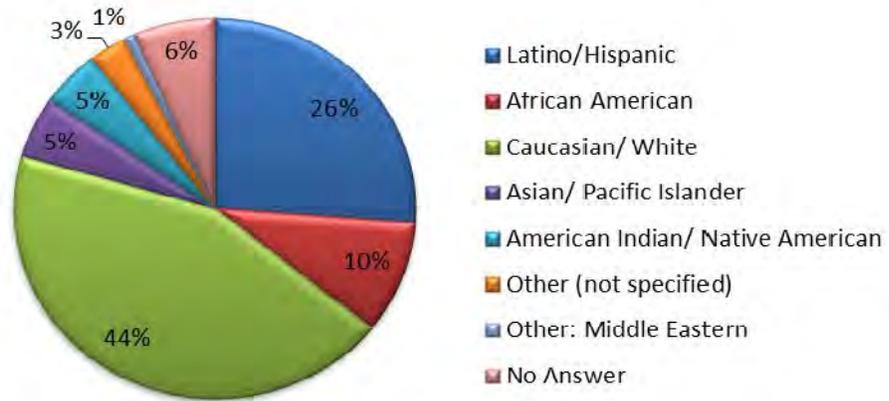


*Data obtained from MHSA Annual Update FY 2013/2014.

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Ethnicity

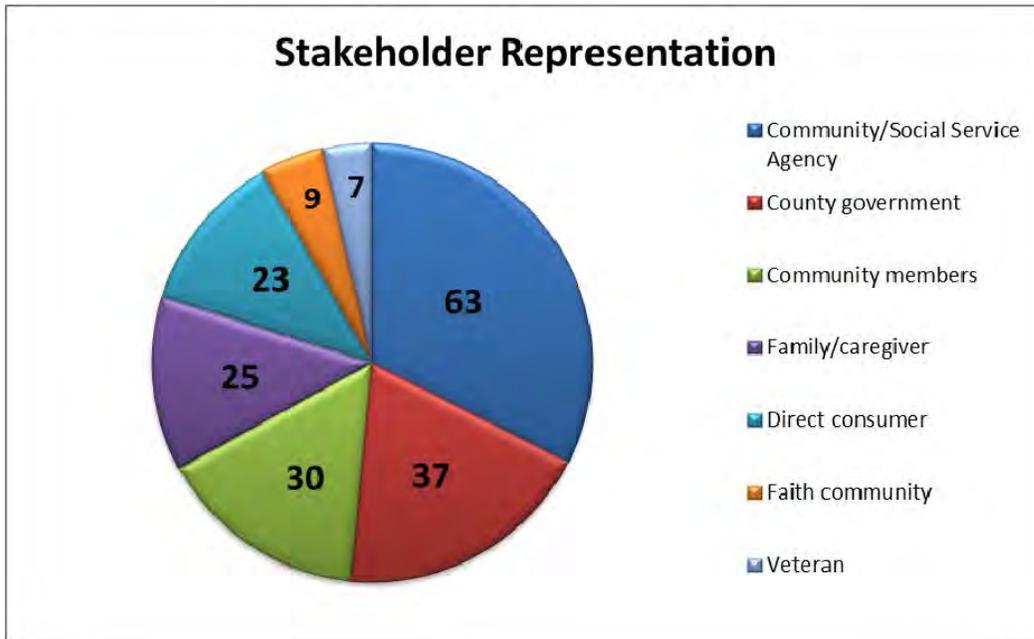


*Data obtained from MHSa Annual Update FY 2013/2014.

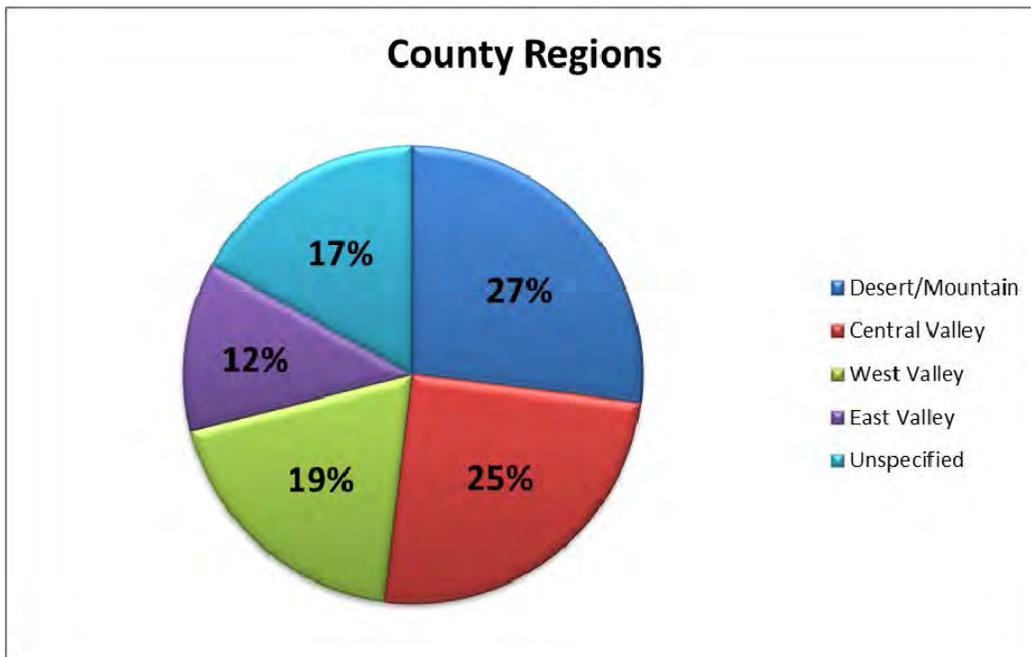
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The demographic information shown on the following pages was obtained from the Community Program Planning (CPP) process in which sixteen (16) stakeholder meetings were conducted for the Department’s Innovation Plan 2014 throughout the months of June and July 2013. These stakeholder meetings were heavily promoted on the Department’s Facebook pages.



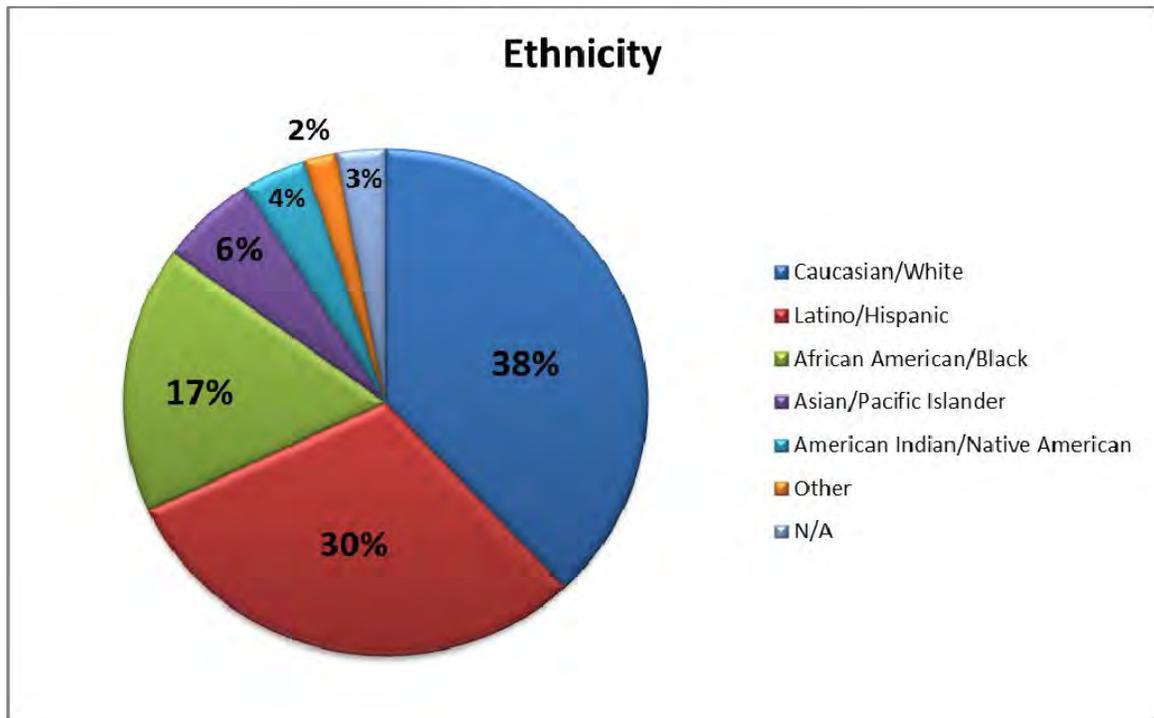
*Data obtained from MHS Innovation Plan 2014.



*Data obtained from MHS Innovation Plan 2014.

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*Data obtained from MHS Innovation Plan 2014.

- 8) *The project will determine if people are more comfortable with mental health services if provided access and a participatory role through social networking sites.*

This learning goal was to determine if consumers became more comfortable with mental health services by utilizing the Department’s social media sites. In evaluating whether the users of the Department’s Facebook page became more comfortable, and based on data received from an online survey, consumers indicated they were more comfortable accessing mental health services as a result of obtaining information from the Department’s social media sites. Based on data received from Facebook, it was identified users “Liked” the Department’s Facebook pages and “Shared” posts and information among their friend network via Facebook.

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- 9) *Work with DBH data and quality management systems to explore, understand, and learn about the impact of social networking on access, referral and linkage processes, where applicable.*

This learning goal was to attempt to learn about the impact of social media regarding mental health services, referrals, and access, if applicable. In evaluating the impact of social networking sites on the ability to access services, referrals, and processes, it was determined the use of the Department's Facebook pages and Twitter account was beneficial. The data revealed users who accessed the social networking sites not only viewed the pages, but "Liked", "Shared", and "Checked In" to the Department's information.

Users were able to "Share" the information that was applicable to them with their circle of "friends" via Facebook. Information regarding this is listed below:

- **205** "Posts" to the site providing information, resources, and upcoming events to the consumers.
- **398** "Likes" of the Departmental Facebook page, which identifies those who visited the site, were in favor of the site and/or items being posted for public information.
- **1,109** is the number of times the Department's Facebook page posts were "Shared" with the user's "friends" on Facebook.
- **369** users "Checked In" to the Department's Facebook pages.

Changes/Modifications

The Department determined that it would not be a prudent use of time to develop a MySpace site, and therefore did not develop a department MySpace.

Additionally, there were changes made to the Facebook site that allowed for a more efficient use of staff time. Facebook now allows administrators of public pages to schedule posts for future dates and times. This feature allowed Department staff to schedule announcements of County of San Bernardino events multiple times and avoid logging in to the Facebook administrator's page daily. When information was approved for posting onto the Facebook pages, staff would log on to the administrator's page and schedule weekly postings. This allowed for systematic dispersal of information through the Department's Facebook and Twitter network.

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Additional Learning

This Innovation project sought to reach consumers, family members, community members and professionals in order to provide ongoing resources, to increase access to services, reduce the stigma associated with mental health and drug/alcohol services, transform the understanding of mental health, and promote wellness, recovery, and resilience. The challenge of posting articles, studies, and research is assuming responsibility for the content. All material had to be pre-approved by the Department's Public Information Office, which can be an extra, but necessary, step in the process.

Another aspect of maintaining a social networking site is monitoring the interactions for inappropriate or concerning comments. The Department determined that the settings for the page would restrict users to be allowed to comment on a post, but not put their own post or comment on the page itself. This proved to be an effective way to allow interaction, that could still be monitored, and maintain some security preferences with respect to posting unapproved content on a county affiliated internet site.

The technology in a social networking environment changes frequently, which may affect the ability to consistently collect data. Learning to the extent described in the Work Plan was restricted due to limitations of the social networking sites. However, a lot of improvement was made to the way community pages can be used. A good administrator will learn to track trends in types of information posted and elements that affect the popularity of a post (such as time of day and frequency of posting). This information can then be used to drive future posts which will reach more users. The recently added feature of future posting makes planning easier for the page administrator.

During the duration of this project, it was realized that social media is a good way to disseminate information to family members, providers, community partners, service agencies, county partners, and other stakeholders.

The presence on social networking sites provides another avenue of information dissemination that did not exist. The more the Department can maximize the promotion of events and distribution of information, the more beneficial it is. The creation of social networking sites, especially the Department's Facebook page, proved to be a valuable resource to the Department. The ability to "Post" information for individuals to view provided an additional platform to disseminate information.

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The ability to obtain information from those who visited the Department’s Facebook page and then “Shared” this information through social media sites is invaluable. Evaluation of the project showed there were users from out of state and even out of the country who were able to view the information “Posted” to the sites by the Department. This is helping the Department increase awareness and knowledge regarding mental health issues, all being done through social networking.

To be more effective, it was determined Twitter should be used to send messages independently of Facebook in order to have a greater impact. By simply duplicating the Facebook information, DBH inadvertently limited the Department’s ability to reach followers. “Tweets” should be unique, individual, specific, and more personal, even though they can still address the same events and types of information provided.

A consistent process to “post” information to the Facebook page should be completed. By incorporating the “Posting” of information to the site on a consistent basis, even more information, resources, and upcoming events can be disseminated to individuals. This will continue to increase access to underserved groups, which was the primary purpose of this Innovation project.

Social media as a whole has undergone a tremendous amount of improvement during the timeframe of this project. Some of the verbiage used in the implementation of this project no longer applies and new terminology has been introduced. For example, the manner in which individuals “Post” and “Share” information via Facebook has changed. A Facebook page no longer has “followers” but instead has users who “Like” pages or “Posts”; and verbiage that was used on one social networking service can be recycled into a new service, such as having “followers” on Twitter.

Additionally, the use of Twitter accounts and other alternate forms of social media has increased. The use of Twitter accounts and the “following” of other groups appear to be very beneficial to further disseminate information in the future.

Recommendation of this project to others

The ability to reach community members through the use of social networking sites proved to be a valuable asset to the Department. The ability to “Post” information, resources, and upcoming events being held in the County of San Bernardino was identified as a success. Based on the number of people who were able to view the Department’s Facebook page from any location the consumer has access to the internet, is an efficient method to disseminate information. The Department recommends the creation of social networking sites by other counties to efficiently communicate with their stakeholders.

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The table below identifies the range of users who self-reported their city of residence and who “Liked” the Department’s Facebook page.

Hometown of Residence*	Number of Users
Kern County	1
Los Angeles County	38
Orange County	3
Riverside County	37
Sacramento County	1
San Bernardino County	274
San Diego County	3
Out of State	23
Out of Country	11
Undeclared	7

* Hometown as defined and reported by Facebook.

Continue the project under a different funding source

In evaluating the use of social networking sites for the Department’s use, it was identified that the use of the Facebook and Twitter sites is beneficial and cost effective for the Department to continue. The ability to disseminate information, resources, and community events held throughout the County of San Bernardino, via Facebook and Twitter, is very useful.

Evaluation of the project indicates it is to the advantage of the Department to continue operating the Facebook and Twitter sites. The cost to run the project is minimal and primarily consists of personnel time to maintain the Facebook and Twitter sites. The ability to optimize the personnel’s time via scheduling “Posts” for the future is advantageous to the Department. The Department has concluded it will continue to maintain both the English and Spanish Facebook pages along with our Twitter account through our Community Outreach and Engagement unit, who oversees the maintenance of the Facebook pages and Twitter account.

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While making the determination to continue using social media efforts to provide information and gain feedback, the Department considered which aspects of the project would be maintained, changed, or discontinued.

Social Media Site	Maintain	Change	Discontinue
Facebook	<ul style="list-style-type: none"> • “Post” flyers, events, and information relevant to behavioral health • Disseminate information to a broader audience • Collect data regarding the users of the Department’s Facebook pages to identify trends to assist with improving the page • Network with other community sites to share information 	<ul style="list-style-type: none"> • Conduct regular periodic surveys of the Department’s “Fans” to find out how the Department is doing and what improvements can be made • Improve the quality and frequency of resources used for “Posts” to the Spanish Facebook page • Improve the consistency of “Posting” information to Facebook • Identify ways to boost Spanish Facebook “Fans” 	N/A
Twitter	Use Twitter to disseminate information and events	“Tweets” will be more unique, individual, and specific in order to make appropriate use of the 140 characters limitation	No longer rely solely on Facebook “Posts”
MySpace	Not used by the Department and will not be used in the future.	N/A	N/A
Other social media sites (e.g. LinkedIn, YouTube, Spotify, etc...)	N/A	Use of these sites may be considered in the future as social media continues to evolve	N/A

Materials developed to communicate lessons learned and project results

This report will be made available on the DBH website at: <http://www.sbcounty.gov/dbh>

No other reports, manual, or materials were developed.

References

1. [Journal of Computer-Mediated Communication Volume 13, Issue 1, pages 210–230, October 2007/](#)
2. ["Facebook: One Billion and Counting"](#). The Wall Street Journal. 2012-10-04. Retrieved 2013-01-14.
3. <https://about.twitter.com/company>

INN – 03: Community Resiliency Model (CRM) - Final Report

This final report is based on the instructions provided in the Department of Mental Health Information Notice 09-02.

Issue Addressed

Each county must provide the 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.

Implemented by the Department of Behavioral Health (DBH) and the Trauma Resource Institute (TRI), the goal of the project was to bring biologically based trauma intervention training, Community Resiliency Model (CRM) Training, to community cultural brokers and their respective communities within the County of San Bernardino who are unserved, underserved or inappropriately served. The intent has been to expand local response capacity by offering training in CRM skills, which are biologically based resiliency skills designed to address the needs of cultural communities regarding mental health education and coping skills. The target groups were chosen because they have been historically unserved, underserved, or inappropriately served with an unmet mental health crisis need.

CRM focuses on the biology of trauma, which crosses cultural boundaries. CRM aids in the development and strengthening of current partnerships with organizations that contract with the County, as well as community-based organizations with ties to our unserved, underserved and inappropriately served communities, which is a key aspect to this project. A total of **157** diverse community leaders and key community members were trained to be CRM Skills Trainers and Ambassadors. They are now equipped to share their knowledge within their communities by training others.

Project Description

Pursuant to Welfare and Institutions Code 5830, the primary purpose of the Community Resiliency Model (CRM) project was to **promote interagency collaboration** as well as to increase **access to underserved groups**.

The CRM project was submitted as part of the County of San Bernardino Innovation Plan in February 2010. The project was approved for Innovation funding by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in March 2010. The Trauma Resource Institute (TRI) received the contract to develop a community model, based on their Trauma Resiliency Model (TRM) and input from the community, and to provide trainings that would expand the DBH TRM Train-the-Trainer model. Implemented from December 14, 2010 through December 31, 2013, CRM introduces a new application to the mental health system of a promising community driven practice/approach that has been successful in non-mental health contexts or settings.

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Developed by Elaine Miller-Karas, LCSW, Director of the Trauma Resource Institute, and used with survivors of catastrophic events, the Trauma Resiliency Model (TRM) is a biologically based model developed as a response to catastrophic events and is suitable and culturally appropriate for use by many unserved, underserved and inappropriately served populations. TRM teaches an individual how to stabilize the nervous system in a short period of time to reduce and/or prevent emotional and physical symptoms of traumatic stress. The emphasis on the biology of trauma makes TRM accessible and relevant to many diverse cultural groups. The TRM model has been well received by the unserved, underserved and inappropriately served diverse cultural communities within the County of San Bernardino.

The Department initially implemented TRM in March 2007, with the DBH Disaster Response team. In October 2007, TRM was used successfully in response to local wildfires. TRM training provided the mental health system with another approach/strategy for the community that, if adapted, could be potentially relevant to an “audience” beyond disaster victims, including diverse communities.

The adaptation of TRM to the Community Resiliency Model (CRM) takes a model that has been used as a response to catastrophic events to a community based model appropriate for use in response to community or individual events/situations within diverse cultural communities. This adaptation to a community model retained the biological emphasis with an added cultural competency focus.



