SAN BERNARDINO COUNTY

MENTAL HEALTH SERVICES ACT (MHSA)

THREE-YEAR PROGRAM and EXPENDITURE PLAN

COMMUNITY SERVICES AND SUPPORTS

Fiscal Years 2005-06, 2006-07, 2007-08

February 7, 2006
COMMUNITY SERVICES AND SUPPORTS PLAN
EXECUTIVE SUMMARY

Background

In November 2004, California voters passed Proposition 63, which imposed a 1% tax on adjusted annual income over $1,000,000. The proposition was enacted into law as the Mental Health Services Act (MHSA) effective January 1, 2005. According to the language in the MHSA, the overall purpose and intent is “to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...to insure that all funds are expended in the most cost effective manner...to ensure accountability to taxpayers and to the public”. This purpose of the Act is to be accomplished by providing funding that would adequately address the mental health needs of the unserved and underserved populations by expanding and developing the types of services and supports that have proven to produce successful outcomes, considered to be innovative, cultural and linguistically competent, community-based, consumer and family centered, and consistent with evidence-based practices.

The vision, as established by the California Department of Mental Health (DMH) who has the responsibility to implement the MHSA through the state, is to “create a state-of-the-art, cultural competent system that promotes recovery/wellness for adults and older adults with serious mental health illness and resilience for children and youth with serious emotional disorders and their families”. The State Department continues that the focus of this vision is to go beyond “business as usual” approaches, and to transform from a “fail-first to help-first” system of public mental health services at the county level. The MHSA calls for five essential elements that are necessary in California to transform the public mental health system which are: community collaboration, cultural competence, client/family driven system of care, wellness focus, and integrated seamless service experiences for clients and families.

The MHSA also requires each county to implement programs that achieve the following outcomes from the services provided:

- Decrease racial disparities, hospitalization, and incarceration
- Increase in timely access to care and treatment
- Decrease out-of-home placements
- Decrease homelessness
- Meaningful use of time and capabilities
The MHSA identifies six primary program components for funding that are critical in rooting this transformational process. These components are:

- Local/County Community Planning
- Community Services and Supports
- Capital (buildings and housing) and Informational Technology
- Education and Training (human resources)
- Prevention and Early Intervention
- Innovation

The County’s Three-Year Community Services and Supports Plan (CSS) is the second component to be implemented by the California Department of Mental Health (DMH). Through a very comprehensive community planning process, San Bernardino County Department of Behavioral Health (DBH) has completed its CSS Plan that is consistent with the intent and essential elements as required by the Mental Health Services Act of 2005.

As required by the Local/County Planning program component under the MHSA, $557,746 in planning funds was distributed to San Bernardino County from the DMH to implement a community planning process to develop a three-year comprehensive plan for improving mental health services and supports for specific target populations (children, transitional age youth, adults, and older adults) identified in the Act. The Board of Supervisors approved submission of the DBH’s “Plan to Plan” to the DMH on February 15, 2005.

The DMH, in their instructions, proposed a planning model in which counties would: (1) identify issues resulting from untreated mental illness, (2) analyze the mental health needs in the community, (3) identify populations for Full Service Partnerships, (4) identify program strategies to meet the needs, (5) assess capacity to expand current programs and implement new strategies, and (6) develop work plans with timeframes and budgets/staffing. The San Bernardino County CSS Plan employed this approach in conducting its planning process.

San Bernardino County’s unprecedented county-wide collaborative planning effort over the last number of months has reached out to approximately 3,000 county residents in order to engage their thoughts, beliefs, concerns, needs, preferences, and creativity ideas on the types of programs and services that would address the mental health needs of our communities. This planning activity was accomplished through the completion of need assessment surveys (English, Spanish, and Vietnamese), participating in community public forums, focus groups, age specific work groups, and a mental health stakeholders advisory group. The County’s community planning process was developed and accomplished according to the instructions and requirements provided by the DMH.

However, there were specific guidelines that DMH imposed on the content of the plans prepared by all counties. For example, DMH requires that more then 50% of the funding
be used for Full Service Partnerships (FSPs). FSPs are programs where a small caseload of clients are assigned to a single case manager who is responsible for ensuring that the clients have access to “whatever it takes” to foster resiliency and recovery. Clients in an FSP have access to someone to provide assistance 24 hours a day, seven days a week. The County’s CSS Plan meets that requirement. DMH also established two other funding categories under the MHSA, System Development and Outreach and Engagement. System Development Funds may be used to improve programs, services, and supports; Outreach and Engagement funds maybe used to conduct activities to reach unserved populations to engage them into services.

The three fiscal years covered by the County’s CSS Plan are 2005-06, 2006-07, and 2007-08. It is expected that San Bernardino County will receive approximately $17.2 million in each of these years. Because a substantial part of the first year was needed for completing the required planning process, DMH has allowed counties to prorate the program funding for Year 1, based on the actual number of months that services will be offered. The DBH is estimating only three months of program costs for services provided under this CSS Plan. However, counties may request the remainder of the first year funding as one-time-only funds to be used for additional planning efforts and system improvement activities (contract development, staff, consumer and family training, housing development, and work force development) to prepare for implementation of the programs and services as proposed in the CSS plan. On January 24, 2005, the Board of Supervisors approved DBH’s proposal to the DMH for use of these one-time-only funds.

The MHSA CSS Plan was endorsed by the stakeholder group, the Community Policy Advisory Committee (CPAC), on December 8, 2005. As part of the planning process, through consensus, the CPAC agreed on the percentage allocation of this year’s MHSA funds for each of the four age groups. The distribution is 19% for Children and Youth, 24% for Transitional Age Youth, 43% for Adults, and 14% for Older Adults

The MHSA CSS Plan was posted for public comment on December 13, 2005. Copies of the Plan were placed at all the DBH clinics and programs and distributed to all the public libraries throughout the county. After the required thirty-day public comment period, the San Bernardino County’s Mental Health Commission held three public hearings: one in Victorville (January 17th), one in Yucca Valley (January 18th), and one in the City of San Bernardino (January 19th) on the CSS Plan. The Mental Health Commission will conduct their final review of the CSS Plan on February 2, 2006, and on February 7th, 2006 the San Bernardino County Board of Supervisors will have their final review.

County/Community Public Planning Process (Part I, Section I)

San Bernardino’s County Department of Behavioral Health embarked on a very comprehensive community planning process which was an open, participatory and inclusive of all major mental health stakeholders, including identified populations who are historically isolated, disenfranchised and underserved. DBH will continue in
reaching out and attempting to engage these populations. Special attention was
directed by DBH to encourage the meaningful participation of consumers and family
members, unserved racial/ethnic groups, and marginalized populations in the planning
process. This effort was supported through a number of mechanisms, including
stipends, transportation, childcare, translation services, and refreshments at meetings.
The Co-Chair of the CPAC was a consumer and is a member of the County’s Mental
Health Commission. In June, July, and August 2005 DBH conducted six community
public forums that were held in four major geographical regions of the county in order to
publicize the “kick off” of the MHSA program planning process, orient the general public,
distribute written materials, and invite further participation from the community.

Through a contractual agreement with the California Institute for Mental Health,
planning process participants were provided broad-based training on topics including,
but not limited to, the Mental Health Services Act, the current public mental health
system, cultural competence, wellness/recovery/resilience, the local planning process,
DMH implementation guidelines, identification of service gaps, and evidence-based
practices. In addition, a special one-day workshop on the role and responsibilities of the
Mental Health Commission under the MHSA was conducted for the commissioners and
staff.

Age Specific Workgroups were established for each of the DMH required target
populations, and a 79 member community stakeholder group was established in
October that was composed of consumers, family members, community leaders,
agency representatives, service providers and other interested parties (e.g. law
enforcement, social services, education, the Office on Aging and the faith-based
community) to provide leadership in the decision-making process. Input was provided
by 120 focus and stakeholder groups and to date 1863 surveys have been received and
analyzed from the community. In addition, MHSA outreach staff went to homeless
shelters, clubhouses, and clinics to interview individuals and families. Again, a total of
approximately 3,000 community residents participated in San Bernardino County’s
MHSA planning activities, demonstrating strong public involvement and support for the
CSS Plan.

**County/Community Public Planning Process (Part II, Section I)**

Through the community planning process, San Bernardino County identified priority
community issues that formed the foundation for preparation of the CSS Plan and
various program proposals for each specified age range. Although a comprehensive list
of issues was identified by the community, the following table displays the critical issues
to be addressed in the first three years by the County’s CSS plan:
### Priority Issues by Age Group

<table>
<thead>
<tr>
<th>CHILDREN/YOUTH</th>
<th>TRANSITIONAL AGE YOUTH</th>
<th>ADULTS</th>
<th>OLDER ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. School failure</td>
<td>2. Institutionalization and incarceration*</td>
<td>2. Frequent hospitalizations and emergency room visits*</td>
<td>2. Frequent hospitalizations, episodes of emergency care, and incidents of relapse to previous behavior*</td>
</tr>
<tr>
<td>3. Involvement in the child welfare system and juvenile justice systems*</td>
<td>3. Frequent hospitalizations and emergency room visits*</td>
<td>3. Inability to work*</td>
<td>3. Inability to manage independence*</td>
</tr>
<tr>
<td>5. Alcohol and drug problems experienced by youth and families dealing with mental illness*</td>
<td>5. Inability to work*</td>
<td>5. Institutionalization and incarceration*</td>
<td>5. Isolation*</td>
</tr>
</tbody>
</table>

*Priority Issues to be addressed in the first three years.

### Mental Health Needs and Disparities (Part II, Section II)

The Department of Behavioral Health prepared a detail analysis of available data to fully understand the scope of mental health needs among the four age specific target populations. The community workgroups reviewed and discussed the analysis, which included estimates of the unserved, underserved, and inappropriately served individuals in the county. This analysis included the four regions that are part of the large geographical area of the San Bernardino County Mental Health System which are: Central Valley, Desert/Mountain, East Valley/San Bernardino, and West Valley.

The estimate of prevalence for severe mental illness in the population is 9% of those living under 200% of the federal poverty level, or 64,435 persons. Of these, approximately 29,635 persons from all age groups are considered unserved by the
public mental health system in San Bernardino County. However, of the 34,800 who are considered to be served in some capacity (fully served, underserved, or inappropriately served), only 9,542 are in the category of fully served. Thus it can be concluded that approximately 54,893 persons in the county remain in need of some level of mental health intervention and services.

As discussed in Part II, Section II of the CSS Plan for each age category, significant racial and ethnic disparities exist among the number of persons unserved, underserved, or inappropriately served by the present public mental health system. To increase equal access to culturally competent mental health programs and service outcomes for racial and ethnic populations in the county is a critical service delivery issue for the DBH.

According to California Department of Finance estimates for 2005, San Bernardino County has a total population of 1,942,091 with a projected population in the next three years of 2,083,637 people in the county. The current breakdown of the population into racial and ethnic categories is: Euro-Americans 30%, Latinos 50%, African-Americans 10%, Asian-Americans 7%, Native-Americans 1%, and all others 2%.

In reviewing the racial and ethnic data for the 29,635 people presently not receiving any level of services from the mental health system, the percentage of Latinos 44%, Euro-Americans 28%, African-Americans 17%, Asian-Americans 6%, Native-Americans 1% and all others 3%. In further analysis of the data for children and youth between 0 and 25 years of age, approximately 60% are Latinos who are considered unserved by the system.

Unserved populations in San Bernardino County

Children & Youth, ages 0 - 15
Refinements of these estimates indicate that 60% (5,314) of the children in need but unserved in our county are Latinos; 18% (1,567) are African-Americans, 10% (868) are Euro-Americans, and the remaining 12% (1,102) are of other and/or multiple ethnicities. By region, 9% of the unserved children live in the Central Valley, 11% in the Desert/Mountain, 24% in the East Valley/San Bernardino, and 56% in the West Valley.

Transition Age Youth (TAY), ages 16 - 25
About 63% (3,468) of the unserved TAY in our county are Latinos; 18% (1,006) are African-Americans, 7% (412) are Euro-Americans, and 12% (660) are of other or multiple ethnicities. By region, 6% of the unserved TAY are in the Central Valley, 20% in the Desert/Mountain, 12% in the East Valley/San Bernardino, and 62% in the West Valley.

Adults, ages 26 - 59
Among adults, 36% (3,312) are Euro-Americans, 34% (3,095) of the unserved in our county are Latinos; 20% (1,828) are African-Americans, and 10% (1,003) are of other and/or multiple ethnicities. By region, 8% of the unserved adults are in the Central
Valley, 13% in the Desert/Mountain, 14% in the East Valley/San Bernardino, and 65% in the West Valley.

**Older Adults, age 60 and over**

For older adults who are unserved, 64% (3,833) in our county are Euro-Americans; 19% (1,129) are Latinos, 12% (716) are African-Americans, and 5% (322) are of other and/or multiple ethnicities. By region, 9% of the unserved older adults are in the Central Valley, 32% in the Desert/Mountain, 27% in the East Valley/San Bernardino, and 32% in the West Valley.

**Identifying Initial Populations for Full Service Partnerships (Part II, Section III)**

San Bernardino County’s CSS Plan is proposing Full Service Partnerships (FSP) for all age groups by the third year. In the third year (2007-2008), 71% of the County’s allocation of MHS funds will be directed to FSPs. Below is a brief description by age group of the situational characteristics of the priority populations to be served by the various mental health programs under the FSP funding category.

**Populations for Full Service Partnerships**

<table>
<thead>
<tr>
<th>Children and Youth (0-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Those children and youth who have serious emotional disturbances</td>
</tr>
<tr>
<td>▪ Those children and youth having problems at school or at risk of dropping out</td>
</tr>
<tr>
<td>▪ Those children and youth at risk of, or are involved in the juvenile justice system</td>
</tr>
<tr>
<td>▪ Those children and youth in need of crisis intervention and /or at serious risk of psychiatric hospitalization</td>
</tr>
<tr>
<td>▪ Those children and youth at risk of residential treatment or are stepping down from residential treatment</td>
</tr>
<tr>
<td>▪ Those children and youth who are homeless or at risk of homelessness</td>
</tr>
<tr>
<td>▪ Those children and children who are high users of service; multiple hospitalizations/institutions</td>
</tr>
<tr>
<td>▪ Those children and youth who are uninsured</td>
</tr>
<tr>
<td>▪ Those children and youth who are at risk due to lack of services because of cultural, linguistic, or economic barriers</td>
</tr>
<tr>
<td>▪ Those children and youth at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse.</td>
</tr>
<tr>
<td>▪ Those children and youth with co-occurring disorders</td>
</tr>
</tbody>
</table>
### Transitional Age Youth (16-25)

- Those transitional age youth who have serious mental illness or serious emotional disturbances
- Those transitional age youth who have repeated use of emergency mental health services
- Those transitional age youth who have co-occurring disorders
- Those transitional age youth who are homeless or at risk of homelessness
- Those transitional age youth who are at risk of involuntary hospitalization or institutionalization
- Those transitional age youth who are involved in the juvenile justice system
- Those transitional age youth who are in out-of-home placement or aging out of the foster care system
- Those transitional age youth who are recidivists of the mental health system who have functional impairment

### Adults (18-59)

- Those adults who are seriously mentally ill
- Those adults who are homeless or at risk of homelessness
- Those adults who have co-occurring substance abuse problems
- Those adults who are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system
- Those adults who are recently discharged from psychiatric hospitals
- Those adults who are frequently hospitalized or are frequent users of emergency room services for psychiatric problems
Older Adults (60 and older)

- Those older adults who have serious mental illness
- Those older adults who are homeless or at risk of homelessness
- Those older adults who are unserved, underserved, or inappropriately served in the mental health system
- Those older adults who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
- Those older adults who have reduced personal and/or community functioning due to physical and/or health problems
- Those older adults who have co-occurring substance abuse problems
- Those older adults who are isolated and at risk for suicide due to stigma surrounding their mental health problems

Community Services and Supports Program Strategies (Part III, Section IV; Exhibit 4s)

The County’s CSS Plan contains nine separate programs that were developed based on the five planning elements required by the MHSA. There is the Comprehensive Child/Family Support System for Children and Youth which has four primary service areas; comprehensive Transitional Age Youth Center for Transitional Age Youth which has six major service components; four programs for Adults, two for Older Adults, and one program for the Crisis Walk-In Centers, that “cuts-across” all of the age groups in the county. It is being planned by the DBH over the next three years that approximately 12,381 individuals will be served by the various programs and services.

The expected outcomes for these funded programs, which are consistent with the goals of the MHSA, are to:

- Reduce the subjective suffering of serious mental illness for adults and serious emotional disorders for children and youth
- Reduce homelessness; increase safe/permanent housing
- 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 the number of multiple out-of-home placement for foster care youth
- Reduce criminal and juvenile justice involvement
- Reduce frequent emergency room visits and unnecessary hospitalizations
- Increase a network of community support services
The CSS Plan also includes a description of “start-up funding” being requested from the 1st Year allocation for the activities that support the effective implementation of the programs (Housing, Information System Improvement, Program Start-up Costs, Capital Purchases, and Training and Education) under the CSS Plan.

Below is a brief summary by age group of the programs for which MHSA funding is being requested. Although all of these programs will be provided in the first three years, because of the availability of one-time-only funds in the first year, program implementations may vary slightly in Years 2 and 3.

**Children & Youth (CY) – Two Programs**

1. **Children’s Wraparound Service Model**

   The Comprehensive Child/Family Support System (CCFSS) will establish a “seamless” system of care to children and families in San Bernardino County to negotiate multiple agencies and funding sources. The goal is to coordinate and access services for families with children that suffer with emotional disturbances. San Bernardino County currently works with the Department of Children’s Services, Juvenile Justice, schools, Regional Centers, Law Enforcement, faith-based agencies, community agencies and stakeholders. The CCFSS plans to broaden those relationships to include law enforcement, domestic violence shelters, and preschool programs. The CCFSS will work with the population, ages 0-15. The plan is to serve **270** children and, youth, plus their families over the three-year period. CCFSS will provide full service partnerships and 24/7 services for children, youth and families that have been unserved or underserved through a Wraparound service model.

2. **Children’s Crisis Response Teams**

   Currently San Bernardino County has one Children’s Crisis Response Team (CCRT) that operates from 8 a.m. to 10 p.m. The expanded CCRT under MHSA will support the CCFSS program as well as provide needed crisis response within the county. Crisis Response services will be expanded to three additional regions. These services will help reduce hospitalizations, out-of-home placements, and help children and youth remain and return to their families. The program services will increase stabilization, independence, help families identify community supports, and encourage resiliency and wellness. With the expansion of the CCRT it is expected that we will serve 25% more children and TAY, which translates to **200** more clients.

**Transitional Age Youth (TAY) – One Program**

1. **One Stop TAY Integrated Services Center**

   The Transitional Age Youth Integrated Services Center will be a community-based, consumer-centered program where individualized, consumer-driven service plans are developed and implemented. It will focus on consumer strengths and meet the needs
of transitional age youth and, in many cases, their families across life domains. This program will promote success in school or work, safety, wellness and recovery through a “whatever-it-takes” approach.

The One Stop Transitional Age Youth (TAY) Centers will assist TAY towards becoming independent, staying out of the hospital or higher level of care, reduce involvement in the criminal justice system, and reduce homelessness. DBH will hire a TAY coordinator who will monitor and provide technical assistance to the centers. Consumers, youth, and their families will be an integral part in the development of age appropriate services that reflect developmental and specialized needs of the TAY population. Adolescents and young adults will be hired to provide services as peer counselors, mentors, and parent partners. The Center will be modeled as a drop-in resource center in order to improve participation. The Centers will serve 345 consumers over the three-year period.

Adult (ADL) – 4 Programs

1. Consumer–Operated Peer-Support and Clubhouse Expansion

Consumer Operated Peer Support

A countywide peer support recovery program will utilize peer education, advocacy, counseling, social and recreational activities, and life skills development to serve 300 adults annually. Two Consumers will be hired to serve as Peer Support Coordinators and coordinate the Office of Consumer and Family Affairs with the long term goal of supporting, coordinating and advocating for system wide Recovery Model planning and implementation.

Clubhouse Enhancement and Expansion

The clubhouses in San Bernardino and Victorville will expand the social and community rehabilitation activities for 300 consumers annually. The expansion will be coordinated from the San Bernardino and Victorville clubhouse sites with outreach to all clubhouses.

2. Forensic Integrated Mental Health Services

Forensic services proposes the expansion of the Crisis Intervention Training Program, the expansion of Mental Health Court treatment to serve an additional 70 consumers annually, and the implementation of a Forensic Assertive Community Treatment program to serve 40 consumers annually. These specialized mental health services will be provided to severely and persistently mentally ill (SPMI) individuals who are involved with the criminal justice system. The Forensic Assertive Community Treatment (FACT) Team will partner with the San Bernardino County Sheriff’s Department West Valley Detention Center (WVDC), San Bernardino County Department of Behavioral Health (DBH), Mental Health Court and the Probation
Department. The Team will be a 24/7, multi-disciplinary team and provide crisis response, case management, peer support, alternatives to hospitalization and incarceration, and housing and employment support and do what ever it takes to assist the consumer in maintaining their independence in the community. The FACT Team will work closely with the Jail Mental Health Services Clinic in WVDC and Mental Health Court to expedite the voluntary participant’s release from WVDC to community treatment resources.

3. **Assertive Community Treatment Team (ACT) for High Users of Hospital and Jail Services**

The program is designed to annually serve 60 SPMI adults who are identified as high users of acute hospital services. The program will provide crisis response, peer support, clinical interventions by staff and consumers, psychiatric services, housing support, employment services and training, and will utilize the "whatever it takes" approach which typifies the Assertive Community Treatment model of community services. Transitional housing, sober living, safe haven housing, and permanent housing will be provided as appropriate.

4. **Psychiatric Triage Diversion Team at County Hospital**

At San Bernardino County's psychiatric hospital, the Department of Behavioral Health (DBH) will provide culturally competent screening and diversion of 300 clients annually who present at the hospital's emergency room in crisis due to homelessness, co-occurring disorders, recent release from incarceration, and medical conditions and who may not be in actual need of hospitalization. A preliminary screening of clients will be provided as they enter the Behavioral Health Unit's ER and the reason for the client's coming to the ER will be determined. The program will divert the client and link the client with existing community resources, which are most appropriate for the client's condition, and ongoing mental health needs.

**Older Adults (OA) – 2 Programs**

1. **CIRCLE OF CARE: System Development-Expansion of AgeWise Senior Peer Counseling Program**

Extend mental health treatment and case management services to older adults in all regions of San Bernardino County. Enhance existing Senior Peer Counseling program with a focus on wellness and recovery that will annually assist 145 older adults in remaining independent and active in their communities and pursuing individualized personal goals for as long as possible. Develop a capacity building component that ensures that staff volunteers and community partners provide client centered and culturally competent services, education and assistance to older adults.
2. **CIRCLE OF CARE: Mobile Outreach and Intensive Case Management**

The **CIRCLE OF CARE**, Mobile Outreach and Intensive case management plan is comprised of two components that will provide services to older adults in the High Desert region, which is a region that has a high percentage of unserved and underserved older adults. The Mobile Outreach program will be comprised of two field-capable multidisciplinary teams, both of which will provide crisis response and crisis prevention services. To launch intensive case management services to seriously mentally ill older adults, a Full Service Partnership (FSP) will be developed for the High Desert region. The FSP will annually provide services for 17 unserved and underserved SMI older adults who are isolated, have the most severe conditions, have a history of repeated emergency health services or several admissions to inpatient services, are at risk for institutionalization, or have been or are at risk of becoming, homeless.

**All Ages - One Program**

1. **Crisis Walk-In Centers**

   Annually, Crisis Walk-In Centers will provide urgent mental health services 24/7 for 3,000 severely and persistently mentally ill (SPMI) persons of all age groups – children, TAY, adults, and older adults – needing immediate access to crisis mental health services. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and this program will provide integrated substance abuse treatment services for dually diagnosed clients. These centers will offer urgent mental health services to the acute and sub-acute mentally ill individuals including crisis intervention, crisis risk assessments, medications, substance abuse counseling, case management, referrals to DBH and contracted clinics, family support and education, transportation, 23-hour crisis stabilization and when required 5150 evaluations.

**Start-Up Activities and One-Time Only Initiatives**

1. **Housing Development Initiative**

   Safe and affordable housing is one of the basic requirements needed in order to promote recovery/wellness for individuals (and their families) with severe mental illness or serious emotional disturbance. Appropriate housing is crucial to maintaining stability in the community for all age specific target populations. For those with very low income and who are homeless, finding safe and affordable housing in San Bernardino County is a real challenge. This housing program will include a flexible pool of money in a housing trust fund to support the members of full service partnerships. A continuum of housing will be developed that will include
short-term transitional, supportive, and permanent housing. One-time funds ($3,975,000 over three years) will be used for short term lodging in shelter slots, motel vouchers, transitional housing, shared group housing, augmented residential care facilities, rental subsidies for permanent supportive housing, security deposits and other potential housing assistance. Funds will be available for housing specialists that can assist in locating housing resources and successfully obtaining housing for individuals and families. Housing will be developed and provided in a culturally sensitive manner, with special attention paid to language, ethnicity, gender, and client culture.

2. **Training and Education**

San Bernardino County is requesting a total of $2,193,533 for a comprehensive staff development program. Staff development is essential for any system of care that aspires to provide treatment services that are culturally appropriate, mindful of the interaction between substance abuse and psychological problems and based in true recovery principles.

A comprehensive staff development program is proposed that will enhance the quality of services and activities on behalf of: existing departmental staff, interns in psychology, social work, marriage and family therapy, occupational therapy, nurses, psychiatric technicians, and psychiatrists in training as well as consumers who are hired by DBH as consumer employees or consumers who volunteer to participate in client activities in a leadership roles on various departmental committees.

Research shows that clinician bias and stereotyping leads to misdiagnosis, discriminatory practices and inappropriate or inadequate treatment. Services that are delivered by a well trained, culturally empathic and recovery principled manner will result in greater treatment outcomes for a greater number of clients.

The ability of DBH to train the new and existing workforce to utilize evidence-based practices will increase the likelihood of:

- Increased employee job satisfaction
- Increased consumer satisfaction with improved treatment outcomes
- Positive employee morale
- Increased public trust
- Increased departmental integrity
- Increased community respect
- Positive employee morale leading to a culturally diverse workforce of competent and highly trained employees

3. **Information System Improvement**

San Bernardino County is requesting a total of $2,264,916 for improvements and extensions of our information system are necessary under the MHSA in order to
adequately support the development, operation, and accountability of new and expanded programs. DBH plans to improve data collection, access, and storage capabilities by implementing an electronic behavioral health record system and information analysis software, and will set up user-friendly information collection and feedback points at various service locations in the county. The data specifically required by the State will include the reporting of key events such as hospitalizations, significant changes of housing or caretaker relationships, etc. In addition, a major upgrade of the existing services and episodes database is anticipated within the next two years.

4. **Program Start-Up**

San Bernardino County is requesting a total of $1,267,311 in the following two areas of funding under the start-up funding available as outlined by the California Department of Mental Health (DMH):

1. Extension of Community Planning
2. System Improvement Funding

The Extension of Community Planning and System Improvement funding requests are as follows:

**I. Additional Community Program Planning Funding ($858,410):**

On September 2, 2005, DMH informed counties that they could request additional planning funds of up to 5% of the counties initial 2005-06 estimated program allocation. The additional funds would finance continued planning activities during the 3-month State review and approval process following the county’s submission of its 3-year CSS plan. San Bernardino County’s 2005-06 program allocation estimate is $17,168,200; therefore, DBH may apply for an additional $858,410 in planning funds.

When the State approves DBH’s request for additional planning funds, DBH will provide continued coordination of the MHSA planning process, coordinate and implement our housing initiative, develop statistical information for determining outcomes, provide fiscal and administrative support, develop consumer training modules, and provide outreach services.

Planning funds will continue to fund other operating costs associated with outreach, training, focus groups, public forums, surveys, statistical analysis, and to reimburse travel, meals, conference and other costs for consumers and other stakeholders participating in the planning process.
II. System Improvement Funding ($408,901):

On September 2, 2005 DMH also informed counties that they could request funding for system improvements and other expenditures necessary to support the CSS plan. This funding can be utilized during the State’s review and approval process of DBH’s 3-year CSS plan. It is anticipated that San Bernardino County's 3-year CSS plan will be submitted to the State in February after Board approval. Types of allowable system improvement activities include, but are not limited to: RFP development, issuance and review, and all necessary HR activities to recruit personnel for the proposed MHSA programs and services.

DBH is requesting $408,901 in system improvement funds. These funds will be used to hire staff to begin developing, reviewing, and issuing RFPs for new and expanded contracted services, provide outcome development and planning, develop training modules for resilience and recovery, expand cultural competency training, and create and coordinate an internship program with local universities. In addition to staffing, the system improvement funding will be used to fund HR costs to recruit service personnel needed for the proposed MHSA programs and services. These costs could include advertising, HR staff time, possible hiring incentives, nationwide recruitments, etc.

5. Capital Purchases

San Bernardino County is requesting $4,033,800 to be utilized for capital purchases for all ten programs to be funded and implemented under the MHSA. Capital Purchases include items such as cars, copiers, computers, furniture, office rents, etc. that are required tools to operate the programs requested in the county’s three year CSS.

Conclusion

The development and preparation of the San Bernardino County’s Community Services and Supports Plan resulted from a very concentrated planning process and intense effort by a large group of consumers, family members, service providers, county agencies, and representatives of interested organizations throughout the county. The primary objective of this planning effort was to develop community mental health program strategies that would expand and increase services for those individuals and families who are the most unserved and underserved by the present public mental health system, especially those who have not traditionally had access to the existing programs.

The CSS Plan being proposed to the DMH for funding under the MHSA cannot meet the increasing demand services and backlog of unmet mental health needs in our communities. However, it can begin to “jump-start” the transformation process in San Bernardino County by enhancing the continuum of services currently available and increasing access to care for racial and ethnic populations that have traditionally been unserved or underserved. The community planning process and the County’s
CSS Plan for using the MHSA funding has also brought intangible benefits to the local community and its residents. Renewed hope has been created for individuals and families affected by mental illness because they have been empowered to have a more meaningful voice in the planning and development of the needed programs and services for their loved ones. Another major benefit resulting from this process has been the involvement among the various community stakeholders in the county who came to the table to contribute their knowledge, experience, creativity and support for the collaborative development of the CSS Plan. This involvement will further the goals and intent of the MHSA for our county and provide the necessary impetus to transform the mental health system from a “fail first to help first” public system of care that truly addresses the mental health needs of the entire community. The future will look different because it is not “business as usual”!

February 7, 2006
Thank you for your interest in San Bernardino County's effort to transform the local mental health service system through an ongoing and community-driven program planning process. Please share your comments using this form by January 12, 2006. This form can be mailed to: Mental Health Services Act Coordination Team, 820 East Gilbert St., San Bernardino, CA 92415. The form can be emailed to elongfellow@dbh.sbcounty.gov.

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<th>25-59 yrs.</th>
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<th>Consumer of Mental Health Services</th>
<th>Law Enforcement</th>
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<th>Community Agency</th>
<th>Faith Community</th>
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<th>Health Provider</th>
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<th>Somewhat Satisfied</th>
<th>Satisfied</th>
<th>Unsatisfied</th>
<th>Very Unsatisfied</th>
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Please discuss the things in the CSS Plan that you found to be positive. Please note the specific age group and program affected, if relevant.

What concerns and recommendations do you have regarding the CSS Plan? Please note the specific age group and program affected, if relevant.

Thank you again for taking the time to review and provide input on the County’s Community Services and Supports program expansion funding proposal. We hope that you will continue to participate in this exciting effort to enhance services for our county’s residents!

Additional forms are available on the web at www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
# SAN BERNARDINO COUNTY
Mental Health Services Act (MHSA)
Three-Year Program and Expenditure Plan
Community Services and Supports
Fiscal Years 2005-06, 2006-07, 2007-08

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Introduction

San Bernardino County Department of Behavioral Health (DBH) has faced many challenges in the last few years. Large budget deficits realized in FY 02/03 resulted in the closure of four clinics and a reduction in the workforce from 734 funded mental health positions to 631 funded positions in FY 04/05. Also, during this critical time DBH saw a significant change in leadership and had no permanent director for fifteen months. Despite these setbacks, DBH has provided innovative services based on the evidence-based practices and the core values of Recovery, Wellness, Resiliency and Cultural Competency.

DBH continues to face the challenge of providing services in the largest geographical county in the United States. San Bernardino County has an area of 20,052 square miles. This is more than the combined area of all San Francisco Bay Area counties, including, Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, as well as Los Angeles, Orange and San Diego counties.

Mental health services are organized into two groups: Children’s and Family Services, and Adult Services. DBH currently operates fourteen Community Outpatient Clinics, eleven of which are integrated service sites for adults, children, TAY and families. The clinics are located throughout the county and, in collaboration with over twenty contractors, provide assessments, individual, group and family therapy, medication support, crisis intervention, and case management in clinics, schools and community settings. Along with the community service sites, the department has specialized services for children, TAY and adults.

In 2001 DBH trained department and contract agency staff on the concepts of Recovery and Wellness. Soon after the training phase was complete, efforts began to engage department and contract clinics to move from concept to action. The programs described here demonstrate DBH’s commitment to the concepts of Recovery and Wellness.

Cultural Competency

The Cultural Competence and Training Unit is currently providing the overall direction and focus on the implementation of the DBH Cultural Competence Plan. The DBH Cultural Competence Plan Update, submitted to the state in May 2004, was one of the few plans that scored in the range of 85-100 points, out of 100 possible points. By implementing this plan, the county is able to address access barriers, differing penetration rates, and develop a system of care that incorporates appropriate cultural and linguistic treatment services. The Cultural Competence Committee serves as an
advisory group to DBH’s programs and services that will assure cultural competence is embedded in critical policy, strategy, and in the planning and delivery of mental health services. This committee is comprised of representatives from DBH, contract agencies, consumers and family members, mental health commission, and the community. Two subcommittees comprised of consumers and family members, English and Spanish, were created to promote consumer and family member participation and to develop strategies necessary to increase the numbers of consumers and family members involved at all levels of the organization.

**Children and Family System of Care**

San Bernardino County DBH provides an array of services to children, youth and families. These services were designed to meet the mental health needs of specific children and youth populations that span across the county’s large geographic regions. The department is also keenly aware of the importance of cultural competency as it relates to service delivery in each region. It is the department’s intention and commitment to train staff on an ongoing basis, conduct focus groups in the community with various ethnic populations at sites that are common to their environment, and integrate the information that is learned into program development. These steps will ensure adequate, appropriate, linguistically sound access to mental health care in our county for all populations.

The department is aware of the unmet needs of Latinos, African-Americans, Asian-Americans and others. DBH has made a commitment to encourage family involvement through the Parent Partner Program. DBH is interested in growing this program so that there will be more consumer representation in all regions in service delivery planning and implementation. DBH has established long-standing collaborative relationships with the Children’s Network, Human Services, Public Health, public schools, the Probation Department, Juvenile Court Judges, District Attorneys, Public Defenders, hospitals, and an assortment of community faith-based and local agencies. These joint endeavors form DBH’s public mental health system. The results of these cooperative relationships are demonstrated in DBH’s service delivery systems.

The Children’s Crisis Response Team (CCRT) works with police, hospitals, schools, group homes, family members, Department of Children’s Services, and others providing services to children at risk of hospitalization. This mobile crisis response program evaluates children/adolescents experiencing psychiatric emergencies, conducts Welfare & Institutions Code 5585 assessments, coordinates psychiatric hospital stays and provides hospital aftercare services to youth and their families. Since the CCRT began operating in May of 2004 there have been 1,334 calls received. Sixty-three percent, or 840 have resulted in avoidance of hospitalization. In addition, there is an Emergency Response Team located in the High Desert Region that provides services to children and adolescents. The team responds to calls from hospitals, family members, foster parents and community agencies. It was clear in the community planning for MHSA that this is a necessary service to expand in order to meet the very complex needs of families that struggle with children that are severely emotionally disturbed.
Centralized Children’s Intensive Case Management Services (CCICMS) provides collaborative services with the schools and the Department of Children’s Services for children and youth in need of intensive case management and placement services who qualify for AB 2726 service delivery. This unit also provides case management and oversight to both in and out of state residential placements and minors placed in contract group homes. CCICMS staff chair weekly Interagency Placement Council meetings to determine appropriate placements, develop discharge plans, and refer for (SB 163) wraparound services. There are currently 200 slots for children and youth to receive wraparound services. However, there are many children and youth who do not qualify for wraparound services as defined by SB 163. These children and youth will be targeted by the MHSA plan to increase stabilization and reduce out-of-home placement.

The Healthy Homes program is another joint program with the Department of Children’s Services (DCS) that conducts strength-based assessments, encourages community referrals, and provides case management for all foster children referred by DCS. This program serves the entire county. Since its implementation, program staff have assessed 1,507 foster children and referred 866 of those for additional mental health services.

For more than two years, a partnership of public and private agencies has worked together to develop the Screening, Assessment, Referral and Treatment (SART) program. In September 2005, DBH contracted with a local SELPA (Special Education Local Planning Areas) in the desert region for assessments of the birth to age five population of children with prenatal drug exposure. DBH is expecting great results from this joint endeavor in the increased readiness of the birth to age five population when they reach school age.

Included in the DBH Mental Health Plan (MHP) are three teams of therapists and psychiatrists that provide mental health services to youth incarcerated in the three San Bernardino County Juvenile Halls: East Valley Juvenile Justice Outpatient Programs (JJOP), West Valley San Bernardino Juvenile Evaluation Treatment Services (JETS) and the High Desert Detention Center in Apple Valley. The teams provide mental health assessments, brief therapy, medication support services, crisis intervention, interagency services/collaboration, and case management. DBH provides services to more than 50 youth per week. This service was identified in the MHSA service planning as a program that should be expanded to include wraparound case management. Currently DBH staff is working with the Juvenile Court Judges to implement a Mental Health Court system and with the Probation Department to increase the services to incarcerated youth and those being discharged from Juvenile Hall.

The Children’s Home and Hospital Program provides intensive case management services to children/adolescents who have had psychiatric hospitalizations. The program’s mission is to prevent re-hospitalizations, improve client functioning, maintain children in the community, and avoid costly acute care. Funding saved from this program is redirected to the enhancement and expansion of other children's programs
that will better maintain children in the community. There are four children’s intensive in-home support programs.

**Families in Transition (FIT)** in the East and Central Valley regions, **PROJECT AFFIRM** in the West Valley region, **Family Intervention and Community Support (FICS)** in the High Desert region and **Pacific Clinics** in the Mid Desert region are teams that provide children and families with support and resources for keeping children at home, in school, out of trouble and out of harm’s way. The teams use a strength-based approach to assess children and help them identify their resiliency. The services of the program are prevention, case management, family therapy, medication support, accessing community resources and managing barriers to adequate and appropriate health care.

Unlike many California County governments' Alcohol and Drug Services (ADS), San Bernardino County has three **Perinatal Programs** that provide intensive outpatient drug and alcohol treatment as well as childcare while parents attend groups. Each site has more than 50 pregnant and parenting mothers enrolled in the program. These programs have been successful in reuniting mothers with their children and increasing recovery and wellness. DBH’s plan is to add therapeutic nursery services and increase the mental health services at all sites.

**Adult Services**

One demonstration of DBH’s commitment to Recovery and Wellness is the **Pathways to Recovery**, a peer support group based at the Behavioral Health Resource Center (BHRC). This peer support operation is 100% consumer and family member driven to provide support to each other while on the recovery journey. Pathways members are involved in activities planning, MHSA planning, system improvement meetings, group facilitations, psycho-educational seminars and trainings. An example of their recovery and empowerment has been the development and implementation of a computer-training center in BHRC. Using decommissioned computers, they provide peer-to-peer computer skills classes with a focus on job readiness. There has been tremendous personal growth in those who have participated in Pathways. Pathways is about transition, as stated in their newsletter – “it’s about being able to move on when the consumer is ready, whether that means moving into their own apartment or getting a job”. Pathways provides support as the client readies for change.

Consumers are also actively involved in another program, the clubhouses. There are six clubhouses spanning all geographic regions of the county. These clubhouses are consumer-operated endeavors that are modeled on the Fountain House model. The clubhouse that paved the way for others is the **T.E.A.M. (Trust, Encouragement and Motivation) House**. Consumers are in charge of activities at the T.E.A.M. House, including running numerous groups, staffing the reception area, operating a clothes closet, cooking, and engaging peers in recreational activities. The T.E.A.M. House is an “Official Food Bank” and serves over 700 lunches a month to homeless consumers. Additionally, the T.E.A.M. House provides a basic education class, computer skills classes, and advocacy and health education classes. The vocational program located at
the T.E.A.M. house, which is part of a collaborative with the State Department of Vocational Rehabilitation, has successfully placed 41 individuals in jobs or job training in one year. The T.E.A.M. House has developed into a true recovery center; the grounds also contain the Housing program, the Vocational program, the Homeless program and the AB 2034 program. The Homeless program provides shelter and case management for up to 62 individuals a day. In September 2005 the T.E.A.M. House was the site of the first Homeless Court in San Bernardino County, a cooperative venture between law enforcement, the Probation Department, the courts, the Public Defender’s Office and the District Attorney’s Office.

DBH was awarded an AB 2034 grant in January 2001. The AB 2034 Program was developed to provide integrated services for homeless mentally ill consumers. It was initially contracted to a private provider. In July 2004, DBH assumed service provision for the grant and assigned dedicated staff to the AB 2034 Program. San Bernardino’s AB 2034 program consists of outreach, case management services, a drop-in center, housing, employment preparation, and socialization. DBH contracted with shelter operators in the community to provide shelter, meals, bathing and laundry facilities for homeless mentally ill consumers in home-like environments. DBH monitors contract agencies and shelters to insure that services are being provided in accordance with contractual agreements and for the purpose for which they were designed.

**Housing**

Housing is recognized as a critical element in Recovery and Wellness. The Housing Authority of San Bernardino County and the San Bernardino County Department of Behavioral Health collaborated in 1995 and again in 1997 to write and submit applications for housing grants to the federal Department of Housing and Urban Development (HUD). Shelter Plus Care Program grants were awarded and funded the Laurelbrook Estates Housing Project (1995) and Project Crossroads (1997). The purpose of both grants was to assist the homeless mentally ill and dual diagnosed individuals and families find permanent housing. Since 1997, DBH and the Housing Authority have collaborated on two other Shelter Plus Care projects, New Horizons and Stepping Stones. More than 500 hundred consumers and family members have attained housing through these programs.

**Reduction of Institutional Care**

Significant efforts have been made to provide consumers with alternatives to institutionalization. Since 1998 DBH has reduced its use of state hospital slots from 30 to 16. In 1998, 13 children occupied state hospital slots; currently, there are no children in the state hospital. Moreover, DBH’s use of Institute of Mental Disease (IMD) slots went from 158 in 1998 to 56 in 2005. DBH is committed to “whatever it takes” to keep consumers in the community. DBH’s 2/3 reduction in institutional placements was accomplished by using ACT programs and community alternatives. In January 2003 DBH initiated an ACT Program. One hundred consumers (70 in IMDs and 30 in Augmented Board and Care facilities) were referred to the program the first day. The
program has had a profound and salutary effect on those in the program, transitioning some of its members from a lifetime in “the system” (many in locked facilities) to independent living, to a return to school or college, and for a smaller number, to gainful employment.

**Crisis Services**

Because of the reduction of staff and the closure of several clinics, there was an increase in the number of consumers seeking treatment in an inpatient setting. Visits to the Arrowhead Regional Medical Center psychiatric emergency room peaked at around 11,000 visits in FY 04/05. Many of these visits were for outpatient type services. In response to this gap in treatment, the department has made significant efforts to provide services to consumers in crisis. Each region now has a walk-in clinic. The Extended Hours Triage Program, implemented in late 2004, is open until 10pm and on holidays. In the High Desert Region, there are emergency response teams that respond to hospital emergency rooms and law enforcement requests for assistance. In the East Valley/San Bernardino Region, a pilot project, the Law Enforcement Alliance Project (LEAP) provides an alternative to hospitalization and incarceration for sub-acute consumers. These collaborations with law enforcement agencies provide officers with viable alternatives to hospitalization.

**Services to Rural Areas**

In October 2002 DBH implemented a Telepsychiatry program at the Victorville Behavioral Health Center. This program addressed the need to provide services to remote regions like Needles and Trona. After the first session 82% of child respondents and 68% of the care respondents reported a positive experience and wanted to continue. Since implementation, services provided by the Telepsychiatry program include assessments, therapeutic interventions, medication evaluation and monitoring, and emergency evaluations. Currently, eight operational sites are located in the county.

**Co-Occurring Disorders**

Recognizing both the prevalence of dual disorders and the importance of integrated approaches to treatment, DBH formed the Co-occurring Disorders Task Force. The task force was charged with shaping policy and implementing proposals to establish procedures for co-occurring programs throughout the DBH system and as part of the MHSA planning process. The task force proposed a single treatment team concept to be phased in over a four-year period that transcends children, adolescents, transitional age youth, adults and older adult populations for integration of substance abuse and mental health services.

In an effort to begin dealing with this issue, DBH conducted a study to identify those high users of acute care services who had a co-occurring disorder. The results of that analysis indicated that in 2003, 804 unique individuals were seen in either Psychiatric Emergency rooms or admitted to the hospital. One hundred percent of these individuals
were seen more than once. The average for the group is 4.6 visits per year. Thirty percent of the costs of acute care could be attributed to treating patients with a co-occurring disorder, compared to seventeen percent in the outpatient system. Many of these consumers had some involvement with law enforcement or have found themselves incarcerated. DBH developed a pilot project, the Therapeutic Alliance Project (TAP) to address these consumers’ needs. After a planning process DBH committed nearly one million dollars of its SAMHSA block grant to a 30-slot 90-day residential program for clients with a co-occurring disorder. To date there have been over 100 hundred graduates from this program.

Collaboration with Law Enforcement

The San Bernardino County Mental Health Court has served as a national model and collaborated with DBH to develop a close working relationship with the Superior Courts, the Public Defender’s Office, the District Attorney’s Office and the Probation Department. DBH Staff are assigned to the Mental Health Court where they provide assessment and evaluation of mentally ill individuals who are arrested. Instead of being incarcerated, the consumer is offered a treatment and residential program. Over 150 clients have graduated from Mental Health Court since its inception in 1999.

San Bernardino County was one of thirteen recipients of a national technical assistance grant from the National Institute of Corrections and the Council of State Governments. This grant provided additional technical assistance to develop effective strategies to improve the response to people with mental illness who are under the supervision of a corrections agency. This grant resulted in a very valuable collaborative, the Criminal Justice Consensus Committee. The Criminal Justice Consensus Committee is an agreement between the San Bernardino County Sheriff’s Department, the Public Defender’s Office, the Superior Court Administration, the District Attorney’s Office, the Probation Department, DBH and the National Alliance of the Mentally Ill (NAMI) The mission of this group is ‘Through identification of the mentally ill and expedited criminal court processing, placements services, and mental health treatment, offenders will be removed from the criminal justice system and become productive and responsible members of their families and the community.’ It is the intent of this group to reduce incarceration, decrease recidivism, advocate mental health treatment, and enhance community protection. Additionally, DBH was part of the California Department of Corrections Mentally Ill Offender Crime Reduction Grant from 1999 to 2004. This program was instrumental in developing, formalizing and implementing key collaboration strategies between the DBH and our law enforcement partners.

Services to Older Adults

The AgeWise Program is a non-traditional mental health program for the high-risk and under served older adult population. The program serves the entire county. Its goal is to assist in preventing inappropriate or premature institutionalization of the elderly. The program, instituted sixteen years ago, is a model for recovery that was instituted long before its time. The program provides groups that are developed based upon Needs
Assessments conducted in the communities in which clients live. Outcome measurements are used to ensure "best practices" and quality services are provided for the clients. A significant component of the program is training to agencies, community members and professionals throughout the county. The AgeWise Program is very successful and has been recognized as a "Model Program, for older adults." The MHSA proposal seeks to expand the AgeWise Program.

The goal of assisting our consumers to identify self-sufficiency and progress toward wellness, recovery and resilience has been an important factor throughout MHSA planning with the hope of complete system transformation that will improve access to mental health services. This goal, with the support of our consumers, will clearly define a mechanism for evaluation and change in the coming years.
EXHIBIT 1: PROGRAM AND EXPENDITURE PLAN FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA)
THREE-YEAR PROGRAM AND EXPENDITURE PLAN
COMMUNITY SERVICES AND SUPPORTS
Fiscal Years 2005-06, 2006-07, 2007-08

County: San Bernardino                  Date: February 7, 2006

County Mental Health Director:

Allan Rawland

Signature

Date: February 7, 2006

Mailing Address:  Director's Office
                  Behavioral Health Resource Center
                  850 E. Foothill Blvd.
                  Rialto, CA 92376

Phone Number: (909) 421-9340       Fax: (909) 873-4480

E-mail: ARawland@dbh.sbcounty.gov

Contact Person: Allan Rawland

Phone: (909) 421-9340
      Fax: (909) 873-4480
      E-mail: ARawland@dbh.sbcounty.gov
PART I: COUNTY/COMMUNITY PUBLIC PLANNING PROCESS AND PLAN REVIEW

PROCESS

Section I: Planning Process

1) Briefly describe how your local public planning process included meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.

The funding proposal for a coordinated planning process to initiate local mental health system transformation was presented to the San Bernardino County Board of Supervisors on February 15, 2005. The proposed Mental Health Services Act (MHSA) Community Program Planning design emphasized comprehensive orientation and training, community forums, consumer-driven input mechanisms such as focus groups, survey tools and strategic outreach to our large county which is both challenged and enriched by a variety of regional and cultural attributes.

Community Public Forums

Six community public forums, supported by press releases (Attachment AC) and local mental health network flyer distribution (Attachments O, P, Q, & R), were held in the four major geographical regions of the county in June, July and August 2005. The purpose was to publicize the “kick off” of the Community Program Planning process, to distribute written materials and to invite further participation. Translation services were provided, for Spanish-speaking, Vietnamese-speaking and the Hearing Impaired. There were a total of 169 attendees at these public forums.

Community Program Planning Process

Throughout the Community Program Planning process, the MHSA Workgroups, in collaboration with the MHSA Coordination Team, worked toward the development of an expanded stakeholder base and an open and ongoing dialogue with community stakeholders. The Community Program Planning process offered a new opportunity to work toward an informed discussion of community concerns and mental health issues. The process involved a decision-making method that considered consumer experiences, concrete public system and service data and the need to deliver services that respond to consumer strengths and resiliencies.

Importantly, the development of the following Community Services and Supports (CSS) proposal reflects more than a spending plan or a program design. Instead, service providers, consumers, advocates, community partners, and county constituents have participated in training, provided input, offered program critiques, identified community challenges, assisted in setting priorities and helped to articulate desired outcomes for consumers and communities. This process is expected to set the foundation for a transformed and evolving local mental health system that can be
continually evaluated according to relevant consumer/family and system outcomes and be held accountable in ways that are meaningful to the community.

Community-Based and Consumer/Family-Driven Focus Group Network

In an effort to reach out to and involve diverse consumers, potential consumers and their families, the county initiated four distinct consumer/family-driven focus group efforts, able to respond to all regions of the county and to a variety of age-specific and cultural/identity issues of our county’s consumers. Supports were arranged through two Recovery model/clubhouse contract providers. The contractors provided reimbursements to focus group facilitators’ for time and additional fiscal supports such as reimbursement for training/travel expense, personal mileage, refreshments and childcare expenses.

The Parent Partners focus group effort included a group of parents affiliated with existing clinics and contractors, experienced in providing advocacy and peer support on family issues. This group fanned out into the county’s communities to ensure that the concerns of children, families and interagency partners were included in the Community Program Planning process.

The DBH AgeWise program’s Senior Peer Counselors focus group effort included an established network of individuals experienced in a self-help and self-advocacy model. Following an orientation/training in MHSA issues, this group also fanned out into the county’s communities to ensure that our county's older adults and family members had an arena in which to express their mental health concerns during the MHSA planning process.

The Jefferson Transitional Programs (JTP), an experienced consumer-driven Recovery/Resiliency consultation/training resource in the Inland Empire, was utilized to develop a new cadre of focus group facilitators. JTP provided training to a team of consumers, family members, advocates, department and interagency staff on focus group facilitation. This model allows facilitators to team up and reach out into their communities and to reach out to consumers within agencies served by interagency staff facilitators.

The Delphi focus group model was another new and specially trained network of consumer facilitators able to tap into networks of consumers and families and underserved stakeholders. This facilitator group assisted us to engage stakeholders within informal networks that might otherwise be inaccessible to us.

Notably, our network of focus group facilitators identified an important need and defined an important role for consumers and families within the system of mental health services and supports. This network will not only serve as the non-threatening “door” through which consumers/families may enter into policy/planning, it will also serve as a foundation for future development of peer support and self-help services and strategies throughout the county.
Outreach to Consumers and Family Members

For those stakeholders, particularly consumers, potential consumers, and their families, who are not accessible through these groups, a special outreach effort was initiated by a new MHSA Outreach Coordinator position to identify community locations, gathering places, and events for publicizing MHSA, linking with new stakeholders and announcing upcoming stakeholder events.

Stakeholder Survey

In addition to those activities described above, in August 2005, a three page multiple choice stakeholder survey (Attachments D and E) was released, along with a postage paid envelope. This input tool was developed in order to allow consumers, families, consumer advocates, professionals, human services agencies, and community members to express their concerns and issues. In September, the survey was released in Spanish. Although Vietnamese is not yet a threshold language in our county, we have released the survey in Vietnamese (Attachment F). In early October, this survey was activated in both English and Spanish on the San Bernardino County website at http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm. In November, the survey was released on the website in Vietnamese. We found that this tool assisted us to reach participants who may not wish to engage in large or small group forums. As of the first week of January 2006, 7,115 paper surveys were distributed. To date, DBH received 1,863 completed surveys (1,622 paper surveys and 241 from the County's website). Of those returned, 1,510 were completed in English, 201 in Spanish, 1 in Vietnamese, and 151 did not indicate preferred language.

2) In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.

Tapping into Existing Collaboratives

In addition to including consumers/families, we have been continually invested in bringing to the table members of the community who are not familiar with the public mental health system but who have concerns about the mentally ill and/or seriously emotionally disturbed, as community members, service providers or interagency partners. San Bernardino County initiated the planning process in December 2004 by reaching out to existing interagency partners, tapping into existing age-specific collaboratives that include county agencies, contractors and community-based organizations and linking with the Mental Health Commission. By January 2005, four age-specific Workgroups (Children, Transitional Age Youth (TAY), Adults, and Older Adults) were established and began meeting at least monthly. Each Workgroup was charged with an ongoing task of reaching out to potential stakeholders to include consumers, family members, service providers, advocates, agency partners, contract agencies, and others. Over a period of nearly a year, membership in each Workgroup exceeded expectations and community agency representation has broadened. This has transformed the local mental health system in that new partners are now fully engaged in the regular dialogue regarding resources, regional and countywide needs, consumer issues and concerns, access issues, system mission and implementing change.
The San Bernardino County MHSA Coordination Team developed and implemented formal protocols and a “menu” of questions for the “interagency targeted forum” (Attachment V) in order to encourage input and participation among public, private and community-based interagency partners. These protocols were utilized by department and interagency staff to facilitate “roundtable discussions” within and across agencies. Workgroup members representing service providers and public agencies took these protocols into their own organizations to generate input for Workgroup consideration. The forum group questions were designed to encourage dialogue regarding the service and systems issues most relevant to local system transformation. Participants were provided with informational brochures on methods for joining Workgroups and subsequent events as well as a comprehensive pamphlet (Attachments W and X) on the county’s demographic and mental health services data. This effort resulted in 34 interagency-targeted forum events, and input from 368 interagency partners and stakeholders.

Early in the planning process, the development of an interagency Community Policy Advisory Committee (CPAC) was proposed which included 79 representatives from 36 key agencies/organizations from the public mental health system, including the Mental Health Commission, law enforcement, education, social services, the health care system, the courts, consumer and family stakeholders, community-based organizations, contractors, other service providers, and other community stakeholders. CPAC members agreed to commit representatives to the age-specific Workgroups. Later in the year, CPAC meetings were convened as the age-specific Workgroups began to report their findings, seek input and move toward setting priorities for CSS proposals. (Attachment Z)

Focus groups were successfully utilized to elicit participation by county and contractor staff, including alcohol and drug services staff. Because staff is viewed as advocates for consumers, as community members, and as crucial resources within the evolving mental health system, this input mechanism was an effective way for advancing the MHSA dialog throughout the local mental health system. This has also had the effect of extending the conversation, via behavioral health staff, into the interagency collaborative utilized by service delivery staff. Fifty-three Clinic/Contract Partner Focus groups were conducted.

MHSA Outreach and Engagement

Through the public forums held from June to August 2005, the surveys released in August and activated as an online survey in October, and the flyers and brochures inviting inquiries/participation, we have attempted to connect with and obtain input from communities, neighborhoods and other “interested” stakeholders. We were pleased with the wide distribution of the stakeholder survey, first via “hard copy” and soon after, via the county’s website. This survey mechanism ensured that individuals who were reluctant to participate in small or large group processes were given an opportunity to engage with us on a more personal and less intrusive basis.

Outreach efforts have expanded, over time, to identify groups and individuals, as well as strategies and mechanisms for facilitating input. Informational brochures, county data pamphlets, event notices and stakeholder surveys were distributed at
community events. As the core outreach staff was put in place, visibility at such events was expanded, incentives were offered for survey completion and information was disseminated. Efforts to reach certain communities will continue to be made as effective strategies are identified and developed.

**Strategic Outreach Planning**

San Bernardino County’s Community Program Planning process was designed to be as far-reaching, inclusive, open and engaging as possible. While the planning process began early with the activation of existing “collaboratives” into Workgroups, the effort to identify willing consumers, family and other community stakeholders has been painstaking. Aware of the severe challenge faced by our county constituents in a county as large as some states, we knew that the lack of visibility in the outer reaches of the county would inhibit our ability to easily engage historically isolated, disconnected and underserved stakeholders. Further, continual population growth has enriched the county with a variety of cultural, ethnic and racial minorities whose social networks defy easy identification or engagement.

In recent years, the county has attracted population migration for “lower cost” housing yet stakeholders resoundingly express a general housing/homeless crisis, characteristic of many parts of the state and other areas of the nation. Thus, our county’s “work was cut out” for us. We hoped to find stakeholders who are unserved and isolated, who are concerned community members and neighbors, individuals who are worried about intrusive and disruptive public agency intervention, who are uncomfortable with stigma issues, and/or who are unaware of the MHSA effort to obtain community assistance in transforming the local mental health system.

To quickly reach this broad variety of planning partners, we endeavored to reach out directly through the survey tool referenced above, through linkage with agencies and organizations that might articulate local community concerns and needs, and through offers of targeted forums and focus groups for local groups interested in gathering for specific discussion with us. In addition, interagency Workgroup members became effective links to agency policy makers, assisting us in gaining access to interagency community networks and client networks. The hard copy and electronic survey showed a broadening of stakeholder participation as they were implemented and collected, as indicated by the demographic data reflected. Written informational, demographic and publicity materials were continually developed, updated and distributed to Workgroup members, focus group facilitators, targeted forum facilitators, community forum attendees and to community members at public/community events in an effort to keep MHSA system transformation visible and “current” during the planning process.

**Targeted Outreach**

A number of overtures were made to the Native American community in an effort to offer training, information, and opportunities for community conversations, focus groups or other participation options. Through several successful contacts, including participation in a local Pow-Wow, flyers, brochures, data pamphlets and stakeholder surveys were disseminated to Native Americans. Additionally, reaching the Spanish speaking community was one of the priorities in our planning process. Information
and surveys were completed with Spanish-speaking first generation families at the consulate of Mexico. More than 1,500 families received information about the MHSA and about 400 completed the needs assessment questionnaire. Further discussions took place regarding focus groups and other appropriate input forums. The focus group mechanism was also utilized to elicit participation by county and contractor behavioral health staff. As the MHSA Coordination Team’s Outreach staff has expanded, targeted efforts are beginning to focus on identified communities of Vietnamese individuals, isolated ethnic/racial groups throughout the regions, and defined age groups, in a strategic and targeted manner. We are also eager to continue efforts to link with advocacy groups for the Lesbian, Gay, Bisexual and Transgender (LGBT) community, as few local resources have been identified and actively engaged to date. In this area, our existing county network will continue to be helpful (e.g., the county Children’s Network to access their expansive community-based organization resource network and the faith-based community).

The San Bernardino County’s stakeholder participation mechanisms described above represent an important infrastructure for continued dialogue and exchange. The initial intensive phase of orientation, training and planning challenged the county to partner with the community, using a variety of methods to achieve the broadest input possible. The “snapshot” grid below reflects stakeholder demographic data collected during this intensive planning phase.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Percentage Participating in Planning Activities (Stakeholder Surveys, MHSA Planning Meetings, Workgroups, Focus Groups, Forums)</th>
<th>Existing Percentage of &lt;200% of County’s Poverty Population – GOAL (TARGET)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Euro-American</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Latino</td>
<td>27%</td>
<td>51%</td>
</tr>
<tr>
<td>Native-American</td>
<td>13%</td>
<td>1%</td>
</tr>
<tr>
<td>Other/Unreported</td>
<td>12%</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Percentage Participating in Planning Activities (Stakeholder Surveys, MHSA Planning Meetings, Workgroups, Focus Groups, Forums)</th>
<th>Existing Percentage of &lt;200% of County’s Poverty Population – GOAL (TARGET)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>2%</td>
<td>29%</td>
</tr>
<tr>
<td>TAY</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Adults</td>
<td>74%</td>
<td>44%</td>
</tr>
<tr>
<td>Older Adults</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Unreported/Unknown</td>
<td>5%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The county’s ongoing MHSA outreach effort is focusing on the initial findings above. In particular an effort to continue working with the Latino community, on a regional basis, in specific gathering places, community centers, and with local community leaders will be made. While the general category of Asian-Americans appears to show adequate outreach, our county continues to be concerned about the more specific Vietnamese segment of the Asian-American community in the county’s West Valley and in other regions of the county.

While the county’s population boasts 11% older adults, this population is the “booming” segment and a continuous focus is warranted. Only 8% of stakeholders were older adults, reiterating the need to make extra provisions in facilitating access for this often homebound and geographically isolated population, many of whom reside in the Desert and Mountain regions. While children constitute 29% of the county’s poverty population, only 2% participated in the planning process. Obviously, there are complicating factors in children’s participation. However, as the county develops the peer support and community-networking infrastructure, the mechanisms and supports for child involvement will be a focus of the ongoing MHSA Coordination process.

When looking further into planning partner or stakeholder characteristics, it is apparent that continued attention should be paid to the county’s distinct mountain communities. While Mountain region stakeholder participants were predominantly Euro-American, there are small communities of Latino individuals and Native Americans, as well as itinerant workers living in the resort areas, all of whom may respond to different outreach approaches. In addition, Mountain residents’ often self-describe mountain living as a distinct cultural issue and as an access challenge. This warrants non-traditional outreach, engagement and, perhaps, service implementation strategies.

As the county’s stakeholder input and feedback mechanisms continue to develop and the peer support networks expand around the systems now in place, the qualitative and quantitative data collected will influence future community conversations, further planning, system transformation and program implementation.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Percentage Participating in Planning Activities (Stakeholder Surveys, MHSA Planning Meetings, Workgroups, Focus Groups, Forums)</th>
<th>Existing Percentage of &lt;200% of County’s Poverty Population – GOAL (TARGET)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>57%</td>
<td>51%</td>
</tr>
<tr>
<td>Male</td>
<td>34%</td>
<td>49%</td>
</tr>
<tr>
<td>Unreported</td>
<td>8+%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3) **Identify the person or persons in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to-date.**

The Director of San Bernardino County Department of Behavioral Health (DBH), in conjunction with the Community Policy Advisory Committee, has central administrative responsibility for the ongoing planning process. The Assistant Director of the DBH provided direct supervision and oversight, at approximately 25% of her time, funded as in-kind support.

Simultaneously with the activation of interagency partners for Workgroup establishment, one half-time administrative MHSA coordinator was assigned to the effort, as in-kind support. This individual provided significant initial support in Workgroup organization, scheduling, outreach to new consumer/family membership, and linkage to the departmental planning committee and county policy advisory committee. The MHSA Executive Planning Committee provided oversight, guidance and support to the implementation of the county’s Community Program Planning proposal, which relied on start-up orientation/training, and the hiring of a core MHSA Coordination Team. The MHSA Executive Planning Committee met weekly to oversee the planning of MHSA orientation/training and staff recruitment/hiring and to design stakeholder outreach, inclusion, input, participation and feedback.

Membership on the MHSA Executive Planning Committee, working on an in-kind basis, and meeting on a weekly basis since January 2005 is as follows:

<table>
<thead>
<tr>
<th>Member</th>
<th>Role/Function</th>
<th>Note(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBH Director, Allan Rawland</td>
<td>Co-Chair</td>
<td>Appointed 9/2005</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>Chair</td>
<td>Appointed 6/2005</td>
</tr>
<tr>
<td>DeAnna Avey-Motikeit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy Director, Children &amp; Families</td>
<td>Member</td>
<td>Hired 6/2005</td>
</tr>
<tr>
<td>Kimm Hurley-Smith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy Director, Alcohol/Drug Services</td>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>Joyce E. Lewis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy Director, Adult System of Care</td>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>Ralph Ortiz</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy Director, Administrative Services</td>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>Kris Letterman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Commissioner/Family Member</td>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>May Farr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Co-Coordinator/Consultant</td>
<td>Staff</td>
<td>January – December 2005</td>
</tr>
</tbody>
</table>
Two consultants were utilized as formal MHSA Co-Coordinators, and assumed responsibility for coordinating the planning process for the Community Program Planning process of the MHSA. The two consultants are returning retirees, formerly Mental Health Program Manager II level employees with the county.

The Assistant Director, through the MHSA Executive Planning Committee, arranged for support from the DBH Research and Evaluation unit for data assessment during the period of recruitment for a dedicated MHSA statistician. In addition, the Assistant Director made similar arrangements for the county’s Human Services Legislative and Research unit to assist in accessing cross-agency data for collaborative evaluation and analysis within age-specific Workgroups. A core MHSA staff unit was hired, over time, to provide dedicated support to the Community Program Planning process. The positions listed below constitute an important infrastructure for the planned local mental health system transformation.

<table>
<thead>
<tr>
<th>Position</th>
<th>Role</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHSA Co-Coordinator/Consultant</td>
<td>Staff</td>
<td>January – December 2005</td>
</tr>
<tr>
<td>Paula Bacchus Roby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Analyst II</td>
<td>Staff</td>
<td>Hired 6/2005</td>
</tr>
<tr>
<td>Scott Nichols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistical Methods Analyst/Researcher</td>
<td>Staff</td>
<td>Assigned/hired 7/2005</td>
</tr>
<tr>
<td>Keith Harris/Manuel Gomez</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Education Consultant/Outreach Coordinator</td>
<td>Staff</td>
<td>Hired 9/2005</td>
</tr>
<tr>
<td>Carlos Lopez</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Administrative Coordinator (MEPS)</td>
<td>Staff</td>
<td>January – September 2005</td>
</tr>
<tr>
<td>Gwen Morse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAMI Representative/Family</td>
<td>Member</td>
<td>Joined 8/2005</td>
</tr>
<tr>
<td>Crystal Lionne</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Secretary</td>
<td>Recorder</td>
<td>Hired 10/2005</td>
</tr>
<tr>
<td>Michelle Brass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Coordinator/Program Manager II</td>
<td>Member/Staff</td>
<td>Hired 11/2005</td>
</tr>
<tr>
<td>Lisa McGinnis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Competence/Ethnic Service Manager</td>
<td>Member</td>
<td></td>
</tr>
<tr>
<td>Myriam Aragon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Staff Position</td>
<td>Role/Function</td>
<td>Commitment</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>MH Program Manager II</td>
<td>Regular county position responsible for sustaining ongoing Coordination of the county MHSA planning/stakeholder participation process. Included is responsibility for integrating outreach, mental health education, peer support systems, and the values of the consumer/family driven services into the local mental health system. Will continue to coordinate the long-term stakeholder-driven planning, self-assessment, outcomes-oriented and collaborative service delivery system. Includes leading, organizing, coordinating, and maintaining stakeholder dialog process, the orientation/training effort, linkage with local educational institutions, collaboration with county Cultural Competence Committee/Minority Services Coordinator, and development of a strategic outreach presence in the county.</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Staff Analyst II</td>
<td>Serve as fiscal and administrative analyst. Perform fiscal oversight, administrative coordination. Provide fiscal expertise for MHSA planning process, assist in budget development, and assist in negotiation of interagency agreements/contract development. Fiscal consultation on interagency funding strategies. Assists in coordination of databases for assessment of needs, input, qualitative and quantitative data.</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>MH Education Consultant</td>
<td>Serve as formal Outreach Coordinator, responsible for facilitating development of outreach strategies for reaching un/underserved consumers and culturally diverse populations. Work with consumers, family members, advocates and other stakeholders in developing peer support networks. Assists in development of media presentations, educational/informational materials. Recruit, outreach and training of community/indigenous workers. Collaborate with Cultural Competence Committee on Outreach effort and MHSA linkage.</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Statistical Methods Analyst</td>
<td>Serve as data and outcomes coordinator for MHSA system transformation. Support stakeholder needs assessment process by providing demographic, consumer/service data and interpretive information. Assist Workgroups in utilizing and applying data to MHSA planning and development tasks. Assist in development/evaluation of program proposals, assessing relevance to consumer and system outcome issues.</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Social Worker II</td>
<td>Serve as supports to region-oriented and culturally focused outreach effort, each position works to develop region-specific and culture-specific community network for tapping into the wide variety of difficult-to-reach participants/stakeholders. Performs community needs assessment, ensures that feedback loop is occurring. Works with public and community-</td>
<td>2.0 FTE</td>
</tr>
</tbody>
</table>
based agencies, enlisting participation in ongoing planning. Conducts focus groups, community meetings, administers stakeholder surveys. Creates resource lists for distribution

<table>
<thead>
<tr>
<th>Office Assistant III</th>
<th>Provide clerical support to MHSA Coordination Team, community focus groups, targeted forums, community public forums, and comprehensive MHSA orientation/training events. Duties include maintaining attendance and demographic records, minutes, reports, and related reference materials for array of planning groups. Interact with stakeholder groups, providing technical support for planning and input events.</th>
<th>1.0 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Services Employee (clerical)</td>
<td>Provide clerical support and assistance to the MHSA Office Assistant III in organizing and maintaining the documentation, public contact and recording-maintenance required.</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Public Services Employee/MH Specialist Consumer Employees</td>
<td>Represents two part-time employees, both focus group facilitators/trainers who are part of existing consumer network. In addition to focus group facilitation activities, these two part-time employees have been hired to facilitate an expansion and strengthening of the consumer network. Tasks include outreach to indigenous workers, to add to focus group facilitator team, outreach campaign to consumers in outlying regions, outreach to homeless population including youth, and expansion of consumer newsletter to include MHSA dialog.</td>
<td>0.625 FTE</td>
</tr>
</tbody>
</table>

The **age-specific Workgroups** were initially chaired by the department’s Deputy Directors and supported by the MHSA Administrative Coordinator, with clerical support from various department clerical/secretarial staff. In addition, staff from the DBH and its contractors served on each age-specific Workgroup, to provide expertise on target population, recovery/resiliency philosophy, regional issues, cultural diversity, and interagency and collaborative service delivery. The Cultural Competence Consumers and Family members committee’s members were assigned to each one of the workgroups with focus on outreaching to consumers and family members for participation in the planning process. Time commitment to Workgroup activities varied according to the stage of the stakeholder engagement, training and planning process.

4) **Briefly describe the training provided to ensure full participation of stakeholders and staff in the local planning process.**

The department initiated the Community Program Planning process by providing a targeted half-day **training for all management and supervisory staff** on February 1, 2005. This was done to ensure that the movement toward a dynamic stakeholder engagement and planning effort would be supported and facilitated by a
knowledgeable and enthusiastic leadership team. This training was provided by the department’s Assistant Director, Deputy Directors and the MHSA Co-Coordinators and allowed for open dialogue among attendees. Following this initial training session, planning continued toward an expanded and detailed training series for department staff, contractors, Mental Health Commissioners and Workgroup members. In collaboration with the California Institute for Mental Health (CIMH), the department sponsored an extensive **MHSA orientation and training** series, covering a broad set of issues, offered over three days for each participant. The series was offered five different times, once in the West Valley region, once in the Upper Desert/Mountain region, once in the Morongo/Yucca Valley region and twice in the East Valley/San Bernardino region. The half-day training included an afternoon session for Workgroup members to evaluate their tasks in light of the day’s training topics. The entire series of trainings offered by CIMH ran from June 20 through August 25. The syllabus included the topics of: history/background on mental health and the MHSA, an overview of the local program planning process, MHSA principles and values, data on service utilization, race and ethnicity, prevalence data, Recovery issues, age-specific service issues and MHSA, and the community input and feedback “loop”. Following the intensive training period, Workgroups were offered Technical Assistance training sessions with CIMH consultants during the months of September and October, so that the concepts, data and issues that emerged during the orientation/training and stakeholder participation/input process could be applied to Workgroup evaluation, discussion and decision-making.

In addition, immediately following the comprehensive orientation/training provided to department and contractor staff and Workgroup members, four distinct groups of **consumer-driven focus group** facilitators were convened. They were given training as described in a previous section and became part of the county’s team of field trainers and facilitators. Their efforts to reach out to consumers, parents, family members, and community members by facilitating focus groups ensured that stakeholders received thorough information regarding the MHSA, as well as the opportunity to ask questions and give input. The **targeted interagency forums** referenced in a previous section also offer training to stakeholders and an opportunity to give input in an interagency focus group format. The **clinic and contractor staff focus groups** represent an additional training experience for department and contract agency staff, providing an overview, demographic information, MHSA information, mental health system history and opportunities for giving input on consumer and family needs, system needs, resource issues, cultural competence and outcome evaluation.

All stakeholder participation activities and events had in common a core of background information, including Recovery concepts, public mental health history, funding issues, local mental health system issues, cultural competence concerns, evidence-based practices and outcome evaluation, and system transformation.
On November 19, 2005 the Community Program Planning Removal of Conditions Request was submitted to the State. This document included specific information and strategies that San Bernardino County used to ensure diversity of input and participation by geographic location, age and race/ethnicity and delineated the types and amounts of training that were provided to various stakeholder groups. The Director of Behavioral Health, Allan Rawland received a letter from the State, dated December 29, 2005 approving the Removal of Conditions to San Bernardino County’s Mental Health Services Act Community Program Planning submission.
Section II: Plan Review

1) Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.

October 20, November 17, December 8, 2005, and January 26, 2006

- The Community Policy Advisory Committee (CPAC) met to review the CSS Plan.

December 1, 2005

- San Bernardino County Mental Health Commission received additional information on public hearings, including legal requirement and timelines from Ed Diksa from the California Institute of Mental Health (CIMH).

The 30-day Public Review period was initiated and copies were made available through the following methods:

December 13, 2005

- The Draft CSS Plan was posted to the San Bernardino County Internet site Home Page, as well as the Home Pages of the County and DBH Intranet sites linking directly to the plan or via www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm

December 16, 2005

- Bound copies of the plan were distributed to all county library branches and to DBH Clinics and Contract Agencies for public display. (Attachment AI)

- Copies were also distributed to the Board of Supervisors, County Administrator’s Office, Mental Health Commission, Workgroup Chairpersons, and to key DBH personnel. (Attachment AI)

December 13, 2005 through January 13, 2006

- All specific requests for copies of the plan were answered on an ongoing basis. (Attachment AI)

- The MHSA Education Consultant and Social Worker II’s kept copies of the Draft Plan on hand and made them available to stakeholders and representatives while conducting ongoing Community Outreach.

- To ensure that knowledge of the plan was countywide, a media advisory was directed to all county residents. Newspaper articles encouraging public input informed residents of Draft Plan viewing locations and upcoming Public Hearings. (Attachment AC and Attachment AE)
• Flyers advertising the Mental Health Commission Public Hearings, which included the plan’s viewing locations, were distributed to all DBH Contract Agency providers, all DBH personnel via email and to the communities via the MHSA Education Consultant and Social Worker II’s, as well as a Media Advisory to all county residents and the newspaper Notice of Public Hearing. (Attachment AC, Attachment AD, and Attachment AE)

**February 2, 2006**

• The San Bernardino County Mental Health Commission reviewed and endorsed the final CSS Plan.

**February 7, 2006**

• San Bernardino County Board of Supervisors approved the CSS Plan for submission to the state.

**February 13, 2006**

• The final CSS Plan submitted to the State Department of Mental Health.

2) **Provide documentation of the public hearing by the mental health board or commission.**

Public hearings were conducted on January 17, 18 and 19, 2006. Due to the geographic diversity of the County, hearings were conducted in three regions, Victorville, Yucca Valley and Rialto. See Attachment AD for Public Hearing flyers and the distribution list. In addition, all attendees were provided with handouts, which included an agenda, Meeting Regulations for MHSA Public Hearings, a Comment Form, the CSS Plan Executive Summary, a copy of the MHSA overview PowerPoint Presentation and a summary of each of the Exhibit 4 Work Plans. (Attachment AF)

Two different Flyers advertising the hearings (Attachment AD) were mailed, emailed and hand carried by MHSA Outreach Staff, as follows:

• With the CSS Draft Plans for public viewing for posting;
• To the Mental Health Commission members;
• To all DBH Clinics and Contract Agencies for posting and public distribution;
• To all DBH staff via email;
• To city libraries, city halls, chamber of commerce offices and city Police departments;
• To various medical facilities, colleges and senior centers; and
• To all county staff.

Newspaper public notices were printed and a media advisory was done to inform all county residents. (Attachments AC and AE)
During the 30-day Public Review Process, DBH received three written comments. One related to improvements in grammar. Another was from a community provider, a director of a domestic violence shelter, wanting to collaborate with DBH to provide services to this population. The other was a local psychiatrist who wanted to increase services to “troubled youth”.

Both community service partners expressed a desire to be part of the ongoing MHSA planning and implementation process. They were invited to become members of the Community Policy Advisory Committee.

One hundred and twenty seven people attended the three Public Hearings, including consumers, their families, service agency representatives, and other community stakeholders. Public testimony and written comments on the feedback forms were received at the hearings.

There were eighteen written comments received during the three Public Hearings. There were also many positive verbal comments about the CSS Work Plans, specifically about the increased intensive case management services, additional housing resources, and crisis walk-in services to be provided to all age groups in three geographic locations in San Bernardino County. Although there were no substantive recommendations for revisions to the Plan, there were many significant comments by consumers and shareholders, which will be taken into consideration during the ongoing planning and implementation process.

**Summary of Substantive Comments**

Several themes emerged from the Public Hearings. The DBH Director and Deputy Directors for the Adult and Children’s programming responded to all verbal comments. The themes included:

- **Staffing Resources:** There is an overall lack of staff resources to address the mental health needs of the population in such a large geographic area.
  - **Response:** The Mental Health Services Act will add much needed staff resources and will increase services to individuals of all ages who have traditionally been underserved, in part, due to their remote geographic locations.

- **Housing Resources:** There were several comments regarding the need for housing resources throughout San Bernardino County. Specifically mentioned was housing for those struggling with substance abuse as well as co-occurring disorders, personality disorders and those who, because of their mental illness, come to the attention of law enforcement.
  - **Response:** Three of the four CSS age specific Work Plans (Transitional Age Youth, Adults and Older Adults) include supportive housing as part of the services to be provided. Many of those served will present with those issues described above.

- **Transportation:** Transportation is a major problem in accessing services in the more remote areas of the County.
- **Response:** The Crisis Walk-in Centers, which cross all age groups in the CSS plan, will provide transportation. In addition, the Circle of Care Program for seniors will include transportation. Ongoing MHSA program planning and implementation will continue to focus on the issue of transportation to increase consumers’ access to mental health services.

- **Serving All Cultural and Ethnic Groups:** An issue was raised about the importance of serving all ethnic and cultural populations, and not just those identified as the “threshold” population.
  - **Response:** It is estimated that 70% of the underserved population in San Bernardino are people of color so outreaching to those individuals and communities will be a priority, with services geared towards meeting the needs of each cultural specific population.

- **Serving the Indigent Population:** There was concern about the provision of services to the indigent population and those mentally ill individuals who need services but do not voluntarily seek assistance.
  - **Response:** While we cannot mandate individuals to seek services, outreach services will be provided to this population, including prevention and education services to increase their awareness of resources in their own communities.

- **Serving More Consumers:** There was a concern raised about the need for the program to serve more individuals.
  - **Response:** It is estimated that approximately 5,797 new consumers will be served each year as a result of MHSA funding. Should funding allocations increase in future years, the number of clients served is expected to increase.

- **Staff Training:** Staff must have training to work with consumers in a caring and emphatic manner, and have smaller caseloads to improve the quality of services.
  - **Response:** Extensive training will be provided for new and existing staff on recovery, and providing culturally appropriate services that address the specific treatment needs of each individual.

- **Consumer Employment:** There is a need to increase consumer/family member employment and prepare consumers for San Bernardino County’s hiring process.
  - **Response:** There will be 41 consumers hired as part of the CSS Plan programs. DBH plans to increase this number as subsequent phases of the MHSA are developed and implemented. In addition, DBH will work with the County’s Human Resources Department to streamline the application and hiring process to make it easier for consumers to enter the county workforce.
4) If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

Throughout the writing process, there were continual changes to the documents to improve grammar, punctuation and syntax.

While the written feedback outlined above is significant, it did not appear to warrant any “substantive changes” to the overall CSS Plan. These comments/suggestions will be incorporated in the ongoing planning and implementation process to further enhance the services offered under the Mental Health Services Act.

Note: The following diagram depicts the planning and review process for the San Bernardino County CSS Plan.
MHSA - COMMUNITY PROGRAM PLANNING (CPP) PROCESS
Development of Community Services & Support (CSS) Funding Proposals

Public Forums & Stakeholder Groups- Feedback Collection Point

DBH Staff & Contracts  |  Policy Partners  |  Large Public Forums (Regional)  |  Targeted Forums & Focus Groups

Workgroup Members assigned from each group to serves in groups below

TASKS- Participate in open forums & provide organized written feedback on service needs, gaps, special needs, etc. OUTPUT- Identify priorities

Age-Specific Work Groups- Draft CSS Program Proposals

CHILDREN  |  TAY  |  ADULT  |  OLDER ADULT

TASKS- Review County & consumer population data/stakeholder input data. OUTPUT- Written draft service-specific plans using CSS requirements

Final CSS Coordination Team

CSS Plan Editing Group
Technical Editing Team

Final CSS Plan

Final CSS Coordination Team
MHSA Executive Planning Committee
Workgroup Chairs

Coordination Team
MHSA Staff Analyst II
Consulting Program Specialist

Technical Edit Team

San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006

Projected Timeline
Feb '06

Final CSS Plan
PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Section I: Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

1) Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years placing an asterisk (*) next to these issues.

San Bernardino County, through the community planning process, identified community issues and needs that formed the foundation of the CSS plan. Workgroup members used this information to formulate the program recommendations set forth in this document.

San Bernardino County Issues Identified in the Public Planning Process (in priority order by age group):

<table>
<thead>
<tr>
<th>Children/Youth</th>
<th>TAY</th>
<th>Adults</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>*1. Family and peer problems; unstable, non-healthy living environments, including out of home placement</td>
<td>*1. Homelessness</td>
<td>*1. Homelessness</td>
<td>*1. Access to care</td>
</tr>
<tr>
<td>*2. School failure</td>
<td>*2. Institutionalized and incarcerated</td>
<td>*2. Frequent hospitalizations</td>
<td>*2. Frequent hospitalizations and frequent episodes of emergency care</td>
</tr>
<tr>
<td>*3. Involvement in the Child Welfare and Juvenile Justice Systems</td>
<td>*3. Frequent hospitalizations</td>
<td>*3. Inability to work</td>
<td>*3. Inability to manage independence</td>
</tr>
<tr>
<td>*5. Alcohol and drug problems experienced by youth and families dealing with mental illness</td>
<td>*5. Inability to work</td>
<td>*5. Institutionalized and incarcerated</td>
<td>5. Isolation</td>
</tr>
<tr>
<td>6. Access to care</td>
<td>6. Access to care</td>
<td>6. Access to care, including lack of transportation</td>
<td></td>
</tr>
</tbody>
</table>
2) Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)

Multiple interrelated processes led to the selection of the community issues described below. First, community input was categorized and aligned with the MHSA and the recommended priority populations set forth in the DMH guidelines. Second, extensive analysis of census and agency data provided estimates of the numbers of unserved and underserved individuals in the county. Third, community input was categorized based on the recommended community and support service strategies outlined in the DMH guidelines. Fourth, community input was ranked in terms of frequency of response. Recommendations were presented to the MHSA Workgroups for discussion and deliberation. The MHSA Workgroups were given the opportunity to add other community issues to be included in their discussions not identified through the community input process.

Access to care was identified as a core issue across all age groups, because it contributes to racial disparities in treatment participation and to the consequences associated with untreated mental illness. This issue is addressed in question #4.

**Children/Youth**

1. **Family and peer problems; at risk of out of home placement**

A comprehensive service approach that supports the entire family was among the top issues identified by community stakeholders, the community mental health needs survey, and planning workgroup members. The top four barriers to services were lack of awareness of available services, too much "red tape", transportation, and embarrassment or stigma. At any given time, approximately 6,000 children are in out-of-home placements in our county. Research indicates that many, perhaps most, of these youth are in need of mental health care. Foster families and caregivers are also a concern for the mental health system, since the top issue identified in the planning process was to improve the long-term outcomes for youth in placement by maintaining a stable living environment.

2. **School failure**

Failing in school was identified as one of the top issues by the community and the most important issue by the families. The four-year "derived rate" for high school dropouts in San Bernardino County was 16.7 per 100 students in 2003, compared to the statewide average of 13.1 per 100 students. Staying in school is one of the most obvious ways to improve academic success. Thus, the need for school-based services was identified as a priority in focus groups held by the Parent Partners, Stakeholder groups in the Department of Children’s Services, Inland Regional Center, and the Children’s Network. An additional goal of the Comprehensive Child/Family Support System (CCFSS), the proposed MHSA children’s program, will be to assist families as they maneuver through
the various agencies to get appropriate school support services for children with mental and emotional problems. The CCFSS will help increase access to care, increase the families’ involvement, and drive the individualized comprehensive service plans for children needing assistance to improve their school functioning and increase their chances of school success.

3. *Involvement in the Child Welfare and Juvenile Justice Systems*

In the most current year (2004/2005), the monthly average number of minors in supervised, out-of-home care was 5,526 children. Approximately 5,200 of these were in the child welfare system. A planning workgroup comprised of community stakeholders, parents, and partner agencies identified the importance of addressing the unmet mental health needs of children entering out-of-home placements (Foster Care, group homes, institutions) and the Juvenile Justice System. In addition, the CCFSS would assist in identifying these children earlier and would assist families to keep their children at home.

4. *Acute psychiatric inpatient hospitalizations*

The planning workgroup comprised of community stakeholders and partner agencies identified the need to address the lack of crisis services in rural areas. The lack of crisis response capabilities in the High and Mid-Desert regions results in unnecessary transports and hospitalizations of children living in those areas. The CCFSS would provide a Crisis Response Team in both the High and Mid Desert regions to reduce the need for psychiatric hospitalizations.

5. *Alcohol and drug problems experienced by youth and families dealing with mental illness*

The community and families identified drug and/or alcohol abuse as one of the most important mental health issues. The results of recent national surveys on substance use among children and adolescents reveal that about 9% of children 17 years of age and younger report having abused drugs or alcohol during the past year. It is believed that the rate of drug use and abuse among children with severe emotional disorders is even higher.

*Transition Age Youth (TAY)*

1. *Homelessness*

Supportive housing for homeless TAY was among the top issues identified by community stakeholders, the community mental health needs survey, and planning workgroup members. The number one way to improve outcomes is to “maintain a stable living environment” for this age group. The affects of homelessness were identified as one of the biggest barriers to accessing needed mental health services. The fear of aging out of Foster Care, the Juvenile Justice System, and out-of-home placements was discussed at length in work groups. TAY often find themselves without the support
or skills needed to live independently, and families and caregivers do not have the education or support needed to appropriately assist these youth. The General Accounting Office (GAO) reported in 1999 that between 25% and 40% of foster youth became homeless after emancipation, likely due to lack of employment and independent living skills.