CRM provides mental health education in the community, which includes coping skills, trauma response skills and resiliency identification and training. During the community planning process, diverse stakeholders shared examples of community crisis, trauma or incidents and the possible correlation of mental health impacts on community members. CRM is designed for use by non-clinicians, para-professionals and multi-cultural groups, emphasizing the participation of a variety of cultural brokers who can effectively serve as credible and accepted “first responders” within established community based organizations.

Seven (7) groups were identified for this training. These groups include: Latino, African American, Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ), Asian/Pacific Islander, Native Americans, Veterans, and At-Risk Youth. Representatives from six (6) of the seven (7) groups were trained with the exception of the Native American group. Although potential trainees from the Native American group were recruited and participated in the orientation, due to time constraints they were not mobilized for the training. This group will be included in future training plans.

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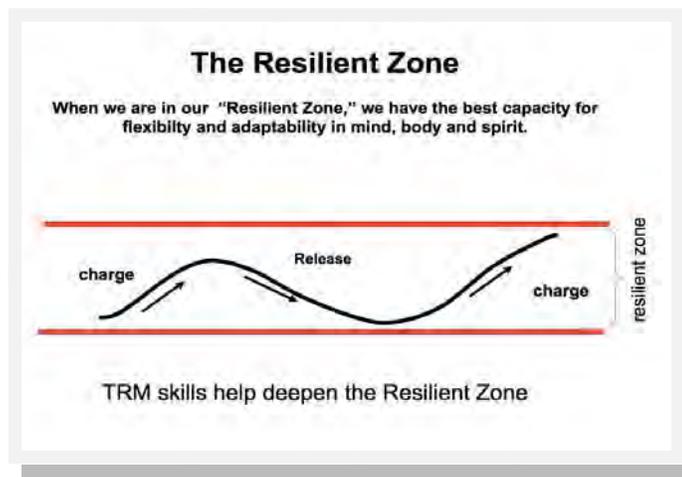
Orientation

In 2011 and 2012, TRI met with groups throughout the County of San Bernardino including the cities of San Bernardino, Big Bear Lake, Rialto, Upland, Colton, Barstow, Victorville, Yucca Valley and Hesperia. They offered a brief Introduction to CRM (1 hour) or a slightly longer Orientation to CRM (2-3 hours), both of which introduced MHSA, Innovation funding, CRM skills, and a discussion of individual reactions to trauma. The goal was to recruit participants to take part in a CRM Train the Trainer session. In total, the 1-hour introduction meetings were attended by **150** participants from eleven(**11**) different community agencies and the 2-3 hour Orientation meetings were attended by **209** participants from eight (**8**) different community agencies. Approximately **60%** of the participants were female, and **40%** were male. The age of the participants ranged from 22-75 years, with an average age of **53**. Eighty-six percent (**86%**) of the participants were people of color. The individuals who attended the meetings were mostly community leaders within one of the target cultural groups, and may also be referred to as Cultural Brokers. It was very important for TRI staff to travel to the various areas within the County where the meetings were scheduled to increase participation; it also resulted in engendering rapport.

Figure 1 on the next page describes these outreach offerings.

A screening tool was developed to assist with identifying ideal candidates from within the group of diverse cultural community members applying for the CRM Train-the-Trainer opportunity to become a CRM Skills Trainer. Suitable groups of trainees were identified using a two-prong approach:

- 1) Working within a community agency and having an agency point person who assisted TRI in recommending trainees for the program, after delivering orientations.
- 2) Identifying individuals within the targeted group who demonstrated an interest and commitment in becoming a CRM Skills Trainer.



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Figure 1. Unserved, underserved or inappropriately served groups that attended CRM Introductions and Orientations

AGENCY or COMMUNITY or GROUP	UNDERSERVED GROUP	INTRODUCTION TO CRM (1 hour)	ORIENTATION TO CRM (2-3 hours)
EL SOL	Latino	24	12
KNOTT'S FAMILY AGENCY/VICTOR	African American/Other	8	18
NATIVE AM HEALTH CLINIC	Native American	22	
ASIAN PACIFIC RESOURCE CTR	Asian/Pacific Islander/ Other	24	
LGBTQ	LGBTQ	12	15
DESERT MENTAL HEALTH CENTER	African American/Other	9	
HUGHES/AF AM MINISTER GROUP	African American	9	
SPIRITUALITY FOCUS GROUP	Other	6	
INTEGRATIVE HEALTH CLINIC	Asian/Pacific Islander/ Other	6	100
BARSTOW/VICTOR COMMUNITY	Latino/Other	22	
VICTORVILLE/VICTOR COMMUNITY	Other	15	
LOMA LINDA HOSPITAL	Veteran	12	
YOUTH SERVICES BIG BEAR	Youth		12
CHAFFEY COLLEGE	Veteran	18	15
TOTAL		150	209

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Training

As training began, there were participants in each group who, for a variety of reasons, were not interested in becoming CRM Skills Trainers, yet wanted to remain a part of the CRM training and community. After discussions within the TRI staff and the Department's Innovation unit, it was decided to create a new classification, called the "CRM Ambassador." A CRM Ambassador would share skills with family and friends and use the skills for self-care, but would not be certified to train community groups. Some of the reasons for becoming a CRM Ambassador were as follows:

- The trainee was not comfortable teaching in a group setting.
- The trainee had gone through a life change (i.e. became employed, family life change, etc.), which did not allow the trainee sufficient time.
- Some members had health problems and needed to take care of their physical well-being, yet wanted to be part of the group.
- A candidate had too many absences from the training which resulted in not fulfilling the requirements to become a trainer, yet they wanted to stay involved with the group.

The CRM Train-the-Trainer session consisted of 40 hours of training. The trainees learned the skills and key concepts of CRM through a combination of lecture, discussion, practice and student teaching. The 40 hours of training included 32 hours of training and one (1) student teaching day. Follow-up sessions were also incorporated into the training plan; they were set for three (3) months after the last day of training and then quarterly for a year. Technical assistance from a TRI staff member by phone, in person, by Skype or email was also made available by TRI. Training sessions were offered in English and Spanish and all materials were available in both languages.



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Training expectations were communicated during the first training session, as well as reinforced multiple times during the subsequent CRM Train the Trainer Sessions:

- 1) Each participant was asked to sign a Statement of Understanding that delineated his or her potential outcomes either as a CRM Skills Trainer or CRM Ambassador.
- 2) The Statement of Understanding clearly stated that if an individual became certified as a CRM Skills Trainer, it would be upon the approval of the CRM Master Trainers (designated TRI staff members are certified as Master Trainers).
- 3) A detailed CRM Structured Observation of Teaching was handed out to each trainee prior to his or her student teaching so that expectations were made clear.
- 4) Each participant was asked to identify two (2) or more reasons why he or she had chosen to be part of the CRM Train-the-Trainer Skills Program.
- 5) During the training the differences between a CRM Skills Trainer and CRM Ambassador was elaborated upon, not only in the Statement of Understanding, but also verbally throughout the training.
- 6) TRI staff emphasized, on multiple occasions, the ethics of using CRM by learning about assessing readiness and how to triage to higher levels of care if the CRM Skills Trainer was concerned about a participant. Information about DBH services was discussed and given out. The “AMP Down Now” cards also have emergency contact information.
- 7) Certificates of Completion were given to the participants either designating them a CRM Skills Trainer or a CRM Ambassador.
- 8) During the training, there was time given to structure a plan on how the CRM Skills Trainers would move forward in their particular communities. The follow-up meetings were also a time to mentor the participants on going forward with CRM Trainings.
- 9) The CRM website was shared with the trainers, along with how to access the protected area of the site to stay up-to-date on materials.

TRI quickly and easily surpassed the goal of training 50-75 community cultural brokers to be CRM Skills Trainers. By project completion in December 2013, there were **120** CRM Trainers and **37** CRM Ambassadors. **Figure 2** on the next page offers a depiction of the training cohort groups (based on the agency/group) and the number trained in each. CRM training participants completed an evaluation of each training session to ensure that culturally competent and relevant training for each of the cohort communities was included.

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Figure 2. Individuals trained, by training cohorts.

TRAINING COHORT	UNDERSERVED GROUP	CRM TRAINERS	CRM AMBASSADORS
El Sol	Latino	20	5
Knott's Family Agency/Victor Community	African American/Latino	5	3
LGBTQ	LGBTQ	11	1
Hughes/African American Minister Group	African American	18	6
Integrative Health Clinic	API	17	1
Big Bear Lake	Youth	5	2
Veteran Yucca Valley*	Veteran	11	2
Veteran Hesperia*	Veteran	9	3
Veteran San Bernardino I	Veteran	8	5
Veteran San Bernardino II*	Veteran	3	8
Victorville Holistic Campus	African American/Latino/ Native American/Youth	13	1
TOTAL		120	37

*These trainings were done under the Veterans Extension Project part of the Innovation Project that will be discussed in detail later in this document.

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Effectiveness

The CRM project evaluation consisted of process components measuring the implementation of the Train-the-Trainer sessions and corresponding outputs, in addition to key outcomes associated with the project objectives. Three (3) tools were used to collect evaluation data:

- 1) Post and Follow-Up Treatment Relevance, Use & Satisfaction Scales (TRUSS) Survey.
- 2) Pre/Post/Follow-Up Symptom Questionnaire (SQ).
- 3) CRM Brief Questionnaire.

Data analyses include evaluation data from all training cohorts. There were three (3) data points being analyzed: pre-training, immediately post-training, and 3-6 month follow-up.

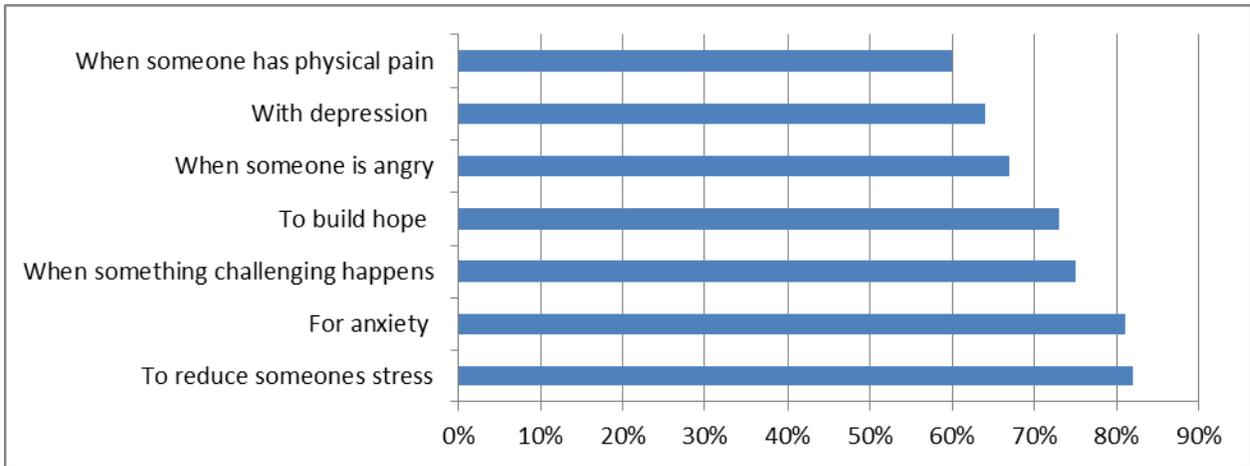
The CRM Project Work Plan outlined several learning goals.

Goal: *The County will learn if the Trauma Resiliency Model can be adapted to a Community Resiliency Model. The original model addresses response to a natural disaster or catastrophe. The new adaptation changes the focus to individuals and how to respond to traumatic individual and community events.*

The TRM model has successfully been adapted to be effectively utilized by diverse cultural community members. The community model offers initial stabilization skills which can then become a wellness practice in a familiar (non-clinical) setting delivered by an appropriate, trusted member of the community (peer, chaplain, community activist, teacher). Results of training evaluations received from approximately 68 trainees immediately after their last training session, indicate that 96% of the respondents believe that the CRM skill trainings will be very to moderately relevant or useful for their work with people in their community, and 90% said they thought they would use the skills very to moderately frequently during the month following the training. One objective of the training was to enable at risk community members to use CRM skills for their own self-care and to prevent burnout. Nearly all (94%) of the trainees reported that they will be able to use the skill learned from the training for their own self-care, and all reported satisfaction with their understanding of the CRM skills. When asked to report on other specific ways they thought the CRM training would help their work with people in their own communities, at the end of the training 60% or more indicated the following: that the CRM skills will be useful to help reduce distress (82%) and anxiety (81%), when facing a challenge (75%), building hope (73%), with anger (67%) and depression (64%), and when someone has physical pain (60%), see **Figure 3**. Follow up data (3-6 months after the training) identifies that the trainees maintained satisfaction with the CRM training, with 97% reporting satisfaction with their understanding of the CRM skills.

Figure 3. How trainees said they will apply the CRM Skills within the community.

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Goal: *The County will learn if training community trainers works and how it works. This might be demonstrated by any of the following:*

- a. *If underserved individuals will attend this type of training in their own community (church, community center, community based organization)*

As demonstrated in **Figure 2**, there were **157** diverse cultural community members, identified as being from unserved, underserved or inappropriately served groups, who not only attended training but also became certified as a CRM Skills Trainer or Ambassador. The Trainers reported that as of the end of the project, approximately **3,531** individuals within communities across the County of San Bernardino were taught CRM skills.

- b. *If the provision of training for the community in the community leads to the de-stigmatization of mental health help seeking for underserved individuals.*

Trainers have stated that there are opportunities for them to deliver the CRM trainings to local churches, community based organizations, community centers, as well as to family and friends. These cultural brokers have been able to deliver trainings to a population that may not be comfortable attending this type of group at traditional mental health clinics.

- c. *If expansion of interagency collaboration through cultural brokers positively influences underserved communities' participation in the mental health system.*

As evidenced by data relating to the effectiveness of the CRM skills within the training group, a positive

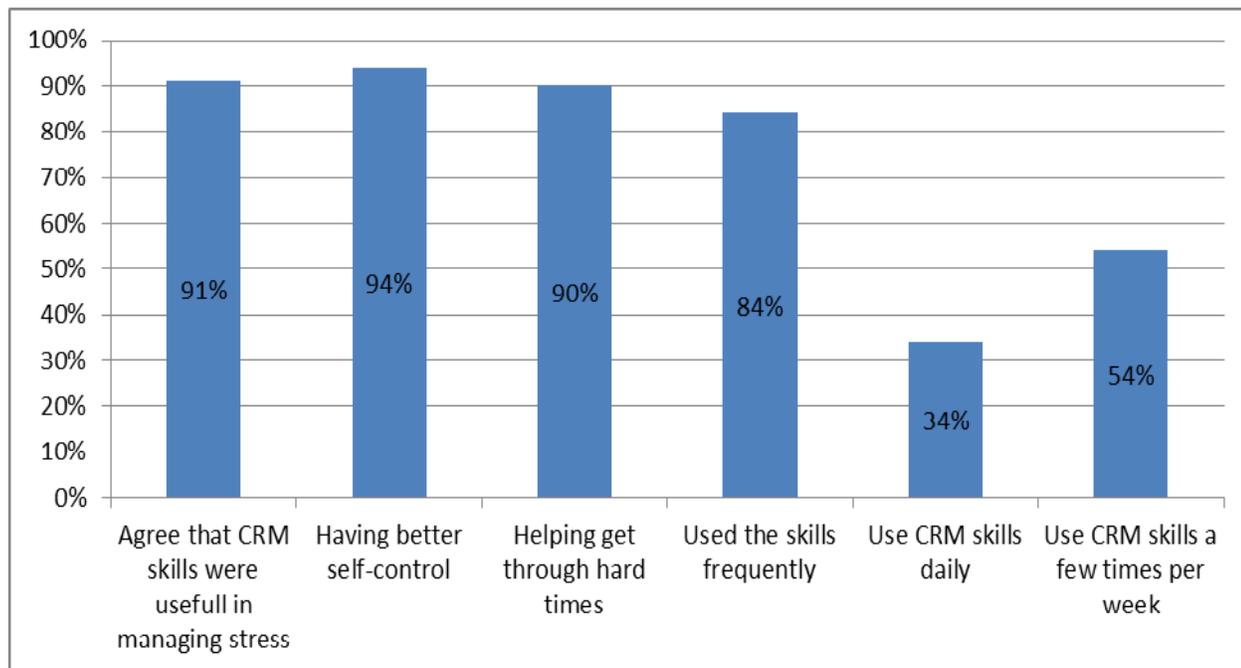
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picture of the communities' participation in the mental health system emerges. This is to say, that knowing and using the CRM skills positively impacted mental health symptoms.

In order to have a preliminary assessment of the stability of treatment effects, trainees' symptoms were assessed 3-6 months after the training. The 3-6 month follow-up response rate of **58% to 100%** was very good among five (5) of the six (6) groups. There was a **45%** response rate for the Asian / Pacific Islander group. Findings indicate that at the 3-6 month follow-up, that although the positive distress and well-being findings were not quite as strong 3-6 months after the training, pre- to follow-up comparison analyses showed positive trends in the desired direction of improvement in every distress and well-being indicator, **with statistically significant improvement pre- to follow-up decreases in anxiety, depression and hostility symptoms.**

Additional 3-6 month follow-up data received from approximately **68** trainees across the six (6) groups indicated that **90%** or more either completely or somewhat agree that the CRM skills were useful in managing stress (**91%**), having better self-control (**94%**), and helping get through hard times (**90%**). The majority (**84%**) used the skills frequently; with **30%** reporting they were using the CRM skills daily and **54%** indicating a few times a week, see **Figure 4**. This data suggests that the perceived usefulness of the CRM skills to trainees personally was likely a motivating factor for trainees to practice them frequently over time.

Figure 4. 3-6 month follow up data received from 68 trainees.



These results indicate that at least in the several months post-training, for a majority of the trainees, the positive

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effects of the training and treatment continued. Even though most of the symptoms did not maintain the level of improvement that they did at the post-treatment data point, they continued to demonstrate improvement from the trainee's pre-training data point. The results of the research suggest that offering Community Resiliency Model Trainings to the underserved, underserved and inappropriately served within San Bernardino County and providing adequate support networks following the initial training, could have a potentially powerful impact in reducing the symptoms of depression and anxiety within a wider population. In this Train-the-Trainer model, most of the trainees reached the level of competency to become CRM Skills Trainers. The fact that so many lay people, across all of the targeted groups, have mastered the CRM skills well enough to become CRM Skills Trainers who can then teach the skills to others in their cohort, speaks to the accessibility, cultural relevancy and ease of learning of the CRM model for diverse cultural community members. **The CRM model can help create stronger, healthier, more resilient communities.**

The County learned the Community Resiliency Model strengthened DBH's linkages and collaboration with San Bernardino County's diverse cultural communities. Extensive feedback was received during the Community Program Planning (CPP) process associated with the creation of the MHSA Innovation Plan 2014. The CPP process provided **16** separate stakeholder meetings focusing on the Innovation funded projects. Stakeholders were provided with information on each project, including outcomes to date. Feedback regarding CRM indicated the value of this project was:

- A wellness practice that is easy and simple to learn and use, regardless of education, culture, or other differences.
- Community-based.
- Stigma reducing.
- Facilitating self-care and individual development.
- Useable by the whole family.

Further, when asked about the options for potential continuation of the project, feedback indicated a need to have CRM Skills trainers in schools, universities, service work of all kinds (as self-help), crisis work, homeless outreach work, and even within DBH non-clinical staff.

"The Resiliency project is very good for the well being especially if the person does not want mental help from the doctor."

"The importance of self care is presented in an easy way."

"That CRM can be used by all. Train the trainer type project that can be passed on to family and others."

"The skills, education, and empowerment of CRM skills help to depathologize reactions to stress/trauma."

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Program Modification

Veteran’s Extension Project

DBH asked TRI to consider an extension of the CRM Innovation Project to focus on veterans. The Veterans Extension project started in February 2012 and ended on June 30, 2012. Implemented collaboratively by DBH and TRI, the goal of the project was to bring biologically based trauma intervention training to a larger cohort of veterans in San Bernardino County who for many cultural reasons may have limited access to mental health resources.