2. Institutionalized and Incarcerated

Many mentally ill TAY in the county’s justice system have been unserved or inappropriately served by the mental health services system prior to incarceration. On any given day about 15% of incarcerated youth in San Bernardino County are identified as having a diagnosable mental disorder. Of these, about 85% are of such severity that referrals for medication evaluations are necessary. Further, of the 1,012 mental health episodes in the Juvenile Justice System in 2004, 340 (34%) were first episodes, meaning the youth were first identified with mental or emotional problems while in custody. It is very likely that many of these juveniles would not have been in the justice system had adequate services been available and accessible. Additionally, adequate services prior to incarceration for those minors already known to be in need could have prevented their involvement in the justice system.

The overrepresentation of Latino and African-Americans in the Juvenile Justice System is a widespread problem across California and the U.S. It was identified within our county as a priority issue. In addition, youth in this age group often present with co-occurring disorders and substance abuse issues that put them and their families at special risk. Community stakeholders, planning workgroup members, and data analysis identified a need for cultural competent aftercare programs to support TAY and their families in the community. Such programs will reduce jail and hospital stays that result from lack of appropriate outpatient services. The State of California reported in 2004 that 46% of juvenile arrests were of Latino youth, 18% were of African-American youth, and 29% were of Euro-American youth.

3. Frequent hospitalizations

The planning workgroup comprised of community stakeholders and partner agencies identified the need to address the frequent and inappropriate use of acute inpatient care by dually diagnosed TAY. In 2003, of the 1,490 minors discharged from psychiatric hospitals within the county, 230 TAY were rehospitalized within 30 days of discharge. This readmission rate is the fourth highest in the state. During the past three years, the average annual recidivism rate for TAY has remained steady at about 325 per year (being rehospitalized within the same calendar year at least once). TAY may also use hospitalizations in lieu of or while awaiting placement sites, due in large part to the lack of services tailored to their needs. The One Stop TAY Center, the proposed MHSA TAY program, with 24/7 access, intensive case management, skill building, technical/vocational training, recreation, and access to housing will be designed to decrease hospitalization rates.
4. **Inability to live independently**

During the community input from stakeholders and planning workgroup members, it was acknowledged that those TAY exiting group homes, Foster Care placement, and the justice system were often not equipped with the skills needed to live and manage their lives independently. The recommendation was to assist TAY who are exiting out-of-home placement by providing supportive housing, intensive case management, and other supportive services through the One Stop TAY Center.

5. **Inability to work**

Community stakeholders ranked needs for supportive education, supported employment and community living classes very high. The One Stop TAY Center will assist TAY in acquiring the skills necessary to obtain and successfully hold employment. New services will include training, job coaching, and access to job developers so that TAY may become gainfully employed and keep their jobs. In addition, the recommended supportive housing program will provide the stability needed to foster recovery and independence.

**Adults**

1. **Homelessness**

On any given day, estimates of homeless persons range from 5,300 to 8,400 in San Bernardino County. This estimate represents between 0.6% and 1% of the adult population. Seventeen percent of homeless people report alcohol as the primary cause for their homelessness, while 12% report mental health issues being a significant contributing factor. During the community planning process, this issue and its consequences were repeatedly identified as major areas of need for our county.

2. **Frequent Hospitalizations**

The community planning process identified a need to address the frequent use of acute psychiatric inpatient care and psychiatric triage services that occurs due to inadequate community-based services. Of the almost 4,000 adult admissions in 2005, 1,081 experienced more than one hospitalization. This recidivism rate has remained steady for the last three years. The establishment of 24/7 Crisis Walk In Centers, a proposed Adult MHSA program, would facilitate access to appropriate outpatient and crisis services by these high utilizers, would give law enforcement personnel better options when dealing with mental health consumers, and would provide a starting point for integrated case management services. These centers will be established at carefully selected locations in the county, including the county hospital, outpatient clinics, primary care providers, and client housing locations.
3. Inability to Work

Both community focus groups and surveys identified mental illness and emotional disorders that impair the ability to work, as well as the lack of related employment supports for persons with serious mental or emotional challenges as a major problem. Staff will receive training by the California Department of Rehabilitation about how to help consumers with employment support. Clubhouse members, utilizing the Fountain House model, would provide employment screening and job placement through onsite and offsite volunteer and paid vocational opportunities.

4. Inability to Manage Independence

Clients and their family members identified the challenges that Severely Mentally Ill (SMI) adults and adults with co-occurring disorders face in managing their lives and making meaningful use of their time and abilities. Consumer-operated peer support services and expansion of clubhouse programs, along with safe and affordable housing options, employment supports and family education, are services that were recommended by the community.

5. Institutionalization and Incarceration

San Bernardino County’s analysis demonstrated that a large number of incarcerated persons receive mental health services while in jail; often these clients are receiving needed services for the very first time. For example, in 2004, 923 (30%) of the 3,123 service episodes for incarcerated persons in San Bernardino County were first episodes. It is likely that many of these incarcerations could have been prevented if mental health interventions had occurred prior to incarceration. Further, the community voiced concern for mentally ill persons who are incarcerated for relatively minor or nuisance crimes. Clearly, there is a need to provide integrated mental health services and supports, designed in such a way as to reduce the number of unnecessary incarcerations of mentally ill persons. Walk-in and drop-off clinics are examples of alternatives to arrests.

Older Adults

1. Access

The Community Planning Process and the Older Adult Workgroup identified access to care for ethnically diverse groups as a critical concern. Older adults are especially vulnerable to the difficulties associated with accessing available services, the stigma associated with mental illness among this age group, and under-identification or misidentification of mental health problems by the individuals, their families, and their health-care providers. Language barriers and experience with discrimination over a lifetime also reduces the likelihood that those who could benefit from services will seek them. Thus, strategies to increase access to care and availability of services for elder adults are essential.
2. Frequent Hospitalizations and Medical Care

The community input process suggested an over-reliance on acute inpatient care for older adults with SMI. Data analysis was able to identify about 200 hospitalizations in psychiatric facilities per year for the past three years. Emergency psychiatric evaluations and hospitalizations are frequently the outcome when community-based mental health resources are not appropriately used. Often, the inpatient hospital provider is not equipped to manage the mental health needs of an older adult who presents in the emergency room. When an older adult with SMI experiences psychiatric distress, caregivers often see inpatient care as the only available resource. This lack of knowledge about alternative community-based help and early intervention is a key issue. In addition, older adults with SMI may not access community based mental health programs in a timely manner due to physical illnesses and geographic distance from service locations. A large percentage of older adults with SMI receive their mental health care from their primary care physicians. Primary care and mental health providers recognize that there is a need to provide integrated community based programs and supports to older adults.

3. Inability to Manage Independence

Seriously mentally ill older adults are often unable to manage their independence and be self-sufficient due to untreated mental health issues, lack of community services and supports, and public attitudes about older adults’ capacities and abilities. Older adults are often more isolated than other adults as their circle of family and friends becomes smaller. Those with mental illnesses may not receive the attention they need from health professionals. Many health professionals lack geriatric mental health expertise; thus, they do not educate, advise and encourage older adults with SMI to seek out and engage appropriate services. Professionals and others who encounter isolated older adults frequently are not trained to assess or screen for mental health issues.

4. Homelessness

This issue was repeatedly raised during the community planning process. Homeless older adults with serious mental illnesses face many additional life complications, such as social isolation, stigma due to their mental disorder, other age-related biases, co-occurring disorders, lack of transportation, difficulty finding affordable housing, scarcity of in-home support services, and the lack of culturally competent health services. Homelessness among older adults requires a more thorough analysis and timely response. A key goal is to provide a range of housing options for older adults with SMI, tailored to their individual levels of functioning and capacities for independence.

5. Isolation

The older adult network repeatedly noted that many older adults, because of loss of role in society, diminished functional capacity, limited finances, lack of accessible and affordable transportation services tend to isolate themselves. This tendency, coupled
with the depression associated with multiple losses, places older adults at high risk of mental illness. There is a need for mental health and social service supports to address older adult SMI. The community input also affirmed that outreach and engagement strategies are needed to reach this population and reduce the high rate of untreated mental health illness and suicide and the inappropriate use of institutionalized care. Due to the size and geography of San Bernardino County, older adults who reside in the Desert and Mountain regions are geographically isolated. This also places them at increased risk of suffering from various forms of abuse. This highly vulnerable group will require targeted efforts to reach and engage them in services and provide interventions that will address their extreme isolation.

3) Describe specific racial, ethnic and gender disparities within the selected issues for each age group.

(Note: This section bases comparisons on total County population figures for each group.)

**Children and Youth 0-15 years old - Key Facts and Disparities**

When the data for San Bernardino County's population of children age 0-15 is divided by ethnicity, it shows that Latino's comprise 59%, Euro-Americans 20%, African-Americans 12%, Asian-Americans 5%, Native-Americans 1% and other ethnicities 3%. (Attachments A3 and A4.)

Data indicates that Latinos and Asian-Americans are significantly underserved, comprising only 32% and 1%, respectively of those receiving services. Euro-Americans comprise 43% and African-Americans 20% of those served, which mean these groups are relatively over-represented compared to Latinos and Asian-Americans.

A report from the San Bernardino County's Department of Children's Services in 2003 indicated differences in the ethnic representation of children in Foster Care. Euro-Americans and African-Americans represented 32% and 16% respectively, while Latinos made up 33% of those in Foster Care placements.

According to the State Department of Education, San Bernardino County reported 5,369 school dropouts in 2003. Fifty-three percent of those who dropped out were Latinos, 25% were Euro-Americans, 15% were African-Americans, Asian-Americans and Native-Americans were 1% each, and the remaining 5% were other ethnicities. Fifty-three percent of dropouts were male. Thus, the data indicates no significant disparity in ethnicity or gender among dropouts.

Data from the San Bernardino County Probation Department shows an ethnic disparity in the incidence of incarceration among youth, with African-Americans being over-represented at 29%. Asian-Americans represent about 4%, Latinos account for 49% and Euro-Americans 17% of those incarcerated. By gender, 95% of those in the justice system are males. Only 3% of incarcerated youth are between the ages of 13 and 15.
In the 2003 San Bernardino County Homeless census survey 737 children were identified, or 14%, as part of the county’s homeless population. There is a slight ethnic disparity with Euro-American families accounting for 52% of the homeless children.

**Transitional Age Youth (TAY) 16-25 years old - Key Facts and Disparities**

When the data for San Bernardino County’s population of TAY (age 16-25) is divided by ethnicity, it shows that Latinos comprise 57%, Euro-Americans 23%, African-Americans 11%, Asian-Americans 6%, Native-Americans 1% and other ethnicities 2%. (Attachments A5 and A6.)

Latinos are significantly underserved, accounting for only 31% of those receiving services, while Euro-Americans comprise 43% and African-Americans 20% of those served. Asian-Americans are also underserved, representing only 1% of those receiving mental health services.

As previously stated, San Bernardino County’s Department of Children’s Services reported a disparity in the ethnic representation of children in Foster Care in 2003. Euro-Americans and African-Americans represented 32% and 16% respectively, while Latinos, at 33%, are underrepresented.

As described above, San Bernardino County reported 5,369 dropouts in the 2003 school year, of which Latinos comprised 53%, Euro-Americans 25%, African-Americans 14%, Asian-Americans and Native-Americans 1% each, and other ethnicities about 5%.

As previously noted, African-Americans are over represented in the justice system, making up 29% of those youth incarcerated while comprising a much lower proportion of the youth sub-population.

A San Bernardino County homeless survey in 2003 identified 116 minors who were unaccompanied by adults and living on the streets. However, this was a pilot project and focused primarily on areas frequented by homeless persons. Local estimates are that there are about 700 homeless TAY in the county. Further, based on national estimates, it is believed that as many as 8% of youth 12 to 17 years of age will be homeless during a 12-month period. TAY comprise about 13% of “adult” homeless figures in the U.S. The vast majority of homeless youth will become part of the human services systems.

**Adult 26-59 years old group - Key Facts and Disparities**

In several geographical regions of the county, Latinos and Euro-Americans are relatively underrepresented in the county’s mental health treatment system. Among the contributing factors to this disparity are the following:
• Limited knowledge about mental health services and recognition of mental health issues
• Language and cultural barriers, including lack of bilingual and bicultural professionals and Consumer/Family Providers
• Stigma associated with seeking mental health services
• Lack of public transportation
• Economic and sociopolitical factors

Barriers to employment, transportation, housing, public services, and even telecommunications impose staggering economic and social costs on communities. These impediments are largely due to stigma, and they undermine efforts to educate, rehabilitate, and provide employment and educational opportunities to individuals with disabilities. Communities can benefit from the skills and capacities of individuals with disabilities, who will in turn be able to lead fuller, more productive lives.

There are 879,804 persons between 26-59 years old in San Bernardino County, or 45% of the total population. Of these, 441,691 (50%) are female and 438,113 (50%) are male. Attachment A7 shows the percentages of total population by ethnic group.

The population living under 200% of the Federal Poverty Level (FPL) in the adult age group is 313,046, or 45% of the poverty population of the county. Of clients served in the last year, about 19,000 were in this age group, representing 54% of the total clients served. Attachment A8 shows the percentages of the total population, population under 200% FPL, and unique clients by ethnic group.

Euro-Americans represent 31% of the total population, 33% of the poverty population, and 40% of clients served, while Latinos represent 49% of the total population, 48% of the poverty population but only 34% of clients served. Thus, Euro- and African-Americans are relatively over represented while Latinos and Asian-Americans are underrepresented in the county mental health services system.

**Older Adult 60+ years old group - Key Facts and Disparities**

There are 232,268 persons ages 60 years and older living in San Bernardino County, representing 12% of the total population. In contrast to the younger groups, 129,563 (56%) of this age group are female and 102,705 (44%) are male. Attachment A9 shows the percentages of total population by ethnic group.

The population living under 200% of the FPL in the Older Adult age group is 69,613, or 10% of the poverty population for the county. There are 1,157 unique clients receiving services in this group, or 3% of the total clients served. Attachment A10 shows the percentages of the total population, population under 200% FPL, and unique clients by ethnic group.

Euro-Americans represent 57% of the older adult population, 55% of the older adult poverty population, and 51% of the older adult clients served. Latinos represent 26% of
the older adult population, 29% of the older adult poverty population, and 22% of the older adult clients served. Relatively speaking, older African-Americans and Asian-Americans are more strongly represented in the treatment system, while Latino and Euro-Americans are somewhat underrepresented. Among all age groups, there are the least racial/ethnic disparities among older adults.

Across all the age groups, a consistent finding in San Bernardino’s analysis is that Latinos are underrepresented in the mental health system.

4) If you selected any community issues that are not identified in the “Direction” section, please describe why these are more significant for your county and how they are consistent with purpose/intent of MHSA.

Access to Care

San Bernardino County is the fourth most populous county in California. Geographically, it is the largest county in the contiguous 48 states, covering 20,052 miles. Mental health needs are broadly distributed throughout the county. Many communities within the county are in remote locations of the Desert and Mountain regions.

Using the accepted standard that about 9% of persons living at or below 200% of the Federal Poverty Level will suffer a serious mental or emotional disorder, we estimate 64,435 individuals of all ages in need of mental health services. Fewer than 10,000 of these can be classified as fully or adequately served in any given year. The creation of an enhanced outpatient and rehabilitation and recovery program will increase access to care. The proposed services include a recovery and wellness focus and will be client and family driven.

<table>
<thead>
<tr>
<th>Persons in Need and Unserved, by Ethnic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Served</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>African-American</td>
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<tr>
<td>Asian-American</td>
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<tr>
<td>Euro-American</td>
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<td>Latino</td>
</tr>
<tr>
<td>Native-American</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>TOTAL</td>
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The analysis also demonstrated that a significant number of ethnically diverse individuals in need are unserved and underserved by the mental health system. Depending on the location and age group, Euro-Americans, Latinos, and African-Americans are significantly unserved. Consistent with DMH guidelines, analysis and community input, San Bernardino County is proposing to improve access to care by integrating primary care and mental health services in multiple community health centers sites. This intervention is considered a best practice at the program level for ethnically diverse populations.

Finally, consistent with current practice, all new services are will be comprehensive, integrated and provide culturally competent services in the delivery of services.
Section II: Analyzing Mental Health Needs in the Community

1) Provide a narrative analysis of the unserved populations by age group. Specific attention should be paid to racial disparities.

San Bernardino Mental Health Program (SBMHP) prepared a detailed analysis to fully understand the scope of mental health needs among all four-target population age groups. The MHSA Workgroups reviewed and discussed the analysis, which included estimates of unserved, underserved and inappropriately served individuals. Because of the large size of the county and the limitations this presents, the analysis also included the four regions that are part of San Bernardino County: Central Valley, Desert/Mountain, East Valley/San Bernardino and West Valley.

Unserved Populations in San Bernardino County

The unserved population in the SBMHP system is approximately 29,700 persons for all age groups. The formula used to determine the number of unserved individuals was based on the estimated prevalence of mental health needs among those in poverty (64,500 persons) minus the unique clients (34,800 persons). Refer to Attachment A11 for the estimated unserved population by ethnic group.

Significant ethnic/racial disparities exist among number of persons unserved. The community input provided by family members, providers and other interested community stakeholders underscored the disparities demonstrated in the data.

Unserved Population Estimates in San Bernardino County by Age Groups and Region:

Children & Youth (0-15): 8,900 persons

Data indicates that 60% (5,314) of the children in need but unserved are Latinos, 18% (1,567) are African-Americans, 10% (868) are Euro-Americans, and the remaining 12% (1,102) are of other or multiple ethnicities. By region, 9% of unserved children live in the Central Valley region, 11% in the Desert and Mountain regions, 24% in the East Valley/San Bernardino region, and 56% in the West Valley region.

Transition Age Youth (TAY) (16-25): 5,500 persons

About 63% (3,468) of the unserved TAY are Latinos, 18% (1,006) are African-Americans, 7% (412) are Euro-Americans, and 12% (660) are of other or multiple ethnicities. By region, 6% of the unserved TAY are in the Central Valley region, 20% in the Desert and Mountain regions, 12% in the East Valley/San Bernardino region, and 62% in the West Valley region.
**Adults (26-59): 9,300 persons**

Among adults, 36% (3,312) of the unserved are Euro-Americans, 34% (3,095) are Latinos, 20% (1,828) are African-Americans, and 10% (1,003) are of other or multiple ethnicities. By region, 8% of the unserved adults are in the Central Valley region, 13% in the Desert and Mountain regions, 14% in the East Valley/San Bernardino region, and 65% in the West Valley region.

**Older Adults (60+): 6,000 persons**

Of older adults who are unserved, 64% (3,833) are Euro-Americans, 19% (1,129) are Latino Americans, 12% (716) are African-Americans, and 5% (322) are of other or multiple ethnicities. By region, 9% of the unserved older adults are in the Central Valley region, 32% in the Desert and Mountain regions, 27% in the East Valley/San Bernardino region, and 32% in the West Valley region.

2) **Use Chart A to indicate total number of persons needing MHSA services who are already receiving services.**

**Service Utilization by Race/Ethnicity**

The tables below provide estimates of the San Bernardino County Population, County Poverty population (Population under 200% FPL), and the number of unique individuals who will receive services in an average 12-month period within the Mental Health Plan. The table includes those fully served and underserved or inappropriately served, by age group, race ethnicity, and gender. The total persons served annually in all age groups are about 34,800.

<table>
<thead>
<tr>
<th>Children &amp; Youth</th>
<th>Fully Served</th>
<th>Underserved or Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
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<td></td>
<td>Male</td>
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<td>0-15 years</td>
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<td>%</td>
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<td>Underserved or Inappropriately Served</td>
<td>Total Served</td>
<td>County Poverty Population</td>
<td>County Population</td>
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<td>Male</td>
<td>Female</td>
<td>#</td>
<td>%</td>
<td>#</td>
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<th>County Population</th>
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<td>26-59 years</td>
<td>Male</td>
<td>Female</td>
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<th>County Poverty Population</th>
<th>County Population</th>
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<td>Female</td>
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<td>%</td>
<td>#</td>
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<tr>
<td>Euro-American</td>
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<td>201</td>
<td>591</td>
</tr>
<tr>
<td>Latino</td>
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<td>129</td>
<td>253</td>
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<td>9</td>
<td>9</td>
<td>28</td>
<td>29</td>
<td>75</td>
</tr>
</tbody>
</table>
3) Provide a narrative discussion of the ethnic disparities in the fully served, underserved and inappropriately served populations by age group identified above, including information about situational characteristics as well as race, and ethnicity.

Analysis of Ethnic Disparities in Fully Served, Underserved or Inappropriately Served Populations in San Bernardino County

The estimated numbers of Fully Served, Underserved or Inappropriately Served Populations in San Bernardino County may have been affected by budget reductions in the past years, which reduced overall system capacity. Estimates and references point out that the Underserved Population is significantly greater than those who have been fully served. The ethnicities with the highest percentages among the underserved in San Bernardino County are: Latinos (39%), Euro-Americans (35%), and African-Americans (17%). The ethnicities with the highest percentages among the fully served are: Euro-Americans (57%), African-Americans (21%), and Latinos (18%). Attachment A12 shows the percentages of the Underserved and Fully Served Population for the County.

Analysis by Age group

Children and Youth (0-15 years old):

The total served Children and Youth populations represent 7,510 persons. Of these, 4,775 (64%) are underserved or inappropriately served and 2,735 (36%) are fully served. The major ethnic disparities within the underserved population are for Latinos (39%), Euro-Americans (36%) and African-Americans (18%). Ethnic data shows that Euro-Americans (53%), African-Americans (25%) and Latinos (22%) are most fully represented in the fully served population. The following regional percentages for SBMHP unique clients are: Central Valley-20%, Desert/Mountain-31%, East Valley/San Bernardino-28%, and West Valley-21%.

Transition Age Youth (16-25 years old):

Of the unique number of TAY served, 7,304 persons, 4,594 (63%) are underserved or inappropriately served and 2,710 (37%) are fully served. The major ethnic disparities within the underserved population are for Latinos (37%), Euro-Americans (35%) and African-Americans (18%). The ethnic data shows that Euro-Americans (54%), African-Americans (24%) and Latinos (22%) are the most significantly represented ethnic groups in the fully served population. The regional percentages for SBMHP unique clients are: Central Valley- 20%, Desert/Mountain-22%, East Valley/San Bernardino-36%, and West Valley-23%.
Adult (26-59 years old):

The total served Adult population represents 18,829 persons. Of these, 15,062 (80%) are underserved or inappropriately served and 3,767 (20%) are fully served. The major ethnic disparities within the underserved population are for Latinos (40%), Euro-Americans (34%), and African-Americans (18%). The ethnic data shows that Euro-Americans (62%), African-Americans (18%) and Latinos (12%) are the most significant ethnic groups in the fully served population. The following regional percentages for SBMHP unique clients are: Central Valley-21%, Desert/Mountain-22%, East Valley/San Bernardino-37%, and West Valley-20%

Older Adult (60+ years old):

The total served Older Adult population represents 1,157 persons. Of these, 827 (71%) are underserved or inappropriately served and 330 (29%) are fully served. The major ethnic disparities within the underserved population are: Euro-Americans (48%), Latinos (23%) and African-Americans (11%). Ethnicity data shows that Euro-Americans (59%), Latinos (18%), and African-Americans (9%) are the most significant ethnic groups in the fully served population. The following regional percentages for SBMHP unique clients are: Central Valley-22%, Desert/Mountain-22%, East Valley/San Bernardino-35%, and West Valley-21%

Some characteristics of Population Served during FY 2004-2005

San Bernardino County DBH served 34,800 unique clients, which represented 57,568 episodes for fiscal year 2004-2005 (an average of 1.65 Episodes per unique client).

Children and Youth (0-15 years old) by Region and Ethnicity Groups:

Of the 7,510 clients in this age group served in FY04/05, the majority of Euro-American children were served in the Desert/Mountain region. Most of the Latinos served lived in the West Valley region, and most African-American clients were concentrated in the East Valley/San Bernardino region. (Attachment A13)

Transition Age Youth (16-25 years old) by Region and Ethnicity Groups:

Of the 7,304 TAY served in FY04/05, the majority of the Euro-American clients were in East Valley/San Bernardino region. Most of the Latinos were concentrated in the East Valley/San Bernardino and West Valley regions. African-American clients were primarily located in the East Valley/San Bernardino region. (Attachment A14)

Adult (26-59 years old) by Region and Ethnicity Groups:

In this age group, 18,829 unique persons were served in FY04/05. Most Euro-Americans were served in the East Valley/San Bernardino, Desert/Mountain and West
Valley regions. Most Latinos served were located in the East Valley/San Bernardino, West Valley and Central Valley regions. Most of the African-American clients were located in the East Valley/San Bernardino region. In order of the highest number of clients served, the regions are: East Valley/San Bernardino, Desert/Mountain and Central Valley. (Attachment A15)

**Older Adult (60+ years old) by Region and Ethnicity Groups:**

Based on the total clients served for this age group (1,157), most Euro-Americans served were in the East Valley/San Bernardino, Desert/Mountain, and Central Valley regions. Latinos were mainly located in the East Valley/San Bernardino, Central Valley, and West Valley regions. Most African-Americans clients were in the East Valley/San Bernardino region. In order of the highest number of clients served, the regions are: East Valley/San Bernardino, Desert/Mountain and Central Valley. (Attachment A16)

**Reported Episodes:**

Attachments A-17 and A-18 show the percentages of diagnosis by category and living situation (at admission) from 57,568 episodes during fiscal year 2004-2005.

**Diagnosis by Category:**

Depression (34%) was the most common diagnosis for the episodes reported during the fiscal year 2004-05. The next most frequent diagnoses were Psychosis (24%), Bipolar (12%), and ADHD (10%). Reported Episodes that involve Children/Youth show the following top three Diagnosis: ADHD (34%), Depression (17%), and Behavioral (17%). (Attachment A17)

**Living Situation**

The top three living situations at admissions were: House or Apartment (41%), House or Apartment with Support (17%) and House or Apartment with supervision (7%). (Attachment A18)

4) **Identify objectives related to the need for and provision of culturally and linguistically competent services based on the population assessment, the county’s threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in the this Plan.**

**Objectives for the Provision of Culturally and Linguistically Competent Services To Address Disparities in Access to Care**

Based on the evident disparities in access to care for the ethnically diverse groups mentioned above, SBMHP is committed to continuing expansion of its culturally competent capacity in the proposed MHSA funded programs described in this plan. The following objectives include specific strategies and interventions to address access to
care disparities. Objectives to increase access to care and reduce health care disparities countywide include:

- Increase the bilingual and bicultural capacity of programs by recruiting, hiring, retaining and retraining culturally competent staff.
- Provide outreach to engage and increase access to care for Latinos and Asian-Americans in the mental health system.
- Increase penetration and client retention rates.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them such as Primary Care Clinics.
- Provide culturally competent mental health services by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.
- Implement a program designed to evaluate ways to address stigma and increase access for selected underserved communities.
Section III: Identifying Initial Populations for Full Service Partnership

1) From your analysis of issues and needs, identify which initial populations, by age, will be served in the first three years. Describe each in terms of situational characteristics.

Children and Youth

Comprehensive Child/Family Support System

Full Service Partnerships (FSP) for Children and Youth will target those with severe emotional disturbances who are uninsured, underinsured, unserved, underserved, and inappropriately served in the age range of 0 to 17 years. Latinos and African-Americans have the greatest need in terms of ethnicity in the age group 0 to 15 years old in San Bernardino County, with African-Americans considered inappropriately served in the Foster Care system. Both African-Americans and Latinos are over-represented in the Juvenile Justice System. Latinos had the highest school dropout rate in the county. Initially, services will be provided regionally then expand countywide.

The children targeted for FSP services will have one or more of the following situational characteristics:

- Those having problems at school or at risk of dropping out,
- Those at risk of, or involved in the Juvenile Justice System,
- Those in need of crisis intervention and/or at serious risk of psychiatric hospitalization,
- Dependents at risk of residential treatment or stepping down from residential treatment,
- Homeless or at risk of homelessness,
- High level service users, and/or
- Those at risk due to lack of services because of cultural, linguistic, lack of insurance or economic factors.

Additional situational characteristics include exposure to domestic violence, physical, emotional and verbal abuse, and access to care barriers. FSP services will incorporate evidence-based practices that are culturally competent and linguistically appropriate. Spanish speaking services will be available, as the highest percentage of children and youth underserved or inappropriately served are Latino. Training will be provided to staff in areas to increase their skills and understanding of the cultural specific communities. Cultural Competence training will begin with the Latino culture, as they are the largest part of the community. Training will include acculturation issues, ethnic identity, engagement skills, working with first generation Latino parents, and Latino values.
Transition Age Youth (TAY)

One Stop TAY Center

FSP services will target unserved/underserved and inappropriately served TAY ages 16 to 25 years old. Latino and African-Americans have the greatest need in terms of ethnicity in the TAY age group in San Bernardino County. Both African-Americans and Latinos are over-represented in the justice system. Latinos have the highest school dropout rate in the county.

The TAY targeted for FSP services will have one or more of the following situational characteristics:

- Have a serious mental illness,
- Repeated use of emergency mental health services,
- Have co-occurring disorders,
- Homeless or at risk of homelessness,
- At risk of involuntary hospitalization or institutionalization,
- High risk youth with serious emotional disturbance in the Justice System and Out-of-home placement, and/or
- Recidivists with significant functional impairment.

A full array of services will be provided to assist in the wellness and recovery of TAY. These services include the Assertive Community Treatment (ACT), a well-researched evidence-based model already utilized in this county with other populations. It is estimated that co-occurring disorders are in over 60% of the seriously mentally ill. Services to dually diagnosed TAY will be assessed through the utilization of Transition to Independence Process System (TIP), a promising practice. The provision of housing units will assist in the reduction of TAY homelessness. Spanish speaking services will be available, as the highest percentage of children and youth underserved or inappropriately served are Latinos. Training will be provided to staff in areas to increase their skills and understanding of the cultural specific communities. Cultural Competence training will begin with the Latino culture, as they are the largest part of the community. Training will include acculturation issues, ethnic identity, engagement skills, working with first generation Latino parents, and Latino values.

Adults

Forensic Mental Health Services

This program will serve adults with serious mental illness and individuals with co-occurring disorders who are released from jail or who are brought to outpatient clinics for services by law enforcement. It will also provide services to those referred to DBH by the courts in the High Desert, Mid Desert, and West Valley regions of the county. DBH currently serves the East Valley/San Bernardino region Courts. Services to transitional age youth will be provided at the 24/7 Crisis Walk-In Centers designed for law enforcement. Since relatively few older adults are involved with law enforcement and
the criminal justice system, older adults will not be a target for services; however, they will not be precluded from receiving services should the need arise. Forensic Mental Health Services will not serve children because the Children’s System of Care, which is involved with the Juvenile Justice System, serves them.

*High Utilizer, Co-Occurring or Homeless, Collaborative Services with Housing Component*

This program will provide integrated services delivered by collaborative partnerships for adults with serious mental illness and co-occurring disorders. It will provide aggressive, community–based case management and wraparound support services, mental health services and psychiatric services on a 24/7 basis, countywide. The target population consists of high users of acute services or jails and who are homeless. A full array of housing options will be part of this program.

Adults targeted for FSP services will have one or more of the following situational characteristics:

- Seriously mentally ill,
- Homeless or at risk of homelessness,
- Co-occurring substance abuse problems,
- Involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system,
- Recently discharged from psychiatric hospitals, and/or
- Frequently hospitalized or are frequent users of emergency room services for psychiatric problems.

*Older Adults*

*Circle of Care*

Due to the absence of a countywide older adult system of care at this time, expansion and enhancement of the AgeWise Program is planned. The expansion includes recruitment, training, and retaining a team of Senior Peer Counselors. Additionally, the Victorville area in the High Desert region will be served with two field-capable Mobile Outreach crisis and prevention multidisciplinary teams.

Older adults targeted for FSP services will have one or more of the following situational characteristics:

- Serious mental illness,
- Homeless or at risk of homelessness,
- Unserved, underserved, or inappropriately served in the mental health system,
- Frequent users of emergency room services for psychiatric problems or are frequently hospitalized,
• Reduced personal and/or community functioning due to physical and/or health problems,
• Co-occurring substance abuse problems, and/or
• Isolated and at risk for suicide due to stigma surrounding their mental health problems.

2) Describe what factors were considered or criteria established that led to the selection.

In selecting, factors considered included (1) priority population criteria that was identified in the MHSA and the DMH final guidelines for the CSS plan; and (2) San Bernardino’s community input process, during which these populations were consistently affirmed and prioritized.

Children
• Community Stakeholder input
• Prevalence need in San Bernardino County
• Children’s Workgroup Committee comprising of representatives from over 40 child serving agencies
• Ability to target racial and ethnic disparities in service delivery
• Existence of programs currently successful in serving the target population
• Ability to carry out a quick start up of an expanded FSP program

TAY
• Community Stakeholder input
• Prevalence need in San Bernardino County
• TAY Workgroup Committee comprising of representatives from over 40 child, youth, and TAY serving agencies
• Ability to target racial and ethnic disparities in service delivery
• Existence of programs currently successful in serving the target population

Adults
• Community stakeholder input
• Prevalence need in San Bernardino County
• Ability to target racial and ethnic disparities in service delivery
• Ability to conduct a start-up of an expanded FSP in a short period of time
• Existence of programs currently successful in serving the target population

Older Adults
• Community Forums
• Targeted Forums
• Community Focus Groups
• Data and analysis conducted by the Older Adult Workgroup
3) Discuss how your selections will reduce racial disparities in the county.

Community stakeholders and an analysis of demographics and racial disparities determined that a variety of ethnic groups and some age populations are underrepresented as recipients of mental health services. There are large numbers of unserved and/or underserved individuals with serious mental illness and co-occurring disorders. San Bernardino County currently has a population of about 1,942,091 individuals (as of July 1, 2005). According to prevalence studies, 64,435 individuals of all ages or 3.32% of the population are in need of mental health services. At the start of fiscal year 2005/2006, estimates and references suggest that the underserved population of those in need is significantly greater than those who have been fully served. At the start of fiscal year 2005/2006, DBH inappropriately served or underserved 17% of African-Americans in need, 3% of Asian-Americans in need, 28% of Latinos in need, 1% of Native Americans in need, 46% of Euro-Americans in need, and 5% of all others in need. This is contrasted to the fully served as follows: 24% African-American, 0% Asian-American, 22% Latinos, 0% Native American, 53% Euro-American, and 1% other.

**Children**

According to prevalence data, Latino children make up the most underserved population. African-American children, although utilizing more services, are inappropriately served. African-Americans are over represented in Foster Care, out-of-home placements, and the Juvenile Justice System. Latino youth have a higher drop out rate from school than any other ethnic group. The Comprehensive Child/Family Support System program will increase access to community mental health services for the priority populations. It will expand service locations, create new services, expand wraparound services, and outreach activities. By focusing on reaching children and families with the highest need and those with racial and ethnic disparities, we can reduce the long-term effects of untreated mental illness, homelessness, and inappropriate treatment of children, youth, and their families.

**TAY**

The One Stop TAY Center will increase access to community mental health, rehabilitation and recovery-based services for the priority populations. It will expand service locations, create new services and outreach activities. San Bernardino County prevalence data indicates Latino TAY are the most underserved and represent the highest group to drop out of high school. African-Americans are over represented in the Foster Care and Justice System. Individuals with the highest needs and those with racial and ethnic disparities will be targeted. With increased access to services, we anticipate a reduction in the long-term effects of untreated mental illness. We anticipate a positive impact by decreasing homelessness, particularly to individuals in the Justice System and out-of-home placement.
**Adults**

For adults, barriers to employment, transportation, public accommodations, treatment and other public services, and telecommunications continue to exist. However, with the development of FSP and program expansions, DBH will improve services designed to reduce ethnic disparities and eliminate barriers to behavioral health programs.

**Older Adults**

The Circle of Care Full Service Partnership will be implemented to target Latino and Euro-American SMI older adults and those with the most severe conditions. Intensive case management and 24/7 services will increase access, as well as provision of comprehensive support and counseling to families and caregivers. The capacity-building program will again ensure that staff, volunteers, and community partners are providing client-centered and culturally competent care. A community education strategy will be implemented to reduce the stigma of mental health problems, to recruit volunteers, and to work with other healthcare professionals regarding the quality and importance of services for SMI older adults in various stages of recovery.
Section IV: Identifying Strategies

1) Strategies listed in this section will be used in those organized programs as approaches to address defined community issues and population needs.

San Bernardino County has selected the following strategies and services described in Part III. All are consistent with the five essential elements of the MHSA:

1. Community collaboration,
2. Cultural competence,
3. Being client and family-driven,
4. Wellness/recovery/resilience focus, and
5. An integrated services experience for clients and families.

Another needed service identified repeatedly by the community that encompasses all age groups is the issue of homelessness and lack of housing for this population. To address this issue, the Ongoing Housing Initiative (OHI) will be developed to provide department wide, centralized administrative oversight and housing support staff to work in conjunction with TAY, Adult and Older Adult housing needs.

OHI's services will include developing the necessary housing as outlined in the TAY, Adult, and Older Adult Exhibit IVs. Administrative staff will pursue expanding and developing a continuum of housing that ranges from permanent housing to short-term supervised treatment-oriented settings. A major objective will be to develop safe and affordable permanent housing (apartments and/or Single Room Occupancy units). Safe havens, transitional, sober living, board and cares, augmented board and cares, detox slots and older adults’ assisted living housing will be established to help stabilize consumers and prepare them to transition into permanent housing. OHI will explore using funds as seed money for HUD grants such as Shelter Plus Care, Supportive Housing Program, HOME development grants and HOME Tenant-Based Rental Assistance grants. Private sector funding through loans and tax credits will be explored.

DBH will pursue using the Governor's Homeless Initiative (Prop 46) to refurbish and/or develop independent/permanent housing as defined by Prop 46 regulations. On an ongoing basis, DBH will provide or contract the necessary support staff, operating costs and rent subsidies to serve the chronically homeless, homeless or at risk of homeless and the severely and persistently mentally ill (SPMI).

With oversight from DBH's administrative management, OHI will partner with outside housing agencies such as San Bernardino County Economic Community Development, Housing Authority, Homeless Coalition's Community Action Partnership, local redevelopment agencies and housing developers, Community Housing Development Organizations (CHDOs), private sector banking, as well as consumers and their families. MOUs with Aging and Adult Services, DCS and other agencies interested in housing "special populations" will be pursued to maximize housing development and resources.
Section V: Assessing Capacity

1) Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. Must address the bilingual staff proficiency for threshold languages.

The San Bernardino County Department of Behavioral Health (DBH), like other counties in Southern California, experienced rapid growth between 1970 and 1990. The 1970 Census reported a population of 684,072 people. Between the 1970 and 1990 Census, the population more than doubled (an increase of 107%), to 1.4 million people. San Bernardino County has continued to grow rapidly since 1990. As of July 2005, San Bernardino County’s population was 1,942,091 residents, largely due to a dramatic influx of people from neighboring counties.

In addition, the population has a number of unique characteristics that are relevant for mental health planning, including a higher proportion of children and youth, and a high proportion of culturally, racially, and linguistically diverse population.

The current population is comprised of more than 50% Latinos, about 30% Euro-Americans, 10% African-Americans, 7% Asian-Americans, and 1% Native-Americans. About 2% of county residents claim a new and growing census category, “multi-ethnic”. About a third of residents report that a language other than English is spoken primarily at home.

DBH strengths include a systematic approach to integrating cultural competence in the mental health plan. The DBH Cultural Competence Plan Update submitted to the state in May 2004 was one of the few plans that scored in the range of 85-100 points out of 100 possible points. The Cultural Competence Plan was developed and implemented to address the cultural and linguistic opportunities. With the implementation of the existing Cultural Competency Plan, the county is able to address access barriers and differing penetration rates, and develop a system of care that incorporates appropriate cultural and linguistic treatment services by reviewing, evaluating and modifying the current system. The Performance Improvement Project (PIP) to improve Latino access to mental health care is one example incorporated into the cultural competence and the Quality Improvement plan.

DBH intends to continue the effort to identify possible operational strategies for embedding cultural competence in all components of the Community Services and Support plans of the MHSA. The strategies to achieve a cultural competent system and thereby eliminate the existing ethnic disparities in access to services are focused on:

- Aggressive recruitment/retention of bilingual/bicultural staff to reflect the county population needs.
- Develop training protocols and implement curriculums to address the needs of cultural, racial, ethnic and linguistic groups in our community, including the...
Lesbian, Gay, Bisexual, Transgender (LGBT) population; and consumers with Disabilities.

- Provide a specific training program for all staff working with high-risk youth, the homeless population, Foster Care consumers and the incarcerated.
- Include the Evaluation and Research component to review the data collected.
- Continue the efforts to increase community-based outreach/engagement strategies to enhance delivery of services to the underserved population. Establish and formalize collaborative relationships with health care providers.
- Continue community forums for input in the development of appropriate cultural and linguistic service delivery.
- Continue to strengthen the Cultural Competency Committee to ensure the completion of Cultural Competence Plan’s goals and objectives by participation in interagency committees.

San Bernardino County has the same barriers/limitations presented as other California counties in providing quality mental health services to ethnic populations to transform the mental health service delivery system. As documented in the analysis included in Attachment B, there are limitations on the penetration and retention rates. This reflects the disparities in access to mental health services for cultural, racial, ethnic and linguistic populations. There is insufficient bilingual staff to meet the language needs of the Spanish and Vietnamese speaking populations. There are limited culturally diverse staff and limited training for all staff.

2) Compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

Staff Resources

The San Bernardino County Department of Behavioral Health has 631 regular employees as of November 2005. Two years earlier, the department lost 103 staff during a serious budget crisis. The department's workforce was reduced by lay-offs, bumping by other departments, and attrition. The department is in the process of updating the current workforce to improve the ability to provide cultural and linguistic services to residents.

The DBH employee breakdown by ethnicity is 47% Euro-American, 26% Latino, 9% Asian-American, and 17% African-American. The population needing services is 35% Euro-American, 38% Latino, 4% Asian-American, and 18% African-American. Currently DBH serves 41% Euro-American, 33% Latino, 2% Asian-American, and 18% African-American. (Attachment B1)

Contract agencies report that 48% of employees are Euro-American, 21% are Latino, 25% are African-American, 2% are Asian-American, and 4% are other.
While 26% of total employees are Latino, only 18% provide direct services. There is a need to further identify percentages by classification for Latinos in Mental Health (i.e. Mental Health Specialist, Social Worker or Clinical Therapists I or II, etc.). (Attachment B4)

Only 15% of DBH staff is bilingual Spanish speaking, and less than 1% are Vietnamese speaking. Contract agencies report similar limitations regarding their bilingual staff with 21% Spanish speaking, and 1% Vietnamese speaking. Overall, San Bernardino County, including DBH and Contract agencies, has 1,203 direct service providers of which only 17% speak Spanish, the single threshold language for San Bernardino County. (Attachment B5)

San Bernardino County has a great need for diverse staffing. This gap is apparent in Attachment B7 that compares the ethnicity breakdown for the county population who may need services (individuals below 200% FPL) and clients that are currently served and unserved with current direct service providers.

3) Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges.

**Barriers Related to Staffing Shortages**

Due to the human resource shortages in the field and strong competition for culturally and linguistically diverse professionals and consumers/family providers, DBH faces difficulties in recruiting and hiring these professionals. As demonstrated in Attachment B, the numbers of bilingual Spanish and Vietnamese speaking staff is low compared to the numbers of residents in need of these services.

**Strategies to address these barriers:**

- Develop training opportunities, retention and recruitment efforts.
- Hire a recruiter.
- Collaborate with local universities and colleges to support and promote training of diverse work force.
- Work closely with the Human Resources Unit to develop and implement recruitment and retention of bilingual Spanish and Vietnamese speaking staff to increase the percentage of bilingual staff hire.
- Recruit bilingual consumers and family members at different levels of the organization.
- Develop a cultural and linguistic internship program with the high schools and colleges in our community.
- Develop a Spanish and Vietnamese speaking volunteer program.
- Provide bilingual staff with opportunities to enhance their verbal and written skills.
Enhance the interpretation and translation services by continuing interpretation training and other skill development trainings.
Create an allocation in the budget for the implementation of statewide interpreters training and certification curriculum for mental health providers.
Develop and implement a “Grow your Own” program.

**Barriers to Hiring Consumers and Family Members**

DBH has had trouble hiring consumers and family members and effectively integrating consumers and family members into services. Part of the challenge is the difficulty in obtaining participation of ethnic and linguistic groups in rural areas of the county.

Strategies to address these barriers:

- Hire bilingual/bicultural volunteer coordinators to eliminate disparities in the ethnically and linguistically underserved and unserved population.
- Establish written procedures and monitoring systems to ensure the participation of consumers and family members at all levels.
- Provide cultural competence training to bilingual consumers and family members to assist in elimination of disparities and to outreach to specific ethnic communities.
- Provide cultural competence training to staff and the community at large.
- Develop and implement a cultural and linguistic outreach program.
- Develop an outreach plan that maximizes input and involvement of multicultural and multilingual communities.
- Provide interpretation and translation services in all activities designed to involve consumers and family members.
- Develop a consumer and family member cultural competence resource center to provide consultation, technical assistance and resources.
- Hire consumers, consultants, and cultural brokers from ethnically specific and culturally diverse communities to create a consumer run library of cultural competence resources, develop consumer cultural training curriculums and create cultural and linguistic educational materials.
- Establish mentoring program in partnership with ethnically specific community groups.

**Barriers in Developing Ethnic, Cultural and Linguistic Specific Services**

Overall, DBH is committed to cultural competence. One of the challenges is the development, implementation and evaluation of practices that result in meaningful and positive outcomes for underserved culturally, ethnically and linguistically diverse populations.

Strategies to address these barriers:
• Participate with the California Institute for Mental Health (CIMH) for Multicultural Development Adapting Culturally Competent Practices Project (ACCP)
• Establish a more focused research method that includes racial and ethnic communities to identify best and promising practices. Create programs that are more effective and cost efficient. Implement outcome studies with these practices.
• Conduct cultural competence training with staff, consumers and the community. Develop process to continually train staff, measure effectiveness of training and monitor staff attendance.
• Participate in the roll out of the California Brief Multicultural Competence Scale Training Program Curriculum to train all DBH and contract agency staff.
• Create an allocation in the budget for implementation of pilot studies on practices that are ethnically and linguistically specific.
• Establish clinical practice standards with measurable objectives, specific to the Mental Health Services Act.

**Barriers in the Implementation and Monitoring of Cultural Competence Program**

During the last three years, DBH has had limited resources for the implementation and monitoring of the Cultural Competence Plan.

Strategies to address these barriers:

• Embed cultural competence and strategies to eliminate and prevent disparities in all the implementation efforts of the MHSA.
• Develop an accountability system that assesses the progress of the department in increasing its culturally competent programs and eliminating disparities.
• Monitor the County and service contractors to verify that the delivery of services is in accordance with local and state mandates as they affect underserved and unserved populations.
• Integrate cultural competence at all levels of the system including policy, programs, operations, treatment, research and evaluation, training and quality improvement.
• Integrate cultural competence as an integral component to Quality Care, Quality Management and Quality Improvement.
• Develop policies and procedures related to the cultural competence committee.
• Create an allocation in the budget for outreach activities to multicultural and multilingual populations.
• Create an allocation in the budget for cultural competence training and consultation to develop and expand local expertise, including consumer’s cultural training.
• Work with cultural, ethnic, and linguistic diverse clients, family, and communities to provide training and support to these under-represented groups.
• Monitor providers’ cultural and linguistic capacity, client outcomes, client satisfaction with services, and penetration and retention for all diverse populations.
• Continue the implementation of human resources development strategies to increase the cultural and linguistic capacity of the agency.
• Implement a cultural competence training policy that includes a mandated training program.
• Include culturally diverse consumers and family members in the development of policies that affect service delivery.
• Develop culturally competent, strength-based, early intervention and prevention strategies.
PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Section VI: Developing Work Plans with Timeframes and Budgets/Staffing

I. Summary information on Programs to be Developed or Expanded

1) Please complete Exhibits 1, 2, and 3 providing summary information related to the detailed work plans contained in the Program Expenditure Plan.

Exhibits 1, 2 and 3 are completed and included with this document.

2) The majority of a county’s total three year CSS funding must be for Full Service Partnerships. Please provide information demonstrating that this requirement has been met.

Detailed in the chart below is a summary of San Bernardino County’s proposed budget information by fiscal year and funding category, including estimated administrative and one-time start up costs. As reflected in this chart, 51% of the funding will serve individuals in Full Service Partnership programs over the three-year funding period.

<table>
<thead>
<tr>
<th>Type of Funding</th>
<th>FY 05/06</th>
<th>FY 06/07</th>
<th>FY 07/08</th>
<th>Totals</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Full Service Partnerships</td>
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<td>$8,790,085</td>
<td>$8,735,236</td>
<td>$19,420,866</td>
<td>51%</td>
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<tr>
<td>Outreach &amp; Engagement</td>
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<td>$1,005,941</td>
<td>$1,060,790</td>
<td>$2,282,913</td>
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<tr>
<td>Sub Total</td>
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<td>$17,168,200</td>
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<td>One-Time Only</td>
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<td>$1,906,251</td>
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<td>Total Budget</td>
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<td>$21,702,270</td>
<td>$19,074,451</td>
<td>$50,237,289</td>
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</table>

3) Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

It is expected that 20% of individuals served by System Development Funds in the first 2 years and 25% the third year will have Full Service Partnerships each year.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>System Development</th>
<th>Full Service Partnerships</th>
<th>%</th>
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<tr>
<td>2005-06</td>
<td>602</td>
<td>120</td>
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<tr>
<td>2006-07</td>
<td>3255</td>
<td>651</td>
<td>20</td>
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<tr>
<td>2007-08</td>
<td>3255</td>
<td>814</td>
<td>25</td>
</tr>
</tbody>
</table>
4) Please provide the estimated and unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

It is expected that 10% of individuals reached through Outreach and Engagement strategies in the first 2 years and 15% the third year will have Full Service Partnerships each year.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Outreach and Engagement</th>
<th>Full Service Partnerships</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>208</td>
<td>21</td>
<td>10</td>
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<tr>
<td>2006-07</td>
<td>1880</td>
<td>188</td>
<td>10</td>
</tr>
<tr>
<td>2007-08</td>
<td>1880</td>
<td>282</td>
<td>15</td>
</tr>
</tbody>
</table>

5) For Children, Youth, and families, the MHSA requires all counties to implement Wraparound services pursuant to W & I code Section 18250, or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies.

Since 2001 DBH, in collaboration with the Department of Children’s Services (DCS) and the Probation Department developed Wraparound services for children and families under the requirements of SB 163. However, during this time available services focused only on the City of San Bernardino and children in group home placements at a level 10 and above, or at risk of placement in group home at a level 10 and above. To be eligible, a child also had to have Medi-Cal and a family member or caretaker to participate in the Wraparound process. Only one contracted provider took referrals for the Wraparound services during the three year pilot program. In 2005, RFPs went out for countywide SB 163 Wraparound Services. Each major region of San Bernardino County will have some Wraparound slots available to provide 200 slots by year-end. The slots will be countywide in each region of the West Valley, East Valley/San Bernardino, Mountains, High Desert (Victor Valley), and Mid Desert (Morongo Basin) regions.

Although San Bernardino County lost funding for the Children’s System of Care services, many of the components have been maintained to ensure that services are provided from an individualized, youth and family driven, strength based perspective with the goal of keeping children in their homes, out of placements, in school, out of trouble and out of harm’s way. The programs for children of San Bernardino County continue to be rooted in the values and principles of the Children’s System of Care. Its concepts include the philosophy of recovery, wellness, and resilience to help strengthen the bonds and attributes of each youth and their family to improve their functioning and stability in the community. A continuum of care has been developed and is overseen in conjunction with the Children’s Network, an organization made up of all of the child serving agencies in San Bernardino County, focused on providing and developing the best programs and services for children and families. DBH works collaboratively with...
these partners. New projects and ideas are constantly being explored to help children, youth and families maintain hope, encouragement and strength.

Such work products as field based, in-home support, and intensive case management services are a major component of the San Bernardino County DBH child and family service network. An Interagency Committee reviews the most difficult cases of children at risk for the highest levels of care. Recommendations are made for case managers to work together to break down barriers so these families can get the services they need and the child can get the help they need without unnecessary red tape. Mobile Crisis Response Teams, Intensive In-Home Support Teams, Wraparound Services, Therapeutic Behavioral Services, Intensive Case Management, coordination with outpatient clinics, intensive group therapy, and medication support services are only a few of the services that are part of the continuum of care. These services help to reduce the number of youth hospitalized, placed in acute and state hospitals, incarcerated, or attempting suicide.

II. Programs to be developed or expanded — the following information is required for each program. Since the review process may approve individual program work plans separately, it is critical that a complete description is provided for each program. If a particular question is not applicable for the proposed program, please so indicate.

Please refer to the Exhibit 4s for details about each program that is to be developed or expanded.
## Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

**Fiscal Year:** 2005-06

<table>
<thead>
<tr>
<th>County: San Bernardino</th>
<th>TOTAL FUNDS REQUESTED</th>
<th>FUNDS REQUESTED</th>
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<tr>
<td>#</td>
<td>Program Work Plan Name</td>
<td>Full Service Partnerships</td>
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<tr>
<td>C-1</td>
<td>Comprehensive Child and Family Support System</td>
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<tr>
<td>TAY-1</td>
<td>One Stop TAY Center</td>
<td>677,121</td>
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<td>A-1</td>
<td>Consumer-Operated Peer Support Svcs &amp; Clubhouse Expansion</td>
<td>181,760</td>
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<tr>
<td>A-2</td>
<td>Forensic Integrated MH Services</td>
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<td>A-3</td>
<td>High Hospital User ACT Team</td>
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<td>A-4</td>
<td>Crisis Walk-in Centers</td>
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<td>A-5</td>
<td>Psychiatric Triage Diversion Team at ARMC</td>
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<td>OA-1</td>
<td>Circle of Care: System Development</td>
<td>226,049</td>
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<td>OA-2</td>
<td>Circle of Care: Mobile Outreach &amp; Intensive Case Management</td>
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<td>AD-1</td>
<td>Administrative Support</td>
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**San Bernardino County MHSA CSS**  
Program and Expenditure Plan-February 2006  
64
## Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

**Fiscal Year:** 2005-06

<table>
<thead>
<tr>
<th>#</th>
<th>Program Work Plan Name</th>
<th>Full Service Partnerships</th>
<th>System Development</th>
<th>Outreach &amp; Engagement</th>
<th>Total Request</th>
<th>Children, Youth, Families</th>
<th>Transition Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
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<tr>
<td>OTO-2</td>
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<td>OTO-3</td>
<td>Cultural Competency activities</td>
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<td>OTO-5</td>
<td>Capital Purchases</td>
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<td>$526,925</td>
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<th>Total Funds Requested</th>
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## Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

**Fiscal Year:** 2006-07

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<th>#</th>
<th>Program Work Plan Name</th>
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<th>Outreach &amp; Engagement</th>
<th>Total Request</th>
<th>Children, Youth, Families</th>
<th>Transition Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
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<tr>
<td>C-1</td>
<td>Comprehensive Child and Family Support System</td>
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<td>81,681</td>
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<td>141,148</td>
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<td>3,528,712</td>
<td>3,528,712</td>
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<td>A-1</td>
<td>Consumer-Operated Peer Support Svcs &amp; Clubhouse Expansion</td>
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<td>A-2</td>
<td>Forensic Integrated MH Services</td>
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<td>769,805</td>
<td>769,805</td>
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<tr>
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**TOTAL FUNDS REQUESTED**

- $8,790,085
- $7,372,174
- $1,005,941
- $17,168,206
- $3,722,801
- $5,005,934
- $5,331,595
- $3,107,870

San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006

66
### Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

**Fiscal Year:** 2006-07

<table>
<thead>
<tr>
<th>#</th>
<th>Program Work Plan Name</th>
<th>Full Service Partnerships</th>
<th>System Development</th>
<th>Outreach &amp; Engagement</th>
<th>Total Request</th>
<th>Children, Youth, Families</th>
<th>Transition Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
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<td>$45,794</td>
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<td>C-1</td>
<td>Comprehensive Child and Family Support System</td>
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<td>TAY-1</td>
<td>One Stop TAY Center</td>
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<tr>
<td>A-1</td>
<td>Consumer-Operated Peer Support Svcs &amp; Clubhouse Expansion</td>
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<td>A-2</td>
<td>Forensic Integrated MH Services</td>
</tr>
<tr>
<td>A-3</td>
<td>High Hospital User ACT Team</td>
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<td>Crisis Walk-in Centers</td>
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<tr>
<td>A-5</td>
<td>Psychiatric Triage Diversion Team at ARMC</td>
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<tr>
<td>OA-1</td>
<td>Circle of Care: System Development</td>
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<tr>
<td>OA-2</td>
<td>Circle of Care: Mobile Outreach &amp; Intensive Case Management</td>
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<td>AD-1</td>
<td>Administrative Support</td>
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### Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

**Fiscal Year:** 2007-08

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<th>Full Service Partnerships</th>
<th>System Development</th>
<th>Outreach &amp; Engagement</th>
<th>Total Request</th>
<th>Children, Youth, Families</th>
<th>Transition Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
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<tr>
<td>OTO-3 Cultural Competency activities</td>
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<td>183,176</td>
<td></td>
<td>$45,794</td>
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<td>$45,794</td>
<td>$45,794</td>
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<td>OTO-4 Housing</td>
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<table>
<thead>
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<th>TOTAL FUNDS REQUESTED</th>
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<tbody>
<tr>
<td></td>
<td>$1,325,000</td>
<td>$581,251</td>
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### EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION - OVERVIEW

Numbers of individuals to be fully served:
- **FY 2005-06:**
  - Children and Youth: 51
  - Transitional Age Youth: 68
  - Adult: 42
  - Older Adult: 0
  - Total: 161
- **FY 2006-07:**
  - Children and Youth: 203
  - Transitional Age Youth: 612
  - Adult: 664
  - Older Adult: 17
  - Total: 1,496
- **FY 2007-08:**
  - Children and Youth: 203
  - Transitional Age Youth: 612
  - Adult: 664
  - Older Adult: 17
  - Total: 1,496

### PERCENT OF INDIVIDUALS TO BE FULLY SERVED

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<tr>
<th>Race / Ethnicity</th>
<th>% Male</th>
<th>% Female</th>
<th>% Male</th>
<th>% Female</th>
<th>% Male</th>
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<th>% Male</th>
<th>% Female</th>
<th>% Male</th>
<th>% Female</th>
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<tr>
<td></td>
<td>%Total</td>
<td>% Non-English Speaking</td>
<td>%Total</td>
<td>% Non-English Speaking</td>
<td>%Total</td>
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<td>0.3%</td>
<td>1.0%</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>3.0%</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
</tr>
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<td>% White</td>
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<tr>
<td>% Other</td>
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<td>0.1%</td>
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<td>0.1%</td>
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<td></td>
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<td>49</td>
<td>7</td>
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<td>5</td>
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<td>5</td>
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</table>

| **2006/07**               |        |          |        |          |        |          |        |          |        |          |       |
| % African American        | 5.5%   | 0.0%     | 5.5%   | 0.0%     | 3.0%   | 0.0%     | 3.0%   | 0.0%     | 17.0% |
| % Asian Pacific Islander  | 1.0%   | 0.3%     | 1.0%   | 0.3%     | 0.5%   | 0.3%     | 0.5%   | 0.3%     | 3.0%  |
| % Latino                  | 12.0%  | 14.0%    | 12.0%  | 14.0%    | 8.0%   | 14.0%    | 8.0%   | 14.0%    | 40.0% |
| % Native American         | 0.3%   | 0.0%     | 0.3%   | 0.0%     | 0.2%   | 0.0%     | 0.2%   | 0.0%     | 1.0%  |
| % White                   | 10.5%  | 0.1%     | 10.5%  | 0.1%     | 7.0%   | 0.1%     | 7.0%   | 0.1%     | 35.0% |
| % Other                   | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 4.0%  |
| **Number of Persons**     | 453    | 66       | 453    | 66       | 295    | 43       | 295    | 43       | 1,496 |

| **2007/08**               |        |          |        |          |        |          |        |          |        |          |       |
| % African American        | 5.5%   | 0.0%     | 5.5%   | 0.0%     | 3.0%   | 0.0%     | 3.0%   | 0.0%     | 17.0% |
| % Asian Pacific Islander  | 1.0%   | 0.3%     | 1.0%   | 0.3%     | 0.5%   | 0.3%     | 0.5%   | 0.3%     | 3.0%  |
| % Latino                  | 12.0%  | 14.0%    | 12.0%  | 14.0%    | 8.0%   | 14.0%    | 8.0%   | 14.0%    | 40.0% |
| % Native American         | 0.3%   | 0.0%     | 0.3%   | 0.0%     | 0.2%   | 0.0%     | 0.2%   | 0.0%     | 1.0%  |
| % White                   | 10.5%  | 0.1%     | 10.5%  | 0.1%     | 7.0%   | 0.1%     | 7.0%   | 0.1%     | 35.0% |
| % Other                   | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 1.0%   | 0.1%     | 4.0%  |
| **Number of Persons**     | 453    | 66       | 453    | 66       | 295    | 43       | 295    | 43       | 1,496 |

San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006  
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## EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

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<th>County:</th>
<th>San Bernardino County</th>
</tr>
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<td>2005-06, 2006-07, 2007-08</td>
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<td>Program Work Plan #:</td>
<td>C-1</td>
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<tr>
<td>Program Work Plan Name:</td>
<td>Comprehensive Child/Family Support System (CCFSS)</td>
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<tr>
<td>Estimated Start Date:</td>
<td>2-4 Months Post MHSA Plan Approval</td>
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### Description of Program:

*San Bernardino County has developed an array of services for children that are challenged with emotional disturbances. Services include school based, home based, hospital and crisis response and wraparound services.*

#### Wraparound Service Model

The Comprehensive Child/Family Support System (CCFSS) will establish a “seamless” system of care for children and families in San Bernardino County to negotiate multiple agencies and funding sources. The goal is to coordinate and access services for families with children that suffer with emotional disturbances. DBH currently works with the Department of Children’s Services, Juvenile Justice, schools, Regional Centers, law enforcement, faith-based agencies, community agencies and stakeholders. The CCFSS plans to broaden those relationships to include domestic violence shelters and preschool programs. The CCFSS will work with the population, ages 0-15. The plan is to serve 203 children and youth, and their families annually. The CCFSS will provide full service partnerships and 24/7 services for children, youth and families that have been unserved or underserved through the current SB 163 Wraparound Program.

The treatment component will utilize evidence-based practices such as Cognitive Based Therapy (CBT), Aggressive Replacement Therapy, and Trauma Focused CBT. Services will include case management, family focus treatment, flexible funding, service coordination, childcare, co-occurring treatment, psychiatric services, family advocacy, and parent partnerships.

In the past fiscal year the SB 163 Wraparound Program has expanded to each region of San Bernardino County and includes 200 slots for youth that meet the SB 163 criteria. The CCFSS program will allow children and youth in need of services that do not meet the SB 163 criteria to be enrolled to prevent them from out-of-home placements (Foster Care, group homes, institutions).
<table>
<thead>
<tr>
<th><strong>Children’s Crisis Response Teams</strong></th>
<th>Currently San Bernardino County has one Children’s Crisis Response Team (CCRT) that operates 8 a.m. to 10 p.m. The expanded CCRT under the MHSA will support the CCFSS program as well as provide needed crisis response within the county. Crisis Response services will be expanded to three additional regions. These services should help reduce hospitalizations, out-of-home placements, and to help children and youth remain and return to their families. The program services will increase stabilization, independence, help families identify community supports, and encourage resiliency and wellness. With the expansion of the CCRT teams it is expected that we will serve 25% more children and youth, which translates to 200 more clients annually.</th>
</tr>
</thead>
</table>
| **Priority Population:**  
*Describe the situational characteristics of the priority population.* | The priority population will include children and youth ages 0-15 that struggle with emotional disturbances and co-occurring disorders. The CCFSS will provide services to children and youth identified as unserved, underserved, or who have experienced inappropriate service delivery in culturally diverse communities. San Bernardino County data demonstrates that Latino and African-American children and youth experience institutionalization, hospitalization, and foster care at higher rates than other children and youth. Children and youth who do not meet the current criteria for mental health services will be targeted. Once families are enrolled in the program they will be evaluated every 6 months to determine their current achievements, movement towards resilience, and recovery progress. Based on the outcomes of these evaluations, continued service in the full service partnership will be determined. |
### Wraparound Service Model

- The Wraparound service model will coordinate comprehensive services that provide strength-based, values-driven, evidence-based, and family focused services that are culturally and linguistically competent.
- Initial components of the program will include mental health, trauma, violence, co-occurring disorders, and substance abuse screening; in order to develop individualized treatment plans.
- The treatment will include evidence-based modalities such as Cognitive Behavioral Therapy (CBT), Aggressive Replacement Therapy, Trauma Focused CBT, and co-occurring treatment consistent with the families’ cultural and linguistic needs.
- The Family Partnership Program, operated by family members, will play a key advocacy role for families. The focuses will be to engage and encourage families from culturally diverse backgrounds and to train and support families to advocate for their specific needs.
- Ongoing Cultural Competency Training will be provided for all staff and consumers.
- Service delivery and supports will be provided at schools, in the community, and in the child or youth’s home.

### Children's Crisis Response Teams (CCRT)

- San Bernardino County Children’s Crisis Response Team will be expanded to include four regions of the county, serving 200 more children.
- Crisis service will include 24-hour phone and on site consultation services.
- Provision of services to unserved and underserved populations through hiring family partners to reach out to those reluctant to enter the system.
- Basic outreach and education to the community regarding the availability of services for youth and families through faith-based, community, and other human service organizations.
- The goal is to engage 67 underserved children.
2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Wraparound Service Model

The Comprehensive Child and Family Support System (CCFSS) addresses MHSA goals for system transformation by increasing wraparound intervention services to unserved, underserved and uninsured children, youth and their families. Many of these families do not qualify for Medi-Cal for other funding sources. Traditionally, many of these families had to wait until the child or youth was failing in several areas in their life in order to receive services. Additionally, families from diverse communities end up in the high-end institutional services because they have not received appropriate services.

This service modality will establish field-based Wraparound Teams throughout the county that will coordinate services for families not eligible for the county’s current SB 163 Wraparound program. These families could be experiencing mental illness and or co-occurring disorders. An individualized assessment would be administered to determine their needs for services. The Team Facilitator, in conjunction with all relevant parties, will explore and prioritize all life domain areas. The Team facilitator will work with the family in a partnership. Safety of the child and their family, ongoing risk assessments and protective factors will be essential components.

The initial target area will be the West Valley region of San Bernardino County. Specific efforts will be made to reach Latino and African-American youth who are over represented in the Juvenile Justice System and in Foster Care, who do not have access to appropriate services, and are inappropriately served or underserved. All staff working with these families will be required to have ongoing cultural competency training to increase the skills needed to meet the needs of culturally diverse populations. The goal will be to recruit, hire, and train bicultural, bilingual and diverse staff.

Services will be delivered in the home or in community settings convenient for the families. The focus will be on meeting the child and family’s prioritized unmet needs. These may include, but are not limited to: individual and family therapy, case management, rehabilitation, medication support, crisis intervention, respite services, skill building, behavior management training of parents and families, managing stigma, sexual orientation education and other challenges that present themselves. The focus will be to do “whatever it takes” to keep the child at home, in school, and in the community. Progress will be measured every six months to track a family’s movement toward independence, wellness and resiliency.

The CCFSS has several components through which families can access services. The Case Management component will provide the coordination to meet the families’ needs. The other components of the program include:
Parent advocacy and support: This component will help engage the family as a partner in the process. A Family or Parent Partner will be hired to assist the parents and families build a support network and to provide a bridge between staff, agencies, and the family. Services that are part of this component include, but are not limited to: a parent support group, family resource conferences, parent trainings, family activities, resource library, and cultural celebrations. In addition, community collaboration and resource development will be a very important part of the program. The location and development of needed resources to help these children, youth and families will be key in their recovery and development of resilience. Their connection to the community will support their healing process. The integrated relationships in the community and the agencies’ expertise and services will assist the families to improve their ability to function effectively. The Parent Partners will help families develop their own skills to develop community partnerships and to maneuver through the system.

Childcare Support Services: Many families are challenged with children that require specialized childcare. These families can benefit from childcare support services. This service will be developed for families by providing alternative caregivers, alternative weekend care, or temporary housing for parents. Flexible funding will be utilized to fund these services. Families will help the team facilitator determine their childcare support needs.

Co-Occurring Treatment Services: Currently, San Bernardino County does not have outpatient or residential treatment services available to address children and youth who suffer from co-occurring disorders. The CCFSS, through its wraparound system of care, will have trained staff that can work with families, children and youth who suffer from co-occurring disorders. Many of the families in the target population are challenged with mental illness and drug and alcohol abuse. This is an underserved population. The teams, through the assessment process, will help families identify their needs and provide coordinated services.

Collaboration: Through the CCFSS, partnerships with community-based organizations and service providers. Some partners will include schools, Law Enforcement, Juvenile Justice, Department of Children’s Services, Inland Regional Center, faith-based agencies and organizations that are culturally specific. The initial collaboration will be with the parents and families to assist them to engage their community.

Cultural Competence: Mental health services will be provided to children and families in their home and community. The services will build on the unique values and strengths of their culture and community. Staff will be recruited that speak the appropriate languages to provide linguistically specific services. Ongoing training on culturally specific services will be provided. The cultural strengths will be an important component in the
service delivery system. Families will help the team identify their unique needs based on cultural, ethnic and religious beliefs and values.

- **Client/family driven system of care**: This component identifies parents and children as the primary decision makers in the goal setting process. They are responsible for making decisions and planning treatment needs and services. This component is based on a partnership with the team and agency members. Parents will be given the information they need to make informed decisions. Clear and direct communication will be utilized.

- **Crisis Response Team services**: This service component, operated by the county, will be available as one of the services offered to the child, youth and their families. Families have crisis and emergencies at all hours; crisis intervention services are an important component to assist families in dealing with their problems rapidly. The CCRT will focus on the child and family’s strengths as well as utilize the cultural characteristics in service delivery. Staff will be trained to work with families in crisis and help them to learn strategies to prevent further crisis. The team can respond to crisis 24 hours a day. They can offer support by telephone or at a family’s home to help them work through challenges as they arise. The team members will increase family homeostasis to prevent out-of-home placement.

Wellness and resilience will build upon the strengths of the children and family. The qualities of optimism, problem solving and the installation of hope will be the team focus. All treatment services will foster confidence, autonomy, and respect for the children, youth and families served. Families will be able to define wellness and resilience based on their unique experiences and goals. Mental and physical health wellness will be the focus of the interventions as defined by the families.

3) **Describe any housing or employment services to be provided.**

The CCFSS will evaluate the family’s need for housing and employment and will work with local public and private agencies to help families meet this need. The adult system of care has developed housing services as part of the MHSA that these families will be able to access.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

The CCFSS will be a Full Service Partnership with an average cost of $12,742 per consumer.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**
San Bernardino County is developing a comprehensive system of monitoring county and contract agencies to ensure the requirements of recovery and resiliency by children, youth and families are met. It will be an expectation that the case progress notes reflect the recovery and resiliency goals. This monitoring process advances DBH’s commitment to achieving recovery and resiliency. The resilience framework draws attention to the importance of hope and success. As the family begins to define themselves and their success in the program, a satisfaction survey will be completed to measure the family’s perception of their recovery and resiliency progress. The results of the surveys can be used to reinforce to contract agencies and county staff that recovery and resiliency is the main focus of our work with families.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

**Wraparound Service Model**

The CCFSS program will be an expansion of the current wraparound services without the SB 163 regulations.

San Bernardino County DBH in collaboration with the Department of Children’s Services implemented a SB 163 Wraparound program with an initial capacity of 35 children. The program was piloted in the East Valley/San Bernardino region with the understanding that a successful pilot would enable the expansion of the program countywide. The pilot ended successfully in May 2005. In 2005 the program was expanded to all regions and an increased capacity of 200 children. The collaborative relationship between the Department of Behavioral Health and the Department of Children’s Services is a successful example that can be used for future programs.

The proposed CCFSS program seeks to expand eligibility to include non-Medi-Cal eligible children and families that have difficulty navigating the system or getting access to appropriate services to meet their needs. The program would increase the array of services available to currently underserved and unserved children, youth and families that may not meet other program criteria. The focus of enrollment will be on serving culturally diverse families. The expansion will include serving children and families referred from community based organizations, the Probation Department, schools, Regional Centers, hospitals, faith-based or culturally specific organizations, and parents who previously may have been unaware of services. The components of the parent and child-focused program are: coordination, assessment, treatment, collaboration, evidence-based practices, and outcome orientated services.

**Children’s Crisis Response Team (CCRT)**

San Bernardino County DBH has a Children’s Crisis Response Team (CCRT), which currently provides crisis services to the East Valley/San Bernardino, Central Valley, and West Valley regions of the county. The team works with the police
department, hospitals, group homes, schools, Department of Children’s Services and other community agencies. The CCRT evaluates children and adolescents experiencing psychiatric emergencies, conducts Welfare and Institutions Code 5585 assessments, coordinates intensive hospital after care services and provides in-home support services. The program began in May 2004. Between May 2004 and December 2005 there were 1334 requests for services. The program’s efforts resulted in 63% avoidance of inpatient hospital stays. The expansion of this program will serve 200 more children and youth. It will include the High Desert and Mid Desert regions as well as add staff to the existing county program for added coverage.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The CCFSS Wraparound Program will have a Parent Partner component. The parents and family members, as a part of the service coordination teams, will operate this component. They will be responsible for working with families directly as advocates. They will help to work with families from diverse backgrounds, holding focus and support groups. They will provide information to the team facilitator to increase the ability of families to be active team members. Additionally, the goal is to have a Parent Partner facilitate monthly Parent Network meetings, support parents on teams and provide program administration staff guidance to better serve the families enrolled.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Historical Collaborations

In 2003, DBH developed a Children’s Services Strategic Plan in collaboration with the Children’s Network. Currently, DBH has collaborative relationships with more than 20 contract providers as well as NAMI. The Children’s Network of San Bernardino County was developed to coordinate interagency collaboration. Currently, the Children’s Policy Council membership includes: Juvenile Court, Transitional Assistance Department, Inland Regional Center, the Probation Department, Public Health, Preschool Services, County Library, the Public Defender's Office, County Counsel, Superintendent of County Schools, San Bernardino City Unified School District, First 5 San Bernardino, Board of Supervisors, Department of Children’s Services, County Administrator’s Office, Children’s Fund, Sheriff's Office, Community Action Partnerships, Economic and Community Development, Arrowhead Regional Center and the District Attorney’s Office. This group meets every other month to discuss issues related to the needs of children, youth and families. The Children’s Network is an existing, effective forum for negotiating collaborative strategies and developing formal agreements around
children’s issues and services. The Children’s Network is the entity that is responsible for facilitating development, revision and renewal of documents that support the interagency collaboration for children. This council examines legislation and makes recommendations to appointing authorities regarding issues related to meeting the needs of children in San Bernardino County.

This network of public and private agencies meets to provide support and resources for services needed in the county. Many of the members were part of the MHSA Community Policy Advisory Committee. The benefit of having this group already established is the ability to have a forum to discuss service delivery, new programming, build collaborations and increase resource development. This provides a regular opportunity to keep stakeholders up to date and get immediate feedback to improve outcomes and build stronger systems.

**Existing Collaborations**

The Probation Department, DCS, DBH, County and Public schools, and the Regional Center participate on an Interagency Placement Review Committee to assess children and youth’s group home needs and or State Hospital placements.

The Probation Department, DCS and DBH have current MOUs for the purpose of participating in Wraparound Services.

The Probation Department and DBH have collaborated on several projects, such as the Vision Quest Residential Treatment Program and the development of Mental Health services in the Juvenile Hall facilities.

The county Special Education Local Planning Areas (SELPA) has a MOU with DBH that describes the working relationship as it relates to providing mental health services in the schools.

DCS has a MOU with DBH to provide services in the Healthy Homes Programs as well as intensive day treatment in the Hospital step down residential program.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

DBH is aware of the growing culturally diverse populations in the county. The data demonstrates the need to provide services to Latino and African-American populations. The initial plan includes hiring several Outreach Coordinators to develop relationships within the community, conduct focus groups and increase the community’s awareness of the services available in the county. DBH has an ongoing commitment to continuing the community-based services already in place and developing other community-based services that can be provided near the consumer populations that need services.
DBH is committed to working with faith-based organizations and community agencies to identify the needs of the community as future programs are developed. Furthermore, DBH is committed to work differently in the community to provide better service delivery and monitoring.

The DBH Cultural Competency Plan (CCP) requires staff to have regular education and training to develop skills to work with lesbian, gay, bisexual, transgender (LGBT), disabled, ethnically diverse and others. Part of the system improvement plan is to hire a resource that focuses solely on the staffing needs of the county. The goal of the CCP is to recruit, hire, train and retain staff, including certified interpreters to meet the cultural and linguistic needs of the populations with which we work.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

DBH plans to continue the existing training program to address meeting the mental health needs in a sensitive manner for all populations, including sexual orientation, gender specific treatment and cultural competency. County staff and contractors will be held accountable for the concepts taught during training. DBH is currently in the hiring process for a trainer to develop competency-based training for staff. Mandatory ongoing training will be a requirement for all staff.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

San Bernardino County has an inter-county agreement that serves as a mechanism for developing contracts with out of county providers. Currently, there are five contracts with out of county providers. DBH is in the process of developing the capacity to provide Therapeutic Behavioral Services TBS to youth residing out of county. We are contracting with a provider that specializes in services to young teen girls out of county. Although the out of county population is not a large part of the population we serve, it is ethically appropriate and responsible to make sure that services are in place for youth that reside out of county. The State is currently working on a funding mechanism that will assist the counties in recouping and paying for services for youth that reside in out of county placements.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

1 to 3 months - RFP process
3 to 12 months - Program fully implemented and goals met

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

- a) Work plans and most budget/staffing worksheets are required at the program level.
- b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

- **a.** Clothing, Food and Hygiene: $2,447
- **b.** Travel and Transportation: $1,721
- **c.** Housing:
  - Master Leases: $0
  - Subsidies: $0
  - Vouchers: $0
  - Other Housing: $0
- **d.** Employment and Education Supports: $1,013
- **e.** Other Support Expenditures (provide description in budget narrative): $5,063

**Total Support Expenditures:** $0

### 2. Personnel Expenditures

- **a.** Current Existing Personnel Expenditures (from Staffing Detail): $844,822
- **b.** New Additional Personnel Expenditures (from Staffing Detail): $94,110
- **c.** Employee Benefits: $124,225

**Total Personnel Expenditures:** $969,988

### 3. Operating Expenditures

- **a.** Professional Services: $4,350
- **b.** Translation and Interpreter Services: $51
- **c.** Travel and Transportation: $8,613
- **d.** General Office Expenditures: $24,621
- **e.** Rent, Utilities and Equipment: $116,708
- **f.** Medication and Medical Supports: $1,839
- **g.** Other Operating Expenses (provide description in budget narrative): $33,441

**Total Operating Expenditures:** $0

### 4. Program Management

- **a.** Existing Program Management: $2,286,843
- **b.** New Program Management: $0

**Total Program Management:** $2,286,843

### 5. Estimated Total Expenditures when service provider is not known

- **Total Estimated Expenditures when service provider is not known:** $0

### 6. Total Proposed Program Budget

- **San Bernardino County MHSA CSS Program Workplan # 83**

**Total Proposed Program Budget:** $969,988

## B. Revenues

### 1. Existing Revenues

- **a.** Medi-Cal (FFP only): $422,411
- **b.** Medicare/Patient Fees/Patient Insurance: $1,143,422
- **c.** Realignment: $42,241
- **d.** State General Funds: $380,170
- **e.** County Funds: $1,029,079
- **f.** Grants: $1,409,249
- **g.** Other Revenue: $1,409,249

**Total Existing Revenues:** $844,822

### 2. New Revenues

- **a.** Medi-Cal (FFP only): $103,212
- **b.** Medicare/Patient Fees/Patient Insurance: $103,212
- **c.** State General Funds: $92,891
- **d.** Other Revenue: $92,891

**Total New Revenue:** $196,102

### 3. Total Revenues

- **Total Revenues:** $998,000

### C. One-Time CSS Funding Expenditures

- **Total One-Time CSS Funding Expenditures:** $998,000

### D. Total Funding Requirements

- **Total Funding Requirements:** $1,123,166

### E. Percent of Total Funding Requirements for Full Service Partnerships

- **Percent of Total Funding Requirements for Full Service Partnerships:** 93.0%
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clothing, Food and Hygiene-based on average annual cost of $145 per client</td>
<td>$ 2,447</td>
</tr>
<tr>
<td>b. Travel and Transportation-based on average annual cost of $102 per client</td>
<td>$ 1,721</td>
</tr>
<tr>
<td>d. Employment and Education Supports-based on average annual cost of $60 per client</td>
<td>$ 1,013</td>
</tr>
<tr>
<td>e. Other Support Expenditures-respite care-based on average annual cost of $300 per client</td>
<td>$ 5,063</td>
</tr>
<tr>
<td>f. Total Support Expenditures</td>
<td>$ 10,243</td>
</tr>
</tbody>
</table>

### 2. Personnel Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Current Existing Personnel Expenditures-existing crisis response team staff full year salary and benefit costs in 2005-06</td>
<td>$ 844,822</td>
</tr>
<tr>
<td>b. New Additional Personnel Expenditures-44 staff salaries budgeted at 25% in 2005-06</td>
<td>$ 470,548</td>
</tr>
<tr>
<td>c. Employee Benefits-33% of of salaries</td>
<td>$ 155,281</td>
</tr>
<tr>
<td>d. Total Personnel Expenditures</td>
<td>$ 1,470,651</td>
</tr>
</tbody>
</table>

### 3. Operating Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE</td>
<td>$ 4,350</td>
</tr>
<tr>
<td>b. Translation and Interpreter Services-based on current average annual cost of $3 per client</td>
<td>$ 51</td>
</tr>
<tr>
<td>c. Travel and Transportation-based on current average annual cost per budgeted employee of $792</td>
<td>$ 8,613</td>
</tr>
<tr>
<td>d. General Office Expenditures-based on current average annual cost per budgeted employee of $2,264</td>
<td>$ 24,621</td>
</tr>
<tr>
<td>e. Rent, Utilities and Equipment-based on current average annual cost per budgeted employee of $7,449 (average does not include average annual building lease costs) plus lease costs for new 7,000 s.f. facility at $1.70 s.g.</td>
<td>$ 116,708</td>
</tr>
<tr>
<td>f. Medication and Medical Supports-based on current average annual cost of $109 per client</td>
<td>$ 1,839</td>
</tr>
<tr>
<td>g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee</td>
<td>$ 33,441</td>
</tr>
<tr>
<td>h. Total Operating Expenditures</td>
<td>$ 189,623</td>
</tr>
</tbody>
</table>

### 4. Program Management

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Existing Program Management-2005-06 provider contracts for Wraparound services</td>
<td>$ 2,286,843</td>
</tr>
<tr>
<td>c. Total Program Management</td>
<td>$ 2,286,843</td>
</tr>
</tbody>
</table>

### 6. Total Proposed Program Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Proposed Program Budget</td>
<td>$ 3,957,359</td>
</tr>
</tbody>
</table>

## B. Revenues

### 1. Existing Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medi-Cal (FFP only)-50% of existing costs</td>
<td>$ 1,565,833</td>
</tr>
<tr>
<td>c. Realignment-5% of existing costs</td>
<td>$ 156,583</td>
</tr>
<tr>
<td>d. State General Funds-EPSDT-45% of existing costs</td>
<td>$ 1,409,249</td>
</tr>
<tr>
<td>h. Total Existing Revenues</td>
<td>$ 3,131,665</td>
</tr>
</tbody>
</table>

### 2. New Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medi-Cal (FFP only)-assume 25% of new clients will be Medi-Cal eligible (30% of costs X 50%)</td>
<td>$ 103,212</td>
</tr>
<tr>
<td>c. State General Funds-EPSDT match to FFP</td>
<td>$ 92,891</td>
</tr>
<tr>
<td>e. Total New Revenue</td>
<td>$ 196,102</td>
</tr>
</tbody>
</table>

### 3. Total Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenues</td>
<td>$ 3,327,767</td>
</tr>
</tbody>
</table>

## C. One-Time CSS Funding Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenant Improvements for lease of facilities totaling 13,000 sq ft-$25 per s.f.</td>
<td>$ 325,000</td>
</tr>
<tr>
<td>Furnishings for 27 employees-$5,000 per employee</td>
<td>$ 135,000</td>
</tr>
<tr>
<td>Computers for 27 employees-$3,000 per employee</td>
<td>$ 81,000</td>
</tr>
<tr>
<td>6 autos ($20,000 each), 1 12-passenger van ($25,000)</td>
<td>$ 145,000</td>
</tr>
<tr>
<td>Training: 27 employees X 40 hours X $100 per hour</td>
<td>$ 108,000</td>
</tr>
</tbody>
</table>

## D. Total Funding Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Funding Requirements</td>
<td>$ 1,627,592</td>
</tr>
<tr>
<td>Classification</td>
<td>Function</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>A. Current Existing Positions</td>
<td></td>
</tr>
<tr>
<td>Clinical Therapist I</td>
<td></td>
</tr>
<tr>
<td>Clinical Therapist II</td>
<td></td>
</tr>
<tr>
<td>MH Clinic Supervisor</td>
<td></td>
</tr>
<tr>
<td>MH Specialist</td>
<td></td>
</tr>
<tr>
<td>Office Assistant III</td>
<td></td>
</tr>
<tr>
<td>Social Worker II</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B. New Additional Positions</td>
<td></td>
</tr>
<tr>
<td>MH Program Manager II</td>
<td></td>
</tr>
<tr>
<td>Clinic Supervisor</td>
<td></td>
</tr>
<tr>
<td>Clinical Therapist I</td>
<td></td>
</tr>
<tr>
<td>Child Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Licensed Psychiatric Technician</td>
<td></td>
</tr>
<tr>
<td>Social Worker II</td>
<td>Family Support Resource Coordinator</td>
</tr>
<tr>
<td>Social Service Aide</td>
<td>Family Partner</td>
</tr>
<tr>
<td>Social Service Aide</td>
<td>Youth Partner</td>
</tr>
<tr>
<td>Office Assistant II</td>
<td></td>
</tr>
<tr>
<td>Office Assistant III</td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Drug Counselor</td>
<td></td>
</tr>
<tr>
<td>Mental Health Specialist</td>
<td></td>
</tr>
<tr>
<td>Staff Analyst II</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Total Program Positions</td>
<td></td>
</tr>
</tbody>
</table>

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   - a. Clothing, Food and Hygiene $39,150
   - b. Travel and Transportation $27,540
   - c. Housing
     - i. Master Leases $0
     - ii. Subsidies $0
     - iii. Vouchers $0
     - iv. Other Housing $0
   - d. Employment and Education Supports $16,200
   - e. Other Support Expenditures (provide description in budget narrative) $81,000
   - Total Support Expenditures $0

2. Personnel Expenditures
   - a. Current Existing Personnel Expenditures (from Staffing Detail) $844,822
   - b. New Additional Personnel Expenditures (from Staffing Detail) $376,437
   - c. Employee Benefits
     - $124,224
     - $496,897
     - $621,121
   - d. Total Personnel Expenditures $1,345,483

3. Operating Expenditures
   - a. Professional Services $17,400
   - b. Translation and Interpreter Services $810
   - c. Travel and Transportation $34,452
   - d. General Office Expenditures $98,484
   - e. Rent, Utilities and Equipment $589,232
   - f. Medication and Medical Supports $29,430
   - g. Other Operating Expenses (provide description in budget narrative) $133,763
   - h. Total Operating Expenditures $1,345,483

4. Program Management
   - a. Existing Program Management $3,561,013
   - b. New Program Management $0
   - c. Total Program Management $3,561,013

5. Estimated Total Expenditures when service provider is not known
   - Total Expenditures $0

## B. Revenues

1. Existing Revenues
   - a. Medi-Cal (FFP only) $422,411
   - b. Medicare/Patient Fees/Patient Insurance $0
   - c. Realignment $42,241
   - d. State General Funds $380,170
   - e. County Funds $0
   - f. Grants $0
   - g. Other Revenue $0
   - h. Total Existing Revenues $844,822

2. New Revenues
   - a. Medi-Cal (FFP only) $446,346
   - b. Medicare/Patient Fees/Patient Insurance $0
   - c. Realignment $0
   - d. State General Funds $401,711
   - e. County Funds $0
   - f. Grants $0
   - g. Other Revenue $0
   - h. Total New Revenue $844,822

3. Total Revenues $1,689,644

## C. One-Time CSS Funding Expenditures
   - Total Funding Requirements $500,661
   - $4,409,071

## E. Percent of Total Funding Requirements for Full Service Partnerships
   - 93.0%
### A. Expenditures

**1. Client, Family Member and Caregiver Support Expenditures**

- a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $39,150
- b. Travel and Transportation-based on average annual cost of $102 per client. $27,540
- d. Employment and Education Supports-based on average annual cost of $60 per client $16,200
- e. Other Support Expenditures-respite care-based on average annual cost of $300 per client. $81,000
- f. Total Support Expenditures $163,890

**2. Personnel Expenditures**

- a. Current Existing Personnel Expenditures-existing crisis response team staff full year salary and benefit costs in 2006-07 $844,822
- b. New Additional Personnel Expenditures-44 staff salaries budgeted at full-year $1,882,186
- c. Employee Benefits-33% of of salaries $621,121
- d. Total Personnel Expenditures $3,348,129

**3. Operating Expenditures**

- a. Professional Services-ongoing training-based on current average annual cost of $400 per employee $17,400
- b. Translation and Interpreter Services-based on current average annual cost of $3 per client $810
- c. Travel and Transportation-based on current average annual cost per budgeted employee of $792 $34,452
- d. General Office Expenditures-based on current average annual cost per budgeted employee of $2,264 $98,484
- e. Rent, Utilities and Equipment-based on current average annual cost per budgeted employee of $7,449 (average does not include average annual building lease costs) plus lease costs for total of 13,000 s.f. in new facilities at $1.70 s.g. $589,232
- f. Medication and Medical Supports-based on current average annual cost of $109 per client $29,430
- g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $133,763
- h. Total Operating Expenditures $903,570

**4. Program Management**

- a. Existing Program Management-2006-07 provider contracts for Wraparound services $3,561,013
- c. Total Program Management $3,561,013

**6. Total Proposed Program Budget** $7,976,603

### B. Revenues

**1. Existing Revenues**

- a. Medi-Cal (FFP only)-50% of existing costs $2,202,918
- c. Realignment-5% of existing costs $220,292
- d. State General Funds-EPSDT-45% of existing costs $1,982,626
- h. Total Existing Revenues $4,405,835

**2. New Revenues**

- a. Medi-Cal (FFP only)-assume 25% of new clients will be Medi-Cal eligible (30% of costs X 50%) $446,346
- c. State General Funds-EPSDT match to FFP $401,711
- e. Total New Revenue $848,057

**3. Total Revenues** $5,253,893

### D. Total Funding Requirements

$2,722,710
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**San Bernardino County MHSA CSS**  
**Program and Expenditure Plan-February 2006**  
88

**County(ies):** San Bernardino  
**Fiscal Year:** 2006-07  
**Program Workplan #:** C-1  
**Date:** 2/1/06  
**Program Workplan Name:** Comprehensive Child and Family Support System  
**Type of Funding:** Full Service Partnership  
**Months of Operation:** 12  
**Proposed Total Client Capacity of Program/Service:** 670  
**Existing Client Capacity of Program/Service:** 200

#### A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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<tbody>
<tr>
<td>Clinical Therapist I</td>
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<td>$73,085</td>
<td>$438,510</td>
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<tr>
<td>Clinical Therapist II</td>
<td></td>
<td>1.00</td>
<td>$85,126</td>
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**Total Current Existing Positions:** 0.00 12.00 $844,822

#### B. New Additional Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
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<tbody>
<tr>
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**Total New Additional Positions:** 10.00 33.50 $1,882,186

#### C. Total Program Positions

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<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
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<td>10.00</td>
<td>45.50</td>
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a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene $39,150 $39,150
   b. Travel and Transportation $27,540 $27,540
   c. Housing
      i. Master Leases $0
      ii. Subsidies $0
      iii. Vouchers $0
      iv. Other Housing $0
d. Employment and Education Supports $16,200 $16,200
e. Other Support Expenditures (provide description in budget narrative) $81,000 $81,000
f. Total Support Expenditures $0 $0 $163,890 $163,890

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures (from Staffing Detail) $844,822 $844,822
   b. New Additional Personnel Expenditures (from Staffing Detail) $376,437 $1,505,749 $1,882,186
   c. Employee Benefits $124,224 $496,897 $621,121
d. Total Personnel Expenditures $1,345,483 $0 $2,002,646 $3,348,129

3. Operating Expenditures
   a. Professional Services $17,400 $17,400
   b. Translation and Interpreter Services $810 $810
   c. Travel and Transportation $34,452 $34,452
   d. General Office Expenditures $98,484 $98,484
   e. Rent, Utilities and Equipment $589,232 $589,232
   f. Medication and Medical Supports $29,430 $29,430
g. Other Operating Expenses (provide description in budget narrative) $133,763 $133,763
h. Total Operating Expenditures $0 $0 $903,570 $903,570

4. Program Management
   a. Existing Program Management $3,644,519 $3,644,519
   b. New Program Management $0
   c. Total Program Management $0 $3,644,519 $3,644,519

5. Estimated Total Expenditures when service provider is not known $0

6. Total Proposed Program Budget $1,345,483 $0 $6,714,625 $8,060,108

### B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only) $422,411 $1,822,259 $2,244,670
   b. Medicare/Patient Fees/Patient Insurance $0
   c. Realignment $42,241 $182,226 $224,467
d. State General Funds $380,170 $1,640,034 $2,020,203
e. County Funds $0
f. Grants $0
g. Other Revenue $0
h. Total Existing Revenues $844,822 $0 $3,644,519 $4,489,341

2. New Revenues
   a. Medi-Cal (FFP only) $446,346 $446,346
   b. Medicare/Patient Fees/Patient Insurance $0
c. State General Funds $401,711 $401,711
d. Other Revenue $0
e. Total New Revenue $0 $0 $848,057 $848,057

3. Total Revenues $844,822 $0 $4,922,576 $5,770,634

### C. One-Time CSS Funding Expenditures

$0

### D. Total Funding Requirements

$500,651 $0 $2,222,049 $2,722,710

### E. Percent of Total Funding Requirements for Full Service Partnerships

93.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports
Budget Narrative
Comprehensive Child and Family Support System Workplan # C-1

County(ies): San Bernardino  Fiscal Year: 2007-08
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $ 39,150
   b. Travel and Transportation-based on average annual cost of $102 per client. $ 27,540
   d. Employment and Education Supports-based on average annual cost of $60 per client $ 16,200
   e. Other Support Expenditures-respite care-based on average annual cost of $300 per client. $ 81,000
   f. Total Support Expenditures $ 163,890

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing crisis response team staff full year salary and benefit costs $ 844,822
   b. New Additional Personnel Expenditures-44 staff salaries budgeted at full-year $ 1,882,186
   c. Employee Benefits-33% of of salaries $ 621,121
   d. Total Personnel Expenditures $ 3,348,129

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per employee $ 17,400
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 810
   c. Travel and Transportation-based on current average annual cost per budgeted employee of $792 $ 34,452
   d. General Office Expenditures-based on current average annual cost per budgeted employee of $2,264 $ 98,484
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted employee of $7,449 (average does not include average annual building lease costs) plus lease costs for total of 13,000 s.f. in new facilities at $1.70 s.g. $ 589,232
   f. Medication and Medical Supports-based on current average annual cost of $109 per client $ 29,430
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 133,763
   h. Total Operating Expenditures $ 903,570

4. Program Management
   a. Existing Program Management-2007-08 provider contracts for Wraparound services $ 3,644,519
   c. Total Program Management $ 3,644,519

6. Total Proposed Program Budget $ 8,060,108

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-50% of existing costs $ 2,244,670
   c. Realignment-5% of existing costs $ 224,467
   d. State General Funds-EPSDT-45% of existing costs $ 2,020,203
   h. Total Existing Revenues $ 4,489,341

2. New Revenues
   a. Medi-Cal (FFP only)-assume 25% of new clients will be Medi-Cal eligible (30% of costs X 50%) $ 446,346
   c. State General Funds-EPSDT match to FFP $ 401,711
   e. Total New Revenue $ 848,057

3. Total Revenues $ 5,337,398

D. Total Funding Requirements $ 2,722,710
EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Bernardino  Fiscal Year: 2007-08
Program Workplan #: C-1  Date: 2/1/06
Program Workplan Name: Comprehensive Child and Family Support System

Type of Funding: Full Service Partnership

Proposed Total Client Capacity of Program/Service: 670
Existing Client Capacity of Program/Service: 200

Client Capacity of Program/Service Expanded through MHSA: 470

Prepared by: Kris Letterman  Telephone Number: (909) 387-7577

<table>
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<td>10.00</td>
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<td>$1,882,186</td>
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<tr>
<td>C. Total Program Positions</td>
<td></td>
<td>10.00</td>
<td></td>
<td>$2,727,008</td>
</tr>
</tbody>
</table>

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

| County: | San Bernardino County |
| Fiscal Year: | 2005-06, 2006-07, 2007-08 |
| Program Work Plan Name: | One Stop TAY Center |
| Program Work Plan #: | TAY - 1 |
| Estimated Start Date: | 2-4 Months Post MHSA Plan Approval |

### Description of Program:
*Describe how this program will help advance the goals of the Mental Health Services Act.*

### Transitional Age Youth

The One Stop Transitional Age Youth (TAY) Center will provide integrated services to the unserved, underserved, and inappropriately served TAY (16-25 years) who are emotionally disturbed, high users of acute facilities, homeless, have co-occurring disorders, are incarcerated, institutionalized, and recidivists with significant functional impairment. An array of services will be available to assist TAY in reaching their goal of independence. There will be a menu of available recovery services at the centers including, but not limited to, 24/7 access to behavioral health/peer counselors, easy access to all needed services from community partner agencies, housing support, educational/vocational training, job search and coaching, skill building necessary for community life, recovery and co-occurring specialized programs, recreation activities, access to showers and laundry facilities, email/internet access, childcare for TAY with infants and toddlers, and other necessary referrals for community integration. Services provided will address the transitional domains of employment, educational opportunities, housing and community life necessary for wellness and recovery of emotionally disturbed Transitional Age Youth (TAY). The One Stop TAY Center will include peer and mentoring support services. MOUs will be developed between DBH and county agencies, faith-based organizations, vocational training facilities, educational systems, and other community based organizations in order to coordinate effective services for TAY. County agencies and community partners will be co-located to provide comprehensive services for TAY in order to reduce out-of-home and high levels of placement, incarceration, and institutionalization. All services will be provided in a culturally competent manner that is age and developmentally appropriate.