There were **46** initial participants among the three (**3**) groups who received the CRM Train-the-Trainer sessions, as well as individual sessions in either demonstrations or in work with a trainer under supervision. Female participants made up **58%** of the group, while **42%** were male. The age of the participants ranged from 28-74 years, with an average age of 53 years.

The participants reported an array of physical and emotional symptoms, reflecting the extensive impact of high stress on the mind-body system when one is a veteran. Participants reported an average of six (**6**) emotional distress symptoms and five (**5**) physical distress symptoms.

In order to assess effectiveness of treatment, trainees were assessed immediately after training was completed, and again 3-6 months later. Results indicated that immediately after training the Symptom Questionnaire (SQ) symptoms of distress improved at the level of significance in the areas of anxiety, depression and hostility. The trainees reported positive improvement in the reduction of the following distress indicators of:

- Anxiety (**74%**)
- Depression (**69%**)
- Somatic (**52%**)
- Hostility (**65%**)

Model Redesign

The CRM project provided TRI staff with substantial learning opportunities which led to modifications with the design of the model as outlined below:

Language

- 1) The language for some of the groups had to be modified to better suit the needs of the group. For example, Ben R. an active duty Marine, wanted to “Marinize” the presentation slides to use language and terms that would be more receptive to Marines.
- 2) A key concept in English is the Resilient Zone; the Spanish language translators decided that “Zona de Bien Estar” more clearly defined the concept for Spanish-speakers.

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Skills

- 1) The model originated with five (5) skills and ended up with six (6) skills by the end of the project. One of the concepts in CRM is bringing awareness to gestures and spontaneous movements that can help a person come back into their Resilient Zone. It was decided through the project to make the concept clearer by creating a new skill called Gesturing and Spontaneous Movements. Gestures may emerge spontaneously and are usually below conscious awareness.
- 2) Upon completion of the training, some individuals were not comfortable becoming CRM Trainers, but found the skills useful for self-help. Some of the Master Trainers also felt uncomfortable in a trainer role, opting instead to be designated as CRM Ambassadors.
- 3) CRM started out calling one of the skills Amp Down. This was confusing and the name was changed to “Help Now” and “Ayuda Inmediata” (Spanish). The intent was to make the skill more user-friendly.
- 4) A teaching aid was developed for use in all CRM skills trainings based on one of the veterans indicating he would like a pocket card listing all of the “Help Now” strategies.
- 5) The skills were reordered to teach Tracking and Resourcing first, before Grounding, because of the challenges that some of the Vietnam veterans had with grounding, which may be a specific cultural consideration for this specific group.
- 6) To enhance the effectiveness of the training, the materials were constantly being updated and changed to make the concepts clearer.
- 7) The PowerPoint presentations were changed by TRI, and the participants were given the flexibility to modify their own presentation to better connect with their communities.
- 8) TRI created Resiliency wristbands, Resiliency pens and “Help Now” pens.; all these were provided in English and Spanish.

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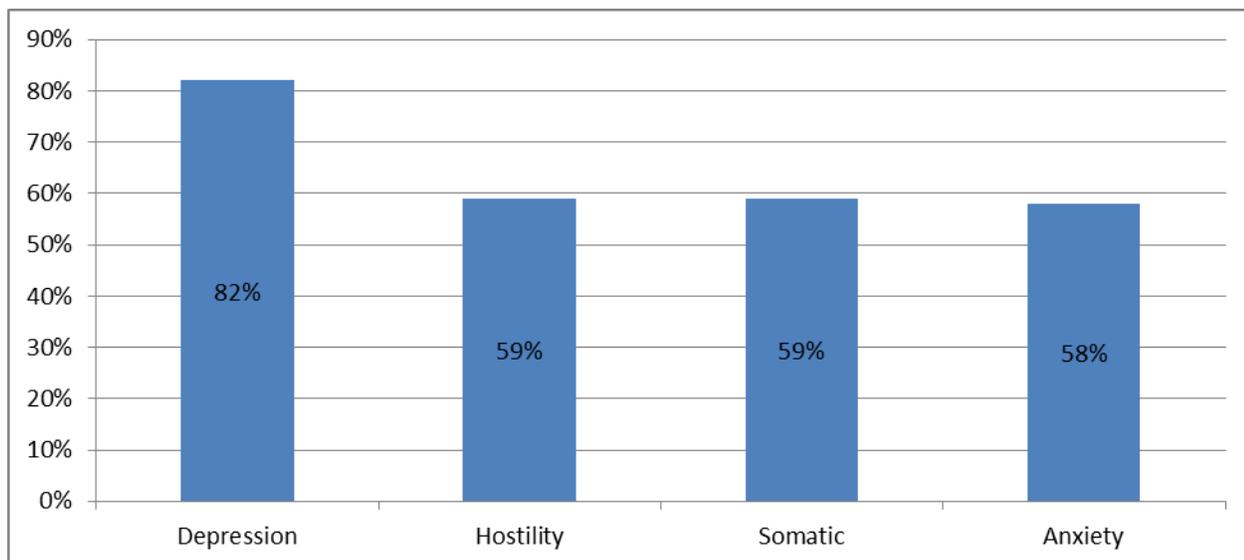
Additional Learning

Cultural appropriateness and applicability to diverse communities provided for the recruitment and training of cultural brokers from six (6) of the seven (7) target cohorts and have successfully strengthened relationships with DBH and the diverse cultural communities throughout the County.

Although the focus of CRM has been providing training, rather than treatment, all of the **109** participants evaluated received group sessions of CRM, as well as individual sessions, in either demonstrations or in work with a trainer under supervision. Approximately **62%** of the participants were female and **38%** were male, and the age of the participants ranged from 22-75 years, with an average age of 51. The participants reported an array of physical and emotional symptoms, reflecting the extensive impact on the mind-body system when one is a member of an at-risk group or population that is unserved, underserved or inappropriately served. Participants reported an average of six (6) physical distress symptoms and an average of six (6) emotional distress symptoms. The high incidence of physical symptoms shows the importance of models that include biological interventions that help stabilize the nervous system and that are not limited to traditional interventions that involve “talk therapy.” Additionally, many ethnic cultures more easily identify physical complaints as appropriate representations of emotional or psychological pain/distress, therefore the premise of the intervention itself was culturally appropriate and applicable.

In order to assess effectiveness of treatment, trainees were assessed immediately after the training was completed, and again 3-6 months later. Combined, the groups reported improvements in the distress indicators of depression, hostility, somatic, and anxiety. **82%** of the respondents indicated less depression symptoms post training, **59%** less hostility symptoms, **59%** less somatic symptoms, and **58%** less anxiety symptoms, see **Figure 5**.

Figure 5. Percentage of trainees who indicated positive changes in distress indicators post training.



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The results indicated a strong positive trend, which demonstrates the positive effects of treatment in all symptoms at the time of the end of the training (i.e., decline of distress symptoms and upsurge in well-being symptoms). Pre-to-post test comparison analyses indicate statistically significant decreases in the average number of depression, hostility, anxiety, and somatic symptoms and statistically significant increases in the average number of symptoms related to relaxed, contented, somatic well-being, and friendly indicators. The most significant area of improvement is related to the depression indicator.

The fact that such a large percentage of depression symptoms are improved across populations suggests that using the CRM skills, which stabilize the nervous system, and learning how to teach them to others, offers trainees a greater experience of control and empowerment, which can result in a sense of renewed hope.

Success Stories

Below is an e-mail received from a CRM Skills Trainer. She was one of the first persons trained as a CRM Skills Trainer and her e-mail embraces how CRM can be used to help our communities one person at a time. Her e-mail is representative of the feedback received from CRM Skills Trainers:

"...I wanted to share with you my use of the CRM skills during this past week. I have been teaching and practicing CRM skills weekly with individual students who experience discomfort in a variety of situations with much success, but I had not used the tools in a stressful situation.

I used grounding with these students individually and it was amazing to watch how quickly they were able to identify and notice how their bodies were telling them that they were "scared" and then by using grounding they were able to notice the change in their bodies to a more comfortable state and return to the activity with the rest of their classmates.

I am grateful to have such an effective tool to use with my students. It was just as you had taught us, with no special equipment or prior knowledge of these skills, these students were able to bring their bodies from an escalated state to calm. Thank you so much."

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Recommendation of this project to others

As a result of the effectiveness, the cultural appropriateness, the ease with which diverse cultural community members can learn and use the skills, the self-care effect of knowing how to use the skills, the ability to easily adapt the skills to a particular culture or target audience, and the flexibility of working with TRI, the CRM project is recommended for implementation or replication by other agencies or organizations.

Interest in learning the CRM skills has been generated throughout the county as a result of the “word-of-mouth” promotion produced by those involved in, and who have received the training. Feedback received during the Innovation Stakeholder meetings showed a desire to have the project continue and yielded many suggestions as to whom and where CRM Skills training should be provided. Current CRM Skills trainers have also compiled a comprehensive list as to where they wish to promote and offer the CRM Skills training, including:

- Schools.
- Homeless shelters.
- Healthcare clinics.
- Hospitals.
- Senior centers.
- Churches.
- Domestic violence shelters.

Some lessons learned during implementation include the following recommendations:

- Stipends to the community members who attend the Train-the-Trainers, is a positive way to encourage participation.
- Identify requirements for the trainers to maintain their certification.
- It is critical to maintain multiple types of current contact information on participants.
- Regular follow-up meetings and refresher trainings are crucial to keeping trainers current and proficient in their CRM Skills knowledge.
- An evaluation of CRM Skills training attendees is helpful to determine if the community is being positively impacted and are using the skills.
- There is a natural attrition rate of trainers over time.

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CRM Accomplishments

Over the last three (3) years, the CRM Innovation project implemented by the Department of Behavioral Health in the County of San Bernardino has expanded the CRM training efforts locally and regionally as well as has had an impact on national and international efforts. The information gleaned from the Innovation project has made the training of CRM more streamlined, stronger and adaptable to cultures. Some highlights of the CRM efforts include:

Local Efforts:

- Children’s Hospital Los Angeles trained eleven (11) of their staff to be CRM Skills Trainers after seeing the research on CRM from the Innovation Project. They are now offering classes to address the vicarious trauma that happens within hospital settings.
- Peace over Violence in Los Angeles and the Center for Community Solutions in San Diego, two (2) well-respected domestic violence prevention organizations were both trained in CRM and are considering bringing CRM Train-the-Trainer to their organization.
- TRI did a large orientation for Women, Infants, and Children (WIC) in San Bernardino County of the CRM Skills in two half-day trainings.
- County of San Bernardino Children and Family Services have contracted with TRI to train their staff in CRM Skills based on the Innovation’s project success.
- Loma Linda University’s School of Social Work and Social Ecology reached out to TRI because of DBH’s recommendation with regard to TRM and CRM.

National Efforts:

- Mountain Area Health Education Center of Asheville, North Carolina is sponsoring a CRM Train-the-Trainer program starting in March of 2014 based on the information from the Innovation project.
- TRI’s director presented CRM in a one-day orientation to Walter Reed Hospital in Bethesda, Maryland in July of 2013.
- National Association of Social Workers (NASW), Montana, has asked TRI to present CRM to a two-day conference in Helena in April 2014.
- In February 2014, TRI presented CRM to 35 grass roots organizers from Hell’s Kitchen, NYC. They have been invited back to present the five (5) day Train-the-Trainer.

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International Efforts:

- The CRM Innovation Project has spawned training materials that have been used in Africa to train community workers helping people recovering and rebuilding from genocide. There are now CRM Skills trainers in Somalia, Uganda, Kenya and Darfur.
- The Spanish language materials translated by the project were used in Guatemala to train **23** indigenous Mayan women working with trauma in their community in Solala. This project is trying to help young women stay in school past the 6th grade to create more women leaders.
- Two (**2**) CRM 5-day trainings were brought to community stakeholders in the Philippines who are using the CRM skills to help survivors of Typhoon Yolanda that killed over 6,000 people.
- In November of 2013, TRI presented CRM in Vancouver, Canada at a grass roots conference for street nurses. TRI is going back to offer the five-day CRM Train-the-Trainer.
- The Medgar and Merilee Evers Institute of Jackson, Mississippi recently contacted TRI. They had heard about the work in San Bernardino and are considering sponsoring a pilot project in Mississippi.

Continue the Project Under a Different Funding Source

The Department is moving forward with the implementation of CRM Skills training into the DBH system of care as a community education offering. DBH and TRI are in discussions regarding a continued collaborative effort that will enable CRM trained cultural brokers to continue to provide CRM skills training throughout diverse communities in the County of San Bernardino, organized, promoted, and tracked through DBH.

DBH will coordinate the trainings by maintaining contact with the cultural brokers and will utilize DBH community outreach resources to schedule CRM trainings throughout the county, as well as promoting CRM to community partners and networks. DBH will also utilize research and evaluation resources to track relevant data and measure outcomes to evaluate effectiveness and reach on an ongoing basis.

The CRM project will be continued and supported using Prevention and Early Intervention (PEI) funding to fund the ongoing support needed from TRI for the CRM Skills Trainers. MHSA Administration will fund the position of Community Education Coordinator, who will work as a part of our Community Outreach and Engagement team. The goal is to expand the CRM skills throughout the communities of San Bernardino County in support of the DBH vision of promoting recovery, resiliency, and wellness.

Materials developed to communicate lessons learned and project results

This report will be made available on the DBH website at: <http://www.sbcounty.gov/dbh>

A website was created to provide information about CRM and to provide support for CRM Skills Trainers:

www.communityresiliencymodel.com

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While making the determination to continue utilizing CRM as a community education resource, the Department considered which aspects of the project would be maintained, changed, or discontinued.

Community Resiliency Model	Maintain (what worked well)	Change (what can be improved)	Discontinue (what didn't work as well)
CRM Skills Trainings	<ul style="list-style-type: none"> • Trainers will utilize CRM skills to train community members • Maintain fidelity of the curriculum by obtaining ongoing training and support from TRI staff, to include face to face or telephonic • Coordinate with TRI to maintain an active pool of certified CRM Skills trainers • Collect data from current trainers for performance outcomes • Culturally and linguistically appropriate trainings • Provide stipends for CRM skills training for conducting or attending trainings or support meetings 	<ul style="list-style-type: none"> • Develop ongoing requirements in order to maintain CRM certification • Administer pre-, post-and 3-month surveys to all attendees for data collection and analysis • Create the ability to remove certification of CRM Skills Trainer if ethical standards are not maintained • Include a virtual option to obtain direct support from TRI 	<ul style="list-style-type: none"> • Symptom Questionnaire tool which consists of a 92 question survey, in favor of a more manageable, less time consuming evaluation tool

Collaborative Partners

Thank you to the following partnering agencies:

Department of Behavioral Health (DBH)

San Bernardino County District Attorney's Office

County of San Bernardino Probation Department

San Bernardino County Sherriff's Department

County of San Bernardino Children and Family Services (CFS)

County of San Bernardino Children's Network

County of San Bernardino Public Defender

San Bernardino County Superintendent of Schools

Transitional Assistance Department (TAD)

Trauma Resiliency Institute (TRI)

Mental Health Services, Inc. (MHS)

Victor Community Support Services (VCSS)

Eastfield Ming Quong (EMQ) Families First, Inc.

Reach Out

Valley Star Children and Family Services

LF Leadership

El Sol Neighborhood Educational Center

Evalcorp



MENTAL HEALTH SERVICES ACT

Capital Facilities

MHSA INTEGRATED PLAN

FISCAL YEAR 14/15-16-17

Service Goals/Outcome Measures

The Goal of Capital Facilities is:

- Improve or replace existing capital projects to meet program infrastructure needs.

The Objective of Capital Facilities is:

- Support the Capital Infrastructure needed to support implementation of the Community Services and Supports and Prevention and Early Intervention programs.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience



Capital Facilities

A “capital facility” is a building secured to a foundation which is permanently affixed to the ground that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices.

DBH has successfully completed the Capital Facilities funded project of renovation of a vacant county owned building into the new One Stop TAY Center. The building includes space to provide crisis residential services for up to **90** days via the Innovation project, The STAY, a TAY Hostel.

Future Projects

During previous and recent stakeholder engagement meetings, two (**2**) possible uses of the remaining Capital Facilities funding have been identified as supported. Potential projects include the acquisition and renovation of a facility in the High Desert region of the County to house DBH’s mobile services units, such as Community Crisis Teams and/or Older Adult Mobile Services, and the first break services funded under the Prevention and Early Intervention Community Wholeness and Enrichment Program.

The other opportunity is to invest in space for expanded crisis services. The space will be used to provide for the health and social service needs of residents throughout the County and fulfill County goals and objectives by increasing access to effective crisis residential and crisis stabilization services, by effectively meeting the needs of individuals experiencing a mental health crisis in the least restrictive manner possible. Through a collaborative approach with local law enforcement, hospitals, and community based providers additional crisis services can be provided.

The proposed project will potentially be used to purchase land and build a new facility, housing a new Crisis Residential Treatment (CRT) program. The expansion would also support an expansion of current Crisis Walk-in Center services, including a co-located Crisis Stabilization Unit (CSU), to individuals throughout the County. DBH anticipates the expansion could serve approximately **332** individuals through the residential facility and **4,380** through the CSU, annually. The utilization of MHSA Capital Facilities funding to support this action is dependent on the ability to obtain the leverage of additional grant funding to support the project.

CAPITAL FACILITIES & TECHNOLOGICAL NEEDS



MENTAL HEALTH SERVICES ACT

Technological Needs

M H S A I N T E G R A T E D P L A N

F I S C A L Y E A R 1 4 / 1 5 - 1 6 - / 1 7

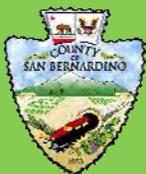
Service Goals/Outcome Measures

The Goals of the Technological Needs Component 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.

The objectives of the Technological Needs Component are:

- To modernize and transform information systems and increase consumer and family empowerment.
- Develop a long term integrated infrastructure for mental health to facilitate the highest quality, cost effective services and supports for consumer and family wellness, recovery and resiliency.
- Provide technology solutions to significantly improve quality of care.



County of San Bernardino - Department of Behavioral Health

Promoting Wellness, Recovery and Resilience

SABER

San Bernardino
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County of San Bernardino - Department of Behavioral Health



BEHAVIORAL HEALTH

Promoting Wellness, Recovery and Resilience

Promoting Wellness, Recovery and Resilience

Technology



The goals of technology are to modernize and transform information systems and increase consumer and family empowerment by improving the quality of care. DBH has been successful in the ongoing development of a long term integrated infrastructure for mental health to facilitate the highest quality, cost effective services and supports for consumer and family wellness, recovery and resiliency.

The list of achievements include:

- Successfully issued a Request for Proposal (RFP) and awarded a contract for the development and implementation of an Electronic Health Record (EHR) and Behavioral Health Information Management System (BHMIS).
- Beginning stages of providing training to DBH staff to ensure proficiency with electronic solutions.
- Implemented Wireless Network at five (5) DBH Locations.
- Purchase of Video Conferencing Equipment.
- Implemented SharePoint and Project Server in Internal Server Farm.
- Implemented Virtual Server Environment at County Data Center.
- Implementation of the Data Warehouse.
- Implemented a pilot using ePrescribing to improve the quality of health care by improving prescribing accuracy and efficiency and reducing adverse drug events.

Over the next series of pages, this component report will demonstrate the significant progress made in DBH technology efforts.

With the implementation of the Data Warehouse and SABER, DBH stakeholders and staff will be working to provide care in an environment in which decision making is supported by data, clinical and administrative information that seeks to improve the quality of service overall.

Over the past year, significant progress has been made in the implementation of the SABER project. Several communications to staff are included in this component report to demonstrate the breadth and depth of the project and its link to the Department's Mission, Vision and critical operations.

TECHNOLOGICAL NEEDS

SABER

San Bernardino
Accessible
Billing &
Electronic
Records



Volume 1, Issue 1

March 2014

What is Project Ripley and SABER? Are they the same or different?

Special points of interest:

- SABER is in full swing! 2014 will be full of SABER activities, as SABER is planned to "go live" July 1, 2015!
- ePrescriptions are part of the new system and is being piloted in a few clinics. Find out if your clinic is involved!



- Have you ever thought of being a trainer? DBH is looking for staff who want to train their peers for SABER. If interested, contact Mariann Ruffolo.
- We need your help! Business processes will be changing. Your input is vital!
- DBH Contractors can view SABER updates on its web-site page:
<http://www.sbcounty.gov/dbh/ContactProviders/ContractProviders.asp#>
- DBH Staff learn more about SABER by visiting the SABER website at:
<http://countyline/dbh/e/hr/>



Beginning in late 2012, Department of Behavioral Health (DBH) staff were out in the clinics talking about Project Ripley, which was the procurement process DBH began when it issued a Request for Proposal for a new billing system to replace SIMON (San Bernardino Information Management Online Network) and to obtain an electronic health record (EHR). DBH called this process Project Ripley, as many staff kept hearing DBH was getting a new system but truly never thought the day would ever come, hence the name. DBH went to each of its clinics and to the Association of Community Based Organizations (ACBO) to explain Project Ripley, obtain the names of staff who were interested in participating in various aspects of the new billing system and EHR and provide status of where DBH was in the procurement phase. DBH called the meetings Project Ripley Spotlights, which were

conducted by a few team members of the new project throughout 2013.

Phases of the procurement process included evaluation and rating of the proposal responses; elimination of vendors to the top three; demonstrations by the top three vendors; selection of the vendor who would be able to work best with the needs of DBH to begin contract negotiations; and verification of vendor to begin contract requirements.

DBH selected and signed a contract with The Echo Group, Inc., on November 5, 2013. Echo's products, ShareCare and the Visual Health Record, offer a behavioral health system with billing capabilities including those required for California Short Doyle Medi-Cal II claims; electronic prescriptions; reporting tool sets; and electronic health record including treatment planning, scheduling and automated billing based on

activity completed. The federal government has certified The Echo Group, Inc.'s system, which enables DBH to pursue EHR incentive dollars available through the American Recovery and Reinvestment Act.

DBH staff contributed to the name of the new system as the Department conducted a contest for a name of the new system. SABER is the new name of the system and it stands for San Bernardino Accessible Billing and Electronic Records. DBH Accountant III, Eric Patrick, created the name and acronym.

As the procurement phase has ended so has the name Project Ripley. Therefore, when you hear the name SABER, know DBH is referring to its new billing system and electronic health record, with a projected implementation date of July 2015.

How Does SABER Affect Me?

SABER will change the way we as a department, health care organization, Mental Health Plan and Substance Use Disorder Service provider do things. No matter if your job is a psychiatrist, contract agency employee or administrative support person, you will undoubtedly be affected by the change from SIMON to SABER or from a paper chart to electronic health record.

DBH wants to ensure that you know you can ask questions at any time—no question is off the table and DBH will be discussing and notifying everyone of changes.

Business processes will be redesigned. While not everyone will be a part of this redesign, many of you and your colleagues will be involved. You will begin seeing lots of information

and communications coming out about SABER. Please be sure to take the time to read these items! You will be using the system after July 1, 2015 and it is important that you engage in learning all along the way!



Communications—Technology in Action

Letter from the Director

August 22, 2013



Electronic health records (EHR) are digitized records that track a client's medical history. EHRs are intended to be user-friendly systems that monitor, retrieve and share health information with an overall goal of improving client care. The Department of Behavioral Health (DBH) has taken steps to procure an EHR and new billing system, which will assist DBH in achieving its Vision, Mission and Values while supporting the Vision of the County, specifically:

- Provide seamless, accessible and effective services to clients using state-of-the-art technology,
- Responsible use of department resources to sustain a high-quality behavioral health system, and
- Empower and support of staff while increasing skill level and technical knowledge.

DBH is implementing an EHR to meet today's technological demands and improve client care. Other reasons to upgrade to an EHR include the following: ability to optimize revenue, utilize funding for technological needs and access financial incentives from the federal government.

Implementation of an EHR will impact all levels of DBH staff as well as clients. The benefits of an EHR include the following:

Clients:

- increase customer service as records will be legible and available despite one's location
- realize continuum of care as medical professionals will have improved, yet appropriate, access to medical records

Administrative Staff

- increase automation of billing processes
- improve tracking of services to increase efficiency
- improve department recordkeeping

Clinical and Medical Staff

- computerize documentation
- allow entry of services to complete the billing process
- provide unique tools aimed to meet chart documentation requirements and provide notification when action is needed
- offer electronic prescription (medical staff only)

Thank you for your support as we work together to move into this new era of technology.

Sincerely,



Casanya Thomas, MPA, CHC
Director Department of Behavioral Health



Communications—Technology in Action

It has happened,
the new
**EHR and Billing
System Contract**
has been
SIGNED!

Stay updated on Electronic Health Records and
Billing System news, please visit:

<http://countyline/dbh/EHR>

iNameit Contest Winner!

If you didn't know....Now you know!

The WINNER is

SABER

**San Bernardino Accessible Billing
and Electronic Records
Submitted by Eric Patrick**

2nd Place - Christy Vidaurri: HERMAN

3rd Place - Melissa Minnick: MERIAM

***Congratulations to our winners and to everyone
who participated. In the end we are ALL winners!***

Coming Soon!

EXCITING

**Billing and Electronic
Health Record**

NEWS



Brought to you by the County of San Bernardino Department of Behavioral Health

TECHNOLOGICAL NEEDS

SABER Project Welcome Page

County of San Bernardino - Department of Behavioral Health Promoting Wellness, Recovery and Resilience

SABER

San Bernardino
 Accessible
 Billing &
 Electronic
 Records

HOME
NEWS
PROJECT INFORMATION
TRAINING
CONTACT US

CaSonya Thomas
Director, Department of Behavioral Health

“The Department of Behavioral Health (DBH) has taken steps to procure an Electronic Health Record (EHR) and new billing system, which will assist DBH in achieving its Vision, Mission and Values while supporting the Vision of the County. Implementation of an EHR will impact all levels of DBH staff as well as clients.”

For more information, please read the [Letter from the Director](#).

DBH Psychiatrists and support staff involved in the ePrescription pilot learning about Dr. First.

DBH staff attending a SABER Walkthrough regarding clinical processes.

DBH Psychiatrists and support staff involved in the ePrescription pilot learning about Dr. First.

PRESSING NEWS

ePrescription is coming!

More

COUNTDOWN

Find out when the SABER Go Live date is...

More

COMM TEAM

Meet your Communications Team!

More

GAMES

SABER Crossword...

More

BUSINESS PROCESS WORKSHOPS

Since the contract has been signed with the Echo Group (Echo), San Bernardino Accessible Billing and Electronic Records (SABER) is really beginning to take momentum. One of the first projects after contract signing was the Business Process Workshops, also referred to as BPWs.

For more information please click [More](#)

SABER WALKTHROUGHS

During the week of February 3-7, 2014, the Echo Group was again on site at DBH to provide walkthroughs of the new system, SABER. Walkthroughs were completed for various DBH processes including, but not limited to clinical, intake, billing, managed care and system settings.

For more information please click [More](#)

CONFIGURATION

The "Configuration" tasks have begun! Configuration refers to the process of setting up the SABER system to meet the specific needs of the department; some decisions will be simple (setting the rounding rules) and some will be complex (treatment plan templates). The Echo Group will be providing "workbooks" that define the configuration tasks and will be used to document the decisions made by DBH. These workbooks will be assigned to the appropriate Team SABER groups to review and make recommendations for configuring SABER for use in our department. The section of the project is expected to complete in October 2014.

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SABER

San Bernardino
 Accessible
 Billing &
 Electronic
 Records

Take a moment to check out SABER News

- SABER Opportunity Drawing
- Project Timeline
- SABER Training Sightings
- Updates on ePrescription
- New SABER Developments

Head on over to

<http://countyline/dbh/ehr/>

for the latest SABER information

Ask the doctors about ePrescribing

ePrescriptions

Q: What is an ePrescription?

A: ePrescriptions are computer generated prescriptions created by a doctor and sent directly to a pharmacy.

Q: What are the benefits of ePrescriptions?

A: ePrescriptions are

- **Fast** – A prescription arrives at the pharmacy before the client leaves the doctor's office
- **Easy** – A client won't have to make that extra trip to drop off their prescription at the pharmacy
- **Readable** – There is no handwriting for the pharmacist to understand
- **Secure** – Prescriptions are transmitted through a secure and private network

Inform consumers about ePrescribing

TECHNOLOGICAL NEEDS

SABER Project Manager Spotlight

As DBH Director I support the movement the Department is making to procure and implement a new billing system and electronic health record. This technology will improve clients services by affording staff the ability to readily access healthcare information. Please read the following letter from me regarding SABER.



As the Assistant Director my goal is to help provide a supportive atmosphere for the introduction and implementation of a high quality Behavioral Health Information Management System. This will shepherd us into the new age of technology with hopes of enhancing our ability to access electronic health information.



Hi, my name is Tanya Bratton, Deputy Director for DBH Administrative Services. My role is to provide executive oversight for this project including budget, project management, contracts and information technology.



Hi, my name is Barbara Knutson, Information Technology Business Applications Manager for DBH. I am the Project Manager for the Billing and EHR Project known as SABER. My role as your Project Manager is to facilitate the successful transition to Electronic Health Record software.



My name is Jess Rodriguez, Business Systems Analyst II with DBH. I am the Co-Project Manager. My duties are to manage project development from initiation to closure. Currently, we are working on E-Prescribing, with Andrew Johnson as project lead. E-Prescribing will allow our providers to send prescriptions electronically direct to the pharmacy.



Marina Espinosa, Chief Compliance Officer for DBH serving as the lead for SABER Communications. The Communications Team is reorganizing and request the input of clinical staff from all levels, so please consider joining this team. You can call or email me directly.



Hi! My name is Mariann Ruffolo, the DBH Workforce Education and Training Manager. I am the lead responsible for training regarding this project. If you are interested in being a trainer for the project, contact me.



Hi, I am Jason Hill, Business Systems Analyst III with DBH-IT. I am the Infrastructure Lead. Tecumseh once said, "A single twig breaks, but the bundle of twigs is strong." If we come together with our business knowledge, talent, and teamwork, we will succeed. Help revolutionize the Department of Behavioral Health... Get involved.



Ted Rodriguez, Business Systems Analyst III for DBH. I am currently the lead for Contracts Negotiations. This role requires me to work with the vendor, DBH staff and DBH Contracts in order to obtain Board approval.



Hello, my name is Tyrone Ramey. I am an Business Systems Analyst I with DBH-IT and lead for the Data Integrity Team. Data is an integral resource within our department. We must ensure our data is migrated exactly as intended. Join our team and assist with establishing measures to shield against unexpected changes in how we store, retrieve and process our data.



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Business Process Workshops

Since the contract has been signed with the Echo Group (Echo), San Bernardino Accessible Billing and Electronic Records (SABER) is really beginning to take momentum. One of the first projects after contract signing was the Business Process Workshops, also referred to as BPWs. The purpose of the BPWs was for DBH staff to provide Echo insight regarding our existing business processes as well as request functionality needed for the new system. The BPWs occurred over the course of one week from December 9-13, 2013. Approximately **100** DBH staff representing various disciplines, clinics and specialty programs participated in the workshops.

Shortly after the BPWs, the Echo Group provided DBH with a summary of the information gathered, recommendations for new practices and advisements on matters needing decision making. The DBH staff who attended the workshops reviewed and document and provided feedback, corrections and edits. The Echo Group is reviewing the DBH feedback and will be providing a revised report of the information gathered during the week of the BPW.

SABER Walkthroughs

During the week of February 3-7, 2014, the Echo Group was again on site at DBH to provide walkthroughs of the new system, SABER. Walkthroughs were completed for various DBH processes including, but not limited to clinical, intake, billing, managed care and system settings. DBH staff selected to participate on the "Team SABER" Leadership Teams participated in the walkthroughs. Team SABER members were selected from the interest lists that circulated during the Project Ripley Spotlights and were selected by their respective Deputy Director as subject matter experts for specific areas or programs.

The goal of the walkthroughs was to provide DBH Staff with a foundational understanding of the SABER system and its capabilities to provide context for their decision-making on setting up the system to work for the Department. The walkthroughs provided DBH staff with a glimpse of the new system and its functionality. The walkthroughs were interactive between DBH and Echo as each asked questions and/or provided information to each other.

SABER Training

Computer Competency training

The initial sessions of computer competency training occurred in January and February. Overall, feedback from participants was excellent. There are make-up sessions scheduled in mid April for those who were unable to attend. If you were one of the folks initially identified this a mandatory training. Once all mandatory participants have registered for the make-up sessions, classes will be open for other interested staff to attend.

ePrescribing training

Six (6) Psychiatrists, seventeen (17) support staff and Project SABER project and support staff are all attending Dr. First (the ePrescribing solution in SABER) training on March 4 and 5. The six physicians will pilot the use of the new software to assist in developing business processes for all physicians when ePrescribing is used department wide. Once it is determined that the pilot is successful, the rest of the physicians and additional support staff will be trained.

End User Training

WET staff is working with the vendor to develop a training plan for end user training. Managers and supervisors assisted by identifying preliminary training needs for all staff. This information is being used to develop a timetable, identify training space and identify the number of trainers needed. More information will be coming soon.

TECHNOLOGICAL NEEDS

Future Goals

The following SABER project implementation priorities are defined for Fiscal Years 2014/15—2016/17:

- *Communications component.*
- *Business process and systems changeover component.*
- *Data integrity and migration component.*
- *Training component.*
- *Electronic health record component.*
- *Managed care replacement component.*
- *Treatment Authorization Request (TAR) replacement component.*
- *Billing system replacement component.*
- *Plan and implement e-Prescribing.*
- *Plan and implement electronic interface for e-Lab transactions.*
- *Integration of non-Medi-Cal services into system, i.e. PEI.*



TECHNOLOGICAL NEEDS

Summary of Program Changes

While there have been no significantly changed programs since FY 2012/13, DBH has identified needs in several program areas that require expansion of services between Fiscal Years 2014/15-16/17 due to increased demand, and 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 department would not characterize the expansion activities as substantive changes as the service philosophy and array of services will not be changed, but expanded and made available to more community members, as well as addressing 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. 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 Mental Health Services Act Oversight and Accountability Commission (MHSOAC) direction to counties in the current Integrated Plan instructions. This means cost per client information includes both MHSA and other funding utilized to serve the clients in MHSA Integrated programs.

The following programs will continue to operate as currently approved through FY 2013/14:

- **Community Services & Supports**
 - ◆ C-1: Comprehensive Children and Family Support Services.
 - ◆ TAY-1: Transitional Age Youth (TAY) One Stop Centers.
 - ◆ A-2: Forensic Integrated Mental Health Services.
 - ◆ A-3: Members Assertive Positive Solutions (MAPS).
 - ◆ A-4: Crisis Walk-In Centers (CWIC).
 - ◆ A-6: Community Crisis Response Team (CCRT).
 - ◆ A-8: Big Bear Full Service Partnership.
 - ◆ OA-1: AgeWise - Circle of Care.
 - ◆ OA-2: AgeWise - Mobile Response.

- **Prevention and Early Intervention**
 - ◆ PEI SI-1: Student Assistance Program.
 - ◆ PEI SI-3: Resilience Promotion in African American Children.
 - ◆ PEI CI-1: Promotores de Salud/Community Health Worker.
 - ◆ PEI CI-2: Family Resource Centers.
 - ◆ PEI CI-3: Native American Resource Center.
 - ◆ PEI CI-4: NCTI Crossroads Education Program.
 - ◆ PEI SE-1: Older Adult Community Services.
 - ◆ PEI SE-2: Child and Youth Connection.
 - ◆ PEI SE-4: Military Services and Family Support.
 - ◆ PEI SE-5: LIFT.

- **Innovation**
- **Capital Facilities and Technological Needs**

Summary of Program Changes

The following programs may be expanded per funding availability to meet consumer needs in FY 2014/15 - 2016/17 and are consistent with stakeholder priority areas identified in past and current stakeholder processes.

COMMUNITY SERVICES AND SUPPORTS (CSS)

C-2: INTEGRATED NEW FAMILY OPPORTUNITIES (INFO)

The Integrated New Family Opportunities (INFO) program has been very successful in serving diverse, justice involved children and youth and their families. INFO will continue the collaborative relationships that have been established with probation. However, nationwide the number of juveniles being detained in the juvenile detention and assessment centers (JDAC) has been on a steady decline, as is the case in the INFO program. This is due, in part, to an increase in community based programs such as INFO. The INFO program has relied primarily on the Probation department and the JDAC's as the primary referral source. A decline in population also results in a decline in minors that can be screened for the program.

INFO has been in existence for over seven years, is a Functional Family Therapy certified site and has the staffing resources and knowledge to expand the referral network to other county departments and community agencies working with the juvenile justice population. The program will focus on expanded collaboration for the coming year and may result in an increase in number of consumers served, thus potentially resulting in a need for additional resources in the future with identifying additional collaborative resources and partners being demonstrated under the approved program and reflected in current operations.

A-7: HOMELESS INTENSIVE CASE MANAGEMENT PROGRAM

The Department will continue to strengthen its outreach efforts to the mentally ill, chronically homeless, and at-risk of homelessness population within all areas of the County of San Bernardino through continued expansion of the A-7: Homeless Intensive Case Management Program. The expanded program provides a continuum of support related to homeless outreach, housing and employment services. Through expanded support and staffing resources the program will be transformed and enhanced to strengthen the entire continuum and ensure supportive services no matter the level of homeless assistance a consumer requires. Multiple types of teams will be established to ensure that staff who can effectively engage homeless clients are utilized.

Collaborative outreach teams that conduct engagement and field based crisis evaluation services where homeless individuals are located will be expanded. The expanded collaborative teams are comprised of behavioral health professionals and the San Bernardino County Sheriff's Department. Teams go to locations such as parks, riverbeds, and mountain areas to conduct outreach to homeless individuals. Through this engagement, potential consumers can be connected with mental health, housing, and other needed resources.

Summary of Program Changes

In addition, multiple Housing and Employment Teams will be established in centralized locations to work with individuals served through the DBH Housing and Employments Master Leasing and Housing and Urban Developments (HUD), Shelter Plus Care Programs. The Master Leasing Program is designed to provide a temporary, emergency housing solution for up to six months for homeless or at-risk of homelessness consumers. Housing and Employment Teams, potentially consisting of qualified mental health and substance use disorder staff, employment specialists, and/or peer support staff, will provide supportive services for consumers that are focused on maintaining residency and obtaining a regular income through employment or other resources.

Participation in temporary emergency housing qualifies individuals to possibly access a long term housing solution available through the Shelter Plus Care program, a tenant-based voucher housing program that offers long term permanent and supportive housing.

Shelter Plus Care housing is for solely homeless individuals who live on the streets or come from homeless emergency shelters. Since the Master Leasing is a homeless emergency shelter, after six (6) months, the participants are qualified and able to transition to HUD's Shelter Plus Care program. The consumers stay in their previously selected residency and simply transfer into Shelter Plus Care long term housing. The result is that this allows for a smooth transition into Shelter Plus Care long term supportive housing. DBH will continue to employ highly skilled, experienced staff to provide for the behavioral health needs of the consumers served. The anticipated long term impact is the potential to strengthen future permanent housing opportunities for leveraged funding available through grants, current MHSA funding and approved plans.

PREVENTION AND EARLY INTERVENTION (PEI)

PEI SE-3: Community Wholeness and Enrichment (CWE)

DBH is continuing to work with county partners and community stakeholders to ensure the continuum of care for Transitional Age Youth (TAY) and Adults is accessible and effective. During the community planning process that defined the expansion of PEI services in 2012, the Community Wholeness and Enrichment (CWE) program was identified as a program for expansion to enhance services related to early intervention for TAY and adults experiencing the first episodes of serious mental illness. The expansion was included in the update of the PEI Plan and DBH, along with stakeholders, identified additional methods for strengthening the effectiveness of the entire program, not just the "first break" service component. Fiscal Year 2014/15 is identified as the year that will begin implementation of the component.