The One Stop TAY Centers will assist TAY to become independent, stay out of the hospital or higher level of care, reduce involvement in the criminal justice system, and reduce homelessness. TAY will attend regular update meetings to measure progress toward their goals in an effort to move them from Full Service Partnership services. Consumers, youth, and their families will be an integral part in the development of age appropriate services that
reflect the developmental and special needs of TAY. TAY will be hired to provide services as peer counselors, TAY mentors, and parent partners. The center will be modeled as a drop-in center and not modeled as a mental health clinic in order to improve TAY participation. The first One Stop Center will be located in the West/Central Valley Region. San Bernardino County Data indicates there is the largest unserved and underserved TAY population living in the West/Central Valley Region. The second center will open in the East Valley/San Bernardino Region. The third and fourth One Stop Centers will be located in the High Desert and Mid Desert regions.

Services will be gender specific, culturally and linguistically appropriate. DBH staff, peer counselors, parent partners, community agency staff, and peer volunteers will receive ongoing cultural competency training to learn skills that will enable them to provide treatment that meets the sexual orientation, gender specific, linguistic and cultural needs of the population. DBH’s Cultural Competency plan reflects the commitment to ongoing staff training, recruitment and retention.

<p>| Priority Population: Describe the situational characteristics of the priority population. | TAY population (16-25 years) under 200% of the federal poverty level with emotional and/or behavioral disturbances will be served at the One Stop Centers. This is a new program, which will be included in the children, youth and family systems of care. San Bernardino county will address the situational characteristics and developmental needs of this specialized population. These needs include treatment for past trauma, homelessness, domestic violence, school issues that lead to dropping out, disconnected families, hopelessness, fear, safety issues, and significant mental health concerns. One of the targeted populations is Latino and African-American youth who are disproportionately over-represented in the Justice System and out-of-home placements (Foster Care, group homes, institutions). Another target population is those with co-occurring disorders, emotional disturbances, unserved, uninsured, and homeless, or at risk of becoming homeless caused by an existing out-of-home placement, high utilizers, and recidivists. The goal of the program is to serve 345 youth and their families annually. |</p>
<table>
<thead>
<tr>
<th>Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)</th>
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<tbody>
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<td><strong>Fund Type</strong></td>
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- Youth and Young adults (15-26) will be hired and used as consultants to develop the Centers.
- Focus groups will be conducted at group home and residential facilities to assist in developing strategies for the early identification and assessment of underserved TAY populations and their families.
- 24/7 access to supportive services will be available at the One Stop TAY Center to underserved TAY and their families to prevent and/or reduce homelessness, abuse, and re-incarceration.
- Individual integrated consumer driven service plans will be developed for each TAY as soon as possible but within 60 days for at least 75% of the TAY.
- Relationships with a variety of community agencies will be developed to help meet the needs of the TAY populations. This would include public health and other public service departments.
- DBH will collaborate with Department of Children’s Services, Probation Department, and other adjunct agencies to work with families to meet the needs of their TAY who are placed out-of-home (Foster Care, group homes, institutionalized). These efforts will improve independence and/or enhance the reunification and return of TAY to their families.
- Care Coordination, skill development, supportive housing, and supported education and employment will be available in the community, at home or at the One Stop TAY Centers.
- Referral services, childcare, transportation and discretionary funds will be available.
- Engagement, outreach and services that are culturally and linguistically appropriate will be provided at the One Stop TAY Centers which is reflected in DBH Cultural Competency Plan.
- Collaboration will be developed with Assertive Community Treatment...
(ACT) teams will help older (18-26) TAY population to help them stay out of the hospital and to develop skills for living in the community. These services will be customized to the individual needs of the consumer. They will also be provided 24 hours a day seven days per week.

- TIP (Transition to Independence Process) systems will be implemented to work with TAY. This system has been found to be successful with this population. TIP targets the transition needs of TAY with emotional and/or behavioral difficulties. TIP prepares and facilitates the transition of TAY across domains of employment, educational opportunity, living situation and community life adjustment.

- Services, which are values driven and evidenced-based, will be provided to TAY to support their recovery process in the community.
- Supportive education will assist TAY in completing their GED or complete college courses.
- Scholarships will be identified and developed with educational, vocational and technical institutions.
- Indoor and outdoor recreational activities will be available including, but not limited to basketball, pool table, video, and television.
- TAY with children between ages 0-5 will have access to childcare and services for their children through referrals to specific programs targeting their needs.
- African-Americans and Latino TAY in out-of-home placement or involved in the Juvenile Justice System, who are underserved or inappropriately served in the mental health programs will be a priority for service of this program.
- Peer and mentoring subsidized positions will be available to TAY and families members to provide services at the One Stop TAY Centers and in the community.
• Educational training seminars will be conducted on topics, which will include co-occurring disorders, mental illness, gender specific treatment, and culturally sensitivity. Trained staff and peer counselors will provide these seminars in a psycho-educational format.

• The Centers will work with enterprise development to support self sufficiency. The TAY Coordinator and staff from the centers will reach out to the business community and work with staff, peer counselors and parent partners to develop a plans for business ventures.

• Services and supports will be provided in non-traditional settings, such as malls, video and game stores, local eateries, and places where TAY frequent.

• Educational material for TAY, family or other caregivers about mental health and co-occurring diagnosis, assessment, medications, services and supports planning, treatment modalities, and other information related to mental health services will be available.

• Emphasis on decreasing level of care or placement for TAY from incarceration, residential care to either independent living or returning to live with family/care providers.

• Staff will meet with TAY and their families to review their individualized plans in an effort to assist them towards independence and decreasing their level of service or exiting Full Service Partnership.

• Peer and mentoring subsidized positions will be available to TAY and families members to provide services at the One Stop TAY Center and in the community.
Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The One Stop TAY Center will offer access to a wide array of services to TAY and their families who are unserved, underserved and inappropriately served. The proposal is to open the first center in the West Valley/Central Valley region. The second center will be opened in the East Valley/San Bernardino region. Then, one center will open in both the High Desert and Mid Desert regions. Services will include outreach, engagement, early identification and assessment, mental health services, medical resources, legal, housing, childcare, vocational and educational support. The centers will be sites where TAY can visit to receive services and referrals, access their email or the internet, take a shower, or just socialize. Culturally and linguistically appropriate ACT intensive case management, and after care services will be provided to prevent hospitalizations and re-incarceration. Transition to Independence Process (TIP) systems will be integrated in the center to prepare and facilitate the transitions of TAY across domains of employment, education, living situation, and community life adjustment. Access to services for the prevention, reduction, and elimination of substance abuse will be provided. Supportive housing and education/employment is a major component of the One Stop TAY Center, since homelessness is a major issue confronting TAY aging out of Foster Care, Juvenile Justice and out-home-placements. Services for TAY transitioning out of the children's services will address their 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, with the goal towards independence.

The centers will address the needs of youth aging out of the Juvenile Justice, Foster Care, and other out-of-home placements by providing after care and intensive case management. These youth, although resilient and survivors, find themselves in need of support to meet their needs for a successful transition into independence. DBH currently provides crisis, assessments, brief therapy, medication support services, interagency services/collaboration, and case management to youth while they reside in three Juvenile Halls. The development of the after care was identified as a major issue addressing the recidivism of youth being re-incarcerated. After care will reduce re-incarceration, out-of-home placement, homelessness, and higher level of care or institutionalization. It will further address the disparity of ethnic youth receiving appropriate mental health services instead of incarceration. Foster Care youth are currently being referred to DBH for a Healthy Homes strength-based assessment, which includes referrals for additional treatment if necessary. Once youth age out of Foster Care and other out-of-home placement they disconnect from any previous services and find themselves at risk of becoming homeless. The goal of after care is for those young adults transitioning out of the children system of care to connect with them before they exit their placement. TAY will be assisted in transitioning to the adult system of care only if necessary. The purpose will be to identify their own and their families' needs to assist them in transitioning out of the children's system of care.

This program addresses MHSA goals for Full Service Partnership and system transformation by providing access to mental health services to an unserved,
underserved and inappropriately served target population. Another MHSA goal addresses the racial and ethnic disparity found in access to mental health services in this county. Collaboration and integration of services with stakeholders will enhance the recovery of the client while in the community.

In addition, this program will instill hope, empower TAY, help them gain respect, and increase self-responsibility, self-esteem, and self-determination through the recovery model. The One Stop Centers look beyond business as usual to provide service to an age specific population. We move from asking the consumer to come to us, to going to the consumer, we integrate mental health services as any other service needed to help consumer reach wellness and recovery. These centers increase the level of participation in the public mental health system for those that are typically underserved or not served. We increase the number of consumers that will work in the system to help us develop and operate the centers. We focus on the specific needs of the TAY populations as it relates to development, sexual orientation, spiritual/religious beliefs, cultural competency and linguistic needs. We identify a point person that is hired to follow these youth and young adults through the public mental health system to manage any barriers to accessing services. The Centers focus on the safety of this age specific population as it relates to housing and other basic needs. These centers are held responsible for outcomes that clearly demonstrate that consumers are moving toward independence. All of these above expectations are the goals of the MHSA. The funding will be a blend of EPSDT, full scope Medi-cal, MHSA dollars, and general trust funds.

3) **Describe any housing or employment services to be provided.**

Housing and employment services will be a major component to the One Stop TAY Centers. Access to vocational services will be provided in collaboration with other stakeholders such as local adult education, vocational/technical certification programs, Regional Occupational Program (ROP), MOUs with the Employment Services Department and Department of Rehabilitation, community colleges, and local universities. TAY will have access to job search, job training and job coaching.

Housing supports for this Full Service Partnership will include 92 units. These include 12 contracted Social Detox units for substance abusers that require short term residential substance abuse treatment. In addition, 10 board and care units, 20 sober living slots, 10 transitional housing units and 40 Tenant-Based Rental Assistance permanent housing units for individuals and families will be utilized. This will support safe and stable housing, recovery and resiliency. It will further keep TAY from becoming homeless. The housing mix will change over time and will reflect the current needs of TAY.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

The One Stop TAY Center will be a Full Service Partnership with an average cost of $11,027 per consumer.
5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

A recovery framework draws attention to the importance of connectedness and hope for the future. The One Stop TAY Center will build upon the strength of connectedness with family and community by providing client/family driven services. The focus on recovery and independence will be the desired outcome. Recovery and resiliency will be a key element in all services provided.

DBH has six client-run clubhouses. TAY and their family members participate in the services. The plan is to encourage these clubhouse participants to become volunteers or paid peer counselors/parent partners in the One Stop Centers. Bilingual and bicultural staff will be hired to reach into communities that typically have not been served or have been inappropriately served. We will work with the faith-based communities to help design and develop a service menu that meets the needs of their communities. TAY and their family members will be the driving force in developing the centers. Staff and volunteers will be trained on the recovery model and cultural competency. Cultural competency training will include issues of diversity among ethnic specific groups and how to engage ethnic families. The centers will be located in ethnically diverse areas and co-located in areas where this age specific population goes to socialize.

DBH will include in the RFP and contract specific requirements that will be monitored on a frequent basis to ensure that resiliency and recovery are the primary focus of the service delivery. Internal systems will be developed to monitor county programs and contract agencies.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

There will be no changes to current programs.

The One Stop TAY Center will provide a continuum of service for TAY and their families. It will be tailored to meet the situational characteristics, developmental, and changing needs of TAY. Culturally and linguistically competent regional teams will dedicate their time to working with TAY aging out of Juvenile Justice, Foster Care, out-of-home placements and institutions. All efforts will be made to begin working with 16-year-old TAY to prepare them for adulthood. The teams will provide TAY and their families support, services and a “what ever it takes” attitude to meet their mental health needs.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

TAY and their families will participate in the development and implementation of the Centers. They will provide peer counseling, milieu oversight, advocacy and
individualized support to the youth and young adults in the program. We will identify, recruit, and encourage TAY and family members from various ethnic backgrounds to apply for paid peer counselors, consultants, and parent partner positions. We will “grow our own” by providing extensive training for volunteers and clubhouse members. TAY volunteers will coordinate activities in the recreation area. Peer Mentors will be active in the center to assist volunteers as they transition into more permanent duties and employment. Peer counselors and parent partners will work directly with participants in providing case management and community resources. Peer counselors and parent partners will be part of the service delivery team.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

Collaboration will occur between DBH, Department of Children’s Services, schools, Probation Department, Courts, Justice System, Public Guardian, Employment Services, Department of Rehabilitation, Public Health, Inland Regional Center, housing providers, Families as Partners, faith-based organizations, medical providers, vocational/technical training, and the business community.

Multi-agency collaboration is the key to success of the One Stop Centers. Representatives from each agency will be co-located in the center for easy access and to eliminate barriers of maneuvering separate systems.

Existing Collaborations
The Probation Department, Children’s Services, DBH, County and Public schools, and the Regional Center participate on an Interagency Placement Review Committee to assess children and youth’s group home needs and or State Hospital placements.

The Probation Department, Children’s Services and DBH have current MOUs for the purpose of providing Wraparound Services.

The Probation Department and DBH have collaborated on several projects, such as the Vision Quest Residential Treatment Program and the development of mental health services in the Juvenile hall facilities.

The County Special Education Local Planning Areas (SELPAs) has a MOU with DBH that describes our working relationship as it relates to providing mental health services in the schools.

The Department of Children’s Services has a MOU with the DBH to provide services in the Healthy Homes Programs as well as intensive day treatment in the Hospital step down residential program.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part
II Section II of this plan and what specific strategies will be used to meet their needs.

The One Stop TAY Centers will be integrated into the overall DBH Cultural Competence Plan with an emphasis on outreach and engagement with the identified unserved, underserved, and inappropriately served TAY. Families will be engaged in education about mental illness and given access to available mental health services to support the recovery process. Appropriate education and outreach that is sensitive to gender and sexual orientation will be an ongoing training component. All services will be provided with close attention to the specific cultural concerns of the family as they relate to the use of relevant community supports, traditional values and beliefs and family histories.

DBH is aware of the growing culturally diverse populations in our county. The data demonstrates the need to provide services to Latino and African-American populations. Part of the initial plan includes hiring several Outreach Coordinators to develop relationships within specific communities, and to conduct focus groups to increase the community’s awareness of the services available in the county. We are also committed to continuing the community-based services already in place and to determine whether other community-based services can be provided near the consumer populations that need services.

DBH will work with faith-based organizations and community agencies to help understand the needs of the community as future programming is developed. DBH is committed to work differently in the community as it relates to service delivery and monitoring.

DBH has a Cultural Competency Plan (CCP) that was given one of the highest scores in the State. The plan requires staff to receive regular education and training to develop skills to work with groups that are lesbian, gay, bisexual, transgender (LGBT), disabled, ethnically diverse and others. As part of the system improvement plan a recruiter will be hired to be a resource that focuses solely on the staffing needs of our county. A goal of the CCP is to recruit, hire, train and retain staffs that meet the cultural and linguistic needs of the populations with which we work; including certified interpreters.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff will continue to receive ongoing training on providing services to participants with respect to their sexual orientation and gender differences. TAY Peer Counselors, Parent Partners, TAY Mentors, and TAY Volunteers will receive training about gender and sexual orientation differences. Paid and volunteer staff will be hired to represent the diverse population to be served. Referrals to current services and partner agencies will be sensitive to the needs of our LGBT youth. Contacts with various groups and organizations specializing in working with LGBT issues will be made. Their expertise will help train staff and develop supports to assist TAY.
11) **Describe how services will be used to meet the service needs for individuals residing out-of-county.**

TAY living out-of-county, either in placement or in the Juvenile Justice System, will receive engagement services to assist them in transitioning back to their community. TAY staff will work with the lead placement agency to return youth to the county. The goal is to assist TAY by strengthening their family support. TAY will be connected to the One Stop TAY Center through the treatment team. Prior to aging out of the placement, the treatment team will assist TAY by building their supports and being available 24/7 to meet the goal of a successful transition to live with their family or independently.

Non-resident TAY residing in San Bernardino County will be served through the One Stop TAY Center. All TAY are welcome to receive services at the One Stop TAY Centers.

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.**

All strategies are listed in Section IV.

13) **Please provide a timeline for this work plan, including all critical implementation dates.**

   1 to 3 months - RFP process

   3 to 12 months - Program fully implemented and goals met

14) **Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.**

   a) Work plans and most budget/staffing worksheets are required at the program level.

   b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
### One Stop TAY Center

| Proposed Total Client Capacity of Program/Service: | 40 | New Program/Service or Expansion: | New |
| Existing Client Capacity of Program/Service: | 0 | Prepared by: | Kris Letterman |

Client Capacity of Program/Service Expanded through MHSA: 40

Telephone Number: (909) 387-7577

### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clothing, Food and Hygiene</td>
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<tr>
<td>b. Travel and Transportation</td>
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<td>$1,021</td>
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<tr>
<td>c. Housing</td>
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<td></td>
</tr>
<tr>
<td>i. Master Leases</td>
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<tr>
<td>ii. Subsidies</td>
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<td>$3,420</td>
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<tr>
<td>iii. Vouchers</td>
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<tr>
<td>iv. Other Housing</td>
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<tr>
<td>d. Employment and Education Supports</td>
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<tr>
<td>e. Other Support Expenditures (provide description in budget narrative)</td>
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<td>$3,000</td>
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<tr>
<td>f. Total Support Expenditures</td>
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#### 2. Personnel Expenditures

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<thead>
<tr>
<th>Item</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<tbody>
<tr>
<td>a. Current Existing Personnel Expenditures (from Staffing Detail)</td>
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<td>b. New Additional Personnel Expenditures (from Staffing Detail)</td>
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<td>c. Employee Benefits</td>
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<td>d. Total Personnel Expenditures</td>
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#### 3. Operating Expenditures

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<tr>
<th>Item</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
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<tr>
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<tr>
<td>b. Translation and Interpreter Services</td>
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<td>c. Travel and Transportation</td>
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<td>d. General Office Expenditures</td>
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<tr>
<td>e. Rent, Utilities and Equipment</td>
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<td>$109,910</td>
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<tr>
<td>f. Medication and Medical Supports</td>
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<tr>
<td>g. Other Operating Expenses (provide description in budget narrative)</td>
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<td>$29,520</td>
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<tr>
<td>h. Total Operating Expenditures</td>
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#### 4. Program Management

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<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<tbody>
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<td>a. Existing Program Management</td>
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<tr>
<td>b. New Program Management</td>
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<tr>
<td>c. Total Program Management</td>
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<td>d. Total Program Management</td>
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#### 5. Estimated Total Expenditures when service provider is not known

**Total Expenditures:** $0

### B. Revenues

#### 1. Existing Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<tbody>
<tr>
<td>a. Medi-Cal (FFP only)</td>
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<tr>
<td>b. Medicare/Patient Fees/Patient Insurance</td>
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<tr>
<td>c. Realignment</td>
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<tr>
<td>d. State General Funds</td>
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<td>e. County Funds</td>
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<tr>
<td>f. Grants</td>
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<td>g. Other Revenue</td>
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<tr>
<td>h. Total Existing Revenues</td>
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#### 2. New Revenues

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<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>$121,384</td>
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<td>b. Medicare/Patient Fees/Patient Insurance</td>
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<tr>
<td>c. State General Funds</td>
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<td>d. Other Revenue</td>
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<tr>
<td>e. Total New Revenue</td>
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#### 3. Total Revenues

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<tr>
<th>Item</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
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<td>b. Total Revenues</td>
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<td>$0</td>
<td>$176,006</td>
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### C. One-Time CSS Funding Expenditures

**Total:** $454,500

### D. Total Funding Requirements

**Total:** $454,500

### E. Percent of Total Funding Requirements for Full Service Partnerships

**Total:** 93.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports
Budget Narrative
One Stop TAY Center - Workplan # TAY-1

County(ies): San Bernardino
Fiscal Year: 2007-08
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 $ 1,457
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 $ 1,021
   c. Housing
      ii. Subsidies-Personal & Incidental for 10 Board & Care. Annual cost per slot $1,368. 25% in 2005-06 $ 3,420
      iv. Other Housing $ 165,015
   Detox-12 slots. Annual cost per slot $7,110. 25% in 2005-06 $ 21,330
   Board and Care (B&C)-10 slots. Annual cost per slot $10,524 25% in 2005-06 $ 26,310
   Sober Living-20 slots. Annual cost per slot $6,000 25% in 2005-06 $ 30,000
   Transitional Housing-10 slots. Annual cost per slot $10,950 25% in 2005-06 $ 27,375
   Permanent-40 slots. Annual cost per slot $6,000 25% in 2005-06 $ 60,000
   d. Employment and Education Supports-based on average annual cost of $60 per client. 25% in 2005-06 $ 600
   e. Other Support Expenditures-respite care-based on average annual cost of $300 per client. 25% in 2005-06 $ 3,000
   f. Total Support Expenditures $ 174,513

2. Personnel Expenditures
   b. New Additional Personnel Expenditures-12 employees salaries budgeted at 25% in 2005-06 $ 417,490
   c. Employee Benefits-33% of of salaries $ 137,772
   d. Total Personnel Expenditures $ 555,262

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 3,840
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 56
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 8,059
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 21,843
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 (average does not include average annual building lease costs) plus lease costs for new 8,000 s.f. facility at $1.60 s.g. for 3 mo $ 109,910
   f. Medication and Medical Supports-based on current average annual cost of $109 per client. 25% in 2005-06 $ 1,090
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 29,520
   h. Total Operating Expenditures $ 174,319

6. Total Proposed Program Budget $ 904,094

B. Revenues

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) Medi-Cal not applied to housing costs $ 121,384
   c. State General Funds-Potential EPSDT match, assuming 50% of the Medi-Cal eligible clients fit the criteria for EPSDT. 95% applied to the net, leaving the 5% match requirement $ 54,623
   e. Total New Revenue $ 176,006

3. Total Revenues $ 176,006

C. One-Time CSS Funding Expenditures
   Tenant Improvements for lease of 8000 sq foot facility in Central/West Vly. $25 per s.f. $ 200,000
   Office furnishings for lease of 8000 sq foot facility in Central/West Vly. $5,000 per employee $ 60,000
   Computers for 12 employees. $3,000 per employee $ 36,000
   Other furnishings (computers,appliances, recreational equipment, tables, recliners) $ 20,500
   2 autos, 2 vans $20,000 per auto, $25,000 per van $ 90,000
   Training: 12 new employees X 40 hours X $100 per hour $ 48,000

D. Total Funding Requirements $ 1,182,587
## A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
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<tbody>
<tr>
<td>Total Current Existing Positions</td>
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<td>0.00</td>
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## B. New Additional Positions

<table>
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<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol &amp; Drug Counselor</td>
<td></td>
<td>0.15</td>
<td>$43,232</td>
<td>$6,485</td>
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<tr>
<td>Child Psychiatrist</td>
<td></td>
<td>0.08</td>
<td>$144,123</td>
<td>$10,809</td>
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<tr>
<td>Office Assistant III</td>
<td></td>
<td>0.23</td>
<td>$30,846</td>
<td>$6,940</td>
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</tr>
<tr>
<td>Mental Health Clinic Supervisor</td>
<td></td>
<td>0.15</td>
<td>$76,209</td>
<td>$11,431</td>
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<tr>
<td>Employment Services Specialist</td>
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<td>0.15</td>
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<tr>
<td>Mental Health Specialist</td>
<td>Family Partner/Peer Counselor</td>
<td>1.50</td>
<td>$35,098</td>
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<td>General Services Worker II</td>
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<td>0.60</td>
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<tr>
<td>Psychiatric Technician I</td>
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<td>0.60</td>
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<tr>
<td>Social Worker II</td>
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<td>Social Service Aide</td>
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<td>$17,940</td>
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<tr>
<td>Total New Additional Positions</td>
<td></td>
<td>1.50</td>
<td>8.10</td>
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<td>$417,490</td>
</tr>
</tbody>
</table>

## C. Total Program Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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<tbody>
<tr>
<td>Total New Additional Positions</td>
<td></td>
<td>1.50</td>
<td>8.10</td>
<td></td>
<td>$417,490</td>
</tr>
</tbody>
</table>

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures
- a. Clothing, Food and Hygiene: $50,025
- b. Travel and Transportation: $35,190
- c. Housing
  - i. Master Leases: $0
  - ii. Subsidies: $13,680
  - iii. Vouchers: $0
  - iv. Other Housing: $660,060
- d. Employment and Education Supports: $20,700
- e. Other Support Expenditures (provide description in budget narrative): $103,500
- Total Support Expenditures: $883,155

### 2. Personnel Expenditures
- a. Current Existing Personnel Expenditures (from Staffing Detail): $0
- b. New Additional Personnel Expenditures (from Staffing Detail): $1,810,514
- c. Employee Benefits: $597,470
- Total Personnel Expenditures: $2,407,984

### 3. Operating Expenditures
- a. Professional Services: $16,000
- b. Translation and Interpreter Services: $1,035
- c. Travel and Transportation: $31,680
- d. General Office Expenditures: $90,560
- e. Rent, Utilities and Equipment: $835,560
- f. Medication and Medical Supports: $37,605
- g. Other Operating Expenses (provide description in budget narrative): $123,000
- h. Total Operating Expenditures: $1,135,440

### 4. Program Management
- a. Existing Program Management: $0
- b. New Program Management: $0
- Total Program Management: $0

### 5. Estimated Total Expenditures when service provider is not known
- $0

### 6. Total Proposed Program Budget
- $0

## B. Revenues

### 1. Existing Revenues
- a. Medi-Cal (FFP only): $0
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. Realignment: $0
- d. State General Funds: $0
- e. County Funds: $0
- f. Grants: $0
- g. Other Revenue: $0
- h. Total Existing Revenues: $0

### 2. New Revenues
- a. Medi-Cal (FFP only): $619,218
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. State General Funds: $278,648
- d. Other Revenue: $0
- e. Total New Revenue: $897,867

### 3. Total Revenues
- $0
- $897,867

## C. One-Time CSS Funding Expenditures
- $1,112,800

## D. Total Funding Requirements
- $1,112,800
- $3,528,712

## E. Percent of Total Funding Requirements for Full Service Partnerships
- 93.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $ 50,025
   b. Travel and Transportation-based on average annual cost of $102 per client. $ 35,190
   c. Housing
      i. Subsidies-Personal & Incidental for 10 Board & Care. Annual cost per slot $1,368 $ 13,680
      iv. Other Housing $ 660,060
      Detox-12 slots. Annual cost per slot $7,110 $ 85,320
      Board and Care (B&C)-10 slots. Annual cost per slot $10,524 $ 105,240
      Sober Living-20 slots. Annual cost per slot $6,000 $ 120,000
      Transitional Housing-10 slots. Annual cost per slot $10,950 $ 109,500
      Permanent-40 slots. Annual cost per slot $6,000 $ 240,000
   d. Employment and Education Supports-based on average annual cost of $250 per client $ 20,700
   e. Other Support Expenditures-respite care-based on average annual cost of $300 per client $ 103,500
   f. Total Support Expenditures $ 883,155

2. Personnel Expenditures
   b. New Additional Personnel Expenditures-40 employees salaries $ 1,810,514
   c. Employee Benefits-33% of of salaries $ 597,470
   d. Total Personnel Expenditures $ 2,407,984

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 16,000
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 1,035
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 31,680
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 90,560
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 (average does not include average annual building lease costs) plus lease costs for total 28,000 s.f. facilities at $1.60 s.f. $ 835,560
   f. Medication and Medical Supports-based on current average annual cost of $109 per client $ 37,605
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 123,000
   h. Total Operating Expenditures $ 1,135,440

6. Total Proposed Program Budget $ 4,426,579

B. Revenues

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) Medi-Cal not applied to housing costs $ 619,218
   c. State General Funds-Potential EPSDT match, assuming 50% of the Medi-Cal eligible clients fit the criteria for EPSDT, 95% applied to the net, leaving the 5% match requirement $ 278,648
   e. Total New Revenue $ 897,867

3. Total Revenues $ 897,867

C. One-Time CSS Funding Expenditures

$ 1,112,800

D. Total Funding Requirements $ 4,641,512
**EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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</thead>
<tbody>
<tr>
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<td>B. New Additional Positions</td>
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<td></td>
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<tr>
<td>Alcohol &amp; Drug Counselor</td>
<td>2.00</td>
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<td>$86,464</td>
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<tr>
<td>Child Psychiatrist</td>
<td>1.00</td>
<td>$144,123</td>
<td>$144,123</td>
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</tr>
<tr>
<td>Office Assistant III</td>
<td>3.00</td>
<td>$30,846</td>
<td>$92,538</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health Clinic Supervisor</td>
<td>1.00</td>
<td>$76,209</td>
<td>$76,209</td>
<td></td>
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<tr>
<td>Clinical Therapist I</td>
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<tr>
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<td>2.00</td>
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<tr>
<td>Employment Services Specialist</td>
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<td>$42,561</td>
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<tr>
<td>Mental Health Specialist</td>
<td>5.00</td>
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<tr>
<td>General Services Worker II</td>
<td>2.00</td>
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<tr>
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<td>Staff Analyst II</td>
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<td>$59,800</td>
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<tr>
<td>Total New Additional Positions</td>
<td>5.00</td>
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<td>$1,810,514</td>
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<td></td>
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<tr>
<td>C. Total Program Positions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,810,514</td>
</tr>
</tbody>
</table>

### Notes:
- **a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
- **b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006 108
## San Bernardino Fiscal Year: 2007-08

### TAY-1 Date: 2/1/06

#### One Stop TAY Center

### Proposed Total Client Capacity of Program/Service: 345 New Program/Service or Expansion: New

### Existing Client Capacity of Program/Service: 0

#### Client Capacity of Program/Service Expanded through MHSA: 345

#### Telephone Number: (909) 387-7577

### A. Expenditures

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
</table>

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene: $50,025
   - b. Travel and Transportation: $35,190
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $13,680
     - iii. Vouchers: $0
     - iv. Other Housing: $660,060
   - d. Employment and Education Supports: $20,700
   - e. Other Support Expenditures (provide description in budget narrative): $103,500
   - f. Total Support Expenditures: $883,155

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail): $0
   - b. New Additional Personnel Expenditures (from Staffing Detail): $1,810,514
   - c. Employee Benefits: $597,470
   - d. Total Personnel Expenditures: $2,407,984

3. **Operating Expenditures**
   - a. Professional Services: $16,000
   - b. Translation and Interpreter Services: $1,035
   - c. Travel and Transportation: $31,680
   - d. General Office Expenditures: $90,560
   - e. Rent, Utilities and Equipment: $835,560
   - f. Medication and Medical Supports: $37,605
   - g. Other Operating Expenses (provide description in budget narrative): $123,000
   - h. Total Operating Expenditures: $1,135,440

4. **Program Management**
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

5. **Estimated Total Expenditures when service provider is not known**: $0

### B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only): $0
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $0
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $0

2. **New Revenues**
   - a. Medi-Cal (FFP only): $619,218
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $278,648
   - d. Other Revenue: $0
   - e. Total New Revenue: $897,867

3. **Total Revenues**: $897,867

### C. One-Time CSS Funding Expenditures**: $0

### D. Total Funding Requirements**: $3,528,712

### E. Percent of Total Funding Requirements for Full Service Partnerships**: 93.0%

---

**San Bernardino County MHSA CSS**

**Program and Expenditure Plan-February 2006**

109
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $ 50,025
   b. Travel and Transportation-based on average annual cost of $102 per client. $ 35,190
   c. Housing
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6. Total Proposed Program Budget $ 4,426,579

B. Revenues

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) Medi-Cal not applied to housing costs $ 619,218
   c. State General Funds-Potential EPSDT match, assuming 50% of the Medi-Cal eligible clients fit the criteria for EPSDT. 95% applied to the net, leaving the 5% match requirement $ 278,648
   e. Total New Revenue $ 897,867

3. Total Revenues $ 897,867

C. One-Time CSS Funding Expenditures
   $ -

   Tenants Improvements for lease of 6000 sq foot facility in High Desert $25 per s.f. $ 150,000
   Office furnishings for lease of 6000 sq foot facility in High Desert (9 emps) $5000 per emp $ 45,000
   Tenant Improvements for lease of 6,000 sq foot facility in Morongo $25 per s.f. $ 150,000
   Office furnishings for lease of 6,000 sq foot facility in Morongo (7 emps) $5000 per emp $ 35,000
   Computers for 16 employees $3000 per emp $ 48,000
   Other furnishings (computers, appliances, recreational equipment, tables, recliners) $ 28,300
   4 autos, 2 vans ($20,000 per auto, $25,000 per van) $ 130,000
   Training: 16 new employees X 40 hours X $100 per hour $ 64,000

D. Total Funding Requirements $ 3,528,712
<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td>0.00</td>
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<td></td>
<td>$0</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Counselor</td>
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<td>$149,166</td>
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a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

<table>
<thead>
<tr>
<th>County:</th>
<th>Fiscal Year:</th>
<th>Program Work Plan Name:</th>
</tr>
</thead>
</table>

### Program Work Plan #: A-1 | Estimated Start Date: 3 months to 12 months

### Description of Program:

**1 Consumer Operated Peer Support Services:** A countywide peer support recovery program utilizing peer education, peer advocacy, peer counselors/specialists, employment support services, life skills development classes, and social/recreational activities. This will be an independent program utilizing two consumers hired as Mental Health Specialists and serving as Peer Support Coordinators to serve 300 consumers annually. They will have office space located in the clubhouses in the East Valley/San Bernardino and High Desert regions and service the regions around these centralized areas. All services will be age, gender and developmentally appropriate. This will be accomplished by hiring culturally diverse staff through a process of outreach into the ethnic communities and identifying training opportunities specific to the populations being served.

**2 Clubhouse Enhancement:** Provides expanded capacity for social and community rehabilitation activities for 300 additional underserved seriously mentally ill (SMI) adults in two regionally centralized locations, beginning in the City of San Bernardino and enhancing services in the High Desert region of San Bernardino County (Victorville); thus providing the integrated clubhouse services within these regions. The clubhouse will become central training sites for both consumers and staff implementing and disseminating the recovery model philosophy throughout the San Bernardino County Department of Behavioral Health (DBH). DBH will have trainers and consultants with consumer and recovery experience to develop and provide formal and informal internships and mentor programs. Funding will be specifically budgeted for this purpose. All regional clubhouses will be affected through enhancement and outreach activities.

**3 Clubhouse Expansion for Services:** Provides underserved seriously mentally ill (SMI) adults with increased social and recreational activities; supported employment and housing; health and psychiatric services; programs for co-occurring disorders; crisis response and respite services; and expanded hours of operation within the County’s existing clubhouse system to include mentor and internship programs; thus, clubhouses will primarily be consumer run operations by 2007-2008. Consumer operation will be defined by the fact that the majority of daily operations (clerical, maintenance, group facilitation, recreational activities, etc.) will be done by consumer participants. There will...
only be 3.5 paid staff assigned to each clubhouse site; and they will function in a consultant/advisory/facilitator role with established consumer leadership at clubhouses. Staffs direct involvement will diminish as consumers become more capable and experienced. In addition, every effort will be made to hire consumers for paid staff positions in the clubhouses by identifying and recruiting consumers who meet the employment requirements for the DBH positions. It should also be noted that consistent with clubhouse philosophy, a consumer council or governing board would oversee and decide on all clubhouse activities and policies utilizing the “nothing about us without us” strategy of client empowerment movement. There will also be an Office of Consumer and Family Affairs that will be staffed by two (2) paid consumers, hired under the Peer Support Services program and budget that will identify all relevant resources for training, curriculum and consultation in Recovery Model programs. Trainers, consultants and training modules from a nationwide search of resources will be utilized to train an ever-expanding number of consumers who will be able to increase their responsibility and leadership roles in the clubhouses and move on to mentoring their peers. Peer Support Coordinators will also outreach into the community to identify underserved and unserved consumers and link them to Recovery programs. They will also train other consumers in the community and do on-site services in the areas of peer support and life skills.

### Priority Population:

**Describe the situational characteristics of the priority population.**

Persons between age 18 - 65 with a diagnosis of severe mental illness (SMI) who are interested in support, rehabilitation and recovery services provided by peers, thus increasing their ability to function in the community. Some un-served people are expected to be served for the first time through this program, although most will have had contact with County Department of Behavioral Health (DBH), yet with no or little prior experience with peer-provided services. Transitional Age Youth (TAY) clients between the ages of 18-25 who are interested or in need of additional supports may also utilize the services of the TAY One-Stop Centers that are being developed in DBH through MHSA funding in coordination with the overall MHSA plan.
- Consumer-Operated Peer-Support: Consumers and Family Members will be recruited as Mental Health Specialists (MHS) who will be assigned to provide a full array of culturally and linguistically appropriate peer recovery and support services throughout San Bernardino County. Two Mental Health Specialists will be divided between two programs utilizing consumers only to staff the Peer Recovery Support Program and be the main staff for the Office of Consumer and Family Affairs. Four MHS positions will be assigned to the clubhouses in San Bernardino and Victorville. These six paid positions will form an initial base of consumer/family member employees who will be used to role model and train other consumers. All efforts will be made to hire culturally diverse consumers for these positions through recruitment and outreach to increase services to underserved ethnic populations. Funding has been allocated to provide the initial consumer employees with training, consultation and support to insure their success. Expansion of additional trained consumers will be an ongoing goal with additional paid positions developed as funding allows. The consumers hired for the Peer Support Program, implemented through the Office of Consumer and Family Affairs, will serve 300 consumers in the community by the end of fiscal year 07-08 through outreach into the community, i.e. board and care facilities, IMD’s, community centers, churches, etc.

- Mental Health Specialists and Occupational Therapists will assist and support 300 members to engage in paid vocational activities by fiscal year 07-08. Currently, with limited employment services available through DBH, up to thirty (30) unduplicated consumers monthly, whose needs cannot be adequately met, request vocational support services.

- An Office of Consumer and Family Affairs will be established in two central and strategic locations in San Bernardino County to establish, support, coordinate and advocate for system-wide planning and
implementation of the Recovery Model programs. The staff will be funded through the budget for the Consumer-Operated Peer Support Services program.

- Two Occupational Therapist positions will be recruited for consumer/volunteer training and program support. Every effort will be made to hire consumers with the appropriate credentials for this program.
- One (1) clerical staff will provide administrative/clerical support.
- Hired consumers will be strategically based each in one of the three clubhouses, West Valley, East Valley/San Bernardino, and High Desert. However, outreach will be provided in all regions throughout the county.
- Expand the number of trained consumers, provide peer recovery services, have regular in-service meetings and follow-up with all consumers to provide ongoing support. The goal will be to train fifty (50) consumers by the second year of program implementation through outside training and mentor programs to provide leadership in the peer recovery and clubhouse programs.
- Clubhouse programs will follow the International Center for Clubhouse Development (ICCD) 36 standards of practice from the ICCD (including the training of all consumer staff in recovery principles).
- In-service training will be provided to paid staff to access supported housing resources and employment supports, such as California Department of Rehabilitation CO-OP programs and Housing Authority subsidized apartment rentals.
- Structured educational activities on a variety of topics will be implemented. These will include, but will not be limited to, adult education, GED classes, symptom management, life skills, etc. These activities will be offered, promoting rehabilitation goals, through staff, peers, and community resources.
- Consumers Advocating Recovery through Empowerment (CARE), arts and crafts, sport activities, recreational outings, self-help advocacy group, etc. will also be available.
- Structured educational activities on a variety of topics will be
implemented. These will include, but are not limited to, adult education, GED classes, symptom management, life skills, ESL classes, and classes that support clients process of acculturation, and anti-stigma education classes. These activities, promoting rehabilitation goals, will be offered through staff, peers, and community resources.

- Use/develop curriculum to include promising and best practices to include: SAMHSA’s Illness Management & Recovery Toolkit, NAMI’s Peer-to-Peer Recovery Program, NEC’s PACE Plan, and/or other approaches (WRAP planning, employment development, housing and educational goal setting, advocacy strategizing, and peer support training, etc.).

- The DBH-run clubhouses that will be operated by primarily consumer-run activities will provide opportunities for social rehabilitation and symptom management through an array of peer-led, gender and cultural-specific educational, and leisure groups and community activities such as Dual Diagnosis Anonymous, Inland Network of Community Clubhouses, Pathways to Recovery, NAMI Consumers Advocating Recovery through Empowerment (CARE), arts and crafts, sport activities, recreational outings, self-help advocacy groups, etc. Consistent with Clubhouse philosophy, all activities will be self-directed by consumer choice and overall groups, activities and clubhouse structure and policies will be determined by consumer representation in collaboration with paid staff through a consumer council or governing board.

- The DBH-operated clubhouses that utilize consumer/member involvement in providing daily programs and utilizing the recovery “model will provide employment screening and job placement through onsite and/or offsite volunteer and/or paid vocational opportunities, e.g. in the areas of clerical, facilities maintenance, retail food preparation, etc. for overall daily operations. The program will also provide ongoing job supports via activities within a network of supportive relationships of peer staff, members who are employed and others who are seeking employment.

- Consumer-operated services will focus on rehabilitation; recovery; and
increased community integration, individualized for each participant while fostering partnership, thus establishing measurable outcomes. Every consumer will be offered to develop a WRAP Plan in helping them achieve their goals for success.

- Culturally competent services will be provided and community outreach initiated consistent with availability of linguistically and culturally capable staff. Every effort will be made to utilize MHSA funding to identify and recruit culturally appropriate staff to serve the unserved and underserved ethnic populations. This will involve contacting community leaders, schools and agencies providing services currently to the ethnic populations identified. Outreach services will be provided to sites including but not limited to clubhouses, outpatient clinics, Board & Care facilities, NAMI affiliates, IMD’s, and other community sites, i.e., churches, etc.

- Ethnic populations of adults as well as those with special needs (hearing and sight impaired) who are underserved, unserved, or inappropriately served will be the priority for services in this program.

- Engagement, outreach and services that are culturally and linguistically appropriate as well as gender-specific will be provided through Consumer-Operated Peer-Support Services.

- Expanded space and equipment, including vans for transportation, will allow for expansion and increased utilization of social and recreational activities such as sports, outings, etc.

- Evening and weekend hours will allow for social events such as dances, holiday celebrations, coffee house and entertainment activities.

- Two (2) six-slot transitional housing programs within easy commuting distance of each clubhouse to increase permanent housing options for SMI adults with little history of independent living.

- Expanded networking/collaboration will be implemented through the use of MOU’s, written referral and interagency cooperation agreements and development of specific protocols with a wide variety of agencies that serve the mentally ill population and can provide resources and support. Currently the clubhouses have contracts, on a
limited basis, with food banks, Goodwill for clothing exchanges, and the District Attorney, the Public Defender, the San Bernardino Police Dept., and the Superior Court for an innovative Homeless Court that is held at the San Bernardino clubhouse site. Building on the experience that DBH already has in developing and implementing MOU’s and contracts with numerous agencies such as California Department of Rehabilitation, the Probation Dept., Mental Health and Drug Courts, etc., this networking and collaboration will be expanded and formalized.

- Track services, sites, and the number of consumers being served.
2) **Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.**

This program will enhance and expand the services of all member-operated clubhouses throughout San Bernardino County with emphasis on two pre-existing clubhouses operated by San Bernardino County Department of Behavioral Health (DBH) East Valley/San Bernardino and High Desert regions. The two pre-existing clubhouses will be transformed into fully integrated recovery programs. Clubhouses will have an estimated average daily attendance of 150-200 members. This program will greatly expand services to underserved as well as new and previously unserved SMI adults and will be culturally and linguistically appropriate. Proposed services to SMI adults could actually be much higher with total membership and daily attendance significantly increasing as word of mouth and outreach spreads. This proposed augmentation of programming, utilizing ICCD standards is consistent with all MHSA goals and essential elements in the transformation of a traditional mental health system.

The goals for the Clubhouse expansion and enhancement will be to have integrated models in all regions of the County. Currently, T.E.A.M. House in the City of San Bernardino has NAMI, Dual Diagnosis Anonymous, and consumer leaders on-site with office space provided. Additionally, there are housing and supported employment programs on the T.E.A.M. House campus, including Department of Rehabilitation counselors who visit weekly. This model will be further expanded with additional space allocated to T.E.A.M. House and developing this integrated approach at the other clubhouses primarily through trained consumer leaders.

Consumer-Operated Peer-Support Services will provide direct services throughout all clubhouses in San Bernardino County.

Culturally competent and linguistically appropriate outreach will be provided to outpatient clinics, Board & Care facilities and other community sites with an emphasis on serving the East Valley/San Bernardino and High Desert regions. This will achieve MHSA goals to expand the consumer network of supportive relationships, and will provide consumers assistance in a wide variety of areas, including education, employment, recreation, housing, and relationships with families, friends and service providers, as well as providing alternatives to institutionalization. Peer Support Specialists will be trained by two Peer Recovery Coordinators (consumers who are culturally and/or linguistically competent in the county’s identified threshold language) while providing services in both group and individual formats. Services to Spanish speaking first generation consumers and family members will focus on issues of acculturation, immigration, language barriers and development of support systems that are valuable to their belief system.

It is expected that at least 300 unduplicated persons with serious mental illness will be served by the Peer Recovery Coordinators during the three-year period. Some may be served only once, while others may have repeated contacts with peer staff and peer
support specialists, thus a large consumer network will be established to help promote peer support.

An Office of Consumer and Family Affairs (OCFA) will be established within the expanded T.E.A.M. House clubhouse. The purpose of the OCFA is to empower consumers and family members by assuring their interests are represented and their input is considered in DBH planning and policy development. This purpose will be accomplished by acting as a liaison between DBH and existing and developing self-help/support organizations for consumers and family members (NAMI, Dual Diagnosis Anonymous (DDA), Inland Network of Community Clubhouses (INCC), Pathways to Recovery the Depression and Bipolar Support Alliance (DBSA), and the San Bernardino County DBH Consumer Council).

The goals of the OFCA will work through the following objectives:

- Provide an internal voice for consumers and family members within San Bernardino County through participation in DBH planning and policy development activities.
- Active liaison work with the aforementioned organizations in order to establish ongoing communications, disseminate information, identify major issues and provide consultation, technical assistance, and ongoing support.
- Maintain an active Consumer Council to advise DBH, the DBH Board of Commissioners, the Cultural Competency Committee, and the DBH Policy Advisory Committee.
- Development, implementation, and monitoring of special projects, including focus groups to solicit consumer and family input on MHSA planning and implementation, identification, training and involvement of consumers in DBH planning activities.

The OCFA is committed to training consumers and families in effective advocacy skills. Advocacy and leadership training will be an integral part of OCFA responsibilities. Advocacy training works to build the skills necessary to advocate on many levels, either to implement personal recovery plans or to bring people together to work toward systems change. Training seminars will be offered through DBH Volunteer Services and these different levels of advocacy will be addressed.

3) **Describe any housing or employment services to be provided.**

Housing services will include a six-slot transitional housing program, affiliated with two of the Clubhouse programs. Staff and consumer assistants will also have training to refer consumers to a full range of other supported housing programs, both in DBH and outside community resources. Employment programs will consist of a full continuum of employment supports including clubhouse work units, and supported employment opportunities. There will be assistance from trained staff in accessing outside resources, including the California Department of Rehabilitation CO-OP programs targeted
specifically for the SMI population. A mentor and supported network approach will be utilized to increase success. All relevant evidence based psychosocial rehabilitation strategies will be utilized in this endeavor.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

This is not a Full Service Partnership

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

All activities provided will be consistent with MHSA recovery goals and increase opportunities for greater independence and functioning in the community through consumer, self-directed Recovery Plans. Surveys, individual outcome tracking forms, and consumer self-report satisfaction instruments will be used to insure all programs are meeting the needs of the consumers. Newsletters, community meetings, extensive outreach, and the DBH Consumer Council will be utilized to promote the successes and activities of consumers in achieving recovery-oriented goals for others to model.

Multicultural service delivery by consumers ensures recovery goals are continually reinforced. Peer support specialists can share their recovery efforts and model the importance of resilience in managing challenges to recovery. The Peer Recovery staff will direct experience with the challenges of the recovery process and be able to share these experiences and insights with the assistants and consumers involved in the programs. Furthermore, a speaker’s bureau will be developed through the San Bernardino County Behavioral Health Consumer Council, operating out of the Office of Consumer and Family Affairs to assist in this task, giving a face to recovery to the community.

The focus of activities within the Consumer-Operated Peer-Support Services and Clubhouse Expansion project will be on adults with persistent serious mental illness (SMI) gaining or maintaining the ability to live, work, learn, and participate fully in their communities. Education and training focused on employment or community living skills, peer and family support, self-help groups, and advocacy training all are rooted in the recovery philosophy. Pathways to Recovery, a local consumer-operated/self-help organization, is active in promoting the Recovery philosophy. Local NAMI Chapters actively reach out to family members to instill hope and provide support. One highly successful strategy NAMI has employed is the sponsoring of the “Family to Family” course and Consumers Advocating Recovery through Empowerment (CARE). Sponsorship of the “Peer to Peer” course is planned through the implementation of MHSA funding. “Family to Family” is conducted throughout the County regularly. It is our goal that the combined interests and efforts of a variety of recovery-oriented groups and individuals will serve to keep Consumer-Operated Peer-Support Services and
Clubhouse Expansion focused on the values of recovery and resiliency; this will be one of the oversights of the Office of Consumer Affairs. In addition, it will be the role of the Office of Consumer and Family Affairs to ensure that the values of recovery and resiliency are promoted and continually reinforced in all DBH activities.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

There are currently 7 clubhouse programs in the County of San Bernardino to serve its large geographic expanse. The clubhouses are located in San Bernardino, Victorville, Rialto, Redlands, Yucca Valley, Upland, and Lucerne Valley.

T.E.A.M. House, located within the City of San Bernardino, and the clubhouse in Victorville will be the initial target of expansion into fully integrated peer-run programs. The San Bernardino and Victorville programs, which currently serve 25-50 consumers daily with an average membership of 150, will be expanded to serve 300 members. All clubhouses within San Bernardino County will be included in expansion activities with a multicultural emphasis, including the recruitment of paid staff that are culturally and linguistically appropriate to the region. Every effort will be made to hire staff with consumer backgrounds for all paid positions.

Peer-Support Services is a new service. Minimal peer support activities currently exist within the county’s clubhouses; however these are under utilized due to transportation issues, or where they are housed, such as an IMD, etc., making clubhouse affiliation and access difficult.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Consumer-Operated Peer-Support Services will be operated by people with consumer experience (with an emphasis of recruiting individuals who are culturally and linguistically competent for the regions where they will work). Every effort will be made to hire qualified consumers in the paid staffing positions who are culturally and linguistically appropriate to the needs of the local area as determined by zip code data. Many individuals (consumers and family members) will be hired as program coordinators, recruiting other consumers/family members to train as peer specialists/assistants to provide peer-support services. Additionally, many of the Peer Recovery program staff and consumer assistants will be utilized to implement the various programs and activities offered. NAMI and other family member organizations will have on-site offices at the clubhouses. Also consistent with the aforementioned models, consumers will have the majority of the responsibility for implementing daily programs and operations.
The core peer-support staff will provide outreach throughout the County to develop a network of services at various locations, utilizing the Peer Recovery model.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

This program will be able to develop Memorandum Of Understanding (MOU) with adult service agencies, consistent with past successful uses of this mechanism by DBH with programs such as the Food Bank, Homeless Court and Adult Education. There will be ongoing collaboration with the California Network of Mental Health Clients (Inland Network of Community Clubhouses), the National Alliance of Mental Illness (NAMI), *Pathways to Recovery* and the San Bernardino County Behavioral Health Consumer Council. These collaborations will assist by providing additional resources, and specified services, that will promote the recovery model and improve the consumer’s functioning on an individual basis.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

All MHSA funded programs, including the clubhouse expansion proposed in this plan, will follow the current San Bernardino County DBH expectations of addressing cultural competence, sexual orientation and gender sensitivity issues. The clubhouse expansions will make it a priority to increase staffing and programs for the identified underserved threshold population of Latino adults. Every effort will be made through ongoing training, consultation, and active planning to insure the staff will have the knowledge and skills to provide culturally competent as well as gender specific services.

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

All services are provided in a manner sensitive to both sexual orientation and gender identity. Gender-specific services will be provided in both group and individual format, recognizing that the impact of traumatic and other significant events is gender-specific. Recovery goals will be formulated based on the individual's unique and personal sexual orientation, gender identity, and preferences. In order to maintain quality in service, a ‘Gender Issues’ sub-committee has been formed under the auspices of the Cultural Competency Committee. This body will advocate for services to be delivered in a gender-sensitive manner.
Staff are trained at least annually on issues of sexual orientation, and gender-sensitivity. Our existing staff is diverse in relation to sexual orientation and provide their additional insight and expertise.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Clubhouse expansion and Peer Support services will be provided to residents in San Bernardino County only.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.

1 to 3 months – Recruit, hire and train staff.

3 to 12 months - Program fully implemented and goals met.

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

a) Work plans and most budget/staffing worksheets are required at the program level.

b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.
## A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene $5,438 $5,438
   - b. Travel and Transportation $3,825 $3,825
   - c. Housing
     - i. Master Leases $0
     - ii. Subsidies $0
     - iii. Vouchers $0
     - iv. Other Housing $32,850 $32,850
   - d. Employment and Education Supports $2,250 $2,250
   - e. Other Support Expenditures (provide description in budget narrative) $0 $0
   - f. Total Support Expenditures $11,513 $0 $32,850 $44,363

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail) $53,029 $53,029
   - b. New Additional Personnel Expenditures (from Staffing Detail) $86,764 $86,764
   - c. Employee Benefits $28,632 $28,632
   - d. Total Personnel Expenditures $168,425 $0 $0 $168,425

3. **Operating Expenditures**
   - a. Professional Services $900 $900
   - b. Translation and Interpreter Services $113 $113
   - c. Travel and Transportation $1,782 $1,782
   - d. General Office Expenditures $5,094 $5,094
   - e. Rent, Utilities and Equipment $16,760 $16,760
   - f. Medication and Medical Supports $0 $0
   - g. Other Operating Expenses (provide description in budget narrative) $6,919 $6,919
   - h. Total Operating Expenditures $31,568 $0 $0 $31,568

4. **Program Management**
   - a. Existing Program Management $0 $0
   - b. New Program Management $0 $0
   - c. Total Program Management $0 $0 $0 $0

5. **Estimated Total Expenditures when service provider is not known**
   - $0

6. **Total Proposed Program Budget**
   - $211,505 $0 $32,850 $244,355

## B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only) $0 $0
   - b. Medicare/Patient Fees/Patient Insurance $0 $0
   - c. Realignment $53,029 $53,029
   - d. State General Funds $0 $0
   - e. County Funds $0 $0
   - f. Grants $0 $0
   - g. Other Revenue $0 $0
   - h. Total Existing Revenues $53,029 $0 $0 $53,029

2. **New Revenues**
   - a. Medi-Cal (FFP only) $0 $0
   - b. Medicare/Patient Fees/Patient Insurance $0 $0
   - c. State General Funds $0 $0
   - d. Other Revenue $0 $0
   - e. Total New Revenue $0 $0 $0 $0

3. **Total Revenues**
   - $53,029 $0 $0 $53,029

## C. One-Time CSS Funding Expenditures
   - $166,000 $166,000

## D. Total Funding Requirements
   - $324,476 $0 $32,850 $357,326

## E. Percent of Total Funding Requirements for Full Service Partnerships
   - 0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 $ 5,438
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 $ 3,825
   c. Housing
      iv. Other Housing $ 32,850
      Transitional Housing-12 slots. Annual cost per slot $10,950 25% in 2005-06
   d. Employment and Education Supports-based on average annual cost of $60 per client. 25% in 2005-06 $ 2,250
   f. Total Support Expenditures $ 44,363

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs in 2005-06 $ 53,029
   b. New Additional Personnel Expenditures-8 employees salaries budgeted at 25% in 2005-06 $ 86,764
   c. Employee Benefits-33% of of salaries $ 28,632
   d. Total Personnel Expenditures $ 168,425

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 900
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 113
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 1,782
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 5,094
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $ 16,760
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 6,919
   h. Total Operating Expenditures $ 31,568

6. Total Proposed Program Budget $ 244,355

B. Revenues

1. Existing Revenues
   c. Realignment $ 53,029
   h. Total Existing Revenues $ 53,029

3. Total Revenues $ 53,029

C. One-Time CSS Funding Expenditures $ 166,000
   3 passenger van @ $25,000 $ 75,000
   Moving Costs to relocate non-clubhouse staff from T.E.A.M. House Annex $ 10,000
   Furnishings for expansion into T.E.A.M. House Annex (9 staff @$5k each) $ 45,000
   Training: 9 employees X 40 hours annually X $100 per hour $ 36,000

D. Total Funding Requirements $ 357,326
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2005-06  
**Program Workplan #:** A-1  
**Date:** 2/1/06  
**Program Workplan Name:** Consumer-Operated Peer Support Svcs & Clubhouse Expansion  
**Type of Funding:** System Development  
**Months of Operation:** 3  
**Proposed Total Client Capacity of Program/Service:** 188  
**Existing Client Capacity of Program/Service:** 38  
**Client Capacity of Program/Service Expanded through MHSA:** 150  
**Prepared by:** Scott Nichols  
**Telephone Number:** (909) 387-7096

<table>
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<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>1.00</td>
<td></td>
<td>$53,029</td>
</tr>
<tr>
<td><strong>Total Current Existing Positions</strong></td>
<td></td>
<td>0.00</td>
<td></td>
<td>$53,029</td>
</tr>
<tr>
<td><strong>B. New Additional Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>1.50</td>
<td></td>
<td>$35,098</td>
</tr>
<tr>
<td>Office Assistant II</td>
<td></td>
<td></td>
<td>0.25</td>
<td>$27,995</td>
</tr>
<tr>
<td>$6,999</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist I</td>
<td></td>
<td></td>
<td>0.25</td>
<td>$64,060</td>
</tr>
<tr>
<td>$16,015</td>
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<tr>
<td>Occupational Therapist Assistant</td>
<td></td>
<td></td>
<td>0.25</td>
<td>$44,412</td>
</tr>
<tr>
<td>$11,103</td>
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<tr>
<td><strong>Total New Additional Positions</strong></td>
<td></td>
<td>1.50</td>
<td></td>
<td>$86,764</td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td>1.50</td>
<td></td>
<td>$139,793</td>
</tr>
</tbody>
</table>

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene $87,000 $87,000
   b. Travel and Transportation $61,200 $61,200
   c. Housing
      i. Master Leases $0
      ii. Subsidies $0
      iii. Vouchers $0
      iv. Other Housing $131,400 $131,400
   d. Employment and Education Supports $36,000 $36,000
   e. Other Support Expenditures (provide description in budget narrative) $0 $0
   f. Total Support Expenditures $184,200 $0 $131,400 $315,600

#### 2. Personnel Expenditures
   a. Current Existing Personnel Expenditures (from Staffing Detail) $53,029 $53,029
   b. New Additional Personnel Expenditures (from Staffing Detail) $347,055 $347,055
   c. Employee Benefits $114,528
   d. Total Personnel Expenditures $514,612 $0 $0 $514,612

#### 3. Operating Expenditures
   a. Professional Services $3,600 $3,600
   b. Translation and Interpreter Services $1,800 $1,800
   c. Travel and Transportation $7,128 $7,128
   d. General Office Expenditures $20,376 $20,376
   e. Rent, Utilities and Equipment $67,041 $67,041
   f. Medication and Medical Supports $0
   g. Other Operating Expenses (provide description in budget narrative) $27,675 $27,675
   h. Total Operating Expenditures $127,620 $0 $0 $127,620

#### 4. Program Management
   a. Existing Program Management
   b. New Program Management
   c. Total Program Management
   d. Total Program Management

#### 5. Estimated Total Expenditures when service provider is not known

#### 6. Total Proposed Program Budget $826,432 $0 $131,400 $957,832

### B. Revenues

#### 1. Existing Revenues
   a. Medi-Cal (FFP only) $0
   b. Medicare/Patient Fees/Patient Insurance $0
   c. Realignment $53,029 $53,029
   d. State General Funds $0
   e. County Funds $0
   f. Grants $0
   g. Other Revenue $0
   h. Total Existing Revenues $53,029 $0 $0 $53,029

#### 2. New Revenues
   a. Medi-Cal (FFP only) $0
   b. Medicare/Patient Fees/Patient Insurance $0
   c. State General Funds $0
   d. Other Revenue $0
   e. Total New Revenue $0 $0 $0

#### 3. Total Revenues $53,029 $0 $0 $53,029

### C. One-Time CSS Funding Expenditures

### D. Total Funding Requirements

### E. Percent of Total Funding Requirements for Full Service Partnerships 0.0%
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clothing, Food and Hygiene-based on average annual cost of $145 per client.</td>
<td>$87,000</td>
</tr>
<tr>
<td>b. Travel and Transportation-based on average annual cost of $102 per client.</td>
<td>$61,200</td>
</tr>
<tr>
<td>c. Housing</td>
<td></td>
</tr>
<tr>
<td>iv. Other Housing</td>
<td>$131,400</td>
</tr>
<tr>
<td>d. Employment and Education Supports-based on average annual cost of $60 per client.</td>
<td>$36,000</td>
</tr>
<tr>
<td>f. Total Support Expenditures</td>
<td>$315,600</td>
</tr>
</tbody>
</table>

### 2. Personnel Expenditures

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs</td>
<td>$53,029</td>
</tr>
<tr>
<td>b. New Additional Personnel Expenditures-9 employees salaries</td>
<td>$347,055</td>
</tr>
<tr>
<td>c. Employee Benefits-33% of of salaries</td>
<td>$114,528</td>
</tr>
<tr>
<td>d. Total Personnel Expenditures</td>
<td>$514,612</td>
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</tbody>
</table>

### 3. Operating Expenditures

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE</td>
<td>$3,600</td>
</tr>
<tr>
<td>b. Translation and Interpreter Services-based on current average annual cost of $3 per client</td>
<td>$1,800</td>
</tr>
<tr>
<td>c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792</td>
<td>$7,128</td>
</tr>
<tr>
<td>d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264</td>
<td>$20,376</td>
</tr>
<tr>
<td>e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449</td>
<td>$67,041</td>
</tr>
<tr>
<td>g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee</td>
<td>$27,675</td>
</tr>
<tr>
<td>h. Total Operating Expenditures</td>
<td>$127,620</td>
</tr>
</tbody>
</table>

### 6. Total Proposed Program Budget

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$957,832</td>
</tr>
</tbody>
</table>

## B. Revenues

### 1. Existing Revenues

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Realignment</td>
<td>$53,029</td>
</tr>
<tr>
<td>h. Total Existing Revenues</td>
<td>$53,029</td>
</tr>
</tbody>
</table>

### 3. Total Revenues

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$53,029</td>
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</tbody>
</table>

### D. Total Funding Requirements

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$904,803</td>
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</tbody>
</table>
## A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs(^a)</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(^b)</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>1.00</td>
<td>$53,029</td>
<td>$53,029</td>
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<td></td>
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<td></td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Total Current Existing Positions: 0.00, 1.00, $53,029

## B. New Additional Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(^b)</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Specialist</td>
<td>6.00</td>
<td>$35,098</td>
<td>$210,588</td>
<td></td>
</tr>
<tr>
<td>Office Assistant II</td>
<td>1.00</td>
<td>$27,995</td>
<td>$27,995</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist I</td>
<td>1.00</td>
<td>$64,060</td>
<td>$64,060</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist Assistant</td>
<td>1.00</td>
<td>$44,412</td>
<td>$44,412</td>
<td></td>
</tr>
</tbody>
</table>

Total New Additional Positions: 6.00, 3.00, $347,055

## C. Total Program Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(^b)</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6.00, 4.00</td>
<td>$400,844</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

\(^b\) Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### EXHIBIT 5a—Mental Health Services Act Community Services and Supports Budget Worksheet

#### San Bernardino County MHSA CSS

**Program Workplan Name:** Consumer-Operated Peer Support Svcs & Clubhouse Expansion  
**Type of Funding:** System Development  
**Proposed Total Client Capacity of Program/Service:** 638  
**New Program/Service or Expansion:** Expansion  
**Existing Client Capacity of Program/Service:** 38  
**Prepared by:** Scott Nichols  
**Client Capacity of Program/Service Expanded through MHSA:** 600  
**Telephone Number:** (909) 387-7096

#### Months of Operation: 12

<table>
<thead>
<tr>
<th>Months of Operation</th>
<th>Type of Funding</th>
<th>Proposed Total Client Capacity of Program/Service</th>
<th>New Program/Service or Expansion</th>
<th>Existing Client Capacity of Program/Service</th>
<th>Client Capacity of Program/Service Expanded through MHSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>2</td>
<td>638</td>
<td>Expansion</td>
<td>38</td>
<td>600</td>
</tr>
</tbody>
</table>

#### County Mental Health Department

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - Clothing, Food and Hygiene: $87,000
   - Travel and Transportation: $61,200
   - Housing:
     - Master Leases: $0
     - Subsidies: $0
     - Vouchers: $0
     - Other Housing: $131,400
   - Employment and Education Supports: $36,000
   - Other Support Expenditures (provide description in budget narrative): $0
   - Total Support Expenditures: $184,200

2. **Personnel Expenditures**
   - Current Existing Personnel Expenditures (from Staffing Detail): $53,029
   - New Additional Personnel Expenditures (from Staffing Detail): $347,055
   - Employee Benefits: $114,528
   - Total Personnel Expenditures: $514,612

3. **Operating Expenditures**
   - Professional Services: $3,600
   - Translation and Interpreter Services: $1,800
   - Travel and Transportation: $7,128
   - General Office Expenditures: $20,376
   - Rent, Utilities and Equipment: $67,041
   - Medication and Medical Supports: $0
   - Other Operating Expenses (provide description in budget narrative): $27,675
   - Total Operating Expenditures: $127,620

4. **Program Management**
   - Existing Program Management: $0
   - New Program Management: $0
   - Total Program Management: $0

5. **Estimated Total Expenditures when service provider is not known**
   - $0

6. **Total Proposed Program Budget**
   - $826,432

#### B. Revenues

1. **Existing Revenues**
   - Medi-Cal (FFP only): $0
   - Medicare/Patient Fees/Patient Insurance: $0
   - Realignment: $53,029
   - State General Funds: $0
   - County Funds: $0
   - Grants: $0
   - Other Revenue: $0
   - Total Existing Revenues: $53,029

2. **New Revenues**
   - Medi-Cal (FFP only): $0
   - Medicare/Patient Fees/Patient Insurance: $0
   - State General Funds: $0
   - Other Revenue: $0
   - Total New Revenues: $0

3. **Total Revenues**
   - $53,029

#### C. One-Time CSS Funding Expenditures
   - $0

#### D. Total Funding Requirements
   - $773,403
   - $131,400
   - $904,803

#### E. Percent of Total Funding Requirements for Full Service Partnerships
   - 0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $ 87,000
   b. Travel and Transportation-based on average annual cost of $102 per client. $ 61,200
   c. Housing
      iv. Other Housing $ 131,400
      Transitional Housing-12 slots. Annual cost per slot $10,950
   d. Employment and Education Supports-based on average annual cost of $60 per client. $ 36,000
   f. Total Support Expenditures $ 315,600

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs $ 53,029
   b. New Additional Personnel Expenditures-9 employees salaries $ 347,055
   c. Employee Benefits-33% of of salaries $ 114,528
   d. Total Personnel Expenditures $ 514,612

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 3,600
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 1,800
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 7,128
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 20,376
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $ 67,041
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 27,675
   h. Total Operating Expenditures $ 127,620

6. Total Proposed Program Budget $ 957,832

B. Revenues

1. Existing Revenues
   c. Realignment $ 53,029
   h. Total Existing Revenues $ 53,029

3. Total Revenues $ 53,029

D. Total Funding Requirements $ 904,803
<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs(^a)</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(^b)</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>1.00</td>
<td>$53,029</td>
<td>$53,029</td>
<td></td>
</tr>
<tr>
<td><strong>Total Current Existing Positions</strong></td>
<td></td>
<td>0.00</td>
<td>1.00</td>
<td>$53,029</td>
<td></td>
</tr>
<tr>
<td><strong>B. New Additional Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>6.00</td>
<td>$35,098</td>
<td>$201,588</td>
<td></td>
</tr>
<tr>
<td>Office Assistant II</td>
<td></td>
<td>1.00</td>
<td>$27,995</td>
<td>$27,995</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist I</td>
<td></td>
<td>1.00</td>
<td>$64,060</td>
<td>$64,060</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist Assistant</td>
<td></td>
<td>1.00</td>
<td>$44,412</td>
<td>$44,412</td>
<td></td>
</tr>
<tr>
<td><strong>Total New Additional Positions</strong></td>
<td></td>
<td>6.00</td>
<td>3.00</td>
<td>$347,055</td>
<td></td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>6.00</td>
<td>4.00</td>
<td>$400,084</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

\(^b\) Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
**EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY**

<table>
<thead>
<tr>
<th>County:</th>
<th>Fiscal Year:</th>
<th>Program Work Plan #: A-2</th>
<th>Program Work Plan Name: Forensic Integrated Mental Health Services</th>
<th>Estimated Start Date: 3 months to 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
<td>2005-06, 2006-07, 2007-08</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Description of Program:**

Describe how this program will help advance the goals of the Mental Health Services Act.

Forensic Integrated Mental Health Services will advance the MHSA goals of increased integration and collaboration through the provision of integrated forensic services in a culturally competent and wellness focused manner.

Forensic services proposes the expansion of the Crisis Intervention Training Program, the expansion of Mental Health Court treatment to serve an additional 70 consumers annually, and the implementation of a Forensic Assertive Community Treatment (FACT) Program to serve 40 consumers annually. These specialized mental health services provided to Severely and Persistently Mentally Ill (SPMI) individuals who are involved with the criminal justice system. The FACT Team will partner with the San Bernardino County Sheriff’s Department West Valley Detention Center (WVDC), San Bernardino County Department of Behavioral Health (DBH), Mental Health Court and the Probation Department. The Team will be a 24/7, multi-disciplinary team and provide crisis response, case management, peer support, alternatives to hospitalization and incarceration, and housing and employment support and what ever it takes to assist the consumer in maintaining their independence in the community. The FACT Team will work closely with with the Jail Mental Health Services Clinic in WVDC and Mental Health Court to expedite the voluntary participant’s release from WVDC to community treatment resources.

The emphasis will be to advance the goals of the Mental Health Services Act: (1) to divert appropriate consumers away from the criminal justice system, and (2) to expand both types and capacity of forensic-specific mental health service modalities, especially the formation of a Forensic Assertive Community Treatment (FACT) Program and the expansion of Mental Health Court and Crisis Intervention Training to law enforcement, and (3) to integrate these consumers more effectively into existing services. This will result in a reduction in homelessness, incarceration, hospitalization, emergency room care, involuntary mental health care, and an increase in the consumer’s ability to work and manage their independence in the community.
<table>
<thead>
<tr>
<th>Priority Population:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the situational characteristics of the priority population.</td>
</tr>
<tr>
<td>To serve over 110 Severely and Persistently Mentally Ill (SPMI) individuals per year who are incarcerated or at risk for incarceration and who are recidivistic for consumption of high cost institutional services.</td>
</tr>
<tr>
<td>According to statistics, African-Americans and Latinos are the highest percentage of individuals that will be targeted with this program.</td>
</tr>
</tbody>
</table>
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

- Expand the Crisis Intervention Training program with the Sheriff’s Department by hiring a Forensic Mental Health Education Consultant to provide mental health training to law enforcement, including the Sheriff’s Department, Community Police Departments, the Probation Department, the District Attorney’s Office, the Public Defender’s Office, Superior Court and other law enforcement partners. Cultural Competency training will be provided to increase the skills and understanding of the cultural specific communities in our county. Cultural Competency training will begin with African-Americans and Latino populations. Training will included diversity among ethnic specific groups, engagement skills, and outreach strategies.
- Expand Mental Health Court from San Bernardino City to outlying courts in the High Desert, Mid Desert, and West Valley regions by adding Case Managers to serve 40 additional consumers’ mental health case management needs in conjunction with the judicial system and add a Mental Health Specialist to act as a liaison to provide support to the expanded Mental Health Court.
- Provide a continuum of housing for 66 forensic mental health consumers, including augmented board and care, regular board and care, sober living housing and independent permanent housing based on the consumers’ needs.
- Increase capacity of current Mental Health Court treatment programs in San Bernardino City as follows:
  - Increase capacity of Day Rehabilitation Program to serve an additional 10 consumers, and
  - Increase capacity of Outpatient Case Management to serve an additional 20 consumers.
- Assertive Community Treatment (ACT) Team to serve 40 consumers, to include peer support and a Probation Officer that focuses on case management that will provide 24/7 support and intensive community support.
services and supports.

- Coordinate with 24/7 Crisis Walk In Centers to increase utilization by law enforcement personnel when dealing with mental health consumers.
Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The proposal includes both enhancements to existing services and the addition of new service components to address unmet needs of the special population comprised of SPMI consumers with criminal justice involvement. The services are specifically designed to identify and provide services to consumers who have not been served because of either service gaps or an inadequate capacity of existing service modalities.

The San Bernardino County Department of Behavioral Health (DBH) has several ongoing criminal justice partnerships, including a very successful Mental Health Court collaboration that has served as a national model. In addition, there have been ongoing collaborations between the Sheriff’s Department, the District Attorney’s Office, the Public Defenders Office, Superior Courts, and the Probation Department through the quarterly meeting of the Criminal Justice Mental Health Consensus Committee, which has formalized a Memorandum of Understanding (MOU) with the goal of improving mental health care in the criminal system of San Bernardino County. Furthermore, DBH has successfully implemented previous new mental health services, such as both phases of the Mentally Ill Offender Crime Reduction (MIOCR) Grant program. The proposed services will advance MHSA goals by providing client-directed services that are individualized, reduce the effects of untreated mental illness, increase access to culturally competent care for ethnically diverse individuals, reduce homelessness, reduce negative outcomes associated with law enforcement (including re-traumatization and incarceration), reduce the inappropriate use of acute inpatient care and medical care, facilitate optimal recovery, community integration, self-sufficiency, and employability of forensic SPMI consumers.

Proposed Services include:

(a) Forensic Mental Health Community Education: dedicated training personnel to expand Crisis Intervention Training (CIT) for law enforcement and to provide countywide training to municipal and county law enforcement agencies, district attorney’s staff, public defenders staff, and residential treatment centers and private mental health providers.

(b) Expansion of the current Mental Health Court in the City of San Bernardino by adding Mental Health Court Case Managers to provide mental health linkage and consultation services to new Mental Health Courts in the High Desert, Mid Desert, and West Valley regions. A Mental Health Court Liaison will also be added to assist in coordinating the expansion of mental health services across all adult and juvenile courts.

(c) Forensic Assertive Community Treatment (FACT) Team, an evidence-based practice, to provide high-level mental health services to 40 high acuity forensic mental health consumers. A Probation Officer/Case Manager will be a member of the multi-disciplinary team providing services. This was a key success indicator for our MIOCR programming, which included a Probation Officer on the treatment
team. The Probation Officer will focus on service coordination and will participate in all treatment planning and discussions. The Probation Officer will have the requisite mental health experience and training to qualify to provide case management services under Title IX. The Probation Officer’s court experience and contact has proven very valuable in streamlining judicial issues for those consumers having criminal justice contact. In addition, there will be peer support for the consumer. The team will provide intensive community services and support, with 24/7 capability, and through direct services be able to provide “what ever it takes” to assist the consumer in maintaining his/her independence in the community. The FACT Team will work closely with Jail Mental Health Services located in the West Valley Detention Center (WVDC) and Mental Health Courts to expedite and facilitate the release of mentally ill consumers from WVDC to community treatment resources.

(d) Increase existing Mental Health Court Supervised Treatment After Release (STAR) Program staffing to serve additional consumers in Day Rehabilitation and additional consumers in outpatient case management. This will allow the expansion of the existing Mental Health Court in the City of San Bernardino.

(e) Active coordination with 24/7 Crisis Walk-In Centers to provide timely mental health care for forensic SPMI consumers in acute crisis.

3) **Describe any housing or employment services to be provided.**

DBH has an existing CO-OP contract with the Department of Rehabilitation and we currently provide employment assistance to consumers. We have a minimum of 20 consumers who participate daily at the Employment Program as part of our T.E.A.M. Clubhouse in the City of San Bernardino. Regional employment specialists currently assist consumers with employment needs and forensic consumers will be linked with these resources.

The Forensic Team will provide a continuum of housing for 66 consumers, including augmented board and care, regular board and care, sober living housing and independent permanent housing, based on the consumers’ needs.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

The Forensic Assertive Community Treatment Program and Mental Health Court expansion will be a Full Service Partnership with an average cost of $17,067 per consumer per year.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**
All provided services are consistent with DBH's system-wide Recovery orientation. Specifically, the proposed services will be consumer-directed and will be integrated into a service matrix including an individualized Recovery Plan that focuses on:

(a) Consumer self-regulation,
(b) Acquisition of necessary basic living skills (including access to and maintenance of food, clothing and shelter),
(c) Creation and maintenance of a personal social network,
(d) Engagement in meaningful activities (including hobbies, leisure activities and paid/unpaid employment).
(e) Cultural outreach activities to be conducted at convenient locations and times. Activities will include discussion and dinner (platicas y comida) and ethnic fairs.

**6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

Existing service components that will be enhanced under this proposal, as follows:

The existing Crisis Intervention Training (CIT) Program provides minimal mental health training to law enforcement personnel in the Central Valley region of the county. Under this proposal it will be expanded to include more distal regions of the county and be expanded to include all local police departments and Sheriff's sites, as well as Public Defenders, District Attorneys, judges, etc.

Current Mental Health Court is located only in the City of San Bernardino and will be expanded to outlying areas of the county to include the cities of Fontana, Chino, Barstow and Yucca Valley. Mental Health Court is a voluntary program that allows mentally ill adults to be diverted from possible incarceration to participate in treatment according to the consumer’s goals and desires. There are currently eleven Superior Court districts that cover over 20,000 square miles of San Bernardino County and with this expansion there will now be mental health court services available to consumers in five (5) of the eleven (11) Superior courts. These expanded courts will start primarily with case management support and linkage of mentally ill consumers at risk of incarceration through this MHSA expansion.