Implementation plans include identification of space, recruitment and hiring of staff, and training for relevant therapeutic services. Enhanced collaboration between psychiatric hospitals, crisis response and crisis walk-in centers will be central to the success of the program as they identify and link consumers to first break services. Costs for services can be leveraged through the use of Medi-Cal, further integrating into the system of care. It is expected that the component expansion will not be fully implemented until Fiscal Year 2015/16.

Summary of Program Changes

Efforts to strengthen the effectiveness of the prevention services available through the CWE program were aligned with statewide capacity building efforts associated with the Statewide PEI Suicide Prevention and Stigma and Discrimination projects. Through the initiatives, several DBH staff and community members participated and were trained in two evidence-based programs: Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA). The scope of work of the CWE program requires community education concerning mental health topics but does not specify a program or curricula to be consistently utilized across the county. The enhancement of this program will include the necessity for program providers to utilize one or both of these programs in the provision of prevention education services. DBH will continue to review additional, appropriate approaches and incorporate them throughout the development of program.

An additional enhancement for the program includes an inclusion of selective prevention services targeted toward self-defined families who have lost a loved one to suicide. Services consisting of curriculum-guided support groups will be developed utilizing an approach developed through the statewide suicide prevention initiative.

PEI SI-2: PRESCHOOL PEI PROGRAM

The current program is being proposed to expand through the addition of more mental health interns and to support evaluation services under the approved plan.

The mental health interns will work across the county at multiple sites and will include the ability to expand Preschool PEI Program services beyond County Head Start sites to State Preschool educational facilities. The additional positions would continue the implementation of important Incredible Years training, development of behavioral support plans for preschool aged children participating in preschool education programs, and bereavement and loss group services that are consistent with the plan.

The Preschool PEI Program has yielded positive preliminary results. Such promising approaches should be evaluated to identify the best methods for replication over time. DBH and the Preschool Services Department plan to enhance the evaluation of the program to include evaluating the long term impacts for program participants.

Additional positions would be implemented through out the fiscal year and would be contingent on funding availability in both contract and county operations.

Summary of Program Changes

PEI SE-5: CASE

The Coalition Against Sexual Exploitation (CASE) program is a collaboration between county and community agencies to help develop and test a collaborative model of interventions and services to reduce the number of diverse children/youth that are sexually exploited within the county. The county is committed to systematically addressing the issue of sexual exploitation and human trafficking, utilizing an interagency collaborative approach and a comprehensive model of interventions and services, addressing outreach, education, interventions, and outcome measurements. Through the development of a multi-disciplinary CASE team, in addition to outreach and education efforts, some direct services being provided include intensive case management, building rapport, advocating in court proceedings and making treatment recommendations in court, provision of therapy, placement, and working with clients' family members. As the CASE program transitions from the Innovation component funding to the Prevention and Early Intervention component, the primary mental health purpose will shift. While still an important focus, the overall goal of the program will no longer be to increase the quality of service, including better outcomes, but will be to reduce prolonged suffering of this high risk population. Similar to the learning goals previously identified in the Innovation project, the program objectives will be:

- Increase knowledge of the traumatic impact of sexual exploitation, risk factors, and the means to establish rapport, initiate effective identification and collaborative intervention and treatment across multiple systems.
- Increase identification of diverse children who are vulnerable to exploitation, including those brought into the probation system who are exploited.
- Improved engagement, rapport building, and communication with victims.
- Improved coping and survival skills for program participants.
- Decreased negative symptoms and increased resiliency factors.
- Increase community-based training and education for those who interact with these children.

Through Innovation, a model that utilizes creative clinical strategies, coupled with existing best practices in trauma care, services will continue to be implemented. The tenants of program evaluation will continue with the newly transitioned CASE program continuing to utilize the Child and Adolescent Strengths and Needs (CANS) tool to follow the progress of and measure the outcomes for the children receiving interventions and treatment services. Additional focus will be placed on identifying PEI specific measures related to the educational services provided through this program.

Summary of Program Changes

PEI STATEWIDE PROJECTS

Over the last three and one half years, the County of San Bernardino has, through the use of time-limited statewide PEI funding, supported the implementation of three statewide PEI projects: the Student Mental Health Initiative, the Suicide Prevention Initiative, and the Stigma and Discrimination Reduction Initiative, through a statewide organization, the California Mental Health Services Authority (CalMHSA). CalMHSA is a joint powers authority whose membership is comprised of California County departments of mental health working collectively to support statewide projects, such as the PEI initiatives. County departments assigned PEI statewide funding to CalMHSA in 2010 to implement these projects intended to support prevention efforts and build the capacity of the prevention and early intervention system across the state through population-based approaches.

Highlights of program successes include:

- The development of Regional Suicide Prevention Networks.
- Building the capacity of community members and caregivers through the ASSIST training.
- The implementation of a large suicide prevention campaign, Know the Signs.
- Establishment of standardized metrics that will be used for suicide prevention call centers across the state.
- Trained employers in Wellness Works, a program designed to educate employers on how to make appropriate accommodations for employees living with a mental illness.
- Development of a comprehensive anti stigma campaign, Each Mind Matters.
- Established collaborative with higher education institutes across the state.
- Trained educators in identification of mental health concerns.

The PEI statewide funding will end in June 2014. As part of the community planning activities, stakeholders took part in discussion concerning continued support of the statewide projects. Stakeholders were overwhelmingly supportive of continuing statewide projects as long as the assignment does not impact local programming.

An analysis of PEI program funding was conducted by DBH staff and concluded that an annual contribution between **4%-6%** will not have a negative effect on the sustainability of local PEI Programs. Thus, the County intends to make an annual contribution to support the continuation of statewide PEI Projects. However, the County will continue to monitor funding and statewide assignment trends to ensure an assignment of funding will produce the anticipated outcomes and will not significantly impact local programming.

Summary of Program Changes

CAPITAL FACILITIES

During previous and recent stakeholder engagement meetings, two possible uses of the remaining Capital Facilities funding have been identified as supported. Potential projects include the acquisition and renovation of a facility in the high desert region of the county to house DBH's mobile services units, such as Community Crisis Teams and/or Older Adult Mobile Services, and the first break services funded under the Prevention and Early Intervention Community Wholeness and Enrichment Program.

The other opportunity is to invest in space for expanded crisis services. The space will be used to provide for the health and social service needs of residents throughout the County and fulfill County goals and objectives by increasing access to effective crisis residential and crisis stabilization services, by effectively meeting the needs of individuals experiencing a mental health crisis in the least restrictive manner possible. Through a collaborative approach with local law enforcement, hospitals, and community based providers additional crisis services can be provided.

The proposed project will potentially be used to purchase land and build a new facility, housing a new Crisis Residential Treatment (CRT) program. The expansion would also support an expansion of current crisis walk-in center services, including a co-located crisis stabilization unit (CSU), to individuals throughout the County. DBH anticipates the expansion could serve approximately **332** individuals through the residential facility and **4,380** through the CSU, annually. The utilization of MHS Capital Facilities funding to support this action is contingent on the ability to obtain and leverage additional grant related funding to support the project.

WORKFORCE EDUCATION AND TRAINING

The Workforce Education and Training (WET) component of the Three-Year Integrated Plan continues to address the County of San Bernardino's Public Mental Health System shortage of qualified individuals to provide behavioral health services. This includes community based organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise the county's Public Mental Health System workforce. Actions funded by the Workforce Education and Training component supplement state administered workforce programs to make a local impact and are outlined in the program report section of this Integrated Plan. To continue the administration of this important component, the program will be transitioned in the Community Services and Support component of MHS.

Summary of Program Changes

COMMUNITY EDUCATION AND PROVIDER TRAINING SUPPORT

Results from ongoing Community Program Planning identified a continued need to improve coordination and information of community education activities across the county. Through the various components of MHSA, several opportunities for community education activities are provided. For example, Prevention and Early Intervention (PEI) programs, such as but not limited to Promotores de Salud/Community Health Worker, Community Wholeness and Enrichment, Family Resource Centers, and Military Services and Family Support each have a required community education component as part of the approved program plan. In addition, the DBH Community OutReach and Education (CORE) team participates in many community outreach and education events across the county. This equates to hundreds of mental health educational opportunities being provided across the county each year per currently approved MHSA plans. Further, community stakeholders continue to report that they are unaware of the multiple services across the county and request enhanced education efforts to this end.

DBH will be establishing a method to coordinate and advertise the multiple community education activities that are occurring across the county. The coordination of such activities includes working with multiple contracted provider agencies, DBH programs, and statewide PEI vendors. DBH will ensure that all community-based education opportunities are identified and, through centralized coordination, that the information is available via web-based technology and other outreach and education activities.

Coordination activities will include additional tasks, such as ensuring that successful trainings, such as the Community Resiliency Model, a former Innovation program, continue to be provided. Activities will include the collection, input, and analysis of education related data across the multiple programs, ensuring a consistent framework is utilized that allows for evaluation of effectiveness of community outreach and education efforts.

In addition to the coordination and evaluation of educational services, the position will also provide support to contracted provider agencies engaged in capacity building activities. The Affordable Care Act (ACA) and new managed care environment is transforming health services across the state and nation. The complexity of blended and leveraged funding, policy changes, implementation of Electronic Health Records, multiple funding requirements is difficult to manage for even the most sophisticated health agency. Direct training and education related to administrative requirements and complexities must be provided to support the public mental health system and support the mental health plan to ensure the department maintains adequate provider networks.

Complex subjects, such as developing cost reports for programs that use multiple funding streams, is an example of the type of administrative training and education activities that will be provided. Coordination activities will include the identification of prioritized training topics, developing a related pool of subject matter experts, and coordinating training and ongoing coaching for agencies that participate in "Capacity Building" activities.

Summary of Program Changes

Additionally, the Department of Behavioral Health is currently focused on increased outreach to family members of individuals living with mental health issues. These efforts emphasize awareness, education, advocacy and support groups for family members living in the County of San Bernardino. Understanding the community mental health system is vital for family members but once treatment of a loved one begins, families often find that many aspects of their lives are affected that require more than just medical support. The Department of Behavioral Health strives to engage family members as an active participant in the recovery process and provide them with access to any systems needed to assist them in their efforts. Planning and implementation of these increased supports is currently underway and will result in greater inclusion and integration of family members as a partner in recovery.

MHSA PROGRAM EVALUATION SUPPORT

When discussing MHSA programs, the Department of Behavioral Health (DBH) recognizes the need to also address the evaluation of projects. As a result, DBH has been revising the current evaluation and outcome process, developing a new framework and approach to assess our programs system-wide. The goal is to increase standardization and consistency across programs and provide a clear logic model for explaining intervention decisions and how the program strategies meet the goals of MHSA. The result will be to demonstrate how our programs and projects meet the expectations of MHSA funding. The new approach aims to not only report data to the state, county administration, and stakeholders, but also to consumers and providers directly and more quickly to improve the treatment process.

The logic models below are works-in-progress and therefore subject to revision. The starting point of the evaluation and outcomes process is with MHSA legislation and regulations. This first model demonstrates the requirements specific to Innovation projects (currently called MHSA Goals and copied directly from the legislation). The Key Outcomes that match the MHSA Goals will be identified. The Key Outcomes will be concrete and measurable ways of determining if the MHSA Goals have been achieved. Measurement Methods will be ways that data can be obtained for the Key Outcomes with the Frequency column describing the specifics of how often the data will be collected. In the model below are initial thoughts as to possible Key Outcomes and associated Measurement Methods for MHSA Goals, including all MHSA funding sources and programs.

<u>Mandatory Goals for INN MHSA Programs</u>				
	MHSA Goals	Key Outcomes (measurement method)	Measurement Method	Frequency
INN	MHSA Requirements	Matches Goals	Outcome Tool(s)	Frequency of Administration
	Increase Access to Underserved Groups	<ul style="list-style-type: none"> • Increased rates of underserved in treatment groups 	<ul style="list-style-type: none"> • Demographic data from SIMON • Reports from OCCES 	
	Increase Quality of Services, Including Better Outcomes	<ul style="list-style-type: none"> • Inclusion of outcomes in treatment planning • Improved year-over-year outcomes 	<ul style="list-style-type: none"> • Comparative outcome data 	
	Promote Interagency Collaboration	<ul style="list-style-type: none"> • Increased services provided by two or more agencies 		
	Increase Access to Services	<ul style="list-style-type: none"> • Increase number of clients served • Increased penetration rate 	<ul style="list-style-type: none"> • SIMON data • County Medi-Cal penetration rate 	

Summary of Program Changes

From this table on the prior page, staff will decide which of the MHSA Goals would be applicable to their program or project. They will be able to take information from this initial table and apply it to the next logic model, which provides a more detailed analysis of how the program or project will achieve the larger MHSA Goals. The example below is fictional, to demonstrate how the model could be completed. The Objectives, Strategies, Interim Outcomes, and Interim Outcomes Measurement will be completed by the program or project staff to reflect the unique attributes of the target population and intervention. By providing expected standards, there will be consistency and standardization across our programs while allowing for diversity in specific implementation.

Completion of DBH frameworks and system-wide rollout will occur over the next several years. These frameworks and logic models will be integrated into program and project proposals, contracts, and reports, and will apply to all MHSA programs.

(INSERT MHSA COMPONENT)								
	Work Plan	MHSA Goals	Objectives	Strategies	Interim Outcomes (IO)	IO Measurement	Key Outcomes (KO)	KO Measurement
Definition	Program/ Project-Specific Work Plan	MHSA Legislative and Regulatory Requirements	Specific Objective that Theoretically Supports Goal	EBPs, Treatment Approaches, Interventions	As Relates to Objective(s)	Measurement Method or Tool and Frequency of Administration	As Relates to MHSA Goal(s)	Measurement Method or Tool and Frequency of Administration
Ex. <i>Language included in this example is not specific to any existing County program</i>	C1: Comprehensive Child and Family Support System - Coordinate and access an array of county services for children who are challenged with emotional disturbances. Uses evidence-based practices and includes case management, flexible funding, family focus treatment, service coordination, child care, co-occurring treatment, psychiatric services, family advocacy, and parent partnerships. Targeted age groups include children and transitional age youth.	Reduce School Failure/ Dropout Rates	Increase teacher skill set to respond to student behavior	Teacher Education Training	Increased teacher use of skills with disruptive students	Teacher observation ratings Pre, Monthly, and Post	Decreased school dropouts	District, school and client level attendance records Pre, 3 Month, Annual, and Post
			Decrease aggressive behavior in the classroom	Aggression Replacement Training	Decreased aggressive behavior in the classroom	Child Behavior Checklist Admission, 3 mo, D/C		
		Reduce number of minor consumers removed from their home	Increase parent's skill set to respond to child's behavior	Parent/Child Interaction Therapy	Increase parent use of skills with disruptive children	Parent observation ratings Pre, Monthly, and Post	Decreased rate of DCFS initiated removal Decreased rate of out-of-home treatment	Reports from DCFS Pre, 3 Month, Annual, and Post

Cost Per Client FY 2014/15

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282	662	220	0	0	882	\$ 14,279	
C-2 Integrated New Family Opportunities	INFO	\$ 1,266,376	26	34	0	0	60	\$ 21,106	
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,843,493	14	1,386	0	0	1,400	\$ 4,174	
A-1: Clubhouse Expansion Program		\$ 2,640,100	4	4	374	68	450	\$ 5,867	
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,392,942	3	75	222	0	300	\$ 17,976	
A-3: Members Assertive Positive Solutions/Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099	0	8	89	3	100	\$ 31,551	
A-4: Crisis Walk-In Centers	CWIC	\$ 7,651,248	348	2,001	6,003	348	8,700	\$ 879	
A-5: Psychiatric Triage Diversion Program		\$ 2,466,360	0	600	2,280	120	3,000	\$ 822	
A-6: Community Crisis Response Team	CCRT	\$ 7,567,491	1,950	2,028	3,432	390	7,800	\$ 970	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 8,777,768	84	156	888	72	1,200	\$ 7,315	
A - 8: Big Bear FSP		\$ 370,000	15	19	108	8	150	\$ 2,467	
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services		\$ 4,514,971	0	1,363	8,177	4,088	13,628	\$ 331	
OA-1: Agewise - Circle of Care		\$ 2,311,277	0	0	48	552	600	\$ 3,852	
OA-2 Agewise - Mobile Response		\$ 878,526	0	0	70	1,330	1,400	\$ 628	
Total Program Costs		\$ 65,429,933							
CSS Administration		\$ 11,836,893							
TOTAL CSS		\$ 77,266,826					38,670	\$ 1,948	

Total Clients Served = **38,670** or **\$1,948** per person

Expenditures by Service Category FY 2014/15

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures by Service Category		
		Full Service Partnership	General System Development	Outreach and Engagement
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282		
C-2 Integrated New Family Opportunities	INFO	\$ 1,266,376		
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,843,493		
A-1: Clubhouse Expansion Program				\$ 2,640,100
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,392,942		
A-3: Members Assertive Positive Solutions/ Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099		
A-4: Crisis Walk-In Centers	CWIC		\$ 7,651,248	
A-5: Psychiatric Triage Diversion Program			\$ 2,466,360	
A-6: Community Crisis Response Team	CCRT		\$ 7,567,491	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 8,777,768		
A - 8: Big Bear FSP		\$ 370,000		
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services			\$ 4,514,971	
OA-1: Agewise - Circle of Care			\$ 2,311,277	
OA-2 Agewise - Mobile Response		\$ 878,526		
Total Program Costs		\$ 38,278,486	\$ 24,511,347	\$ 2,640,100
CSS Administration		59%	37%	4%
TOTAL CSS				

Cost Per Client FY 2014/15

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Holistic Campus	HC	\$ 1,811,508	252	756	2,124	468	3,600	\$ 503	
Interagency Youth Resiliency Team	IYRT	\$ 1,471,944	57	143	50	50	300	\$ 4,906	
Transitional Age Youth Behavioral Health Hostel	TAYBHH	\$ 2,500,000	0	156	0	0	156	\$ 16,025	
Recovery Based Engagement Support Teams	RBEST	\$ 1,750,338	0	45	210	45	300	\$ 5,834	
Total Program Costs		\$ 6,933,790							
Innovation Administration		\$ 811,160							
Total INN		\$ 7,744,950					4,320	\$ 1,793	

Total Clients Served = **4,320** or **\$1,793** per person

Cost Per Client FY 2014/15

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

PREVENTION & EARLY INTERVENTION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Child and Youth Connection	CYC	\$ 13,608,875	5,039	54	271	54	5,418	\$ 2,512	
Community Wholeness and Enrichment	CWE	\$ 2,050,017	0	880	1,320	0	2,200	\$ 932	
Family Resource Centers	FRC	\$ 3,349,615	9,020	3,300	9,020	660	22,200	\$ 152	
Lift - Home Nurse Visitation Program	Lift	\$ 396,000	0	54	66	0	120	\$ 3,300	
Military Services and Family Support	MSFS	\$ 725,000	126	294	1,680	0	2,100	\$ 345	
National Crossroads Education Institute Training	NCTI	\$ 532,900	2000	2000	0	0	4,000	\$ 133	
Native American Resource Center	NARC	\$ 500,000	272	765	459	0	1,496	\$ 294	
Older Adult Community Services	OACS	\$ 900,000	0	0	0	7,000	7,000	\$ 129	
PEI Preschool Program	PPP	\$ 425,000	657	0	243	0	900	\$ 472	
Promotores de Salud	PdS	\$ 1,148,630	600	2,100	25,500	1,800	30,000	\$ 38	
Resiliency in African American Children	RPiAAC	\$ 672,477	1,900	20	80	0	2,000	\$ 336	
Coalition Against Sexual Exploitation	CASE	\$ 426,169	40	10	0	0	50	\$ 8,523	
Student Assistance Program	SAP	\$ 2,970,246	20,250	1,750	3,000	0	25,000	\$ 119	
Total Program Costs		\$ 27,704,929							
PEI Administration		\$ 3,216,377							
PEI TOTAL		\$ 30,921,306					102,484	\$ 302	