The Supervised Treatment After Release (STAR) Day Rehabilitation Program is the core treatment component of the San Bernardino County Mental Health Court. It provides a broad array of recovery-oriented services to seriously and persistently mentally ill individuals who have committed various felonies and misdemeanors. Most of these individuals have a co-occurring substance abuse disorder.

While the path to recovery is unique to each individual, common themes often experienced by those recovering from mental illness include:

1) **Hope**: looking forward to the future with the positive expectation that one’s inner life and external circumstances can get better, and that one’s basic core values can be realized.
2) **Empowerment**: the sense that one has increasing power and control over his/her life, including his/her illness, thoughts, feelings, actions, and outcomes. Fundamental to empowerment is the concept of self-regulation through education/knowledge, skills acquisition, medication management, and engagement in the treatment planning process. The following are commonly observed in the process of recovery:
   a. Taking responsibility for one’s decisions and actions,
   b. Acquisition of necessary basic living skills (including skills related to the acquisition of food, clothing, shelter, and medical care),
   c. Finding positive, adaptive, life-affirming alternatives to dysfunctional self-regulatory strategies like substance abuse, suicide, abuse, illegal behavior, etc.

3) **Social Engagement**: the development and maintenance of a supportive social network that includes peers, family, friends and mental health professionals. The development of a personal social network is critical to reducing the individual’s sense of isolation and alienation and allows one to obtain an integral role in society.

4) **Engagement in Meaningful Activities**: developing interests and skills in a variety of “active” endeavors, including hobbies, leisure activities, paid or unpaid employment, self-chosen spiritual activities, etc. Often such engagement is the basis for profound change in the core identity of the individual, including gaining a sense of purpose and value.

The STAR Day Rehabilitation Program works with individuals to optimize their growth and recovery through a variety of treatment resources consistent with the Recovery Model. Titles of group activities included in the current and recent schedules are the following: Community Meeting (daily), Recovery Lifestyles, Interpersonal Relations, Health/Exercise, Criminal Thinking and Behavior, Life Management, Responsible Living, Self-Esteem, Anger Management, Men's/Women's Issues, Grief Recovery, Trauma Recovery, Independent Living Skills, Leisure Skills, Creative Expression, Pre-Vocational Skills, and Pro-Social Values.

The existing City of San Bernardino Mental Health Court Day Rehabilitation Program currently has a maximum capacity of 30 consumers and will increase capacity by 10 consumers.

The existing Mental Health Court outpatient intensive case management team currently has a maximum capacity of forty (40) consumers and will increase capacity by 20 consumers.

The expanded Mental Health Court in the City of San Bernardino and expansion to outlying courts in Fontana, Chino, Barstow and Yucca Valley will serve an additional 70 consumers.
7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Consumers will be encouraged to provide guided peer support to other consumers. Consumers will also be utilized to coordinate with county agencies and community groups and in training activities coordinated by the Mental Health Education Consultant. A key component of the ACT Team for forensic will be a Mental Health Specialist consumer to provide hope and promote the recovery philosophy to both team members and consumers.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

**MIOCR Grant Recipient:**

DBH was part of the California Department of Corrections Mentally Ill Offender Crime Reduction Grant from 1999 to 2004. This program was instrumental in developing, formalizing and implementing key collaboration strategies between the Department of Behavioral Health and local law enforcement partners.

**National Technical Assistance Grant Recipient:**

In addition, the San Bernardino County was one of thirteen recipients of a national technical assistance grant from the National Institute of Corrections and the Council of State Governments. This grant provided additional technical assistance to develop effective strategies to improve the response to people with mental illness who are under the supervision of a corrections agency.

**Criminal Justice Mental Health Consensus Collaboration and MOU:**

The Criminal Justice Mental Health Consensus Review Committee was formulated by way of a MOU between the Sheriff’s Department, the Probation Department, Mental Health Court, DBH, the Public Defender’s Office, the District Attorney’s Office, the San Bernardino City Police Department, the Office of County Counsel, and the National Alliance for the Mentally Ill (NAMI) to collaboratively address mental health issues of those with contact with the criminal justice system. This is an ongoing collaboration in which all partners meet on a quarterly basis to address mental health issues within the criminal justice system. It also has served as the coordinating committee to develop and propose additional services, including the development and start-up of the Crisis Intervention Training (CIT), and its members have played a key role in the formulation of these Forensic priorities and recommendations under the Mental Health Services Act.

**Ongoing Criminal Justice and Mental Health Collaboration:**
These recommended Forensic programs will be highly collaborative in nature, coordinating the system responses of DBH, the Superior Court, the District Attorney's Office, the Public Defender's Office, the Probation Department, the Sheriff's Department, municipal police departments, and contract residential drug and alcohol treatment providers. Transformational input from the National Alliance for the Mentally Ill, consumers, consumer family members, and community residential providers, and community groups (e.g. faith-based groups, special interest groups) will be actively sought. Collaboration through the Criminal Justice Mental Health Consensus Committee will continue and will be instrumental in assisting in the goals of reducing incarceration, institutionalization, hospitalization, and criminalization of individuals who have serious mental illness.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

All services will be provided to consumers without discrimination based on ethnic or cultural affiliation, religious beliefs, sexual orientation or gender identity, disability or primary language. The Department of Behavioral Health (DBH) has the DBH Cultural Competence Plan, which is overseen by the Cultural Competence Committee for implementation. The Cultural Competence Plan is developed and implemented to address the cultural and linguistic opportunities present in San Bernardino County. For the integrated Forensic Team, the following cultural competency strategies will be emphasized: aggressive recruitment of bilingual/bicultural staff to reflect the forensic population, develop training protocols and curriculum to address the needs of forensic cultural, racial, ethnic and linguistic groups, provide specific training regarding the homeless and incarcerated populations, and focus on outreach and engagement strategies to enhance delivery of services to underserved forensic populations.

In accord with the DBH's overall emphasis on cultural sensitivity and competence, all services will be provided in a manner consistent with the individual consumer's core cultural and identity beliefs, and with a recovery goal of:

(a) Providing basic living skills required by the consumer's preferred cultural milieu,
(b) Establishing a social network and support system consistent with the consumer's native and/or acquired cultural orientation,
(c) Training the consumer in culture-syntonic self-regulation behaviors, and
(d) Facilitating engagement in culturally meaningful activities.

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**
All services are provided in a manner sensitive to both sexual orientation and gender identity. Gender-specific services will be provided in both group and individual format, recognizing that the impact of traumatic and other significant events is gender-specific. Recovery goals will be formulated based on the individual's unique and personal sexual orientation, gender identity, and preferences. Staff are trained at least annually on issues of sexual orientation, and gender-sensitivity. Our existing staff is diverse in relation to sexual orientation and provide their additional insight and expertise.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

Services will be provided only to in-county residents, but Full Service Partnerships will follow their clients that leave San Bernardino County, as needed.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

Not applicable.

13) Please provide a timeline for this work plan, including all critical implementation dates.

The Full Services Partnership of the Forensic Assertive Community Treatment Program will be contracted out via RFP with the contractor selected in one to three months.

Mental Health Court Expansion will consist of both internal DBH hiring to be completed in three months and interdepartmental contracts completed with the Superior Court in three months.

Crisis Intervention Training hiring and training to take place in one to three months.

Full implementation and meeting program goals is expected within three to twelve months.

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

a) Work plans and most budget/staffing worksheets are required at the program level.

b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.
## A. Expenditures

<table>
<thead>
<tr>
<th>Classification</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Client, Family Member and Caregiver Support Expenditures</td>
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</tr>
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<td>a. Clothing, Food and Hygiene</td>
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<td>i. Master Leases</td>
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<td>iii. Vouchers</td>
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<td>iv. Other Housing</td>
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### 2. Personnel Expenditures

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<tbody>
<tr>
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<td>c. Employee Benefits</td>
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### 3. Operating Expenditures

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<td>d. General Office Expenditures</td>
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<td>h. Total Operating Expenditures</td>
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### 4. Program Management

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<tr>
<td>b. New Program Management</td>
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<td>c. Total Program Management</td>
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### 5. Estimated Total Expenditures when service provider is not known

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<tr>
<td>b. New Program Management</td>
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<td>c. Total Program Management</td>
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### 6. Total Proposed Program Budget

- $840,861
- $0
- $231,209
- $1,072,070

## B. Revenues

### 1. Existing Revenues

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<th>Other Governmental Agencies</th>
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<td>c. Realignment</td>
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<td>d. State General Funds</td>
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<td>e. County Funds</td>
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<td>f. Grants</td>
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<tr>
<td>a. Medi-Cal (FFP only)</td>
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<tr>
<td>b. Medicare/Patient Fees/Patient Insurance</td>
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<td>$0</td>
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<tr>
<td>c. State General Funds</td>
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<tr>
<td>d. Other Revenue</td>
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<tr>
<td>e. Total New Revenue</td>
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### 3. Total Revenues

- $690,139
- $0
- $231,209
- $921,431

## C. One-Time CSS Funding Expenditures

- $260,000

## D. Total Funding Requirements

- $410,722
- $0
- $231,209
- $641,931

## E. Percent of Total Funding Requirements for Full Service Partnerships

- 100.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports

Budget Narrative

Forensic Integrated MH Services - Workplan #A-2

County(ies): San Bernardino  Fiscal Year: 2005-06
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 $ 906
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 $ 638
   c. Housing
      iv. Other Housing $ 231,209
      Board and Care (B&C)-14 slots. Annual cost per slot $10,524. 25% in 2005-06 $ 36,834
      Augmented Board and Care (ABC)-38 slots. Annual cost per slot $18,250. 25% in 2005-06 $ 173,375
      Sober Living-14 slots. Annual cost per slot $6,000. 25% in 2005-06 $ 21,000
   d. Employment and Education Supports-based on average annual cost of $60 per client. 25% in 2005-06 $ 8,550
   f. Total Support Expenditures $ 241,303

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing STAR staff full year salary and benefit costs in 2005-06 $ 609,663
   b. New Additional Personnel Expenditures-12.1 employees salaries budgeted at 25% in 2005-06 $ 132,384
   c. Employee Benefits-33% of salaries $ 43,687
   d. Total Personnel Expenditures $ 785,734

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 1,210
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 19
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 2,396
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 6,849
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $ 22,533
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 9,302
   h. Total Operating Expenditures $ 45,033

6. Total Proposed Program Budget
   f. Total Support Expenditures $ 241,303
   g. Total Personnel Expenditures $ 785,734
   h. Total Operating Expenditures $ 45,033
   i. Total Proposed Program Budget $ 1,072,070

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-33% of existing clients $ 80,476
   b. Medicare/Patient Fees/Patient Insurance
   c. Realignment $ 609,663
   h. Total Existing Revenues $ 690,139

3. Total Revenues $ 690,139

C. One-Time CSS Funding Expenditures
   7 vehicles (1 ACT, 1 STAR, 1 MH Liaison, 4 MH Case Mgrs) @ $20,000 ea $ 140,000
   Training: 10 new employees X 40 hours annually X $100 per hour $ 40,000
   Startup equipment (cell phones, computers, etc.) 10 employees X $8,000 $ 80,000

D. Total Funding Requirements
   f. Total Support Expenditures $ 241,303
   g. Total Personnel Expenditures $ 785,734
   h. Total Operating Expenditures $ 45,033
   g. Total Revenues $ 690,139
   i. One-Time CSS Funding Expenditures $ 260,000
   i. Total Funding Requirements $ 641,931
## EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2005-06

<table>
<thead>
<tr>
<th>Program Workplan #</th>
<th>A-2</th>
<th>Date: 2/1/06</th>
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<tr>
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<tr>
<td>Type of Funding 1. Full Service Partnership</td>
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<tr>
<td>Proposed Total Client Capacity of Program/Service:</td>
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<td>Existing Client Capacity of Program/Service:</td>
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### Classification

<table>
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<tr>
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<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
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<tr>
<td>A. Current Existing Positions</td>
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<td></td>
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<tr>
<td>Alcohol &amp; Drug Abuse Counselor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$65,019</td>
<td>$65,019</td>
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<tr>
<td>Clinical Therapist II</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$85,126</td>
<td>$85,126</td>
<td></td>
</tr>
<tr>
<td>MH Clinic Supervisor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$108,989</td>
<td>$108,989</td>
<td></td>
</tr>
<tr>
<td>MH Specialist</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$53,029</td>
<td>$53,029</td>
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<tr>
<td>Occupational Therapist II</td>
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<td>$92,914</td>
<td>$92,914</td>
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</tr>
<tr>
<td>Office Assistant</td>
<td>Existing STAR Staff</td>
<td>2.00</td>
<td>$37,180</td>
<td>$74,360</td>
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</tr>
<tr>
<td>Social Worker II</td>
<td>Existing STAR Staff</td>
<td>2.00</td>
<td>$65,113</td>
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<tr>
<td>B. New Additional Positions</td>
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<tr>
<td>Mental Health Education Consultant</td>
<td>Forensic Mental Health Community Education</td>
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<tr>
<td>Clinical Supervisor</td>
<td>Forensic-specific ACT Team</td>
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<td>Forensic-specific ACT Team</td>
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<td>$3,603</td>
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<tr>
<td>Clinical Therapist I</td>
<td>MH Court Day Rehabilitation (STAR)</td>
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<tr>
<td>Social Worker II</td>
<td>MH Court Outpatient Case Management (STAR)</td>
<td>0.25</td>
<td>$43,587</td>
<td>$10,897</td>
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<tr>
<td>C. Total Program Positions</td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

---

<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures
   - a. Clothing, Food and Hygiene: $15,950
   - b. Travel and Transportation: $11,220
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $0
     - iii. Vouchers: $0
     - iv. Other Housing: $924,836
   - d. Employment and Education Supports: $150,480
   - e. Other Support Expenditures (provide description in budget narrative): $0
   - f. Total Support Expenditures: $1,102,486

### 2. Personnel Expenditures
   - a. Current Existing Personnel Expenditures (from Staffing Detail): $609,663
   - b. New Additional Personnel Expenditures (from Staffing Detail): $506,860
   - c. Employee Benefits: $167,264
   - d. Total Personnel Expenditures: $1,283,787

### 3. Operating Expenditures
   - a. Professional Services: $4,840
   - b. Translation and Interpreter Services: $83
   - c. Travel and Transportation: $9,583
   - d. General Office Expenditures: $27,394
   - e. Rent, Utilities and Equipment: $90,133
   - f. Medication and Medical Supports: $11,990
   - g. Other Operating Expenses (provide description in budget narrative): $37,208
   - h. Total Operating Expenditures: $181,231

### 4. Program Management
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

### 5. Estimated Total Expenditures when service provider is not known
   - $0

### 6. Total Proposed Program Budget
   - County Mental Health Department: $1,642,667
   - Other Governmental Agencies: $0
   - Community Mental Health Contract Providers: $924,836
   - Total: $2,567,503

## B. Revenues

### 1. Existing Revenues
   - a. Medi-Cal (FFP only): $80,476
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $609,663
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $690,139

### 2. New Revenues
   - a. Medi-Cal (FFP only): $0
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $0
   - d. Other Revenue: $0
   - e. Total New Revenues: $0

### 3. Total Revenues
   - $690,139

## C. One-Time CSS Funding Expenditures
   - $0

## D. Total Funding Requirements
   - $952,529
   - $924,836
   - $1,877,365

## E. Percent of Total Funding Requirements for Full Service Partnerships
   - 100.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports
Budget Narrative
Forensic Integrated MH Services - Workplan #A-2

County(ies): San Bernardino
Fiscal Year: 2006-07
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $15,950
   b. Travel and Transportation-based on average annual cost of $102 per client. $11,220
   c. Housing
      iv. Other Housing $924,836
      Board and Care (B&C)-14 slots. Annual cost per slot $10,524 $147,336
      Augmented Board and Care (ABC)-38 slots. Annual cost per slot $18,250. $693,500
      Sober Living-14 slots. Annual cost per slot $6,000 $84,000
   d. Employment and Education Supports-based on average annual cost of $60 per client. $150,480
   f. Total Support Expenditures $1,102,486

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing STAR staff full year salary and benefit costs $609,663
   b. New Additional Personnel Expenditures-12.1 employees salaries $506,860
   c. Employee Benefits-33% of of salaries $167,264
   d. Total Personnel Expenditures $1,283,787

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $4,840
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $83
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $9,583
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $27,394
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $90,133
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $37,208
   h. Total Operating Expenditures $181,231

6. Total Proposed Program Budget $2,567,503

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-33% of existing clients $80,476
   c. Realignment $609,663
   h. Total Existing Revenues $690,139

3. Total Revenues $690,139

D. Total Funding Requirements $1,877,365
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2006-07  
**Program Workplan #:** A-2  
**Date:** 2/1/06  
**Program Workplan Name:** Forensic Integrated MH Services  
**Type of Funding:** Full Service Partnership  
**Months of Operation:** 12  
**Proposed Total Client Capacity of Program/Service:** 180  
**Existing Client Capacity of Program/Service:** 70  
**Client Capacity of Program/Service Expanded through MHSA:** 110  
**Prepared by:** Scott Nichols  
**Telephone Number:** (909) 387-7096

#### A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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</thead>
<tbody>
<tr>
<td>Alcohol &amp; Drug Abuse Counselor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$65,019</td>
<td>$65,019</td>
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<tr>
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<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$85,126</td>
<td>$85,126</td>
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<tr>
<td>MH Clinic Supervisor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$108,989</td>
<td>$108,989</td>
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<tr>
<td>MH Specialist</td>
<td>Existing STAR Staff</td>
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<td>$53,029</td>
<td>$53,029</td>
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<td>Existing STAR Staff</td>
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<td>$92,914</td>
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<td>Existing STAR Staff</td>
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<td>$37,180</td>
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</table>

**Total Current Existing Positions:** 0.00 9.00 $609,663

#### B. New Additional Positions

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<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
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<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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**Total New Additional Positions:** 0.00 12.10 $506,860

#### C. Total Program Positions

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<th>Function</th>
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<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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</table>

**Total Program Positions:** 0.00 21.10 $1,116,523

---

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

**County(s):** San Bernardino  
**Fiscal Year:** 2007-08  
**Program Workplan #:** A-2  
**Date:** 2/1/06  
**Page:__1__ of __1__**

### Proposed Total Client Capacity of Program/Service: 180  
**New Program/Service or Expansion:** Expansion  
**Existing Client Capacity of Program/Service:** 70  
**Prepared by:** Scott Nichols  
**Client Capacity of Program/Service Expanded through MHSA:** 110  
**Telephone Number:** (909) 387-7096

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
</table>
### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene  
   $15,950 $15,950  
   b. Travel and Transportation  
   $11,220 $11,220  
   c. Housing
   i. Master Leases  
   $0  
   ii. Subsidies  
   $0  
   iii. Vouchers  
   $0  
   iv. Other Housing  
   $924,836 $924,836  
   d. Employment and Education Supports  
   $150,480 $150,480  
   e. Other Support Expenditures (provide description in budget narrative)  
   $0 $0  
   f. Total Support Expenditures  
   $177,650 $0 $924,836 $1,102,486

#### 2. Personnel Expenditures
   a. Current Existing Personnel Expenditures (from Staffing Detail)  
   $609,663 $609,663  
   b. New Additional Personnel Expenditures (from Staffing Detail)  
   $506,860 $506,860  
   c. Employee Benefits  
   $167,264  
   d. Total Personnel Expenditures  
   $1,283,787 $0 $0 $1,283,787

#### 3. Operating Expenditures
   a. Professional Services  
   $4,940 $4,940  
   b. Translation and Interpreter Services  
   $83 $83  
   c. Travel and Transportation  
   $9,583 $9,583  
   d. General Office Expenditures  
   $27,394 $27,394  
   e. Rent, Utilities and Equipment  
   $90,133 $90,133  
   f. Medication and Medical Supports  
   $11,990 $11,990  
   g. Other Operating Expenses (provide description in budget narrative)  
   $37,208 $37,208  
   h. Total Operating Expenditures  
   $181,231 $0 $0 $181,231

#### 4. Program Management
   a. Existing Program Management  
   $0  
   b. New Program Management  
   $0  
   c. Total Program Management  
   $0 $0 $0

#### 5. Estimated Total Expenditures when service provider is not known
   $0

#### 6. Total Proposed Program Budget
   $1,642,667 $0 $924,836 $2,567,503

### B. Revenues

#### 1. Existing Revenues
   a. Medi-Cal (FFP only)  
   $80,476 $80,476  
   b. Medicare/Patient Fees/Patient Insurance  
   $0 $0  
   c. Realignment  
   $609,663 $609,663  
   d. State General Funds  
   $0 $0  
   e. County Funds  
   $0 $0  
   f. Grants  
   $0 $0  
   g. Other Revenue  
   $0 $0  
   h. Total Existing Revenues  
   $690,139 $0 $0 $690,139

#### 2. New Revenues
   a. Medi-Cal (FFP only)  
   $0 $0  
   b. Medicare/Patient Fees/Patient Insurance  
   $0 $0  
   c. State General Funds  
   $0 $0  
   d. Other Revenue  
   $0 $0  
   e. Total New Revenue  
   $0 $0 $0 $0

#### 3. Total Revenues  
   $690,139 $0 $0 $690,139

### C. One-Time CSS Funding Expenditures
   $0

### D. Total Funding Requirements
   $952,529 $0 $924,836 $1,877,365

### E. Percent of Total Funding Requirements for Full Service Partnerships
   100.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports
Budget Narrative
Forensic Integrated MH Services - Workplan #A-2

County(ies): San Bernardino
Fiscal Year: 2007-08
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $15,950
   b. Travel and Transportation-based on average annual cost of $102 per client. $11,220
   c. Housing
      iv. Other Housing $924,836
   d. Employment and Education Supports-based on average annual cost of $60 per client. $150,480
   f. Total Support Expenditures $1,102,486

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing STAR staff full year salary and benefit costs $609,663
   b. New Additional Personnel Expenditures-12.1 employees salaries $506,860
   c. Employee Benefits-33% of of salaries $167,264
   d. Total Personnel Expenditures $1,283,787

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $4,840
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $83
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $9,583
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $27,394
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $90,133
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $37,208
   h. Total Operating Expenditures $181,231

5. Total Proposed Program Budget $2,567,503

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-33% of existing clients $80,476
   c. Realignment $609,663
   h. Total Existing Revenues $690,139

3. Total Revenues $690,139

D. Total Funding Requirements $1,877,365
<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Current Existing Positions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Drug Abuse Counselor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$65,019</td>
<td>$65,019</td>
<td></td>
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<tr>
<td>Clinical Therapist II</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$85,126</td>
<td>$85,126</td>
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<tr>
<td>MH Clinic Supervisor</td>
<td>Existing STAR Staff</td>
<td>1.00</td>
<td>$108,989</td>
<td>$108,989</td>
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<td>MH Specialist</td>
<td>Existing STAR Staff</td>
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a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

<table>
<thead>
<tr>
<th>County:</th>
<th>Fiscal Year:</th>
<th>Program Work Plan Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
<td>2005-06, 2006-07, 2007-08</td>
<td>Assertive Community Treatment (ACT) Team for High Utilizers of Arrowhead Regional Medical Center Behavioral Health Hospital</td>
</tr>
</tbody>
</table>

Program Work Plan #: A-3  Estimated Start Date: 3 months to 12 months

**Description of Program:**

*Describe how this program will help advance the goals of the Mental Health Services Act.*

This program will be modeled after San Bernardino Department of Behavioral Health’s (DBH) successful Assertive Community Treatment (ACT) Program, started in January of 2003. However, the target population will be different for the current program. Where the first ACT program was designed to assist clients transitioning from locked facilities (IMDs, state hospitals) and Augmented Board and Care facilities into the community and support their independent living, the current program is designed to provide community-based assertive case management and support, 24 hours a day, to 60 seriously and persistently mentally ill (SPMI) clients who are frequent users of acute psychiatric hospitalization and/or who are caught in the cycle of arrest for minor crimes - jailed - released - re-offend - jailed again, etc. Many of these clients are homeless and have co-occurring disorders.

The program will provide crisis response, peer support, clinical interventions by staff and consumers, psychiatric services, housing support, employment services and training, and will utilize the "whatever it takes" approach which typifies the ACT model of community services. Transitional housing, sober living, safe haven housing, and permanent housing will be provided as appropriate.

The goals of the program are to reduce homelessness in the county's mentally ill population, reduce frequency and length of acute psychiatric hospitalization, increase clients' involvement in their recovery plans, increase clients' ability to find and hold meaningful employment, increase independent decision-making, and provide our clients with a durable sense of hope about their futures.

**Priority Population:**

*Describe the situational characteristics of the priority population.*

The program is designed to serve 60 SPMI adults annually who are identified as high users of acute hospital services. This population is characterized by crisis-only contact with the mental health system, homelessness, co-occurring disorders, and minimal skills with which to manage their lives.
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP</td>
<td>Sys Dev</td>
</tr>
<tr>
<td>OE</td>
<td>CY</td>
</tr>
<tr>
<td>TAY</td>
<td>A</td>
</tr>
<tr>
<td>OA</td>
<td></td>
</tr>
</tbody>
</table>

- Provide community-based ACT-type assertive case management and wrap-around services.
- Services to be provided to consumers 24/7, ratio of consumers to staff will not exceed 15 to 1.
- Services to include needed mental health interventions, assertive case management, and the full range of community-based services consistent with the Recovery Model. ("Whatever it takes.")
- Services to be provided in partnership with families, Probation Dept., Parole Department, private medical and psychiatric providers, and providers of acute care.
- Services will include education and employment preparation, training and support.
- Support for sober living, safe havens, transitional shelter, single room occupancy and permanent housing, as appropriate, will be included.
- Case management services will include substance abuse interventions and will provide access to substance abuse services, including detox.
- Psychiatric services will be provided by program staff.
Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

This program is based on the well known Assertive Community Treatment (ACT) model which as been in use across the country for over thirty years. The model is researched, proven to be effective, and constitutes a “best practices” approach to treating the target population described above. San Bernardino County Department of Behavioral Health (DBH) has been operating such a program (but with a different purpose and a different target population) for the past three years, with very good success.

The proposed ACT program will provide assertive community-based case management, clinical interventions, needed mental health services, crisis intervention, wraparound support services and psychiatric services on a 24/7 basis throughout the county.

Services will include:
- Care plans that are culturally competent, developed by the client with team support,
- Multidisciplinary mental health assessment and treatment,
- Assessment and intervention with a focus on risk reduction,
- Medication management and support,
- Substance abuse interventions and treatment or referral and transportation to same,
- Education about mental illness, management of symptoms, medications and substance abuse,
- Attention to medical needs and transportation to needed appointments and services,
- Culturally competent services in the client’s native language,
- Coaching in skills needed for independent living,
- Coaching in skills needed for finding and holding a job, and
- Housing support

Consumers will be included as members of the team on a voluntary basis.

Services are intended to be provided where the clients are located. At least 75% of the ACT Team’s activities will occur outside of the office, in the community, supporting client recovery with whatever means possible. ACT Team will meet daily to discuss the needs of each person in the program, to review the events of the previous night’s on-call and to determine how staff time will be allocated to the clients in the program. Clients will be seen at least once weekly; those with more pressing needs will be seen more often, sometimes more than one per day. (Whatever it takes.) Clients will remain in the ACT program unless:

a. They are unavailable to participate in the program for three months or more;
b. They are sent to the state hospital for three months or more;
c. They decide to discontinue participation in the program,
d. They move outside of San Bernardino County.
Absent the above conditions, clients will remain in the program. Clients who are disenrolled can be reenrolled if circumstances change and there is capacity for them in the program. Clients who are doing well in the community will be visited by the ACT team less often than those with urgent needs, but they will retain the comfort of 24/7 support based on their individual needs.

3) **Describe any housing or employment services to be provided.**

DBH will provide five homeless shelter slots for the program. These slots are seen as transitional in nature, providing short-term housing until the case management team can locate more permanent housing for the consumers. DBH will also provide five sober living slots for consumers with co-occurring disorders who need such housing.

DBH will also provide 25 independent living units that can accommodate single individuals, shared housing for two or more, or families. We are interested in such options as master leasing of mid-size apartment buildings or complexes that would accommodate groups of clients. We are particularly interested in the leasing of single-family homes with multiple bedrooms to accommodate at least six clients per home (single room occupancy). A clean and safe environment for clients is the goal. We are considering residential areas in the High Desert, the Mid Desert, the East Valley/San Bernardino and the West End regions of the county along the I-10 corridor.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

The Assertive Community Treatment (ACT) Team for High Utilizers of Arrowhead Regional Medical Center Behavioral Health Hospital will be a Full Service Partnership with an average cost of $12,243 per consumer per year.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

ACT programs are client-driven. Recovery plans are made only with the client's active participation. The program will be focused on learning the client's views on his/her recovery and it will help the client to identify his/her strengths and weaknesses, preferences and personal goals. Individualized wellness and recovery plans will be created for each participating client. A client council will be formed and will meet regularly to provide program participants with a forum for discussion of their needs, wishes, and provide input into the operation of the program.

A consumer will be a part of the ACT Team. DBH will select a consumer who is in the advanced stages of recovery who can provide meaningful services to the participating clients ("members") and who can be an inspirational example to them. Modeling is a powerful intervention.
Our ACT Program is recovery-centered, meaning that it emphasizes the client's recovery of hopes and dreams as well as the building of skills and abilities needed for more independent living. A key component of an ACT Program is the 24/7 availability of an ACT Team member to guide clients through times of crisis without having to resort to hospitalization. With each successful crisis intervention, clients learn that they are capable of managing these difficult moments (empowerment) and they begin to feel better about themselves (increased self-esteem), all of which builds hope. Hope is a powerful motivator when it comes from within.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

DBH presently operates an ACT Program that is designed to prepare clients to move out of IMDs and state hospitals and support them as they remain in the community. This proposed program is an expansion of the idea of an ACT model, but it will be a separate program with separate staff, directed at the identified priority underserved populations in this county: the SPMI high utilizer of acute hospital or jail services, homeless and/or diagnosed with co-occurring disorders. The current ACT Program does not serve that population.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

A consumer will be hired as part of the Assertive Case Management Team. Some groups and activities will be led by consumers in the program or peer volunteers. Participation of family members will be sought and encouraged. As the program develops, consumer volunteers will be sought for "peer recovery specialist" activities.

8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

DBH learned from its first ACT Program that other agencies desire to be involved and that their involvement is critical to the success of the program. This proposed program staff will be contacting other agencies who will be providing services to the program participants: the Public Guardian's Office (for clients who are on conservatorship), providers of safe haven, transitional, sober living and permanent housing, substance abuse treatment programs, both outpatient and residential, and private medical providers. We will be sharing the criteria for client participation in the program and will develop a set of expectations for all agencies involved. We will jointly develop a plan for providing services based on that input. Meetings will be scheduled wherein representatives from each agency will meet and resolve shared problems. Clear responsibilities will be developed for each agency. Example: if a mentally ill consumer is a conservatee and is on probation, what part will the Probation Dept. play, and what part will the Public Guardian's office play in his/her recovery? Stakeholder collaboration
will be ongoing among all involved agencies to make program modifications as necessary to successfully deliver services to the target population. DBH currently has a Memorandum of Understanding (MOU) with the Public Guardian’s office, and criminal justice system, and others will be developed as needed.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

DBH has a Cultural Competency Officer who is responsible for the implementation of the DBH's Cultural Competency Plan. That office has developed standards and guidelines for all DBH staff, which are directed and expected to adhere to its principles.

This program will conduct outreach advertising to Latino and African-American families via the radio and TV media, will contact faith-based organizations relevant to the target population, and will conduct outreach efforts as well. The program will be staffed with culturally competent and linguistically appropriate employees who will reflect the target population to be served, thus reducing barriers to accessing services by these underserved populations. Since linguistic barriers are often the most daunting to clients, bilingual staff (Spanish/English) will be included in this program. There is no other threshold language in San Bernardino County. Other language barriers can be bridged with existing DBH staff or with translation services.

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

Services will be provided in a confidential setting that will take into consideration the impact on the client of his/her sexual orientation or gender. DBH staff is already diverse with respect to gender and to sexual orientation. We will implement appropriate strategies and interventions, which address the needs, attitudes and values, attached to each of these groups and will consult with appropriately skilled and knowledgeable DBH staff as needed.

11) **Describe how services will be used to meet the service needs for individuals residing out-of-county.**

Because the services to be provided are going to be community-based, they will be provided only within the borders of San Bernardino County, to residents of San Bernardino County.

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.**
All of the strategies selected are listed in Section IV.

13) **Please provide a timeline for this work plan, including all critical implementation dates.**

1 to 3 months - RFP process.

3 to 12 months - Program fully implemented and goals met.

14) **Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.**

   a) Work plans and most budget/staffing worksheets are required at the program level.

   b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
## A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene: \$544
   - b. Travel and Transportation: \$383
   - c. Housing
     - i. Master Leases: \$37,500
     - ii. Subsidies: \$0
     - iii. Vouchers: \$0
     - iv. Other Housing: \$21,188
   - d. Transitional Sober Living
   - e. Employment and Education Supports: \$225
   - f. Other Support Expenditures (provide description in budget narrative): \$0
   - g. Total Support Expenditures: \$59,839

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail): \$0
   - b. New Additional Personnel Expenditures (from Staffing Detail): \$89,947
   - c. Employee Benefits: \$29,683
   - d. Total Personnel Expenditures: \$119,630

3. **Operating Expenditures**
   - a. Professional Services: \$900
   - b. Translation and Interpreter Services: \$11
   - c. Travel and Transportation: \$1,782
   - d. General Office Expenditures: \$16,760
   - e. Medication and Medical Supports: \$409
   - f. Other Operating Expenses (provide description in budget narrative): \$6,919
   - g. Total Operating Expenditures: \$179,630

4. **Program Management**
   - a. Existing Program Management: \$0
   - b. New Program Management: \$0
   - c. Total Program Management: \$0

5. **Estimated Total Expenditures when service provider is not known**: \$0

6. **Total Proposed Program Budget**: \$0

## B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only): \$0
   - b. Medicare/Patient Fees/Patient Insurance: \$0
   - c. Realignment: \$0
   - d. State General Funds: \$0
   - e. County Funds: \$0
   - f. Grants: \$0
   - g. Other Revenue: \$0
   - h. Total Existing Revenues: \$0

2. **New Revenues**
   - a. Medi-Cal (FFP only): \$22,898
   - b. Medicare/Patient Fees/Patient Insurance: \$0
   - c. State General Funds: \$0
   - d. Other Revenue: \$0
   - e. Total New Revenue: \$22,898

3. **Total Revenues**: \$22,898

## C. One-Time CSS Funding Expenditures

\$76,000

## D. Total Funding Requirements

\$264,445

## E. Percent of Total Funding Requirements for Full Service Partnerships

100.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 $ 544
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 $ 383
   c. Housing
      i. Master Leases-Permanent Housing-25 slots. Annual cost $6,000 per slot. 25% in 2005-06 $ 37,500
      iii. Vouchers
      iv. Other Housing $ 21,188
      Transitional Living-5 slots. Annual cost per slot $10,950. 25% in 2005-06 $ 13,688
      Sober Living-5 slots. Annual cost per slot $6,000 25% in 2005-06 $ 7,500
   d. Employment and Education Supports-based on average annual cost of $60 per client. 25% in 2005-06 $ 225
   f. Total Support Expenditures $ 59,839

2. Personnel Expenditures
   b. New Additional Personnel Expenditures-9 employees salaries budgeted at 25% in 2005-06 $ 89,947
   c. Employee Benefits-33% of of salaries $ 29,683
   d. Total Personnel Expenditures $ 119,630

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 900
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 11
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 1,782
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 5,094
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $ 16,760
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 6,919
   h. Total Operating Expenditures $ 31,875
   6. Total Proposed Program Budget $ 211,343

B. Revenues

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%). Housing costs not included. $ 22,898
   e. Total New Revenue $ 22,898

3. Total Revenues $ 22,898

C. One-Time CSS Funding Expenditures
   Training: 9 new employees X 40 hours annually X $100 per hour $ 36,000
   2 cars @ $20,000 each $ 40,000

D. Total Funding Requirements $ 264,445
San Bernardino Fiscal Year: 2005-06

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

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<th>Fiscal Year:</th>
<th>2005-06</th>
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<td>Program Workplan #:</td>
<td>A-3</td>
<td>Date:</td>
<td>2/1/06</td>
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<tr>
<td>Program Workplan Name:</td>
<td>High Hospital User ACT Team</td>
<td>Prepared by:</td>
<td>Scott Nichols</td>
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<td>Type of Funding:</td>
<td>Full Service Partnership</td>
<td>Months of Operation:</td>
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Proposed Total Client Capacity of Program/Service: 15
Existing Client Capacity of Program/Service: 0
Client Capacity of Program/Service Expanded through MHSA: 15

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<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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<tr>
<td>A. Current Existing Positions</td>
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<td>0.00</td>
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<td>B. New Additional Positions</td>
<td>Mental Health Specialist</td>
<td>Unlicenced Consumers</td>
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Total New Additional Positions: 1.00 1.25 $89,947

C. Total Program Positions: 1.00 1.25 $89,947

---

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2006-07  
**Program Workplan #:** A-3  
**Date:** 2/1/06  
**Proposed Total Client Capacity of Program/Service:** 60  
**New Program/Service or Expansion:** New

#### A. Expenditures

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<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<td>a. Clothing, Food and Hygiene</td>
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<tr>
<td>b. Travel and Transportation</td>
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</tr>
<tr>
<td>c. Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Master Leases</td>
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</tr>
<tr>
<td>ii. Subsidies</td>
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<tr>
<td>iii. Vouchers</td>
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<td>iv. Other Housing</td>
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<tr>
<td>d. Employment and Education Supports</td>
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<tr>
<td>e. Other Support Expenditures (provide description in budget narrative)</td>
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<td>f. Total Support Expenditures</td>
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<td><strong>2. Personnel Expenditures</strong></td>
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<td>a. Current Existing Personnel Expenditures (from Staffing Detail)</td>
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<td>b. New Additional Personnel Expenditures (from Staffing Detail)</td>
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<tr>
<td>c. Employee Benefits</td>
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<tr>
<td>d. Total Personnel Expenditures</td>
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<tr>
<td><strong>3. Operating Expenditures</strong></td>
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<td></td>
</tr>
<tr>
<td>a. Professional Services</td>
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<tr>
<td>b. Translation and Interpreter Services</td>
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<tr>
<td>c. Travel and Transportation</td>
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<td>d. General Office Expenditures</td>
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<td>e. Medication and Medical Supports</td>
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<td>$6,540</td>
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<td><strong>5. Estimated Total Expenditures when service provider is not known</strong></td>
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<td><strong>6. Total Proposed Program Budget</strong></td>
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#### B. Revenues

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<tr>
<td>a. Medi-Cal (FFP only)</td>
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<td>b. Medicare/Patient Fees/Patient Insurance</td>
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<td>c. Realignment</td>
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<td>d. State General Funds</td>
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<tr>
<td>f. Grants</td>
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<td>g. Other Revenue</td>
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<td>b. Medicare/Patient Fees/Patient Insurance</td>
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<td>c. State General Funds</td>
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<td><strong>3. Total Revenues</strong></td>
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#### C. One-Time CSS Funding Expenditures

<table>
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<tbody>
<tr>
<td><strong>Total</strong></td>
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<td>$0</td>
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#### D. Total Funding Requirements

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
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<tbody>
<tr>
<td><strong>Total</strong></td>
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#### E. Percent of Total Funding Requirements for Full Service Partnerships

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 1. Client, Family Member and Caregiver Support Expenditures

- **a. Clothing, Food and Hygiene** based on average annual cost of $145 per client: $8,700
- **b. Travel and Transportation** based on average annual cost of $102 per client: $6,120
- **c. Housing**
  - i. Master Leases-Permanent Housing-25 slots. Annual cost $6,000 per slot: $150,000
  - iii. Vouchers
  - iv. Other Housing: $84,750
  - **Transitional Living**-5 slots. Annual cost per slot $10,950: $54,750
  - **Sober Living**-5 slots. Annual cost per slot $6,000: $30,000
- **d. Employment and Education Supports** based on average annual cost of $60 per client: $3,600

**f. Total Support Expenditures:** $253,170

### 2. Personnel Expenditures

- **b. New Additional Personnel Expenditures**-9 employees salaries: $359,787
- **c. Employee Benefits**-33% of salaries: $118,730

**d. Total Personnel Expenditures:** $478,517

### 3. Operating Expenditures

- **a. Professional Services**-ongoing training-based on current average annual cost of $400 per budgeted FTE: $3,600
- **b. Translation and Interpreter Services**-based on current average annual cost of $3 per client: $180
- **c. Travel and Transportation**-based on current average annual cost per budgeted FTE of $792: $7,128
- **d. General Office Expenditures**-based on current average annual cost per budgeted FTE of $2,264: $20,376
- **e. Rent, Utilities and Equipment**-based on current average annual cost per budgeted FTE of $7,449: $67,041
- **g. Other Operating Expenses**-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee: $27,675

**h. Total Operating Expenditures:** $132,540

### 6. Total Proposed Program Budget

**Total Proposed Program Budget:** $864,227

### B. Revenues

### 2. New Revenues

- **a. Medi-Cal (FFP only)**-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%). Housing costs not included: $94,422
- **e. Total New Revenue:** $94,422

**Total Revenues:** $94,422

### D. Total Funding Requirements

**Total Funding Requirements:** $769,805
EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Bernardino
Program Workplan #: A-3
Fiscal Year: 2006-07
Date: 2/1/06

Program Workplan Name: High Hospital User ACT Team

Type of Funding: 1. Full Service Partnership

Proposed Total Client Capacity of Program/Service: 60
New Program/Service or Expansion: New
Existing Client Capacity of Program/Service: 0

Prepared by: Scott Nichols
Telephone Number: (909) 387-7096

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Current Existing Positions</td>
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<td>0.00</td>
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<td>B. New Additional Positions</td>
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<td>Total New Additional Positions</td>
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<td>C. Total Program Positions</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>4.00</td>
<td>5.00</td>
<td></td>
<td>$359,787</td>
</tr>
</tbody>
</table>

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

<table>
<thead>
<tr>
<th>County: San Bernardino</th>
<th>Fiscal Year: 2007-08</th>
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<tbody>
<tr>
<td>Program Workplan #: A-3</td>
<td>Date: 2/1/06</td>
</tr>
<tr>
<td>Program Workplan Name: High Hospital User ACT Team</td>
<td>Months of Operation: 12</td>
</tr>
<tr>
<td>Proposed Total Client Capacity of Program/Service: 60</td>
<td>Prepared by: Scott Nichols</td>
</tr>
<tr>
<td>Existing Client Capacity of Program/Service: 0</td>
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</tr>
<tr>
<td>Client Capacity of Program/Service Expanded through MHSA: 60</td>
<td>Telephone Number: (909) 387-7096</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Expenditures</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<tbody>
<tr>
<td>1. Client, Family Member and Caregiver Support Expenditures</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Clothing, Food and Hygiene</td>
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<td>$8,700</td>
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</tr>
<tr>
<td>b. Travel and Transportation</td>
<td>$6,120</td>
<td>$6,120</td>
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</tr>
<tr>
<td>c. Housing</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>i. Master Leases</td>
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<td>$150,000</td>
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</tr>
<tr>
<td>ii. Subsidies</td>
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<tr>
<td>iii. Vouchers</td>
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<tr>
<td>iv. Other Housing</td>
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<tr>
<td>d. Employment and Education Supports</td>
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<td>$3,600</td>
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<td></td>
</tr>
<tr>
<td>e. Other Support Expenditures (provide description in budget narrative)</td>
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<tr>
<td>f. Total Support Expenditures</td>
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<tr>
<td>a. Current Existing Personnel Expenditures (from Staffing Detail)</td>
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<tr>
<td>b. New Additional Personnel Expenditures (from Staffing Detail)</td>
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<td>a. Professional Services</td>
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<td>b. Translation and Interpreter Services</td>
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<td>c. Travel and Transportation</td>
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<td>d. General Office Expenditures</td>
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<td>$27,675</td>
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<td>a. Existing Program Management</td>
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<td>b. New Program Management</td>
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<tr>
<td>5. Estimated Total Expenditures when service provider is not known</td>
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<td>6. Total Proposed Program Budget</td>
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<th>B. Revenues</th>
<th>County Mental Health Department</th>
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<td>c. Realignment</td>
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<table>
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<th>C. One-Time CSS Funding Expenditures</th>
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<tr>
<th>D. Total Funding Requirements</th>
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<th>$769,805</th>
</tr>
</thead>
</table>

| E. Percent of Total Funding Requirements for Full Service Partnerships | 100.0% |
Fiscal Year: 2007-08  
Date: 2/1/06

## 1. Client, Family Member and Caregiver Support Expenditures

- **Clothing, Food and Hygiene**
  - Based on average annual cost of $145 per client.
  - Total: $8,700

- **Travel and Transportation**
  - Based on average annual cost of $102 per client.
  - Total: $6,120

- **Housing**
  - **Master Leases-Permanent Housing**
    - 25 slots, Annual cost $6,000 per slot.
    - Total: $150,000
  - **Vouchers**
    - Total: $4,750
  - **Transitional Living-5 slots**
    - Annual cost per slot $10,950.
    - Total: $54,750
  - **Sober Living-5 slots**
    - Annual cost per slot $6,000
    - Total: $30,000

- **Employment and Education Supports**
  - Based on average annual cost of $60 per client.
  - Total: $3,600

- **Total Support Expenditures**: $253,170

## 2. Personnel Expenditures

- **New Additional Personnel Expenditures**
  - 9 employees salaries: $359,787

- **Employee Benefits**
  - 33% of salaries: $118,730

- **Total Personnel Expenditures**: $478,517

## 3. Operating Expenditures

- **Professional Services-ongoing training**
  - Based on current average annual cost of $400 per budgeted FTE.
  - Total: $3,600

- **Translation and Interpreter Services**
  - Based on current average annual cost of $3 per client.
  - Total: $180

- **Travel and Transportation**
  - Based on current average annual cost per budgeted FTE of $792.
  - Total: $7,128

- **General Office Expenditures**
  - Based on current average annual cost per budgeted FTE of $2,264.
  - Total: $20,376

- **Rent, Utilities and Equipment**
  - Based on current average annual cost per budgeted FTE of $7,449.
  - Total: $67,041

- **Other Operating Expenses**
  - General liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee.
  - Total: $27,675

- **Total Operating Expenditures**: $132,540

## 4. Total Proposed Program Budget

- **Total Proposed Program Budget**: $864,227

## B. Revenues

- **New Revenues**
  - **Medi-Cal (FFP only)**
    - Assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%).
    - Housing costs not included.
    - Total: $94,422

- **Total New Revenue**: $94,422

## C. Total Revenues

- **Total Revenues**: $94,422

## D. Total Funding Requirements

- **Total Funding Requirements**: $769,805
### A. Current Existing Positions

<table>
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<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
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**Total Current Existing Positions**

<table>
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<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
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</tr>
</tbody>
</table>

### B. New Additional Positions

- **Mental Health Specialist**
  - Unlicensed Consumers
  - 4.00
  - $35,097
  - $140,388

- **Social Worker II**
  - 3.00
  - $43,587
  - $130,761

- **Clinical Therapist II**
  - 1.00
  - $58,152
  - $58,152

- **Office Assistant III**
  - 1.00
  - $30,486
  - $30,486

**Total New Additional Positions**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
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<td>4.00</td>
<td>5.00</td>
<td>$359,787</td>
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### C. Total Program Positions

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<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
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<td>4.00</td>
<td>5.00</td>
<td>$359,787</td>
<td>$359,787</td>
</tr>
</tbody>
</table>

---

<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
**EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY**

| County: | San Bernardino County |
| Fiscal Year: | 2005-06, 2006-07, 2007-08 |
| Program Work Plan #: | A-4 |
| Estimated Start Date: | 3 months to 12 months |

**Description of Program:**

Describe how this program will help advance the goals of the Mental Health Services Act.

San Bernardino County Department of Behavioral Health (DBH) is proposing a redesign and expansion of DBH’s current walk-in clinics into countywide system of three 24/7 Crisis Walk-In Centers (CWIC). Currently DBH has fragmented and incomplete urgent care coverage that mainly operate during weekday business hours and evenings. DBH’s Crisis Response Teams provide limited weekend and geographical coverage, but suspend services at 9:00 PM or 10:00 PM. Thus clients have had to utilize inpatient units, emergency rooms, and law enforcement for urgent mental health services when DBH clinics are not open. When responding to sub-acute mentally ill persons in the community after DBH business hours, law enforcement personnel are left few resource options beyond involuntary holds or arrest.

The proposed CWIC program will provide urgent mental health services 24/7 for seriously mentally ill (SMI) persons of all age groups – children, TAY, adults, and older adults – needing immediate access to crisis mental health services. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and this program will provide integrated substance abuse treatment services for dually diagnosed clients. These centers will offer urgent mental health services to the acute and sub-acute mentally ill individuals including crisis intervention, crisis risk assessments, medications, substance abuse counseling, case management, referrals to DBH and contracted clinics, family support and education, transportation, 23-hour crisis stabilization and when required 5150 evaluations. Direct linkage to the high users’ team, the proposed Assertive Community Treatment (ACT) program, residential drug/alcohol programs for dually diagnosed person, DBH and DBH contracted mental health clinics, and housing and employment programs will be made by CWIC staff. All services will be provided in a culturally, linguistically, and developmentally competent manner.

The goals for this program are soundly based in recovery principals by using less restrictive settings, client driven treatment delivery, and client support systems. The goals are to:

- Maintain mentally ill persons in the community with familial and social support.
- Reduce utilization of emergency rooms by mentally ill persons for mental health needs.
<table>
<thead>
<tr>
<th>Priority Population:</th>
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<tbody>
<tr>
<td>Describe the situational characteristics of the priority population.</td>
</tr>
<tr>
<td>Inappropriately served, underserved, and unserved seriously mentally ill adults and children who frequently use acute care hospitals or jails care services for their mental health, substance abuse treatment, and shelter needs.</td>
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</tbody>
</table>

- Reduce hospitalizations, incarcerations, and residential placements.
- Provide access to crisis mental health and substance abuse services to previously unserved and underserved persons through the use of outreach presentations to community stakeholders.
### Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP</td>
<td>Sys Dev</td>
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</tbody>
</table>

- Three Crisis Walk-In Centers (CWIC) will be strategically located throughout the county that will be readily accessed by the priority population. Proposed locations are the Morongo Basin, Rialto, and Victorville.
- All services will be community-based, developmentally and culturally competent, and focused on maintaining clients within the community. This will reduce reliance on acute care settings and incarceration.
- Linkage to local mental health clinics and/or intensive case management services will be made when clients are stable.
- Referrals to physical health care and housing programs.

- Peer advocates, as paid staff and volunteers, will provide hospitality, support, and guidance to clients receiving services. Peer advocates will be recruited from DBH's current consumer run programs and clubhouses such as the *Pathways to Recovery* consumer group and the T.E.A.M. House clubhouse.
- A “warm line” will be created and manned by trained peer advocates.
- Families and friends of clients will be included in the crisis interventions and will be educated and supported to assist them in better intervening and supporting the clients in the community.
- Collaboration with local law enforcement agencies, local school districts, children service agencies, homeless shelters, community health care providers, clubhouses, faith-based organizations will be an essential aspect of this program.

- Services will be individually provided and will include crisis intervention, risk assessment, emergency medication, medical screening (nursing assessments), substance abuse counseling, and 23-hour crisis stabilization. There will be separate sections for treating children and adults in the 23-hour crisis stabilization unit.

- Presentations and written materials on the CWIC program will be provided to clubhouses, physical health care providers, local hospitals,
homeless shelters and programs, NAMI, faith-based organizations, and local law enforcement agencies.
Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

San Bernardino County is the largest county in the country and contains large, sparsely populated rural areas and small, densely populated, rapidly growing, and highly congested urban areas. These factors, combined with recent budgetary constraints and a changing DBH and county leadership, have challenged DBH in creating a comprehensive, community-based crisis system. Currently DBH has fragmented and spotty crisis coverage that mainly operate during weekday business hours and evenings. Only two DBH programs, DBH’s Children’s Crisis Response Team and the Victorville Valley Emergency Response Team, provide limited weekend, but not round-the-clock coverage. Thus clients have had to utilize inpatient units, emergency rooms, and law enforcement for urgent 24/7 mental health services when DBH clinics were closed. When handling sub-acute mentally ill persons in the community after business hours, law enforcement personnel are left few resource options beyond involuntary holds or arrest.

The proposed Crisis Walk-In Centers (CWIC) program will provide a community-based, lower-level-of-care alternative to emergency rooms, acute care hospitals, residential placements, and the jails in meeting the needs of severely mentally ill adults and children. CWIC’s will be strategically located throughout the county to benefit the most clients possible while accounting for a geographically large county. Proposed locations are Upland, the Morongo Valley, Rialto, and Victorville, and as such will significantly reduce transportation times and access to crisis mental health facilities. Presently, clients may drive (or law enforcement officials may transport clients) for several hours and hundreds of miles to and from the closest facility. Many clients do not have personal transportation and/or cannot afford the costs of these trips. This alone is a significant barrier to accessing services, posing a hardship on clients and their families, and limits or precludes families and friends from participating in treatment. Additionally, the lengthy transportation time to these facilities tie-up law enforcement staff and thus impair their departments from fully serving their community. The proposed locations will significantly increase access to mental health services after hours and allow for clients’ families to engage in the treatment process with treatment staff. They will, also, allow law enforcement personnel to return to other duties more quickly while simultaneously provide better access and services to the community.

The proposed CWIC program will provide urgent mental health services 24/7 for seriously mentally ill persons of all age groups – children, TAY, adults, and older adults – needing immediate access to crisis mental health services. The recovery principle of, "Do whatever it takes" to stabilized clients and keep them in the community will be a core value of the centers. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and so this program will have integrated substance abuse treatment services for dually diagnosed clients. The urgent mental health services provided to the acute and sub-acute mentally ill individuals by CWIC’s include crisis intervention, crisis risk assessments, medications, substance abuse counseling, case management, referrals to DBH and contracted clinics, family support and education, transportation, 23-hour crisis stabilization, and when required 5150...
evaluations. Direct linkage to DBH’s High Users Team, the proposed ACT Program, residential drug/alcohol programs for dually diagnosed persons, DBH and DBH contracted mental health clinics, contracted homeless shelters, and housing and employment programs will be made by CWIC staff. All CWIC services will be provided for individuals in a culturally, linguistically, and developmentally competent manner to populations served. In urban areas, an option will be to have CWIC’s be home base for Crisis Response Teams and can assist in stabilizing clients and thus avert hospitalization. Transportation to emergency rooms, psychiatric hospitals and client residences will be provided.

Staffing at CWIC’s will be DBH staff and paid or volunteer Peer Advocates working together. Peer Advocates will be recruited from DBH’s consumer-run programs and clubhouses such as Pathways to Recovery and T.E.A.M. House, and trained to provide treatment support, hospitality, and links to DBH clinics and consumer-run recovery centers. A “warm line” will be established that will be staffed by trained Peer Advocates and will assist clients with resource information, links to DBH services and clubhouse, and lend an empathetic ear. Families and the natural support systems of clients are an essential aspect of their recovery. Families and friends of clients will be included in the crisis resolution process and will be educated and supported to assist them in better intervening and supporting the clients in the community. Extensive and ongoing outreach presentations will be made to stakeholders to ensure the community remains aware of these resources. Clients can be self referred, transported by local law enforcement agencies, referred by local schools and child-welfare agencies, or referred by local area emergency rooms, physical health care providers, homeless shelters, and/or faith-based organizations.

By reducing hospitalizations, incarcerations, and placements, by improving the outreach activities and thereby community accesses to crisis services, and by increasing family and Peer Advocates in the crisis resolution process, the proposed CWIC program advances the MHSA goals. Further, it is estimated that by providing an alternative to acute care and residential facilities that is available 24/7, there will be a significant revenue savings that will be applied to enhancing current DBH clinics, programs, and contracts. The MHSA funding will be leveraged to allow current costs on acute care facilities to be redirected to community-based programs to meet the growing mental health and substance abuse treatment needs in our county.

3) Describe any housing or employment services to be provided.

No direct housing is available through this program. Referrals to contracted residential centers, homeless shelters, board and cares, and DBH's housing program will be made.

4) Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.
This program is not a full service partnership program, but can be accessed by full service partnership teams.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

DBH has long had Resiliency, Wellness, and Recovery (RWR) principles as its core values and has demonstrated such through assertive promotion, program implementation, and system changes. Staff has received extensive Resiliency, Wellness and Recovery training and ongoing RWR trainings are planned. Regular DBH Quality Management Unit monitoring audits that include RWR values will be conducted to ensure these principles are being employed. Focus groups consisting of clients, family members, and stakeholders will be regularly held to gain needed feedback on the program’s effectiveness of meeting RWR values. This feedback will be used for program modification and development. Additionally, the program’s goals are soundly based in RWR principles by using less restrictive settings, client driven treatment delivery, and the client support systems.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

Currently, San Bernardino County has limited and fragmented crisis response capabilities. During normal work days/hours, county clinics provide bulk of outpatient urgent care and crisis services. DBH has limited evening, holiday, and weekend coverage, and these programs are only available until 9:00 PM or 10:00 PM. At other times, clients rely on hospital-based services. Due to the county’s large size, clients seeking/requiring crisis mental health services may be required to drive (or be transported) hundreds of miles to receive these services.

Under this proposal, the CWIC’s will be blended with current DBH or DBH contract walk-in clinics and expand service capability to 24/7. They will be located within the communities with high-rates of mental illness, homelessness, and high use of acute care services to facilitate immediate access to services. Additionally, local law enforcement agencies will have an alternative to hospitals and possibly jails where they can bring clients who require mental health services, but do not warrant involuntary hospitalization or incarceration. Currently, clients are not incorporated into DBH’s crisis service delivery system. CWICs will use Peer Advocates to man a “warm line,” assist in client stabilization, and assist in linking clients to DBH and other resources. Though families, and to a lesser degree, friends are included in treatment planning and implementation, there is no formal system of education and support system development within the walk-in clinics. CWICs will engage the natural support system of the client and through education and support, assist them in maintaining clients in community settings.
7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Peer Advocates, in hired and volunteer positions, will be used at CWIC to aid clients in their recovery process. They will provide hospitality, reassurance, and linkage to client support systems within their communities such as clubhouses and NAMI. Peer Advocates will man a “warm line” that will be a first point of contact for the community. Areas will be designated for family participation in crisis interventions that allow for privacy and comfort during the crisis resolution process.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

Presentations, trainings, and written materials will be provided to clubhouses, child-welfare agencies, physical health care providers, local hospitals, school district personnel, homeless shelters and programs, NAMI, faith-based organizations, and local law enforcement agencies. Presentations will include criteria for admission, services provided, means of access/referring to CWIC, and informational cards for distribution to the community.

Law enforcement agencies will receive specific training on identifying and differentiating between clients needing acute care facilities and CWIC. These trainings have been successful in DBH's Law Enforcement Alliance Project (LEAP) pilot project conducted in the communities of Rialto, Fontana, Bloomington, and San Bernardino. LEAP provided the above services for law enforcement transported/referred clients during regular business hours. The DBH Emergency Response Team based in Victorville works in collaboration with emergency rooms in the High Desert area hospitals and with local law enforcement agencies in the High Desert. This collaboration has been effective in reducing involuntary hospitalizations and redirecting consumers to outpatient mental health and substance abuse treatment facilities. Two years ago, in response to the closing of the county’s children’s inpatient unit, the Children’s Crisis Response Team was created. Working in partnership with local law enforcement agencies, school districts, and lower level group homes and Foster Care providers, they have provided crisis services in the community. The working relationships with these agencies have been instrumental in addressing the rapidly growing need for mental health services.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

Under current DBH policies and procedures, staff and contract agencies are required to provide services in a culturally competent manner with sensitivity to the unique cultural
views clients and their families hold. These expectations are currently integrated into our service delivery systems and are monitored for compliance by the DBH Quality Management Unit. Services in the CWIC’s will also linguistically appropriate. Since the county’s Latino population is underserved and this is due, in part, to lack of bilingual staff, CWIC programs will have bilingual Spanish speaking treatment staff available on all shifts. Where this is not possible and for non-threshold languages, contracted interpreter services will be used. Also, all non-Spanish speaking staff will attend Spanish classes and learn enough Spanish to politely welcome monolingual Spanish speakers when fluent staff are detained or unavailable. For the deaf and hard of hearing, American Sign Language (ASL) fluent department staff will be called-in when needed. Aggressive recruitment/retention of bilingual/bicultural staff will continue under this proposal and efforts will be made to balance the cultures and ethnicities of CWIC staff to the population served by the center. As the current Cultural Competence Plan mandates, all staff are trained and evaluated, at least, annually. DBH’s Cultural Competency Committee will be strengthened and ensure the completion of Cultural Competence Plan’s goals and objectives by participation in interagency committees.

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

Sexual orientation and genderal issues are currently a part of DBH’s cultural competency trainings and staff development plan. The refining of the DBH’s training protocols and curriculums addressing lesbians, gays, bisexuals, transgender (LGBT) persons and families members of these groups will be based upon client and family input collected from focus groups. Genderal issues for men and women as well as developmental and general issues for boys and girls will also be addressed by training and monitoring. Since a 23 hour stabilization unit is proposed under this plan, children and younger TAY clients will have physically separate treatment rooms from adult clients with staff and physical barriers between them.

11) **Describe how services will be used to meet the service needs for individuals residing out-of-county.**

Out-of-County residents may access CWIC when requiring urgent mental health intervention. However, they will be referred to an acute care facility (if symptoms require) or their county of residence for ongoing services. Every effort will be made to properly link them to providers in their counties.

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.**

As Listed in Section IV.
13) **Please provide a timeline for this work plan, including all critical implementation dates.**

Month 1-3: RFP process for CWIC clinics in High and Mid Desert. Staff recruitment, hiring and training. Facilities identification and negotiation for DBH Crisis Walk-In Clinic.

Months 3-12: Crisis Walk In Clinics fully implemented and operational to meet goals.

14) **Develop Budget Requests:** Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

a) Work plans and most budget/staffing worksheets are required at the program level.

b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene $2,117 $2,117
   b. Travel and Transportation $1,489 $1,489
   c. Housing
     i. Master Leases $0
     ii. Subsidies $0
     iii. Vouchers $0
     iv. Other Housing $0
   d. Employment and Education Supports $0 $0
   e. Other Support Expenditures (provide description in budget narrative) $0 $0
   f. Total Support Expenditures $0 $0

### 2. Personnel Expenditures
   a. Current Existing Personnel Expenditures (from Staffing Detail) $722,872 $722,872
   b. New Additional Personnel Expenditures (from Staffing Detail) $52,426 $52,426
   c. Employee Benefits $238,548 $17,301
   d. Total Personnel Expenditures $961,420 $0 $69,727 $1,031,146

### 3. Operating Expenditures
   a. Professional Services $400 $400
   b. Translation and Interpreter Services $44 $44
   c. Travel and Transportation $1,188 $1,188
   d. General Office Expenditures $3,396 $3,396
   e. Rent, Utilities and Equipment $2,793 $2,793
   f. Medication and Medical Supports $6,366 $6,366
   g. Other Operating Expenses (provide description in budget narrative) $4,613 $4,613
   h. Total Operating Expenditures $0 $0 $18,999 $18,999

### 4. Program Management
   a. Existing Program Management $0
   b. New Program Management $0
   c. Total Program Management $0 $0

### 5. Estimated Total Expenditures when service provider is not known
   $0

### 6. Total Proposed Program Budget $961,420 $0 $92,332 $1,053,752

## B. Revenues

### 1. Existing Revenues
   a. Medi-Cal (FFP only) $480,710 $480,710
   b. Medicare/Patient Fees/Patient Insurance $0
   c. Realignment $480,710 $480,710
   d. State General Funds $0
   e. County Funds $0
   f. Grants $0
   g. Other Revenue $0
   h. Total Existing Revenues $961,420 $0 $0 $961,420

### 2. New Revenues
   a. Medi-Cal (FFP only) $13,850 $13,850
   b. Medicare/Patient Fees/Patient Insurance $0
   c. State General Funds $0
   d. Other Revenue $0
   e. Total New Revenue $0 $0 $13,850 $13,850

### 3. Total Revenues $961,420 $0 $13,850 $975,270

## C. One-Time CSS Funding Expenditures $137,200 $137,200

## D. Total Funding Requirements $137,200 $0 $78,482 $215,682

## E. Percent of Total Funding Requirements for Full Service Partnerships 0.0%
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

- a. Clothing, Food and Hygiene-based on 20% of clients @ average annual cost of $145 per client. 25% in 2005-06 $2,117
- b. Travel and Transportation-based on 20% of clients @ average annual cost of $102 per client. 25% in 2005-06 $1,489
- c. Housing
- d. Total Support Expenditures $3,606

### 2. Personnel Expenditures

- a. Current Existing Personnel Expenditures-existing staff full year costs in 2005-06 $722,872
- b. New Additional Personnel Expenditures-6 employees salaries budgeted at 25% in 2005-06 $52,426
- c. Employee Benefits-33% of of salaries $255,848
- d. Total Personnel Expenditures $1,031,146

### 3. Operating Expenditures

- a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $600
- b. Translation and Interpreter Services-based on current average annual cost of $3 per client (20% of clients) $44
- c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $1,188
- d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $3,396
- e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $2,793
- f. Medication and Medical Supports-based on current average annual cost of $109 per client. 25% in 2005-06 (20% of clients) $6,366
- g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $4,613
- h. Total Operating Expenditures $18,999

### 6. Total Proposed Program Budget $1,053,752

#### a. Medi-Cal (FFP only)-30% of existing clients $480,710
#### b. Medicare/Patient Fees/Patient Insurance $-
#### c. Realignment $480,710
#### d. State General Funds-EPSDT-45% of existing costs $-
#### e. County Funds $-
#### f. Grants $-
#### g. Other Revenue $-
#### h. Total Existing Revenues $961,420

#### 2. New Revenues

- a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) $13,850
- b. Medicare/Patient Fees/Patient Insurance $-
- c. State General Funds-Potential EPSDT match, assuming 50% of the Medi-Cal eligible clients fit the criteria for EPSDT, 95% applied to the net, leaving the 5% match requirement $-
- d. Other Revenue $-
- e. Total New Revenue $13,850

#### 3. Total Revenues $975,270

#### C. One-Time CSS Funding Expenditures

- 3 caged vehicles $60,000
- Rialto: Furnishings for expanded leased facilities: 6 employees X $5,000 per employee $30,000
- Rialto: Computers 6 employees X $3000 $18,000
- Rialto: Training - 6 new employees X 40 hours annually X $100 per hour $24,000
- Rialto: 8 Recliners and tables/chairs $5,200

#### D. Total Funding Requirements $215,682
**EXHIBIT 5b—Mental Health Services Act Community Services and Supports Staffing Detail Worksheet**

County(ies): San Bernardino  
Fiscal Year: 2005-06  
Program Workplan # A-4  
Date: 2/1/06  
Program Workplan Name Crisis Walk-in Centers  
Prepared by: Scott Nichols  
Telephone Number: (909) 387-7096

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<th>Classification</th>
<th>Function</th>
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<th>Total Number of FTEs</th>
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<th>Total Salaries, Wages and Overtime</th>
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<td>B. New Additional Positions</td>
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<tr>
<td>Clinical Therapist II</td>
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<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   - a. Clothing, Food and Hygiene: $87,000
   - b. Travel and Transportation: $61,200
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $0
     - iii. Vouchers: $0
     - iv. Other Housing: $0
   - d. Employment and Education Supports: $36,000
   - e. Other Support Expenditures (provide description in budget narrative): $0
   - f. Total Support Expenditures: $184,200

2. Personnel Expenditures
   - b. New Additional Personnel Expenditures (from Staffing Detail): $1,155,235
   - c. Employee Benefits: $238,548
   - d. Total Personnel Expenditures: $1,536,463

3. Operating Expenditures
   - a. Professional Services: $12,120
   - b. Translation and Interpreter Services: $9,000
   - c. Travel and Transportation: $23,998
   - d. General Office Expenditures: $68,599
   - e. Rent, Utilities and Equipment: $327,000
   - f. Medication and Medical Supports: $327,000
   - g. Other Operating Expenses (provide description in budget narrative): $93,173
   - h. Total Operating Expenditures: $1,085,994

4. Program Management
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

5. Estimated Total Expenditures when service provider is not known: $0

6. Total Proposed Program Budget: $3,768,076

### B. Revenues

1. Existing Revenues
   - a. Medi-Cal (FFP only): $480,710
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $480,710
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $961,420

2. New Revenues
   - a. Medi-Cal (FFP only): $420,998
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $0
   - d. Other Revenue: $0
   - e. Total New Revenue: $420,998

3. Total Revenues: $420,998

### C. One-Time CSS Funding Expenditures

- $731,800

### D. Total Funding Requirements

- $2,385,658

### E. Percent of Total Funding Requirements for Full Service Partnerships

- 0.0%
EXHIBIT 5a--Mental Health Services Act Community Services and Supports
Budget Narrative
Crisis Walk-in Centers - Workplan # A-4

County(ies): San Bernardino
Fiscal Year: 2006-07
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. (20% of clients) $87,000
   b. Travel and Transportation-based on average annual cost of $102 per client. (20% of clients) $61,200
   d. Employment and Education Supports-based on average annual cost of $60 per client. (20% of clients) $36,000
   f. Total Support Expenditures $184,200

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs in 2005-06 $722,872
   b. New Additional Personnel Expenditures-30.3 employees salaries $1,155,235
   c. Employee Benefits-33% of of salaries $619,775
   d. Total Personnel Expenditures $2,497,882

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $12,120
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $9,000
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $23,998
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $68,599
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 (average does not include lease costs) + 16000 s.f. X $1.70 s.f. X 12 mos $552,105
   f. Medication and Medical Supports-based on current average annual cost of $109 per client. $327,000
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $93,173
   h. Total Operating Expenditures $1,085,994

6. Total Proposed Program Budget $3,768,076

B. Revenues

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) $1,382,418
   e. Total New Revenue $1,382,418

3. Total Revenues $1,382,418

C. One-Time CSS Funding Expenditures
   $731,800
   Victoria: Furnishings for new leased facilities-12 employees X $5,000 per employee $60,000
   Victoria: Tenant Improvements for Leased Space 8500 s.f. (400 s.f. per emp + 3600 s.f. clinic spac $212,500
   Victoria: Computers 12 employees X $3000 $36,000
   Victoria: 8 Recliners and tables/chairs $5,200
   Victoria: Training - 12 new employees X 40 hours X $100 per hour $48,000
   Rialto: Furnishings for expanded leased facilities: 6 employees X $5,000 per employee $30,000
   Rialto: Computers 6 employees X $3000 $18,000
   Rialto: Training - 6 new employees X 40 hours X $100 per hour $24,000

D. Total Funding Requirements $3,117,458
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2006-07  
**Program Workplan #** A-4  
**Date:** 2/1/06

**Program Workplan Name:** Crisis Walk-in Centers  
**Type of Funding:** System Development  
**Months of Operation:** 12

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Therapist II</td>
<td></td>
<td>6.00</td>
<td></td>
<td>$85,126</td>
<td>$510,756</td>
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<tr>
<td>Mental Health Specialist</td>
<td></td>
<td>4.00</td>
<td></td>
<td>$53,029</td>
<td>$212,116</td>
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**Total Current Existing Positions**: 0.00 10.00 $722,872

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<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. New Additional Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinic Supervisor</td>
<td></td>
<td>0.80</td>
<td></td>
<td>$76,209</td>
<td>$60,967</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td>1.00</td>
<td></td>
<td>$144,123</td>
<td>$144,123</td>
</tr>
<tr>
<td>Clinical Therapist II</td>
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<td>4.00</td>
<td></td>
<td>$58,152</td>
<td>$232,608</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Counselor</td>
<td></td>
<td>4.00</td>
<td></td>
<td>$43,231</td>
<td>$172,924</td>
</tr>
<tr>
<td>Licensed Vocational Nurse I</td>
<td></td>
<td>4.00</td>
<td></td>
<td>$32,000</td>
<td>$128,000</td>
</tr>
<tr>
<td>Peer Mentor</td>
<td></td>
<td>6.50</td>
<td></td>
<td>$29,266</td>
<td>$190,229</td>
</tr>
<tr>
<td>General Service Worker</td>
<td></td>
<td>6.00</td>
<td></td>
<td>$19,094</td>
<td>$114,564</td>
</tr>
<tr>
<td>Office Assistant II</td>
<td></td>
<td>4.00</td>
<td></td>
<td>$27,955</td>
<td>$111,820</td>
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**Total New Additional Positions**: 12.50 17.80 $1,155,235

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<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>12.50</td>
<td></td>
<td>17.80</td>
<td>$1,878,107</td>
</tr>
</tbody>
</table>

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

### San Bernardino County MHSA CSS

**Program and Expenditure Plan-February 2006**

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
</table>

### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures

- **a. Clothing, Food and Hygiene**
  - $87,000
- **b. Travel and Transportation**
  - $61,200
- **c. Housing**
  - **i. Master Leases**
  - $0
  - **ii. Subsidies**
  - $0
  - **iii. Vouchers**
  - $0
  - **iv. Other Housing**
  - $0
- **d. Employment and Education Supports**
  - $36,000
- **e. Other Support Expenditures (provide description in budget narrative)**
  - $0
- **f. Total Support Expenditures**
  - $0

#### 2. Personnel Expenditures

- **a. Current Existing Personnel Expenditures (from Staffing Detail)**
  - $722,872
- **b. New Additional Personnel Expenditures (from Staffing Detail)**
  - $1,155,235
- **c. Employee Benefits**
  - $238,548
- **d. Total Personnel Expenditures**
  - $2,116,655

#### 3. Operating Expenditures

- **a. Professional Services**
  - $12,120
- **b. Translation and Interpreter Services**
  - $9,000
- **c. Travel and Transportation**
  - $23,998
- **d. General Office Expenditures**
  - $68,599
- **e. Rent, Utilities and Equipment**
  - $327,000
- **f. Medication and Medical Supports**
  - $327,000
- **g. Other Operating Expenses (provide description in budget narrative)**
  - $93,173
- **h. Total Operating Expenditures**
  - $1,085,994

#### 4. Program Management

- **a. Existing Program Management**
  - $0
- **b. New Program Management**
  - $0
- **c. Total Program Management**
  - $0

#### 5. Estimated Total Expenditures when service provider is not known

- **Total**
  - $0

### B. Revenues

#### 1. Existing Revenues

- **a. Medi-Cal (FFP only)**
  - $480,710
- **b. Medicare/Patient Fees/Patient Insurance**
  - $0
- **c. Realignment**
  - $480,710
- **d. State General Funds**
  - $0
- **e. County Funds**
  - $0
- **f. Grants**
  - $0
- **g. Other Revenue**
  - $0
- **h. Total Existing Revenues**
  - $961,420

#### 2. New Revenues

- **a. Medi-Cal (FFP only)**
  - $420,998
- **b. Medicare/Patient Fees/Patient Insurance**
  - $0
- **c. State General Funds**
  - $0
- **d. Other Revenue**
  - $0
- **e. Total New Revenue**
  - $420,998

#### 3. Total Revenues

- **Total Revenues**
  - $1,382,418

### C. One-Time CSS Funding Expenditures

- **Total**
  - $0

### D. Total Funding Requirements

- **Total**
  - $2,385,658

### E. Percent of Total Funding Requirements for Full Service Partnerships

- **Percent**
  - $0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. (20% of clients)  $ 87,000
   b. Travel and Transportation-based on average annual cost of $102 per client. (20% of clients)  $ 61,200
   d. Employment and Education Supports-based on average annual cost of $60 per client. (20% of clients)  $ 36,000
   f. Total Support Expenditures  $ 184,200

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary costs in 2005-06  $ 722,872
   b. New Additional Personnel Expenditures-30.3 employees salaries  $ 1,155,235
   c. Employee Benefits-33% of of salaries  $ 619,775
   d. Total Personnel Expenditures  $ 2,497,882

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE  $ 12,120
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client  $ 9,000
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792  $ 23,998
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $7,449 (average does not include lease costs) + 16000 s.f. X $1.70 s.f. X 12 mos  $ 552,105
   f. Medication and Medical Supports-based on current average annual cost of $109 per client.  $ 327,000
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee  $ 93,173
   h. Total Operating Expenditures  $ 1,085,994

6. Total Proposed Program Budget  $ 3,768,076

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-30% of existing clients  $ 480,710
   b. Medicare/Patient Fees/Patient Insurance  $ 480,710
   c. Realignment  $ 480,710
   d. State General Funds-EPSDT-45% of existing costs  $ 961,420
   e. County Funds
   f. Grants
   g. Other Revenue
   h. Total Existing Revenues  $ 961,420

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%)  $ 420,998
   e. Total New Revenue  $ 420,998

3. Total Revenues  $ 1,382,418

C. One-Time CSS Funding Expenditures

D. Total Funding Requirements  $ 2,385,658
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**San Bernardino Fiscal Year:** 2007-08  
**A-4 Date:** 2/1/06  
**Crisis Walk-in Centers**

#### Function Client, FM & CG FTEs\(a\)  
**Total**  
**Salary, Wages and Overtime per FTE\(b\)**  
**Total Salaries, Wages and Overtime**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
</table>
| **A. Current Existing Positions**  
Clinical Therapist II | 6.00 | $65,126 | $510,756 |
| Mental Health Specialist | 4.00 | $53,029 | $212,116 |
| **Total Current Existing Positions** | 10.00 | | $722,872 |
| **B. New Additional Positions**  
Clinic Supervisor | 0.80 | $76,209 | $60,967 |
| Psychiatrist | 1.00 | $144,123 | $144,123 |
| Clinical Therapist II | 4.00 | $58,152 | $232,608 |
| Alcohol & Drug Counselor | 4.00 | $43,231 | $172,924 |
| Licensed Vocational Nurse I | 4.00 | $32,000 | $128,000 |
| Peer Mentor | 6.50 | $29,266 | $190,229 |
| General Service Worker | 6.00 | $19,094 | $114,564 |
| Office Assistant II | 4.00 | $27,955 | $111,820 |
| **Total New Additional Positions** | 17.80 | | $1,155,235 |
| **C. Total Program Positions** | 12.50 | 27.80 | | $1,878,107 |

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
<table>
<thead>
<tr>
<th><strong>EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY</strong></th>
</tr>
</thead>
</table>
| **County:** San Bernardino County  
  **Fiscal Year:** 2005-06, 2006-07, 2007-08  
  **Program Work Plan Name:** Psychiatric Triage Diversion Team at County Hospital  
  **Program Work Plan #: A-5  
  Estimated Start Date: 3 months to 12 months** |
| **Description of Program:** |
| *Describe how this program will help advance the goals of the Mental Health Services Act.* |
| At San Bernardino County's psychiatric hospital, the Department of Behavioral Health (DBH) will provide culturally competent screening and diversion of clients who present at the hospital's emergency room and who may not be in actual need of hospitalization. It is DBH's experience that many mentally ill consumers go to the hospital's Emergency Room (ER) for a variety of services such as prescription refills, resolution of homelessness, resolution of crisis, assistance with substance-abuse crises, hunger, seeking information regarding mental health services, and similar issues. It is also the department's experience that approximately 40% of those going to the ER can be provided services which will meet their needs in a less restrictive environment and which will give them opportunities to increase their coping skills and decrease their reliance on hospitalization. The proposed program will provide a preliminary screening of clients as they enter the Behavioral Health Unit's ER and will determine the reason for the client's coming to the ER. The program will divert the client and link the client with existing community resources which are most appropriate for the client's condition and ongoing mental health needs. Preventing unnecessary acute hospitalizations promotes recovery and resiliency, decreases dependency on "the system", and promotes responsible wellness. |
| **Priority Population:** |
| *Describe the situational characteristics of the priority population.* |
| The priority population to be served is 300 adults annually who are presenting at the psychiatric ER in crisis due to homelessness, co-occurring disorders, recent release from incarceration, and medical conditions. The target population will include clients who are uninsured, and who will most likely represent the full range of racial, cultural and ethnic diversity found in this county. |
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

- Provide integrated case management services at the psychiatric triage location in the county hospital, in collaboration with outpatient clinics, primary care providers and housing providers. Clients who are frequently hospitalized in acute psychiatric care will be linked to existing intensive community-based case management services and with existing outpatient clinics.
- After stabilization, provide facilitation of community placement at the lowest appropriate level of care.
- Advocate for and facilitate the clients' negotiations to return to their previous location if at all possible.
- Advocate for clients with family and caregivers to support recovery and aftercare.
- Advocate for clients to have access to treatment for co-occurring disorders and link with residential treatment or transitional housing as needed.
- Clients will be encouraged and empowered to actively participate in their diversion and recovery plan. Options regarding mental health care and housing will be presented, with clients being encouraged to make choices that will promote their long-term recovery goals.
- Transportation assistance will be made available to clients to facilitate their return to community-based recovery. Again, clients will be encouraged to make their own decisions as much as possible.
- Advocate for clients' use of existing community support and self-help services that will simultaneously enhance their recovery goals.
- Clients who do not speak English or who are hearing-impaired will be provided with linguistic services that will allow for immediate access to mental health services.
- Provide education and consultation to clients and families regarding community services and facilitate their engagement in and accessing of those services. Educational materials will be developed in the client’s language and with cultural considerations.
2) **Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.**

The primary objective of this program is to identify those clients coming to the county hospital's psychiatric unit who can be better served by an alternative to acute hospitalization, and then linking the client with that alternative. This program will meet the needs of unserved and underserved clients by diverting them from a "crisis-to-crisis" style of mental health treatment into more consistent and long-term recovery-oriented activities. Many of the clients who come to the psychiatric triage only do so when in crisis and do not avail themselves of services at other times. This program will allow San Bernardino County Department of Behavioral Health (DBH) to identify them and to encourage them to remain involved in their recovery.

The program will operate during the daytime hours and until 10:00 PM each evening, after which time the inflow of clients tends to slow down significantly. During those hours the program staff (psychiatrist, clinician, social worker) will be able to screen, assess, and refer to other DBH outpatient clinics, crisis stabilization units, ongoing assertive case management programs, medication clinics, sober living or homeless shelter programs, residential or out-patient treatment programs for co-occurring disorders, and to all the available community resources which might be helpful to the client. Of course, if acute psychiatric hospitalization is indicated, the client will be admitted by the regular hospital staff. Clients will be continually encouraged to be actively involved in all phases of decision-making regarding their treatment and recovery. Transportation will be provided to assist clients in accessing the needed services.

The program advances the goals of MHSA by increasing the coping skills of the clients while they are in crisis and by decreasing their dependence upon hospitalization as an answer to each crisis. Resiliency is increased as a result. It is well known that acute hospitalizations are seen by clients as "failures" or "relapses." Successful efforts to decrease their frequency is going to benefit the client's self-esteem, a critical factor in successful recovery. It is expected that as the Crisis Walk In Clinics are fully operational and established that there will be a decreased need for these services as fewer consumers present at Arrowhead Regional Medical Center (ARMC) emergency room. The need for this psychiatric triage service will be reevaluated annually.

3) **Describe any housing or employment services to be provided.**

To prevent hospitalization and homelessness, DBH will provide ten homeless shelter slots and ten sober living slots (described in the one-time funding proposal) to consumers transitioning out of the hospital's triage unit, as appropriate.

Referrals to existing employment services will be made as appropriate, although DBH's experience is that this service is not typically appropriate for this population.
4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

This is not an FSP program.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

DBH has been committed to the idea of promoting recovery and wellness and the services and programs that will help clients in achieving those goals. Although there are many aspects to recovery which are unique to the individual client, some of the common factors are empowerment, increased involvement in decision-making (especially in areas regarding their treatment), self-direction, independent management of symptoms, reduced impairment, a feeling of being in charge of one's life and one's treatment, and the sense of hope and fulfillment which follows. By giving clients an opportunity to redirect from acute psychiatric hospitalization (where most treatment decisions are necessarily made by hospital staff) to programs and locations where clients can have more of a say in designing their treatment and can make known their individual needs and wishes, recovery and the goals of MHSA can be advanced. An important element of this program is educating clients about the services available to them in their communities and educating them about how to access those services, and then assisting them to do so.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

This is an existing program in its very early stages, started in September of 2005. It presently consists of a Mental Health Clinic Supervisor (a newly-created position) working in the county hospital's triage area. The proposed program will expand staffing and service capability.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

DBH acknowledges that a client's "natural" support system (those people in the client's life that the client believes are most important to him/her) is the best support system and the one most likely to promote long-term recovery. The triage staff in this program will make every effort to include and involve the people in the client's natural support system, providing education and support on how to best support and promote recovery. Referrals to community self-help and support such as NAMI, AA, NA, recovery clubhouses, etc. will be provided. Clients may be added as volunteers or as paid staff as the program develops.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population,**

San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006 192
including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

DBH's experience with the very successful Assertive Community Treatment (ACT) Program has highlighted for us the benefits of good collaboration with a wide variety of stakeholders: the Public Guardian's Office, other mental health providers, law enforcement agencies and the criminal justice system, owners of board and care homes and of other transitional housing facilities, employment services, and faith-based service providers. All of them have been key in making that program work, and all of them are now ongoing partners in creating these new programs under MHSA. This hospital triage-based program will succeed to the extent that those partnerships are extended to this new effort, allowing the client in crisis to gain immediate access to a broad array of services and supports from the single location of the triage unit.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

DBH has a Cultural Competency Officer who is responsible for the implementation of the DBH's Cultural Competency Plan. That office has developed standards and guidelines for all DBH staff, who are directed to adhere to its principles.

The most pressing need in a triage-based program such as the one proposed here is linguistic competence. People in crisis need to be relieved of the burden of having to translate, which decreases effective communication. Particular attention will be paid to finding staff that is bilingual (the primary need is Spanish/English). Creating a culturally and linguistically competent staff will reduce the barriers to services for monolingual clients who are in need.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

DBH staff receives ongoing training in the areas of lesbian, gay, bisexual and transgender issues. DBH staff itself is diverse in the area of sexual orientation, and can lend valuable knowledge and expertise to this new program. Because all recovery plans are based on the client's strengths and needs, those plans will be sensitive to gender and to sexual orientation.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

This program will not serve individuals residing outside of San Bernardino County, unless they happen to be in the county at the time of a mental health crisis. If that is the case, they will be seen as any other client in crisis would be seen. Staff would then
collaborate with programs and service providers from the client's home county to facilitate continued services in the client's home area.

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.**

All strategies selected are listed in Section IV.

13) **Please provide a timeline for this work plan, including all critical implementation dates.**

   Months 1-3: Staff recruitment, hiring and training.