Total Clients Served = **102,484** or **\$302** per person

Cost Per Client FY 2015/16

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282	662	220	0	0	882	\$ 14,279	
C-2 Integrated New Family Opportunities	INFO	\$ 1,291,558	26	34	0	0	60	\$ 21,526	
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,887,829	14	1,386	0	0	1,400	\$ 4,206	
A-1: Clubhouse Expansion Program		\$ 2,665,686	4	4	374	68	450	\$ 5,924	
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,445,326	3	75	222	0	300	\$ 18,151	
A-3: Members Assertive Positive Solutions/Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099	0	8	89	3	100	\$ 31,551	
A-4: Crisis Walk-In Centers	CWIC	\$ 7,709,132	348	2,001	6,003	348	8,700	\$ 886	
A-5: Psychiatric Triage Diversion Program		\$ 2,522,613	0	600	2,280	120	3,000	\$ 841	
A-6: Community Crisis Response Team	CCRT	\$ 7,665,706	1,950	2,028	3,432	390	7,800	\$ 983	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 8,953,073	84	156	888	72	1,200	\$ 7,461	
A - 8: Big Bear FSP		\$ 370,000	15	19	108	8	150	\$ 2,467	
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services		\$ 3,434,906	0	1,363	8,177	4,088	13,628	\$ 252	
OA-1: Agewise - Circle of Care		\$ 2,346,299	0	0	48	552	600	\$ 3,910	
OA-2 Agewise - Mobile Response		\$ 900,330	0	0	70	1,330	1,400	\$ 643	
Total Program Costs		\$ 64,941,840							
CSS Administration		\$ 12,088,805							
TOTAL CSS		\$ 77,030,645					39,670	\$ 1,942	

Total Clients Served = **39,670** or **\$1,942** per person

Expenditures by Service Category FY 2015/16

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures by Service Category		
		Full Service Partnership	General System Development	Outreach and Engagement
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282		
C-2 Integrated New Family Opportunities	INFO	\$ 1,291,558		
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,887,829		
A-1: Clubhouse Expansion Program				\$ 2,665,686
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,445,326		
A-3: Members Assertive Positive Solutions/ Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099		
A-4: Crisis Walk-In Centers	CWIC		\$ 7,709,132	
A-5: Psychiatric Triage Diversion Program			\$ 2,522,613	
A-6: Community Crisis Response Team	CCRT		\$ 7,665,706	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 8,953,073		
A - 8: Big Bear FSP		\$ 370,000		
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services			\$ 3,434,906	
OA-1: Agewise - Circle of Care			\$ 2,346,299	
OA-2 Agewise - Mobile Response		\$ 900,330		
Total Program Costs		\$ 38,597,498	\$ 23,678,656	\$ 2,665,686
CSS Administration		59%	36%	4%
TOTAL CSS				

Cost Per Client FY 2015/16

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Transitional Age Youth Behavioral Health Hostel	TAYBHH	\$ 2,500,000	0	156	0	0	156	\$ 16,026	
Recovery Based Engagement Support Teams	RBEST	\$ 1,763,073	0	45	210	45	300	\$ 5,877	
Total Program Costs		\$ 4,263,073							
Innovation Administration		\$ 814,973							
Total INN		\$ 5,078,046					456	\$ 11,136	

Total Clients Served = **456** or **\$11,136** per person

Cost Per Client FY 2015/16

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

PREVENTION & EARLY INTERVENTION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Child and Youth Connection	CYC	\$ 13,652,119	5,039	54	271	54	5,418	\$ 2,520	
Community Wholeness and Enrichment	CWE	\$ 2,815,528	0	960	1,440	0	2,400	\$ 1,173	
Family Resource Centers	FRC	\$ 3,349,615	9,020	3,300	9,020	660	22,000	\$ 152	
Lift - Home Nurse Visitation Program	Lift	\$ 396,000	0	54	66	0	120	\$ 3,300	
Military Services and Family Support	MSFS	\$ 600,000	126	294	1,680	0	2,100	\$ 286	
National Crossroads Education Institute Training	NCTI	\$ 532,900	2000	2000	0	0	4,000	\$ 133	
Native American Resource Center	NARC	\$ 500,000	272	765	459	204	1,700	\$ 294	
Older Adult Community Services	OACS	\$ 900,000	0	0	0	7,000	7,000	\$ 129	
PEI Preschool Program	PPP	\$ 425,000	657	0	243	0	900	\$ 472	
Promotores de Salud	PdS	\$ 1,148,630	806	2,821	25,500	1,800	30,927	\$ 37	
Resiliency in African American Children	RPiAAC	\$ 672,477	1,900	20	80	0	2,000	\$ 336	
Coalition Against Sexual Exploitation	CASE	\$ 426,169	40	10	0	0	50	\$ 8,523	
Student Assistance Program	SAP	\$ 2,970,246	22,166	1,916	3,000	0	25,100	\$ 119	
Total Program Costs		\$ 28,388,685							
PEI Administration		\$ 3,280,960							
PEI TOTAL		\$ 31,669,645					103,715	\$ 305	

Total Clients Served = **103,715** or **\$305** per person

Cost Per Client FY 2016/17

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282	662	220	0	0	882	\$ 14,279	
C-2 Integrated New Family Opportunities	INFO	\$ 1,317,495	26	34	0	0	60	\$ 21,958	
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,933,496	14	1,386	0	0	1,400	\$ 4,238	
A-1: Clubhouse Expansion Program		\$ 2,692,039	4	4	374	68	450	\$ 5,982	
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,499,282	3	75	222	0	300	\$ 18,331	
A-3: Members Assertive Positive Solutions/Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099	0	8	89	3	100	\$ 31,551	
A-4: Crisis Walk-In Centers	CWIC	\$ 7,768,753	348	2,001	6,003	348	8,700	\$ 893	
A-5: Psychiatric Triage Diversion Program		\$ 2,580,554	0	600	2,280	120	3,000	\$ 860	
A-6: Community Crisis Response Team	CCRT	\$ 7,766,868	1,950	2,028	3,432	390	7,800	\$ 996	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 9,133,638	84	156	888	72	1,200	\$ 7,611	
A - 8: Big Bear FSP		\$ 370,000	15	19	108	8	150	\$ 2,467	
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services		\$ 3,528,103	0	1,363	8,177	4,088	13,628	\$ 259	
OA-1: Agewise - Circle of Care		\$ 2,382,371	0	0	48	552	600	\$ 3,971	
OA-2 Agewise - Mobile Response		\$ 922,788	0	0	70	1,330	1,400	\$ 659	
Total Program Costs		\$ 65,644,768							
CSS Administration		\$ 12,348,275							
TOTAL CSS		\$ 77,993,043					39,670	\$ 1,966	

Total Clients Served = **39,670** or **\$1,966** per person

Expenditures by Service Category FY 2016/17

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbreviation	Estimated Total Mental Health Expenditures by Service Category		
		Full Service Partnership	General System Development	Outreach and Engagement
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 12,594,282		
C-2 Integrated New Family Opportunities	INFO	\$ 1,317,495		
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 5,933,496		
A-1: Clubhouse Expansion Program				\$ 2,692,039
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 5,499,282		
A-3: Members Assertive Positive Solutions/ Assertive Community Treatment Team	MAPS/ACT	\$ 3,155,099		
A-4: Crisis Walk-In Centers	CWIC		\$ 7,768,753	
A-5: Psychiatric Triage Diversion Program			\$ 2,580,554	
A-6: Community Crisis Response Team	CCRT		\$ 7,766,868	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 9,133,638		
A - 8: Big Bear FSP		\$ 370,000		
A-9: Access, Coordination and Service Enhancement of Quality Behavioral Health Services			\$ 3,528,103	
OA-1: Agewise - Circle of Care			\$ 2,382,371	
OA-2 Agewise - Mobile Response		\$ 922,788		
Total Program Costs		\$ 38,926,080	\$ 24,026,649	\$ 2,692,039
CSS Administration		59%	37%	4%
TOTAL CSS				

Cost Per Client FY 2016/17

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Transitional Age Youth Behavioral Health Hostel	TAYBHH	\$ 2,500,000	0	156	0	0	156	\$ 16,026	
Recovery Based Engagement Support Teams	RBEST	\$ 1,776,190	0	45	210	45	300	\$ 5,921	
Total Program Costs		\$ 4,276,190							
Innovation Administration		\$ 576,782							
Total INN		\$ 4,852,972					456	\$ 10,642	

Total Clients Served = **456** or **\$10,642** per person

Cost Per Client FY 2016/17

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 MHSA Integrated Plan FY 2014/15–2016/17

PREVENTION & EARLY INTERVENTION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group					Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)			
Child and Youth Connection	CYC	\$ 13,696,661	5,039	54	271	54	5,418	\$ 2,528	
Community Wholeness and Enrichment	CWE	\$ 2,831,505	0	960	1,440	0	2,400	\$ 1,180	
Family Resource Centers	FRC	\$ 3,349,615	9,020	3,300	9,020	662	22,002	\$ 152	
Lift - Home Nurse Visitation Program	Lift	\$ 396,000	0	54	66	0	120	\$ 3,300	
Military Services and Family Support	MSFS	\$ 600,000	126	294	1,680	0	2,100	\$ 286	
National Crossroads Education Institute Training	NCTI	\$ 532,900	2,100	2,000	0	0	4,100	\$ 130	
Native American Resource Center	NARC	\$ 500,000	272	765	459	204	1,700	\$ 294	
Older Adult Community Services	OACS	\$ 900,000	0	0	0	7,000	7,000	\$ 129	
PEI Preschool Program	PPP	\$ 425,000	657	0	243	0	900	\$ 472	
Promotores de Salud	PdS	\$ 1,148,630	600	2,100	25,500	1,800	30,000	\$ 38	
Resiliency in African American Children	RPiAAC	\$ 672,477	1,900	20	80	0	2,000	\$ 336	
Coalition Against Sexual Exploitation	CASE	\$ 426,169	40	10	0	0	50	\$ 8,523	
Student Assistance Program	SAP	\$ 2,970,246	22,166	1,916	3,284	0	27,366	\$ 109	
Total Program Costs		\$ 28,449,203							
PEI Administration		\$ 3,347,481							
PEI TOTAL		\$ 31,796,683					105,156	\$ 302	

Total Clients Served = **105,156** or **\$302** per person

Attachments

- A. County Certification
- B. County Fiscal Accountability Certification
- C. Press Releases (English & Spanish): Community Planning Meetings
- D. Media Outlet List for Public Releases
- E. Stakeholder Meeting Schedule (English & Spanish)
- F. Community Planning Meeting Comment Forms (English & Spanish)
- G. Press Releases (English & Spanish): 30-Day Public Posting Notice
- H. Stakeholder 30-Day Public Posting Comment
- I. Public Hearing Notice (English & Spanish)
- J. Press Releases (English & Spanish): Public Hearing

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary**

County: San Bernardino

Date: 5/30/14

	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 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	35,330,559	18,932,192	5,642,726	3,790,586	8,699,940	
2. Estimated New FY2014/15 Funding	65,160,478	16,291,439	4,285,276			
3. Transfer in FY2014/15 ^{a/}	(4,589,409)				4,589,409	
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	95,901,628	35,223,631	9,928,002	3,790,586	13,289,349	
B. Estimated FY2014/15 MHSA Expenditures	51,615,359	20,050,590	7,070,552	1,914,947	8,665,734	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	44,286,269	15,173,041	2,857,450	1,875,639	4,623,615	
2. Estimated New FY2015/16 Funding	56,241,614	14,059,084	3,699,481			
3. Transfer in FY2015/16 ^{a/}	(5,324,320)			1,965,284	3,359,036	
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	95,203,562	29,232,125	6,556,931	3,840,923	7,982,651	
D. Estimated FY2015/16 Expenditures	51,001,342	20,776,428	3,798,397	1,965,284	4,175,145	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	44,202,220	8,455,697	2,758,534	1,875,639	3,807,506	
2. Estimated New FY2016/17 Funding	57,492,366	14,370,453	3,783,920			
3. Transfer in FY2016/17 ^{a/}	(5,137,625)			2,017,132	3,120,493	
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	96,556,962	22,826,150	6,542,454	3,892,770	6,927,999	
F. Estimated FY2016/17 Expenditures	51,574,569	20,880,290	3,810,033	2,017,132	3,718,750	
G. Estimated FY2016/17 Unspent Fund Balance	44,982,393	1,945,860	2,732,421	1,875,639	3,209,249	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	22,152,363
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	22,152,363
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	22,152,363
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	22,152,363

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 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C-1 Comprehensive Child and Family Support System	12,594,282	690,694	6,531,878		2,903,182	2,468,528
2. C-2 Integrated New Family Opportunity Prog	1,266,376	1,073,025	81,618		111,733	
3. TAY - One Stop Center	5,843,493	4,750,726	718,305		374,462	
4. A-2 Forensic Integrated Mental Health Srv	5,392,942	3,866,885	777,062		9,108	739,887
5. A-3 Hospital High User Act Team	3,155,099	2,219,294	935,805			
6. A-7 Homeless Intensive Case Mgmt & Outreach	8,777,768	6,111,494	1,832,696		959	832,619
7. A-8 Alliance for Behavioral and Emotional Treatment	370,000	370,000				
8. OA-2 Older Adult Case Management	878,526	686,855	191,671			
9. A-9 Assessment, Coordination & Enhancement	4,514,971	3,344,423	1,170,548			
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. A-1 Clubhouse	2,640,100	2,640,100				
2. A-4 Crisis Walk-In Center	7,651,248	5,288,270	1,933,617		429,361	
3. A-5 Psych Diversion Team at ARMC	2,466,360	2,399,066	55,799		11,495	
4. A-6 Community Crisis Response Team	7,567,491	5,731,329	690,705		1,145,457	
5. OA-1 Circle of Care	2,311,277	1,774,437	536,840			
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					
CSS Administration	11,836,893	10,668,761	950,603			217,529
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	77,266,826	51,615,359	16,407,147	0	4,985,757	4,258,563
FSP Programs as Percent of Total	82.9%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C-1 Comprehensive Child and Family Support System	12,594,282	690,694	6,531,878		2,903,182	2,468,528
2. C-2 Integrated New Family Opportunity Prog	1,291,558	1,092,406	84,067		115,085	
3. TAY - One Stop Center	5,887,829	4,762,279	739,855		385,696	
4. A-2 Forensic Integrated Mental Health Srv	5,445,326	3,873,488	800,374		9,381	762,084
5. A-3 Hospital High User Act Team	3,155,099	2,219,294	935,805			
6. A-7 Homeless Intensive Case Mgmt & Outreach	8,953,073	6,206,811	1,887,677		988	857,598
7. A-8 Alliance for Behavioral and Emotional Treatment	370,000	370,000				
8. OA-2 Older Adult Case Management	900,330	702,909	197,421			
9. A-9 Assessment, Coordination & Enhancement	3,434,906	2,229,241	1,205,664			
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. A-1 Clubhouse	2,665,686	2,665,686				
2. A-4 Crisis Walk-In Center	7,709,132	5,275,265	1,991,625		442,242	
3. A-5 Psych Diversion Team at ARMC	2,522,613	2,453,300	57,473		11,840	
4. A-6 Community Crisis Response Team	7,665,706	5,774,460	711,426		1,179,821	
5. OA-1 Circle of Care	2,346,299	1,793,354	552,945			
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					
CSS Administration	12,088,805	10,892,155	979,121			217,529
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	77,030,645	51,001,342	16,675,331	0	5,048,234	4,305,738
FSP Programs as Percent of Total	82.4%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi- Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C-1 Comprehensive Child and Family Support System	12,594,282	690,694	6,531,878		2,903,182	2,468,528
2. C-2 Integrated New Family Opportunity Prog	1,317,495	1,112,369	86,589		118,538	
3. TAY - One Stop Center	5,933,496	4,774,179	762,050		397,267	
4. A-2 Forensic Integrated Mental Health Srv	5,499,282	3,880,288	824,385		9,663	784,946
5. A-3 Hospital High User Act Team	3,155,099	2,219,294	935,805			
6. A-7 Homeless Intensive Case Mgmt & Outreach	9,133,638	6,304,988	1,944,307		1,017	883,325
7. A-8 Alliance for Behavioral and Emotional Treatment	370,000	370,000				
8. OA-2 Older Adult Case Management	922,788	719,444	203,344			
9. A-9 Assessment, Coordination & Enhancement	3,528,103	2,286,268	1,241,834			
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. A-1 Clubhouse	2,692,039	2,692,039				
2. A-4 Crisis Walk-In Center	7,768,753	5,261,870	2,051,374		455,509	
3. A-5 Psych Diversion Team at ARMC	2,580,554	2,509,162	59,197		12,195	
4. A-6 Community Crisis Response Team	7,766,868	5,818,884	732,769		1,215,215	
5. OA-1 Circle of Care	2,382,371	1,812,838	569,533			
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					
CSS Administration	12,348,275	11,122,251	1,008,495			217,529
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	77,993,043	51,574,569	16,951,560	0	5,112,586	4,354,329
FSP Programs as Percent of Total	82.3%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2014/15					
	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	2,970,246	2,970,246				
2. SI-2 Preschool Program	425,000	425,000				
3. SI-3 Resilience in African-Amr Children CI-1 Promotores de Salud/Comm Health	672,477	672,477				
4. Worker CI-4 National Crossroads Education	1,148,630	1,148,630				
5. 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	3,349,615	3,349,615				
12. CI-3 Native American Resource Centers	500,000	500,000				
13. SE-2 Child and Youth Connection SE-3 Community Wholeness and	13,608,875	2,176,265	3,143,666		2,512,849	5,776,095
14. Enrichment SE-6 Coalition Against Sexual Exploitation	2,050,017	2,050,017				
15. (CASE)	426,169	426,169				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	3,216,377	3,216,377				
PEI Assigned Funds	561,894	561,894				
Total PEI Program Estimated Expenditures	31,483,200	20,050,590	3,143,666	0	2,512,849	5,776,095

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	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	2,970,246	2,970,246				
2. SI-2 Preschool Program	425,000	425,000				
3. SI-3 Resilience in African-Amr Children CI-1 Promotores de Salud/Comm Health	672,477	672,477				
4. Worker CI-4 National Crossroads Education	1,148,630	1,148,630				
5. Institute Training	532,900	532,900				
6. SE-1 Older Adult Community Services	900,000	900,000				
7. SE-4 Military Services & Family Support	600,000	600,000				
8. SE-5 LIFT	396,000	396,000				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. CI-2 Family Resource Centers	3,349,615	3,349,615				
12. CI-3 Native American Resource Centers	500,000	500,000				
13. SE-2 Child and Youth Connection SE-3 Community Wholeness and	13,652,119	2,197,008	3,152,122		2,526,894	5,776,095
14. Enrichment SE-6 Coalition Against Sexual Exploitation	2,815,528	2,815,528				
15. (CASE)	426,169	426,169				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	3,280,960	3,280,960				
PEI Assigned Funds	561,894	561,894				
Total PEI Program Estimated Expenditures	32,231,539	20,776,428	3,152,122	0	2,526,894	5,776,095

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2016/17					
	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	2,970,246	2,970,246				
2. SI-2 Preschool Program	425,000	425,000				
3. SI-3 Resilience in African-Amr Children CI-1 Promotores de Salud/Comm Health	672,477	672,477				
4. Worker CI-4 National Crossroads Education	1,148,630	1,148,630				
5. Institute Training	532,900	532,900				
6. SE-1 Older Adult Community Services	900,000	900,000				
7. SE-4 Military Services & Family Support	600,000	600,000				
8. SE-5 LIFT	396,000	396,000				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. CI-2 Family Resource Centers	3,349,615	3,349,615				
12. CI-3 Native American Resource Centers	500,000	500,000				
13. SE-2 Child and Youth Connection SE-3 Community Wholeness and	13,696,661	2,218,374	3,160,832		2,541,360	5,776,095
14. Enrichment SE-6 Coalition Against Sexual Exploitation	2,831,505	2,831,505				
15. (CASE)	426,169	426,169				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	3,347,481	3,347,481				
PEI Assigned Funds	561,894	561,894				
Total PEI Program Estimated Expenditures	32,358,577	20,880,290	3,160,832	0	2,541,360	5,776,095

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2014/15					
	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. Holistic Campus	1,811,508	1,811,508				
2. Interagency Youth Resilience Team	1,471,944	1,471,944				
3. Youth Hostel	2,500,000	1,400,636	810,000		289,364	
4. Recovery Based Engagement Supp Team	1,750,338	1,575,304	175,034			
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	811,160	811,160				
Total INN Program Estimated Expenditures	8,344,950	7,070,552	985,034	0	289,364	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	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	1,400,636	810,000		289,364	
2. Recovery Based Engagement Supp Team	1,763,073	1,582,788	180,285			
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	814,973	814,973				
Total INN Program Estimated Expenditures	5,078,046	3,798,397	990,285	0	289,364	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2016/17					
	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	1,400,636	810,000		289,364	
2. Recovery Based Engagement Supp Team	1,776,190	1,590,497	185,693			
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	818,900	818,900				
Total INN Program Estimated Expenditures	5,095,090	3,810,033	995,693	0	289,364	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2014/15					
	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	928,082	928,082				
2. Training and Technical Assistance	197,300	197,300				
3. Mental Health Career Pathways Program	19,900	19,900				
4. Residency and Internship Program	1,240,672	677,778	562,894			
5. Financial Incentive Program	19,840	19,840				
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	72,047	72,047				
Total WET Program Estimated Expenditures	2,477,841	1,914,947	562,894	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	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	955,924	955,924				
2. Training and Technical Assistance	197,300	197,300				
3. Mental Health Career Pathways Program	19,900	19,900				
4. Residency and Internship Program	1,277,892	698,111	579,781			
5. Financial Incentive Program	19,840	19,840				
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	74,208	74,208				
Total WET Program Estimated Expenditures	2,545,065	1,965,284	579,781	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2016/17					
	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	984,602	984,602				
2. Training and Technical Assistance	197,300	197,300				
3. Mental Health Career Pathways Program	19,900	19,900				
4. Residency and Internship Program	1,316,229	719,055	597,174			
5. Financial Incentive Program	19,840	19,840				
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	76,435	76,435				
Total WET Program Estimated Expenditures	2,614,306	2,017,132	597,174	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2014/15					
	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. Crisis Services	1,800,000	1,800,000				
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	1,892,020	1,892,020				
12. Empowered Communication/Sharepoint Pro	7,502	7,502				
13. Virtual Infrastructure Project	35,000	35,000				
14. Electronic Health Record Project	1,236,443	1,236,443				
15. BHMS Replacement Proj	3,411,917	3,411,917				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	282,852	282,852				
Total CFTN Program Estimated Expenditures	8,665,734	8,665,734	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	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	726,621				
12. Empowered Communication/Sharepoint Proj	7,877	7,877				
13. Virtual Infrastructure Project	35,000	35,000				
14. Electronic Health Record Project	814,985	814,985				
15. BHMS Replacement Proj	2,444,320	2,444,320				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	146,342	146,342				
Total CFTN Program Estimated Expenditures	4,175,145	4,175,145	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: San Bernardino

Date: 5/30/14

	Fiscal Year 2016/17					
	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	762,952	762,952				
12. Empowered Communication/Sharepoint Pro	8,271	8,271				
13. Virtual Infrastructure Project	35,000	35,000				
14. Electronic Health Record Project	664,463	664,463				
15. BHMS Replacement Proj	2,109,383	2,109,383				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	138,681	138,681				
Total CFTN Program Estimated Expenditures	3,718,750	3,718,750	0	0	0	0

Attachments

- A. County Certification
- B. County Fiscal Accountability Certification
- C. Press Releases (English & Spanish): Community Planning Meetings
- D. Media Outlet List for Public Releases
- E. Stakeholder Meeting Schedule (English & Spanish)
- F. Community Planning Meeting Comment Forms (English & Spanish)
- G. Press Releases (English & Spanish): 30-Day Public Posting Notice
- H. Stakeholder 30-Day Public Posting Comment
- I. Public Hearing Notice (English & Spanish)
- J. Press Releases (English & Spanish): Public Hearing

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Bernardino

- Three-Year Program and Expenditure Plan
 Annual Update

Local Mental Health Director	Program Lead
Name: CaSonya Thomas	Name: Michelle Dusick
Telephone Number: (909) 382-3133	Telephone Number: (909) 252-4046
E-mail: cthomas@dbh.sbcounty.gov	E-mail: mdusick@dbh.sbcounty.gov
Local Mental Health Mailing Address:	
268 West Hospitality Lane, Suite 400 San Bernardino, CA 92415	

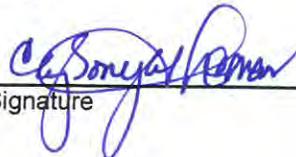
I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 17, 2014.

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

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

CaSonya Thomas
Local Mental Health Director (PRINT)


Signature 6/23/14
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION ¹

County/City: San Bernardino

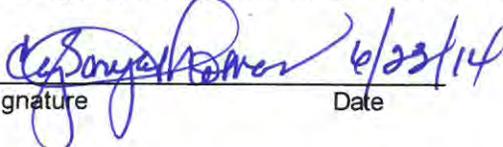
- Three-Year Program and Expenditure Plan
 Annual Update
 Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: CaSonya Thomas	Name: Larry Walker
Telephone Number: (909) 382-3133	Telephone Number: (909) 386-9000
E-mail: cthomas@dbh.sbcounty.gov	E-mail: larry.walker@atc.sbcounty.gov
Local Mental Health Mailing Address:	
268 West Hospitality Lane, Suite 400 San Bernardino, CA 92415	

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

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

CaSonya Thomas
Local Mental Health Director (PRINT)


Signature Date

I hereby certify that for the fiscal year ended June 30, 2013, 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 12/29/2013 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013, 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.

Joon Cho
~~Sonia Hermosillo~~
County Auditor Controller / City Financial Officer (PRINT)


Signature Date

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

NEWS

From the County of San Bernardino
www.sbcounty.gov

FOR IMMEDIATE RELEASE

February 28, 2014



For more information, contact
Michelle Dusick, Acting MHSA Coordinator
County of San Bernardino
Department of Behavioral Health
(909) 252-4046
mdusick@dbh.sbcounty.gov

You are invited by the Department of Behavioral Health to attend a Mental Health Services Act (MHSA) Annual Update Stakeholder Engagement.

WHO: All residents living in the County of San Bernardino who are interested in the public mental health service delivery system, learning about the Mental Health Services Act (MHSA) and participating in the three year MHSA Integrated Plan Update for Fiscal Year 2014/15 as well as 2016/17 and Innovation Stakeholder Meeting.

WHAT: There is a series of public meetings planned that will take place throughout the county to promote community conversation and participation regarding the three year MHSA Integrated Plan Update for Fiscal Year 2014/15 as well as 2016/17 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 the three year MHSA Integrated Plan Update for Fiscal Year 2014/15 as well as 2016/17 and how it will affect the residents of the County of San Bernardino. Also, we will be facilitating a discussion to obtain ideas, topics, and suggestions for the future of mental health policy and program planning.

WHEN & WHERE:

Join us on the Pathway to Integration at the Community Policy Advisory Committee (CPAC) meeting, Cultural Competency Advisory Committee meeting (CCAC) or one of the local District Advisory Committee (DAC) meetings:

CPAC Meeting Thursday, March 20, 2014 9:00 – 11:00 a.m. CSBHS - Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact: Aidery Hernandez (909) 252-4069	CCAC Meeting Thursday, March 20, 2014 1:00 – 3:00 p.m. CSBHS - Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact: Aidery Hernandez (909) 252-4069
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First District DAC Wednesday, March 19, 2014 11:00 a.m. — 12:30 p.m. Victor Community Holistic Campus 15400 Cholame Rd. Victorville, CA 92392 Contact: Chris Croteau (760) 955-7287	Second District DAC Thursday, March 13, 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Contact: April Guzman (909) 854-3440	
Third District DAC Tuesday, March 18, 2014 11:00 a.m. — 12:00 p.m. Phoenix Community Counseling Center 820 E. Gilbert St. San Bernardino, CA 92415 Contact: Debbi Cazarez (909) 387-7219	Fourth District DAC Thursday, March 13, 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Contact: April Guzman (909) 854-3440	Fifth District DAC Monday, March 24, 2014 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

NOTE: If special accommodations or interpretation services are required, or to learn more about the Spanish language forum please call 1-800-722-9866 or 7-1-1 for TTY users.

CONTACT: For additional information, please contact Michelle Dusick (909) 252-4046.

-END-

NOTICIAS

Del Condado de San Bernardino
www.sbcounty.gov

PARA PUBLICACION INMEDIATA

28 de febrero del 2014



Para más información, comuníquese con
Michelle Dusick, Actuando como Coordinador de MHSA
Departamento de Salud Mental
(909) 252-4046
mdusick@dbh.sbcounty.gov

El Departamento de Salud Mental le invita a asistir a una reunión sobre la Actualización Anual de la Planificación Pública de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés).

Quién: Todos los residentes del Condado de San Bernardino que estén interesados en el sistema de la prestación de servicios de salud mental, que quieran aprender sobre la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés), y participar en la actualización de un plan trienal Integrado MHSA para el año fiscal 2014/15, así como 2016/17 y la Innovación Reunión de Partes Interesadas.

Qué: Hay una serie de reuniones públicas planificadas, que se llevarán a cabo en todo el condado para promover las conversaciones comunitarias y la participación con respecto a la actualización del Plan Integrado de MHSA tres años para el año fiscal 2014/15, así como 2016/17, y para discutir temas para el futuro de la política de salud mental y planificación del programa.

La Ley De Servicios de Salud Mental (también conocida como Proposición 63, MHSA por sus siglas en inglés) fue aprobada por los electores de California en noviembre del 2004 para ampliar los servicios de salud mental para niños y adultos. MHSA es financiada por un impuesto adicional de 1% para aquellos cuyos ingresos personales son más de un millón de dólares al año.

Por qué: Para proporcionar información y promover conversaciones comunitarias sobre la Actualización del Plan Integrado de MHSA tres años para el año fiscal 2014/15, así como 2016/17 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 el futuro de la política de salud mental y planificación del programa.

Dónde y Cuándo:

Acompáñenos en el camino hacia la integración en la reunión del Comité Asesor de Política Comunitaria (CPAC, por sus siglas en inglés), reunión del Comité Asesor de Competencia Cultural (CCAC, por sus siglas en inglés) o una de las reuniones locales (DAC, por sus siglas en inglés) Comité Asesor del Distrito.

CPAC reunión local Jueves, 20 de marzo del 2014 9:00 – 11:00 a.m. CSBHS - Auditorio 850 E. Foothill Blvd. Rialto, CA 92376 Contacte: Aidery Hernandez (909) 252-4069	CCAC reunión local Jueves, 20 de marzo del 2014 1:00 – 3:00 p.m. CSBHS - Auditorio 850 E. Foothill Blvd. Rialto, CA 92376 Contacte: Aidery Hernandez (909) 252-4069
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Primer Distrito de DAC Miércoles, 19 de marzo del 2014 11:00 a.m. — 12:30 p.m. Victor Community Holistic Campus 15400 Cholame Rd. Victorville, CA 92392 Contacte: Chris Croteau (760) 955-7287	Segundo Distrito de DAC Jueves, 13 de marzo del 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Contacte: April Guzman (909) 854-3440
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Tercera Distrito de DAC Martes, 18 de marzo del 2014 11:00 a.m. — 12:00 p.m. Phoenix Community Counseling Center 820 E. Gilbert St. San Bernardino, CA 92415 Contacte: Debbi Cazarez (909) 387-7219	Cuarto Distrito de DAC Jueves, 13 de marzo del 2014 3:00 — 5:00 p.m. Rancho Cucamonga Family Resource Center 9791 Arrow Rte. Rancho Cucamonga, CA 91730 Contacte: April Guzman (909) 854-3440	Quinto Distrito de DAC Lunes, 24 de marzo del 2014 5:30 — 7:30 p.m. New Hope Family Life Center Auditorio 1505 W. Highland Ave. San Bernardino, CA 92411 Contacte: Crista Wentworth (909) 421-4606
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NOTA: Si necesitan arreglos especiales (relacionados con alguna discapacidad), servicios de interpretación, si desea saber más sobre la reunión en español por favor de llamar al (800) 722- 9866 ó al 7-1-1 si es usuario de TTY.

CONTACTO: Para más información, por favor comuníquese con Michelle Dusick (909) 252-4046.

-FINAL-

Media Outlet List for Press Releases

Media

KCAL9
Associated Press
CBS2
Univision
Inland Newspaper
VVDaily Press
Desert Dispatch
Blooming Town
ABC-Bobby D
Press Enterprise
LA Times
Desert Trail News
KFrog
City News Group
Highland News
Mountain News
Fox 11 News
IECN
Info Rim of the World
Grizzly
NBC
Daily Journal
CBS Radio
Westside Story Newspaper
City Newsgroup
High Desert Daily
KBHR93.3
Needles Desert Star
News Line
News Radio
USPS
Link Freedom
SoCal News
The Alpenhorn News
Travel 980
Bus Journal
Z 107.7 fm

Community News

Black Voice
Black Voice News
Fontana Herald
Highland Community News
Homeless Times
Inland Empire Community Newspaper
Inland Empire Hispanic News
La Prensa
News Mirror
Princt Reporter
San Bernardino American
San Bernardino City News
VV Daily Press
Westside Story

Join us on the Pathway to Integration!

Thursday, March 20, 2014

for the

**Community Policy Advisory
Committee (CPAC) meeting**

or

**Cultural Competency Advisory
Committee (CCAC) meeting**

9:00 – 11:00 a.m.

CSBHS - Auditorium

850 E. Foothill Blvd., Rialto, CA 92376

1:00 – 3:00 p.m.

CSBHS - Auditorium

850 E. Foothill Blvd., Rialto, CA 92376

These special 2-hour community stakeholder engagement meetings will focus on the MHSA Integrated Plan. The CPAC meeting will be hosted by Department of Behavioral Health Director, CaSonya Thomas and the CCAC meeting will be hosted by Department of Behavioral Health Assistant Director, Veronica Kelley.

Special focus will be placed on sharing how the Mental Health Services Act has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

For questions, interpretation services or requests for disability-related accommodations please contact: Aidery Hernandez (909)252-4069 or 7-1-1 for TTY users

The MHSA (Prop 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.



¡Acompañenos en el Camino a la Integración!

Jueves, 20 de marzo de 2014

para la

Junta de Comité Asesor de Política Comunitaria

(CPAC por sus siglas en inglés)

9:00 – 11:00 a.m.

CSBHS - Auditorio

850 E. Foothill Blvd., Rialto, CA 92376

O

Junta de Comité Asesor de Competencia Cultural

(CCAC por sus siglas en inglés)

1:00 – 3:00 p.m.

CSBHS - Auditorio

850 E. Foothill Blvd., Rialto, CA 92376

Estos sesiones especiales de participación de los interesados de la comunidad de 2 horas se concentrarán en el Plan Integrado de la Ley de Servicios de Salud Mental. La junta de Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés) será organizada por la Directora de el Departamento de Salud Mental, CaSonya Thomas y la junta de Comité Asesor de Competencia Cultural (CCAC por sus siglas en inglés) será organizada por la Director asistente de departamento el Departamento de Salud Mental, Veronica Kelley.

Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

Para preguntas, servicios de interpretación o petición de acomodos relacionados con alguna incapacidad, por favor llame al: Aidery Hernandez (909)252-4069 o 7-1-1 para usuarios de TTY.

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más a un millón de dólares al año.

Join us on the Pathway to Integration!

District Advisory Committee Meetings

These community stakeholder engagement will focus on the MHSA Integrated Plan. Special focus will be placed on sharing how the Mental Health Service Act has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

First District

Wednesday, March 19, 2014

11:00 a.m. — 12:30 p.m.

Victor Community Holistic Campus
15400 Cholame Rd.
Victorville, CA 92392

Hosted by Andy Gruchy

Contact: Chris Croteau (760) 955-7287

Second District

Thursday, March 13, 2014

3:00 — 5:00 p.m.

Rancho Cucamonga
Family Resource Center
9791 Arrow Rte.

Rancho Cucamonga, CA 91730

Hosted by Sarah Eberhardt-Rios and Mike Schertell

Contact: April Guzman (909) 854-3440

Third District

Tuesday, March 18, 2014

11:00 a.m. — 12:00 p.m.

Phoenix Community Counseling Center
820 E. Gilbert St.
San Bernardino, CA 92415

Hosted by Sharon Nevins and Tanya Bratton

Contact: Debbi Cazarez (909) 387-7219

Fourth District

Thursday, March 13, 2014

3:00 — 5:00 p.m.

Rancho Cucamonga
Family Resource Center
9791 Arrow Rte.

Rancho Cucamonga, CA 91730

Hosted by Sarah Eberhardt-Rios and Mike Schertell

Contact: April Guzman (909) 854-3440

Fifth District

Monday, March 24, 2014

5:30 — 7:30 p.m.

New Hope Family Life Center
Auditorium
1505 W. Highland Ave.

San Bernardino, CA 92411

Hosted by Dr. Frausto and Andy Gruchy

Contact: Crista Wentworth (909) 421-4606

For questions, interpretation services or requests for disability-related accommodations please contact: Aidery Hernandez (909)252-4069 or 7-1-1 for TTY users

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.

County of San Bernardino |  | Department of Behavioral Health

¡Acompáñenos en el camino a la integración!

Juntas del Comité Consultivo del Distrito

Estas sesiones especiales de participación de los interesados de la comunidad se concentrarán en la Ley de Servicios de Salud Mental Plan Integrado. Especial atención se pondrá en compartir cómo ha sido la Ley de Servicios de Salud Mental integrado en los servicios existentes y discusión sobre el futuro de la política de salud mental y planificación del programa.

Primer Distrito

Miércoles, 19 de marzo del 2014

11:00 a.m. — 12:30 p.m.

Victor Community Holistic Campus

15400 Cholame Rd.

Victorville, CA 92392

Conducido por Andy Gruchy

Contacte: Chris Croteau (760) 955-7287

Segundo Distrito

Jueves, 13 de marzo del 2014

3:00 — 5:00 p.m.

Rancho Cucamonga

Family Resource Center

9791 Arrow Rte.

Rancho Cucamonga, CA 91730

Conducido por Sarah Eberhardt-Rios y Mike Schertell

Contacte: April Guzman (909) 854-3440

Tercer Distrito

Martes, 18 de marzo del 2014

11:00 a.m. — 12:00 p.m.

Phoenix Community Counseling Center

820 E. Gilbert St.

San Bernardino, CA 92415

Conducido por Sharon Nevins y Tanya Bratton

Contacte: Debbi Cazarez (909) 387-7219

Cuarto Distrito

Jueves, 13 de marzo del 2014

3:00 — 5:00 p.m.

Rancho Cucamonga

Family Resource Center

9791 Arrow Rte.

Rancho Cucamonga, CA 91730

Conducido por Sarah Eberhardt-Rios y Mike Schertell

Contacte: April Guzman (909) 854-3440

Quinto Distrito

Lunes, 24 de marzo del 2014

5:30 — 7:30 p.m.

New Hope Family Life Center

Auditorio

1505 W. Highland Ave.

San Bernardino, CA 92411

Conducido por Dr. Frausto y Andy Gruchy

Contacte: Crista Wentworth (909) 421-4606

Para preguntas, servicios de interpretación o petición de acomodados relacionados con alguna incapacidad, por favor llame al: Aidery Hernandez (909)252-4069 o 7-1-1 para usuarios de TTY.

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más a un millón de dólares al año.





**County of San Bernardino Department of Behavioral Health
Mental Health Services Act (MHSA) Three-Year Integrated Plan
FY 14/15 through FY 16/17**

Stakeholder Comment Form

What is your age?