   Month 3-12: Full implementation of program

   FY06-07 and FY 07-08. Full implementation to meet program goals

14) **Develop Budget Requests:** Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

   a) Work plans and most budget/staffing worksheets are required at the program level.

   b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
### A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene: $4,078
   - b. Travel and Transportation: $2,869
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $0
     - iii. Vouchers: $0
     - iv. Other Housing: $0
   - d. Employment and Education Supports: $1,688
   - e. Other Support Expenditures (provide description in budget narrative): $0
   - f. Total Support Expenditures: $8,634

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail): $109,785
   - b. New Additional Personnel Expenditures (from Staffing Detail): $46,928
   - c. Employee Benefits: $15,486
   - d. Total Personnel Expenditures: $172,199

3. **Operating Expenditures**
   - a. Professional Services: $200
   - b. Translation and Interpreter Services: $113
   - c. Travel and Transportation: $396
   - d. General Office Expenditures: $1,132
   - e. Rent, Utilities and Equipment: $3,725
   - f. Medication and Medical Supports: $4,088
   - g. Other Operating Expenses (provide description in budget narrative): $1,538
   - h. Total Operating Expenditures: $11,190

4. **Program Management**
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

5. **Estimated Total Expenditures when service provider is not known**
   - $0

6. **Total Proposed Program Budget**
   - $192,024

### B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only): $0
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $109,785
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $109,785

2. **New Revenues**
   - a. Medi-Cal (FFP only): $12,336
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $0
   - d. Other Revenue: $0
   - e. Total New Revenue: $12,336

3. **Total Revenues**
   - $122,121

### C. One-Time CSS Funding Expenditures
   - $40,000

### D. Total Funding Requirements
   - $109,903

### E. Percent of Total Funding Requirements for Full Service Partnerships
   - 0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 $ 4,078
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 $ 2,869
   c. Housing
      iv. Other Housing $ -
         Sober Living-10 slots. Annual cost per slot $6,000 25% in 2005-06 $ 15,000
         Transitional Housing-10 slots. Annual cost per slot $10,950 25% in 2005-06 $ 27,375
   d. Employment and Education Supports-based on average annual cost of $60 per client. 25% in 2005-06 $ 1,688
   f. Total Support Expenditures $ 8,634

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs in 2005-06 $ 109,785
   b. New Additional Personnel Expenditures-5 employees salaries budgeted at 25% in 2005-06 $ 46,928
   c. Employee Benefits-33% of of salaries $ 15,486
   d. Total Personnel Expenditures $ 172,199

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $ 200
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $ 113
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $ 396
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $ 1,132
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $ 3,725
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $ 1,538
   h. Total Operating Expenditures $ 11,190

6. Total Proposed Program Budget $ 192,024

B. Revenues

1. Existing Revenues
   c. Realignment $ 109,785
   h. Total Existing Revenues $ 109,785

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%). Housing costs not included. $ 12,336
   e. Total New Revenue $ 12,336

3. Total Revenues $ 122,121

C. One-Time CSS Funding Expenditures $ 40,000
   2 cars @ $20,000 each $ 40,000

D. Total Funding Requirements $ 109,903
**EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet**

<table>
<thead>
<tr>
<th>County(ies):</th>
<th>San Bernardino</th>
<th>Fiscal Year:</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Workplan #:</td>
<td>A-5</td>
<td>Date:</td>
<td>2/1/06</td>
</tr>
<tr>
<td>Program Workplan Name:</td>
<td>Psychiatric Triage Diversion Team at ARMC</td>
<td>Prepared by:</td>
<td>Scott Nichols</td>
</tr>
<tr>
<td>Type of Funding:</td>
<td>Full Service Partnership</td>
<td>Months of Operation:</td>
<td>3</td>
</tr>
<tr>
<td>Proposed Total Client Capacity of Program/Service:</td>
<td>250</td>
<td>New Program/Service or Expansion:</td>
<td>Expansion</td>
</tr>
<tr>
<td>Existing Client Capacity of Program/Service:</td>
<td>100</td>
<td>Prepared by:</td>
<td>Scott Nichols</td>
</tr>
<tr>
<td>Client Capacity of Program/Service Expanded through MHSA:</td>
<td>150</td>
<td>Telephone Number:</td>
<td>(909) 387-7096</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Current Existing Positions</td>
<td>Clinic Supervisor</td>
<td>1.00</td>
<td>$109,785</td>
<td>$109,785</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. New Additional Positions</td>
<td>Clinical Therapist I</td>
<td>0.00</td>
<td>$49,722</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>0.25</td>
<td>$144,123</td>
<td>$36,031</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker II</td>
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<td>$10,897</td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total New Additional Positions</td>
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<td>0.50</td>
<td></td>
<td>$46,928</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>C. Total Program Positions</td>
<td></td>
<td>1.50</td>
<td></td>
<td>$156,713</td>
<td></td>
</tr>
</tbody>
</table>

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures
- a. Clothing, Food and Hygiene: $32,625
- b. Travel and Transportation: $22,950
- c. Housing:
  - i. Master Leases: $0
  - ii. Subsidies: $0
  - iii. Vouchers: $0
  - iv. Other Housing: $0
- d. Employment and Education Supports: $13,500
- e. Other Support Expenditures (provide description in budget narrative): $0
- f. Total Support Expenditures: $69,075

#### 2. Personnel Expenditures
- a. Current Existing Personnel Expenditures (from Staffing Detail): $109,785
- b. New Additional Personnel Expenditures (from Staffing Detail): $187,710
- c. Employee Benefits: $61,944
- d. Total Personnel Expenditures: $359,439

#### 3. Operating Expenditures
- a. Professional Services: $900
- b. Translation and Interpreter Services: $900
- c. Travel and Transportation: $1,584
- d. General Office Expenditures: $4,528
- e. Rent, Utilities and Equipment: $14,898
- f. Medication and Medical Supports: $8,175
- g. Other Operating Expenses (provide description in budget narrative): $6,150
- h. Total Operating Expenditures: $37,035

#### 4. Program Management
- a. Existing Program Management: $0
- b. New Program Management: $0
- c. Total Program Management: $0

#### 5. Estimated Total Expenditures when service provider is not known
- $0

#### 6. Total Proposed Program Budget
- $465,549

### B. Revenues

#### 1. Existing Revenues
- a. Medi-Cal (FFP only): $0
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. Realignment: $109,785
- d. State General Funds: $0
- e. County Funds: $0
- f. Grants: $0
- g. Other Revenue: $0
- h. Total Existing Revenues: $109,785

#### 2. New Revenues
- a. Medi-Cal (FFP only): $53,365
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. State General Funds: $0
- d. Other Revenue: $0
- e. Total New Revenue: $53,365

#### 3. Total Revenues
- $163,150

### C. One-Time CSS Funding Expenditures
- $0

### D. Total Funding Requirements
- $302,400

### E. Percent of Total Funding Requirements for Full Service Partnerships
- 0.0%
EXHIBIT 5a–Mental Health Services Act Community Services and Supports
Budget Narrative
Psychiatric Triage Diversion Team at ARMC - Workplan #A-5

County(ies): San Bernardino
Fiscal Year: 2006-07
Date: 2/1/06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $32,625
   b. Travel and Transportation-based on average annual cost of $102 per client. $22,950
   c. Housing
      iv. Other Housing $-
         Sober Living-10 slots. Annual cost per slot $6,000 $60,000
         Transitional Housing-10 slots. Annual cost per slot $10,950 $109,500
   d. Employment and Education Supports-based on average annual cost of $60 per client. $13,500
   e. Other Support Expenditures-respite care-based on average annual cost of $300 per client. $69,075
   f. Total Support Expenditures $69,075

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs $109,785
   b. New Additional Personnel Expenditures-5 employees salaries $187,710
   c. Employee Benefits-33% of of salaries $61,944
   d. Total Personnel Expenditures $359,439

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $800
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $900
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $1,584
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $4,528
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $14,898
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $6,150
   h. Total Operating Expenditures $37,035

6. Total Proposed Program Budget $465,549

B. Revenues

1. Existing Revenues
   c. Realignment $109,785
   h. Total Existing Revenues $109,785

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%). Housing costs not included. $53,365
   e. Total New Revenue $53,365

3. Total Revenues $163,150

D. Total Funding Requirements $302,400
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td>Clinic Supervisor</td>
<td>1.00</td>
<td>$109,785</td>
<td>$109,785</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total Current Existing Positions</strong></td>
<td></td>
<td>1.00</td>
<td></td>
<td>$109,785</td>
</tr>
<tr>
<td><strong>B. New Additional Positions</strong></td>
<td>Clinical Therapist I</td>
<td>0.00</td>
<td>$49,722</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>1.00</td>
<td>$144,123</td>
<td>$144,123</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker II</td>
<td>1.00</td>
<td>$43,587</td>
<td>$43,587</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total New Additional Positions</strong></td>
<td></td>
<td>2.00</td>
<td></td>
<td>$187,710</td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td><strong>Total</strong></td>
<td>3.00</td>
<td></td>
<td>$297,495</td>
</tr>
</tbody>
</table>

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

- a. Clothing, Food and Hygiene: $32,625
- b. Travel and Transportation: $22,950
- c. Housing
  - i. Master Leases: $0
  - ii. Subsidies: $0
  - iii. Vouchers: $0
  - iv. Other Housing: $0
- d. Employment and Education Supports: $13,500
- e. Other Support Expenditures (provide description in budget narrative): $0
- f. Total Support Expenditures: $69,075

### 2. Personnel Expenditures

- a. Current Existing Personnel Expenditures (from Staffing Detail): $109,785
- b. New Additional Personnel Expenditures (from Staffing Detail): $187,710
- c. Employee Benefits: $61,944
- d. Total Personnel Expenditures: $359,439

### 3. Operating Expenditures

- a. Professional Services: $800
- b. Translation and Interpreter Services: $900
- c. Travel and Transportation: $1,584
- d. General Office Expenditures: $4,528
- e. Rent, Utilities and Equipment: $14,898
- f. Medication and Medical Supports: $8,175
- g. Other Operating Expenses (provide description in budget narrative): $6,150
- h. Total Operating Expenditures: $37,035

### 4. Program Management

- a. Existing Program Management: $0
- b. New Program Management: $0
- c. Total Program Management: $0

### 5. Estimated Total Expenditures when service provider is not known

- $0

### 6. Total Proposed Program Budget

- $465,549

## B. Revenues

### 1. Existing Revenues

- a. Medi-Cal (FFP only): $0
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. Realignment: $109,785
- d. State General Funds: $0
- e. County Funds: $0
- f. Grants: $0
- g. Other Revenue: $0
- h. Total Existing Revenues: $109,785

### 2. New Revenues

- a. Medi-Cal (FFP only): $53,365
- b. Medicare/Patient Fees/Patient Insurance: $0
- c. State General Funds: $0
- d. Other Revenue: $0
- e. Total New Revenue: $53,365

### 3. Total Revenues

- $163,150

## C. One-Time CSS Funding Expenditures

- $0

## D. Total Funding Requirements

- $302,400

## E. Percent of Total Funding Requirements for Full Service Partnerships

- 0.0%
### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures

- a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 
  - $32,625
- b. Travel and Transportation-based on average annual cost of $102 per client. 
  - $22,950
- c. Housing
  - iv. Other Housing
    - Sober Living-10 slots. Annual cost per slot $6,000
    - $60,000
    - Transitional Housing-10 slots. Annual cost per slot $10,950
    - $109,500
- d. Employment and Education Supports-based on average annual cost of $60 per client. 
  - $13,500
- e. Other Support Expenditures-respite care-based on average annual cost of $300 per client. 
  - $69,075

#### 2. Personnel Expenditures

- a. Current Existing Personnel Expenditures-existing staff full year salary and benefit costs 
  - $109,785
- b. New Additional Personnel Expenditures-5 employees salaries 
  - $187,710
- c. Employee Benefits-33% of of salaries 
  - $61,944
- d. Total Personnel Expenditures 
  - $359,439

#### 3. Operating Expenditures

- a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE 
  - $800
- b. Translation and Interpreter Services-based on current average annual cost of $3 per client 
  - $900
- c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 
  - $1,584
- d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 
  - $4,528
- e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 
  - $14,898
- g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee 
  - $6,150
- h. Total Operating Expenditures 
  - $37,035

#### 6. Total Proposed Program Budget 
- $465,549

### B. Revenues

#### 1. Existing Revenues

- c. Realignment 
  - $109,785
- h. Total Existing Revenues 
  - $109,785

#### 2. New Revenues

- a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%). Housing costs not included. 
  - $53,365
- e. Total New Revenue 
  - $53,365

#### 3. Total Revenues 
- $163,150

### D. Total Funding Requirements 
- $302,400
## A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries. Wages and Overtime</th>
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<tbody>
<tr>
<td>Clinic Supervisor</td>
<td></td>
<td>1.00</td>
<td></td>
<td>$109,785</td>
<td>$109,785</td>
</tr>
</tbody>
</table>

**Total Current Existing Positions**

<table>
<thead>
<tr>
<th>Total Number of FTEs</th>
<th>$109,785</th>
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</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

**Total Current Existing Positions**

| Total Current Existing Positions | 0.00 | 1.00 | $109,785 |

## B. New Additional Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries. Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Therapist I</td>
<td></td>
<td>0.00</td>
<td></td>
<td>$49,722</td>
<td>$0</td>
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<tr>
<td>Psychiatrist</td>
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<td>1.00</td>
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<td>$144,123</td>
<td>$144,123</td>
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<tr>
<td>Social Worker II</td>
<td></td>
<td>1.00</td>
<td></td>
<td>$43,587</td>
<td>$43,587</td>
</tr>
</tbody>
</table>

**Total New Additional Positions**

| Total New Additional Positions | 0.00 | 2.00 | $187,710 |

**Total New Additional Positions**

<table>
<thead>
<tr>
<th>Total Number of FTEs</th>
<th>$187,710</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.00</td>
<td></td>
</tr>
</tbody>
</table>

## C. Total Program Positions

| Total Program Positions | 0.00 | 3.00 | $287,495 |

**Total Program Positions**

<table>
<thead>
<tr>
<th>Total Number of FTEs</th>
<th>$287,495</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

| County: | San Bernardino County |
| Fiscal Year: | 2005-06, 2006-07, 2007-08 |
| Program Work Plan #: | OA-1 |
| Estimated Start Date: | 3 months to 12 months |

### Description of Program:
*Describe how this program will help advance the goals of the Mental Health Services Act.*

Extend mental health treatment and case management services to older adults in all regions of San Bernardino County. Enhance existing Senior Peer Counseling program with a focus on wellness and recovery to assist older adults in remaining independent and active in their communities and pursuing individualized personal goals for as long as possible. Create a capacity-building component in which partnerships are developed between staff, volunteers and community providers with specific expertise with older adults to ensure community collaboration, ongoing training and supervision for staff and volunteers, and culturally competent and evidence-based services for older adults are provided.

### Priority Population:
*Describe the situational characteristics of the priority population.*

145 Unserved and underserved Older Adults (60 years and older) who are isolated and may be in declining health and, because of stigma, lack of transportation, and/or lack of awareness of availability of services do not come into contact with the mental health system until they are at risk of hospitalization.
### Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP</td>
<td>Sys</td>
</tr>
</tbody>
</table>

- Increase staff to extend services to diverse populations of older adults not currently receiving mental health and case management services.
- Provide services to all who meet the unserved/underserved criteria. Assure that mental health services will be delivered in a manner that is culturally, racially, ethnically, and age-cohort appropriate.
- Provide ongoing education, linkage and consultation related to insurance and SSI benefits for the Transitional Age Older Adult population (ages 55-59) and for those Older Adults 60-65 years that may need assistance in obtaining benefits.
- Link those interested in employment to programs, such as Vocational Rehabilitation, DAAS Senior Employment Program, and State of California Employment Development Program.
- The **AgeWise** Senior Peer Counselor Program provides facilitation of peer support groups in the High Desert and East Valley regions of San Bernardino County. Expand the existing Senior Peer Counseling Program to provide mental health counseling with the focus on wellness and recovery and to include the following: outreach and engagement to groups in communities throughout the county, facilitation of support groups for consumers, families, and caregivers, social service referrals, advocacy, telephone support and referral with the implementation of a "Warm Line" (telephone program to those who are isolated and in need of emotional support) and provide education to the community regarding older adult mental health issues to reduce the stigma about mental illness. **AgeWise** Senior Peer Counselors will provide in-home supportive peer counseling to older adults suffering from situational difficulties related to aging (i.e. bereavement, caregiver stress, grandparents raising grandchildren, coping with physical and cognitive decline, etc.). Will recruit and train volunteers from various geographical regions with special attention to racial, ethnic, and cultural representation. Bilingual volunteers will be recruited.
• Training for Primary Care Physicians on evidence-based and promising clinical practices for coordination and integration of mental health and primary care, covering clinical practices guidelines, screening and assessment protocols (particularly for depression and suicidality), chronic disease management, and cultural competence. Use of evidence-based treatment models such as the IMPACT model, which identifies and treats in primary care physicians’ offices those older adults with depression, who may be particularly at high risk for suicidality, and Promotores Model, a healthy aging program targeting Latino populations.

• Capacity-building component in which specific modules of training, consultation, and mentoring regarding important areas related to older adult mental health concerns will be provided by community agencies with specific expertise (e.g. Alzheimer's Association, Inland Caregiver Resource Center, Department of Aging and Adult Services (DAAS)). Training that is responsive to the needs of new and existing staff, volunteers, and community partners will be developed by DBH to identify the most urgent areas of training needed. A technical assistance network comprised of community experts in the field of geriatric mental health and older adult issues will act as consultants and mentors to individual staff with challenging care cases and participate in multidisciplinary team meetings.

• Develop/purchase a range of information and educational tools for distribution to users of AgeWise services, their families, and other support persons and for distribution to professionals in allied health fields (i.e. M.D.'s, clinics, Public Health, churches, etc.). Link with respite care vendors/providers, as needed, by referral.
In transforming the system of mental health services to older adults, the CIRCLE OF CARE: System Development Plan is designed to accomplish three goals: develop a capacity building component to ensure that staff, volunteers and community partners provide client-centered and culturally competent services, education and assistance to older adults, extend mental health treatment and case management services to older adults in all regions of the county, and enhance the existing Senior Peer Counseling program by focusing on wellness and recovery and encompassing a broader geographical region and arena of duties. Qualitative and quantitative data demonstrate a lack of appropriate mental health services available for older adults. In general, older adults have been an unserved and underserved population.

This program will broaden treatment and case management services to every geographical region of the county and target those populations of older adults that have been more underserved. Services will be improved in that they will integrate the multiple treatment and case management needs that older adults with mental health concerns have. A key focus will be to extend in-home tenure and prevent premature institutionalization. Collaboration with family and community will ensure that services are comprehensive, focused on client goals, and provided in those settings in which older adults are more often receptive to accessing services (i.e. community senior centers, physicians’ offices, clients’ homes, etc.). Supporting families through education, emotional support (individually or in group settings), and providing referrals will be emphasized. Besides an extension of the current treatment and case management services provided through the AgeWise program, services will be integrated with primary care physicians in a unique outreach program designed to assist them in identifying and treating older adults with depression and other mental health issues. The Senior Peer Counselor Program enhancement will foster wellness and recovery principles. Senior peer counselors will be recruited, trained and supervised in every region of the County and serve as models of healthy aging and recovery to the community, clients and their families. They will provide community presentations on wellness topics, facilitate a greater breadth of support group topics to respond to more diverse needs of families and older adults, and provide telephone support, referrals, and individual counseling.

In the numerous Outreach and Engagement activities and settings proposed in this Plan, identifying a client’s specific economic situation may be difficult or interfere with an older adult accessing services (for example, a brief contact through a community presentation at a senior center or distributing healthy aging guidelines at a health fair). However, every effort will be made to focus the outreach activities in meeting areas where residents are more likely to be living under 200% below poverty, in compliance with MHSA targeted population guidelines.
A capacity building component will be developed to provide training, consultation and mentoring to staff through collaboration with community agencies with specific expertise regarding older adults mental health needs. This will help ensure that services that are appropriate for and sensitive to the needs of consumers and older adults are provided. This capacity building component will include ongoing training and supervision of staff and volunteers. Through the consulting/mentoring relationships with community experts in the geriatric field, training of primary care physicians and staff, the unique treatment needs and responses of older adults, particularly regarding evidence-based practices, will be taught.

Cultural competence is a key ingredient throughout this Plan. Culturally and linguistically appropriate services will be provided. Specifically, outreach efforts to Latino populations will include the hiring of bilingual staff and recruitment of bilingual (English/Spanish) Senior Peer Counselors. Educational materials about mental health concerns, in general, and mental health and older adults, specifically, will be developed or purchased in languages for specific populations and with consideration and sensitivity to the needs of older adults. The Promotores model, a healthy aging treatment program designed for Latino populations, will be used to develop culturally competent treatment and outreach responses to those populations. In addition, a relationship with the Latino-American Health Initiative will be nurtured. To reach out to the African-American community, DBH will foster and expand its relationship with the African-American Health Initiative and faith-based organizations.

The AgeWise program will work toward serving the lesbian, gay, bisexual, and transgender (LGBT) population and those adults who are physically disabled with sensitivity and understanding. Efforts will be made to reduce the stigma associated with physical disability, HIV/AIDS, “coming out,” and to offer a safe environment for support, therapy, and education for consumers and family members.

3) **Describe any housing or employment services to be provided.**

In providing an expansion and enhancement of mental health treatment and case management services participants will be assisted with their housing and employment needs on an individual need and recovery goal basis. In enhancing the Senior Peer Counselor Program, referrals to community supports that provide employment and housing assistance will be provided. With expansion of existing staff and development of the Senior Peer Counseling Program, these services that address the needs of employment and housing will be addressed in a broader, more comprehensive way. Regions of the county, which are currently not receiving services, will be served and programs responding to these specific needs will be identified, resulting in greater linkage of needs and services.

Those interested in employment opportunities will be assisted by being provided referrals to programs, such as Vocational Rehabilitation, Department of Aging and Adult Services (DAAS), Senior Employment Program, and State of California Employment Development Program, as well as other community organizations such as the faith-based community.
4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

Not applicable.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

In expanding services to a broader geographical region and spectrum of care, more older adults will have access to services. Services will be driven by client needs and individually identified recovery goals. In training primary care physicians in identification, assessment and treatment of mental health issues, particularly depression, older adults will be able to access these services in an environment in which older adults feel most comfortable. Recovery will be promoted in that staff, volunteers and community partners will be provided ongoing training and supervision in evidence-based practices and those principles that facilitate the establishment of a therapeutic relationship and client progress. Senior Peer Counselors will model the principles of recovery and healthy aging. Client recovery, that strives to keep clients living independently for as long as possible, involved in their communities and focused on individual goals, will be promoted and reinforced in the expanded Senior Peer Counselor Program. Senior Peer Counselors will serve geographical regions and populations not currently served and provide services not currently provided, such as emotional support through a Warm Line, individual counseling, referrals, and presentations to community on healthy aging topics.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

In the current **AgeWise** Program services through DBH, mental health and case management are provided in clients' homes or central clinic. These services are provided by two clinicians to those older adult clients who predominantly live in two regions (Central/East Valley and High Desert), are homebound, and have serious mental health issues. Clinicians also collaborate and participate in multidisciplinary teams with community partners (Adult Protective Services and other DAAS programs, Inland Caregiver Resource Center, the Alzheimer’s Association, etc.) and provide consultation regarding older adult mental health needs to other DBH staff and professionals and private community members. Due to staff shortage, minimal outreach, in terms of advertising DBH services and providing presentations to community groups on mental health needs of older adults, is provided. Each clinician provides monthly group supervision to a group of approximately five Senior Peer Counselors from two regions (East Valley/San Bernardino and High Desert). Senior Peer Counselors facilitate several support groups with foci ranging from healthy aging to general mental health support.
In many ways, an increased number of older adults and their families can be provided comprehensive and effective services under MHSA funding. The clinical and peer counseling services provided by \textbf{AgeWise} can be extended to include every geographic region of the County and more diverse populations, including bilingual and monolingual Spanish-speaking clients and at risk Transitional Age Adults (ages 55 – 59). Services can be provided in many settings that are conducive for older adults to access mental health services, such as physicians’ offices, senior centers, as well as more homes. Services can be expanded so that treatment, case management, peer counseling and wellness information can be made available in various venues, such as community presentations, health fairs, and broader support group topics offered by both clinical and volunteer staff. MHSA funding would enable increased collaboration with community partners, which will provide greater networking to meet the varied needs of the older adult population as well as ongoing training and consultation to support staff in being more effective with clients.

\textbf{7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.}

The expansion of the Senior Peer Counselor Program will include a focus on wellness and recovery by enabling the Senior Peer Counselors to provide information through community presentations and facilitation of support groups designed around healthy aging topics. The Senior Peer Counselors themselves will serve as models for clients recovering from life challenges and difficulties and promoting wellness and recovery through volunteerism and sharing of their own strengths. Family members will participate as part of a service program by providing education and facilitating support groups for others with a seriously mentally ill family member. Extensive collaboration with community partners, in the capacity-building component of this plan, as well as the interfacing of expanded staff (salaried and volunteer) with community providers will ensure a network of supports to assist in meeting the treatment/case management recovery goals of clients served.

\textbf{8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.}

A capacity-building component in which specific modules of training, consultation, and mentoring regarding important areas related to older adult mental health concerns will be provided by community agencies with specific expertise (e.g. Alzheimer's Association, Inland Caregiver Resource Center, DAAS, University of California San Bernardino, law enforcement, National Alliance for the Mentally Ill, etc.). Training that is responsive to the needs of new and existing staff volunteers, and community partners will be developed, based on the results of an assessment conducted by DBH to identify the most urgent areas of training needed. A technical assistance network comprised of community experts in the field of geriatric mental health and older adult issues will act
as consultants and mentors to individual staff with challenging client care cases and participate in multidisciplinary team meetings. This program will enable older adults to maintain optimal independence, prevent frequent hospitalization and relapse to previous behaviors. In addition, DBH AgeWise staff currently collaborates on a regular basis with the Department of Aging and Adult coalitions, through Multidisciplinary Team Meetings and the Aging and Adult Coalition. Several DAAS staff participated significantly in the development of this Plan. This collaborative relationship will be continued and strengthened with DAAS, and expanded to include other community agencies. Formal Memorandums of Understanding will be developed upon approval of this Plan.

9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

Cultural competence, sexual orientation and gender sensitivity will be grounded in the education and training of staff and team members and the critical expectations of partnership/contractual guidelines. Clinical staff and Senior Peer Counselors will have ongoing cultural competency, age and gender sensitivity training, including sensitivity related to lesbians, gays, bisexuals, transgender (LGBT) issues specific to the older population. Bilingual staff will be hired. Promotores and the IMPACT Program more specifically address the unique perspectives and needs of Latino and older adult populations, respectively.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Refer to question 9.

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

San Bernardino County Department of Behavioral Health has approximately 41 individuals residing in skilled nursing facilities out of the County. Although there is concern about these individuals remaining out-of-county, the focus of the proposed Plan is to prevent individuals from going into skilled nursing facilities.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

All strategies are listed in Section IV.

13) Please provide a timeline for this work plan, including all critical implementation dates.
Months 1-3: Recruiting, hiring and training staff.

Months 3- 12: Services are expected to be implemented and meeting program goals.

14) **Develop Budget Requests:** Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

   a) Work plans and most budget/staffing worksheets are required at the program level.

   b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures
- **Clothing, Food and Hygiene:** $680
- **Travel and Transportation:** $478
- **Housing:**
  - Master Leases: $0
  - Subsidies: $0
  - Vouchers: $0
  - Other Housing: $0
- **Employment and Education Supports:** $0
- **Other Support Expenditures (provide description in budget narrative):** $1,406
- **Total Support Expenditures:** $2,564

### 2. Personnel Expenditures
- **Current Existing Personnel Expenditures (from Staffing Detail):** $187,196
- **New Additional Personnel Expenditures (from Staffing Detail):** $171,226
- **Employee Benefits:** $56,505
- **Total Personnel Expenditures:** $414,927

### 3. Operating Expenditures
- **Professional Services:** $1,420
- **Translation and Interpreter Services:** $14
- **Travel and Transportation:** $2,812
- **General Office Expenditures:** $8,037
- **Medication and Medical Supports:** $0
- **Other Operating Expenses (provide description in budget narrative):** $10,916
- **Total Operating Expenditures:** $49,643

### 4. Program Management
- **Existing Program Management:** $0
- **New Program Management:** $0
- **Total Program Management:** $0

### 5. Estimated Total Expenditures when service provider is not known
- **Total Proposed Program Budget:** $467,134

## B. Revenues

### 1. Existing Revenues
- **Medi-Cal (FFP only):** $29,717
- **Medicare/Patient Fees/Patient Insurance:** $0
- **Realignment:** $157,479
- **State General Funds:** $0
- **County Funds:** $0
- **Grants:** $0
- **Other Revenue:** $0
- **Total Existing Revenues:** $187,196

### 2. New Revenues
- **Medi-Cal (FFP only):** $41,991
- **Medicare/Patient Fees/Patient Insurance:** $0
- **State General Funds:** $0
- **Other Revenue:** $0
- **Total New Revenue:** $41,991

### 3. Total Revenues
- **Total Revenues:** $229,187

## C. One-Time CSS Funding Expenditures
- **One-Time CSS Funding Expenditures:** $220,000

## D. Total Funding Requirements
- **Total Funding Requirements:** $457,947

## E. Percent of Total Funding Requirements for Full Service Partnerships
- **Percent:** 0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. 25% in 2005-06 680 $
   b. Travel and Transportation-based on average annual cost of $102 per client. 25% in 2005-06 478 $
   c. Other Support Expenditures-respite care-based on average annual cost of $300 per client. 25% in 2005-06 1,406$
   d. Total Support Expenditures 2,564$

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing Agewise staff full year salary and benefit costs in 2005-06 187,196$
   c. Employee Benefits-33% of salaries 56,505$
   d. Total Personnel Expenditures 414,927$

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE 1,420$
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client 14$
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 2,812$
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 8,037$
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 26,444$
   f. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee 10,916$
   g. Total Operating Expenditures 49,643$

6. Total Proposed Program Budget 467,134$

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-30% of existing clients 29,717$
   c. Realignment $ 157,479
   h. Total Existing Revenues 187,196$

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) 41,991$
   e. Total New Revenue 41,991$

3. Total Revenues 229,187$

C. One-Time CSS Funding Expenditures
   a. Furnishings for 15 employees housed at BHRC & other existing space 75,000$
   Computers for 15 employees 45,000$
   2 autos 40,000$
   Training: 15 employees X 40 hours X $100 per hour 60,000$

D. Total Funding Requirements 457,947
## EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Therapist I</td>
<td></td>
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<td>2.00</td>
<td>$73,085</td>
<td>$146,170</td>
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<td>1.00</td>
<td>$41,026</td>
<td>$41,026</td>
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<tr>
<td><strong>Total Current Existing Positions</strong></td>
<td></td>
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<td>3.00</td>
<td>$154,196</td>
<td>$187,196</td>
</tr>
<tr>
<td><strong>B. New Additional Positions</strong></td>
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</tr>
<tr>
<td>MH Clinic Supervisor</td>
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<tr>
<td>Clinical Therapist I</td>
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<td>$62,153</td>
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<td>Interns</td>
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<td>$31,720</td>
<td>$23,790</td>
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<td>0.25</td>
<td>$35,098</td>
<td>$0</td>
</tr>
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<td>Senior Peer Counselor</td>
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<td>$31,720</td>
<td>$7,930</td>
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<td>Mental Health Education Consultant</td>
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<td>Occupational Therapist I</td>
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<td>0.25</td>
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<tr>
<td><strong>Total New Additional Positions</strong></td>
<td></td>
<td></td>
<td>3.25</td>
<td>$171,226</td>
<td>$171,226</td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td></td>
<td>3.25</td>
<td>$171,226</td>
<td>$358,422</td>
</tr>
</tbody>
</table>

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a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Client, Family Member and Caregiver Support Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Clothing, Food and Hygiene $21,025    $21,025</td>
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</tr>
<tr>
<td>b. Travel and Transportation $14,790    $14,790</td>
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</tr>
<tr>
<td>c. Housing $0    $0</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>i. Master Leases $0    $0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Subsidies $0    $0</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>iii. Vouchers $0    $0</td>
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<tr>
<td>iv. Other Housing $0    $0</td>
<td></td>
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<tr>
<td>d. Employment and Education Supports $0    $0</td>
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<tr>
<td>e. Other Support Expenditures (provide description in budget narrative) $43,500    $43,500</td>
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<tr>
<td>f. Total Support Expenditures $79,315    $0    $0    $79,315</td>
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<tr>
<td><strong>2. Personnel Expenditures</strong></td>
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<td></td>
</tr>
<tr>
<td>a. Current Existing Personnel Expenditures (from Staffing Detail) $187,196    $187,196</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. New Additional Personnel Expenditures (from Staffing Detail) $684,900    $684,900</td>
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<tr>
<td>c. Employee Benefits $226,017    $226,017</td>
<td></td>
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<tr>
<td>d. Total Personnel Expenditures $1,098,113    $0    $0    $1,098,113</td>
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<tr>
<td><strong>3. Operating Expenditures</strong></td>
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<tr>
<td>a. Professional Services $5,680    $5,680</td>
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<tr>
<td>b. Translation and Interpreter Services $436    $436</td>
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<tr>
<td>c. Travel and Transportation $11,246    $11,246</td>
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<tr>
<td>d. General Office Expenditures $32,149    $32,149</td>
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<tr>
<td>e. Rent, Utilities and Equipment $105,776    $105,776</td>
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<tr>
<td>f. Medication and Medical Supports $0    $0</td>
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<tr>
<td>g. Other Operating Expenses (provide description in budget narrative) $43,665    $43,665</td>
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<tr>
<td>h. Total Operating Expenditures $198,951    $0    $0    $198,951</td>
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<tr>
<td><strong>4. Program Management</strong></td>
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<td></td>
</tr>
<tr>
<td>a. Existing Program Management $0    $0</td>
<td></td>
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<tr>
<td>b. New Program Management $0    $0</td>
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<td>c. Total Program Management $0    $0    $0    $0</td>
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<tr>
<td><strong>5. Estimated Total Expenditures when service provider is not known</strong></td>
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<tr>
<td>$0    $0    $0    $0</td>
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<tr>
<td><strong>6. Total Proposed Program Budget</strong></td>
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<tr>
<td>$1,376,379    $0    $0    $1,376,379</td>
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</tbody>
</table>

## B. Revenues

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Existing Revenues</strong></td>
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<td></td>
</tr>
<tr>
<td>a. Medi-Cal (FFP only) $28,079    $28,079</td>
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<tr>
<td>b. Medicare/Patient Fees/Patient Insurance $0    $0</td>
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<tr>
<td>c. Realignment $159,117    $159,117</td>
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<tr>
<td>d. State General Funds $0    $0</td>
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<tr>
<td>e. County Funds $0    $0</td>
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<td>f. Grants $0    $0</td>
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<tr>
<td>g. Other Revenue $0    $0</td>
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<tr>
<td>h. Total Existing Revenues $187,196    $0    $0    $187,196</td>
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<td><strong>2. New Revenues</strong></td>
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<td>b. Medicare/Patient Fees/Patient Insurance $0    $0</td>
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<td>c. State General Funds $0    $0</td>
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<td>d. Other Revenue $0    $0</td>
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<tr>
<td>e. Total New Revenue $178,377    $0    $0    $178,377</td>
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<tr>
<td><strong>3. Total Revenues</strong></td>
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<tr>
<td>$365,573    $0    $0    $365,573</td>
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## C. One-Time CSS Funding Expenditures

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>$0    $0    $0    $0</td>
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</table>

## D. Total Funding Requirements

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,010,806    $0    $0    $1,010,806</td>
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</table>

## E. Percent of Total Funding Requirements for Full Service Partnerships

<table>
<thead>
<tr>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0%    0.0%    0.0%    0.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client. $21,025
   b. Travel and Transportation-based on average annual cost of $102 per client. $14,790
   c. Other Support Expenditures-respite care-based on average annual cost of $300 per client. $43,500
   f. Total Support Expenditures $79,315

2. Personnel Expenditures
   a. Current Existing Personnel Expenditures-existing Agewise staff full year salary and benefit costs $187,196
   b. New Additional Personnel Expenditures-15 employees salaries $684,900
   c. Employee Benefits-33% of salaries $226,017
   d. Total Personnel Expenditures $1,098,113

3. Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $5,680
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client $435
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $11,246
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $32,149
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 $105,776
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $43,665
   h. Total Operating Expenditures $198,951

6. Total Proposed Program Budget $1,376,379

B. Revenues

1. Existing Revenues
   a. Medi-Cal (FFP only)-30% of existing clients $28,079
   c. Realignment $159,117
   h. Total Existing Revenues $187,196

2. New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) $178,377
   e. Total New Revenue $178,377

3. Total Revenues $365,573

D. Total Funding Requirements $1,010,806
## EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
<td></td>
<td></td>
<td>2.00</td>
<td>$73,085</td>
<td>$146,170</td>
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<tr>
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<td></td>
<td></td>
<td>1.00</td>
<td>$41,026</td>
<td>$41,026</td>
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<tr>
<td>Office Assistant III</td>
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</tr>
<tr>
<td><strong>Total Current Existing Positions</strong></td>
<td></td>
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<td>3.00</td>
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<tr>
<td><strong>B. New Additional Positions</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Clinic Supervisor</td>
<td></td>
<td></td>
<td>1.00</td>
<td>$75,673</td>
<td>$75,673</td>
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<tr>
<td>Clinical Therapist II</td>
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<td></td>
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<td>$58,152</td>
<td>$58,152</td>
</tr>
<tr>
<td>Clinical Therapist I</td>
<td></td>
<td></td>
<td>5.00</td>
<td>$49,722</td>
<td>$248,610</td>
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<tr>
<td>Interns</td>
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<td>$31,720</td>
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<td>$0</td>
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<td>$28,825</td>
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<td>$30,846</td>
<td>$30,846</td>
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<td>$31,720</td>
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<tr>
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<td>$51,854</td>
</tr>
<tr>
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<td>$64,060</td>
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<tr>
<td><strong>Total New Additional Positions</strong></td>
<td></td>
<td></td>
<td>1.00</td>
<td>13.20</td>
<td>$684,900</td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td></td>
<td>1.00</td>
<td>16.20</td>
<td>$872,096</td>
</tr>
</tbody>
</table>

<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.

<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

#### 1. Client, Family Member and Caregiver Support Expenditures
- a. Clothing, Food and Hygiene $21,025 $21,025
- b. Travel and Transportation $14,790 $14,790
- c. Housing $0 $0
  - i. Master Leases $0 $0
  - ii. Subsidies $0 $0
  - iii. Vouchers $0 $0
  - iv. Other Housing $0 $0
- d. Employment and Education Supports $0 $0
- e. Other Support Expenditures (provide description in budget narrative) $43,500 $43,500
- f. Total Support Expenditures $79,315 $79,315

#### 2. Personnel Expenditures
- b. New Additional Personnel Expenditures (from Staffing Detail) $684,900 $684,900
- c. Employee Benefits $226,017 $226,017
- d. Total Personnel Expenditures $1,098,113 $0 $0 $1,098,113

#### 3. Operating Expenditures
- a. Professional Services $5,680 $5,680
- b. Translation and Interpreter Services $435 $435
- c. Travel and Transportation $11,246 $11,246
- d. General Office Expenditures $105,776 $105,776
- e. Rent, Utilities and Equipment $105,776 $105,776
- f. Medication and Medical Supports $0 $0
- g. Other Operating Expenses (provide description in budget narrative) $43,665 $43,665
- h. Total Operating Expenditures $198,951 $0 $0 $198,951

#### 4. Program Management
- a. Existing Program Management $0 $0
- b. New Program Management $0 $0
- c. Total Program Management $0 $0 $0

#### 5. Estimated Total Expenditures when service provider is not known

#### 6. Total Proposed Program Budget
- $1,376,379 $0 $0 $1,376,379

### B. Revenues

#### 1. Existing Revenues
- a. Medi-Cal (FFP only) $28,079 $28,079
- b. Medicare/Patient Fees/Patient Insurance $0 $0
- c. Realignment $159,117 $159,117
- d. State General Funds $0 $0
- e. County Funds $0 $0
- f. Grants $0 $0
- g. Other Revenue $0 $0
- h. Total Existing Revenues $187,196 $0 $0 $187,196

#### 2. New Revenues
- a. Medi-Cal (FFP only) $178,377 $178,377
- b. Medicare/Patient Fees/Patient Insurance $0 $0
- c. State General Funds $0 $0
- d. Other Revenue $0 $0
- e. Total New Revenue $178,377 $0 $0 $178,377

#### 3. Total Revenues
- $365,573 $0 $0 $365,573

### C. One-Time CSS Funding Expenditures
- $0 $0

### D. Total Funding Requirements
- $1,010,806 $0 $0 $1,010,806

### E. Percent of Total Funding Requirements for Full Service Partnerships
- 0.0%
A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures
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   e. Total New Revenue $178,377

3. Total Revenues $365,573

D. Total Funding Requirements
   $1,010,806
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2007-08  
**Program Workplan #:** OA-1  
**Date:** 2/1/06  
**Program Workplan Name:** Circle of Care: System Development  
**Type of Funding:** 2. System Development  
**Months of Operation:** 12

#### Proposed Total Client Capacity of Program/Service: 162  
#### New Program/Service or Expansion: Expansion  
#### Existing Client Capacity of Program/Service: 17  
#### Prepared by: Kris Letterman  
#### Telephone Number: (909) 387-7577

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Current Existing Positions</strong></td>
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<tr>
<td>Clinical Therapist I</td>
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<td></td>
</tr>
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</table>

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>Program Work Plan #: OA-2</td>
<td>Estimated Start Date:</td>
<td>SD - 3 months to 12 months FSP - Year 2</td>
</tr>
</tbody>
</table>

**Description of Program:**

*Describe how this program will help advance the goals of the Mental Health Services Act.*

This Plan is comprised of two distinct components: Mobile Outreach and Intensive Case Management services. Mobile Outreach provides crisis response and crisis prevention, comprehensive mental health and substance abuse screening, integrated geriatric assessment, benefits eligibility, information, linkages and referrals to clients, family, and care providers through outreach to isolated seniors in their homes and to the homeless in vivo settings, including on-site services such as senior centers, nutrition sites, churches, and other community settings. A transportation component includes the purchase of (2) 4-wheel drive vans to facilitate team mobility and reach geographically isolated older adults in the High Desert region. Additionally, a Full Service Partnership (FSP) system of care for unserved and underserved seriously mentally ill (SMI) older adults will be established, initially, in the High Desert to provide a long-term multidisciplinary team approach and seamless delivery of case management services. Goals of the FSP are to increase access to care and the ability to manage independence while reducing episodic institutionalization and incidents of relapse. One vehicle will be included in this aspect of this Plan to assist staff in reaching geographically isolated older adults in the High Desert. While Mobile Outreach and Full Service Partnership are two distinct components of this Plan, Mobile Outreach can provide referrals to clients in need of the more intensive case management services of the Full Service Partnership component.

**Priority Population:**

*Describe the situational characteristics of the priority population.*

The Mobile Outreach component will provide services to 750 unserved and underserved older adults (60 years and older) who are homeless or are at risk for homelessness. Priority for services will be given to those older adults with the most severe conditions and with the highest incidence of emergency and inpatient services utilization, or those having the most difficulty accessing care due to system barriers. In the Full Service Partnership component the priority population will be 17 SMI older adults with the most severe conditions, i.e. clients who have a) history of repeated emergency health services; b) several admissions to inpatient services or are at risk for institutionalization; c) been homeless or at risk for homelessness. For both components, services may be extended to adults, ages 55 – 59 years, whose service needs are likely to extend into older adulthood.
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

- Two mobile field-capable multidisciplinary outreach teams that provide crisis response and crisis prevention to isolated or frail older adults who are homebound or homeless and at risk for deterioration and/or out-of-home placement.
- Provide evidence-based practices, individualized Geriatric Field Screening (GFS) for mental health, substance abuse, and physical health status, benefits eligibility information, linkages and referrals.
- The Mobile Teams will provide a mechanism to refer individuals appropriate for the Full Service Partnership component.
- Senior Peer Counseling component that recruits, trains, and supervises Older Adult volunteers, primarily consumer volunteers, who participate in mobile teams to provide peer crisis counseling and linkages to services and supports to older adults. Provide outreach to community, families, and older adults.
- Senior Peer Counselors will receive initial orientation and training, which will include information about the unique mental health needs of older adults and evidence-based and culturally and linguistically appropriate crisis intervention and prevention strategies. The Senior Peer Counselors will receive ongoing supervision and in-service trainings.
- Identify appropriate supplemental housing for older adults; provide referrals as needed.
- Support and education, and sharing of knowledge, to clients and families about navigating the mental health system, and understanding older adult mental health issues in general; support and education for families and caregivers who are housing and/or supporting those with serious mental illness (i.e. grandchildren, adult children, spouses, other family members, etc.). Provide comprehensive support and counseling to families and caregivers to diminish caregiver burden and postpone out-of-home placement. Coordinate with existing community services for short-term respite services for caregivers.
• Utilize a capacity building program to ensure client-centered and culturally competent services are provided by staff, volunteers and community partners in the CIRCLE OF CARE program. Individuals will participate in knowledge and skills building seminars throughout the County. A needs assessment will identify the most urgent areas of training needed to ensure linguistically appropriate, generational and sexual orientation sensitivity, and understanding of an optimal client/provider relationship. Utilize community experts, mentors and train-the-trainer programs to create a positive team atmosphere, respect for others and prevention of barriers to a successful CIRCLE OF CARE program.

• Certificated training in geriatric mental health for mental health professionals and other aging network service providers (i.e. Senior Peer Counselors, all volunteers, staff, service agencies, etc.). Outreach to Skilled Nursing Facilities (SNFs), convalescent hospitals, and physicians offices to educate about and assist in identification of older adult mental health issues.

• Assist those interested in employment opportunities by referral to programs, such as Vocational Rehabilitation, Department of Aging and Adult Services (DAAS) Senior Employment Program, State of California Employment Development Program, and other community agencies such as faith organizations. Contract with community services for episodic transportation needs. Multidisciplinary mobile teams share responsibility for treatment, support and referrals for any rehabilitation services.

• Provide 24/7 multidisciplinary teams services. Multifaceted interventions to be provided wherever needed. Teams work in partnership with collaborative services. There are no time limits for appropriate services for those clients and families participating in the Full Service Partnerships.

• Provide intensive case management and treatment follow-up for FSP clients. Sustained management is focused on self-directed client goals, comprehensive planning with community/family support to reach optimal mental and physical health. Utilize existing Residential Care
Facilities for the Elderly (RCFEs) and assisted living facilities for placement, as needed. Provide for residential care that has an augmentation for special care to provide modified older adult wraparound services with contracts for 9 units. The placement will enable the older adult to live at the lowest level of care for as long as possible.

- FSP staff ratio of 1:10. **CIRCLE OF CARE** team members and Senior Peer counselors specifically trained to work with SMI older adults. Mobile team members share responsibility for treatment, support and referrals for any rehabilitative services.
The CIRCLE OF CARE: Mobile Outreach and Intensive Case Management will be comprised of two distinct plans that provide services to older adults in the High Desert region. The Mobile Outreach will consist of two field-capable multidisciplinary teams, both of which will provide crisis response and crisis prevention services.

The crisis response component will respond to crises and provide appropriate follow-up care following crisis stabilization. It will also provide assessments, referrals, and linkages to other needed services.

The crisis prevention component will provide education, mental health screenings, support to clients, family members, and caregivers and will engage in outreach activities to promote wellness and healthy aging, with a focus on prevention of institutionalization to unserved and underserved mentally ill older adults. This component will reduce barriers to the recognition of mental health problems by older adults, their families and primary support systems.

Each team will provide comprehensive mental health and substance abuse screening, integrated geriatric assessment, benefits eligibility information, linkages and referrals to clients, their family members, and care providers. Outreach will be provided to geographically isolated older adults living in the High Desert region, in their homes and in community sites, such as senior centers, nutrition sites, churches, and other community settings, and to the homeless in vivo settings. The Senior Peer Counselors will be trained and supervised in the unique mental health needs of older adults, in general, and those seriously mentally ill, in particular; training and supervision will include crisis intervention and effective outreach/prevention strategies. An outreach program will be developed to educate and assist in the identification of older adult mental health issues in Skilled Nursing facilities, convalescent hospitals, and physician's offices. This plan also provides certificated training in geriatric mental health for mental health professionals and other service providers. This plan is focused on reducing cultural and racial disparities in access to care, reduction in hospitalizations and premature institutionalization, isolation, and providing services to unserved and underserved geographically isolated older adults in the High Desert region.

Whereas crises will be responded to and outreach activities provided to older adults without necessarily knowing their economic status, every effort will be made to focus the Mobile Teams’ responses in geographical and meetings areas where residents are more likely to be living under 200% poverty, in compliance with MHSA targeted population guidelines.

Additionally, a Full Service Partnership (FSP) will be developed. The FSP will provide services for 17 unserved and underserved SMI older adults (60 years and older) who are isolated, have the most severe conditions, have a history of repeated emergency health services or several admissions to inpatient services, are at risk for institutionalization, or have been, or are at risk of becoming, homeless. Services may be
extended to adults aged 55-59 years old whose service needs are likely to continue into older adulthood. FSP staff ratio will be 1:10, with CIRCLE OF CARE team members and Senior Peer Counselors specifically trained to work with SMI older adults to share responsibility for treatment, support, and referrals for any rehabilitation services. The older adult clients receiving mental health and case management services from the clinical staff from OA-1 and Mobile Teams from OA-2 will provide a mechanism to refer individuals appropriate for the FSP program. Other referral sources include network providers of services to older adults. The FSP component to the older adult CIRCLE OF CARE will be established to provide a long-term multidisciplinary team approach and seamless delivery of intensive case management services. Intensive case management will maximize client access to care and the ability to manage independence while reducing episodic or premature institutionalization and incidences of relapse to previous problematic behavior. Sustained management includes integrated substance abuse treatment, mental health care and support to decrease symptoms, and attention to adverse side effects of medication. Referrals to physical healthcare providers for further medical and alternative healthcare options will be included in case management services. The FSP services will be provided 24/7, wherever needed, and multidisciplinary teams will work collaboratively. There will be no time limits for those clients and families participating in the FSP. Follow-up for FSP clients and families will be included. Sustained management will be focused on self-directed client goals, comprehensive planning with community/family support with the goal of optimal mental and physical health.

Linking caregivers with community services for short-term respite care will be offered. The services offered will be culturally, racially, ethnically, and age-cohort appropriate. Integrated services, benefits eligibility review, and referrals for clients, family members, advocates, and caregivers will be conducted in the home or suitable environment and in vivo settings for the homeless.

3) **Describe any housing or employment services to be provided.**

In the Mobile Team plan, housing resources in the High Desert region, that are adapted for the physical, mental and socialization needs of older adults, will be identified and referrals provided for those in need of safe and adequate shelter.

In the FSP Plan, residential care that has an augmentation for special care will be provided through contracts for 9 units at RCFEs and assisted living facilities in the High Desert region. These placement contracts will enable the older adult to receive modified older adult wraparound services and live at the lowest level of care for as long as possible.

Linkage to those interested in employment opportunities by referral to programs, such as Vocational Rehabilitation, DAAS Senior Employment Program, State of California Employment Development Program, and other community agencies such as faith-based organizations, will be provided.
4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

The CIRCLE OF CARE: Mobile Outreach and Intensive Case Management will be a Full Service Partnership with an average cost of $16,125 per consumer per year.

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

This plan is consistent with the MHSA goals of recovery, and wellness. The mobile outreach, including crisis response and outreach and prevention, will assist older adult clients and their families in getting the help they need in a timely manner, and help them link with other services to address their mental health and support needs by providing services in their homes and in community settings. This will increase the ability of older adult clients to live independently for as long as possible, achieve personal goals, and contribute to their communities. The mobility of the teams will help to reduce the barriers to accessing services, and will help reduce the stigma associated with mental illness that older adults typically encounter. Ongoing training and supervision and interagency collaboration will insure the adherence to the intent of the MHSA.

The FSP plan is consistent with the fulfillment of an ongoing structured CIRCLE OF CARE concept which is person-centered and results-driven to continue client assistance as long as necessary to meet unique individual needs and requirements. The program is consistent with recovery and rehabilitation values incorporated in the MHSA. Clients will be assisted to receive the needed services at any time of day. Intensive, sustained case management and treatment follow-up will focus on self-directed client goals of recovery. Staff will be trained to encourage optimal wellness with emphasis on strengthening self-management skills and coping skills. Peer counselors, consumers, and family advocates will model independence and recovery. Recovery for the older adult is a self-choice to change goals and behavioral patterns to live a satisfying life despite limitations or to continue the effects of mental illness. Clients will exit the FSP component when they have achieved their recovery goals and risk factors have been resolved. They will receive appropriate referrals to maintain and encourage continued success, including to less intensive services offered through Plan 1 – CIRCLE OF CARE: System Development.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

Mobile Outreach is a new program for San Bernardino County. The existing AgeWise Program currently has a small Senior Peer Counselor Program. Due to lack of funding it has been reduced in size and limited in availability to do outreach. The Senior Peer Counseling Program is currently limited to seniors who are facilitating groups in their communities. There has been no recruitment and training of new Senior Peer Counselors for the past three years. Under the new proposal, recruitment, training and
retention of Senior Peer Counselors will play a larger role in working with SMI older adults in crisis response, crisis prevention and outreach in geographically isolated communities in the High Desert.

The FSP plan will be a new program for San Bernardino County.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Recovering clients and other older adults will be recruited, supervised, and trained to be Senior Peer Counselors as part of the mobile teams and will be involved in crisis response and crisis prevention/outreach. Their role as part of the outreach and assessment process will be vital. The outreach program will provide information about navigating the mental health system, understanding older adult mental health issues, and differentiating between SMI and situational problems. Clients, their caregivers, and their families will receive education and support needed to cope with mental health problems, with the possibility of including respite care as a component of support.

Client and family-run services in the FSP program include senior peer counseling, drawing on consumer skills and experience, family and caregiver support, community support groups, educational programs, and respite care. Case management services will enable the older adult to remain in their current residency for as long as possible. Family members and caregivers will be educated about their family members' mental health issues and experiences. Education and training will aid recovering clients and family members to facilitate support groups and serve as role models and mentors for older adults.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

The vision of this plan is to educate, collaborate, and strengthen current partnerships with other agencies and service providers who interact with older adults in their communities. Development of Memorandum of Understandings with aging network providers will be explored and formalized upon approval of this Plan. Crisis referrals will be made by multiple sources in the community. With the goal of the development of the CIRCLE OF CARE (Older Adult System of Care), providers such as Department of Aging and Adult Services, Skilled Nursing Facilities, hospitals, and other aging network partners (i.e. Alzheimer’s Association, Inland Caregiver’s Resource Center, Family and Elder Care Program, etc.) will collaborate to address seriously mentally ill older adults. The collaboration will include interagency cooperation and information sharing and build on the existing supportive relationship between DBH/AgeWise staff and volunteers and community agencies. Additionally, outreach team members will actively participate in meetings that specifically network regarding challenging older adult cases and concerns, such as the Multidisciplinary Team Meetings and the Aging and Adult
Coalition, sponsored by the Department of Aging and Adult Services, formal linkages with primary care, social service agencies, and designated mental health professionals will improve current services and outcomes. Special attention will be given to assuring the ethnic communities are partners in this effort, particularly in the geographically isolated communities in the High Desert.

Through close partnerships and linkages with numerous community agencies, healthcare institutions, local business organizations and joint planning with clients, families, etc., the FSP will establish collaboration for planning, developing, funding, and providing services for older adults as an integrated system. Through the proposed strategies of the CIRCLE OF CARE program and collaboration with community provisions, services and outcomes will be maximized for the individual older adult client.

**9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

Through community-based senior centers, faith-based organizations, and other community organizations, the mobile crisis response and prevention/outreach teams will target the populations that have been identified as underserved and unserved by DBH. The crisis response and prevention/outreach teams will be trained to be culturally astute and sensitive to client’s disabilities and impairments, their strengths, sexual orientations, gender issues, and awareness of the differing psychologies of men and women. Team members will be knowledgeable of the diverse reactions to crises. In addition, teams will be prepared to respond to crises with culturally appropriate interventions. Staff and volunteers will be recruited and trained to be racially, ethnically, culturally, and age-cohort appropriate.

The capacity-building educational program will ensure that client-centered, culturally competent, age and gender sensitive services will be delivered. Individuals will participate in knowledge and skill-building seminars throughout the county.

**10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

All efforts will be made to assure the CIRCLE OF CARE programs provide for sensitivity to gender, to sexual orientation and to the different psychological needs of women and men. Refer to question #9.

**11) Describe how services will be used to meet the service needs for individuals residing out-of-county.**

Not applicable. Services provided in this Plan are for in-county residents only.
12) *If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.*

All strategies are listed in Section IV.

13) *Please provide a timeline for this work plan, including all critical implementation dates.*

Months 3-12: System Development/Outreach and Engagement services are expected to be implemented and meeting program goals.

FSP services are expected to be implemented in year 2.

14) *Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.*

a) Work plans and most budget/staffing worksheets are required at the program level.

b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) *Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.*
<table>
<thead>
<tr>
<th>A. Expenditures</th>
<th>County Mental Health Department</th>
<th>Other Governmental Agencies</th>
<th>Community Mental Health Contract Providers</th>
<th>Total</th>
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<th>Community Mental Health Contract Providers</th>
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C. One-Time CSS Funding Expenditures                                            $385,500
D. Total Funding Requirements                                                   $635,607
E. Percent of Total Funding Requirements for Full Service Partnerships          25.0%
## A. Expenditures

### 1. Client, Family Member and Caregiver Support Expenditures

a. Clothing, Food and Hygiene-based on average annual cost of $145 per client (55% of clients). 25% in 2005-06  
   $3,803

b. Travel and Transportation-based on average annual cost of $102 per client (55% of clients). 25% in 2005-06  
   $2,675

c. Housing  
   iv. Other Housing (55% of clients)  
   $7,528  
   Safe Haven housing - 5 slots. Annual cost per slot $10,950. 25% in 2005-06  
   $14,006

### 2. Personnel Expenditures

b. New Additional Personnel Expenditures-9 employees salaries budgeted at 25% in 2005-06  
   $156,761

c. Employee Benefits-33% of of salaries  
   $51,731

d. Total Personnel Expenditures  
   $208,492

### 3. Operating Expenditures

a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE  
   $1,420

b. Translation and Interpreter Services-based on current average annual cost of $3 per client (55% of clients)  
   $79

c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792  
   $2,812

d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264  
   $8,037

e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449  
   $44,294  
   (average does not include lease costs) + lease costs for 3500 s.f. facility @ $1.70 s.f. for 3 mos  
   $2,859

f. Medication and Medical Supports-based on current average annual cost of $109 per client (55% of clients). 25% in 2005-06  
   $10,916

g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee  
   $70,417

h. Total Operating Expenditures  
   $208,492

### 6. Total Proposed Program Budget  
   $292,915

## B. Revenues

### 2. New Revenues

a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%)  
   $42,808

e. Total New Revenue  
   $42,808

### 3. Total Revenues  
   $42,808

## C. One-Time CSS Funding Expenditures

- Tenant improvements for lease of 3,500 sq foot facility  
  $87,500
- Furnishings for 9 employees  
  $45,000
- Computers for 9 employees  
  $27,000
- 2 4WD Vans  
  $60,000
- Training: 9 employees X 40 hours X $100 per hour  
  $36,000

## D. Total Funding Requirements  
   $635,607
EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): San Bernardino
Program Workplan # OA-2
Program Workplan Name Circle of Care: Mobile Outreach

Fiscal Year: 2005-06
Date: 2/1/06

Type of Funding 2. System Development
Months of Operation 3

Proposed Total Client Capacity of Program/Service: 191
New Program/Service or Expansion New
Existing Client Capacity of Program/Service: 0
Prepared by: Kris Letterman
Client Capacity of Program/Service Expanded through MHSA: 191
Telephone Number: (909) 387-7577

<table>
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<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs(a)</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(b)</th>
<th>Total Salaries, Wages and Overtime</th>
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Total Current Existing Positions: 0.00 0.00 $0

B. New Additional Positions

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<tr>
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Total New Additional Positions: 0.50 3.05 $156,761

C. Total Program Positions

<table>
<thead>
<tr>
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<th>Function</th>
<th>Client, FM &amp; CG FTEs(a)</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE(b)</th>
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</table>

Total Program Positions: 0.50 3.05 $156,761

\(a\) Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
\(b\) Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
## A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene: $61,089
   - b. Travel and Transportation: $42,973
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $0
     - iii. Vouchers: $0
     - iv. Other Housing: $30,113
   - d. Employment and Education Supports: $0
   - e. Other Support Expenditures (provide description in budget narrative): $0
   - f. Total Support Expenditures: $134,174

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail): $0
   - b. New Additional Personnel Expenditures (from Staffing Detail): $627,043
   - c. Employee Benefits: $206,924
   - d. Total Personnel Expenditures: $833,967

3. **Operating Expenditures**
   - a. Professional Services: $5,680
   - b. Translation and Interpreter Services: $1,264
   - c. Travel and Transportation: $11,246
   - d. General Office Expenditures: $32,149
   - e. Rent, Utilities and Equipment: $177,176
   - f. Medication and Medical Supports: $45,922
   - g. Other Operating Expenses (provide description in budget narrative): $43,665
   - h. Total Operating Expenditures: $317,102

4. **Program Management**
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

5. **Estimated Total Expenditures when service provider is not known**
   - $0

6. **Total Proposed Program Budget**
   - $1,285,242

## B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only): $0
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $0
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $0

2. **New Revenues**
   - a. Medi-Cal (FFP only): $188,269
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $0
   - d. Other Revenue: $0
   - e. Total New Revenue: $188,269

3. **Total Revenues**
   - $188,269

## C. One-Time CSS Funding Expenditures
   - $385,500

## D. Total Funding Requirements
   - $1,482,473

## E. Percent of Total Funding Requirements for Full Service Partnerships
   - 25.0%
## A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene-based on average annual cost of $145 per client (55% of clients). $61,089
   - b. Travel and Transportation-based on average annual cost of $102 per client (55% of clients). $42,973
   - c. Housing
     - iv. Other Housing (55% of clients) $30,113
     - Safe Haven housing-5 slots. Annual cost per slot $10,950.
   - f. Total Support Expenditures $134,174

2. **Personnel Expenditures**
   - b. New Additional Personnel Expenditures-9 employees salaries $627,043
   - c. Employee Benefits-33% of of salaries $206,924
   - d. Total Personnel Expenditures $833,967

3. **Operating Expenditures**
   - a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE $5,680
   - b. Translation and Interpreter Services-based on current average annual cost of $3 per client (55% of clients) $1,264
   - c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792 $11,246
   - d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264 $32,149
   - e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449 (average does not include lease costs) + lease costs for 3500 s.f. facility @ $1.70 s.f. for 12 mo $177,176
   - f. Medication and Medical Supports-based on current average annual cost of $109 per client (55% of clients). $45,922
   - g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee $43,665
   - h. Total Operating Expenditures $317,102

6. **Total Proposed Program Budget**
   $1,285,242

## B. Revenues

2. **New Revenues**
   - a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%) $188,269
   - e. Total New Revenue $188,269

3. **Total Revenues**
   $188,269

## D. Total Funding Requirements
   $1,096,973
## EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

### County(ies): San Bernardino

**Fiscal Year:** 2006-07  
**Date:** 2/1/06  
**Program Workplan # OA-2**  
**Program Workplan Name:** Circle of Care: Mobile Outreach

### Type of Funding  
2. System Development  

### Months of Operation  
12

### Proposed Total Client Capacity of Program/Service: 766

### Existing Client Capacity of Program/Service: 0

### Total New Additional Positions

### Telefon Number: (909) 387-7577

### Prepared by: Kris Letterman

### Program Workplan Name:

### Page 1 of 1

### Classification: A. Current Existing Positions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs</th>
<th>Total Number of FTEs</th>
<th>Salary, Wages and Overtime per FTE</th>
<th>Total Salaries, Wages and Overtime</th>
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<tbody>
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<td>$75,673</td>
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<tr>
<td>Mental Health Nurse</td>
<td>2.00</td>
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**Total Current Existing Positions: 0.00 0.00 $0**

### Classification: B. New Additional Positions

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**Total New Additional Positions: 2.00 12.20 $627,043**

### Classification: C. Total Program Positions

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<td>$63,440</td>
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**Total Program Positions: 2.00 12.20 $627,043**

---

**a/** Enter the number of FTE positions that will be staffed with clients, family members or caregivers.  
**b/** Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.
### A. Expenditures

1. **Client, Family Member and Caregiver Support Expenditures**
   - a. Clothing, Food and Hygiene: $61,089
   - b. Travel and Transportation: $42,973
   - c. Housing
     - i. Master Leases: $0
     - ii. Subsidies: $0
     - iii. Vouchers: $0
     - iv. Other Housing: $30,113
   - d. Employment and Education Supports: $0
   - e. Other Support Expenditures (provide description in budget narrative): $0
   - f. Total Support Expenditures: $134,174

2. **Personnel Expenditures**
   - a. Current Existing Personnel Expenditures (from Staffing Detail): $0
   - b. New Additional Personnel Expenditures (from Staffing Detail): $627,043
   - c. Employee Benefits: $206,924
   - d. Total Personnel Expenditures: $833,967

3. **Operating Expenditures**
   - a. Professional Services: $5,680
   - b. Translation and Interpreter Services: $1,264
   - c. Travel and Transportation: $11,246
   - d. General Office Expenditures: $32,149
   - e. Rent, Utilities and Equipment: $177,176
   - f. Medication and Medical Supports: $45,922
   - g. Other Operating Expenses (provide description in budget narrative): $43,665
   - h. Total Operating Expenditures: $317,102

4. **Program Management**
   - a. Existing Program Management: $0
   - b. New Program Management: $0
   - c. Total Program Management: $0

5. **Estimated Total Expenditures when service provider is not known**: $0

6. **Total Proposed Program Budget**: $1,285,242

### B. Revenues

1. **Existing Revenues**
   - a. Medi-Cal (FFP only): $0
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. Realignment: $0
   - d. State General Funds: $0
   - e. County Funds: $0
   - f. Grants: $0
   - g. Other Revenue: $0
   - h. Total Existing Revenues: $0

2. **New Revenues**
   - a. Medi-Cal (FFP only): $188,269
   - b. Medicare/Patient Fees/Patient Insurance: $0
   - c. State General Funds: $0
   - d. Other Revenue: $0
   - e. Total New Revenue: $188,269

3. **Total Revenues**: $188,269

### C. One-Time CSS Funding Expenditures**: $0

### D. Total Funding Requirements**: $1,096,973

### E. Percent of Total Funding Requirements for Full Service Partnerships**: 25.0%
A.  Expenditures

1.  Client, Family Member and Caregiver Support Expenditures
   a. Clothing, Food and Hygiene-based on average annual cost of $145 per client (55% of clients).  $ 61,089
   b. Travel and Transportation-based on average annual cost of $102 per client (55% of clients).  $ 42,973
   c. Housing
      iv. Other Housing (55% of clients)  $ 30,113
      Safe Haven housing-5 slots. Annual cost per slot $10,950.
   f. Total Support Expenditures  $ 134,174

2.  Personnel Expenditures
   b. New Additional Personnel Expenditures-9 employees salaries  $ 627,043
   c. Employee Benefits-33% of of salaries  $ 206,924
   d. Total Personnel Expenditures  $ 833,967

3.  Operating Expenditures
   a. Professional Services-ongoing training-based on current average annual cost of $400 per budgeted FTE  $ 5,680
   b. Translation and Interpreter Services-based on current average annual cost of $3 per client (55% of clients)  $ 1,264
   c. Travel and Transportation-based on current average annual cost per budgeted FTE of $792  $ 11,246
   d. General Office Expenditures-based on current average annual cost per budgeted FTE of $2,264  $ 32,149
   e. Rent, Utilities and Equipment-based on current average annual cost per budgeted FTE of $7,449
      (average does not include lease costs) + lease costs for 3500 s.f. facility @ $1.70 s.f. for 12 mo  $ 177,176
   f. Medication and Medical Supports-based on current average annual cost of $109 per client (55% of clients).  $ 45,922
   g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premiums based on current average annual cost of $3,075 per budgeted employee  $ 43,665
   h. Total Operating Expenditures  $ 317,102

6.  Total Proposed Program Budget  $ 1,285,242

B.  Revenues

2.  New Revenues
   a. Medi-Cal (FFP only)-assume 30% of new clients will be Medi-Cal eligible (30% of costs X 50%)  $ 188,269
   e. Total New Revenue  $ 188,269

3.  Total Revenues  $ 188,269

D.  Total Funding Requirements  $ 1,096,973
### EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

**County(ies):** San Bernardino  
**Fiscal Year:** 2007-08  
**Program Workplan #:** OA-2  
**Date:** 2/1/06  
**Program Workplan Name:** Circle of Care: Mobile Outreach  
**Type of Funding:** 2. System Development  
**Proposed Total Client Capacity of Program/Service:** 766  
**Proposed Total Client Capacity of Program/Service:** New  
**Existing Client Capacity of Program/Service:** 0  
**Client Capacity of Program/Service Expanded through MHSA:** 766  
**Telephone Number:** (909) 387-7577

<table>
<thead>
<tr>
<th>Classification</th>
<th>Function</th>
<th>Client, FM &amp; CG FTEs&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total Number of FTEs</th>
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<tr>
<td><strong>Total New Additional Positions</strong></td>
<td>2.00</td>
<td>12.20</td>
<td></td>
<td>$627,043</td>
<td></td>
</tr>
<tr>
<td><strong>C. Total Program Positions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.00</td>
<td>12.20</td>
</tr>
</tbody>
</table>

---

*<sup>a</sup> Enter the number of FTE positions that will be staffed with clients, family members or caregivers.*  
*<sup>b</sup> Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.*
### A. Expenditures

#### 1. Personnel Expenditures

- **a. MHSA Coordinator(s)**: 0.25 FTE, $18,511
- **b. MHSA Support Staff**: 0.16 FTE, $115,504
- **c. Other Personnel** (list below)
  - i. **Finance**: 1.00 FTE, $49,880
  - ii. **R&E**: 0.75 FTE, $37,069
  - iii. **Compliance/Quality Management**: 0.75 FTE, $39,102
  - iv. **DBH Payroll**: 0.25 FTE, $6,783
  - v. **Contracts Unit**: 0.50 FTE, $28,371
  - vi. **Business Office**: 0.25 FTE, $7,886
  - vii. **Training/Staff Development**: 0.50 FTE, $35,074
  - viii. **Computer Services**: 1.00 FTE, $53,364

#### d. Total FTEs/Salaries: 0.16 FTE, 7.75 $391,543

#### e. Employee Benefits: $129,209

**f. Total Personnel Expenditures: $520,752**

#### 2. Operating Expenditures

- **a. Professional Services**: $3,164
- **b. Travel and Transportation**: $6,265
- **c. General Office Expenditures**: $17,908
- **d. Rent, Utilities and Equipment**: $102,385
- **e. Other Operating Expenses (provide description in budget narrative)**: $24,323
- **f. Total Operating Expenditures**: $154,045

#### 3. County Allocated Administration

- **a. Countywide Administration (A-87)**: $14,634
- **b. Other Administration (provide description in budget narrative)**
- **c. Total County Allocated Administration**: $14,634

**4. Total Proposed County Administration Budget**: $689,431

### B. Revenues

#### 1. New Revenues

- **a. Medi-Cal (FFP only)**
- **b. Other Revenue**: $11,612

**2. Total Revenues**: $11,612

### C. Start-up and One-Time Implementation Expenditures

**D. Total County Administration Funding Requirements**: $289,000

---

**COUNTY CERTIFICATION**

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: 2/1/06
Signature ___________________________________________
Local Mental Health Director

Executed at ___________________________________________, California
### A. Expenditures

#### 1. Personnel Expenditures

All costs calculated for 3 months in first year (2005-06)

<table>
<thead>
<tr>
<th>Position</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHSAs Coordinator(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Manager II</td>
<td>0.25</td>
<td>$18,511</td>
</tr>
<tr>
<td>MHSAs Support Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Analyst II (1 for Housing)</td>
<td>0.50</td>
<td>$28,371</td>
</tr>
<tr>
<td>Office Assistant III</td>
<td>0.25</td>
<td>$7,814</td>
</tr>
<tr>
<td>Secretary I</td>
<td>0.25</td>
<td>$9,703</td>
</tr>
<tr>
<td>PSE Office Assistant III</td>
<td>0.25</td>
<td>$5,861</td>
</tr>
<tr>
<td>Statistical Methods Analyst</td>
<td>0.25</td>
<td>$11,690</td>
</tr>
<tr>
<td>MH Education Consultant</td>
<td>0.25</td>
<td>$11,136</td>
</tr>
<tr>
<td>Social Worker II</td>
<td>0.75</td>
<td>$36,717</td>
</tr>
<tr>
<td>PSE Consumer Advocates</td>
<td>0.16</td>
<td>$4,211</td>
</tr>
<tr>
<td>Total MHSAs Support Staff</td>
<td>2.66</td>
<td>$115,504</td>
</tr>
</tbody>
</table>

#### 2. Operating Expenditures

All costs calculated for 3 months in first year (2005-06)

<table>
<thead>
<tr>
<th>Position</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Office Expenditures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent, Utilities and Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Expenditures</td>
<td>5.00</td>
<td>$257,529</td>
</tr>
</tbody>
</table>

#### 3. County Allocated Administration

<table>
<thead>
<tr>
<th>Position</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countywide Administration (A-87)</td>
<td>0.25</td>
<td>$14,634</td>
</tr>
<tr>
<td>Other Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total County Allocated Administration</td>
<td></td>
<td>$14,634</td>
</tr>
</tbody>
</table>

#### 4. Total Proposed County Administration Budget

$689,431

### B. Revenues

#### 1. New Revenues

<table>
<thead>
<tr>
<th>Source</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal (FFP only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Revenue</td>
<td></td>
<td>$11,612</td>
</tr>
</tbody>
</table>

#### 2. Total Revenues

$11,612

### C. Start-up and One-Time Implementation Expenditures

Construction costs and furnishings for new employees; 2 vehicles, training and copy machine

$289,000

### D. Total County Administration Funding Requirements

$966,819
EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): San Bernardino County  Fiscal Year: 2006-07  Date: 2/1/06

<table>
<thead>
<tr>
<th>Client, Family Member and Caregiver FTEs</th>
<th>Total FTEs</th>
<th>Budgeted Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1. Personnel Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. MHSA Coordinator(s)</td>
<td>1.00</td>
<td>$98,475</td>
</tr>
<tr>
<td>b. MHSA Support Staff</td>
<td>0.63</td>
<td>$621,093</td>
</tr>
<tr>
<td>c. Other Personnel (list below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Finance</td>
<td>4.00</td>
<td>265,359</td>
</tr>
<tr>
<td>ii. R&amp;E</td>
<td>3.00</td>
<td>197,207</td>
</tr>
<tr>
<td>iii. Compliance/Quality Management</td>
<td>3.00</td>
<td>208,018</td>
</tr>
<tr>
<td>iv. DBH Payroll</td>
<td>1.00</td>
<td>36,085</td>
</tr>
<tr>
<td>v. Contracts Unit</td>
<td>2.00</td>
<td>150,936</td>
</tr>
<tr>
<td>vi. Business Office</td>
<td>1.00</td>
<td>41,956</td>
</tr>
<tr>
<td>vii. Training/Staff Development</td>
<td>2.00</td>
<td>186,591</td>
</tr>
<tr>
<td>viii. Computer Services</td>
<td>4.00</td>
<td>283,894</td>
</tr>
<tr>
<td>d. Total FTEs/Salaries</td>
<td>0.63</td>
<td>31.00</td>
</tr>
<tr>
<td>e. Employee Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Total Personnel Expenditures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Operating Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Professional Services</td>
<td></td>
<td>$12,652</td>
</tr>
<tr>
<td>b. Travel and Transportation</td>
<td></td>
<td>$25,051</td>
</tr>
<tr>
<td>c. General Office Expenditures</td>
<td></td>
<td>$71,610</td>
</tr>
<tr>
<td>d. Rent, Utilities and Equipment</td>
<td></td>
<td>$260,695</td>
</tr>
<tr>
<td>e. Other Operating Expenses</td>
<td></td>
<td>$97,262</td>
</tr>
<tr>
<td>f. Total Operating Expenditures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. County Allocated Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Countywide Administration (A-87)</td>
<td></td>
<td>$58,516</td>
</tr>
<tr>
<td>b. Other Administration (provide description in budget narrative)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Total County Allocated Administration</td>
<td></td>
<td>$58,516</td>
</tr>
<tr>
<td><strong>4. Total Proposed County Administration Budget</strong></td>
<td></td>
<td>$2,615,400</td>
</tr>
<tr>
<td><strong>B. Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. New Revenues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Medi-Cal (FFP only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Other Revenue</td>
<td></td>
<td>$46,433</td>
</tr>
<tr>
<td><strong>2. Total Revenues</strong></td>
<td></td>
<td>$46,433</td>
</tr>
<tr>
<td><strong>C. Start-up and One-Time Implementation Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Total County Administration Funding Requirements</strong></td>
<td></td>
<td>$2,568,967</td>
</tr>
</tbody>
</table>

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution C

Date:  
Signature:  
Local Mental Health Director

Executed at ______________________________________, California
## A. Expenditures

### 1. Personnel Expenditures

<table>
<thead>
<tr>
<th>Position</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Manager II</td>
<td>coordinate MHSA programs</td>
<td>1.00</td>
<td>$74,041</td>
</tr>
<tr>
<td>Staff Analyst II (1 for Housing)</td>
<td>coordinate, implement and maintain housing projects associated with program proposals</td>
<td>2.00</td>
<td>$113,486</td>
</tr>
<tr>
<td>Office Assistant III</td>
<td>Additional clerical support</td>
<td>1.67</td>
<td>$52,196</td>
</tr>
<tr>
<td>Secretary I</td>
<td>Required to support program Coordinators</td>
<td>1.00</td>
<td>$38,813</td>
</tr>
<tr>
<td>PSE Office Assistant III</td>
<td>Provide temporary clerical support</td>
<td>0.33</td>
<td>$7,736</td>
</tr>
<tr>
<td>Statistical Methods Analyst</td>
<td>To provide management with statistical information for determining outcomes, budgeting and program monitoring</td>
<td>1.00</td>
<td>$46,761</td>
</tr>
<tr>
<td>MH Education Consultant</td>
<td>To facilitate educational needs for consumers</td>
<td>1.00</td>
<td>$44,545</td>
</tr>
<tr>
<td>Social Worker II</td>
<td>Provide case management and outreach services</td>
<td>3.00</td>
<td>$146,869</td>
</tr>
<tr>
<td>PSE Consumer Advocates</td>
<td>Work with program staff to develop, implement and monitor programs for consumers and their families.</td>
<td>0.63</td>
<td>$16,579</td>
</tr>
<tr>
<td><strong>Total MHSA Support Staff</strong></td>
<td></td>
<td><strong>10.63</strong></td>
<td><strong>$466,987</strong></td>
</tr>
<tr>
<td><strong>c. Other Personnel (list below)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Finance</td>
<td>Required to stay current on legislative changes, reporting requirements, monitor fiscal operations associated with the MHSA, prepare reports for administration and to participate in the annual budget and cost report process.</td>
<td>1.00</td>
<td>$56,743</td>
</tr>
<tr>
<td>Accountant II</td>
<td>To act as a liaison between program and administrative staff. Participate in the contracting process and provide administrative support to MHSA Coordinator</td>
<td>1.00</td>
<td>$56,743</td>
</tr>
<tr>
<td>Accounting Technician</td>
<td>Provide technical support under the supervision of the Accountant II</td>
<td>1.00</td>
<td>$42,700</td>
</tr>
<tr>
<td>Supervising Fiscal Specialist</td>
<td>Required to evaluate clerical job functions, develop fiscal desk procedures, implement a cross-training process and to coordinate automation of job functions where necessary</td>
<td>1.00</td>
<td>$43,332</td>
</tr>
<tr>
<td>Automated Systems Analyst I</td>
<td>To develop and maintain database applications, provide statistical and financial information to administration</td>
<td>1.00</td>
<td>$60,277</td>
</tr>
<tr>
<td>Staff Analyst II</td>
<td>Analyze statistical and financial data related to the MHSA. Work with Automated Systems Analyst I to assess department needs and develop applications</td>
<td>1.00</td>
<td>$56,743</td>
</tr>
<tr>
<td>Office Assistant III</td>
<td>Provide additional clerical support</td>
<td>1.00</td>
<td>$31,256</td>
</tr>
<tr>
<td>ii. Compliance/Quality Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH Nurse II</td>
<td>Required to do chart monitoring, HIPAA compliance and Quality Management</td>
<td>1.00</td>
<td>$69,481</td>
</tr>
<tr>
<td>Clinical Therapist I</td>
<td>Required to do chart monitoring, HIPAA compliance and Quality Management</td>
<td>1.00</td>
<td>$55,667</td>
</tr>
<tr>
<td>Office Assistant III</td>
<td>Provide additional clerical support</td>
<td>1.00</td>
<td>$31,256</td>
</tr>
<tr>
<td>iv. DBH Payroll</td>
<td>Additional Specialist required to handle increase in staffing</td>
<td>1.00</td>
<td>$27,132</td>
</tr>
<tr>
<td>Payroll Specialist</td>
<td>Work with program and fiscal staff to prepare contracts for MHSA services. Full participation in the contract process, including monitoring and reporting</td>
<td>2.00</td>
<td>$113,486</td>
</tr>
<tr>
<td>Staff Analyst II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Assistant III</td>
<td>Additional billing staff due to increased client volume</td>
<td>1.00</td>
<td>$31,546</td>
</tr>
<tr>
<td>v. Business Office</td>
<td>To coordinate and provide training to department staff, contractors, consumers, families of consumers and the general public</td>
<td>1.00</td>
<td>$66,253</td>
</tr>
<tr>
<td>Fiscal Specialist</td>
<td>To develop and maintain database applications, provide statistical and financial information to administration</td>
<td>1.00</td>
<td>$60,277</td>
</tr>
<tr>
<td>vi. Training/Staff Development</td>
<td>Analyze and support training of department staff and contractors.</td>
<td>1.00</td>
<td>$60,277</td>
</tr>
<tr>
<td>Staff Development Training Coordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Competency Officer</td>
<td>Required to ensure consumer cultural needs are met. Facilitate training of DBH and CCHG Staff</td>
<td>1.00</td>
<td>$74,041</td>
</tr>
<tr>
<td>vii. Computer Services</td>
<td>Required to support additional PC needs</td>
<td>2.00</td>
<td>$92,901</td>
</tr>
<tr>
<td>Automated Systems Tech</td>
<td>Required to support expanded use of client data system</td>
<td>2.00</td>
<td>$120,553</td>
</tr>
<tr>
<td>Automated Systems Analyst I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Other Personnel</strong></td>
<td></td>
<td><strong>20.00</strong></td>
<td><strong>$1,030,110</strong></td>
</tr>
<tr>
<td>d. Total FTEs/Salaries</td>
<td></td>
<td><strong>31.63</strong></td>
<td><strong>$1,571,138</strong></td>
</tr>
<tr>
<td>e. Employee Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Total Personnel Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. Operating Expenditures

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Professional Services</td>
<td>Ongoing training based on current average annual cost of $400 per budgeted FTE</td>
<td></td>
<td>$12,652</td>
</tr>
<tr>
<td>Travel and Transportation</td>
<td>Travel and Transportation based on current average annual cost per budgeted employee of $792</td>
<td></td>
<td>$25,051</td>
</tr>
<tr>
<td>b.</td>
<td>General Office Expenditures based on current average annual cost per budgeted employee of $2,264</td>
<td></td>
<td>$71,610</td>
</tr>
<tr>
<td>c. General Office Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Rent, Utilities and Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Other Operating Expenses (general liability, vehicle, medical malpractice insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Total Operating Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. County Allocated Administration

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Countywide Administration</td>
<td>Proportionate cost per employee</td>
<td></td>
<td>$58,516</td>
</tr>
<tr>
<td>b. Other Administration (provide description in budget narrative)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Total County Allocated Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Total Proposed County Administration Budget

**$2,615,400**

## B. Revenues

### 1. New Revenues

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medi-Cal (FFP only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Other Revenue</td>
<td>Average MAA revenue per employee</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. Start-up and One-Time Implementation Expenditures

**$0**

### D. Total County Administration Funding Requirements

**$2,568,967**
### A. Expenditures

#### 1. Personnel Expenditures

- **a. MHSA Coordinator(s)**
  - Total FTE: 1.00
  - Budgeted Expenditures: 98,475.00

- **b. MHSA Support Staff**
  - Total FTE: 0.63
  - Budgeted Expenditures: 621,093.00

- **c. Other Personnel (list below)**
  - Finance
    - Total FTE: 4.00
    - Budgeted Expenditures: 265,359.00
  - R&E
    - Total FTE: 3.00
    - Budgeted Expenditures: 197,207.00
  - Compliance/Quality Management
    - Total FTE: 3.00
    - Budgeted Expenditures: 208,018.00
  - DBH Payroll
    - Total FTE: 1.00
    - Budgeted Expenditures: 36,085.00
  - Contracts Unit
    - Total FTE: 2.00
    - Budgeted Expenditures: 150,936.00
  - Business Office
    - Total FTE: 1.00
    - Budgeted Expenditures: 41,956.00
  - Training/Staff Development
    - Total FTE: 2.00
    - Budgeted Expenditures: 186,591.00
  - Computer Services
    - Total FTE: 4.00
    - Budgeted Expenditures: 283,894.00
- **Total FTEs/Salaries**
  - Total FTE: 0.63
  - Budgeted Expenditures: 2,089,614

- **e. Employee Benefits**

- **f. Total Personnel Expenditures**
  - Budgeted Expenditures: 2,089,614

#### 2. Operating Expenditures

- **a. Professional Services**
  - Budgeted Expenditures: $12,652

- **b. Travel and Transportation**
  - Budgeted Expenditures: $25,051

- **c. General Office Expenditures**
  - Budgeted Expenditures: $71,610

- **d. Rent, Utilities and Equipment**
  - Budgeted Expenditures: $260,695

- **e. Other Operating Expenses (provide description in budget narrative)**
  - Budgeted Expenditures: $97,262

- **f. Total Operating Expenditures**
  - Budgeted Expenditures: $467,270

#### 3. County Allocated Administration

- **a. Countywide Administration (A-87)**
  - Budgeted Expenditures: $58,516

- **b. Other Administration (provide description in budget narrative)**

- **c. Total County Allocated Administration**
  - Budgeted Expenditures: $58,516

#### 4. Total Proposed County Administration Budget

- **Total Proposed County Administration Budget**
  - Budgeted Expenditures: $2,615,400

### B. Revenues

#### 1. New Revenues

- **a. Medi-Cal (FFP only)**

- **b. Other Revenue**
  - Budgeted Expenditures: $46,433

#### 2. Total Revenues

- **Total Revenues**
  - Budgeted Expenditures: $46,433

### C. Start-up and One-Time Implementation Expenditures

### D. Total County Administration Funding Requirements

- **Total County Administration Funding Requirements**
  - Budgeted Expenditures: $2,568,967

### COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution C

**Date:** 

**Signature:** _____________________________

Local Mental Health Director

**Executed at _____________________________, California**
### A. Expenditures

**1. Personnel Expenditures**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. MHSA Coordinator(s)</td>
<td>Program Manager II</td>
<td>1.00</td>
<td>$74,041</td>
</tr>
<tr>
<td>b. MHSA Support Staff</td>
<td>Staff Analyst II (1 for Housing)</td>
<td>2.00</td>
<td>$113,486</td>
</tr>
<tr>
<td></td>
<td>Office Assistant III</td>
<td>2.00</td>
<td>$52,198</td>
</tr>
<tr>
<td></td>
<td>Secretary I</td>
<td>1.00</td>
<td>$38,813</td>
</tr>
<tr>
<td></td>
<td>PSE Office Assistant III</td>
<td>0.00</td>
<td>$7,736</td>
</tr>
<tr>
<td></td>
<td>Statistical Methods Analyst</td>
<td>1.00</td>
<td>$46,761</td>
</tr>
<tr>
<td></td>
<td>MH Education Consultant</td>
<td>1.00</td>
<td>$44,545</td>
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<td></td>
<td>Social Worker II</td>
<td>3.00</td>
<td>$146,869</td>
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<tr>
<td></td>
<td>PSE Consumer Advocates</td>
<td>0.63</td>
<td>$16,579</td>
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<tr>
<td>Total MHSA Support Staff</td>
<td></td>
<td>10.63</td>
<td>$466,987</td>
</tr>
<tr>
<td>c. Other Personnel (list below)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Finance</td>
<td>Accountant II</td>
<td>1.00</td>
<td>$56,743</td>
</tr>
<tr>
<td></td>
<td>Staff Analyst II</td>
<td>1.00</td>
<td>$56,743</td>
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<tr>
<td></td>
<td>Accounting Technician</td>
<td>1.00</td>
<td>$42,700</td>
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<tr>
<td></td>
<td>Supervising Fiscal Specialist</td>
<td>1.00</td>
<td>$43,332</td>
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<tr>
<td>ii. R&amp;E</td>
<td>Automated Systems Analyst I</td>
<td>1.00</td>
<td>$60,277</td>
</tr>
<tr>
<td></td>
<td>Staff Analyst II</td>
<td>1.00</td>
<td>$56,743</td>
</tr>
<tr>
<td></td>
<td>Office Assistant III</td>
<td>1.00</td>
<td>$31,256</td>
</tr>
<tr>
<td>iii. Compliance/Quality Management</td>
<td>MH Nurse II</td>
<td>1.00</td>
<td>$69,481</td>
</tr>
<tr>
<td></td>
<td>Clinical Therapist I</td>
<td>1.00</td>
<td>$55,667</td>
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<td></td>
<td>Office Assistant III</td>
<td>1.00</td>
<td>$31,256</td>
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<tr>
<td>iv. DBH Payroll</td>
<td>Payroll Specialist</td>
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<td>$27,132</td>
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<td>v. Contracts Unit</td>
<td>Staff Analyst II</td>
<td>2.00</td>
<td>$113,486</td>
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<tr>
<td>vi. Business Office</td>
<td>Fiscal Specialist</td>
<td>1.00</td>
<td>$31,546</td>
</tr>
<tr>
<td>vii. Training/Staff Development</td>
<td>Staff Development Training Coordinator</td>
<td>1.00</td>
<td>$66,253</td>
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<tr>
<td></td>
<td>Cultural Competency Officer</td>
<td>1.00</td>
<td>$74,041</td>
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<tr>
<td>viii. Computer Services</td>
<td>Automated Systems Tech</td>
<td>2.00</td>
<td>$92,901</td>
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<tr>
<td></td>
<td>Automated Systems Analyst I</td>
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<tr>
<td>Total Other Personnel</td>
<td></td>
<td>20.00</td>
<td>$1,030,110</td>
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<tr>
<td>d. Total FTEs/Salaries</td>
<td></td>
<td>31.63</td>
<td>$1,571,138</td>
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<td>e. Employee Benefits</td>
<td></td>
<td></td>
<td>$518,476</td>
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<tr>
<td>f. Total Personnel Expenditures</td>
<td></td>
<td></td>
<td>$2,089,614</td>
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**2. Operating Expenditures**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Professional Services</td>
<td>Ongoing training-based on current average annual cost of $400 per budgeted FTE</td>
<td></td>
<td>$12,652</td>
</tr>
<tr>
<td>b. Travel and Transportation</td>
<td>Travel and Transportation-based on current average annual cost per budgeted employee of $792</td>
<td></td>
<td>$25,051</td>
</tr>
<tr>
<td>c. General Office Expenditures</td>
<td>General Office Expenditures-based on current average annual cost per budgeted employee of $2,264</td>
<td></td>
<td>$71,610</td>
</tr>
<tr>
<td></td>
<td>e. Rent, Utilities and Equipment</td>
<td></td>
<td>$260,695</td>
</tr>
<tr>
<td>d. Rent, Utilities and Equipment</td>
<td>e. Rent, Utilities and Equipment-based on current average annual cost per budgeted employee of $7,449</td>
<td></td>
<td>$260,695</td>
</tr>
<tr>
<td>g. Other Operating Expenses</td>
<td>g. Other Operating Expenses-general liability, vehicle, medical malpractice insurance premium based on current average annual cost of $3,076 per budgeted employee</td>
<td></td>
<td>$97,262</td>
</tr>
<tr>
<td>f. Total Operating Expenditures</td>
<td></td>
<td></td>
<td>$467,270</td>
</tr>
</tbody>
</table>

**3. County Allocated Administration**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Countywide Administration (A-87)</td>
<td>Proportionate cost per employee</td>
<td></td>
<td>$58,516</td>
</tr>
<tr>
<td>b. Other Administration</td>
<td>(provide description in budget)</td>
<td></td>
<td>$58,516</td>
</tr>
<tr>
<td>c. Total County Allocated Administration</td>
<td></td>
<td></td>
<td>$58,516</td>
</tr>
</tbody>
</table>

**4. Total Proposed County Administration Budget**

$2,615,400

### B. Revenues

**1. New Revenues**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FTEs</th>
<th>Salaries/Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medi-Cal (FFP only)</td>
<td></td>
<td></td>
<td>$46,433</td>
</tr>
<tr>
<td>b. Other Revenue</td>
<td>Average MAA revenue per employee</td>
<td></td>
<td>$46,433</td>
</tr>
</tbody>
</table>

**2. Total Revenues**

$46,433

### C. Start-up and One-Time Implementation Expenditures

$0

### D. Total County Administration Funding Requirements

$2,566,967
EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Bernardino County

Fiscal Year: 2005-06, 2006-07, 2007-08

Program Work Plan Name: Information Technology Improvement

Program Work Plan #: OTO-1 Estimated Start Date: 3 months to 12 months

Description of Program: Describe how this program will help advance the goals of the Mental Health Services Act.