- 0-17 yrs 18-24 yrs 25-59 yrs 60 + yrs

What is your gender?

- Male Female Other _____

What region of the County of San Bernardino do you live in?

- Central Valley Region Desert/Mountain Region East Valley Region West Valley Region

What group(s) do you represent?

- Family member of consumer
 Consumer of Mental Health Services
 Law Enforcement
 School Personnel
 Community Agency
 Faith Community
 County Staff
 Human Services
 Health Provider
 Veteran Organization
 Alcohol or Drug consumer/family member

What is your ethnicity?

- Latino/Hispanic
 African American/Black
 Caucasian/White
 Asian/Pacific Islander
 American Indian/Native American
 Other (specify) _____

What is your primary language?

- English
 Spanish
 Vietnamese
 Other _____

What is your general feeling about the MHSA Integrated Plan in the County of San Bernardino?

- Very Satisfied Somewhat Satisfied Satisfied Unsatisfied Very Unsatisfied

Do you have other concerns not addressed in this discussion?

What did you learn about the MHSA Integrated Plan?

What else would you like to learn about the MHSA process (please select all that apply)?

- Mental Health Policy Program Planning Implementation Monitoring
 Quality Improvement Evaluation Budget Allocations

Thank you for taking the time to review and provide input on the MHSA Integrated Plan in the County of San Bernardino.



**Departamento de Salud Mental del Condado de San Bernardino
Plan Integrado de Tres Años de la
Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)
Años Fiscales 14/ al 16/17**

Formulario de Comentarios para Personas Interesadas

¿Cuál es su edad?

0-17 años 18-24 años 25-59 años 60 años o más

¿Cual es su género?

Masculino Femenino Otro _____

¿En qué región vive?

Región Valle Central Región Desierto/Montañas Región Valle Este Región Valle Oeste

¿Cuál grupo representa?

- Miembro de familia de consumidor
- Consumidor de Servicios de Salud Mental
- Departamento de Policía
- Personal Escolar
- Agencia Comunitaria
- Comunidad de Fe
- Personal Del Condado
- Servicios Humanos
- Proveedor de Salud
- Miembro Comunitario

¿Cual es su origen étnico?

- Latino/Hispano
- Afroamericano
- Caucásico
- Asiático/Islas de Pacifico
- Indígenas Estadounidenses
- Otro (especifique) _____

¿Cual es su idioma principal?

- Inglés
- Español
- Vietnamita
- Otro _____

¿Cuál es su opinión general sobre el Plan Integrado de MHSA en el Condado de San Bernardino?

Muy Satisfecho Algo Satisfecho Satisfecho Insatisfecho Muy insatisfecho

¿Tiene alguna otra duda que no haya sido hablada en esta junta?

¿Qué aprendió sobre el Plan Integrado de MHSA?

¿Qué más le gustaría aprender sobre el proceso de la MHSA (por favor marque todas las que apliquen?)

- Política de Salud Mental
- Planificación de programas
- Implementación
- Supervisión
- Mejora de Calidad
- Evaluación
- Asignaciones de presupuesto

Gracias de nuevo por tomar el tiempo de revisar y proveer su opinión en el proceso de el Plan Integrado de MHSA en el Condado de San Bernardino.

NEWS

From the County of San Bernardino
www.sbcounty.gov



FOR IMMEDIATE RELEASE

April 7, 2014

For more information, contact
 Michelle Dusick, Acting MHSA Coordinator
 Department of Behavioral Health
 (909) 252-4046
mdusick@dbh.sbcounty.gov

A draft of the Mental Health Services Act (MHSA, Prop. 63) Three-Year Integrated Plan for fiscal years 2014/15 through 2016/17 is now posted for public review.

WHO: All county residents who are interested in the public mental health service delivery system, learning about the Mental Health Services Act (MHSA, Prop. 63) and reviewing the draft MHSA Three-Year Integrated Plan for fiscal years 2014/15 through 2016/17.

WHAT: The County of San Bernardino utilizes MHSA funding to create new or expand existing behavioral health services. The services are geared to target the unserved, underserved and inappropriately served members of our community.

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 Three-Year Integrated Plan posted for public comment depicts the progress made by the Department of Behavioral Health, and our contracted partners, in providing behavioral health services since implementation. The public is invited to review the Plan and provide feedback on the comment forms, which are posted in English and Spanish.

The MHSA was passed by the California voters 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.

WHEN: A draft of the Plan will be available for review and public comment until May 7, 2014.

WHERE: The draft Plan and comment forms are posted on the County of San Bernardino Department of Behavioral Health Intra and Internet websites. To review please visit: <http://countyline/dbh/> or <http://www.sbcounty.gov/dbh/>.

CONTACT: For additional information, please contact Michelle Dusick at (909) 252-4046 or 711 for TTY users.

-END-

NOTICIAS

Del Condado de San Bernardino

www.sbcounty.gov



PARA PUBLICACION INMEDIATA

7 de abril del 2014

Para más información, comuníquese con
Michelle Dusick, Coordinadora Interina de MHS
Departamento de Salud Mental
(909) 252-4046
mdusick@dbh.sbcounty.gov

Borrador del Plan Integrado de Tres Años para los años fiscales 2014/15 al 2016/2017 de la Ley de Servicios de Salud Mental (MHS, por sus siglas en inglés, también conocida como Proposición 63,) está presentado para revisión pública.

QUIEN: Todos los residentes del Condado de San Bernardino que estén interesados en el suministro de servicios del sistema de salud mental que quieran aprender sobre la Ley de Servicios de Salud Mental (MHS por sus siglas en inglés) también conocida como Proposición 63, que quieran revisar el borrador del Plan Integrado de Tres Años de la MHS para los años fiscales 2014/15 al 2016/17.

QUE: El Condado de San Bernardino utiliza los fondos de MHS para crear nuevos servicios de salud mental o expandir los servicios que ya existen. Los servicios estarán orientados hacia aquellos miembros de la comunidad que carecen de servicios, que reciben servicios insuficientemente o que los reciben de manera inapropiada.

Hay varios componentes de la MHS que incluyen servicios y apoyos comunitarios, prevención e intervención temprana, capacitación laboral y educativa, servicios y mantenimiento de instalaciones, tecnología e innovación.

El Plan Integrado de Tres Años está publicado para comentarios públicos representa el progreso que el Departamento de Salud Mental y nuestros contratistas han logrado en el suministro de servicios de salud mental desde su implementación. Se le invita al público a revisar este informe y a proveer sugerencias en los formularios de comentarios, los cuales han sido publicados en inglés y en español.

La Ley De Servicios de Salud Mental 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.

CUANDO: El borrador del Plan estará disponible para revisión y comentarios públicos hasta el 7 de mayo del 2014.

DONDE: El borrador del Plan y el formulario para comentarios están publicados en los sitios de Intranet y Internet del Departamento de Salud Mental del Condado de San Bernardino. Para revisarlos, por favor visite: <http://countyline/dbh/> o <http://www.sbcounty.gov/dbh/>.

CONTACTO: Para información adicional, por favor comuníquese con Michelle Dusick al: (909) 252-4046 o 711 para usuarios de TTY.

-FIN-



972 N. Mt. Vernon Ave. | San Bernardino, CA 92411

P.O. Box 449 | San Bernardino, CA 92402

Tel. (909) 884-3735 | (909) 714-50031

www.elsolnec.com

May 5, 2013

CaSonya Thomas, MPA, CHC
 Director, Department of Behavioral Health
 County of San Bernardino
 268 West Hospitality Lane, Suite 400
 San Bernardino, CA 92415-0026

Re: RESPONSE TO MHSA INTEGRATED PLAN 2014/2015 THROUGH 2016/2017 PUBLIC NOTICE

Dear Ms. Thomas:

Thank you for your leadership at the Department of Behavioral Health (DBH). El Sol Neighborhood Educational Center (El Sol) continues to be supportive of efforts to increase access to culturally-competent and linguistically-appropriate high quality behavioral health services.

We also appreciate the opportunity to respond to the Mental Health Services Act (MHSA) Integrated Plan 2014/2015 through 2016/2017. After a very careful review of the proposed plan, El Sol respectfully brings to your attention some considerations that are reasons for concern and request that these be addressed prior to official approval:

1) **Purpose of Innovation:** Per the Integrated Plan, the purposes of the Innovation program are to 1) Increase access to underserved groups; 2) Increase the quality of services, including better outcomes; 3) Promote interagency collaboration; 4) Increase access to services. Additionally, Innovation projects must contribute to learning and be developed within the community through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served populations.

Concern: DBH is currently funding several projects under the Innovation component, including the Coalition Against Sexual Exploitation (CASE), Inter-agency Youth Resilience Team, and Holistic Campus. Per the proposed plan, CASE is to be integrated into Prevention and Early Intervention (PEI) plan. Furthermore, the Integrated Plan confirms intent to discontinue several Innovation projects but does not provide the justification for the decision. There are no references to evaluation results or specific findings of community engagement process (e.g. surveys, key informant interviews, or focus groups) that justify the decision to discontinue the program. For example, it is not clear what factors contributed to the determination that Youth Hostel would receive further funding whereas other projects would be terminated, even though all of these projects were initiated around the same time. Furthermore, the county is proposing to implement a new project, Recovery Based Engagement Support Team (submitted in February 2014). As expected by the Mental Health Services Oversight and Accountability Commission -MHSOAC (see Innovation Work Plan Success Top Ten List), it is not clear how these decisions were made and who participated in the resulted key decisions about Innovation.

2) **Innovation Funding:** As stated earlier, per the proposed plan, CASE is to be integrated into Prevention and Early Intervention (PEI) plan. Per the Integrated Plan, specific to the Holistic Campus projects "options for

funding are varied and have not been determined at the time of this report; however, stakeholder feedback has shown the services being offered through this project to be of value to the community (page 193 of 303).

Concern: DBH indicates that “options for funding are varied and have not been determined”, however, the proposed budget (pages 281-283 of 303) confirms that the Holistic Campus is being discontinued despite stakeholder feedback showing that the services are of value to the community. We respectfully propose that unless compelling justification (e.g. evidence that program is not effective, budget overruns, etc.) the Integrated Plan should honor the voice of the community as documented through the stakeholder engagement process.

3) **Community Engagement:** The plan describes the process for community and stakeholder confirming support for expansion of services.

Concern: The review of key findings during “stakeholder engagement process” does not seem to provide support for the decision of discontinuation of services. This was confirmed during the various stakeholder meetings as community members verbally expressed their opinions. For example, during stakeholder meetings facilitated by LF Leadership, community members were asked about current programs and they expressed the need for expansion of services. As confirmed in the proposed Integrated Plan, some of the written comments encapsulate the general community consensus: need for “future funding opportunities and expansion of the services that are being provided” (page 27 of 303, line 16). Community stakeholders expressed the need to “expand services that are being provided” and not to “discontinue programs”. During these data gathering stakeholder sessions, participants were never informed of intent to cut or discontinue services.

4) **Holistic Campus Program Evaluation:** Per the Integrated Plan, “the Holistic Campus project will continue through June 2015, with the third holistic campus INSPIRE (contracted to El Sol Neighborhood Educational Center) providing services. A final report for this project, with comprehensive evaluation and outcomes information, will be developed in compliance with the regulations set forth for Innovation reporting by the Mental Health Services Oversight and Accountability Commission (MHSOAC)” (page 193 of 303).

Concern: Decisions to continue or discontinue current programs do not appear to be the result of program outcome evaluation. Specifically, the proposed Integrated Plan acknowledges that the Holistic Campus projects have not been evaluated for outcomes and impact, especially in terms of learning. Decisions for funding or continuation of the Holistic Campus appears to be being made absent of outcome evaluation, which is in direct contradiction to the purpose that Innovation projects, including “contribution to learning”. In fact, the decision to discontinue is being made a priori, in other words, BEFORE the comprehensive evaluation and outcomes information is presented in compliance with applicable regulations by the MHSOAC.

5) **Innovation Projects and Learning:** Consistent with MHSA program requirements, “innovation projects must contribute to learning and be developed within the community”. Per the MHSOAC Innovation Programs Plan Review Tool, 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.

Concern: Community stakeholders are now concerned that DBH has opted to discontinue funding Innovation projects being implemented by local community-based organizations, in favor of designing new projects to be directly operated by DBH.

Ms. Thomas, as demonstrated above, there are several reasons for concerns regarding the proposed MHSA Integrated Plan. We respectfully request that these issues be addressed prior to approval. Our letter stems from

a significant number of stakeholder forms and comments which we have received (see sample enclosed). We reiterate our support for the Department of Behavioral Health and commend you for your leadership and the ongoing organizational transformation aimed at ensuring increased access to culturally-competent behavioral health services.

We respectfully present this public comment in response to the proposed MHSA Integrated Plan.

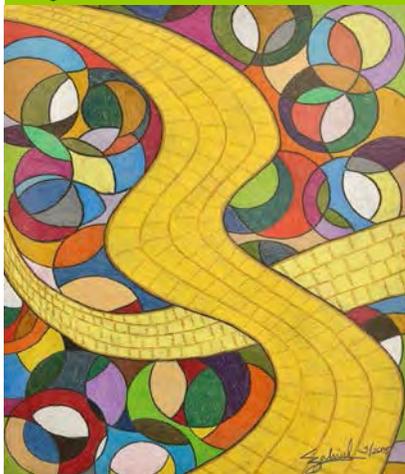
Respectfully,



Alex Fajardo, MPC
Executive Director

cc. Consul of Mexico, Carolina Zaragoza
African American Mental Health Coalition, Linda Hart
Loma Linda University, School of Behavioral Health, Beverly Buckles
Cal State University, Jeffrey Thompson, Ph.D. Associate Provost for Research
Department of Behavioral Health, Commissioners
Inspire Multicultural Holistic Center, Advisory Committee
DBH, Cultural Competence Subgroups
Inland Empire Concern African American Churches
Kulesa, Susanne DBH Innovation

**County of San Bernardino
Department of Behavioral Health**



**Public Hearing
Information**

Thursday, June 5, 2014

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.**



You Are Invited:

The County of San Bernardino Department of Behavioral Health invites you to attend a public hearing regarding the Mental Health Services Act Three-Year Integrated Plan for Fiscal Years 2014/15 through 2016/17.

The Mental Health Services Act (MHSA) Integrated Plan depicts the progress made by the Department of Behavioral Health and contracted partners, in providing public behavioral health services since the implementation of the Act.

This public hearing will provide community members the opportunity to participate in an overview of the MHSA Integrated Plan stakeholder process. In addition to the overview, there will be time set aside for attendees to ask questions and share comments and/or concerns regarding the stakeholder process. 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.

County of San Bernardino Department of Behavioral Health
Mental Health Services Act
1950 South Sunwest Lane, Suite 200
San Bernardino, CA 92415

For additional information please call 800-722-9866 or 711 for TTY users



Condado de San Bernardino Departamento de Salud Mental

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 Integral Trienal de la Ley de Servicios de Salud Mental para los años fiscales: 2014/15 y 2016/17.

El Plan Integral 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 desde la implementación de dicha ley.

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 Integral 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 entró en vigor en enero de 2005.

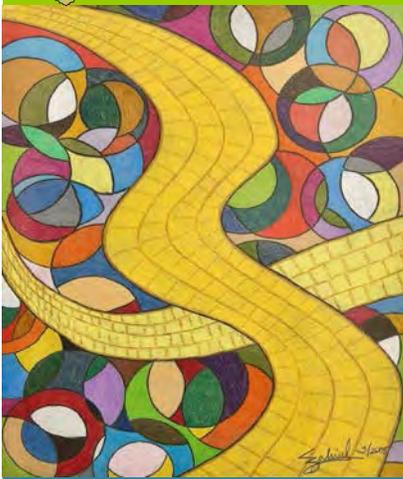
Esta ley está financiada por un impuesto adicional del 1% sobre aquellos contribuyentes cuyos ingresos personales son mayores de un millón de dólares al año.

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
Ley de Servicios de Salud Mental
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**



Información sobre la audiencia pública

Jueves, 5 de junio, 2014

County of San Bernardino
Health Services, Auditorium
(antes conocido como el
Behavioral Health
Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

**La reunión de la
comisión de salud
mental será realizada
de
12:00 p.m. - 2:00 p.m.**



NEWS

From the County of San Bernardino
www.sbcounty.gov



FOR IMMEDIATE RELEASE

May 29, 2014

For more information, contact
Michelle Dusick, Acting MHSA Coordinator
Department of Behavioral Health
909-252-4046
mdusick@dbh.sbcounty.gov

You are invited to attend a public hearing regarding the county's Mental Health Services Act (MHSA) Three-Year Integrated Plan for fiscal years 2014/15 through 2016/17

- WHO:** All DBH department staff, county departments, community and faith based organizations, and community members interested in enhancing mental health services for children and youth with serious emotional disturbance and adults and older adults with serious mental illness.
- WHAT:** The Three-Year Integrated Plan depicts the progress made by the Department of Behavioral Health and our contracted partners in providing behavioral health services over the past nine years.
- WHY:** This public hearing is being held to provide information regarding the MHSA Three-Year Integrated Plan for the County of San Bernardino for fiscal years 2014/15 through 2016/17.
- The public hearing will provide community members the opportunity to participate in the MHSA Three-Year Integrated Plan stakeholder process and receive an overview of the Community Program Planning process for the County of San Bernardino. In addition to the overview, there will be time set aside for attendees to ask questions and share comments and/or concerns regarding the stakeholder MHSA Three-Year Integrated Plan.
- The public hearing will be an agenda item during the regularly scheduled Behavioral Health Commission Meeting.
- WHEN:** Thursday, June 5, 2014
12:00 p.m. to 2:00 p.m.
- WHERE:** County of San Bernardino Health Services Auditorium
Formerly the Behavioral Health Resource Center (BHRC)
850 E. Foothill Blvd.
Rialto, CA 92376

CONTACT: For additional information, please contact Michelle Dusick at (909) 252-4046 or mdusick@dbh.sbcounty.gov.

For special accommodations or interpretation needs please call 1-800-722-9866.

-END-

NOTICIAS

Del Condado de San Bernardino
www.sbcounty.gov



PARA PUBLICACION INMEDIATA

29 de mayo de 2014

Para más información, comuníquese con
Michelle Dusick, Coordinadora Actuante de MHSA
Departamento de Salud Mental
909-252-4046
mdusick@dbh.sbcounty.gov

Usted está invitado a asistir a una audiencia pública sobre el Plan Integrado de Tres Años MHSA de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para los años fiscales: 2014/15 y 2016/17.

QUIEN: Todo el personal del Departamento de Salud Mental, departamentos del condado, las organizaciones basadas en la fe y en la comunidad, y los miembros de la comunidad interesados en la mejora de los servicios de salud mental para niños y jóvenes con problemas emocionales serios y adultos o adultos mayores con enfermedades mentales graves.

QUE: El Plan Integrado de Tres Años representa el progreso realizado por el Departamento de Salud Mental y de nuestros proveedores contratados en la prestación de servicios de salud mental en los últimos nueve años.

POR QUE: Esta audiencia pública se llevará a cabo para proveer información sobre el Plan Integrado de Tres Años MHSA para el Condado de San Bernardino para el año fiscal 2014/15 hasta 2016/17.

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 Integrado de Tres Años MHSA. Además, habrá tiempo para que los asistentes hagan preguntas y compartan sus comentarios y/o dudas por lo que se refiere al Plan Integrado de Tres Años MHSA.

La audiencia pública será un punto en el orden del día durante la reunión de la Comisión de Salud Mental.

FECHA: Jueves, 05 de junio 2014 de 12:00pm- 2:00pm.

LUGAR: County of San Bernardino Health Services Auditorium
Antes conocido como el Behavioral Health Resource Center
850 E. Foothill Blvd.
Rialto, CA 92376

CONTACTO: Para información adicional, por favor comuníquese con Michelle Dusick al (909) 252-4046 o mdusick@dbh.sbcounty.gov.

Para acomodación especial o necesidades de interpretación por favor llame al 1-800-722-9866.

-FIN-