One Time Only funds will be used to purchase multiple software applications designed to better track the success of the MHSA implementation. Software applications will include:

- Implementation of electronic behavioral health records (EBHR)
- Implementation of Data Analytics so data and information from multiple and disparate sources can be automatically collected, processed, integrated and compiled, and the results presented in both reports and visual formats.
- Replace the department's multiple legacy VAX hardware infrastructure that supports the InSyst Mental Health application with an HP ProLiant server environment running CHARON-VAX emulation software.
- Implement the use of the County's GIS application by building a layer or layers of relevant and real-time information to enhance the support and reporting of performance outcomes, providers, department, client services and support.

Priority Population: Describe the situational characteristics of the priority population.

N/A

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP</td>
<td>Sys Dev</td>
</tr>
<tr>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

Innovative MHSA services and service delivery systems will necessitate flexible data management applications that can be tailored and revised as the MHSA programs evolve. In order to fine tune the transformation process of our mental health service system in accordance with the MHSA, administrators and managers will need real-time feedback about how the system is operating, what works best for consumers, and which areas can be made more efficient.

**Electronic Behavioral Health Records**

Electronic behavioral health records will provide immediate recording of and access to important service information, ensuring that services are fully integrated across departmental units and geographic regions. Electronic behavioral health records will overcome logistic obstacles to the HIPAA-compliant sharing of service information for the consumer's benefit, will eliminate redundancy in record keeping, and reduce or prevent diagnostic and medication error rates.

**Data Analytics**

Data analytics is an approach that increasingly used in health care systems for these purposes. Data and information from multiple and disparate sources is automatically collected, processed, integrated and compiled, and the results presented in both reports and visual formats. For example, information about the number and lengths of hospital stays might be combined with information about kinds of outpatient treatments, quality of life variables and feedback from consumers in order to give managers a comprehensive understanding of the causes of hospitalizations. To date, county departments of behavioral health have not had the capability to take advantage of the wealth of information and data that is potentially available.

Target data sources include basic consumer information (including level of functioning, symptoms, and family history), services information (e.g., medications associated with various diagnoses), clinic information (including locations, staff qualifications, hours of operation, etc.) and demographic information. Combining data from these sources could enable prediction models to be built for the types of conditions and treatments likely to be experienced in future months, for various clinics. In turn, this could also help in staff and skill assessments at the various clinics.

**VAX Hardware Replacement**

The implementation of the CHARON-VAX emulation processing solution will provide the required technological advancements in data collection, manipulation, and reporting to support the ambitious and aggressive goals of the various MHSA programs. This will be accomplished by providing:
Substantially higher data transfer rates,
Increased memory speeds,
Same day availability of client service data,
Unlimited number of concurrent system users,
The maintenance of a single production environment,
An improved daily and month-end batch processing and reporting cycles, and
The implementation of state-of-the-art server technology.

Geographical Information System (GIS)

The GIS Behavioral Health layer will provide a new and exciting methodology by which data representing client-participation in the various programs developed for the MHSA may be presented and evaluated to complement the effective and efficient management of resources. Building a layer or layers of relevant and real-time information using the existing county GIS application will enhance support and reporting of performance outcomes, providers, department, and client services. The GIS proposal will assist the department to maintain best practices by:

- Achieving and maintaining cultural competency by identifying cross-cultural situations,
- Identifying possible ethic and racial disparities,
- Defining the required expansion of services based upon client populations and their relationship to specific providers,
- Assisting in developing trends and performance outcome reporting, and
- Identifying client and family operated services.

GIS will provide for the integration of multiple data resources via queries and statistical analysis in presenting a visualization of the departments complex and diverse client services (Who, What, Where and When).

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you
will ensure the values of recovery and resiliency are promoted and continually reinforced.

A comprehensive understanding of how the various aspects and environments of peoples’ lives contribute to their need for, and potential benefit from, different mental health programs will help establish best practices and will improve outcomes for individuals receiving services under the MHSA.

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

N/A

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

N/A

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

N/A

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

N/A

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

N/A

11) **Describe how services will be used to meet the service needs for individuals residing out-of-county.**

N/A

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in**
**Detail including how they are transformational and how they will promote the goals of the MHSA.**

N/A

<table>
<thead>
<tr>
<th>13) Please provide a timeline for this work plan, including all critical implementation dates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 3 months - RFP process</td>
</tr>
<tr>
<td>3 to 12 months - Program fully implemented and goals met</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Work plans and most budget/staffing worksheets are required at the program level.</td>
</tr>
<tr>
<td>b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.</td>
</tr>
</tbody>
</table>

| 15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. |
## Information Technology OTO costs

<table>
<thead>
<tr>
<th>Translation and Professional Services</th>
<th>General Office Expenditures</th>
<th>Rent, Utilities and Equipment</th>
<th>Other</th>
<th>2005-06 (3 Mos)</th>
<th>2006-07</th>
<th>2007-08</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Behavioral Health Records (EBHR)</td>
<td></td>
<td></td>
<td></td>
<td>300 Concurrent User License Price</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Implementation Services</td>
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<td>18,741</td>
<td>130,478</td>
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<tr>
<td></td>
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<td>Travel Reimbursement (vendor)</td>
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<td>Database Driver</td>
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<td>9,996</td>
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<td></td>
<td></td>
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<td>Visual DataFlex 260</td>
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<td>Pro-Rated Support Agreement</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Staff required for data migration and implementation</td>
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<td>150,000</td>
<td>150,000</td>
</tr>
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<td>Travel Costs</td>
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<td></td>
<td>Additional training costs (not covered in contract)</td>
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<td>Infrastructure upgrades</td>
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<td></td>
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<td>TOTAL EBHR</td>
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<td>Touch-Screens</td>
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<td></td>
<td></td>
<td>75,000</td>
<td>75,000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infrastructure upgrades (network bandwidth)</td>
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<td></td>
<td>Touch-Screens (25 @ $800)</td>
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<td>4,000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Minor equipment (cable, routers, etc...)</td>
<td>10,000</td>
<td>5,000</td>
<td>2,500</td>
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<td>Furniture and Hardware</td>
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<td>TOTAL TOUCH SCREEN</td>
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<td>GIS Behavioral Health Layer</td>
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<td>132,000</td>
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<tr>
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<td>Aerial Imagery</td>
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<td>31,500</td>
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<td>32,000</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Application Maintenance</td>
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<td>32,000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IT Tech Support</td>
<td>24,675</td>
<td>24,675</td>
<td>24,675</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IT Application Management</td>
<td>32,900</td>
<td>32,900</td>
<td>32,900</td>
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<tr>
<td></td>
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<td></td>
<td>TOTAL GIS</td>
<td>189,575</td>
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<tr>
<td>VAX Hardware Replacement</td>
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<td></td>
<td></td>
<td>15,400</td>
<td>15,400</td>
<td>15,400</td>
<td>15,400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Application &amp; System Software</td>
<td>78,600</td>
<td>78,600</td>
<td>78,600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Application Support</td>
<td>15,000</td>
<td>15,000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Installation Support</td>
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<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>56,538</td>
<td>1,030,195</td>
</tr>
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San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006
### EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

<table>
<thead>
<tr>
<th>County:</th>
<th>Fiscal Year: 2005-06, 2006-07, 2007-08</th>
<th>Program Work Plan Name: Department Training Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bernardino County</td>
<td>Program Work Plan #: OTO-2</td>
<td>Estimated Start Date: 3 months to 12 months</td>
</tr>
</tbody>
</table>

#### Description of Program:

*Describe how this program will help advance the goals of the Mental Health Services Act.*

A comprehensive staff development program is essential for any system that aspires to provide full-service partnership services that are culturally appropriate, mindful of the interaction of substance and psychological problems, truly recovery-oriented, and quality-oriented. A comprehensive staff development program is proposed that will enhance the quality of services and activities of: all staff including, interns in psychology, social workers, marriage and family therapists, occupational therapists, nurses, psychiatric technicians, and psychiatrists in training as well as consumers who are hired by DBH or who participate in consumer activities in leadership roles.

#### Priority Population:

*Describe the situational characteristics of the priority population.*

The entire MHSA consumer population should benefit from this program because services will be delivered with a more empathic understanding of consumers, greater cultural sensitivity and competence, greater empowerment of consumers and expectations of consumers, higher awareness of substance issues and better understanding of evidence-based practices.

#### Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sys Dev</td>
<td>OE</td>
</tr>
<tr>
<td>CY</td>
<td>TAY</td>
</tr>
<tr>
<td>A</td>
<td>OA</td>
</tr>
</tbody>
</table>

- Establishment of Staff Development Unit, with responsibility for:
  - Internship programs
  - New staff orientation and preparation for working in the community and in clinics in a recovery model
  - Training for volunteers
- Training about the development of peer support networks
- Structured program about evidence-based practices
- Establish training program for all interested consumers (to teach principles of helping and principles of behavioral health that can be useful for consumers themselves and useful for consumers in helping peers)
- Learning opportunities for consumers and family members regarding recovery, mental health, and helping others
- Research in programs, services, and outcomes
- Co-occurring disorders training for all staff
- Cultural competency training for all staff
- Recovery training for all staff
- Documentation training for all staff
- Quality improvement and HIPAA training for all staff
- Training in working with the elderly for all staff
- Customer service training for all staff
- Programs sponsoring employees to gain language skills and to advance professionally
- Ongoing assessment of training effectiveness
2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

To have a workforce that provides quality services with emphasis on recovery, cultural competence, quality improvement, co-occurring disorders, and services for the elderly, considerable training, re-training, and re-orientation is needed. The new Staff Development Unit will develop a creative approach to change. All of the training functions will be consolidated in a Staff Development Unit. Various strategies for achieving re-orientation of staff to the importance of recovery, cultural competence, quality improvement, evidence-based practices, co-occurring disorders, and services for the elderly, as well as for consumers will be utilized. MHSA goals will be furthered by training staff to take these new practices and understandings and applying them to their work with consumers. The infusion of these emphases into all work in DBH will be assessed by surveying consumers. Some strategies to maximize workforce competence include encouraging staff to gain significant language skills in threshold languages and a "grow your own" methodology to encourage current staff to advance in their careers by becoming eligible for hiring in the various mental health professions by using financial aid, time off, flexible work hours, CalSWIC funds, and developing internships. Psychiatric Technician and Social Worker shortages will be addressed first. San Bernardino County already has a successful program to assist female staff to advance, which will be used as a model to build upon.

3) Describe any housing or employment services to be provided.

N/A

4) Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

MHSA goals will be furthered by providing training for staff on the values of the MHSA, including an understanding about recovery and resiliency, cultural competence, continuous quality improvement, and co-occurring disorders.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Currently, the Psychology Internship Program is reduced in size. Additionally, the Social Worker and MFT internship programs are inoperative due to recent budget
problems. The One Time Only Funds provided by the MHSA will allow DBH to expand its training programs for all staff.

**7) Describe which services and supports consumers and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Consumers and family members will be involved in recovery training to illustrate the experience of consumers and families that deal with mental illness and interact with DBH. Qualified consumers will be involved in training for other consumers.

**8) Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

The Staff Development Unit will work closely with consumer organizations to assess staff needs for training via feedback from consumers about their experiences and treatment in DBH. The Staff Development Unit will use input from community groups to ensure that staff are up-to-date in their understanding of these specific consumer groups (e.g., developmentally disabled consumers, consumers utilizing 12-step groups, consumers in board and care homes, consumers in IMD's, indigenous helpers, etc.).

**9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

A primary purpose of the Staff Development unit is to ensure adequate cultural competency training for all staff, interns, and volunteers. This training will benefit those of other cultures in all target consumer groups. Most of the training focus will be on the Latino culture since that is the target population of the MHSA.

**10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

N/A

**11) Describe how services will be used to meet the service needs for individuals residing out-of-county.**

N/A

**12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail**
including how they are transformational and how they will promote the goals of the MHSA.

<table>
<thead>
<tr>
<th>13) Please provide a timeline for this work plan, including all critical implementation dates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-12 months</td>
</tr>
<tr>
<td>12-36 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Work plans and most budget/staffing worksheets are required at the program level.</td>
</tr>
<tr>
<td>b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.</td>
</tr>
</tbody>
</table>

| 15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. |
## Training and Internship Program

<table>
<thead>
<tr>
<th></th>
<th>Translation Services</th>
<th>Interpreter Services</th>
<th>Professional Services</th>
<th>General Office Expenditures</th>
<th>Rent, Utilities and Equipment</th>
<th>Other</th>
<th>2005-06 (3 Mos)</th>
<th>2006-07</th>
<th>2007-08</th>
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<tr>
<td><strong>Children</strong></td>
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<td><strong>TAY</strong></td>
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<tr>
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<td>222,000</td>
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<td>1,327,500</td>
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</tbody>
</table>
EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: San Bernardino County
Fiscal Year: 2005-06, 2006-07, 2007-08
Program Work Plan Name: Cultural Competence Program
Program Work Plan #: OTO-3
Estimated Start Date: 3 months to 12 months

Description of Program:
Describe how this program will help advance the goals of the Mental Health Services Act.
A comprehensive cultural competence program designed to develop a transformed culturally competent system. The Cultural Competence Program will focus on the development of strategies to achieve cultural competence and to eliminate the existing ethnic disparities in access to services, as well as to meet the needs of the underserved, unserved and inappropriately served ethnically and linguistically diverse population.

Priority Population:
Describe the situational characteristics of the priority population.
The implementation of comprehensive cultural competence program will improve service access, including cultural and linguistic early interventions. This program will ensure the embedding of cultural competence in the organization impacting the MHSA program delivery; successful engagement of underserved/unserved population; increased participation of ethnic consumers, family members and community leaders; and delivery of cultural competence trainings for the staff, consumers, family members and community.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
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<tbody>
<tr>
<td>Sys Dev</td>
<td>OE</td>
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</tbody>
</table>

- Establish a community, consumers and family outreach program that will implement culturally and linguistically competent strategies to increase the mental health service access by ethnic communities.
- Establish a "Promotoras de Salud" program to reach the first generation Spanish-Speaking Latinos in our community.
- Establish an African-American and Asian-American outreach program.
- Develop a Mental Health multicultural and multilingual Anti-Stigma project and education program for consumers and family members.
- Create a translation unit to translate necessary documents and information materials. Print and distribute in Spanish, Vietnamese, and other languages as needed.
- Establish ongoing community meetings and focus groups to identify unmet needs in the community.
- Establish a consumer and family member volunteer program to provide training and certification in Spanish and Vietnamese to consumers, family members and community leaders.
- Establish a consumer and family member Resource Center Facility to provide needed technical assistance and resources for the development of culturally diverse, linguistically competent self-help centers throughout the county. The mission is to improve communication and access to information among consumers, staff and the community. The Resource Center will hire culturally diverse consumers, consultants, and cultural brokers to develop cultural competence resources, create consumers culture training curriculums, create cultural and linguistic educational materials, develop a consumer and family member leadership training program, and to participate in research and outcome studies.
- Hire consumers and have stipends for volunteers, consumers and family members.
- Develop Latino, Asian-American and African-American access studies and implement the recommendations of the studies.
- Roll out the California Brief Multicultural Scale Statewide training Curriculum.
- Roll out the Mental Health Providers Interpreters Statewide Training and Certification curriculum.
- Purchase equipment to provide simultaneous on-site interpretation services.
- Provide on-site simultaneous interpretation services for community meetings and focus groups.
- Hire Ethnic and linguistic specific trainers and consultants.
2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The cultural competence program proposed will facilitate the development of an effective and efficient, culturally and linguistically competent organization and programs. The lack of these components in the mental health system will defeat the purpose of the MHSA. This program emphasizes engagement/participation of clients, family members and communities within the ethnic and linguistic groups that comprise 65% of the county population; provides training for consumers, family members and community on cultural competence and leadership, and provides interpretation and translation services to ensure that the programs are reaching the monolingual, limited English Speaking clients and their families. Engaging these groups is vital to the implementation of MHSA.

3) Describe any housing or employment services to be provided.

The multicultural and multilingual team of consumers and family members, communities and experts consultants will assist in the implementation, monitoring and evaluation of all the services described in the MHSA-CSS plan, including housing and employment services.

4) Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.

N/A

5) Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

The application of cultural competence values, philosophy and guiding principles to the implementation of the services described in the MHSA-CSS plan will advance the goals of recovery for adults and older adults and the resiliency for children and youth. By increasing the number of client run programs that are culturally and linguistically competent, the clients and their families will have the support system to move towards progress in their goals of recovery and resiliency. Establishing collaboration with non-mental health community groups, including cultural based healers will provide the environment for culturally and linguistically appropriate recovery and resiliency programs.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

The county is currently implementing the cultural competence plan approved by the State in May 2004. The implementation of the plan has funding limitations that have limited activities designed to address access barriers, differing penetration rates, and
development of a system of care that incorporates appropriate cultural and linguistic services. The MHSA allows DBH to advance work into a transformed, cultural competent mental health system for the underserved ethnic and linguistic groups.

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

Consumers and family members will participate in the implementation of outreach activities, anti-stigma programs, training on consumers' culture, focus groups, dissemination of translated information, policy development committees, and other activities designed to improve the engagement of ethnically diverse populations. Consumers will have the opportunity to receive training on cultural competence and leadership. Consumers and family members will be hired and provided with stipends for their participation in the cultural competence program.

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

Currently the cultural competence program has ongoing outreach activities in the community that facilitates the identification and engagement of community members, consumers and family members, including the Consulate of Mexico, Latino Health Collaborative, African American Initiative, Bi-National Health Week, and Spanish-speaking radio programs. With the expansion of the cultural competence program, we will implement a "Promotoras de Salud Mental" program in coordination with the current "Promotoras de Salud" program in our communities; establish collaborations with other ethnic specific radio stations and newspapers for the African-American and Asian-American communities; and identify strategies to reach out to the Native Americans in the community.

9) **Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.**

The cultural competence program is designed to achieve a culturally competent system of care with the implementation of the MHSA-CSS activities and programs. It is focused on outreach and engagement of ethnic groups in the community. San Bernardino County has 65% of ethnic specific communities that need services. The cultural competence program is designed to provide the training, consultation, consumer and family member resources, outreach activities, translated materials, interpretation services, interpreter training for the implementation of culturally and linguistically competent services targeting the multicultural and multilingual population. The cultural competence program will utilize leaders in ethnic services to
assist in the efforts to identify and include client/community multicultural perspectives in the planning and implementation of the MHSA in order to eliminate and prevent ethnic and linguistic disparities. It will develop an accountability system to assess progress in eliminating disparities.

10) **Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.**

The cultural competence program has two core areas: to assure quality services to high-risk ethnic communities in the county, and to ensure the identification of and response to service inequities and health disparities experienced by culturally diverse communities. The cultural competence program addresses diversity in the broadest sense by including strategies that are sensitive to age, gender, sexual orientation, socioeconomic backgrounds, and persons with disabilities.

11) **Describe how services will be used to meet the service needs for individuals residing out-of-county.**

N/A

12) **If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.**

N/A

13) **Please provide a timeline for this work plan, including all critical implementation dates.**

   Months 1-3: Staff recruitment, hiring and training
   Month 3-12: Full implementation of program
   FY06-07 and FY 07-08: Full implementation to meet program goals

14) **Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.**

   a) Work plans and most budget/staffing worksheets are required at the program level.
   b) **Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.**

15) **A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.**
## Cultural Competency OTO costs

<table>
<thead>
<tr>
<th>Service Description</th>
<th>2005-06 (3 Mos)</th>
<th>2006-07</th>
<th>2007-08</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Translation Services</td>
<td>36,136</td>
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<td>36,136</td>
</tr>
<tr>
<td>Document translation</td>
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<td>36,136</td>
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<td>36,136</td>
</tr>
<tr>
<td>Promotoras De Salud Program</td>
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</tr>
<tr>
<td>Meetings/focus groups</td>
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<td>24,000</td>
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<tr>
<td>Advertisement</td>
<td></td>
<td>36,000</td>
<td></td>
<td>36,000</td>
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<td>Equipment/furniture</td>
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<tr>
<td>Stipends</td>
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<td>Latino access study</td>
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<td>Asian access study</td>
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<td>African American access study</td>
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<td>MH providers interpreters training</td>
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<td>50,000</td>
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<tr>
<td>Ethnic &amp; linguistic specific consultants</td>
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<td>10,000</td>
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<tr>
<td>Consumer leadership training</td>
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<td>Consumer volunteer training</td>
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<td>Educational materials</td>
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<td><strong>TOTAL CULTURAL COMPETENCY PROGRAM COSTS</strong></td>
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<td><strong>68,000</strong></td>
<td><strong>37,040</strong></td>
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</table>
**EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY**

<table>
<thead>
<tr>
<th>County: San Bernardino County</th>
<th>Fiscal Year: 2005-06, 2006-07, 2007-08</th>
<th>Program Work Plan Name: Housing and Employment Program</th>
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<tbody>
<tr>
<td>Program Work Plan #: OTO-4</td>
<td>Estimated Start Date: 3 months to 12 months</td>
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</table>

**Description of Program:**
Describe how this program will help advance the goals of the Mental health Services Act

This department wide program will provide administrative oversight and limited clinical support services for selected programs and consumers who are involved with the continuum of housing options which include: independent/permanent, transitional, sober living, board and care, augmented and older adults' assisted living units. Employment services staff will assist consumers in job development skills and seeking gainful employment.

**Priority Population:**
Describe the situational characteristics of the priority population

The Housing and Employment Program will serve the TAY, Adult and Older Adult target populations. Housing and employment support services will be offered that are both age and level of care appropriate.

**Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)**

<table>
<thead>
<tr>
<th>Fund Type</th>
<th>Age Group</th>
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<tbody>
<tr>
<td>FSP</td>
<td>Sys Dev</td>
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</table>

- **Housing and Employment Program:** Provide Departmental wide oversight of the administration and support services for the housing and employment components of each age group.

- **One Stop TAY Center:** This program will develop 2-4 county wide locations that provides a continuum of housing assistance that includes 92 units comprising of board and care slots, social model drug/alcohol detox slots, sober living, transitional and independent/permanent housing units.

- **Forensic Integrated Mental Health Services:** This program would place 66 criminal justice/mental health consumers in augmented board and cares, regular board and cares, sober living housing and independent/permanent housing.

- **High User ACT Program:** This program serving SPMI/Dually Diagnosed consumers of acute and jail services will provide 50 units in the San Bernardino region comprised of sober living, transitional and independent/permanent housing options. In the

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San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006 265
<table>
<thead>
<tr>
<th>Program</th>
<th>Slots</th>
<th>High Desert</th>
<th>San Bernardino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Triage Diversion Program: Twenty units comprised of sober living and transitional housing will be the basis for this hospital diversion program.</td>
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<tr>
<td>Clubhouse and Consumer Peer Support Program; This consumer run, support and recovery program will utilize 12 transitional housing units in the High Desert and San Bernardino regions.</td>
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<tr>
<td>Circle of Care-Services for the Seriously Mentally Ill Older Adults: This countywide program will provide 10 augmented board and care slots and 10 assisted living slots.</td>
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<tr>
<td>Circle of Care-Mobile Outreach Services: This outreach program will utilize 5 transitional units in the High Desert region.</td>
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<tr>
<td>Employment Services: To complement the housing, DBH will provide supportive employment services for selected TAY consumers and those referred from the Forensic Integrated Mental Health Services, High User ACT Program, Clubhouse and Consumer Peer Support Program and the Older Adults program.</td>
<td>☐ ☑ ☐ ☐ ☐ ☑ ☐</td>
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</table>
2) **Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.**

The Housing and Employment Program will provide administrative oversight for the required housing and treatment staff to support consumers in selected housing sites. For selected consumers, supportive employment staff will assist consumers in developing job skills and seeking gainful employment. Various funding sources will be explored to meet the housing needs of the programs proposed in the MHSA. Permanent housing will consist of both Single Room Occupancies (SROs) and Tenant-Based Rental Assistance (TBRA) units. Treatment-oriented housing will include a social model detox program, board and care slots, augmented board and care slots, sober living, transitional housing and older adults' assisted living facility.

The funding possibilities include, but are not limited to, HUD grants such as Shelter Plus Care, Supportive Housing Program, HOME funded development grants, HOME Tenant-Based Rental Assistance grants, Prop 46, capitol subsides, tax credits, private sector funding and MHSA one time funds. To offset some of the costs, DBH will explore ways of subsidizing rental costs through SSI benefits, Interim Assistance and various HUD funded Tenant-Based Rental Assistance grants. Housing structures will be a complement of master leases at multi-site locations as well as developing and/or refurbishing properties as funds and properties become available.

The supportive employment services will be offered through a collaboration of providers including DBH in-house services, Department of Rehabilitative contracted services, Transitional Assistance Department, Aging and Adults Vocational Services and the California Employment Development Program.

3) **Describe any housing or employment services to be provided.**

The MHSA proposed programs will utilize the Housing and Employment Program as follows:

- The One Stop TAY Center program will utilize 92 slots. The slots will consist of 12 contracted Social Detox slots for substance abusers that require short term residential substance abuse treatments. In addition, 10 board and care slots, 20 sober living slots, 10 transitional housing units and 40 Tenant-Based Rental Assistance permanent housing units for individuals and families will be utilized.

- The Forensic Integrated Mental Health Services Program will utilize 66 slots comprised of 10 permanent housing units, 14 sober living slots, 14 board and care slots and 28 augmented board and care slots.

- The High User ACT program will incorporate 50 slots in the San Bernardino region as follows: 40 TBRA permanent units, 5 transitional units and 5 sober living slots; in the High Desert region there will be 12 sober living slots, 15 safe haven slots and 16 transitional slots.
• The Psych Triage Diversion Program includes 10 sober living slots and 10 transitional units.

• Twelve transitional units (6 in the High Desert Region and 6 in the San Bernardino region) will be utilized for the Clubhouse and Consumer Peer Support program.

• The Older Adults housing includes 10 augmented board and care slots, 5 transitional units in the High Desert and 10 assisted living beds/units.

In summary, the total housing and employment needs for all age groups include 308 housing slots: 12 social model detox slots, 24 board and care slots, 38 augmented board and care slots, 61 sober living slots, 15 safe haven slots, 58 transitional units, 10 assisted living slots and 90 permanent SRO/TBRA units. Supported employment services will offer specific programs for those consumers who are interested in pursuing gainful employment.

4) **Please provide the average cost for each Full Service Partnership participant including all fund type and fund sources for each Full Service Partnership proposed program.**

N/A

5) **Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.**

N/A

6) **If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.**

N/A

7) **Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.**

N/A

8) **Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.**

N/A
9) Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

N/A

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

N/A

11) Describe how services will be used to meet the service needs for individuals residing out-of-county.

N/A

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

N/A

14) Develop Budget Requests: Exhibit 5 provides formats and instructions for developing the Budget and Staffing Detail Worksheets and Budget Narrative associated with each program work plan.

Housing Trust will be set up using One Time Only funds for $3,975,000 to be spent during the initial 3-year period for the establishment of long-term consumer housing projects and initiatives.

a) Work plans and most budget/staffing worksheets are required at the program level.

b) Information regarding strategies is requested throughout the Program and Expenditure Plan Requirements.

15) A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served.
## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** C-1  
**Program Work Plan Name:** Comprehensive Child/Family Support System (CCFSS)  
**Fiscal Year:** 2005-06  
*Please complete one per fiscal year*

<table>
<thead>
<tr>
<th>Full Service Partnerships</th>
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<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
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<tbody>
<tr>
<td>Age Group</td>
<td>Description of Initial Populations</td>
<td>Target</td>
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<td>Target</td>
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<tr>
<td>Child/Youth</td>
<td>Children, youth, and families at high risk of the effects of serious emotional illness, co-occurring disorders, behavior problems at home, in school and community and have not had access to needed services.</td>
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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006
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<tr>
<th>Total Number to be served</th>
<th>Services/Strategies</th>
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<td>50</td>
<td>Crisis service will include 24-hour phone and on site consultation services.</td>
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<tr>
<td>17</td>
<td>Provide services to unserved and underserved populations by hiring family partners to reach out to those reluctant to enter the system and provide basic outreach and education to the community regarding the availability of services for youth and families through faith-based, community, and other organizations.</td>
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**EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT**

**Estimated/Actual Population Served**

County: **San Bernardino**
Program Work Plan #: **C-1**
Program Work Plan Name: **Comprehensive Child/Family Support System (CCFSS)**
Fiscal Year: **2006-07**

(Please complete one per fiscal year)

<table>
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<td>Children, youth, and families at high risk of the effects of serious emotional illness, co-occurring disorders, behavior problems at home, in school and community and have not had access to needed services.</td>
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<td>Transition Age Youth</td>
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<td>Older Adults</td>
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<td>System Development</td>
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<td>Services/Strategies</td>
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<tr>
<td>200 Crisis service will include 24-hour phone and on site consultation services.</td>
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<tr>
<th>Outreach and Engagement</th>
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<tr>
<td>67 Provide services to unserved and underserved populations by hiring family partners to reach out to those reluctant to enter the system and provide basic outreach and education to the community regarding the availability of services for youth and families through faith-based, community, and other organizations.</td>
<td>16</td>
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<td>67</td>
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</tbody>
</table>
## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** C-1  
**Program Work Plan Name:** Comprehensive Child/Family Support System (CCFSS)  
**Fiscal Year:** 2007-08  
*(Please complete one per fiscal year)*

<table>
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<th>Age Group</th>
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<tr>
<td>Transition Age</td>
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<td>Total Number to be served</td>
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<td>200</td>
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<td>67</td>
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</tr>
</tbody>
</table>
## Exhibit 6: Three-Year Plan – Quarterly Progress Goals and Report

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** TAY-1  
**Program Work Plan Name:** One Stop TAY Center  
**Fiscal Year:** 2005-06  
*(Please complete one per fiscal year)*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Description of Initial Populations</th>
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<th>Qtr 3</th>
<th>Qtr 4</th>
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</thead>
<tbody>
<tr>
<td>Child/Youth</td>
<td>TAY (16-25 years) will be served. Significant efforts will be made to work with Latino and African-American youth who are disproportionately over-represented in the justice system and out-of-home (Foster Care, Group Homes, Institutions) placements. TAY with co-occurring (mental health and drug/alcohol) disorders, SPMI, unserved, uninsured, and homeless or at</td>
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<tr>
<td>Transition Age Youth</td>
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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006  

276
risk of becoming homeless due to exiting out-of-home, high utilizers, and recidivists will be targeted.

<table>
<thead>
<tr>
<th>Adults</th>
<th>Qtr 1</th>
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<tr>
<td>Older Adults</td>
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### System Development

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>10</td>
<td>Services to underserved/unserved TAY who are contacted by Peer Counselor, Mentor, or Family Partner. It also includes TAY seeking one-time services at the One Stop TAY Center, such as a shower, use of computer, single referral, use of activity room, homeless referral, or connect with the other agencies co-located in the center.</td>
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<tr>
<td>Outreach and Engagement</td>
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<tr>
<td>Services/Strategies</td>
<td>Outreach and engagement to unserved/underserved populations through hiring peer counselors, mentors, and family partners. Outreach activities will include reaching out to those reluctant to enter the system and community presentations to other TAY organizations, justice system, Department of Children’s Services, Probation, education system, faith-based, community, other human service organizations and local businesses.</td>
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EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: San Bernardino
Program Work Plan #: TAY-1
Program Work Plan Name: One Stop TAY Center
Fiscal Year: 2006-07
(Please complete one per fiscal year)

<table>
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<tr>
<th>Age Group</th>
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<tr>
<td>39</td>
<td>Services to underserved/unserved TAY who are contacted by Peer Counselor, Mentor, or Family Partner. It also includes TAY seeking one-time services at the One Stop TAY Center, such as a shower, use of computer, single referral, use of activity room, homeless referral, or connect with the other agencies co-located in the center.</td>
<td>9</td>
<td>10</td>
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</tr>
<tr>
<td>Outreach and Engagement</td>
<td>Qtr 1</td>
<td>Qtr 2</td>
<td>Qtr 3</td>
<td>Qtr 4</td>
<td>Total</td>
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<tr>
<td><strong>Total Number to be served</strong></td>
<td>34</td>
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</tr>
<tr>
<td><strong>Services/Strategies</strong></td>
<td>Outreach and engagement to unserved/underserved populations through hiring peer counselors, mentors, and family partners. Outreach activities will include reaching out to those reluctant to enter the system and community presentations to other TAY organizations, justice system, Department of Children's Services, Probation, education system, faith-based, community, other human service organizations and local businesses.</td>
<td>8</td>
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<td>9</td>
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</table>
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** TAY-1  
**Program Work Plan Name:** One Stop TAY Center  
**Fiscal Year:** 2007-08  
*(Please complete one per fiscal year)*

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<thead>
<tr>
<th>Full Service Partnerships</th>
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<th>Qtr 4</th>
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<td><strong>Age Group</strong></td>
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<tr>
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<tr>
<td>Transition Age Youth</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
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</tbody>
</table>

TAY (16-25 years) will be served. Significant efforts will be made to work with Latino and African-American youth who are disproportionately over-represented in the justice system and out-of-home (Foster Care, Group Homes, Institutions) placements. TAY with co-occurring (mental health and drug/alcohol) disorders, SPMI, unserved, uninsured, and homeless or at risk. 
risk of becoming homeless due to exiting out-of-home, high utilizers, and recidivists will be targeted.

<table>
<thead>
<tr>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adults</td>
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</table>

<table>
<thead>
<tr>
<th>System Development</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
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**EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT**

**Estimated/Actual Population Served**

County: **San Bernardino**  
Program Work Plan #: **A-1**  
Program Work Plan Name: **Consumer-Operated Peer-Support Services and Clubhouse Expansion**  
Fiscal Year: **2005-2006**  
(please complete one per fiscal year)

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## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-1  
**Program Work Plan Name:** Consumer-Operated Peer-Support Services and Clubhouse Expansion  
**Fiscal Year:** 2006-2007  
*(please complete one per fiscal year)*

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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006
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### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-1  
**Program Work Plan Name:** Consumer-Operated Peer-Support Services and Clubhouse Expansion  
**Fiscal Year:** 2007-2008  
(please complete one per fiscal year)

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<td>75</td>
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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006  
291
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</tr>
</tbody>
</table>
## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-2  
**Program Work Plan Name:** Forensic Integrated Mental Health Services  
**Fiscal Year:** 2005-2006  
(please complete one per fiscal year)

<table>
<thead>
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<th>Age Group</th>
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<th>Qtr 1</th>
<th>Qtr 2</th>
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<th>Qtr 4</th>
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<tr>
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<td>Target: Actual</td>
<td>Target: Actual</td>
<td>Target: Actual</td>
</tr>
<tr>
<td>Transition Age Youth</td>
<td>Severe and Persistently Mentally Ill adults who are incarcerated or at risk of incarceration and who are recidivistic for consumption of high cost institutional services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Older Adults</td>
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<td>Target: Actual</td>
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<th>Number to be served</th>
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<tr>
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<td>Target: Actual</td>
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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006
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<th>Outreach and Engagement</th>
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## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-2  
**Program Work Plan Name:** Forensic Integrated Mental Health Services  
**Fiscal Year:** 2006-2007  
*(please complete one per fiscal year)*

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<td>27</td>
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<td>110</td>
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<tr>
<td>Older Adults</td>
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### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #: A-2**  
**Program Work Plan Name:** Forensic Integrated Mental Health Services  
**Fiscal Year:** 2007-2008

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San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

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<tbody>
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</tr>
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<td>Program Work Plan Name: Assertive Community Treatment (ACT) Team for High Utilizers of Arrowhead Regional Medical Center Behavioral Health Hospital</td>
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EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

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San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006
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### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

**Estimated/Actual Population Served**

**County:** San Bernardino  
**Program Work Plan #:** A-3  
**Program Work Plan Name:** Assertive Community Treatment (ACT) Team for High Utilizers of Arrowhead Regional Medical Center Behavioral Health Hospital  
**Fiscal Year:** 2007-2008  
*(please complete one per fiscal year)*

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<td>Seriously and Persistently Mentally Ill (SPMI) adults who are identified as high users of acute hospital services. This population is characterized by crisis only contact with the mental health system, homelessness, co-occurring disorders, and minimal skills with which to manage their lives.</td>
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San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006  
304
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## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-4  
**Program Work Plan Name:** Crisis Walk-In Centers  
**Fiscal Year:** 2005-2006

(please complete one per fiscal year)

<table>
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<tr>
<th>Full Service Partnerships</th>
<th>Qtr 1</th>
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<th>Qtr 3</th>
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### System Development

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<th>Total Number to be served</th>
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<tr>
<td>182</td>
<td>All services will be community-based, developmentally and culturally competent, and focused on maintaining clients within the community. This will reduce reliance on acute care settings and</td>
</tr>
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</table>

### Notes

San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006  
306
incarceration.

Services will be individually provided and will include crisis intervention, risk assessment, emergency medication, medical screening (nursing assessments), substance abuse counseling, and 23-hour crisis stabilization. There will be separate sections for treating children and adults in the 23-hour crisis stabilization unit.

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<tr>
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<tr>
<td>110 Linkage to local mental health clinics and/or intensive case management services will be made when clients are stable. Referrals will be made to physical health care and housing programs.</td>
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**EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT**

**Estimated/Actual Population Served**

**County:** San Bernardino  
**Program Work Plan #:** A-4  
**Program Work Plan Name:** Crisis Walk-In Centers  
**Fiscal Year: 2006-2007**  
*(please complete one per fiscal year)*

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<th>Qtr 2</th>
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<td>1876</td>
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<td><strong>Services/Strategies</strong></td>
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EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: San Bernardino
Program Work Plan #: A-4
Program Work Plan Name: Crisis Walk-In Centers
Fiscal Year: 2007-2008
(please complete one per fiscal year)

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Number to be served Services/Strategies

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<tr>
<td>75</td>
<td>Provide integrated case management services at the psychiatric triage location in the county hospital, in collaboration with outpatient clinics, primary care providers</td>
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</table>

**County:** San Bernardino  
**Program Work Plan #:** A-5  
**Program Work Plan Name:** Psychiatric Triage Diversion Team at County Hospital  
**Fiscal Year:** 2005-2006

(please complete one per fiscal year)
Clients who are frequently hospitalized in acute psychiatric care will be linked to existing intensive community-based case management services and with existing outpatient clinics.

After stabilization, provide facilitation of community placement at the lowest appropriate level of care.

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## EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-5  
**Program Work Plan Name:** Psychiatric Triage Diversion Team at County Hospital  
**Fiscal Year:** 2006-2007  
(please complete one per fiscal year)

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<tr>
<td><strong>Total Number to be served</strong></td>
<td>Services/Strategies</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>300</td>
<td>Provide integrated case management services at the psychiatric triage location in the county hospital, in collaboration with outpatient clinics, primary care providers</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
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</tr>
</tbody>
</table>

San Bernardino County MHSA CSS  
Program and Expenditure Plan-February 2006
Clients who are frequently hospitalized in acute psychiatric care will be linked to existing intensive community-based case management services and with existing outpatient clinics.

After stabilization, provide facilitation of community placement at the lowest appropriate level of care.

<table>
<thead>
<tr>
<th>Outreach and Engagement</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number to be served</td>
<td>Services/Strategies</td>
<td>Target</td>
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<td>San Bernardino County MHSA CSS Program and Expenditure Plan-February 2006</td>
<td>315</td>
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</table>
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** A-5  
**Program Work Plan Name:** Psychiatric Triage Diversion Team at County Hospital  
**Fiscal Year:** 2007-2008  
*(please complete one per fiscal year)*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Description of Initial Populations</th>
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<th>Qtr 2 Target</th>
<th>Actual</th>
<th>Qtr 3 Target</th>
<th>Actual</th>
<th>Qtr 4 Target</th>
<th>Actual</th>
<th>Total Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
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<td>Transition Age Youth</td>
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<td>Older Adults</td>
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#### System Development

<table>
<thead>
<tr>
<th>Total Number to be served</th>
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<th>Qtr 1 Target</th>
<th>Actual</th>
<th>Qtr 2 Target</th>
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<th>Qtr 3 Target</th>
<th>Actual</th>
<th>Qtr 4 Target</th>
<th>Actual</th>
<th>Total Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>300</td>
<td>Provide integrated case management services at the psychiatric triage location in the county hospital, in collaboration with outpatient clinics, primary care providers</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
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</tbody>
</table>
Clients who are frequently hospitalized in acute psychiatric care will be linked to existing intensive community-based case management services and with existing outpatient clinics.

After stabilization, provide facilitation of community placement at the lowest appropriate level of care.

<table>
<thead>
<tr>
<th>Outreach and Engagement</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
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<tbody>
<tr>
<td><strong>Total Number to be served</strong></td>
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<td>Target</td>
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<td>Target</td>
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<tr>
<td><strong>Services/Strategies</strong></td>
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### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

<table>
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<tbody>
<tr>
<td>Program Work Plan #: OA-1</td>
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<tr>
<td>Program Work Plan Name: Circle of Care: System Development</td>
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<tr>
<td>Fiscal Year: 2005-06</td>
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</table>

(please complete one per fiscal year)

<table>
<thead>
<tr>
<th>Full Service Partnerships</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
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<tr>
<td>Child/Youth</td>
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<tr>
<td>Transition Age Youth</td>
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<tr>
<td>Adults</td>
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<tr>
<td>Older Adults</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>19</td>
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</table>

Unserved and underserved Older Adults (60 years and older) who are isolated and may be in declining health and, because of stigma, lack of transportation, and/or lack of awareness of availability of services.
<table>
<thead>
<tr>
<th>Services/Strategies</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase staff to extend services to diverse populations of older adults not currently receiving mental health and case management services; assure that mental health services will be provided in a manner that is culturally, racially, ethnically, and age-cohort appropriate. Provide ongoing education, linkage and consultation related to insurance and SSI benefits for the Transitional Age Older Adult population (ages 55 – 59) and for those Older Adults 60 – 65 years that may need assistance in obtaining benefits.</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Outreach and Engagement</td>
<td>Qtr 1</td>
<td>Qtr 2</td>
<td>Qtr 3</td>
<td>Qtr 4</td>
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<tr>
<td>San Bernardino County MHSA CSS Program and Expenditure Plan-February 2006</td>
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</table>

San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Description of Initial Populations</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
<td>Unserviced and underserved Older Adults (60 years and older) who are isolated and may be in declining health and, because of stigma, lack of transportation, and/or lack of awareness of availability of services.</td>
<td>25</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>145</td>
</tr>
<tr>
<td>Transition Age Youth</td>
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<td></td>
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<tr>
<td>Adults</td>
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<tr>
<td>Total Number to be served</td>
<td>Services/Strategies</td>
<td>Qtr 1</td>
<td>Qtr 2</td>
<td>Qtr 3</td>
<td>Qtr 4</td>
<td>Total</td>
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<tr>
<td>90</td>
<td>Increase staff to extend services to diverse populations of older adults not currently receiving mental health and case management services; assure that mental health services will be provided in a manner that is culturally, racially, ethnically, and age-cohort appropriate. Provide ongoing education, linkage and consultation related to insurance and SSI benefits for the Transitional Age Older Adult population (ages 55 – 59) and for those Older Adults 60 – 65 years that may need assistance in obtaining benefits.</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>30</td>
<td>90</td>
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</table>
### Outreach and Engagement

<table>
<thead>
<tr>
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<th>Services/Strategies</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55 Senior Peer Counselors will provide in-home supportive peer counseling to older adults suffering from situational difficulties related to aging. They will provide mental health counseling with a focus on wellness and recovery which includes the following: outreach and engagement to the communities throughout the County, facilitation of support groups for consumer families and caregivers, social service referrals, advocacy, telephone support and referral with the implementation of a “Warm Line”.</td>
<td>10</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>55</td>
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San Bernardino County MHSA CSS
Program and Expenditure Plan-February 2006
### Full Service Partnerships

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Description of Initial Populations</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Transition Age Youth</td>
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<tr>
<td>Adults</td>
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<td></td>
</tr>
<tr>
<td>Older Adults</td>
<td>Unserved and underserved Older Adults (60 years and older) who are isolated and may be in declining health and, because of stigma, lack of transportation, and/or lack of awareness of availability of services.</td>
<td>25</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>145</td>
</tr>
<tr>
<td>System Development</td>
<td>Qtr 1</td>
<td>Qtr 2</td>
<td>Qtr 3</td>
<td>Qtr 4</td>
<td>Total</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>Target</strong></td>
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<td><strong>Target</strong></td>
<td><strong>Actual</strong></td>
<td><strong>Target</strong></td>
<td><strong>Actual</strong></td>
</tr>
<tr>
<td><strong>Number to be served</strong></td>
<td>90</td>
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</tr>
<tr>
<td><strong>Services/Strategies</strong></td>
<td>Increase staff to extend services to diverse populations of older adults not currently receiving mental health and case management services; assure that mental health services will be provided in a manner that is culturally, racially, ethnically, and age-cohort appropriate. Provide ongoing education, linkage and consultation related to insurance and SSI benefits for the Transitional Age Older Adult population (ages 55 – 59) and for those Older Adults 60 – 65 years that may need assistance in obtaining benefits.</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>30</td>
<td>90</td>
</tr>
<tr>
<td>Outreach and Engagement</td>
<td>Qtr 1</td>
<td>Qtr 2</td>
<td>Qtr 3</td>
<td>Qtr 4</td>
<td>Total</td>
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<td>Total Number to be served</td>
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<tr>
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<tr>
<td>Services/Strategies</td>
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</tr>
<tr>
<td>55 Senior Peer Counselors will provide in-home supportive peer counseling to older adults suffering from situational difficulties related to aging. They will provide mental health counseling with a focus on wellness and recovery which includes the following: outreach and engagement to the communities throughout the County, facilitation of support groups for consumer families and caregivers, social service referrals, advocacy, telephone support and referral with the implementation of a &quot;Warm Line&quot;.</td>
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</tbody>
</table>
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** OA-2  
**Program Work Plan Name:** Circle of Care: Mobile Outreach and Intensive Case Management  
**Fiscal Year:** 2005 - 2006  
*(please complete one per fiscal year)*

<table>
<thead>
<tr>
<th>Full Service Partnerships</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
</tr>
<tr>
<td>Child/Youth</td>
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<tr>
<td>Transition Age Youth</td>
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<td>Adults</td>
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<td>0</td>
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</tbody>
</table>

*Older Adults with the most severe conditions. i.e. clients who have a) history of repeated emergency health services; b) several admissions to inpatient services or are at risk for institutionalization; c) been homeless or at risk for homelessness. Services may be extended to adults, ages 55 - 59 years.*
whose service needs are likely to extend into older adulthood.

<table>
<thead>
<tr>
<th>Total Number to be served</th>
<th>Services/Strategies</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>191</td>
<td>Two mobile, field-capable multidisciplinary outreach teams providing Crisis Response and Crisis Prevention Outreach to isolated older adults in their homes and to the homeless, who are at risk for deterioration and/or out-of-home placement. Mental health and substance abuse screening, comprehensive and integrated geriatric assessment, benefits eligibility information, linkages and referrals. Provide a mechanism to refer appropriate individuals to the Full Service Partnership component. Senior Peer Counseling component that recruits trains and supervises Older Adult</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>191</td>
<td>191</td>
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</tbody>
</table>
volunteers who participate in the Mobile Teams. Senior Peer Counselors receive initial orientation and training that includes information about the unique mental health needs of older adults and evidence-based and culturally and linguistically appropriate crisis intervention and prevention strategies. Senior Peer Counselors will receive ongoing supervision and in-service trainings. Support and education to clients, families and caregivers and coordination with community services for short-term respite care. Utilize community experts to provide consultation, education and support to ensure client-centered and culturally competent services are provided. Provide a certificated training in geriatric mental health.
for staff, volunteers and other aging network providers. Assistance with employment and housing referrals that are specific to older adult needs. Share responsibility for treatment, support and referrals for rehabilitative services.

<table>
<thead>
<tr>
<th><strong>Outreach and Engagement</strong></th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Number to be served</strong></td>
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<td>0</td>
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<tr>
<td>Outreach to Skilled Nursing Facilities (SNFs), convalescent hospitals, and physicians offices to educate about and assist in identification of older adult mental health issues. Senior Peer Counselors provide peer crisis counseling and linkages to services and supports to older adults. Senior Peer Counselors provide outreach and prevention to community, families</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>and older adults. Contract with community services for episodic transportation needs.</td>
<td></td>
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</tr>
</tbody>
</table>
### EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

#### Estimated/Actual Population Served

**County:** San Bernardino  
**Program Work Plan #:** OA-2  
**Program Work Plan Name:** Circle of Care: Mobile Outreach and Intensive Case Management  
**Fiscal Year:** 2006 - 2007  
(please complete one per fiscal year)

<table>
<thead>
<tr>
<th>Full Service Partnerships</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
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<tbody>
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<td><strong>Age Group</strong></td>
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<tr>
<td>Child/Youth</td>
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<tr>
<td>Transition Age Youth</td>
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<td>Adults</td>
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<tr>
<td>Older Adults</td>
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</tr>
<tr>
<td><strong>Description of Initial Populations</strong></td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
</tr>
<tr>
<td>Older Adults</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>

**San Bernardino County MHSA CSS**  
Program and Expenditure Plan-February 2006
whose service needs are likely to extend into older adulthood.

<table>
<thead>
<tr>
<th>Total Number to be served</th>
<th>Services/Strategies</th>
<th>System Development</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>450</td>
<td>Two mobile, field-capable multidisciplinary outreach teams providing Crisis Response and Crisis Prevention Outreach to isolated older adults in their homes and to the homeless, who are at risk for deterioration and/or out-of-home placement. Mental health and substance abuse screening, comprehensive and integrated geriatric assessment, benefits eligibility information, linkages and referrals. Provide a mechanism to refer appropriate individuals to the Full Service Partnership component. Senior Peer Counseling component that recruits, trains and supervises Older Adult</td>
<td></td>
<td>105</td>
<td>115</td>
<td>115</td>
<td>115</td>
<td>450</td>
</tr>
</tbody>
</table>
volunteers who participate in the Mobile Teams. Senior Peer Counselors receive initial orientation and training that includes information about the unique mental health needs of older adults and evidence-based and culturally and linguistically appropriate crisis intervention and prevention strategies. Senior Peer Counselors will receive ongoing supervision and in-service trainings. Support and education to clients, families and caregivers and coordination with community services for short-term respite care. Utilize community experts to provide consultation, education and support to ensure client-centered and culturally competent services are provided. Provide a certificated training.
in geriatric mental health for staff, volunteers and other aging network providers. Assistance with employment and housing referrals that are specific to older adult needs. Share responsibility for treatment, support and referrals for rehabilitative services.

<table>
<thead>
<tr>
<th>Outreach and Engagement</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number to be served</strong></td>
<td><strong>Target</strong></td>
<td><strong>Actual</strong></td>
<td><strong>Target</strong></td>
<td><strong>Actual</strong></td>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>300</td>
<td>Outreach to Skilled Nursing Facilities (SNFs), convalescent hospitals, and physicians offices to educate about and assist in identification of older adult mental health issues. Senior Peer Counselors provide peer crisis counseling and linkages to services and supports to older adults. Senior Peer Counselors provide outreach and prevention to</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
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<tr>
<td>Community, families and older adults. Contract with community services for episodic transportation needs.</td>
<td></td>
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**EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT**

**Estimated/Actual Population Served**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Description of Initial Populations</th>
<th>Qtr 1 Target</th>
<th>Qtr 1 Actual</th>
<th>Qtr 2 Target</th>
<th>Qtr 2 Actual</th>
<th>Qtr 3 Target</th>
<th>Qtr 3 Actual</th>
<th>Qtr 4 Target</th>
<th>Qtr 4 Actual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td>Transition Age Youth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Adults</td>
<td>Older Adults with the most severe conditions. i.e. clients who have a) history of repeated emergency health services; b) several admissions to inpatient services or are at risk for institutionalization; c) been homeless or at risk for homelessness. Services may be extended to adults, ages 55 - 59 years,</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>13</td>
<td></td>
<td></td>
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</table>
whose service needs are likely to extend into older adulthood.

<table>
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<td></td>
<td></td>
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<tr>
<td>Services/Strategies</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
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</tr>
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<td>105</td>
<td>115</td>
<td>115</td>
<td>115</td>
<td>115</td>
<td>450</td>
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</table>

Two mobile, field-capable multidisciplinary outreach teams providing Crisis Response and Crisis Prevention Outreach to isolated older adults in their homes and to the homeless, who are at risk for deterioration and/or out-of-home placement. Mental health and substance abuse screening, comprehensive and integrated geriatric assessment, benefits eligibility information, linkages and referrals. Provide a mechanism to refer appropriate individuals to the Full Service Partnership component. Senior Peer Counseling component that recruits trains and supervises Older Adult.
volunteers who participate in the Mobile Teams. Senior Peer Counselors receive initial orientation and training that includes information about the unique mental health needs of older adults and evidence-based and culturally and linguistically appropriate crisis intervention and prevention strategies. Senior Peer Counselors will receive ongoing supervision and in-service trainings. Support and education to clients, families and caregivers and coordination with community services for short-term respite care. Utilize community experts to provide consultation, education and support to ensure client-centered and culturally competent services are provided. Provide a certificated training
in geriatric mental health for staff, volunteers and other aging network providers. Assistance with employment and housing referrals that are specific to older adult needs. Share responsibility for treatment, support and referrals for rehabilitative services.

<table>
<thead>
<tr>
<th>Outreach and Engagement</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number to be served</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
<td>Actual</td>
<td>Target</td>
</tr>
<tr>
<td>300 Outreach to Skilled Nursing Facilities (SNFs), convalescent hospitals, and physicians offices to educate about and assist in identification of older adult mental health issues. Senior Peer Counselors provide peer crisis counseling and linkages to services and supports to older adults. Senior Peer Counselors provide outreach and prevention to</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>300</td>
</tr>
<tr>
<td>community, families and older adults. Contract with community services for episodic transportation needs.</td>
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### Attachment List

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<td>Assessing Capacity Charts</td>
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<td>Needs Survey-English</td>
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<td>Needs Survey Vietnamese</td>
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<tr>
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<td>Public Forum flyer-BHRC-Spanish</td>
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<td>Q</td>
<td>Public Forum flyer-Victorville-English</td>
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<td>R</td>
<td>Public Forum flyer-Victorville-Spanish</td>
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<tr>
<td>S</td>
<td>Community Focus Group Protocols-English and Spanish</td>
<td>47</td>
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<tr>
<td>T</td>
<td>Technical Assistance for CSS Proposal Flyer</td>
<td>61</td>
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<td>U</td>
<td>DBH Staff Contract Agency Protocols</td>
<td>62</td>
</tr>
<tr>
<td>V</td>
<td>Targeted Forum Protocols-English and Spanish</td>
<td>69</td>
</tr>
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<td>W</td>
<td>MHSA Planning Data Booklet-English</td>
<td>86</td>
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<td>X</td>
<td>MHSA Planning Data Booklet-Spanish</td>
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<td>Y</td>
<td>Stakeholder Comments by Issue</td>
<td>98</td>
</tr>
<tr>
<td>Z</td>
<td>Community Policy Action Committee (CPAC) Charge</td>
<td>108</td>
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<td>AA</td>
<td>CPAC Minutes</td>
<td>111</td>
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<td>Removal of Conditions Letter</td>
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<td>AC</td>
<td>Press Releases-Review Process/Public Hearings</td>
<td>123</td>
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<td>AD</td>
<td>Public Hearing Flyers and Distribution List</td>
<td>130</td>
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<tr>
<td>AE</td>
<td>Newspaper Articles-Review Process/Public Hearings</td>
<td>140</td>
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<td>AF</td>
<td>Public Hearing Handout</td>
<td>148</td>
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<td>AG</td>
<td>Mental Health Commission Letter</td>
<td>189</td>
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<td>AH</td>
<td>Subject References by Age Groups</td>
<td>193</td>
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<tr>
<td>AI</td>
<td>Plan Distribution List</td>
<td>198</td>
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Attachment A

Population Charts

Attachment A-1

SB County Total Population Trend 2000 to 2005
and Estimated Projections 2006-2008

Data Sources: California Department of Finance, Demographic Research Unit
US Census Bureau

Attachment A-2

<table>
<thead>
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<th>Year</th>
<th>SB County Population Estimated Projection</th>
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<tr>
<td>2006</td>
<td>1,988,661</td>
</tr>
<tr>
<td>2007</td>
<td>2,036,149</td>
</tr>
<tr>
<td>2008</td>
<td>2,083,637</td>
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</table>

Data Sources: California Department of Finance, Demographic Research Unit
US Census Bureau
Attachment A-3

**SB COUNTY POPULATION 00-15 YEARS OLD GROUP BY ETHNICITY**

- Latino-Amer: 93%
- Euro-Amer: 20%
- Asian-Amer: 5%
- African-Amer: 12%
- Native-Amer: 4%
- Other: 3%

Data Sources: California Department of Finance, Demographic Research Unit

Attachment A-4

**SB COUNTY 0-15 YEARS OLD POPULATION PERCENTAGES OF TOTAL POPULATION, POPULATION <200% FPL, AND MHP UNIQUE CLIENTS BY ETHNICITY GROUPS**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total Population</th>
<th>Population &lt;200% FPL</th>
<th>MHP Unique Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-Amer</td>
<td>12</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Asian-Amer</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Euro-Amer</td>
<td>20</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Latino-Amer</td>
<td>60</td>
<td>61</td>
<td>32</td>
</tr>
<tr>
<td>Native-Amer</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Data Sources: California Department of Finance, Demographic Research Unit
SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment A-5

SB COUNTY POPULATION 16-25 YEARS OLD GROUP BY ETHNICITY GROUPS

Data Sources: California Department of Finance, Demographic Research Unit

Attachment A-6

SB COUNTY 16-25 YEARS OLD POPULATION PERCENTAGES OF TOTAL POPULATION, POPULATION <200% FPL, AND MHP UNIQUE CLIENTS BY ETHNICITY GROUPS

Data Sources: California Department of Finance, Demographic Research Unit
SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment A-7

SB COUNTY POPULATION 26-59 YEARS OLD GROUP BY ETHNICITY GROUP

Data Sources: California Department of Finance, Demographic Research Unit

Attachment A-8

SB COUNTY 26-59 YEARS OLD POPULATION PERCENTAGES OF TOTAL POPULATION, POPULATION <200% FPL, AND MHP UNIQUE CLIENTS BY ETHNICITY GROUP

Data Sources: California Department of Finance, Demographic Research Unit
SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment A-9

SB COUNTY POPULATION 60+ YEARS OLD GROUP BY ETHNICITY GROUP

Data Sources: California Department of Finance, Demographic Research Unit

Attachment A-10

SB COUNTY 60+ YEARS OLD PERCENTAGE OF TOTAL POPULATION, POPULATION <200% FPL, AND MHP UNIQUE CLIENTS BY ETHNICITY GROUPS

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total Population</th>
<th>Population &lt;200% FPL</th>
<th>MHP Unique Clients</th>
</tr>
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<tbody>
<tr>
<td>African-Amr</td>
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<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Asian-Amr</td>
<td>7</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Euro-Amr</td>
<td>57</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td>Latino-Amr</td>
<td>26</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>Native-Amr</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>6</td>
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Data Sources: California Department of Finance, Demographic Research Unit
SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment A-11

PERCENTAGE OF UNSERVED POPULATION BY ETHNICITY GROUP

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
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<tbody>
<tr>
<td>African-American</td>
<td>17</td>
</tr>
<tr>
<td>Asian-American</td>
<td>6</td>
</tr>
<tr>
<td>Euro-American</td>
<td>28</td>
</tr>
<tr>
<td>Latino-American</td>
<td>44</td>
</tr>
<tr>
<td>Native-American</td>
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<td>Other</td>
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Data Sources: SB County Department of Behavioral Health, Research & Evaluation Data Bases

Attachment A-12

SB County Percentage of Population Underserved and Fully Served

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
<th>Underserved or Inappropriately Served</th>
<th>Fully Served</th>
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</thead>
<tbody>
<tr>
<td>African-American</td>
<td>17</td>
<td>21</td>
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<tr>
<td>Asian-American</td>
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<td>1</td>
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<tr>
<td>Euro-American</td>
<td>35</td>
<td>87</td>
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<td>Latino-American</td>
<td>39</td>
<td>18</td>
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<tr>
<td>Native-American</td>
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<tr>
<td>Other</td>
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</table>
Attachment A-13

**SB COUNTY MHP UNIQUE CLIENTS 00-15 YEARS OLD GROUP BY REGION AND ETHNICITY**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>CV</th>
<th>DM</th>
<th>EV</th>
<th>WV</th>
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<tbody>
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<td>African-American</td>
<td>366</td>
<td>306</td>
<td>566</td>
<td>204</td>
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<td>Asian-American</td>
<td>8</td>
<td>17</td>
<td>22</td>
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<tr>
<td>Euro-American</td>
<td>438</td>
<td>1,393</td>
<td>782</td>
<td>665</td>
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<td>Latino-American</td>
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<td>419</td>
<td>641</td>
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Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases

Attachment A-14
Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases

Attachment A-15

Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment A-16

SB COUNTY MHP UNIQUE CLIENTS 60+ YEARS OLD GROUP BY REGION AND ETHNICITY

Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases

Attachment A-17

<table>
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<td>Psychosis</td>
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<td>Bipolar</td>
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<td>ADHD</td>
<td>10</td>
</tr>
<tr>
<td>Behavior</td>
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<tr>
<td>Adjustment</td>
<td>5</td>
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<td>Anxiety</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td>Total</td>
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Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases

Attachment A-18
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<tr>
<td>House or Apt w/support</td>
<td>17</td>
</tr>
<tr>
<td>House or Apt w/supervision</td>
<td>7</td>
</tr>
<tr>
<td>Justice Related</td>
<td>5</td>
</tr>
<tr>
<td>Homeless, no identifiable county residence</td>
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<tr>
<td>Large Board &amp; Care Home (7+ beds)</td>
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<td>Group Home</td>
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<td>Foster Family Home - Children</td>
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<tr>
<td>Other</td>
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<tr>
<td>No Answer / Unknown</td>
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<td>Grand Total</td>
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Data Source: SB County Department of Behavioral Health, Research & Evaluation Data Bases
Attachment B
Assessing Capacity Charts

Attachment B-1
DBH Current Staff Composition by Ethnicity

- Euro-American: 48%
- Latino: 26%
- African-American: 17%
- Asian-American: 9%
- Caucasian: 2%
- Other: 25%

Attachment B-2
Contract Agencies Current Composition by Ethnicity
Source: DBH survey to contract providers 2005

- Euro-American: 48%
- Caucasian: 21%
- Latino/Hispanic: 25%
- African-American: 4%
### Attachment B-3

**Overall Composition Of County Mental Health Staff – Ethnicity By Function**  
Source: HR report 2005

<table>
<thead>
<tr>
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<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Euro-American</td>
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<td>185</td>
<td>54</td>
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<td>African-American</td>
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<td>50</td>
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<td>Latino</td>
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### Attachment B-4

**Overall Composition Of Mental Health Staff - Contract Providers Ethnicity By Function**  
Source: DBH survey to Contract providers 2005

<table>
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<th></th>
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</thead>
<tbody>
<tr>
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<td>%</td>
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<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Administration/Management 122</td>
<td>77</td>
<td>63</td>
<td>16</td>
<td>13</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Direct Services 857</td>
<td>426</td>
<td>51</td>
<td>138</td>
<td>16</td>
<td>227</td>
<td>26</td>
</tr>
<tr>
<td>Support Services 216</td>
<td>92</td>
<td>43</td>
<td>63</td>
<td>29</td>
<td>50</td>
<td>23</td>
</tr>
<tr>
<td>Volunteers/Consumers 175</td>
<td>63</td>
<td>36</td>
<td>71</td>
<td>41</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>658</td>
<td>48</td>
<td>288</td>
<td>21</td>
<td>336</td>
<td>25</td>
</tr>
</tbody>
</table>
Attachment B-5

Overall Composition of County Mental Health Providers
Bilingual Staff by Function and Language
Source: HR report 2005

<table>
<thead>
<tr>
<th>Total: 651</th>
<th>English Speaking Only</th>
<th>Bilingual Spanish</th>
<th>Bilingual Vietnamese</th>
<th>Bilingual Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
<td>#</td>
</tr>
<tr>
<td>Administration/Management 107</td>
<td>94</td>
<td>88%</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td>Direct Services 346</td>
<td>294</td>
<td>85%</td>
<td>35</td>
<td>10%</td>
</tr>
<tr>
<td>Support Services 145</td>
<td>98</td>
<td>68%</td>
<td>45</td>
<td>31%</td>
</tr>
<tr>
<td>Volunteers/Consumers 53</td>
<td>44</td>
<td>83%</td>
<td>7</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>530</td>
<td>82%</td>
<td>100</td>
<td>15%</td>
</tr>
</tbody>
</table>

- Includes 5 staff that are sign language providers.

Attachment B-6

Overall Composition of Mental Health Staff
Contract Providers Bilingual Staff by Function and Language
Source: DBH Survey to contract providers 2005

<table>
<thead>
<tr>
<th>Total: 1370</th>
<th>English Speaking Only</th>
<th>Bilingual Spanish</th>
<th>Bilingual Vietnamese</th>
<th>Bilingual Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
<td>#</td>
</tr>
<tr>
<td>Administration/Management 119</td>
<td>92</td>
<td>77%</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>Direct Services 904</td>
<td>757</td>
<td>84%</td>
<td>101</td>
<td>11%</td>
</tr>
<tr>
<td>Support Services 154</td>
<td>140</td>
<td>91%</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Volunteers/Consumers 193</td>
<td>142</td>
<td>74%</td>
<td>43</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td>1,131</td>
<td>83%</td>
<td>166</td>
<td>12%</td>
</tr>
</tbody>
</table>
### Attachment B-7

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
<th>Residents Below 200% FPL</th>
<th>Residents Needing Services</th>
<th>Residents Currently Served</th>
<th>Residents Currently Unserved</th>
<th>Direct Service Providers (DBH and Contract Agencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Euro-American</td>
<td>209,729</td>
<td>30</td>
<td>22,745</td>
<td>35</td>
<td>14,320</td>
</tr>
<tr>
<td>African-American</td>
<td>68,956</td>
<td>10</td>
<td>11,537</td>
<td>18</td>
<td>6,420</td>
</tr>
<tr>
<td>Latino</td>
<td>355,681</td>
<td>51</td>
<td>24,485</td>
<td>38</td>
<td>11,479</td>
</tr>
<tr>
<td>Asian-American</td>
<td>37,647</td>
<td>5</td>
<td>2,590</td>
<td>4</td>
<td>783</td>
</tr>
<tr>
<td>Native-American</td>
<td>4,608</td>
<td>1</td>
<td>672</td>
<td>1</td>
<td>378</td>
</tr>
<tr>
<td>Other</td>
<td>20,796</td>
<td>3</td>
<td>2,406</td>
<td>4</td>
<td>1,420</td>
</tr>
</tbody>
</table>
### SB COUNTY DBH DATA BY REGIONS

<table>
<thead>
<tr>
<th>Region</th>
<th>Population (*1,2005)</th>
<th>Area (sq. miles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Valley (CV)</td>
<td>257,648 (13%)</td>
<td>631 (3%)</td>
</tr>
<tr>
<td>Desert/Mountain (DM)</td>
<td>391,025 (20%)</td>
<td>15,249 (76%)</td>
</tr>
<tr>
<td>East Valley (EV)</td>
<td>474,985 (24%)</td>
<td>4,054 (20%)</td>
</tr>
<tr>
<td>West Valley (WV)</td>
<td>818,433 (43%)</td>
<td>118 (1%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,9420,91 (100%)</td>
<td><strong>20,052 (100%)</strong></td>
</tr>
</tbody>
</table>

*(* Estimated Population July 1,2005

**Legend**
- Red: Central Valley
- Beige: Desert/Mountain
- Blue: East Valley
- Green: West Valley
COUNTY OF SAN BERNARDINO
Department of Behavioral Health
Survey on Community Mental Health Needs

Thank you for completing this survey. In November 2004, California voters passed a law to provide funding to expand mental health services in the community. These funds are to be used to address the biggest concerns in our community related to people suffering from untreated mental health problems. We are asking community members to tell us what they see as the most needed to address those needs.

If you are a provider of services or client advocate, please respond to these questions based on your experiences with consumers in your community and on your assessment of needs and issues.

The information you share is confidential and anonymous

1. What is your age? □ Under 16 □ 16-25 □ 26-59 □ Over 60
2. What is your gender? □ Male □ Female
3. What is your zip code? __________
4. What is your race? □ Native-American □ European-American □ Asian American/Pacific Islander
□ African-American □ Hispanic or Latino □ Other
5. What is your preferred language? □ English □ Spanish □ Vietnamese □ Other
6. Which of the following groups apply to you?

- Consumer
- Contract agency staff/employee
- Primary Medical Care Provider
- DBH staff/employee
- Guardian/Foster Parent
- Community Based Organization
- Family Member
- Faith Based Organization
- Human Services Agency
- School staff/employee
- Other

7. Have you or your family ever received mental health services from San Bernardino DBH? □ Yes □ No

8. Which of these are important issues in your community and/or family? (Check all that apply)

<table>
<thead>
<tr>
<th>In my community</th>
<th>For myself or my family</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Homelessness/runaway</td>
<td></td>
</tr>
<tr>
<td>b. Sadness and depression</td>
<td></td>
</tr>
<tr>
<td>c. Isolation and loneliness</td>
<td></td>
</tr>
<tr>
<td>d. Unable to work</td>
<td></td>
</tr>
<tr>
<td>e. Anxiety and fear</td>
<td></td>
</tr>
<tr>
<td>f. Violence in the home</td>
<td></td>
</tr>
<tr>
<td>g. Violence in the community</td>
<td></td>
</tr>
<tr>
<td>h. Grief and loss of a loved one</td>
<td></td>
</tr>
<tr>
<td>i. Medical problems</td>
<td></td>
</tr>
<tr>
<td>j. Failing in school</td>
<td></td>
</tr>
<tr>
<td>k. In trouble with the law or police</td>
<td></td>
</tr>
<tr>
<td>l. Being in a psychiatric hospital</td>
<td></td>
</tr>
<tr>
<td>m. Abuse by parents/others</td>
<td></td>
</tr>
<tr>
<td>n. Removal from the home</td>
<td></td>
</tr>
<tr>
<td>o. Drug or alcohol abuse</td>
<td></td>
</tr>
<tr>
<td>p. Memories of trauma</td>
<td></td>
</tr>
<tr>
<td>q. Other</td>
<td></td>
</tr>
</tbody>
</table>

Date Completed

For Office Use
9. In what ways can we improve or expand services in relation to the concerns listed in the left hand column? (Check all that apply)

**Access**

How can we make it easier for residents to find and use mental health services in their communities? (Check all that apply)

- Help other agencies understand and respond to mental health issues before a crisis occurs
- Offer services during crisis situations
- Offer resources that include services run by clients/family members
- Increase information in community about mental health and mental illness
- Increase or change types of services in mental health clinics
- Offer mental health services in primary care doctor offices
- Offer mental health services in schools
- Offer mental health consultation & services in other locations like social services, child welfare, law enforcement, and schools
- Other ________________________________

**Client/Family driven services and support**

What can we do to increase family involvement in the treatment of clients receiving mental health services? (Check all that apply)

- Offer classes about mental illness for family members
- Develop/Implement peer/support groups
- Develop/Implement Parenting classes
- Increase education about improving family relationships
- Offer more mental health education regarding the role of medication, therapy, and other services in a client's recovery
- Develop/Implement Early children's services (0-5)
- Offer support groups for care providers (adult children caring for elders, parents, or adult clients)
- Provide opportunities for family involvement in the client's unique plan for recovery
- Teach clients and families how to move through the system of multiple agencies that are involved
- Other ________________________________

**Outcomes**

Please check the goals or outcomes that you feel are most important for mental health clients and their family members? (Check all that apply)

- Staying in school or vocational training program
- Maintain a stable living environment
- Positive social activity and recreation with friends or peers
- Staying out of trouble with the law, or out of jail
- Being able to work in spite of mental illness
- Learning to cope independently with minimal amounts of services
- Learning how to get the most of my plan for recovery
- Other ________________________________

**Recovery & resiliency - Delivery of services**

What service approaches can we develop in an effort to tap into clients' strengths and resiliencies to promote recovery? (Check all that apply)

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

What changes would you suggest to better integrate services between the department, other agencies, and the community? (Check all that apply)

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

What do you believe presents the biggest barrier to services for most community members? (Check all that apply)

- Homelessness
- Social isolation
- Embarrassment or stigma
- Too much "red tape", forms, waiting lists
- Transportation
- Language problems
- Service offered is not appealing
- Lack of awareness that services are available
- Fear of being locked up
- Fear of losing children
- Fear of losing privacy
- Fear of medications
- Other

Cultural competence

What steps do you suggest we take together to insure the services we deliver are appropriate and sensitive to the age, gender, culture, lifestyle, and beliefs of our clients? (Check all that apply)

- Expand mental health services for my culture and/or language
- Provide counseling in places of worship (church, synagogue, temple, mosque)
- Create more support groups that can be run by consumer/family or special needs groups
- Find the locations where cultural, ethnic groups meet and offer services in these locations
- Offer educational classes for clients and family members on high risk groups & offer support groups
- Make sure staff understand how to work with clients of various cultural groups
- Make sure staff know how to find resources for all cultural groups in our county
- Other

Please include additional comments here:  

---------------------------------------------

---------------------------------------------

---------------------------------------------

Thank you for your help!

Department of Behavioral Health
Research and Evaluation
700 E Gilbert Street
San Bernardino, CA 92415
(909)387-7712 or (909)387-7708
Gracias por contestar estas preguntas. En Noviembre del 2004, los votantes de California pasaron la ley que provee fondos para expandir los servicios de salud mental en la comunidad. Estos fondos son para ser usados a prestar atención a la mayor preocupación en nuestra comunidad relacionada con las personas que están sufriendo de problemas de salud mental aún no tratados. Estamos pidiéndole a los miembros de nuestra comunidad que nos digan lo que consideran la necesidad más grande para prestarle atención a esa necesidad.

Si usted es proveedor de servicios, está recibiendo servicios, o es una persona que está representando un cliente, por favor responda a estas preguntas basado en su experiencia con los clientes en su comunidad y en su evaluación de las necesidades y situaciones...

La información que usted comparte con nosotros es:

1. ¿Cuál es su edad? □ Menor de 16 □ 16-25 □ 26-59 □ Mayor de 60
2. ¿Cuál es su género/sexo? □ Masculino □ Femenino
3. ¿Cuál es su código Postal? ________ - ________
4. ¿Cuál es su raza? □ Norteamericano □ Europeo-Americano □ Afroestadounidense □ Hispano o Latino(a) □ Otros __________________________
5. ¿Cuál es su lenguaje preferido? □ Inglés □ Español □ Vietnamés □ Otros __________________________
6. ¿Cuál es de los siguientes grupos aplica a usted?
   □ Consumidor/cliente □ Empleado de agencia de contrato □ Empleado de Salud Mental
   □ Médico Primario □ Organización basada en la fe/religión □ Organización basada en la comunidad
   □ Empleado del Departamento de Salud Mental □ Guardián/padres de cuidados
   □ Miembro Familiar □ Empleado de la escuela □ Otros __________________________
7. ¿Ha recibido usted o su familia servicios de salud mental del condado de San Bernardino? □ Sí □ No
8. ¿Cuáles de estas situaciones son importantes para usted y su comunidad/la familia? (Marque todas las que aplican)

<table>
<thead>
<tr>
<th>En Mi comunidad</th>
<th>Para Mi o Mi Familia</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Falta de vivienda/irse de la casa</td>
<td>O</td>
</tr>
<tr>
<td>b. Tristeza y depresión</td>
<td>O</td>
</tr>
<tr>
<td>c. Aislamiento y soledad</td>
<td>O</td>
</tr>
<tr>
<td>d. No poder trabajar</td>
<td>O</td>
</tr>
<tr>
<td>e. Ansiedad y miedo</td>
<td>O</td>
</tr>
<tr>
<td>f. Violencia en la casa</td>
<td>O</td>
</tr>
<tr>
<td>g. Violencia en la comunidad</td>
<td>O</td>
</tr>
<tr>
<td>h. Perdida de un ser querido</td>
<td>O</td>
</tr>
<tr>
<td>i. Problemas médicos</td>
<td>O</td>
</tr>
<tr>
<td>j. Perdiendo el año en la escuela</td>
<td>O</td>
</tr>
<tr>
<td>k. Problemas con la policía</td>
<td>O</td>
</tr>
<tr>
<td>l. Estar en un hospital psiquiátrico</td>
<td>O</td>
</tr>
<tr>
<td>m. Aviso u otros problemas</td>
<td>O</td>
</tr>
<tr>
<td>n. Estar en la escuela</td>
<td>O</td>
</tr>
<tr>
<td>o. Abuso de drogas</td>
<td>O</td>
</tr>
<tr>
<td>p. Mueren en circulación de tránsito</td>
<td>O</td>
</tr>
<tr>
<td>q. Otros</td>
<td>O</td>
</tr>
</tbody>
</table>

Fecha Completada: / /  
Fecha de Vencimiento: / /  
For Office Use: __________________________
Encuesta Acerca de las necesidades de Salud Mental en la Comunidad

9. ¿En qué formas a nosotros podemos ofrecer o expandir servicios relacionados con las situaciones mencionadas en la columna de la derecha? (Marque todas las que aplican)

**Acceso**

- ¿Cómo o podrían os hacer más fácil para que los habitantes en nuestra comunidad encuentren los servicios de salud mental? (Marque todas las que aplican)
  - Ayudar a otras agencias a entender y responder a las situaciones de salud mental antes de que se hagan una crisis.
  - Ofrecer servicios en las situaciones de crisis.
  - Ofrecer servicios y otros recursos, incluyendo servicios operados por los consumidores y sus familias.
  - Aumentar la información en la comunidad acerca de la salud mental y las enfermedades mentales.
  - Aumentar el acceso a los servicios de salud mental en las oficinas de los doctores que dan los servicios de salud médica general.
  - Ofrecer servicios de salud mental en las escuelas.
  - Aumentar el acceso a los servicios de salud mental y consultoría en otras localidades con el departamento de servicios sociales, oficinas del ayuda del gobierno, departamentos de policía, y escuelas.

**Servicios dirigidos y apoyados por los clientes y sus familias.**

- ¿Qué podemos hacer para aumentar la participación de la familia en el tratamiento de los clientes que están recibiendo servicios de salud mental? (Marque todas las que aplican)
  - Ofrecer clases acerca de las enfermedades mentales para los familiares.
  - Desarrollar y implementar grupos de apoyo entre los clientes y las familias.
  - Desarrollar y implementar clases para padres.
  - Aumentar la educación acerca de cómo mejorar las relaciones familiares.
  - Ofrecer servicios de salud mental relacionados con las oficinas, la terapia, y otros servicios que son ofrecidos en los programas de recuperación escolares.
  - Desarrollar y implementar servicios para niños entre los 0 a los 5 años.
  - Ofrecer consultoría para que los clientes y sus familias participen en el plan de recuperación del cliente.
  - Enseñar a las familias y sus clientes cómo navegar el sistema con todas las agencias que están envueltas en proveer servicios.

**Resultados**

Por favor marque las metas o resultados que usted piensa son más importantes para los clientes y las familias que reciben servicios de salud mental (Marque todas las que aplican)

- Estar en la escuela o un programa vocacional.
- Mantener un ambiente de vivienda estable.
- Tener actividades sociales y recreacionales positivas con amigos y con la familia.
- No tener problemas con la justicia, o estar fuera de la cárcel.
- Poder trabajar aun teniendo una enfermedad mental.
- Aprender a vivir con pocos servicios.
- Aprender a lograr lo máximo del plan de recuperación.

**Servicios de Recuperación**

- ¿Qué servicios podemos desarrollar para poder capturar todas las habilidades y conocimiento de nuestros clientes para promover su recuperación? (Marque todas las que aplican)
  - Servicios en la propia comunidad donde yo me relaciono.
  - Servicios donde los niños se mantengan después de la escuela.
  - Programas que ayuden a construir las habilidades para resolver problemas y conflictos.
  - Consejería y educación en cómo obtener educación y cómo encontrar empleo.
  - Educación para los familiares que quieren ayudar a la persona en su familia con una enfermedad mental.

Otros: __________________________
ENCUESTA ACERCA DE LAS NECESIDADES DE SALUD MENTAL EN LA COMUNIDAD

INTEGRACIÓN Y COLABORACIÓN DE SERVICIOS

¿Qué cambios usted sugiere para mejorar la integración y colaboración de los servicios entre los departamentos del condado, otras agencias, y la comunidad? (Marque todas las que aplican)

☐ Transporte a los servicios
☐ Participación temprana de otras agencias.
☐ Asistencia para obtener beneficios que se necesitan, y servicios de apoyo
☐ Consultación con los profesores de las escuelas acerca de las señales tempranas de problemáticas en ocio y tratamientos posibles
☐ Otras ____________________________

¿Qué cree usted es la más grande barrera en recibir servicios para la mayoría de los miembros de nuestra comunidad? (Marque todas las que aplican)

☐ Falta de vivienda
☐ Aislamiento social
☐ Vergüenza o estigma
☐ Muchas formas y requisitos, y listas de espera
☐ Transporte
☐ Problemas de lenguaje
☐ Los servicios que se ofrecen no son atractivos
☐ Falta de conocimiento de los servicios que están disponibles
☐ Miedo a que se le encierre en un hospital psiquiátrico
☐ Miedo de perder los niños
☐ Miedo de perder la privacidad
☐ Miedo a las medicinas
☐ Otras ____________________________

COMPETENCIAS CULTURALES

¿Qué sugiere usted son los pasos a tomar para asegurarnos que los servicios que se ofrecen son apropriados y sensitivos a la edad, el sexo, la cultura, el estilo de vida, y las creencias de los clientes? (Marque todas las que aplican)

☐ Expandir los servicios de salud mental para mi cultura y/o mi idioma
☐ Proveer servicios de salud mental en los lugares de reunión en la comunidad (iglesias, sinagogas, templos, mezquitas)
☐ Crear grupos de apoyo y grupos de necesidades especiales que pueden ser facilitados por consumidores y las familias
☐ Buscar los lugares donde los grupos culturales y grupos étnicos se reúnen y ofrecer servicios allí
☐ Ofrecer clases educacionales para los clientes y sus familias para grupos de alto riesgo y ofrecer grupos de apoyo
☐ Asegurarse que los en plenos entiendan cómo trabajar con clientes de varios grupos culturales
☐ Asegurarse que los en plenos saben cómo encontrar recursos para todos los grupos culturales en la comunidad
☐ Otras ____________________________

Por favor incluya comentarios adicionales:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

GRACIAS POR SUAYUDA!

DEPARTAMENTO DE SALUD MENTAL Y COMPORTAMIENTO

Unidad de Evaluación y Análisis
700 E Gilbert Street
San Bernardino, CA 92415
(909)387-7712 or (909)387-7708

SBC-DBH Rev S2a Sept 2005
Xin cảm ơn quý vị và gia đình đã tham gia khảo sát. Trong tháng 11 năm 2004, ở California, chúng tôi đã thực hiện một khảo sát với mục đích thao tác và giải quyết những vấn đề về sức khỏe xã hội có thực. Quá trình khảo sát được tiến hành từ 18h đến 21h, từ 0h đến 03h, và từ 06h đến 09h. Các phỏng vấn được thực hiện tại nhà của quý vị và gia đình.

Để giúp chúng tôi hiểu rõ hơn về tình hình sức khỏe của quý vị và gia đình, xin trả lời các câu hỏi sau:

1. Quý vị bao nhiêu tuổi? □ Đổi 16 □ 16-25 □ 25-59 □ Trên 60
2. Quý vị giới tính? □ Nam □ Nữ
3. Số người trong gia đình?
4. Quốc tịch của quý vị là? □ Mỹ □ Mỹ-Á - Ảnh - Đại Đông Dương

5. Tiếng Anh □ Anh □ Pháp
6. Quý vị đang làm trong nhóm nào?
□ Thanh niên □ Toàn bộ tín đồ □ Ngộ độc hoặc cha mẹ của quý vị □ Toàn bộ người đang làm.
□ Khách hàng □ Truyền thông □ Quý vị
7. Quý vị có bao nhiêu người trong gia đình?
8. Quý vị có bao nhiêu người trong gia đình?

Trong quá trình phỏng vấn, chúng tôi đã nhận được nhiều phản hồi có giá trị. Các câu hỏi sau được hỏi:

a) Khỏe não có vấn đề gì?
□ Có □ Không
b) Sống sót, có vấn đề gì?
□ Có □ Không
c) Quá sức, có vấn đề gì?
□ Có □ Không
d) Không thể thức ăn ở nhà
□ Có □ Không
e) Sống sót, có vấn đề gì?
□ Có □ Không
f) Vê và tốt trong nhà
□ Có □ Không
g) Vê và tốt trong nhà
□ Có □ Không
h) Sống sót, có vấn đề gì?
□ Có □ Không
i) Ăn uống
□ Có □ Không
j) Hoặc thiếu
□ Có □ Không
k) Dùng đồ uống Luke hoặc vô công an
□ Có □ Không
l) Đơn vị bảo vệ
□ Có □ Không
m) Báo cáo cho các cơ quan
□ Có □ Không
n) Đơn vị bảo vệ
□ Có □ Không
o) Các vấn đề khác
□ Có □ Không
p) Vê và tốt trong nhà
□ Có □ Không
q) Vê và tốt trong nhà
□ Có □ Không
9. Vây chùng toâcoùtheânhô ńô khoâng móc mòông dòch vuîliêa heâî vxîu vaâ ńêâaéra oîbeâ trauñôc theá naâ? (Caâ trauñôc theáho môâ).
   Vây chùng toâcoùtheânhô quyûvôtîm ra söôlùng vuîsô khoâng oîcoâng ńôc guâ quyûvô - caâng dêađaông ńôc nhô theánaâ?.
   □ Giûp nhâa véiêa khoaè hieá vaâñap ńôc sô khoaè taân lytrôcôc kî xaç ra.
   □ Cung caâ dôch vuîgiîoâ luç coûââ ńêâa ra.
   □ Cung caâ nguôo taengquyeâ keâcâûch vulmâaxé xêp do thá chuñuânh véia gia ńînh.
   □ Taêc côông tîoô trong coâng ńôc veàsô khoaè taân lyùvâbeâm taân tháa.
   □ Taêc côông hoâo ńôc thay ńôzôalô dôch vuùophoïng maçh sô khoaè taân tháa.
   □ Cung caâ dôch vuîsô khoaè taân tháa óvâa phôo Bô sócâaîn sô bô ban ńâa.
   □ Cung caâ dôch vuîsôc khoaè taân tháa ôûhuatôông.
   □ Cung caâ véiêa coàvââ vaânh dôch vuîsô khoaè taân tháa óûchoókhaâ nhô dôch vuûxaâhoâ Bô veàsô khoaè treâm, véiêa thôc hieá luaâphap vuùyhaatôông.
   □ Vâa vâa.

Vây chùng toâphaülâm gi ńêâaâc côông moâquâ vuûxôugia ńînh trong cuôôc véia trô beân nhâa maùnhâa dôch vuîsô khoaè taân tháa (Caâ traùñôc theáho môâ).

Ø

□ Cung caâ véiêa hôt taâ veàbeâm taân tháa ńêa tháa hôt véia gia ńînh.
□ Tháâh laâ vaânhôc hieá cuû nhôô uûg hoâl ńôtâa.
□ Tháâh laâ vaânhôc hieá véiêa hôt taâ vaâvéia lam cha meî.
□ Taêc côông sôgïaâu dôc veàmôaçuân heâa gia ńînh caâng toâñep hôîn.
□ Cung caâ véiêa giôa dôc sô khoaè taân tháa theán nôî, dôc vaâ choô trôc cuû cuû véia véia trô cêh véia trôvâaûch vuûxâh nôî.
□ Tháâh laâ vaânhôc hieá veàcucuî tre(0-5 tuôî).
□ Cung caâ nhôô uûg hoâdaâh cho nhôô ngôôi cung caâ chaânh sôû (Tuôo trôûng thââh chaânh sôû ngôôugia yeâ, cha meihoîe khoaì haôg).
□ Tâb tôôcôc véia quân heâa gia ńînh trong keâhoăc cuûtêcâuâ khoaì haôg.
□ Dây cho tháa chûûvâaia ńînh véaçêh tôôrûa vuûxêahoâ na soáhâa véia liêa heá
□ Vâ vaâ.

Xîn gaçh veâyúînhô hoaê naâg suâa maâquûyô muôa ńat ńôc ńîhie nhâa ńêàc hoâ khoaì haôg sô khoaè taân lyùvâaheâh véia gia ńînh cuû hoî(coûtheáho môâ)
□ Aô ńôî nhâtôông hoaê chûôông trînh naâ toâ thoàû chuyeà moâ.
□ Gîn giôöôstrôông sôâg bêa vûôîg.
□ Hoôaî ńôc xadôôhtieâ boàavieâ nhôôgôi vôûbân hoâl ńôtâa.
□ Coûtheáaâ véia ńôc, dôcê hoáh taân tháa.
□ Hoô nhâa xeûôôc lâp vêuôôdôîg tôôûtîêe cuû dôc vuû.
□ Hoô véâçêh thôô lâm keäukoânôq quân trôc nhâa
□ Vâ vaâ.

Vâp phôông thôô dôch vuûna maçhuûg toâcoùtheáhânh laâp leà, ńêàm cho beân nhâa cuû theáôc vûôîg vaâc vaâdêh bêaî, ńêàcâc côôc véia laâh bêaî nhânch còûth (Caâ traùñôc theáho môâ).

□ Cung caâ dôch vuîûcoâng ńôc trò dîêa maçôuûmôa ńôc.
□ Cung caâ dôch vuîûcôaçeûem taà hôp lâî sau khi ra hoîc.
□ Cung caâ chûôông trînh maqûiûp nôûthânh laâp chuyeà moâ trong véia giaûquyeâvaâ ńeàvagäg goânâu :
□ Cung caâ yëiêe giôa dôc theàûn vàâmîm kieàm véia laâm.
□ Cung caâ véia giôa dôc ńeà gia ńînh maîmuôa giûp tháa véia gia ńînh cûbeâh taân lyùcûa beân nhâa.
□ Vâ vaâ.
Vậy việc thấy rối não ma quỷ vô muôn rối, ngớ ngẩn hợp cho rối nét thở hồn vẻ dị chục việc nhà lại khá, việc viết rối? (Ca đề họ cười hồn mở).

- Việc vá chuyể nế e łożuì chăng căp đìch vui
- Cô mơ quan he bình vô cùng năm việc khá.
- Việc nhái việc trói mà nhà lối ích việc dieser vui vui hoà.
- Việc gợp yêu kiến nế cả thằng có giai vể trái chòng ban năm cá và việc sở boiattles
- Ta Chánh vắc vän nế ñró cười hồn nát.
- Vá vả.

- Tình trạng khoảng cũng hào.
- Việc thoảng ra ngoài xa hoái
- Việc hoảng hào có năm việc kho đăng toả
- Cơ hęp ta, thứ tử, sở đó hồ hói nhe khác quà
- Việc vả chuyện.
- Triệu nỗi
- Địch vuimacung cå khó ng ngõng nóh ma mảnh muôn nát rối.
- Thieá thoá kie và thò tốt vạch vui mà năm năm nát.
- Sô lôlucuă sòígiam cahn.
- Sô lôluçucuă viế mà nhở con.
- Sô lôlувièe mà mành sôíbi mà
- Sô lôluçucuă viế và trõ
- Vá vả.

- Việc caugi ma quỷ vô muôn rối, mả muôn cho chứng to hôp chứng, ngớ ngẩn ra sa, đìch vui mà cung cả cho phù hợp vả và năm giáo vùi vô ta và không giáo, nòi dòi vâi và hối ngõ ngão cự thằng chủ (Ca đề trau lọ cười hồn mở).
- Mờ mờ đìch vui sô khoe thành ly đà chô vâ ho và thằng triệu nõc sau toả
- Cung cả yêu kiến đìch vui sô ba (Theo chua chie và vả Há chánh nế nhó nha thọ không thằng và năm vả và ẩn Islam).
- Thanh la nhôm ủng hộ giàu nhie và, mái cười kha cể bò tham chử giữa mình hoài nhơn như ca và ná biế.
- Tìm kiếm ca Cheney Regel bao.addData và và và hoa và khổ gái và năm và năm cò đìch vui và nói nòu
- Cung cả viế chò thằng thằng chư vadoras và viế giới mình tôn thơn liế mà trong vàu sô ló tăng nguy hiện cao và năm năm có thơn ủng hộ và
- Pháp xã minh kyräng : nhá viế viế và xã thằng thằng và và năm vàu thằng chủ và năm còn ba và khổ khá châu.
- Pháp xã minh lài kyräng : nhá viế bień ve và xã thằng thằng và và năm vàu thằng chủ và năm còn ba và khổ khá châu trong vung ta.
- Vá vả.

- Xin yeá ca và quỳ vô góc yêu kiến thằng nõ dở ủ nhá : .................................................................

- Xin ca và nên vể dõi giúp rối năm quỳ vô!
Attachment G

Newspaper Articles

SAN BERNARDINO
Prop. 63 forums planned for public

San Bernardino County officials are hosting more public forums on Prop. 63, California’s mental health services act. The legislation, which took effect Jan. 1, puts a 1 percent tax on personal income of more than $1 million to expand mental health services. County officials plan to inform the public about mental health services and discuss community mental health issues.

The forums are scheduled:
- 6-8 p.m. today, Victorville Performance, Education & Resource Center, 17770 Bear Valley Road, Suite 106, Victorville
- 2-4:30 p.m. Monday, Behavioral Health Resource Center, 850 E. Foothill Blvd., Tahlequah

For more information, call Elizabeth Longfellow at (909) 873-4496 or Gwen Morse at (909) 873-4476.

—Gregg McKean
gregmckan@gs.com

County taps LA County alum for HR post

San Bernardino County has tapped a 14-year veteran of the Los Angeles County Sheriff’s Department to become its next human resources director.

The county hired Andrew L. Lambert to lead the department, County Administrative Officer Mark Uffer said in a statement.

Lambert had been the director of the Los Angeles County Sheriff’s Department Administrative Services Division, where he was responsible for personal and employee relations.

Lambert replaces Elizabeth Sanchez, who lost her job in December after a potential conflict of interest.
County to get help treating mentally ill

PROP 63: Funding from this measure is expected to give nonprofit service agencies a major break.

BY GREGG McGAVIN
THE PRESS-ENTERPRISE

Mental-health officials throughout San Bernardino County and the state are asking the public how to spend millions of dollars from a state tax on millionaires.

The effort is aimed at identifying unmet mental-health needs. It is targeted at parents, teachers, police, mental-health advocates and clients — and anyone else affected by how the state cares for people with mental illnesses.

Gathering public comment is required before state officials give any county its share of funds resulting from Prop. 63, the Mental Health Services Act passed in November.

“Because San Bernardino County is the largest county in the contiguous United States, we’ve got a lot of ground to cover,” said Paula Holley, a programs manager with the county Department of Behavioral Health. “Our next goal is to start tracking all this input.”

San Bernardino County is expected to get roughly $31.2 million a year under Prop. 63, which places a 1 percent tax on any personal income over $1 million. Although the tax took effect this year, the money is not expected to become available until early next year.

In the meantime, counties must decide how to spend the

MENTAL-HEALTH SERVICES

Inland Empire is one of the areas in California that are expected to receive the largest share of money from Prop. 63. Here's how the money is expected to be distributed:

- San Bernardino County: $11.7 million
- Riverside County: $11.7 million
- Statewide: $31.2 million

“The biggest change, we’re talking about it the shift away from thinking that we have very limited dollars, so we can only serve a few people, so who are the people we absolutely have to serve?” said Rusty Selts, who heads the California Council of Community Mental Health Agencies.

The council represents nonprofit clinics that are likely to be hired to provide many of the services paid for by the new tax. Selts is a co-author of the law.

“This is literally a transformation of the public mental-health system,” Selts said. “It’s something that’s new done before, and we encourage everyone to come and get a right.”

Among those at last meetings were repress of Dual Diagnoses and a San Bernardino-based program that helps the suffer from too much and substance abuse frequently get help.

“We’re out of money July,” said Kim Neg, office clerk at David D. who suffers from demoniae over the past year. “We’re out of money July,” said Kim Neg, office clerk at David D. who suffers from depression and substance abuse.

The group, which banded 12-step meetings in the United States, decided to fund a federal grant that would give Dual D $30,000 for the next years.

The last federal grant in September, and with the money from the county, we want the money for the other bills, there has been been for the seven years.

The amazing thing people who worked for that to volunteer,” said McArthur, who headed D for seven six years ago.

Reach Gregg McGavin at 909-585-9081 or gmcavin@pe.com

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MENTAL HEALTH

Area counties cash in on Prop. 63 mandates

BY SHARON McNARY

San Bernardino and Riverside counties are rounding new mental health programs to reach out and treat people who normally might not have their way to county clinics.

It will be paid for by a newly enacted tax on millionaires.

However, a ballot initiative is in the works to repeal the Mental Health Services Act, which passed in November as Prop. 63, and to make refunds to taxpayers.

Riverside and San Bernardino counties are likely to get a disproportionately large amount of the new money because, according to the same tax on unmet needs for mental health services, said Rusty Selix, executive director of the California Council of Community Mental Health Agencies.

"Riverside and San Bernardino counties will be able to show that, relative to other counties, they have bigger unmet needs," Selix said. "They might be in line for a larger share of the money."

Collection of the millionaires' tax began this year, and counties are planning how to spend the money. The public impact won't be felt until about 2006, Selix said.

"People need to realize that this is a significant amount of new money and we want to take the time to do it right at both the state and local level," said Selix, a co-author of Prop. 63.

**NEW TAX**

County mental health departments stand to collect millions from an income tax on millionaires to pay for new programs to treat uninsured populations.

**RIVERSIDE COUNTY:**

**ESTIMATED ANNUAL NEW REVENUE:** $187 million

**TARGETS:** Undecided

**TO HELP PLAN:**

http://mentalhealth.ca.gov/

**RIVERSIDE COUNTY:**

**SAN BERNARDINO COUNTY:**

**ESTIMATED ANNUAL REVENUE:** $117 million

**TARGETS:** Women, teens, young adults ages 16-29, adults, seniors, those with combined problems of drug or alcohol abuse and mental illness.

**TO HELP PLAN:** (909) 476-5040

Behavioral Health Department spokesman Ralph Ortiz.

Finding culturally competent ways to reach people who need help are critical issues to mental health providers in the Inland area, Ortiz said.

"It's probably one of the more important issues in mental health because it's an income tax on millionaires," Ortiz said.

About one in every 100 of the state's residents will pay the tax, which collects an additional 1 percent of their income over $1 million to fund new mental health services, the state legislative analyst's office said. The top state income tax bracket rises to 10.3 percent on income over $3 million.

The act requires counties to get mental health services to populations that are underserved.

Counties are defining what fits into that category and plan meetings to hear them out.

In San Bernardino County, it's teens and young adults ages 16 to 21, adults, people who have combined problems of drug or alcohol abuse and mental illness, seniors and children, said Behavioral Health Department spokesman Ralph Ortiz.

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Mental-health forum gauges those in need

By Annette Wells

Services continued from page A1

of training for the California Institute of Mental Health, said young black males are the county's impatient service more than any other group.

As a result, he said, this group should be an area of interest.

When the two hours of discussion were over, about 75 people had identified more than 35 groups in desperate need of mental-health care in the county. The groups included children, at-risk minority youth, the homeless, parolees, Latino families, low-income residents and individuals suffering from post-traumatic stress disorder.

Undocumented immigrants and the elderly also were mentioned.

Attendees also shared dozens of ideas on how to fix the county's problems, including getting the homeless mentally ill off the streets and getting earlier to school-aged children who have behavioral problems.

Tuesday's forum at the Behavioral Health Resource Center in Rialto was in complete contrast to Monday's in Victorville where no one showed up, except Behavioral Health staff and volunteers.

"People talk about mental-health needs and say they are important, but people don't want to put in the time to fix the system," said Mark Ulrich, the county's chief administrative officer, when asked about why the Victorville meeting was unproductive.

Ulrich said he didn't anticipate much participation during this first wave of community input. But, he said, it should pick up as more people become interested and learn more.

Some mental-health advocates say it's going to take a bigger effort on the part of Behavioral Health because it lags behind other counties as far as planning for Proposition 63 funding.

Riverside County, which is set to receive about $16 million this first phase, has already had four public forums and about 50 focus group meetings.

Written responses from the public on that county's online survey have also been received, as well as individual e-mails. Donna Dalal, program chief for its Department of Mental Health, said,

"We're basically at the stage of putting all that info together into recommendations," she said.

"It is now up to our committees to use all of this community input and use it as part of their deliberations to develop those recommendations."

May Farr, a San Bernardino County mental-health commissioner, said she has heard that people are concerned the county isn't putting forth much of an effort, but said that wasn't true.

See SERVICES / Page A4
Please take a moment to answer the questions below. Although your participation in this survey is optional, your responses will assist San Bernardino County in determining how we can best meet the needs of the community using the funds of the MHS A. Surveys may be submitted anonymously or, if you prefer, you may include your name and contact information.

1. Your involvement with mental health services: (please check only one of the boxes below)
   - Consumer
   - Family member
   - Guardian or foster parent
   - School staff or employee
   - DBH staff or employee
   - Contract agency staff or employee
   - Network provider
   - Other

2. If you represent an agency or organization, please tell us which one, and describe your role or position:

   Agency Name

   Role/Position

3. The area of the county with which you are most involved or concerned:
   - San Bernardino City area
   - West Valley (Ontario, Upland, etc)
   - Central Valley (Rialto, Redlands, etc)
   - High Desert area
   - Other

4. Your gender
   - Male
   - Female

5. Your age
   - Under 15
   - 15 to 20
   - 21 to 25
   - 26 to 35
   - 36 to 55
   - 56 to 65
   - Over 65

6. The ethnic or cultural group with which you most closely identify: (please check only one)
   - Asian-American
   - African-American
   - Native-American
   - Hispanic or Latino
   - European-American
   - Other

7. Your primary/preferred language:
   - English
   - Spanish
   - Vietnamese
   - Other

Contact information (Optional)

Date Completed

For Office Use

SBC-DBH Research and Evaluation, Rev D July 2005
Por favor responda las siguientes preguntas. A pesar de que su participación en esta encuesta es opcional, su participación en la encuesta ayudará al departamento de salud mental a determinar cómo podemos ayudarles con las necesidades de salud mental en su comunidad usando los fondos recibidos por la ley de servicios de salud mental. Esta encuesta puede completarse anónimamente, pero si usted prefiere puede incluir su nombre y información para contactarlo.

1. Su participación en los servicios de salud mental: ( marque solo una de las respuestas)
   - [ ] Recibe servicios de salud mental
   - [ ] Empleado de DBH
   - [ ] Empleado de una agencia de contrato
   - [ ] Empleado de DBH
   - [ ] Empleado de otra agencia en la comunidad
   - [ ] Otro

2. Si usted está representando otra agencia o organización, por favor digámos cuál, y describa su posición o trabajo que tiene:

   Nombre de la Agencia

   Posición/Trabajo

3. Cuál es el área del condado que usted tiene más conocimiento o más preocupación:
   - [ ] Ciudad de San Bernardino
   - [ ] Región del Oeste (Ontario, Upland, etc)
   - [ ] Área de los montes antaños
   - [ ] Región Central (Rialto, Redlands, etc)
   - [ ] Área del desierto
   - [ ] Otras

4. Su Sexo
   - [ ] Masculino
   - [ ] Femenino

5. Su edad
   - [ ] Menor de 15
   - [ ] 15 a 20
   - [ ] 21 a 25
   - [ ] 26 a 35
   - [ ] 36 a 55
   - [ ] Más de 65

6. El grupo étnico o cultural con el cual usted se identifica: ( marque solo uno)
   - [ ] Asiático-Amerindio
   - [ ] Nativo-Amerindio
   - [ ] European-American
   - [ ] otro

7. Su lenguaje nativo de preferencia:
   - [ ] Inglés
   - [ ] Español
   - [ ] Otro

Información para contacto (Opcional)

Fecha

Para uso de la oficina

SBC-DBH Research and Evaluation, Rev. D 2005
MENTAL HEALTH SERVICES ACT (MHSA)

Overview
The Mental Health Services Act (MHSA) is a law that took effect January 1, 2005. It was voted in by California voters in November 2004 via Proposition 63, and intends to expand mental health services for children and adults, using programs proven to be effective.

Prop 63 is funded by a 1% tax surcharge on personal income over $1 million per year.

Introduction
For years, mental health services for children and adults in California have been grossly underfunded. People who suffer from mental illness were released from state hospitals 35 years ago, but funds to provide community mental health services never reached the community, resulting in increased suffering, homelessness and incarceration, repeat hospitalization and unemployment.

The MHSA will generate approximately $800 million dollars per year statewide, with each county receiving funds to deliver services to the extent that they demonstrate significant unmet need for services and the capability to deliver the services.

Use of MHSA funds
MHSA funds must be used to expand, not supplant, existing state or county mental health services. The components include:

- Community Program Planning
- Community Services and Supports (System of Care Services) for:
  - Children
  - Youth, Including Transition Age (Ages 16 – 25)
  - Adults
  - Older Adults (Over 60)
- Capital Improvements and Technology
- Education and Training Programs
- Prevention and Early Intervention Programs
- Innovative Programs

Additional requirements
The MHSA also requires that 5% of the funds for children’s system of care, adult and older adult systems of care, and prevention and early intervention be used for innovative programs. Innovative programs include:

- Services that increase access for underserved groups.
- Increase in the quality/positive outcomes of services.
- Promotion of interagency collaboration.

Continued on next page
Phase one

Counties are currently involved in the first phase of the MHSA, the Community Program Planning. This involves extensive training and gathering of stakeholder input through public hearings, and meaningful response to comments from families and consumers, prior to developing and submitting the county’s Community Services and Supports (CSS) plan.

The CSS requirements were released by the State DMH in August, 2005 after extensive stakeholder reviews and input.

MHSA text

For full text of the MHSA, please visit the State DMH website: http://www.dmh.cahwnet.gov/

For more information about San Bernardino County MHSA Activities visit the San Bernardino County DBH Web page: http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
LEY DE SERVICIOS DE SALUD MENTAL (PROPOSICIÓN 63)

Resumen
La ley de Servicios de Salud mental (Proposición 63) es la ley que entro en efecto el 1ro de Enero del 2005. Los votantes de California votaron por esta ley en Noviembre 2004, y su propósito es aumentar los servicios para los niños y adultos, usando programas que se han probado ser efectivos.

Introducción
Por muchos años los servicios de salud mental para los niños y adultos en California no han tenido suficientes fondos. Las personas con problemas de salud mental en los hospitales del estado fueron integradas en la comunidad, hace 35 años, pero los fondos para los servicios de salud mental nunca llegaron a la comunidad, resultando en aumento del sufrimiento, falta de vivienda, encarcelamiento, hospitalizaciones repetidas, y desempleo. La ley de servicios de salud mental va a generar aproximadamente $800 millones de dólares cada año en todo el estado de California, y cada condado recibirá fondos para que ofrezcan servicios a las comunidades que no están recibiendo servicios y que tengan la capacidad de proveer esos servicios.

Uso de los Fondos
Los fondos de la Ley de Servicios de Salud Mental deben ser usados para expandir y no contribuir a servicios de salud mental en existencia. Los componentes incluye:
- Planeamiento de los programas con la comunidad.
- Servicios en la comunidad y de apoyo para:
  - Niños
  - Jóvenes, incluyendo la edad de transición (edad 16-25)
  - Adultos
  - Personas de edad avanzada/ ancianos
- Mejoramiento de las clínicas y su tecnología
- Programas de educación y entrenamiento
- Programas de prevención e intervención primaria
- Programas innovadores.

Requisitos Adicionales
La ley de Salud Mental requiere que el 5% de los fondos para los programas de los niños, adultos y personas de edad avanzada, y de prevención e intervención temprana, sean usados para programas innovadores. Los programas innovadores incluye:
- Servicios para mejorar el acceso de los grupos que no están recibiendo servicios.
- Aumentar la calidad/ resultados positivos de los servicios
- Promover la colaboración entre las agencias.

Continued on next page
Primera Fase

Los condados están actualmente en la primera fase de planeamiento de la Ley de Servicios De Salud Mental. Esto requiere entrenamiento extensivo y colección de las opiniones de las agencias en la comunidad a través de las pláticas comunitarias, respuestas y comentarios de las familias y consumidores de los servicios, antes de desarrollar y someter a evaluación el plan.

Los requisitos para completar el plan fueron publicados por el departamento de Salud Mental del estado en Agosto del 2005 después de una intensa revisión y recomendaciones de la comunidad.

Documentos Relacionado Con el esta ley

Para obtener una información completa de esta ley, puede obtener los documentos en la página de Internet del estado:
http://www.dmh.iahwet.gov/

Para mas información acerca de las actividades que se están llevando acabo en el condado de San Bernardino puede entrar a la pagina del Internet:
http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
There are several ways to get involved and to be a part of our county’s MHSA effort!

- Check our Website for updates
- Send your suggestions via e-mail (See our MHSA website)
- Monitor the State DMH MHSA Web Site for the latest updates
- Join an Age-Specific MHSA Workgroup or Advisory Sub-Committee
- Attend DBH Stakeholder Meetings
- Attend a MHSA Focus Group
- Host a MHSA Focus Group

Phone: (909) 873-4486
www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm

COME OUT AND BE A PART OF TRANSFORMING YOUR COMMUNITY’S MENTAL HEALTH SERVICES.
Voters in California passed Proposition 63 in the November 2004 general election. This proposition became law in January 2005 and is called the Mental Health Services Act (MHSA).

This law imposes an additional tax of 1% on the portion of an individual taxpayer’s taxable income that is over $1 million. It is expected that the funds raised through this tax may be as high as $800 million in California each year. California counties will submit funding proposals in order to receive portions of these monies for expansion of mental health services for children and adults, using programs proven to be effective.

The MHSA provides funding for six broad components of new or expanded services and supports, to be funded and implemented over a period of five years.

These components include:
1. Community Program Planning
2. Community Services & Supports for
   • Children
   • Youth, including Transitional Age Youth (ages 16-25)
   • Adults
   • Older Adults
3. Capital Improvements & Technology
4. Education & Training Programs
5. Prevention & Early Intervention
6. Innovative Programs

MHSA funding is intended to assist counties (1) to decrease the negative impact on individuals/families and on state and local budgets from untreated mental illness, (2) enhance and expand innovative, culturally competent and successful California programs for children, adults, and elders, and (3) assure that funds are utilized cost effectively and that services and supports are provided consistent with “best practices” and subject to local and state oversight and accountability.

San Bernardino County is currently involved in the first phase of the MHSA, a comprehensive community-based program planning process. This involves extensive input and participation from stakeholders, including consumers, their families, interagency partners, community organizations, and community members, We will have an opportunity to submit a funding proposal for Community Services & Supports in Fall, 2005.
Hay varias formas de participar y ser parte del proceso de planeamiento para MHSA!

- Revise nuestra página del Internet para la información más reciente.
- Mande sugerencias por el correo electrónico (vea nuestra página de Internet)
- Revise la página de Internet del estado de California, departamento de salud mental
- Hágase parte de un grupo de trabajo o un sub.-comité
- Atienda reuniones del departa-

Hágase parte de la transformación de los servicios de salud mental en su comunidad.

Condado de San-Bernardino
Departamento de Salud Mental Y Comportamiento

La ley de Servicios de Salud Mental (Proposición 63) (MHSA)

850 E. Foothill Blvd
Rialto, CA 92376

Para más información llame: (909) 873-4486

Teléfono: (909) 873-4486
www.san-bernardino.ca.us/dbh/
Mental_Health_Services_Act.htm
Los votantes de California pasaron la proposición 63 en las elecciones generales de Noviembre 2004. Esta proposición se convirtió en ley en enero del 2005 y se le llama ley de servicios de salud mental (MHSA).

Esta ley impone un impuesto adicional del 1% a los individuos que tienen un ingreso de más de $1 millón. Estos fondos van a ser de hasta de $800 millones en California cada año. Cada condado de California debe entregar una propuesta de financiamiento para que puedan recibir una porción de esos fondos para expandir los servicios de salud mental para los niños y adultos, usando programas que demuestren ser efectivos.

La ley de servicios de salud mental (MHSA) provee fondos para seis componentes generales de un nuevo o programa de expansión, y apoyo que se implementado por un periodo de cinco años.

Estos componentes incluyen:

1. Programas de planeamiento con la comunidad
2. Servicios comunitarios y de apoyo para:
   - niños
   - Jóvenes, incluyendo jóvenes en edad de transición (edad de 16-25)
   - Adultos
   - Adultos de la tercera edad / edad avanzada
3. Mejoramiento de locales y tecnología
4. Programas de educación y entrenamiento
5. Programas de prevención e intervención temprana
6. Programas innovadores

Los fondos para MHSA son con la intención de asistir a los condados (1) disminuir el impacto en el individuo, las familias, y /o los presupuestos locales, de las enfermedades mentales sin tratamiento; (2) Mejorar y expandir programas que son culturalmente competentes y efectivos para niños, jóvenes, adultos y personas de la tercera edad/edad avanzada; y (3) asegurarse que los fondos sean utilizados efectivamente y que los servicios y apoyos son proveídos de acuerdo con las “mejores practicas” y sometidos a revisión y responsabilidad local y del estado.

El condado de San Bernardino está actualmente en la primera fase del planeamiento, desarrollando un proceso de planeamiento basado en la comunidad y con la comunidad. Esto requiere sugerencias y participación de todas las agencias de la comunidad, incluyendo los consumidores y sus familias, agencias colaboradoras y miembros de la comunidad en general. Estamos entregando una propuesta para recibir fondos en el Otoño del 2005.

Hágase parte de la transformación de los servicios de salud mental en su comunidad.

Teléfono: (909) 873-4486
August 1, 2005

To: All Contract Agency Providers

From: Elizabeth Longfellow, Office Assistant III & Cynthia Waldron, Office Assistant III
Department of Behavioral Health

Subject: Mental Health Services Act (MHSA)

We would appreciate your assistance in promoting the upcoming Public Forums/Community Conversations regarding the MHSA process to be held on August 9, 2005 in Victorville*and on August 15, 2005 in Rialto*

Please display and/or distribute the flyers to consumers, community members and other partnering agencies.

Encourage everyone to participate and let them know this is how they can get involved in shaping the future of mental health services in their community!

*SPANISH INTERPRETATION SERVICES AVAILABLE

For additional information:
Phone: 909-873-4486 or 909-421-9372
Or visit our website:
http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
Thank you for agreeing to participate in the Community Focus Group Facilitator Training.

What/Why: Participants will be trained to conduct meetings throughout the community during which all interested parties will be invited and encouraged to provide feedback and recommendations for the design and delivery of effective mental health services in San Bernardino County.

- Participants will work with the trainers to develop appropriate structure and format for community focus groups.
- Specific methods for conducting the focus groups will be developed, and training will be provided in accordance with the established method.
- These individuals will be trained on MHSA and how to make focus groups relevant to the planning process.

Registration information will be sent soon.

When: August 15th, 16th and 17th, 2005
8:30 a.m. to 4:30 p.m

LUNCH & REFRESHMENTS WILL BE PROVIDED

Where: TEAM House
201 W. Mill Street
San Bernardino, CA 92408

Contact: For additional information please call: (909) 873-4486 or (909) 421-9372
To: Rene DaMetz  
850 E. Foothill Blvd.  
Rialto, CA 92376

Thank you for agreeing to participate in the Community Focus Group Facilitator Training.

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Where: TEAM House  
201 W. Mill Street  
San Bernardino, CA 92408

Contact: For additional information please call: (909) 873-4486 or (909) 421-9372
All Workgroup Members

**SAVE THE DATE**

**OCTOBER 25, 2005**

What: **MANDATORY** - Follow-up Technical Assistance Session

Why: It will be the final opportunity to provide the age-specific workgroups technical assistance to ensure their proposals are ready for integration into the county’s CSS proposal.

When: October 25, 2005

9:00 a.m. – 4:00 p.m.

**LOCATION AND REGISTRATION INFORMATION TO BE ANNOUNCED.**

For more information call 909-387-7712 or 909-387-7708
Your Voice Matters!

You are invited to participate in a public forum to discuss priority stakeholder concerns of community mental health issues and to provide suggestions for services and system enhancements to the San Bernardino Co. Mental Health Services Act (MHSA) Planning Committee.

Community Conversation

In November 2004 California voters passed a law to provide funding to expand mental health services in the community. These funds are to be used to address the biggest concerns in our community related to people suffering from untreated mental health problems. We are asking community members what they see as the most important mental health needs for youth, adults and seniors in San Bernardino County, and what services they think are most needed to address those needs.

Attend the Conversation and share your ideas and comments!

Date: Monday, August 15, 2005
Time: 7:00 p.m. to 9:00 p.m.
Location: Behavioral Health Resource Center
850 E. Foothill Blvd.
Rialto, CA 92376
Spanish Interpretation Services Available

For additional information:
Phone: 909-873-4486 or 909-421-9372
Or visit our website:
www.co.san-bernardino.ca.us/Mental_Health_Services_Act.htm
La Ley de Servicios de Salud Mental (Proposición 63) 
Foro público en Rialto, 8-15-2005

Su participación es importante!

Lo estamos invitando al foro público para hablar de las prioridades relacionadas con la salud mental en la comunidad y para que haga sugerencias, al comité de planeamiento de la ley de salud mental, de cómo mejorar los servicios de salud mental en el condado de San Bernardino.

Platicas Comunitarias

En noviembre del 2004 los votantes de California pasaron la ley que provee fondos para expandir los servicios de salud mental en su comunidad. Estos fondos son para mejorar las necesidades más grandes en la comunidad relacionadas con las personas que sufren de enfermedades mentales y que no reciben servicios de tratamiento. Estamos preguntándole a usted, como miembro de la comunidad, qué considera son las necesidades de Salud mental más importantes para los niños, jóvenes, adultos y personas de edad avanzada en el condado de San Bernardino, y cuáles son los servicios que se necesitan para solucionar estas necesidades.

PARTICIPE Y COMPARTA SUS IDEAS!

Fecha: Lunes 15 de Agosto, 2005
Hora: 7:00 p.m. to 9:00 p.m.
Lugar: Behavioral Health Resource Center 
850 E. Foothill Blvd. 
Rialto, CA 92376

HAY SERVICIOS DE INTERPRETACION EN ESPAÑOL

Para más información:
Teléfono: 909-873-4486 o 909-421-9372
O visite la pagina del Internet:
www.co.san-bernardino.ca.us/Mental_Health_Services_Act.htm
IN November 2004 California voters passed a law to provide funding to expand mental health services in the community. These funds are to be used to address the biggest concerns in our community related to people suffering from untreated mental health problems. We are asking community members what they see as the most important mental health needs for youth, adults and seniors in San Bernardino County, and what services they think are most needed to address those needs.

**ATTEND THE CONVERSATION AND SHARE YOUR IDEAS AND COMMENTS!**

**Date:** Tuesday, August 9, 2005  
**Time:** 6:00 p.m. to 8:00 p.m.  
**Location:** Victorville PERC  
17270 Bear Valley Rd. Suite107  
Victorville, CA 92392  
**Spanish Interpretation Services Available**

For additional information:  
Phone: 909-873-4486 or 909-421-9372  
Or visit our website:  
www.co.san-bernardino.ca.us/Mental_Health_Services_Act.htm
Lo estamos invitando al foro público para hablar de las prioridades relacionadas con la salud mental en la comunidad y para que haga sugerencias, al comité de planeamiento de la ley de salud mental, de cómo mejorar los servicios de salud mental en el condado de San Bernardino.

**Platicas Comunitarias**

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**Participe y compartá sus ideas!**

**Fecha**: Martes 9 de Agosto, 2005  
**Hora**: 6:00 p.m. to 8:00 p.m.  
**Lugar**: Victorville PERC  
17270 Bear Valley Rd. Suite107  
Victorville, CA 92392

**Hay servicios de interpretación en Español**

Para más información:  
Teléfono: 909-873-4486 o 909-421-9372  
O visite la pagina del Internet:  
www.co.san-bernardino.ca.us/Mental_Health_Services_Act.htm
## Community Focus Group Protocol & Checklist

<table>
<thead>
<tr>
<th>Activity</th>
<th>Instructions</th>
<th>Responsible Individual</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCHEDULING &amp; REGISTERING YOUR COMMUNITY FOCUS GROUP/PRIOR TO THE MEETING (Registration)</strong></td>
<td>Contact the DBH MHSA Coordinating Committee to REGISTER YOUR COMMUNITY FOCUS GROUP WITH: Liz Longfellow 909-387-7712 or Cindy Waldron 909-387-7708 or Gwen Morse 909-873-4476. You will be asked for: 1. The date of the community focus group 2. The location of the community focus group 3. The agency/targeted group for which the group will be conducted. You will then be assigned a GROUP NUMBER (for tracking purposes). Please put that tracking number ON THE SIGN IN ROSTER (Second entry, top line)</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>WELCOME SIGN</strong></td>
<td>Optional (hang sign at entrance to event) Hang a sign on door of meeting room (if needed).</td>
<td>Facilitator/Co-Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>SIGN IN ROSTER</strong></td>
<td>Start roster around table with pen, asking participants to complete all items (PRINT) and to pass it around the table. As attendees arrive, ensure that they are asked to sign.</td>
<td>Facilitator/Co-Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>Demographic Collection Data Tool</strong></td>
<td>Distribute salmon-colored data collection tool to all attendees and request they complete and leave the form at their seat or in a pre-designated location at the meeting prior to leaving the community focus group session. Attendees who have already completed this form at another time need not complete another one.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
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<tr>
<td>DISTRIBUTE THE INFORMATION PACKETS</td>
<td>(1) Distribute MHSA summary to orient all participants, acknowledging that some attendees may be work group members or may have attended a MHSA Public Forum already and may be familiar with the MHSA. (2) Encourage attendees to review the demographic overview brochure due to its importance in our effort to transform/design the MH system around careful study of the county’s varied regional/ demographic issues. Point out some of the issues that you find interesting or ask if participants notice any issues deserving special attention. (3) Turn to the brochure and review the variety of MHSA activities that are in progress or planned and invite participation in workgroups/sub-committees and several stakeholder forums.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>Information Packet Contents:</td>
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<tr>
<td>(1) MHSA Summary</td>
<td></td>
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<tr>
<td>(2) Summary of County’s Regional – Demographic Characteristics, with some graphic illustrations</td>
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<tr>
<td>(3) Brochure/flyer outlining opportunities for participation and contact information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DESCRIBE THE FOCUS GROUP DISCUSSION PROCESS</td>
<td>SUGGESTED SCRIPT: “Today, we’d like to hear from you. What we’d like to do is to put several structured questions on the table and have a discussion of each one. We hope to touch on issues related to access to services issues, types of services, and the impact of mental illness from your perspectives. We’d like to take one question at a time, letting each of you take a couple of minutes to respond. (Insert name of note taker) will be jotting down on the flip chart, as accurately as possible, your main comments. We want you to check the accuracy of the notes as we go.”</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>DESCRIBE THE FEEDBACK GATHERING PROCESS</td>
<td>SUGGESTED SCRIPT: “Once you have all had a chance to respond and discuss these issues with us, we’ll have a pile of flip chart notes. We will be transcribing those notes and reporting your input to the MHSA work groups as they continue their effort to evaluate needs and formulate initial plans for new services/supports.”</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
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<tr>
<td><strong>DISTRIBUTE THE COMMUNITY FOCUS GROUP QUESTIONS</strong></td>
<td>Allow 2 minutes for distribution and review of discussion questions. <strong>NOTE:</strong> Distribute the Community Focus Group Questions page (containing the discussion questions) for participants to review.</td>
<td>Facilitator/Co-Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>CAPTURE THE RESPONSES (NOTE TAKING)</strong></td>
<td>Use flip chart to capture the responses – be sure to annotate responses by question #.</td>
<td>Clerical support, co-facilitator or facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>STARTING THE SESSION:</strong></td>
<td><strong>SUGGESTED SCRIPT:</strong> Let’s start with the first question: “ (read your first question and let discussion ensue!) <strong>NOTE:</strong> Begin with the first two questions and proceed through all questions. If time DOES NOT PERMIT, select the 3 most relevant questions for your community focus group participants.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>CAPTURE ALL PARTICIPANT FEEDBACK</strong></td>
<td><strong>SUGGESTED QUESTION:</strong> Is there anything you would like to add or recommend? Try to get 100% participation from participants at some point through the discussion. <strong>Note:</strong> Capture all input/ideas/responses and invite recommendations for each question.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>MEETING CLOSURE (HOUSEKEEPING ISSUES - ATTENDANCE ROSTER &amp; DEMOGRAPHIC DATA COLLECTION TOOLS)</strong></td>
<td>Remind participants to sign attendance roster if they were not able at the beginning of the session. Collect the attendance roster(s) and review for completeness and legibility. Collect the Demographic Data Collection Tools (Salmon forms) and review for completeness and legibility. (Return both with Meeting Minutes)</td>
<td>Facilitator/Co-Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>CONCLUDING THE SESSION:</strong></td>
<td><strong>THANK ALL PARTICIPANTS</strong> for their participation and encourage them to continue their involvement in the MHSA Community Focus Group process and their willingness to provide their input in this process.</td>
<td>Facilitator</td>
<td></td>
</tr>
</tbody>
</table>
### AFTER THE MEETING

(Converting the notes taken at the focused forum)

Please accomplish your minutes document in **MICROSOFT WORD or longhand**, using the attached **Community Focus Group Form Minutes Format** (See page 5) to consolidate the information gathered from your community focus group. Be sure to reference the question number with the responses. Please forward the document by one of these methods:

1. Email the document to (preferred method): elongfellow@dbh.sbcounty.gov
2. County interoffice mail: hard copy Liz Longfellow (mail code 0928)
3. US Mail: 820 E. Gilbert St., San Bernardino, CA 92415
   
   **Attention: ELIZABETH LONGFELLOW**

**NOTE:** Please forward your meeting summaries to DBH within 5 days of the completion of the community focus group session.

### SUPPLIES SUGGESTED

- flip chart, masking tape (just in case), markers,
- Demographic Data Collection tool, sign in rosters & participant packages.

**OPTIONAL:** bottled water or coffee/condiments, pens for sign-in sheet (just in case)

| Facilitator/Co-Facilitator |  |  |
Minutes – Community Focus Group

Select at least one question from each category, gearing each question to the interests of the focus group. If time is limited, not all categories must be discussed. Select areas of highest interest to the audience.

<table>
<thead>
<tr>
<th>Question #</th>
<th>Discussion</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 ACCESS:</td>
<td>What are your suggestions for making it easier for individuals and their families to find Mental Health services?</td>
<td>Have you or your family members had problems trying to find or obtain mental health services?</td>
</tr>
<tr>
<td>#2 CLIENT/FAMILY-DRIVEN SERVICES:</td>
<td>In your experience with mental health services, what level of involvement have you had in the development of your treatment or service plans or those of your family member?</td>
<td>In what ways have your treatment or service plans reflected your own goals, your family’s goals, your strengths, beliefs, needs or cultural identity?</td>
</tr>
<tr>
<td></td>
<td>What do you think client &amp; family involvement should include?</td>
<td></td>
</tr>
<tr>
<td>Question #</td>
<td>Discussion</td>
<td>Recommendations</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td><strong>#3 OUTCOMES &amp; ACCOUNTABILITY:</strong> Can you suggest some ways to determine or the ways you can tell if Mental Health Services are effective?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>#4 EFFECTIVE SERVICES: SERVICE INTEGRATION, RECOVERY AND RESILIENCE:</strong> What mental health services and supports would you find most helpful to you, your family member or your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What mental health services and supports would be most helpful to you as a family member of an adult?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What mental health services and supports would be most helpful to you and your child and his or her family?</td>
<td></td>
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<td>------------</td>
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</tr>
<tr>
<td><strong>#5 SERVICE INTEGRATION:</strong></td>
<td>What are some of the ways that mental health staff could work with you to help you achieve your goals? Your child’s goals? Your family member’s goals?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who are the critical people or agencies that should work together to help you or your family member succeed in your goals? Why are these people or agencies so important?</td>
<td></td>
</tr>
<tr>
<td><strong># 6 CULTURAL COMPETENCE:</strong></td>
<td>Do you have suggestions about how mental health services could be more sensitive and responsive to clients’ age, gender, language, beliefs, ethnic and cultural background?</td>
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<tr>
<th>Actividad</th>
<th>Instrucciones</th>
<th>Individual Responsable</th>
<th>Completado</th>
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<tbody>
<tr>
<td><strong>ORGANIZANDO &amp; REGISTRANDO SU GRUPO EN LA COMUNIDAD / ANTES DE LA REUNION (Registración)</strong></td>
<td>Comuníquese con la Comité de Coordinación del DBH MHSA para <strong>REGISTRAR SU GRUPO EN LA COMUNIDAD</strong> con: Liz Longfellow 909-387-7712 o Cindy Waldron 909-387-7708 o Gwen Morse 909-873-4476. <strong>A usted le pedirán:</strong> 3. La fecha del Grupo en la Comunidad 4. El lugar donde tendrá lugar el Grupo en la Comunidad 5. La agencia/ o nombre del grupo con quien será realizado. Usted entonces será asignado un NUMERO DE GRUPO (para propósitos de documentación). <strong>Por favor ponga el número del grupo EN LA LISTA DE REGISTRO DE LOS PARTICIPANTES</strong> (la segunda entrada, en la primera línea)</td>
<td>Facilitador</td>
<td></td>
</tr>
<tr>
<td><strong>LETRERO DE BIENVENIDA</strong></td>
<td>Opcional( Cuelgue un letrero de bienvenida en la puerta de entrada al evento (Señales de cómo llegar al salón de reunión, si es necesario)</td>
<td>Facilitador/ Co-Facilitador</td>
<td></td>
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<tr>
<td><strong>LISTA DE FIRMAS DE LOS PRESENTES</strong></td>
<td>Empiece una lista, con pluma alrededor de mesa, pidiendo que los participantes completen toda la información (<strong>LETRA DE IMPRENTA</strong>) y que lo pasen alrededor de la mesa. Cuando llegan más participantes, aseguren de pedir que ellos firmen la lista de registro.</td>
<td>Facilitador/ Co-Facilitador</td>
<td></td>
</tr>
<tr>
<td><strong>Instrumentos para Colectar Datos Demográficos</strong></td>
<td>Distribuya instrumentos de colección de datos, de color salmón, a todos los asistentes y pida que ellos completen y dejen la forma en su asiento o en una área designada antes de salir de la sesión del Grupo. Los participantes que ya han completado esta forma en el pasado no tienen que completar otra.</td>
<td>Facilitador/ Co-Facilitador</td>
<td></td>
</tr>
<tr>
<td><strong>DISTRIBUYA LOS PAQUETES DE INFORMACION</strong></td>
<td><strong>Los Paquetes de Información Contienen:</strong> (1) Distribuya el resumen de MHSA para orientar a todos los participantes, reconociendo que algunos asistentes pueden ser miembros de grupo de trabajo o pueden haber asistido al entrenamiento de MHSA y están familiarizados con la información. (2) Revise la información demográfica con los asistentes debido a la importancia en nuestro esfuerzo a transformar / diseñar el sistema de Salud Mental de estar basados en un estudio cuidadoso del condado con sus variaciones regionales y demográficas. Indique algunos de los aspectos que usted encuentra interesante o pregunta si los participantes encuentran cualquier aspecto que merece atención especial. (3) Revise el folleto y la variedad de actividades de MHSA que están en progreso o en planeamiento e invite a la participación en el grupo de trabajo/ sub-comités y varios foros públicos.</td>
<td>Facilitador</td>
<td></td>
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<tr>
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<tr>
<td>DESCRIBA EL PROCESO DE DISCUSION DEL GRUPO.</td>
<td><strong>Recomendación de cómo empezar la discusión:</strong> “Hoy, queremos oír de usted. Lo que nosotros queremos hacer es hacer varias preguntas y tener una discusión de cada pregunta. Esperamos hablar de asuntos relatados al acceso al servicio, tipos de servicios, y la perspectiva de usted sobre el impacto de la enfermedad mental. Queremos tomar una pregunta a la vez, permitiendo unos cuantos minutos a cada uno de ustedes para responder. (Diga el nombre de la persona que tomará las notas) estará apuntando, lo más correcto posible, sus comentarios principales. Queremos que usted verifique la certeza de las notas en la medida en que se escriben en el papel”</td>
<td>Facilitador</td>
<td></td>
</tr>
<tr>
<td>DESCRIBA EL PROCESO DE COLECCIÓN DE RECOMENDACIONES</td>
<td><strong>Recomendaciones de cómo describir el proceso de colección de recomendaciones:</strong> “Una vez que ustedes han tenido una oportunidad de responder y discutir las preguntas, nosotros tendremos las notas. Estaremos transcribiendo esas notas y reportando su opinión a los grupos del trabajo de MHSA. Esta información les permitirá a los grupos de trabajo continuar el esfuerzo de evaluar las necesidades y formular los planes iniciales para servicios / apoyos nuevos.” <strong>NOTAS:</strong> Describa el proceso de la colección de las recomendaciones, incluyendo explicación de cómo la opinión se envía y es utilizada por el grupo de trabajo del Condado MHSA y el grupo de líderes de MHSA por medio de foros y comunicaciones subsiguientes.</td>
<td>Facilitador</td>
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<tr>
<td>DISTRIBUIR LAS PREGUNTAS PARA LA DISCUSIÓN EN GRUPO</td>
<td>Distribuye la pagina con las Preguntas para el Grupo (conteniendo las preguntas de la discusión) para que los participantes lo revisen.</td>
<td>Facilitador/ Co-Facilitador</td>
<td></td>
</tr>
<tr>
<td>CAPTURE LAS RESPUESTAS (TOMANDO NOTAS)</td>
<td>Utilice tableta de papel grande para escribir las respuestas – asegurase de anotar las respuestas bajo el número de la pregunta.</td>
<td>Persona asignada a tomar notas, co-facilitador o facilitador</td>
<td></td>
</tr>
<tr>
<td>EMPEZAR LA SESION:</td>
<td>Recomendaciones para empezar la sesión: Comience con la primera pregunta: “ (¡lea su primera pregunta y permita que la discusión se desarrolle!) NOTA: Empieza con las primeras dos preguntas y avance por todas las preguntas. Si el tiempo NO PERMITE, escoja las 3 preguntas más pertinentes para sus participantes.</td>
<td>Facilitador</td>
<td></td>
</tr>
<tr>
<td>CAPTURE TODAS LOS COMENTARIOS DE LOS PARTICIPANTES</td>
<td>Recomendaciones de cómo preguntar y solicitar participación: ¿Hay algo que usted quisiera agregar o recomendar? Trate de recibir 100% de participación de todos los participantes en algún punto en la discusión. Nota: Reciba todas las sugerencias/ ideas/ respuestas y solicite las recomendaciones para cada pregunta.</td>
<td>Facilitador</td>
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</tr>
<tr>
<td>CONCLUYENDO LA REUNION (ASUNTOS DE IMPORTANCIA - LISTA DE TODOS LOS PARTICIPANTES &amp; INSTRUMENTOS DE COLECTAR PARA DATOS DEMOGRAFICA)</td>
<td>Recuerde a los participantes que firmen la lista de asistencia si ellos no lo han hecho en el principio de la sesión. Recoja la lista (listas) de asistencia y revise que este completo y legible. Recoja los Instrumentos de Colección para Datos Demográficos (la hoja de color Salmón) revise que este completo y legible.</td>
<td>Facilitador/ Co-Facilitador</td>
<td></td>
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<tr>
<td>TERMINANDO LA SESION:</td>
<td>AGRADEZCA A TODOS LOS PARTICIPANTES por su participación y animelos a continuar su participación en el proceso del Grupos en la Comunidad de MHSA, y por su consentimiento para proveer su opinión en este proceso.</td>
<td>Facilitador</td>
<td></td>
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</tbody>
</table>
### DESPUES DE LA REUNION

(Convirtiendo las notas tomadas en los foros dirigidos)

Por favor complete sus notas en un documento de **MICROSOFT WORD** usando el estilo de la Forma del Grupo Enfocado a la Comunidad (vea pagina 5) para consolidar la información que colectó de su foro dirigido. Asegúrese que mencione el número de la pregunta con las respuestas. Por favor entregue el documento por uno de los siguientes métodos:

1. Mande el documento por e-mail (**la manera preferida**): elongfellow@dbh.sbcounty.gov
2. Por correo entre oficinas del condado: envíe una copia impresa a Liz Longfellow (**código de correo: 0928**)
3. Correo de Estados Unidos: 820 E. Gilbert, San Bernardino, CA 92415 Attention: ELIZABETH LONGFELLOW

**NOTA:** Por favor envié sus resúmenes de la reunión a DBH dentro de 5 días de la terminación de la sesión dirigida del foro.

### MATERIALES NECESITADOS:
Tableta de papel grande, cinta adhesiva (por si acaso), marcadores, herramienta para Colectar Datos Demográficos, lista de firma de los presentes & paquetes para los participantes.
**OPCIONAL:** agua embotellada o café / refrescos, lapicero para firmar la lista de los presentes (por si acaso)

<table>
<thead>
<tr>
<th>Facilitador/Co-Facilitador</th>
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Notas – Grupo Enfocado en la Comunidad

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<th>Fecha:</th>
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<tr>
<td>Lugar:</td>
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<tr>
<td>Nombre del Facilitador:</td>
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<tr>
<td>Nombre de la persona que toma las notas:</td>
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</table>

Escoja por lo menos una pregunta de cada categoría, enfocando cada pregunta a los intereses del grupo. Si el tiempo es limitado, no tienen que hablar de todas las categorías. Escoja las áreas de más interés a la audiencia.

<table>
<thead>
<tr>
<th>Número de Pregunta</th>
<th>Discusión</th>
<th>Recomendaciones</th>
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<tbody>
<tr>
<td><strong>#1 ACCESO:</strong></td>
<td></td>
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<tr>
<td>• ¿Cuáles son sus recomendaciones para hacer que las personas y sus familias encuentren los servicios de salud mental fácilmente?</td>
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<tr>
<td>• ¿Ha tenido usted, o un miembro de su familia problemas para encontrar y obtener servicios de Salud Mental?</td>
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<tr>
<td><strong>#2 Participación del los Clientes y / o la familia</strong></td>
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<tr>
<td>• En su experiencia con servicios de salud mental, ¿qué nivel de participación ha tenido usted o su familia en el desarrollo del tratamiento o planes de servicios?</td>
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<tr>
<td>• ¿En qué forma el plan de tratamiento ha reflejado sus propias metas, o planes de servicios, las metas de sus familiares, tu fortaleza, creencias y valores, necesidades o identidades culturales?</td>
<td></td>
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<tr>
<td>• ¿Qué piensa usted se debe incluir para facilitar la participación del cliente y familia?</td>
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<tr>
<td>Número de Pregunta</td>
<td>Discusión</td>
<td>Recomendaciones</td>
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<tr>
<td><strong>#3 Medidas de Logros y Responsabilidades</strong></td>
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<tr>
<td>• ¿Puede usted sugerir algunas maneras para determinar si los servicios de salud mental son efectivos?</td>
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</table>

<p>| <strong>#4 Servicios Efectivos: Integración de Servicio, Recuperación</strong> | | |
| • ¿Cuáles servicios de salud mental y de apoyo usted encontraría de más ayuda para usted y su familia? | | |
| • ¿Cuáles servicios de salud mental y de apoyo encontraría de más ayuda para usted como familiar de un adulto con problemas de salud mental? | | |
| • ¿Cuáles son los servicios de salud mental y de apoyo que usted encontraría de más ayuda para usted, su niño y toda la familia? | | |</p>
<table>
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<th>Recomendaciones</th>
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</table>
| #5 Integración de Servicios | ¿Cuáles serían algunas formas en que los empleados de salud mental pudieran trabajar con usted para ayudarlo a que logre sus metas?, ¿Las metas de su niño(a)?, ¿Las metas de un miembro de su familia?  
¿Cuáles son las personas más importantes o agencias importantes que deben de estar trabajando juntas para ayudarlo a usted y su familia a lograr sus metas? ¿Porque estas personas o agencias son importantes? | |
| # 6 Competencia Cultural | ¿Tiene usted sugerencias en cómo los programas de salud mental pueden ser más sensítivos y que reconozcan la edad, el sexo, el lenguaje / idioma, el estilo de vida, identidad étnica y la cultura de las personas que reciben los servicios? | |
MENTAL HEALTH SERVICES ACT

TECHNICAL ASSISTANCE SESSION FOR CSS PROPOSAL DEVELOPMENT

****ATTENDANCE IS MANDATORY****

WHO: All MHSA workgroup members

WHAT: Technical Assistance Session For CSS Proposal Development

WHY: To provide technical assistance, update information, opportunities for networking and a hands on approach for all workgroup members regarding the CSS requirements and developing funding proposals.

WHEN: Tuesday, September 27, 2005
9am-4pm  Registration will begin at 8:30 am
Lunch and Morning/Afternoon Refreshments will be Provided

WHERE: San Bernardino Public Employees Association
433 North Sierra Way
San Bernardino, CA 92402

REGISTRATION INFORMATION: Class #17829
San Bernardino County employees will call (909) 388-4110 for automated registration.
Non-County employees will call (909) 388-4250 for registration assistance.

The automated registration information for PERC is as follows:

- To register call: (909) 388-4110 (7am – 9pm). You will be asked to enter your birth date and the last four (4) numbers of your employee number followed by the # key.
- Then you will be asked to enter the first three (3) letters of your last name, followed by the # key. Example if your birth date is January 1, 1975, Your employee number is A0000, and your last name is Smith, when asked, you will enter: 0101750000# and then when asked you will enter smi#.
- If you know the ID number of the class you want, you may press “1” and go directly to the class information.

CONTACT: For additional information please call Elizabeth Longfellow at (909) 387-7712 or Cynthia Waldron (909) 387-7708
<table>
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<tr>
<th>Activity</th>
<th>Instructions</th>
<th>Responsible Individual</th>
<th>Completed</th>
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<tbody>
<tr>
<td><strong>SCHEDULING &amp; REGISTERING YOUR DBH STAFF/CONTRACT AGENCY FOCUS GROUP/PRIOR TO THE MEETING (Registration)</strong></td>
<td>Contact the DBH MHSA Coordinating Committee to REGISTER YOUR DBH STAFF/CONTRACT AGENCY FOCUS GROUP WITH: Liz Longfellow 909-387-7712 or Cindy Waldron 909-387-7708. <strong>You will be asked for:</strong> 1. The date of the DBH Staff/Contract Agency focus group 2. The location of the focus group 3. The agency/targeted group for which the group will be conducted. You will then be assigned a GROUP NUMBER (for tracking purposes). <strong>Please put that tracking number ON THE SIGN IN ROSTER</strong> (Second entry, top line)</td>
<td>Clerical Support or Facilitator</td>
<td></td>
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<tr>
<td><strong>WELCOME SIGN</strong></td>
<td>Optional (hang sign at entrance to event) Hang a sign on door of meeting room (if needed).</td>
<td>Clerical Support</td>
<td></td>
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<tr>
<td><strong>SIGN IN ROSTER</strong></td>
<td>Start roster around table with pen, asking participants to complete all items (PRINT) and to pass it around the table. As attendees arrive, ensure that they are asked to sign.</td>
<td>Clerical Support / Facilitator</td>
<td></td>
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<tr>
<td><strong>Demographic Collection Data Tool</strong></td>
<td>Distribute salmon-colored data collection tool to all attendees and request they complete and leave the form at their seat or in a pre-designated location at the meeting prior to leaving the focus group session. Attendees who have already completed this form at another time need not complete another one.</td>
<td>Facilitator</td>
<td></td>
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<tr>
<td>Activity</td>
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</table>
| **DISTRIBUTE THE INFORMATION PACKETS**      | (1) Distribute MHSA summary to orient all participants, acknowledging that some attendees may be work group members or may have attended a MHSA Public Forum already and may be familiar with the MHSA  
(2) Encourage attendees to review the demographic overview brochure due to its importance in our effort to transform/design the MH system around careful study of the county’s varied regional/demographic issues. Point out some of the issues that you find interesting or ask if participants notice any issues deserving special attention.  
(3) Turn to the brochure and review the variety of MHSA activities that are in progress or planned and invite participation in workgroups/sub-committees and several stakeholder forums. | Facilitator             |           |
| **Information Packet Contents:**             | (1) MHSA Summary  
(2) Summary of County’s Regional – Demographic Characteristics, with some graphic illustrations  
(3) Brochure/flyer outlining opportunities for participation and contact information.                                                                                                                                                        |                         |           |
<p>| <strong>DESCRIBE THE FOCUS GROUP DISCUSSION PROCESS</strong> | <strong>SUGGESTED SCRIPT:</strong> “Today, we’d like to hear from you. What we’d like to do is to put several structured questions on the table and have a discussion of each one. We hope to touch on issues related to access to services issues, types of services, and the impact of mental illness from your perspectives. We’d like to take one question at a time, letting each of you take a couple of minutes to respond. (Insert name of note taker) will be jotting down on the flip chart, as accurately as possible, your main comments. We want you to check the accuracy of the notes as we go.” | Facilitator             |           |
| <strong>DESCRIBE THE FEEDBACK GATHERING PROCESS</strong>  | <strong>SUGGESTED SCRIPT:</strong> “Once you have all had a chance to respond and discuss these issues with us, we’ll have a pile of flip chart notes. We will be transcribing those notes and reporting your input to the MHSA work groups as they continue their effort to evaluate needs and formulate initial plans for new services/supports.” | Facilitator             |           |</p>
<table>
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<th>Completed</th>
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<tbody>
<tr>
<td><strong>DISTRIBUTE THE DBH STAFF/CONTRACT AGENCY FOCUS GROUP QUESTIONS</strong></td>
<td>Allow 2 minutes for distribution and review of discussion questions. <strong>NOTE:</strong> Distribute the DBH Staff/Contract Agency Focus Group Questions page (containing the discussion questions) for participants to review.</td>
<td>Facilitator or Clerical Support</td>
<td></td>
</tr>
<tr>
<td><strong>CAPTURE THE RESPONSES (NOTE TAKING)</strong></td>
<td>Use flip chart to capture the responses – be sure to annotate responses by question #.</td>
<td>Clerical support, co-facilitator or facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>STARTING THE SESSION:</strong></td>
<td><strong>SUGGESTED SCRIPT:</strong> Let’s start with the first question: “ (read your first question and let discussion ensue!) <strong>NOTE:</strong> Begin with the first two questions and proceed through all questions. If time DOES NOT PERMIT, select the 3 most relevant questions for your focus group participants.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>CAPTURE ALL PARTICIPANT FEEDBACK</strong></td>
<td><strong>SUGGESTED QUESTION:</strong> Is there anything you would like to add or recommend? Try to get 100% participation from participants at some point through the discussion. <strong>Note:</strong> Capture all input/ideas/responses and invite recommendations for each question.</td>
<td>Facilitator</td>
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<tr>
<td><strong>MEETING CLOSURE</strong> (HOUSEKEEPING ISSUES - ATTENDANCE ROSTER &amp; DEMOGRAPHIC DATA COLLECTION TOOLS)</td>
<td>Remind participants to <strong>sign attendance roster</strong> if they were not able at the beginning of the session. Collect the attendance roster(s) and <strong>review for completeness and legibility</strong>. Collect the Demographic Data Collection Tools (Salmon forms) and <strong>review for completeness and legibility</strong>. (Return both with Meeting Minutes)</td>
<td>Clerical Support or Facilitator</td>
<td></td>
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</table>
### CONCLUDING THE SESSION:

**THANK ALL PARTICIPANTS** for their participation and encourage them to continue their involvement in the MHSA DBH Staff/Contract Agency Focus Group process and their willingness to provide their input in this process.

**Facilitator**

### AFTER THE MEETING

(Converting the notes taken at the focus group)

Please accomplish your minutes document in **MICROSOFT WORD or longhand**, using the attached **DBH Staff/Contract Agency Focus Group Form Minutes Format** (See page 5) to consolidate the information gathered from your focus group. Be sure to reference the question number with the responses. Please forward the document by one of these methods:

1. Email the document to (preferred method): elongfellow@dbh.sbcounty.gov
2. County interoffice mail: hard copy Liz Longfellow (mail code 0928)
3. US Mail: 820 E. Gilbert St., San Bernardino, CA 92415
   
   **Attention: ELIZABETH LONGFELLOW**

**NOTE:** Please forward your meeting summaries to DBH within 5 days of the completion of the DBH Staff/Contract Agency focus group session.

**Clerical Support or Facilitator**

### SUPPLIES SUGGESTED:

flip chart, masking tape (just in case), markers, Demographic Data Collection tool, sign in rosters & participant packages.
Select at least one category, gearing discussion to the interests of the focus group. If time is limited, not all categories must be discussed. Select areas of highest interest to the audience.

<table>
<thead>
<tr>
<th>Question #</th>
<th>Discussion</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#1 ACCESS:</strong></td>
<td>What are your suggestions for making it easier for individuals and their families to find Mental Health services?</td>
<td></td>
</tr>
<tr>
<td><strong>#2 CLIENT/FAMILY-DRIVEN SERVICES:</strong></td>
<td>What do you think client &amp; family involvement should include?</td>
<td></td>
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<tr>
<td>Question #</td>
<td>Discussion</td>
<td>Recommendations</td>
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<tr>
<td>#3 OUTCOMES &amp; ACCOUNTABILITY:</td>
<td>Can you suggest some ways to determine or the ways you can tell if Mental Health Services are effective?</td>
<td></td>
</tr>
<tr>
<td>#4 EFFECTIVE SERVICES: SERVICE INTEGRATION, RECOVERY AND RESILIENCE:</td>
<td>What mental health services and supports would you recommend that would be most helpful to your clients served by your program?</td>
<td></td>
</tr>
<tr>
<td>Question #</td>
<td>Discussion</td>
<td>Recommendations</td>
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<tr>
<td><strong>#5 SERVICE INTEGRATION:</strong></td>
<td>What are some of the ways that you could work with person’s served to help achieve their goals?</td>
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<tr>
<td></td>
<td>Who are the critical people or agencies that should work together to help person’s served succeed in their goals? Why are these people or agencies so important?</td>
<td></td>
</tr>
<tr>
<td><strong># 6 CULTURAL COMPETENCE:</strong></td>
<td>Do you have suggestions about how mental health services could be more sensitive and responsive to clients’ age, gender, language, beliefs, ethnic and cultural background?</td>
<td></td>
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<td>Activity</td>
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</tbody>
</table>
| SCHEDULING & REGISTERING YOUR TARGETED FORUM/PRIOR | Contact the DBH MHSA Coordination Committee to REGISTER YOUR TARGETED FORUM WITH: Liz Longfellow 909-387-7712 or Cindy Waldron 909-387-7708 or Gwen Morse 909-873-4476.  
You will be asked for:  
1. The date of the targeted forum  
2. The location of the targeted forum  
3. The agency/targeted group for which the group will be conducted.  
You will then be assigned a GROUP NUMBER (for tracking purposes). Please put that tracking number ON THE SIGN IN ROSTER (Second entry, top line) | Clerical support or facilitator           |           |
| TO THE MEETING (Registration)                     |                                                                                                                                                   |                                         |           |
| WELCOME SIGN                                      | Optional (hang sign at entrance to event) 
Hang a sign on door of meeting room (if needed).                                                                                                   | Clerical support                        |           |
<p>| SIGN IN ROSTER                                    | Start roster around table with pen, asking participants to complete all items (PRINT) and to pass it around the table. As attendees arrive, ensure that they are asked to sign. | Clerical Support/monitor                 |           |
| Demographic Collection Data Tool                  | Distribute salmon-colored data collection tool to all attendees and request they complete and leave the form at their seat or in a pre-designated location at the meeting prior to leaving the targeted forum session. | Facilitator                             |           |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>Instructions</th>
<th>Responsible Individual</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISTRIBUTE THE INFORMATION PACKETS</strong></td>
<td>(1) Distribute and discuss/ “Walk” through MHSA summary briefly to orient all participants, acknowledging that some attendees may be work group members or may have attended MHSA training already. (2) Encourage attendees to review the demographic overview due to its importance in our effort to transform/design the MH system around careful study of the county’s varied regional and demographic issues. Point out some of the issues that you find interesting or ask if participants notice any issues deserving special attention. (3) Turn to the brochure and review the variety of MHSA activities that are in progress or planned and invite participation in workgroups/sub-committees and several stakeholder forums.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>Information Packet Contents:</strong></td>
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<tr>
<td>(1) MHSA Summary</td>
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<tr>
<td>(2) Summary of County’s Regional – Demographic Characteristics, with some graphic illustrations</td>
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<tr>
<td>(3) Brochure/flyer outlining opportunities for participation and contact information.</td>
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<tr>
<td><strong>DESCRIBE THE ROUNDTABLE DISCUSSION PROCESS</strong></td>
<td>SUGGESTED SCRIPT: “Today, we’d like to hear from you. What we’d like to do is to put several structured questions on the table and have a “roundtable” discussion of each one. We hope to touch on issues related to policy, resources, shared agenda and the impact of mental illness from your perspectives. We’d like to take one question at a time, letting each of you take a couple of minutes to respond. (Insert name of note taker) will be jotting down on the flip chart, as accurately as possible, your main comments. We want you to check the accuracy of the notes as we go.”</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>DESCRIBE THE FEEDBACK GATHERING PROCESS</strong></td>
<td>SUGGESTED SCRIPT: “Once you have all had a chance to respond and discuss these issues with us, we’ll have a pile of flip chart notes. We will be transcribing those notes and reporting your input to the MHSA work groups as they continue their effort to evaluate needs and formulate initial plans for new services/supports.” <strong>NOTES:</strong> Describe the feedback gathering process, including how the input will be forwarded and used by the County MHSA workgroups and MHSA leadership bodies via subsequent forums and communications.</td>
<td>Facilitator</td>
<td></td>
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<tr>
<td>Activity</td>
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<tr>
<td><strong>DISTRIBUTE THE ROUNDTABLE</strong></td>
<td>Allow 2 minutes for distribution and review of discussion questions. <strong>NOTE:</strong> Distribute the roundtable <em>Targeted Forum Questions</em> page (containing the discussion questions) for participants to review</td>
<td>Facilitator or clerical support</td>
<td></td>
</tr>
<tr>
<td><strong>TARGETED FORUM QUESTIONS</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>CAPTURE THE RESPONSES</strong> (NOTE TAKING)</td>
<td>Use flip chart to capture the responses – be sure to annotate responses by question #.</td>
<td>Clerical support, co-facilitator or facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>STARTING THE SESSION:</strong></td>
<td><strong>SUGGESTED SCRIPT:</strong> Let’s start with the first question: “ (read your first question and let discussion ensue!) <strong>NOTE:</strong> Begin with the first two questions and proceed through all questions. If time DOES NOT PERMIT, select the 3 most relevant questions for your targeted forum participants.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>CAPTURE ALL PARTICIPANT FEEDBACK</strong></td>
<td><strong>SUGGESTED QUESTION:</strong> Is there anything you would like to add or recommend? Try to get 100% participation from participants at some point through the discussion. <strong>Note:</strong> Capture all input/ideas/responses and invite recommendations for each question.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td><strong>TAKING MHSA INFO BACK TO AGENCIES</strong></td>
<td>Point out again the brochure and invite them to circulate the information within their agencies. <strong>NOTE:</strong> Invite participants to use these discussion questions with their own agencies and offer the protocols and feedback tools for doing so. Invite their participation in future MHSA activities.</td>
<td>Facilitator</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Instructions</td>
<td>Responsible Individual</td>
<td>Completed</td>
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</tbody>
</table>
| **MEETING CLOSURE**  
(HOUSEKEEPING ISSUES - ATTENDANCE ROSTER & DEMOGRAPHIC DATA COLLECTION TOOLS) | Remind participants to sign attendance roster if they were not able at the beginning of the session. Collect the attendance roster(s) and **review for completeness and legibility**. Collect the Demographic Data Collection Tools (Salmon forms) and **review for completeness and legibility**. *(Return with Meeting Minutes)* | Clerical support or Facilitator |   |
| **CONCLUDING THE SESSION:** | **THANK ALL PARTICIPANTS** for their participation and encourage them to continue their involvement in the MHSA process and to bring information back to their respective agencies. | Facilitator |   |
| **AFTER THE MEETING**  
(Converting the notes taken at the focused forum) | Please accomplish your minutes document in **MICROSOFT WORD** using the attached **Targeted forum Form Minutes Format** *(See page 5)* to consolidate the information gathered from your targeted forum. Be sure to reference the question number with the responses. Please forward the document by one of these methods:  
1. Email the document to *(preferred method):* elongfellow@dbh.sbccounty.gov  
2. County interoffice mail: hard copy Liz Longfellow *(mail code 0928)*  
3. US Mail: 820 E. Gilbert St., San Bernardino, CA 92415  
   Attention: ELIZABETH LONGFELLOW  
**NOTE:** Please forward your meeting summaries to DBH within 5 days of the completion of the targeted forum session. | Clerical support or Facilitator |   |
**SUPPLIES NEEDED**: flip chart, masking tape (just in case), markers, Demographic Data Collection tool, sign in rosters & participant packages. **OPTIONAL**: bottled water or coffee/condiments, pens for sign-in sheet (just in case)
# 1 OUTCOMES: Discuss some ways to determine that Mental Health Services have been effective.

# 2 INTERAGENCY COLLABORATION: Can you suggest one or two changes that could be made now – without additional funding – which would help facilitate integrated services and transform the mental health system in our county?
<table>
<thead>
<tr>
<th>Question #</th>
<th>Discussion</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td># 3 SERVICES INTEGRATION &amp; COLLABORATION: Who are the critical people and/or agencies that must be involved in working together to facilitate client success in the community? Why are these individuals or agencies so critical?</td>
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<tr>
<td># 4 ACCESS: How can we make it easier for people to find Mental Health services in our county?</td>
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</tr>
<tr>
<td># 5 CLIENT/FAMILY-DRIVEN: In what ways can we be more effective in involving families of both children and adults in Mental Health services?</td>
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<td></td>
</tr>
<tr>
<td>Question #</td>
<td>Discussion</td>
<td>Recommendations</td>
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<tr>
<td># 6 CULTURAL COMPETENCE: What steps can we take to ensure that services and supports are sensitive and responsive to a client’s age, gender, cultural background, lifestyle and beliefs?</td>
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</tr>
<tr>
<td># 7 RECOVERY &amp; RESILIENCY – DELIVERY OF SERVICES: What are the types of treatment services and supports that can be developed and offered which will tap into client strengths, resiliencies and promote recovery?</td>
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<tr>
<td>Who would else do you think should be include/invited to the MHSA discussion table (that is not here today)?</td>
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</tbody>
</table>
### Organizando & Registrando su Foro Dirigido/antes de la Reunion (Registro)

**Actividad**

**Instrucciones**

- Comuníquese con la Comité de Coordinación del DBH MHSA para **Registrar su Foro Dirigido con:**
  - Liz Longfellow 909-387-7712 o
  - Cindy Waldron 909-387-7708 o
  - Gwen Morse 909-873-4476.
- **A usted le pedirán:**
  1. La fecha del Foro Dirigido
  2. El lugar del Foro Dirigido
  3. La agencia/grupo dirigido que el grupo será realizado.
- Usted entonces será asignado un **Número de Grupo** (para propósitos de rastreo). **Por favor ponga el número de rastreo en la lista de entrada (la segunda entrada, en la primera línea)**

**Individual Responsable**

- Soporte de oficinesco o facilitador

**Letrero de Bienvenido**

- **Instrucciones**
  - Opcional (cuelga el letrero en la entrada al acontecimiento)
  - Cuelga un letrero en la puerta de encontrar al cuarto de reunión (si es necesario).

**Individual Responsable**

- Soporte de oficinesco

**Lista de Firmas de los Presentes**

- **Instrucciones**
  - Empiece una lista con pluma alrededor de mesa, pidiendo que los participantes completen todos los artículos (**LETRA DE IMPRENTA**) y que lo pasen alrededor de la mesa. Cuando llegan más participantes, aseguren de pedir que ellos firmen la lista de entrada.

**Individual Responsable**

- Soporte de oficinesco /monitor

**Instrumentos para Colectar Datos Demográficos**

- **Instrucciones**
  - Distribuya instrumentos de colección de datos de color salmón a todos los asistentes y pida que ellos completan y dejen la forma en su asiento o en una aria designada antes de salir de la sesión de foro dirigida.

**Individual Responsable**

- Facilitador
<table>
<thead>
<tr>
<th>Actividad</th>
<th>Instrucciones</th>
<th>Individual Responsable</th>
<th>Completado</th>
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</thead>
</table>
| **DISTRIBUYA LOS PAQUETES DE INFORMACION**    | (1) Distribuya y hable brevemente sobre el resumen de MHSA para orientar a todos los participantes, reconociendo que algunos asistentes pueden ser miembros de grupo de trabajo o pueden haber asistido al entrenamiento de MHSA en el pasado.  
(2) Anime a los asistentes a revisar la demográfica debido a la importancia en nuestro esfuerzo a transformar/diseñar el sistema de Salud Mental (MH) alrededor del cuidadoso estudio del condado con sus variadas regionales y demográficos asuntos. Indique algunos de los asuntos que usted encuentra interesante o pregunta si los participantes encuentran cualquier asunto que merece atención especial.  
(3) Mire al folleto y revise la variedad de actividades de MHSA que están en el progreso o planeados e invitan la participación en el grupo de trabajo/sub-comités y varios foros de las personas involucradas. | Facilitador             |            |
<p>| <strong>DESCRIBA EL PROCESO DE DISCUSION DE LA MESA REDONDA</strong> | <strong>ESCRITURA SUGERIDA:</strong> “Hoy, queremos oír de usted. Lo qué nosotros querremos hacer es poner varias preguntas estructuradas sobre la mesa y tener una discusión de “mesa redonda” para cada pregunta. Esperamos hablar de asuntos relacionados a la política, recursos, compartir orden del día y el perspectivo de usted sobre el impacto de la enfermedad mental. Queremos tomar una pregunta a la vez, permitiendo unos cuantos minutos a cada uno de ustedes para responder. (Agregar el nombre de la persona que tomará las notas) estará apuntando, lo más correcto posible, sus comentarios principales. Queremos que usted verifique la certeza de las notas como nosotros vamos.” | Facilitador             |            |</p>
<table>
<thead>
<tr>
<th>Actividad</th>
<th>Instrucciones</th>
<th>Individual Responsable</th>
<th>Completado</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIBA EL PROCESO DE RECOLECTAR REACCIONES</td>
<td>ESCRITURA SUGERIDA: “Una vez que ustedes han tenido una oportunidad de responder y discutir estos asuntos con nosotros, nosotros tendremos un montón de notas. Estaremos transcribiendo esas notas y reportando su opinión a los grupos del trabajo de MHSA como ellos continúan su esfuerzo de evaluar las necesidades y formular los planes iniciales para servicios/apoyos nuevos.” NOTAS: Describa el proceso de la colección de las reacciones, inclusive cómo la opinión se enviado y utilizada por el grupo de trabajo del Condado MHSA y el grupo de lideres de MHSA vía foros y comunicaciones subsiguientes.</td>
<td>Facilitador</td>
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<tr>
<td>DISTRIBUIR LAS PREGUNTAS DE FORO DIRIGIDO DE LA MESA REDONDA</td>
<td>Permita 2 minutos para la distribución y la revisión de preguntas de discusión. NOTA: Distribuye la pagina con las Preguntas de Dirigidas del Foro de la mesa redonda (conteniendo las preguntas de la discusión) para que los participantes lo revisen</td>
<td>Facilitador o Soporte de oficinesco</td>
<td></td>
</tr>
<tr>
<td>CAPTURE LAS RESPUESTAS (TOMANDO NOTAS)</td>
<td>Utilice una porta mapas para escribir las respuestas – asegurase de anotar las respuestas por el número de la pregunta.</td>
<td>Soporte de oficinesco, co-facilitador o facilitador</td>
<td></td>
</tr>
<tr>
<td><strong>EMPEZAR LA SESION:</strong></td>
<td><strong>ESCRITURA SUGERIDA:</strong></td>
<td><strong>Facilitador</strong></td>
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<td>Comencemos con la primera pregunta: “(lea su primera pregunta y permita que la discusión resulte!) <strong>NOTA:</strong> Empieza con las primeras dos preguntas y avanza por todas las preguntas. Si tiempo NO PERMITE, escoge las 3 más pertinentes preguntas para sus participantes de dirigidos del foro.</td>
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</table>

| **CAPTURE TODAS LAS REACCIONES DE LOS PARTICIPANTES** | **PREGUNTAS SUGERIDAS:** ¿Hay algo que usted querría agregar o recomendar? Trate de recibir 100% de participación de todos los participantes en algún punto en la discusión. **Nota:** Reciba todas las sugerencias/ ideas/ respuestas e **invita las recomendaciones** para cada pregunta. | **Facilitador** |

| **LLEVANDO LA INFORMACION DE MHSA A LAS AGENCIAS** | Mencione otra vez el folleto y **invítelos a distribuir la información dentro de sus agencias.** **NOTA:** Invite a los participantes a utilizar estas preguntas de la discusión con sus propias agencias y ofrecer los equipos de protocolos y reacciones para hacer esto. Invite su participación en actividades futuras de MHSA. | **Facilitador** |

<p>| <strong>CONCLUYENDO LA REUNION</strong> (ASUNTOS DE CONCIERNO - LISTA DE TODOS LOS PARTICIPANTES &amp; INSTRUMENTOS DE COLECTAR PARA DATOS DEMOGRAFICA) | Recuerde a los participantes que <strong>fírmenn la lista de asistencia</strong> si ellos no eran capaces en el principio de la sesión. Recoja la lista (listas) de asistencia y revise que este completo y legible. Recoja los Instrumentos de Colección para Datos Demográficos (la hoja de color Salmón) revise que este completo y legible. | <strong>Soporte de oficinesco o Facilitador</strong> |</p>
<table>
<thead>
<tr>
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<th>Completado</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TERMINANDO LA SESION:</strong></td>
<td>AGRADEZCA A TODOS LOS PARTICIPANTES por su participación y animelos a continuar su participación en el proceso de MHSA y para regresar información a sus agencias respectivas.</td>
<td>Facilitador</td>
<td></td>
</tr>
</tbody>
</table>
| **DESPUES DE LA REUNION** (Convirtiendo las notas tomadas en los foros dirigidos) | Por favor complete sus notas en un documento de **MICROSOFT WORD** usando el estilo de la Forma de Foro Dirigido (vea pagina 5) para consolidar la información que colecto de su foro dirigido. Asegurase que mencione el número de la pregunta con las respuestas. Por favor entregue el documento por uno de los siguientes métodos:  
1. Mande el documento por e-mail (**la manera preferida**): elongfellow@dbh.sbcounty.gov  
2. Por correo entre oficinas del condado: envíe una copia imprimida a Liz Longfellow (**código de correo: 0928**)  
3. Correo de Estados Unidos:  
   820 E. Gilbert St., San Bernardino, CA 92415  
   Attention: ELIZABETH LONGFELLOW  
**NOTA:** Por favor envié sus resúmenes de la reunión a DBH dentro de 5 días de la terminación de la sesión dirigida del foro. | Soporte de oficinesco o Facilitador |  |
| **RECURSOS NECESITADOS:** porta mapas, cinta adhesiva (por si acaso), marcadores, herramienta para Colectar Datos Demográficos, lista de firma de los presentes & paquetes para los participantes. **OPCIONAL:** agua embotellada o café/condimentos, lapicero para firmar la lista de los presentes (por si acaso) |  |  |
Por favor todas las preguntas (si tiempo permite). Si el tiempo no permite. Por favor conteste las preguntas que son más pertinentes a los participantes del foro dirigido.

<table>
<thead>
<tr>
<th>Número de Pregunta</th>
<th>Discusión</th>
<th>Recomendaciones</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1 RESULTADOS:</td>
<td>Hablar de algunas formas que los Servicios de Salud Mental han sido efectivo.</td>
<td></td>
</tr>
<tr>
<td># 2 COLABORACION ENTRE ORGANIZACIONES:</td>
<td>¿Puede sugerir usted uno o dos cambios que se podrían hacer ahora – sin fondos adicionales – cuál ayudaría a facilitar los servicios integrados y se transforma el sistema de la salud mental en nuestro condado?</td>
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<tr>
<td>Número de Pregunta</td>
<td>Discusión</td>
<td>Recomendaciones</td>
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</tr>
<tr>
<td># 3 INTEGRACION &amp; COLABORACION DE LOS SERVICIOS:</td>
<td>¿Quiénes son las personas y/o las agencias críticas que deben ser implicadas a trabajar juntos para facilitar el prospero del cliente en la comunidad? ¿Por qué estos individuos o agencias son tan críticos?</td>
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<tr>
<td># 4 ACCESO:</td>
<td>¿Cómo podemos hacer nosotros más fácil para que personas encuentren los servicios de Salud Mental en nuestro condado?</td>
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<tr>
<td>Número de Pregunta</td>
<td>Discusión</td>
<td>Recomendaciones</td>
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<tr>
<td># 5  <strong>DIRIGIDO POR EL CLIENTE/LA FAMILIA:</strong> ¿En qué manera podemos nosotros ayudar a involucrar a las familias de los niños y los adultos en servicios de Salud Mental?</td>
<td></td>
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</tr>
<tr>
<td># 6  <strong>COMPETENCIA CULTURAL:</strong> ¿Qué podemos hacer nosotros para asegurarnos que los servicios y soporte son sensible y alertos a la edad del cliente, el género, la cultural, estilo de vida y creencias?</td>
<td></td>
<td></td>
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<tr>
<td>Número de Pregunta</td>
<td>Discusión</td>
<td>Recomendaciones</td>
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<tr>
<td><strong># 7 RECUPERACION &amp; ELASTICIDAD</strong> – ENTREGA DE SERVICIOS: ¿Cuales son los tipos de servicios de tratamiento y soporte que se pueden desarrollar y pueden ser ofrecido que ayudara a sacar lo mejor del cliente, las elasticidades y promover recuperación?</td>
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<tr>
<td>¿Quién más piensa que debe ser incluido/invitado a la mesa de discusión de MHSA (que no está aquí hoy)?</td>
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</table>
San Bernardino County

Who are county residents?

What mental health services do we need?

Who is currently receiving services?

Mental Health Services Act
Community Planning Program Data

Plan Together

Succeed Together

MHSA Coordinating Committee
850 East Foothill Blvd
Rialto, CA 92376
(909) 873-4486
www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
or
http://tinyurl.com/8po36

San Bernardino County

- Who are county residents?
- What mental health services do we need?
- Who is currently receiving services?
San Bernardino County Demographics

San Bernardino County boasts the largest land area of any county in the contiguous United States, containing more than 21,000 square miles and stretching from Los Angeles on the west to the Arizona state line on the east. San Bernardino County is larger, geographically, than the state of Rhode Island.

The county’s widely differing terrains – the Inland Valley area, San Gabriel and San Bernardino Mountains, and Mojave Desert – accentuate San Bernardino County’s population diversity.

Due in large part to a dramatic influx of people from neighboring counties, the estimated population of San Bernardino County in 2005 is almost 2 million residents. This growth trend is expected to continue for the foreseeable future.

Where Do We Go From Here

The information contained in this brief summary is just a starting place. The job of concerned stakeholders – our work group and task force members – is to understand our community while taking into account issues of cultural and ethnic identity, age-related factors, ease of access to services, the effectiveness and relevance of the services rendered by public system providers, service outcomes and system accountability, recovery and resilience, service integration and community collaboration, and the need for client, family, and consumer input about the services provided.
About 12% of our residents are now over the age of 65. The Desert and Mountain areas of the county are home to larger proportions of retirees and older adults than are the Inland Valley and western areas of the county.

The County’s growth in the past two decades can be partially attributed to the lower cost of housing compared to adjacent counties. Thus, its lower than average per capita income level and relatively lower median income could be viewed within that context. However, the County’s “below poverty” statistics have remained higher than the average poverty statistics for California for some time.

San Bernardino County’s sheer size and its distinct geographical regions complicate any effort to provide a simple “snapshot” of our residents and our resiliencies, strengths, stressors, community issues, mental health consumer experiences, perceptions of the mental health system, or our highest priorities.

For example, the urban/suburban Inland Valley region contains a spectrum of socioeconomic, racial, cultural and ethnic groups and presents several unique access challenges. The Mountains are comprised of several defined communities with documented service needs and concerns but limited resource networks.

There are undoubtedly many other reasons people do not receive needed services, and one of our first tasks is to identify these additional reasons.

**Persons in Need and Persons Served**

In fiscal year 2004/2005, the Mental Health Plan provided at least one service to over 35,000 unique persons, which is far below the 61,000 persons who are believed to need care from the public mental health services system.

This chart shows the difference between those in need and those served, by age category.
Prevalence and Need for Services

A prevalence rate refers to the proportion of people in a group that have a specified condition or disorder.

Estimates of persons with serious mental or emotional disorders among those living below 200% of the Federal Poverty Level averages about 9%. These are people who are believed to have either serious mental illnesses or severe emotional disorders that would usually make them eligible for treatment in a public mental health system.

The chart below represents the number of our county’s residents in each age category who need services from our Mental Health Plan.

Below is a bar graph showing the estimated number of county residents in each of four age categories who are living below 200% of the Federal Poverty level as of 2005.

The chart below shows the same group of residents, but categorized by ethnic group rather than age.
The Mojave Desert area, stretching from the San Bernardino Mountains north to Death Valley and east to Arizona, includes a cluster of mid-size cities with a wide scattering of smaller towns. The desert’s mental health system has historically required flexible, informal collaboratives that spring up to solve access issues.

Estimating the County’s Mental Health Services Needs

Because of its diversity and geography, there is no simple or single method of answering the question of what additional mental health services are most needed in San Bernardino County.

The information in the following charts is intended to be useful to the task forces and work groups that will analyze our community and its mental health services needs.

County Residents Living in Poverty

The number of residents living in poverty is a significant factor in estimating the need for public mental health services, because these are the residents most likely to seek out public services when they need help.
The next chart compares those in need and those served by ethnic group.

![Persons in Need and Clients Served, by Ethnic Group](chart.png)

The two charts above clearly demonstrate that the Mental Health Plan, which includes the Department of Behavioral Health clinics and service units, its contract agencies, and the Fee-for-Service Provider Network, are not yet able to provide the full range and extent of services that are needed in our community.

In addition, our population has a number of unique characteristics that are relevant for mental health planning, including a higher proportion of children and youth than most other California counties. The percentage of residents under age 18 in San Bernardino County is currently at about 30% and our community is especially culturally, racially and linguistically diverse.

As of 2005, over half of the county’s population is of Hispanic/Latino origin, about 30% of European-American descent, 10% of African-American ethnicity, Asians/Pacific Islanders about 7% of the population, and Native Americans about 1% of the County’s population. A new and growing census category, “multi-ethnic,” is claimed by about 2% of our residents.

About a third of our residents report that a language other than English is primarily spoken at home (as per 2000 census data).

Our homeless population is currently estimated at over 8,300 people, many of whom are known to suffer from mental disorders.
¿Quiénes son los residentes?

¿Qué tipo de servicios de salud mental ocupan?

¿Quién está recibiendo servicios?

La Ley de Servicios de Salud Mental (Proposición 63)
Información Demográfica
Planeamiento Comunitario

MHSA Comité de Coordinación
850 East Foothill Blvd
Rialto, CA 92376
(909) 873-4486
www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
http://tinyurl.com/8po36

El Condado de San Bernardino

☐ ¿Quiénes son los residentes?
☐ ¿Qué tipo de servicios de salud mental ocupan?
☐ ¿Quién está recibiendo servicios?
La Área Demográfica de San Bernardino

El Condado de San Bernardino se considera el condado más grande en los Estados Unidos, tiene más de 21,000 millas cuadradas y se estira desde el Oeste de Los Ángeles hasta la frontera Este de Arizona.

Hay diferentes áreas del condado – La área del Valle Interior, el área de las montañas de San Gabriel y San Bernardino, y el Desierto Mojave – estas áreas resaltan la diversidad de la población del Condado de San Bernardino.

Debido a la entrada de personas de diferente condado, la población estimada del Condado de San Bernardino en el 2005 es casi 2 millones de residentes. Este crecimiento se espera que continué en el futuro.

¿Cuál es nuestro siguiente paso?

La información contenida en este resumen solamente es el comienzo. El trabajo de todos los interesados – los de nuestro grupo y los miembros de los grupos de trabajo – es entender nuestra comunidad tomando en cuenta todos los aspectos culturales, identidad étnica, aspectos relacionados con la edad, facilidad de acceso a servicios, la efectividad y relevancia de los servicios disponibles en el sistema público, los resultados de los servicios, responsabilidades del sistema, recuperación y descubrimiento, integración del servicio y colaboración de la comunidad, y la importancia de la participación de los clientes y su familia.
Cerca del 12% de nuestros residentes son mayores de 65 años. En las áreas de desierto y las montañas se encuentra un gran número de residentes retirados y mayores de edad que en las otras áreas del condado.

El crecimiento del condado en las últimas dos décadas se debe parcialmente al bajo costo de la vivienda comparado con los condados vecinos. Por lo tanto, es más bajo que el promedio per capita de nivel de ingresos y relativamente bajo promedio de ingreso económico, se puede mirar dentro de este contexto. Sin embargo, las estadísticas del condado relacionadas con los “niveles de pobreza” se han mantenido más altas que las estadísticas de California.

El tamaño del condado de San Bernardino y sus distintas regiones geográficas hacen difícil cualquier esfuerzo de presentar una foto rápida de nuestros residentes, sus experiencias y su percepción del sistema de salud mental, o de nuestras prioridades.

Por ejemplo, el área urbana / suburbana de la región del valle contiene un espectro socio-económico, racial, cultural de los diferentes grupos étnicos que presenta situaciones relacionadas con el acceso a los programas que son únicas. Las montañas están compuestas de varias comunidades con necesidades de servicios que se han documentado muchas veces pero con limitación de recursos.

Hay muchas otras razones por las cuales los residentes no reciben los servicios que necesitan, y una de nuestra primera tarea es identificar estas razones adicionales.

**Personas Necesitadas y Personas que han recibido servicios**

En el año fiscal 2004/2005, el plan de salud mental dio servicios, por lo menos una vez, a más de 35,000 personas, lo cual está por debajo de 61,000 personas que se cree necesitan servicios del servicio público de salud mental.
La grafica de abajo muestra el numero estimado de residentes en cada una de las cuatro categorías de edades que están viviendo bajo el 200% de nivel de pobreza federal en el 2005.

**Residents Living Below 200% Poverty Level, by Age Category**

La grafica de abajo muestra el mismo grupo de residentes, pero en las diferentes categorías étnicas en lugar que la edad.

**Residents Living Below 200% of Poverty Level, by Ethnicity**

Necesidad de Servicios Prevalecientes

La medida de prevalecencia se refiere a la proporción de personas en un grupo que tiene una condición o desorden específico.

La estimación de personas con enfermedades mentales o desordenes emocionales severos, entre las personas que están por debajo del 200% de nivel de pobreza, es de un promedio cerca al 9%. Estas son personas que se cree que tienen enfermedades mentales o desordenes emocionales severos que los hacen elegibles para tratamiento en el sistema de salud mental publico. La grafica de abajo representa el número de residentes del condado en cada categoría de edad que necesita servicios del plan de salud mental del condado.
El área del desierto Mojave, desde las montañas de San Bernardino, el norte y este del Valle Muerto hasta Arizona, incluye áreas de ciudades de tamaño mediano con áreas extendidas de pequeñas ciudades. El sistema de salud mental en el desierto históricamente requiere un sistema de colaboración flexible e informal que pueda resolver los problemas de acceso.

Estimando las Necesidades de Servicios de Salud Mental en el Condado

Debido a la diversidad y la geografía, no hay un método simple o un solo método para responder a la pregunta de qué servicios de salud mental adicionales son necesitados en el condado de San Bernardino.

La información en las siguientes graficas es con el propósito de ayudar a los grupos de trabajo que van a analizar nuestra comunidad y sus necesidades de servicios de salud mental.

Residentes del Condado que Viven en la Pobreza.

El número de residentes que viven en la pobreza es un factor significante en la estimación de las necesidades de servicios de salud mental, porque estos son residentes que tienden a usar los servicios públicos cuando necesitan ayuda.

Los números en las graficas de arriba sugieren que aproximadamente 61,000 personas que están viviendo por debajo del 200% de nivel de pobreza tienen necesidad de servicios de salud mental en cualquier momento.

Barreras, Acceso, y uso de servicios

La siguiente pregunta es: ¿Cuántas de estas personas están actualmente recibiendo nuestros servicios? A pesar de que muchos están necesitados de los servicios, no todos ellos van a recibir los servicios necesitados. Algunas razones obvias por las cuales las personas no reciben los servicios que necesitan incluyen dificultades tales como el transporte y el cuidado de los niños. Otra de las razones es la limitación de servicios disponibles en las regiones.

La grafica adicional abajo muestra el número de personas que necesitan servicios en cada una de las categorías étnicas.

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La grafica adicional abajo muestra el número de personas que necesitan servicios en cada una de las categorías étnicas.
La siguiente grafica compara aquellos con necesidad y los que han recibido servicios en los grupos étnicos.

Las dos graficas arriba claramente demuestran que el plan de salud mental, que incluye las clínicas del departamento de salud mental, sus agencies contratadas, y otros proveedores, no están todavía capacitados para proveer todos los servicios que son necesitados en nuestra comunidad.

Además, nuestra población tiene características únicas que son relevantes en el planeamiento de servicios de salud mental, incluyendo una proporción alta de niños y jóvenes comparado con otros condados en California. El porcentaje de residentes que son menores de 18 años en el condado de San Bernardino es de cerca de un 30% y nuestra comunidad es culturalmente, racialmente y lingüísticamente diversa.

En el 2005, más de la mitad de la población en el condado es de origen hispano/latino, cerca del 30% son de descendencia Europea-Americana, 10% de Afro-Americanos, Asiáticos/Islandeños del Pacífico 7% de la población, y Nativos Americanos cerca del 1% de la población del condado. La nueva categoría del censo que se conoce como “Multi-étnico” es identificada por el 2% de nuestros residentes.

Cerca del una tercera parte de los residentes reportan que el lenguaje que hablan en sus casas es otro diferente al inglés. (Basado en las estadísticas del censo del 2000).

Nuestra población de personas sin lugar de residencia es aproximadamente más de 8,300 personas, muchos de ellos se sabe que sufren de un desorden mental.
## Stakeholder Feedback from Public Forums/Focus Groups/Targeted Forums

### Sorted by Key Issues

**Thursday, December 01, 2005 04:00 PM**

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Access (233 remarks)</strong></td>
<td></td>
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<tr>
<td>-(2) Advertise services/outreach</td>
<td></td>
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<tr>
<td>-(3) Provide transportation (there &amp; home)</td>
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<tr>
<td>-(3) Outreach into the schools</td>
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<tr>
<td>-(1) Comprehensive pamphlet of services [countywide]</td>
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<tr>
<td>-(10) Bus passes (City and Access)</td>
<td></td>
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<tr>
<td>-(4) Consumer hotline</td>
<td></td>
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<tr>
<td>-(2) Website to give info [about mental health] and where to get services</td>
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<tr>
<td>-(4) Outreach - libraries, churches, etc.</td>
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<tr>
<td>-Phone access- kiosk in public place with information on where to go for help, in multiple languages</td>
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<tr>
<td>-(10) Van on site - with driver; could be consumer who has been authorized to drive; to transport individuals and groups to where they need to go</td>
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<tr>
<td>-(1) Infoline</td>
<td></td>
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<tr>
<td>-More outgoing phone lines [in program building]</td>
<td></td>
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<tr>
<td>-(3) Advertisements - at libraries, schools, community centers</td>
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<tr>
<td>-(1) Pamphlets (info/resource)</td>
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<tr>
<td>-(5) List of agencies – with locations, contact info, hours, &amp; esp. free services</td>
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<td>-(3) Low-cost or free services</td>
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<tr>
<td>-(2) “Equal” criteria so more can access the services</td>
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<tr>
<td>-(3) Website/web-based info &amp; resources --`in Spanish &amp; other languages (as well as English)</td>
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<tr>
<td>-(7) Outreach funds – workers out in ‘field’</td>
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<tr>
<td>-(2) Mental health staff at schools</td>
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<tr>
<td>*(1) Affordable services/programs (incl. waivers and scholarships, incl. for vocational programs)</td>
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<td>*(1) Transportation (incl. for parents)</td>
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<tr>
<td>-People (staff) available at/for crisis services</td>
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<tr>
<td>-Services need to be available</td>
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<tr>
<td>-Childcare</td>
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<td>-Transportation</td>
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<tr>
<td>-* More public education about mental health/alcohol &amp; drug services--billboards, mass mailings, at community centers, make easy to find in phone book</td>
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<td>-* Transportation</td>
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<tr>
<td>-Transportation to school</td>
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<tr>
<td>-(3) Advertising: commercials, flyers, brochures; put in grocery stores, doctors’ offices, restaurants</td>
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<td>-(5) Free and/or affordable services</td>
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<tr>
<td>-More services available</td>
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<tr>
<td>-(5) A place to find out about services (a ‘central’ office that people could go to)</td>
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<tr>
<td>-(4) Free/affordable transportation: city busses, county vans, Access vans</td>
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<td>-Do not screen out Regional Center clients from Access line.</td>
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<td>-Provide first appointment no matter what the disability is.</td>
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<td>-Non-public school – assessing Intake during IEP process.</td>
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<tr>
<td>-Access to drop-in services in community, i.e. van, churches.</td>
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<tr>
<td>-Mass advertising (cable, community bulletin boards)</td>
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<td>-Target behavior mod vendors.</td>
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<td>Key Issues</td>
<td>Comments</td>
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<tr>
<td>Recognize need for mental health services.</td>
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<td>Provide more info on phone as to eligibility</td>
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<td>Advertising in schools</td>
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<td>Radio and TV ads</td>
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<td>Community health fairs (booths)</td>
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<td>Pamphlets to educate parents on mental health services</td>
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<td>Educating teachers and counselors on mental health services and AB2726</td>
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<td>More acute services in upper desert</td>
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<td>Preventive services</td>
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<td>Transportation difficulties</td>
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<tr>
<td>(2) Inpatient access to case managers and social workers; assistance for relocation needs.</td>
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<tr>
<td>Psychiatric service local or county or by regions</td>
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<td>Improve access all age groups</td>
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<td>Transportation is a real issue</td>
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<td>Should be a single place to obtain info on psychiatric issues (all) local, county &amp; state level</td>
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<td>In home services</td>
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<td>Outreach – Use facilities such as Sr. Centers, Community Centers, negotiate w/ cities for space.</td>
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<td>Expand resources</td>
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<td>Transportation</td>
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<td>Wheel Chair Van available for consumers</td>
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<td>Staffing available to drive vans</td>
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<td>One-Stop programs for the consumers</td>
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<td>Central Location – that provide all sorts of services for the consumers</td>
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<tr>
<td>Transportation – Bus tickets, token or discount coupons. The biggest problem is lack of transportation in the community.</td>
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<td>On advertising money for mental health newspapers, phonebook, flyers, magazines &amp; TV.</td>
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<td>Inpatient access to case managers and social workers</td>
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<td>Lack transportation</td>
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<td>Have to wait for non-emergency/non-crisis</td>
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<td>Wait between initial contact and response</td>
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<td>Assume no other problem if mental retardation or autism diagnosis</td>
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<td>Transition from adolescence/adult</td>
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<td>Limited or lack of communication skills</td>
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<td>Centralized info center</td>
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<td>Affordable psychiatrists</td>
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<td>Clubhouses</td>
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<td>Advertising</td>
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<td>Accessibility with the disabled consumers.</td>
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<td>Having clinical therapist come to local schools (Elementary and High School).</td>
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<td>Local community services group – Hotline services with 800’s number.</td>
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<td>Funding opportunities to attend classes.</td>
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<td>Counseling to be held at local schools and colleges.</td>
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<td>Telephone lists of emergency contacts</td>
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<td>Info on classes (PSPS)</td>
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<td>Transportation issues</td>
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<td>SELPA newsletter</td>
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<td>#1 No income barrier for services – outreach to homeless and support groups run by mentally disabled – Network like AA</td>
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<td>#2 Having mental health booths at community events to educate the public and get word out to mentally disabled</td>
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<td>Decrease cost</td>
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<td>Key Issues</td>
<td>Comments</td>
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<td>---------------------------------------------------------------------------</td>
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<td>- increase psyche units</td>
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<td>- involvement of schools</td>
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<td>- advertisement and media</td>
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<td>- adolescent hospitals near to home</td>
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<td>- female therapist</td>
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<td>- Everywhere people go the information should be available and obvious:</td>
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<td>online, more public service announcements in all media</td>
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<tr>
<td>- County Mental Health Van</td>
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<td>- Transportation Vouchers</td>
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<td>- Educating family members</td>
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<td>- Transportation</td>
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<td>- Television ads</td>
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<td>- Billboards</td>
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<td>- Educate day programs and workshops</td>
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<td>- Reach-out programs for mild mental retardation</td>
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<td>- Educate schools and teachers</td>
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<td>- More small clinics in remote areas</td>
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<td>- Support groups in communities</td>
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<td>- Community info papers</td>
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<td>- Educate doctors</td>
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<td>- Advertise clubhouse activities</td>
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<td>- Traveling DBH clinic or van</td>
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<td>- Public Health Fairs</td>
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<td>- Monthly education</td>
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<td>- Government hearing offices in outlying areas (TAD Appeals, SSA)</td>
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<tr>
<td>- Tel-a-Health Services (Pilot in Yucca Valley, Barstow)</td>
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<tr>
<td>- Make it easier to qualify</td>
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<tr>
<td>- Better information and Referral Services</td>
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<td>- Need on-site advocate</td>
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<td>- Increase the budget</td>
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<td>- Provide alternate applications sites</td>
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<td>- Take medi-cal applications on a regular basis</td>
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<td>- Increase client desire to be there</td>
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<td>- Educate the community through advertising (pamphlets, TV)</td>
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<td>- Schools and support groups</td>
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<tr>
<td>- Case managers need to be educated</td>
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<td>- Yellow pages</td>
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<td>- Information line</td>
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<td>- Educate primary physicians</td>
<td></td>
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<tr>
<td>- Transportation – Therapist to go to client</td>
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<tr>
<td>- Faith based services through church</td>
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<tr>
<td>- No</td>
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<tr>
<td>-(1) More Doctors</td>
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<tr>
<td>-(2) A 1-800 number</td>
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<tr>
<td>-(2) More staff</td>
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<td>-(3) More neighborhood locations</td>
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<td>-(0) Pamphlets</td>
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<td>-(4) T.V., Radio, Commercials</td>
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<td>-(4) Billboards</td>
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<tr>
<td>Key Issues</td>
<td>Comments</td>
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<tr>
<td>5) T.V. and Radio, commercials</td>
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<tr>
<td>- Transitional Assistance Department</td>
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<td>2) Jails</td>
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<td>-0) Pamphlets</td>
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<tr>
<td>- Residential</td>
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<td>- Doctors Office</td>
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<td>3) State Hospitals</td>
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<td>-1) Conventions, open to public</td>
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<td>- Phone Book</td>
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<td>4) School Offices</td>
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<tr>
<td>- Mail</td>
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<tr>
<td>- Internet</td>
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<td>- Billboards</td>
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<tr>
<td>(2) More Bilingual doctors</td>
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<td>(1) More Bilingual therapist</td>
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<td>(1) Parenting groups</td>
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<td>(1) More advertisement</td>
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<tr>
<td>- More Bilingual staff</td>
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<td>- Lack of services-no one on one</td>
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<td>- One professional interpreter per clinic</td>
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<tr>
<td>- Group therapy for Spanish speaking class</td>
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<tr>
<td>- More financial aid available</td>
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<td>- Drop in centers</td>
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<tr>
<td>- 24/7 walk in clinics and police drop offs in all regions of the county</td>
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<tr>
<td>- Transportation to and from appointments, hospital and clinics, phone access to it</td>
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<tr>
<td>- Keep a list of agencies CURRENT and available to law enforcement of DBH options and places to take people that are open</td>
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<tr>
<td>- Increase 5150 facilities or 23 hour beds especially in areas that have lost theirs or at out in more remote parts of the county</td>
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<tr>
<td>- Access to Medical Utilization Review boards.</td>
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<td>- Improve transportation to services</td>
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<tr>
<td>- Contact with other facilities-Senior Centers, Community Centers, churches.</td>
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<tr>
<td>- Increase in funding means preventing hospitalizations</td>
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<tr>
<td>- Keep the windows open 8-5 everyday.</td>
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<tr>
<td>- Have coverage during lunchtime.</td>
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<tr>
<td>- Have back-up if both staff need to be out of office at same time.</td>
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<tr>
<td>- Have staff take lunch at separate times.</td>
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<tr>
<td>- More staff.</td>
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<tr>
<td>- Full time on-site licensed counselor.</td>
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<tr>
<td>- More training for staff and agencies in area.</td>
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<tr>
<td>- Easier access to location.</td>
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<tr>
<td>- Possible change in location.</td>
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<tr>
<td>- Planned community advertising of mental health hotline resources to include DBH resources.</td>
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<tr>
<td>- Targeted community advertising to list resources by name, e.g. anger management rather than “mental health services”.</td>
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<tr>
<td>- Expand mental health resources by specific intervention in the high desert areas of San Bernardino county by enhancing school SELPA resources.</td>
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<tr>
<td>- A program be designed for DCS to partner with DBH, where DBH assigns clinicians (not an intern) to seriously impacted kids upon entry into the DCS system. The DBH clinician shall be required to stay with the kid throughout their placement history and upon exit into the community to enhance the quality of care element.</td>
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<tr>
<td>- A system be developed/enhanced to support the SERT concept for early intervention.</td>
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<tr>
<td>Key Issues</td>
<td>Comments</td>
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<tr>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>- Make available a mobile unit to provide services to the outlying areas of the low desert community. Provide access to more housing for individuals.</td>
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<tr>
<td>- Provide literature and maps in each courthouse and probation office regarding clinics, what services are available and hours of treatment. Provide neighborhood clinics and training for law enforcement regarding locations and the hours of service.</td>
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<tr>
<td>- Prepare a resource guide for all the Courts that is updated quarterly that includes what services are available and how a person qualifies for services. Have a Kiosk with an interactive system placed in the Courthouse to allow people to obtain information about services and directions to clinics. Place and individual in the Courthouse on a part-time basis to provide on-site information to the Courts, probation, and clients regarding treatment options and availability. Provide some mechanism for transportation to the clinics and services.</td>
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<tr>
<td>- Provide literature and maps in each courthouse, hospital and probation office regarding clinics, what services are available and hours of treatment. Provide neighborhood clinics and training for law enforcement regarding locations and the hours of service. Provide transportation and bilingual services in more areas.</td>
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<tr>
<td>- Provide transportation from the jail or hospital to the clinic or home. Provide transportation to services, make arrangements to coordinate service times that are convenient for clients, not staff.</td>
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<tr>
<td>- Provide transportation from jails and hospitals for clients in need of services. Have DBH and Probation staff provide maps and bus passes at court or clinics to make sure clients have a means to go to treatment.</td>
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<tr>
<td>- Perhaps advertise available services.</td>
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<tr>
<td>- Staff need to carefully listen to clients to better help determine service needs.</td>
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<tr>
<td>- More doctors needed.</td>
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<tr>
<td>- Increase public awareness via distribution of educational material, advertisements, and public events.</td>
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<tr>
<td>- Increase staff sensitivity to the idea that people that have substance abuse problems can still benefit from treatment and the need for information to be passed on.</td>
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<tr>
<td>- While it may not be possible to have a clinic in the remote desert community, utilizing the Senior Center as a drop in “on site clinic” was recommended. DBH could provide services at this clinic at least monthly.</td>
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<tr>
<td>- Website</td>
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<tr>
<td>- Toll Free number</td>
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<td>- Easier to find in the phone book</td>
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<td>- 24 hour counselor on the phone</td>
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<tr>
<td>- 4 Advertising</td>
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<tr>
<td>- 1 Counselors need better training at Schools and better access Programs</td>
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<tr>
<td>- Had to know someone to get help</td>
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<tr>
<td>- Communication problems</td>
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<td>- Slow getting answers for where to get proper education for child</td>
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<tr>
<td>- Quick clinics to include counseling, evaluation for inpatient, nonemergency services.</td>
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<tr>
<td>- Services without medical (insurance).</td>
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<tr>
<td>- Hire more employees so the caseloads are low.</td>
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<td>- Help with prescriptions.</td>
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<td>- More big conventions (NA or similar) in local area</td>
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<tr>
<td>- Don’t make the availability of MH services contingent upon one’s insurance status (has Medi-Cal, doesn’t have Medi-Cal, has Medicare, etc.).</td>
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<tr>
<td>- The idea of crisis and non-crisis drop-in centers is what is being proposed here. Provide a place where people can go when they are in need, where qualified MH staff and volunteers will be available to assist them with interventions, information, referrals, transportation.</td>
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<tr>
<td>- Provide half-way house for mentally ill.</td>
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<td>- DBH provide education to community leaders so they can inform appropriate individuals seeking MH services.</td>
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<tr>
<td>- DBH provide transportation assistance to appts. &amp; programs.</td>
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<tr>
<td>- Better communication between Medi-Cal users and county.</td>
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<tr>
<td>- Better listings from medical coverage providers.</td>
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<tr>
<td>- Developing a program that pays for medication for anyone that needs them, who cannot afford them.</td>
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<tr>
<td>- After hours calls return from Psychiatrist in a timely manner.</td>
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<tr>
<td>- A possible answering service to answer calls for Doctors to return calls.</td>
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<tr>
<td>- After hour meds line for care</td>
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<tr>
<td>- Access data from main line computer.</td>
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<td>- Have someone to assist in filling out forms.</td>
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<tr>
<td>- Larger crisis team</td>
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<tr>
<td>- Waive HIPAA laws to assist family members.</td>
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<tr>
<td>Key Issues</td>
<td>Comments</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>- Provide and pay for psych in our area</td>
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<tr>
<td>- Trained staff to do outreach</td>
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<tr>
<td>- Ex filling out forms</td>
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<tr>
<td>- Crisis Hotline 24 hours/daily</td>
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<td>- Family therapy support</td>
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<tr>
<td>- Commercials, Ads, Flyers, Outreach efforts</td>
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<tr>
<td>- More publicity</td>
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<tr>
<td>- Marketing – PSA’s, flyers, newspapers</td>
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<tr>
<td>- Communication between agencies to clients</td>
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<tr>
<td>- Use volunteers to spread by word of mouth</td>
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<tr>
<td>- Outreach</td>
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# Key Issues

## Client/Family Driven Services and Support (200 remarks)

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>- (11) Plan to address particular symptoms</td>
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<tr>
<td>- (8) Plan [having them] - that help somewhat</td>
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<tr>
<td>- (8) Clinician driven plans - what clients/family want is ignored [don't want to be ignored]</td>
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<tr>
<td>- (4) Little outreach to families/consumers - staff overworked [think outreach is beneficial]</td>
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<tr>
<td>- (10) Consumers need to push to get any support services [services should be offered more readily]</td>
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<td>- (5) Need more family involvement</td>
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<td>- (4) Childcare/Daycare – for use with all services</td>
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<tr>
<td>- Learning to communicate with children/services</td>
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<tr>
<td>- (5) Limited in what can help with [what staff are allowed to help with [want all goals to be acceptable/accepted]</td>
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<td>- (6) Geared to Medi-Cal requirements/tme limits on how long [staff] can work on something [staff, and parents, want to not be constrained to these, but rather to be able to work on client’s desired goal, until goal completed/changed]</td>
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<td>- (5) Hard to get youth to participate in services [would like youth to be engaged more]</td>
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<tr>
<td>- (1) Parent education/skills training</td>
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<td>- (2) Family therapy</td>
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<td>- “Parent Project” [a specific program; staff &amp; parents both praised this program]</td>
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<td>- “Support at home”</td>
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<td>- Need guidance for choosing services (i.e., what groups to take, not just to be told ‘take what you want/what you think you need’)</td>
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<td>- “Know what goal(s) for group are (currently, is unclear)</td>
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<td>- Service plans that are clear (currently, “over my head”); would like to have one</td>
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<tr>
<td>- “Want to have way to know that is moving toward goal –incl. wants staff’s assistance with this (knows own goal, is getting services, but unclear if services are actually moving toward goal)</td>
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<td>- More effective assessments – “consider family dynamics”. Recommended more pointed questions about family members’ personalities and family culture, that time was wasted by not getting to these issues until several sessions into treatment.</td>
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<td>- Family counseling, incl. “sibling counseling”</td>
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<tr>
<td>- Need to have clear plans that are realistic</td>
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<tr>
<td>- Need to have goals and plans, ways to keep busy; would like assistance with this</td>
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<td>- (4) There is no service plan—kids have them but adults don’t</td>
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<tr>
<td>- (15) Would like to have treatment plan and goals</td>
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<td>- (2) Funds for birthday celebrations</td>
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<tr>
<td>- Be willing to accept Axis I diagnosis from other source.</td>
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<td>- Need staff who are more comfortable treating developmental disabilities.</td>
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<td>- Understanding that placement is last option for children.</td>
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<td>- Family counseling.</td>
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<td>- Family groups</td>
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<tr>
<td>- Educating families</td>
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<tr>
<td>- Expansion of the NAMI program</td>
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<tr>
<td>- Require families of children to be trained in mental health services</td>
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<td>- Our developmentally disabled consumers to be treated equally by Mental Health</td>
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<td>- Counseling services for families.</td>
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<tr>
<td>- Effective interview by person on phone (Comes across as “why cannot serve” vs. “How can we serve”.</td>
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<td>- Increased family involvement</td>
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<td>- Cross train therapist – children with special needs</td>
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<td>- Work with parents to deal with guilt – behavior mod</td>
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<tr>
<td>- Increase local services for family</td>
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<td>- Increase level of frequency with visits/therapies</td>
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<td>- Inform on IEP services</td>
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<tr>
<td>- Need diagnosis from DBH for mentally retarded persons</td>
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<tr>
<td>- Support groups for families in upper desert</td>
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</table>
- Involve families more with treatment
- Make families more accountable
- Classes for families in understanding mental illness
- Require families of children to participate in programs and follow through
- (2) Is client direct involvement in service and recovery plan.
- Family counseling
- Consumers as an untapped resource – look at underlying passivity & resiliency
- Constant stigma of mental health and ageism
- Family involvement – education, early involvement of MH providers before family burnout
- Include family
- Respite for family
- Education for family
- Create goal w/ family & consumer
- Is not aware of having any signed treatment plan Would like to have a plan—know how is doing in moving toward goal, when ready to leave
- lack of involvement of clients with service or recovery plan
- Clients need awareness of services
- family members involvement in goals
- Down syndrome patients
- Staff are too overloaded, have too many people to see
- Safety
- unpredictability of who will come through door that day
- can take days to ‘restabilize’ the environment and participants at clubhouse after crisis happens.
- Sense of being in there on their own—peers only have peers to come to, for all problems
- participants don’t feel qualified to give advice to other peers.
- Feeling of isolation—not enough staff in programs to help them progress, but don’t feel well enough to be out in the community more (would like to grow in that direction, though).
- Educational groups
- Art therapy
- Peer counselors
- More focus groups (peer support).
- Child Care program for parents who have children.
- Day treatment services.
- Medication Management Group.
- Understanding their (homeless) lifestyles.
- Life skills
- Grieving groups
- CPR
- Emergency beds
- Support Grps – Needed
- Family therapy should be given to whoever asks and everyone should be told about the family groups.
- Education should be given to family members of disease.
- Increase inventions in jail because that’s where you end up and if you can get set up with support groups and after care
- Involve families in counseling sessions
- Involve families in treatment activities
- Educate families about specific mental health issues
- Be aware of cultural differences and support
- Targeting those who have just turned 18
- Availability on weekends and after school hours
- Increase home based services
- Caregiver support groups
- Plan and provide regular social activities that normalize the experience
- Let clients know that they are not alone
- More parent and/or patient positions...volunteers paid
- Support groups to increase education and awareness that Sheriff's Office is not the only option
- Do crisis intervention...not an automatic call to CPS/DCS
- Crisis mental health emergency team IN THE HIGH DESERT (PET)
- Parent workshops
- Family support groups
- Involve family in therapy
- Bilingual education
- Fairs and festivals
- Do not like to take Medi-Cal only
- (3) More time for one on one therapy
- (4) Longer study time by staff
- (4) Don’t know what a treatment plan is
- (4) They need a twelve step program
- Outreach in Communities
- Community Meetings
- Flyers
- School meetings
- TV Ads
- Local Fairs
- Outreach Workers
- Outreach
- Advertising
- Have DBH Therapist or representative at schools and Probation Dept. Office
- Training for staff for children with challenging behaviors and emotional issues
- Non-threatening services to parents (therapy counseling).
- 60% Latino (Hispanic) and majority mono-lingual
- Tie in Prop 63 with the new SART program, primarily for the patients
- Counseling
- One on One therapy
- 4) Parenting classes
- Social Skills classes
- 5) Day Care
- 2) Family Events
- Anger Management
- ADD classes
- Cognitive classes
- 4) Better Communication classes
- 1) Parent and Child Drug classes
- 5) More youth centers
- 2) ADV classes
- 5) Job Training
- First Aid and CPR
- (3) Better communication at the clients level
Key Issues

- More family therapy
  - More participation in the highest level
  - Do much education with families on how to access services, advertise the clinic times and locations regularly.
  - Have crisis housing/churches or other community placements available to the families to take their mentally ill or D/A loved one.
  - Involve churches and ask for volunteers in the faith based community to assist with one night housing/crisis beds so clients and cops have somewhere else to go
  - Do service plan.
  - Review with the client.
  - Involve the family.
  - Follow the plan.
  - Resolve the issues.
  - Don't just medicate.

- Train parents/community and school personnel to identify tell-tell signs and see help/resources immediately.
- Increase availability and access to unique resources dealing with unique mental health issues countywide.
- Design mental health services to go to families and children rather than them coming to clinicians.
- Provide resources at the Court for families and more access to DBH staff. Provide encouragement to families through court interaction and access to staff during court hearings to reduce the number of extra visits or trips families are required to make.
- Make resources accessible for everyone.
- MOU for Family Law Courts, DCS, and DBH to address confidentiality issues in both the treatment field and legal field.
- Make resources accessible even when clients do not have family support.
- Make resources accessible to everyone.
- Staff should more actively engage in helping clients as they work towards their goals and involve family as indicated.
- Staff should be sure to allow clients to have input into their goals and how to achieve them
- Only involve family in treatment planning and goals if it is indicated and desired by the consumer.
- Need to help consumers overcoming barriers, find what resources are available, and perhaps create new resources/opportunities.
- Staff and peer support seen as valuable as well as increased self-empowerment.
- Personal contact is needed.
- Advertise services in the local paper.
- Also place on the monthly Senior calendar.
- There is a need to educate community about services and programs.
- Important to protect privacy.
- Occasional family meetings to give information & progress reports

- 2 Diagnosis Testing in every clinic
- Goal plans do not include Parents or child
- Parents are not included in goal plans
- Better support for parents and their family
- More parent and family involvement
- Therapist need better support for their clients
- Law enforcement needs to be more involved
- Each person is responsible for their own family involvement at home everyday (don’t bring it to treatment)
- Increase family activities and make them free or low cost so we can participate.
- Assist with real life issues like housing, utilities ect until we can get a job.
- Real life financial assessment – stop letting lack of money or insurance be a barrier for svcs or meds.
- Family svcs to help deal with issues re: older adults and bx issues of children
- Several had bad experiences being placed in restraints and thought it should be more carefully regulated, resorted to less often.
- Most of the participants believe they are not being respected by the people who provide mental health services.
- Promises but no action
- Therapy that is needed instead of the quick fix.
- Staff to treat us with respect in regards to our emotions.
San Bernardino County
Department of Behavioral Health
Mental Health Services Act
Community Policy Advisory Committee

Introduction:

To ensure meaningful community involvement in the planning and implementation of Proposition 63 in San Bernardino County, the Department of Behavioral Health is establishing a broad-based community policy advisory group. The group will be representative of the major stakeholders in the county who are interested in the effective and efficient transformation of public mental health services as envisioned by the enactment of the Mental Health Services Act of 2005 (MHSA).

This leadership group will be comprised of representatives from consumer groups, family member groups, education, probation, mental health providers, law enforcement, juvenile and criminal justice, sheriff, human services, children services, mental health commission, substance abuse providers, community advocacy groups for children, adolescents, transitional age youth, adults and older adults, racial, ethnic and special populations, public health, faith-based groups, Mental Health Plan providers, and primary health care providers.

Composition:

The MHSA Community Policy Advisory Committee (CPAC) will have ______ members representing the following organizations and groups:

- Consumers
- Family Members
- Sheriff
- Education
- Probation
- Law Enforcement
- Alcohol & Drug Services Contract Providers
- Arrowhead Regional Medical Center
- County District Attorney
- Mental Health Contract Providers
- County Mental Health Commission
- County Public Defender
- County DBH
- Juvenile & Criminal Justice System
- Ethnic & Special Population Advocacy Groups
- County Children’s Network
- County Public Health
Purpose and Responsibilities:

Consistent with the requirements of the MHSA, the purpose of the Community Policy Advisory Committee will be to assist the DBH to ensure that the program strategies that are identified through the community planning process are pursuant to the vision and intent of Proposition 63. Specifically, the community advisory group will provide general guidance to the department in the preparation of the various implementation and funding plans for those program components (Community Services and supports, Early Intervention and Prevention, Education and Training, Capital and Technology, and Innovation) that are required by the MHSA. The expectations of the group (CPAC) will be accomplished through reviewing program priorities and proposed service strategies, and by recommending goals and planning assumptions for proposal development. The group will review proposals recommended by the DBH regarding the funding of community services and support programs resulting from the community planning process, and provide input during the implementation phase of those MHSA approved programs and services.

Further, the CPAC will assist the DBH to reach out and engage the participation and perspective from unserved and underserved populations, especially from racial, ethnic and cultural communities. A critical factor in the effective planning and implementation of those programs funded under the MHSA is to obtain meaningful input from those who suffer from severe mental illness and their family members.

The responsibilities of the MHSA Community Policy Advisory Committee members are to:

- Share perspective on the important community issues that influence the effective delivery of mental health services in the county;
- Assist the DBH in identifying the mental health needs in the community; identify approaches to improve or expand services to meet those needs;
- Review community data and information prepared by the various community work groups that result from the on-going planning process;
• Assist the DBH in developing the service strategies that will address the mental health issues and needs in the community;

• Review DBH program proposals that have been proposed by the community planning process; discuss recommendations on those proposals for funding under the MHSA;

• Identify approaches that would increase collaboration and cooperation among consumers, family members, community members, key agencies and stakeholders;

• Assist the DBH in identifying the strategies that will increase access to behavioral health services for racial, ethnic, limited English proficiency populations, and unserved and underserved populations;

• Assist the DBH in increasing public awareness of stigma and discrimination against those individuals who suffer serious mental illness;

• Assist the DBH to identify strategies to provide equitable services across regions;

**Meetings:**

In order to meet the planning timelines for preparation of the Community Services and Supports Plan (CSS) for submission to the State Department of Mental Health in January 2006, the Department’s MHSA Community Advisory Committee will need to meet at least three to four times over the next 90 days. After submission of the CSS Plan to the state, the meetings of the advisory group will be monthly.

**Procedural Process for Making Recommendations:**

To avoid any perception of a conflict of interest by participants during the proceedings of the CPAC, recommendations by the group on the funding of specific program strategies will be advisory to the DBH, the Mental Health Commission, and the County Board of Supervisors.

October 19, 2005
San Bernardino County
Department of Behavioral Health
Mental Health Services Act
Community Policy Advisory Committee (CPAC)
October 20, 2005

Present:
DBH – Allan Rawland, DeAnna Avey-Motikeit, Ralph Ortiz, Kimm Hurley-Smith, Joyce Lewis, Dr. Jatin Dalal, Paula Roby, Michele DeCourten, David Denkers, Marilyn Ashton, Scott Nichols, Carlos Lopez, Carolyn Havert
CIMH – Ed Diksa
Inland Valley Drug & Alcohol Recovery Services – Stacy Smith
Superior Courts – Nancy Stevenson, Debbie Cima, Judge Larry Allen
Sheriffs Department – Kathy Wild, Debby Lucas
Children’s Network – Kent Paxton
Pacific Clinics – Peter Lopez
Hospital Association of Southern California – Monty Clark
District Attorney – Jim Hackleman
Department of Children’s Services – Cathy Cimbalo
NAMI – Beverly Scott, Pat Willis
Public Health – Margaret Easley
Department of Aging & Adult Services – Ginny Stafford
Mental Health Commission – Dr. Nick Andonov, May Farr, Christopher Massa
Consumers – Lisa Partaker, Renee Compton Quiroga
Public Defender – Gerald Farber, Lauri Ferguson
Arrowhead Regional Medical Center – Judith McCurdy
Probation – Sharron Egan

Introductions – Allan Rawland welcomed attendees and thanked them for taking time out of their schedules to be here. Participants introduced themselves and indicated the agencies represented and/or roles in the Mental Health Services Act.

Overview of the MHSA – Transforming the local mental health system into a system for the community decided by the community.
What are we doing?
Who are we doing it to?
How much is it costing us?
What meaningful outcomes will be achieved for consumers and communities?

Role of MHSA Community Policy Advisory Committee – Will be meeting monthly for several months. Allan will serve as Co-Chair. He requested that a consumer volunteer serve as the other Co-Chair. Christopher Massa, also a Mental Health Commission member, volunteered. The committee will be providing advisory direction to DBH, the Mental Health Commission and the Board of Supervisors. There has not been a limit set on how many members the CPAC will have. Allan referred to a draft outline of the role of the CPAC in the informational binder provided.

Attachment AA
Proposed responsibilities of this committee will be to: Discuss areas in the document, Use areas of expertise in your departments, Assist the department in developing service strategies, and Review Community Services & Support (CSS) proposals. The Plan can be changed over the years and the funding will change and increase. In order to make the local transformation dynamic and relevant to our communities, we will need collaboration from all departments/agencies and community stakeholders. Demographics in this county are changing dramatically and access will be an issue, along with public awareness and stigma busting, equitable services across regions – upper desert and lower desert populations are increasing. We are shooting for the rough draft of the CSS Plan to be completed by December 8, 2005.


**MHSA CSS Funding Requirements** – The biggest challenge is making what you write operational. San Bernardino County will receive roughly 17.1 million for the CSS Phase. The goal is to transform the system not to expand services already in place. Areas to be addressed in the plan are: Recovery/Wellness & Resilience, Cultural Competency, Collaboration, Client Involvement, Integrated Services.

It is to be targeted to the Unserved – Now anyone, in need, under 200% Poverty Level, to receive services. Special attention to outreach to racial/ethnic communities in view of disparities in access to services. The state considers everyone underserved unless they are AB2034 or receiving Wrap-around services.

The components of the CSS are:
1. Full-Service Partnerships (51% of the funds), which involve Small Caseloads (20) 24/7 availability Individual integrated service plans “Whatever it takes”
2. System Development For example: Consumer operated services, Co-location of screening/assessment
3. Outreach & Engagement Unserved communities

The targeted age groups are: Children, Transitional Age Youth (TAY), Adults, and Older Adults (Elders) The regions are: San Bernardino/East Valley/Central/West Valley, Upper Desert/Mountains, Lower Desert/Yucca Valley.
The state has added several No Can “Do’s” to its regulations: (1) Supplantation, (2) Involuntary services or programs and (3) MHSA funding cannot be sued to pay staff from other agencies unless staff are functioning in mental health capacity. The challenge will be getting plans in and implemented quickly. The act allows us to place money aside “Prudent Reserve” for times when the economy dips.

In order to better understand the MHSA and the complex planning and proposal development process, it is recommended that participants review the materials provided.

In order to formulate relevant CSS proposals, our Age-Specific Workgroups will be using Stakeholder input, which will be linked to quantitative/demographic data. This, in turn will allow them to formulate program models that can be measured according to issues raised by communities and validated by hard data. The State MHSA guidelines are very prescriptive but are guiding us toward an accountable and participatory system transformation.

In later stages of the MHSA, there will be funding opportunities for programs under the following categories:

- Prevention/Early Intervention
- Innovative
- Infrastructure/IT
- Training/HRD (Human Resources Development)

**Status of Community Program Planning Process** – The stage we are in now is the CPP (Community Program Planning). We are reaching out to the community, have implemented Age-Specific Workgroups, and provided training for DBH Staff/Contract Agencies. Consumers, family members and community advocates are running Focus Groups in the community. Interagency Targeted Forums are promoting cross-agency brainstorming and agenda setting. Stakeholder surveys were created to elicit input from a broad variety of stakeholders and are available in three languages in paper and online/website versions. We will be using all of these input mechanisms to get input back to the workgroups. We will also be using 5% of the Voter Registration rosters to send out surveys to the voting community. Our feeling is that the community who voted for this proposition should have direct input into the implementation.

**Reports for MHSA CSS Workgroup Chairs** –

Children’s: The workgroup is comprised of a variety of interagency partners, and family members. They are looking at the needs of the system, Early wraparound for children ages 3-17, expanded crisis services, and developing Co-Occurring residential and outpatient services. Specifically looking at the Latino population and Non Medi-Cal (Uninsured).

Transitional Age Youth: The workgroup is comprised of a variety of interagency partners, family members and youth. Targeting reducing homelessness among youth, incarceration, and hospitalizations. They are focusing on reaching youth in familiar settings such as recreational settings, specialty housing and Educational settings. Looking
at assisting this population in applying for services that will assist in transition to adulthood. Service components – Synchronized Aftercare Services – Foster Care, Juvenile Justice, Children’s Behavioral Health. One-Stop centers – 1st in the West Valley and over the next 3 years at least one in each region. Supported Housing Program. The workgroup has a variety of ideas.

**Adult:** The workgroup is comprised of a variety of stakeholders across the county. This workgroup also has 4 subcommittees: Forensics, High Users & Homeless, Housing & Employment, Recovery & Wellness. The Workgroup’s proposal, at this point, is focusing on Homelessness and Incarceration. They have written the 1st draft of their plan. The next meeting will be on November 2, 2005. If you are interested, please attend.

**Older Adults/Elders:** This workgroup has about 25-30 members comprised of a variety of stakeholders. The priorities are to reduce frequent hospitalization (both psychiatric and medical) and incidents of relapse to previous behaviors, increase ability to manage independence and improve access to care. CSS Proposal is emphasizing: Intensive case management, working closely with families, Multi-Disciplinary Team for treatment and rehabilitation services, and increase Senior Peer Counselors – recruit & train consumers.

**Policy Advisory Committee Tasks/Support** – At the November 17, 2005 meeting, we will have a document in which the workgroups have summarized and prioritized their ideas based on the needs assessment. These proposal summaries will include a budget/cost approximation. Hopefully you should receive this draft via e-mail before the 17th. At the December 8, 2005 meeting, we will be discussing a very rough draft of the CSS Proposal. (It will not be a perfect plan, but it can be revised and refined over the next three years.) The proposed plan posting will be December 8, 2005 for the 30-day public review. The Mental Health Commission will hold at least two public hearings to review the document and receive public input. Following this process, the county Board of Supervisors will review and approve for submission of the Plan to the State Department of Mental Health. We are hoping for the end of January 2006 to send the CSS to the state.

**Questions** – **Assistant DA Jim Hackelman:** Q. If money can’t be used for involuntary services can it be used to expand MH Court services? A. Yes, if planning pre-release and support to keep them out of jail. Aggressive case management.

**Chris Massa:** Q. Can we recognize the people who are giving the money for Proposition 63, possibly an ad in the newspaper? A. Yes.

**Kathy Wild:** Does the plan submitted in January encapsulate all 3 years? A. Yes, we will be using projections but the plan will be updated annually.

**Beverly Scott:** Q. Is the 5% that must be set aside for innovative programs included in the 17 million? A. No, it is not included in the 17 million and the guidelines for that 5% have not been set yet but it must be spent on innovative programs.
May Farr: Q. If plan is not submitted by January do we lose funding? A. Yes, the instructions say if you don’t spend all of the money it is going to go into a “prudent reserve” fund to be distributed among all of the counties.

Q. The main topic in focus groups has been the need for education. Can we use the money for this? A. Yes, we can draw from training money and we can set aside one-time only money for education.

Q. In the 16-25 age group, there are hidden consumers in every ethnic background, upper and middle class where the family has hidden the mental illness or taken them to private providers. When they reach 18 they abandon them. How do you get the families re-involved? A. This issue will be addressed by the TAY workgroup.

Conclusion - Allan appreciates everyone’s involvement and enthusiasm. Dr. Andonov, Mental Health Commission Chairman, made a few comments in support of the departments efforts and importance of the open county planning process.

Next Meeting: November 17, 2005 at 9:00 a.m. in the DCS Multipurpose Room at 128 Carousel Mall in San Bernardino.

Respectfully Submitted,
Elizabeth Longfellow
Office Assistant III
Co-Chair: Allan Rawland, Director of County of San Bernardino Department of Behavioral Health
Co-Chair: Chris Masa, Team House in San Bernardino
Recorder: Michelle Brass, Executive Secretary to Allan Rawland

Present: See Attached List

Introductions – Allan Rawland welcomed attendees and thanked them for taking time out of their schedules to be here. Participants introduced themselves and indicated the agencies represented and/or roles in the Mental Health Services Act.

Purpose of the Meeting - Decide and comment on the proposals to put forth and be submitted to the state by the end of January.

Other County proposals - 20 counties have submitted online.

Discussion on Proposals - Currently the proposals are more than 17.1 million. Through consensus the group will pick proposals, to kick off a three to five year transformation process for all county mental health programs, especially to meet the needs of the unserved and underserved population.

Transforming the system to redirect resources after the third year. Not every proposal can be done to its full extent and reflect all four age groups. Because this is a large county with different regional needs, this has to be reflected into plan. Proposals need to include an overview of the county and what are the needs and individual age groups by region.

One time funding. Money came in last June or April for MHSA. We only have couple months this year to spend the money, the rest is going to be used for one time funds to get these programs up and running.

Using fewer high end services. Develop systems to reduce high-end services, use realignment funds to do the programs proposed; outreaching into new communities, people who haven’t received services. Where can we save realignment dollars?

Cultural Competence. How to outreach to the various racial and ethnic communities? How do you give opportunities to employees who are interested in obtaining professional degrees?

In the document that outlines the requirements for preparing the plans, page one has the six major outcomes that will be used to evaluate the proposals.
1. Meaningful use of time… consumer orientated
2. Safe and adequate housing… major component, working w/ housing authorities is critical to leverage available funding.
3. Network of supportive relationships, consumer and family
4. Timely access in time of crisis, response teams, urgent care, receiving adequate treatment in crisis situations; working closely with law enforcement
5. Reduction in incarceration in adult jails and in juvenile halls, - need to provide integrated services in the halls and jails.
6. Reduction in involuntary services, reduction in institutionalization and reduction in out-of-home placement.

PRESENTATIONS OF PROPOSALS
Each chair had 10 minutes. Information came from packets
CHILDREN’S WORK GROUP
  Comprehensive Child and Family Support.
  Co-occurring residential treatments
  Wrap around. Focus on Latino child and families.
  Crisis intervention
  Co-Occurring Outpatient Program

TAY- Transitional age youth workgroup
  Starting in the west end, most un-served population, 2nd year is san Bernardino.
  3rd mid dessert, Morongo Basin area
  One Stop TAY Center
  Supportive Housing Services Program (25 housing vouchers, 15 for families, some of TAY could have their own families, need to help w/own families and maintain their own house.)
  Synchronized Resources System – TAY aftercare
  (Children aging out of foster care, group homes and institutions, help them into community, peer counselors, 24/7 access. Co-located in various clinics; No cost for buildings.)

ADULT WORK GROUPS
  Consumer-Operated Peer Support
  Clubhouse Expansion
  High Hospital User ACT Team
  Forensic Integrated MH Services
  Crisis Walk-in Centers
  Psychiatric Triage Diversion Team at ARMC
  (Proposal deals with homeless, frequent hospitalizations, inability to work, incarceration, access.6 main programs in packets)

ELDER AND OLDER ADULT WORKGROUP
  Plan 1 circle of care - expansion of existing age wise program
  Plan 2 – out reach to older population especially in high desert
Plan 3 – health care for older adults, systematic approach, for underserved and unserved.

PROPOSAL FOR ONE TIME FUNDING
Scott, overview of budget – 1st page in packet, spreadsheet. Totals are over the 17.1 million budget. Allocation for 05/06 is 17.1 million, already in fiscal year, so let funding be used by county.

PLANNING
County can get additional planning money. Get 5% additional from the 17.1 for planning. 400,000 to 800,000.
System improvement funding – request money to use for one time only, how to improve system for implementation, doesn’t have set dollar amount.
One-Time Only
Allow us one time only – depending on allocation to put into housing trust, can be rolled over the next three years.

The Department may only have two months to implement the approved programs. Accordingly, only 2 months of the 17.1 to be used. Any balance that isn’t earmarked for system improvement or one-time only will be distributed to all counties to establish a prudent reserve fund at the state level for each county. Policy of the State is that each county will have 50% of their initial first year allocation in a state account. For San Bernardino County this would be approximately $9 million dollars.

DISCUSSION/ OPINIONS REGARDING PROPOSALS.

- Construction of new buildings. .. integrating buildings, efficiency in terms of cost.
- 1st proposal. Children – did not hear approach, burden of need, demography. .. all pointed toward Latinos. What about black population, Asian, Pacific Islanders, etc.
- Focus on zipcodes, not by regions to combat the needs and representations of that area not to focus on a demographic.
- Question for TAY – Assessments for children in Juvenile Halls?? Would like to see in one stop service center.

Children uses 20%
Tay 25%
Adult is 45%
Older adults is 9%
Admin overhead is 6-10%

Put priorities on proposals – carve out housing for each of the programs.
CHILDREN’S priorities: wraparound program, integrating w/ current foster care wraparound programs. Comprehensive child system, c3 is part. c1 and c3 to include in and become C1 to eliminate c3. C4 is now C2. C2 is now c3. C5 would be c4.

TAY, all programs combined to be one comprehensive program.

ADULTS, A-1 and A2 are A1; A3, A5, A6 are A-2 and A4 is A3.

OLDER ADULTS
Circle of care older Adults All Important programs.

Dollars—Break down 17.1 million by percentages:
3,237,000 - Children 20% 
4,043,000 – TAY 25%
7,268,000 - Adult 45%
1,517,000 -aging adults 9-10%
2,565,000 - administration 15% of total.

Older adult. Would like to get 2.8 million. Not get cut in half percent, they were very realistic in their projections. Consensus of Group for Older adults to get 2 million. – 12% of the monies.
17.1 million then take 12% and then 2 million for admin then take the percentages off the rest.
Children and youth, TAY and Adult

NEXT MEETING: December 8, 2005
**MHSA Community Policy Advisory Committee (CPAC)**

*Minutes for December 8, 2005*

**Meeting Called to Order:** Chair, Allan Rawland acknowledged staff for making magnets and decorating the auditorium. He informed the committee of posting the plan if a consensus was made today.

**Welcome and Introductions:** Allan Rawland welcomed attendees and attendees introduced themselves.

**Overview:** Through the consensus process, the committee came to an agreement of the plan to propose to the state. The meeting will consist of presentations of the plan, discussion of one-time only, consensus of the committee of the draft plan presented, the public hearings that will be held and acknowledgements. Allan Rawland acknowledged Lisa McGinnis as the new coordinator for the Mental Health Services Team and her staff.

**Community Services & Support (CSS) Proposal:** Attendees were provided a binder with the executive summary and information about the Community Program Planning Process and Plan Review Process. Allan Rawland gave an overview of the CSS plan which consisted of:

- **Part I:** County/Community Program Planning Process
  - Section I: Planning Process
  - Section II: Plan Review – (Distribution of the Plan, holding public hearings, incorporating any recommended changes and further public review)

- **Part II:** Program & Expenditure Plan Requirements

- **Part III:** Required Exhibits

General Attachments

The executive summary with cover letter will be posted with the plan on the web. Copies will be distributed to the Board of Supervisors and there will be a press release.

**Presentations:** Ralph Ortiz, Deputy Director of Adult Services for the County of San Bernardino Department of Behavioral Health was introduced by Allan Rawland. Ralph Ortiz acknowledged work group chairs and introduced Rosa Gomez.

**Summary of Community Program Planning Process** was presented by Rosa Gomez in which she discussed:

- Cultural Competency was presented by Ms. Aragon and attendees were given a copy of the Cultural Competence Plan Update.

Kimm Hurley-Smith, Deputy Director of Children and Family System of Care acknowledged staff and introduced Rosa Gomez.
Children and Youth and Transitional Age Youth was presented by Rosa Gomez.
Adults was presented by David Denkers
Older Adults was presented by Carolyn Havert
One time only proposal was presented by Allan Rawland and Scott Nichols who presented the budget.

**Discussion:** It is estimated that there will be a period of 3 months for implementation. When state approves plan the process can start in the spring. The state has not sent out any letters approving any of the plans already submitted. Additional funding is expected into the system, according to the state in which they have estimates of a possible 2% increase in the MHSA trust fund. The projections are between 75 to 100 million into San Bernardino County in the next 3 years.

**Consensus:** The committee approved the plan as presented

**Acknowledgements:** Individuals who have participated in the Community Policy Advisory Committee were acknowledged and given a certificate of involvement as a member. Meeting was adjourned.

**Next Meeting:** January 25, 2006 at 9:00 a.m. in the DCS Multipurpose Room at 128 Carousel Mall in San Bernardino.
December 29, 2005

Allan Rawland, Director
San Bernardino County
Department of Behavioral Health
850 East Foothill Boulevard
Rialto, CA 92376

Dear Mr. Rawland:

This letter is to inform you of the Removal of Conditions to San Bernardino County’s Mental Health Services Act (MHSÅ) Community Program Planning submission.

A team of DMH staff reviewed the package of supplemental information provided by your Department and found that the concerns expressed in the initial review of your plan have been addressed.

Feel free to contact Troy Konarski, your County Operations liaison, at (916) 654-2643 if you have any questions. I look forward to continuing this effective partnership for transforming the delivery of mental health services in California.

Sincerely,

[Signature]

CAROL HOOD
Deputy Director
Systems of Care

cc: California Mental Health Planning Council
Chief, County Operations
Chief, Adult and Older Adult Program Policy
Chief, Child and Family Program Policy
Media Advisory: County Seeks Input on Mental Health Service Needs
Survey Available on County Website to Solicit Opinions for Mental Health Services Act

WHO: Persons living in the San Bernardino County area who are interested in:
- Expressing opinions regarding a variety of mental health issues
- Identifying concerns about the impact of mental illness on communities

WHAT: As part of the County’s ongoing Mental Health Services Act (MHSA) “Prop 63” Community Program Planning process it is important for the public to participate in the planning process in a variety of ways. The MHSA opinion Survey can now be found on the San Bernardino County website @ http://www.sbcounty.gov/

WHY: The Mental Health Services Act is a law that took effect January 1, 2005, after being voted in by California voters in November 2004. It establishes a 1% tax surcharge on income over $1 million per year to fund expanded mental health services for children and adults. The County has sponsored a variety of stakeholder participation activities, including community forums and focus groups. This online survey provides another way for the County to obtain information from the public regarding mental health needs, concerns and priorities as the Community Program Planning process progresses.

WHEN: Available effective October 3, 2005

CONTACT: For additional information and to learn about opportunities to participate, please call the San Bernardino County MHSA Coordination Team at 909-387-7712.
Media Advisory: County Seeks Input on Mental Health Services Act (MHSA), Proposition 63

WHO: All residents of San Bernardino County

WHAT: MHSA Three-Year Community Services and Supports Program Plan (CSS) Draft posted for public review and comment.

WHY: In November 2004, California voters approved Proposition 63 to expand mental health services funding for a comprehensive community–based mental health system for Californians who need it most. The San Bernardino County Department of Behavioral Health has completed its initial three-year CSS draft plan for how to use new MHSA funding to meet the needs of unserved and underserved residents of our county. The county’s comprehensive CSS plan is the result of collaboration among public and community agencies, community members, consumers, family members, advocates and other county constituents. The plan is designed to begin to address the mental health needs of children, transitional age youth, adults and older adults in ways that enhance and strengthen the local mental health system. As part of the process, the State Department of Mental Health requires counties to post their CSS plans for a 30-day public review and comment period.

WHEN: Tuesday December 13, 2005

WHERE: County’s Department of Mental Health website on http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm Additional copies will be available for review at select County branch libraries and community mental health clinics

CONTACT: For additional information, please contact Lisa McGinnis at (909) 387-7712.
Public hearings on proposed mental health services planned

The County of San Bernardino is inviting the public to participate in open hearings to review and comment on the County’s draft plan for Community Services and Support as provided within the Mental Health Services Act.

The Mental Health Services Act (MHSA), more commonly known as Proposition 63, was passed by California voters in November 2004 and imposes an additional 1 percent tax on that portion of a taxpayer’s taxable income over $1 million.

As required by the act, the County Department of Behavioral Health developed the draft Community Services and Support plan with input from local community stakeholders. This process involved a 79-member Community Policy Advisory Committee, community public forums, targeted outreach, stakeholder surveys, workgroups targeted to age and communities, training and technical assistance sessions, and community and staff focus groups.

More than 280 meetings, trainings and events have been held. Consumers, family members and advocates have played a significant role in drafting this phase of the plan, which seeks to enhance the local mental health system for children, youth and adults of all ages throughout the county.

The draft plan is now ready for final public review and comment prior to submission to the California Department of Mental Health. Hearing locations and dates are as follows:

- **Tuesday, Jan. 17, 6-8 p.m.**, Victor Valley Clubhouse, 12625 Hesperia Road, Victorville
- **Wednesday, Jan. 18, noon-2 p.m.**, Yucca Valley Community Center, 57090 Twenty-Nine Palms Highway, Yucca Valley
Thursday, Jan. 19, 6-8 p.m., Behavioral Health Resource Center, 850 E. Foothill Blvd., Rialto

A link to the plan and additional information on the MHSA can be found at [www.sbcounty.gov](http://www.sbcounty.gov).
STATE OF CALIFORNIA
County of San Bernardino

I am a citizen of the United States and a resident of the County aforesaid: I am over the age of eighteen years, and not a party to or interested in the above-entitled matter. I am the principal clerk of the printer of the:

HI-DESERT STAR
a newspaper of general circulation, printed and
Published BI-WEEKLY

In the City of YUCCA VALLEY,
County of San Bernardino, and which newspaper has been adjudged a newspaper of general circulation by the Superior Court of the County of San Bernardino, State of California,

under the date of 11/27/19

Case Number 107762: that the notice, of which the annexed is a printed copy (set in type not smaller than nonpareil), has been published in each regular and entire issue of said newspaper and not in any supplement thereof on the following dates, to wit:

1/4

All in the year 2006

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Dated at YUCCA VALLEY

California, this 4th day of January 2006

Signature

Nerissa Parker
STATE OF CALIFORNIA
County of San Bernardino

I am a citizen of the United States, I am over the age of eighteen years, and am a party to or interested in the above-entitled matter. I am the principal clerk of the printer of INLAND VALLEY DAILY BULLETIN, a newspaper of general circulation printed and published daily in the City of Ontario, County of San Bernardino, and which newspaper has been adjudged a newspaper of general circulation by the Superior Court of the County of San Bernardino, State of California, on the date of August 24, 1951, Case Number 70683.

The notice, of which the annexed is a true printed copy, has been published in each regular and entire issue of said newspaper and not in any supplement thereof on the following dates, to wit:

1/4/06

I declare under penalty of perjury that the foregoing is true and correct.

Executed at Ontario, San Bernardino Co, California this 4 day of January 20 06.

[Signature]
NOTICE OF PUBLIC HEARING

BEFORE THE SAN BERNARDINO COUNTY MENTAL HEALTH COMMISSION

REVIEW THE MENTAL HEALTH SERVICES ACT (MHS) COMMUNITY SERVICES AND SUPPORTS DRAFT PLAN

Public Meetings have been scheduled for January 17, 18, and 19, 2009, before the San Bernardino County Mental Health Commission regarding the Mental Health Services Act (MHS) Community Services and Supports (CSS) Draft Plan.

A list of the topics, times, and locations of these hearings is provided in this notice. The purpose of these hearings is to review the plan and to gather public comments on the plan. The MHS was passed by the California voters as Proposition 63 in November 2004. This CSS plan is the second of six MHS components to be awarded for local county funding by the State Department of Mental Health. These community services and supports are designed to enhance the mental health service system for children and transition age youth with serious emotional disturbance and adults with serious mental illness and substance abuse.

Copies of the CSS Plan documents presented to the San Bernardino County Department of Behavioral Health (DBH) community clinics, contracted clinical, and local county programs that are listed in this notice. The plan is also available on the Internet at the County website, which is: http://www.sbc.sal.ca.us/boards/mental_health-services传统产业.

Any person wishing to comment on the CSS Draft Plan may do so in writing prior to the CSS hearings or may appear and be heard at the location and time stated in the notice. All comments received by January 12, 2005, will be reviewed by the Mental Health Commission and will be considered with any other testimony prior to preparing the final version of the CSS Plan for approval by the Board of Supervisors. Please send all written correspondence to:

San Bernardino County Department of Behavioral Health, 820 E. Gibson Street, San Bernardino, CA 92405-0920.

San Bernardino, CA 92405-0920

* * *

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SANTA ANA
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SANTA ROSA
(707) 545-1166
You are invited by the San Bernardino County Mental Health Commission and the Department of Behavioral Health to attend

**PUBLIC HEARINGS**

These public hearings are being held to gather comments on the draft plan for the Community Services and Supports (CSS) component of the Mental Health Services Act.

The Mental Health Services Act (MHSA), Proposition 63, was passed by California voters in November 2004. The CSS component is the second of six to be released by the State Department of Mental Health and represents $17.1 million. This plan’s services and supports are designed to enhance mental health services for children and youth with serious emotional disturbance and for transition age youth, adults and older adults with serious mental illness.

Please join us at one of the listed public hearings to learn more about the plan and to voice your opinion.

*Language interpretation services will be available.*

*Call (909) 387-7712 by January 10, 2006.*

For additional information on the MHSA Community Services and Supports plan, you may visit,

[http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm](http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm)
The Draft Community Services and Supports Plan may be viewed at the following San Bernardino County Library locations:

<table>
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<tr>
<th>Administration Branch</th>
<th>Adelanto Branch</th>
<th>Apple Valley Branch</th>
<th>Barstow Branch</th>
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And at the following clinic sites:

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<th>Boys' &amp; Girls' Club</th>
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<td>Hesperia Clinic</td>
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<td>Lucerne Valley Clinic</td>
<td>Mesa Counseling Center</td>
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<td>Phoenix Clinic</td>
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<td>1300 Bailey Avenue</td>
<td>209 N. 10th Street</td>
<td>700 East Gilbert, Bldg 4</td>
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<td>Vista Community Counseling</td>
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These public hearings are being held for the purpose of public review of and comment on the county’s plan for the Community Services and Supports (CSS) portion of California’s Mental Health Services Act (MHSA). The plan will be submitted for funding to the California Department of Mental Health following review and comment by county residents.

The Mental Health Services Act (MHSA), or Proposition 63, was passed by California voters in November 2004. MHSA imposes an additional 1% tax on that portion of a taxpayer’s taxable income over one million dollars. The Community Services and Supports (CSS) Plan is the second phase of six phases to be initiated by the California Department of Mental Health. In order to receive MHSA CSS funds, each county must submit a three-year expenditure plan to the State Department of Mental Health, following standard requirements.

The Plan must be developed with local community stakeholder participation. Our county’s planning process involved a 79 member Community Policy Advisory Committee process, Workgroups for targeted age groups, community and staff focus groups, targeted forums, training and technical assistance sessions, community public forums, targeted outreach and stakeholder surveys. Consumers, family members and advocates played a significant role in our community input process and were provided supports such as reimbursements for time, refreshments and transportation. In all, it is estimated that more than 280 meetings, trainings and events were held during the community planning process in our county.

The result of the comprehensive planning process is the proposed CSS plan, ready for public review and comment. This plan seeks to enhance the local mental health system, addressing issues affecting children and youth with serious emotional disturbance and seriously and persistently mentally ill adults and older adults throughout the county.

WE LOOK FORWARD TO SEEING YOU AT ONE OF THE PUBLIC HEARINGS LISTED BELOW.

Language interpretation services will be available.

**January 17, 2006**
*Location:* Victor Valley Clubhouse
12625 Hesperia Road,
Victorville, CA 92392

**January 18, 2006**
*Location:* Yucca Valley Community Center
57090 Twenty-Nine Palms Highway, Yucca Valley, CA 92284

**January 19, 2006**
*Location:* Behavioral Health Resource Center
850 E. Foothill Blvd.
Rialto, CA 92376

For additional information on the MHSA Community Services and Supports plan, you may visit [http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm](http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm)
El condado de San Bernardino, la comisión de Salud Mental y el Departamento de Salud Mental les invitan a asistir.

AUDIENCIAS PUBLICAS

Estas audiencias se llevarán a cabo para colectar comentarios y recomendaciones acerca de la versión del plan para los servicios comunitarios y de apoyo (CSS) como parte de la Ley de Servicios de Salud Mental.

La Ley de Servicios de Salud Mental (MHSA), Proposición 63, fue aprobada por los votantes de California en Noviembre del 2004. El componente de CSS es el Segundo de seis que serán publicados por el Departamento Estatal de Salud Mental y representa $17.1 millones. Este plan de servicios y apoyo está diseñado para mejorar los servicios de salud mental para niños y adolescentes con serios trastornos emocionales, para adultos y personas mayores de edad con enfermedades mentales serias.

Por favor participe con nosotros en una de estas audiencias públicas, para aprender más acerca del plan y para expresar su opinión.

Habrá Servicios de Interpretación en Español
Llame al (909) 387-7712 antes del 10 de Enero, 2006

Para más información visite
La pagina web de MHS
http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm

County of San Bernardino Department of Behavioral Health
Mental Health Services Act Coordination Team, 820 East Gilbert St., Room 117, San Bernardino, CA 92415
La Ley de Servicios Comunitarios y Plan de Apoyo se encuentra en las siguientes Bibliotecas del Condado de San Bernardino:

Administration Branch  Adelanto Branch  Apple Valley Branch  Barstow Branch  
104 W. Fourth St.  11744 Bartlett St.  14901 Dale Evans Parkway  304 East Buena Vista  
San Bernardino, CA 92415  Adelanto, CA 92301  Apple Valley, CA 92307  Barstow, CA 92311  
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Yucaipa Branch  Yucca Valley Branch  
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Yucaipa, CA 92399  Yucaipa Valley, CA 92284  

Y en las siguientes clínicas:

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Rialto, CA 92376  San Bernardino, CA 92411  Lucerne Valley, CA 92356  Rialto, CA 92376  
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Yucca Valley, CA 92286  Needles, CA 92363  Colton, CA 92324  San Bernardino, CA  
TEAM House  Upland Community  Victor Valley  Vista Community  
201 W. Mill St.  934 N. Mountain Ave., #C  Behavioral Health  Counseling  
San Bernardino, CA 92408  Upland, CA 91783  Victorville, CA 92392  Fontana, CA 92337
January 6, 2006

To: All Contract Agency Providers

From: Elizabeth Longfellow, Office Assistant III & Cynthia Waldron, Office Assistant III

Subject: Mental Health Services Act (MHSA)

On behalf of the Mental Health Commission we would appreciate your assistance in promoting the upcoming Public Hearings being held to gather comments on the draft plan for the Community Services and Supports (CSS) component of the Mental Health Services Act.

**PLEASE DISPLAY AND/OR DISTRIBUTE THE FLYERS TO CONSUMERS, COMMUNITY MEMBERS AND OTHER PARTNERING AGENCIES.**

*Encourage everyone to participate and let them know this is how they can get involved in shaping the future of mental health services in their community!*

*LANGUAGE INTERPRETATION SERVICES AVAILABLE*

For additional information:
Phone: 909-387-7712

Or visit our website: 
http://www.co.san-bernardino.ca.us/dbh/Mental_Health_Services_Act.htm
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<td>Vista Guidance Centers</td>
<td>PO Box 7369</td>
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<td>Vista, Highland Guidance Center</td>
<td>3694 Highland Avenue, Suites 19, 23 &amp; 24</td>
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<td>WestCare Arizona I, Inc.</td>
<td>800 W. Broadway, Suite D</td>
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</table>
San Bernardino County Sun
Your Town-12/19/2005

ET CETERA
Public input sought on mental-health plan

The San Bernardino County Department of Behavioral Health is seeking public input through Jan. 13 on its Community Services and Supports plan, which outlines expanded mental-health services through 2008.

The 415-page plan was the result of opinions from 2,700 people in the county, 900 of whom were clients along with their families. It outlines local spending of new money for public mental health provided by Prop. 63, which was passed by California voters in 2004.

The county has received $17 million this year through the proposition.

The six-part plan calls for integrating services, improving prevention, focusing on clients and wellness, and decreasing homelessness, hospitalizations and incarcerations.

In addition to private responses to the plan, public hearings will be held in the county Jan. 17-19.

To view the report, visit www.co.san-bernardino.ca.us/dbh/ and click on "Mental Health Services Act." Or call (909) 387-7712 for locations where the report is available.

emily.sachs@sbsun.com
County to submit Prop. 63 proposal in ’06

By Annette Wells
Staff Writer

San Bernardino County’s three-year proposal on how it expects to raise $17 million in Proposition 63 funding should be headed for Sacramento sometime in late January or early February.

Although it won’t be the first county to submit a proposal, it will be among the last, according to new Behavioral Health Director Allan Rawland.

So far, at least a dozen other counties have submitted proposals, he said. Fresno County, which was one of the first, is closest to being reviewed by the state Department of Mental Health, said Kirsten Macintyre, assistant director of external affairs.

“One of the advantages of not being first is you can learn from what others have submitted — as long as you’re not last,” said Rawland, who touted Fresno County for being the first to get a plan in.

“We won’t be last.”

DBH’s plan is to have a rough draft of its plan on the county’s Web site for public review and comment by mid-November.

“By December, and following the 30-day public review, the proposal should be ready for modifications,” Rawland said.

“I know December is a busy time, but everyone is committed,” Rawland said. “After we do modifications, we can get it to the Board of Supervisors. We’re shooting for January.”

Passed by voters in November, Proposition 63 imposes a 1 percent tax on personal incomes of more than $1 million.

Funds will be used to expand mental health services and develop programs for mentally ill children, teens, adults and seniors in the areas of prevention, early intervention, education and job training.

In order to receive funding, each county must submit a three-year proposal outlining what its unmet needs are, the costs of meeting those needs and the capacity in staff and facilities.

Although there’s no actual deadline for these proposals, Macintyre said it would behoove counties to get them in as soon as possible.

Counties will not receive the funds according to a formula, though. Funding will be based on the proposals they submit.

Proposals are required annually.

“The counties are not competing against each other for money because each already knows what their cap is. They are trying to get to that full amount,” Macintyre said. “We want to approve that amount.”

Revenues from Proposition 63 are expected to reach $700 million in fiscal year 2005-06 and $700 million in 2006-07.

Riverside County is estimated to receive $16.7 million and Los Angeles County about $90 million.

Those amounts should increase annually.

More than anything, though, the state is likely to save hundreds of millions of dollars annually through reductions in state prison costs and county jail operations that often house the mentally ill, officials said.

Octavio Luna, executive director of Patton State Hospital near San Bernardino, said he anticipates less of a capacity problem once Proposition 63 funding is in full swing. Patton is one of five state mental institutions in California.

Patton is licensed for 1,287 beds, but it has about 1,480 psychiatric patients.

The average population at Patton for fiscal year 2004-05 was 1,513.

“We have a lot more patients than we’re licensed for,” Luna said. “There is a bed crisis in all our state hospitals.”

Costs for medical care, homeless shelters and social services programs are also expected to be offset because of the measure.

Earlier this week, the county’s Mental Health Services Act Coordination Team released a survey to solicit public opinion about what the unmet mental health needs are in the community.

That survey is available on the county’s Web site at www.sbcounty.gov. The survey is in both English and Spanish, Rawland said.

Rawland said the county will also pursue “one-time-only funding” under Proposition 63.

“This could be used to increase our outreach into the community and do more training for our staff,” he said. “This money can’t be used to provide programs, but you can begin to prepare for programs.”

For more information about the Mental Health Services Act, call (909) 387-7712.

Contact writer Annette Wells at (909) 385-3855 or via e-mail at annette.wells@sbsun.com.
County drafts mental-health plan

Locating 60,000 people needing treatment is proposed by agency

By Annette Wells
Staff Writer

The county Behavioral Health Department's proposal to spend $17 million in Proposition 63 funding doesn't appear to cut any corners.

The 415-page draft calls for creating more mental health courts, four 24-hour one-stop centers for youth, three 24-hour crisis walk-in clinics, community-outreach programs and locating an estimated 60,000 people who aren't receiving treatment in San Bernardino County's four regions.

The majority of mental-health services currently are located in or near San Bernardino, even though the county is the largest in the nation and a large part of its population lives in the desert and mountains.

Allan Rawland, county director of behavioral health, said geography was a big factor in determining how the money was to be spent and how the county was to meet the mental-health needs of everyone.

ONLINE EXTRA

- Read the draft plan developed by the county.
- "It's like planning for three counties," he said.
- Passed in 2004, Proposition 63, or the Mental Health Services Act, imposed a 1 percent income tax on individuals earning $1 million or more this year and in the future. The money is to be used to expand mental-health services to children, transitional "aged-youth" adults (16-24) and the elderly.
- But first, each county had to draw up a comprehensive plan on how to spend the money in a three-year period.
- Spending highlights of the county's plan include:
  - $2.4 million to redesign and expand the county's current walk-in clinics into a countywide system of three 24-7 crisis walk-in centers.

See PLAN / Page B3
Plan

continued from page B1

- $1 million for mobile outreach to the elderly mentally ill who live in areas of the county that are hard to reach.
- $2.7 million to assist 270 families with children who are emotionally disturbed.
- $1.9 million to provide specialized mental-health services to 110 severely and persistently mentally ill individuals who are involved with the criminal justice system.
- $3.5 million to provide 24-hour access to fully integrated services for transition-age youth through the creation of four one-stop centers.

"We have a major push to get youth between ages 16 and 24 who fall out of the foster-care system and into the mental-health and criminal-justice systems," Rawland said. "That is key.

According to the county's proposal, one-stop centers would provide much-needed intensive case management, after-care services, medical support, educational and vocational services and housing to this group.

Any roadblocks to employment and education as well as substance-abuse treatment would be addressed.

The first center would open in the West Valley next year, in the East Valley in 2007 and the Morongo Basin and High Desert by 2008.

"This is really to try and keep them from cycling in and out of the system," Rawland said.

Robin Aaron, chief executive director of Redlands-based Vista Guidance Center, said she is in the process of reading the plan and really couldn't comment. But, she said, the county's diligence about getting the plan together should be recognized.

Formerly known as the Redlands-Yucaipa Guidance Clinic Association, Vista Guidance Center provides mental-health and substance-abuse services to children and adults in San Bernardino, Riverside and Los Angeles counties.

Other issues addressed in the plan pertain to reaching people of color and the homeless mentally ill.

"We are meeting with the Housing Authority about that," Rawland said. "We hope to secure some facilities where we can possibly add housing in the future."

The plan can be viewed for the next 20 days at www.co.san-bernardino.ca.us. Afterward, it will be revised and submitted to the Board of Supervisors for review, then to the state.

Carol Hood, deputy for systems of care for the state Department of Mental Health, said Thursday that about 30 counties, including Los Angeles and Riverside, have posted their proposals. About 20 have submitted their proposals to the state.

Hood said those proposals will be reviewed for 90 days and, if approved, the counties will start receiving their funding sometime next year.

If approved, San Bernardino County will receive $17.68 million. Riverside County would get about $16.7 million.

Bill Brunner, Mental Health Service Act coordinator for Riverside County, said its plan was posted on Nov. 9. Jan. 10 is the target date to get it to the Board of Supervisors, he said.

Contact writer Annette Wells at (909) 398-3555 or via e-mail at annette.wells@absun.com.
MAKING IT WORK

County moves to help mentally ill

**OUR VIEW:** San Bernardino County moves closer to being able to draw from Proposition 63 funds.

When Proposition 63 passed in 2004, it signaled a renewed effort in California to provide more extensive and accessible mental health resources for the people who need it.

The Mental Health Services Act imposed a 1 percent income tax on individuals earning $1 million or more a year to help fund the expansion of mental health services to children, teenagers, young adults and the elderly.

However, in order to receive state funding, each county was required to draw up a comprehensive plan on how to allocate the money during a three-year period. It is a task that San Bernardino County, with a sizable population of mentally ill, has taken very seriously.

The Behavioral Health Department has submitted an extensive 415-page proposal asking for $17 million that would be used to upgrade and expand mental health services in the county’s four regions.

Proposed projects include three walk-in crisis centers, 24-hour integrated access to services and a mobile outreach program.

The plan still must be reviewed by the Board of Supervisors and then sent to the state for final approval, but we are hoping that this process is conducted as expeditiously as possible.

With an estimated 60,000 people in San Bernardino County not receiving the mental health treatment they need, it is vital that such a plan be enacted without delay.

Leaving the mentally ill without such needed services is unacceptable. It contributes, in no small part, to the county’s problems with homelessness, unemployment and increased criminal activity.

Mental illness is not something that can be ignored—as is evident to anyone who travels the streets of San Bernardino. Mental illness must be dealt with head on, and not only for the sake of those in need of mental health services, but for the entire community that must deal with them.
Helping mentally ill

In my capacity as the director of the Department of Behavioral Health for San Bernardino County, I would like to applaud The Sun for its very supportive Jan. 3 editorial, "County moves to help mentally ill."

The editorial demonstrates the newspaper's commitment to reducing stigma surrounding services for the mentally ill.

It also advocates for the development of community-based mental-health services in the least restrictive setting for the most vulnerable members of our communities.

Keeping with the intent of the goals of Proposition 63, the Mental Health Services Act, San Bernardino County's Community Services and Support plan is designed to aggressively reach out to many underserved or uninsured populations that traditionally have not access to the public mental-health systems — for example, the homeless mentally ill, racial and ethnic populations, children and families who lack mental-health coverage, youth growing out of the foster-care system, children in out-of-home placement, persons making the transition from the juvenile and criminal justice systems and isolated older adults who have health-care issues.

We appreciate your statement that "mental illness is not something that can be ignored" by the community.

The county's proposed plan to the state Department of Mental Health lays the foundation and begins to transform the behavioral-health system in a responsive, culturally competent, family- and consumer-driven system oriented to wellness and recovery and resilience for all the residents of the county who are suffering from serious mental illness and serious emotional disturbance.

We appreciate The Sun's concern and support.

ALLAN HAYLAND
Director,
San Bernardino County
Department of Behavioral Health
Residents to have say in mental-health plan

By Kelly Rush
Staff Writer

The community will have several chances next week to comment on a $17 million county plan to better serve mentally ill children and adults before it is submitted to the state for approval.

San Bernardino County would receive a total of $51 million over three years. The proposition, also known as the Mental Health Services Act, imposes an additional 1 percent tax on incomes exceeding $1 million.

San Bernardino County's draft Community Services and Support Plan is a three-year proposal on how it expects to spend money from Proposition 63, passed by voters in November 2004.

See PLAN / Page A10
Plan X

continued from page A1

As a requirement of the act, the county Department of Behavioral Health created the plan with the input of mental-health providers, community groups and a 79-member advisory committee.

The three hearings, to be held on Tuesday, Wednesday and Thursday, offer people a chance to review and criticize the document before it’s forwarded on to the state Department of Mental Health.

The plan was released Dec. 13 and circulated for a month-long period, which ends today.

The Board of Supervisors also must approve the plan, said county Behavioral Health Director Allan Rawland.

He expects to present the document to the board at its Feb. 7 meeting, after which he’ll personally deliver it to Sacramento, he said. Rawland hopes to receive state approval sometime in May, which would be symbolic since May is Mental Health Month, he said.

“It’s very exciting to be involved in helping to implement this new social policy,” he said. “As long as we stay within the intent (of the law), it gives us the chance to provide creative and innovative services we normally couldn’t provide.”

The plan addresses four main areas, including services for children, young adults between 18 and 25, adults and seniors.

Some of the most significant aspects of the plan include the creation of crisis centers for urgent psychiatric needs and comprehensive service centers for young adults which will provide educational, mental-health and housing services.

If you want to go

The public is invited to attend any of the following hearings on San Bernardino County’s draft Community Services and Support plan, as required by the Mental Health Services Act.

• Tuesday, 6 to 8 p.m., Victor Valley Clubhouse, 12825 Hesperia Road, Victorville.
• Wednesday, noon to 2 p.m., Yucaipa Valley Community Center, 57090 Twentymile Palma Highway.
• Thursday, 6 to 8 p.m., Behavioral Health Resource Center, 850 E. Foothill Blvd., Redlands.

“We’re not only providing mental-health intervention, but the necessary support services to make that intervention successful,” Rawland said.

Bob Sudol, director of the Behavioral Health Department’s homeless program, was a member of the plan’s writing committee. He said homelessness and economic instability are some of the biggest factors plaguing people with mental illness.

Sudol said the plan increases treatment options both for the homeless and other underserved populations in the county.

“I think the plan is going to provide more access to emergency and 24/7 services, which has been limited, so people can be seen and get help after hours,” he said.

A portion of the state funds also will be set aside to be used for housing programs, something that hasn’t been done before because of the expense, county officials said.

Contact writer Kelly Rush at (909) 986-3899 or via e-mail at kelly.rush@absun.com.
San Bernardino County
Mental Health Commission
Mental Health Services Act (MHSA)
Community Services and Supports (CSS)
Draft Plan

PUBLIC HEARING

AGENDA

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<th>Time</th>
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<td>6:00-8:00 pm</td>
<td>Yucca Valley</td>
<td>January 18, 2006</td>
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<td>Rialto</td>
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<td>Behavioral Health Resource Center</td>
<td>850 E. Foothill Blvd.</td>
<td>Rialto, CA 92376</td>
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Victorville
January 17, 2006
6:00-8:00 pm
Victor Valley Clubhouse
12625 Hesperia Rd.
Victorville, CA 92392

Yucca Valley
January 18, 2006
12:00 – 2:00 p.m.
Yucca Valley Community Center
57090 TwentyNine Palms Hwy.
Yucca Valley, CA 92284

Rialto
January 19, 2006
6:00 – 8:00 p.m.
Behavioral Health Resource Center
850 E. Foothill Blvd.
Rialto, CA 92376

Agenda Item

CALL TO ORDER

INTRODUCTIONS

REVIEW OF AUTHORITY FOR PUBLIC HEARING

REVIEW GROUND RULES

PURPOSE OF PUBLIC HEARING
   A. Public Hearing to Receive Public Comments
   B. Review Agenda
   C. Review Next Steps

OVERVIEW OF SAN BERNARDINO COUNTY’S MHSA
COMMUNITY SERVICES AND SUPPORTS DRAFT PLAN

PUBLIC COMMENT PERIOD

CLOSING REMARKS

ADJOURNMENT
The Public Hearing is accessible to people with disabilities.

Person(s) Responsible

Commission Chair or Designee
All Commissioners
Ed Diksa – CIMH Training Coordinator
Ed Diksa
Allan Rawland – DBH Director
Ed Diksa – Facilitator
Commission Chair or Designee
Commission Chair or Designee
MEETING REGULATIONS FOR
MHSA PUBLIC HEARINGS
1/17/06, 1/18/06 and 1/19/06

These hearings are focused exclusively on the draft Community Services and Supports Plan. All testimony must address its contents only. To assure that every person who wishes to address the plan has an opportunity to do so, these guidelines will drive the meeting.

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 age related program in the CSS 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.
Thank you for your interest in San Bernardino County's effort to transform the local mental health service system through an ongoing and community-driven program planning process.

What is your age?
- □ 0-17 yrs.
- □ 18-24 yrs.
- □ 25-59 yrs.
- □ 60 + yrs.

What is your gender?
- □ Male
- □ Female

What region do you live in?
- □ Central Valley Region
- □ Desert/Mountain Region
- □ East Valley Region
- □ West Valley Region

Which Age-Group Plan most interests you?
- □ Child
- □ Transition Age Youth (TAY)
- □ Adult
- □ Older Adult

What group 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
- □ Community Member

What is your ethnicity?
- □ Latino/Hispanic
- □ African/American
- □ Caucasian/White
- □ Asian/Pacific Islander
- □ American Indian/Native American
- □ Other (specify) ______________

What is your general feeling about the San Bernardino County CSS Plan?
- □ Very Satisfied
- □ Somewhat Satisfied
- □ Satisfied
- □ Unsatisfied
- □ Very Unsatisfied

Please discuss the things in the CSS Plan which you found to be positive. Please note the specific age group and program affected, if relevant. (If additional space is needed, please use reverse side of this form.)

What recommendations do you have regarding the improvement of the CSS Plan? Please note the specific age group and program affected, if relevant. (If additional space is needed, please use reverse side of this form.)

Thank you again for taking the time to review and provide input on the County’s Community Services and Supports program expansion funding proposal. We hope that you will continue to participate in this exciting effort to enhance services for our county’s residents!
Ley de Servicios de Salud Mental
Plan de Presupuesto por Tres años de Servicios y Apoyo
Condado de San Bernardino Departamento de Salud Mental Y Comportamiento
Comisión de Salud Mental Foro Publico forma Para Comentarios
Gracias por su interés en el esfuerzo del condado de San Bernardino de transformar los servicios de salud mental en su localidad a través de un proceso de planeamiento continuo y basado en las necesidades de la comunidad.

¿Cuál es su edad?
☐ 0-17. ☐ 18-24. ☐ 25-59. ☐ 60 o más.

¿Cuál es su Genero?
☐ Masculino ☐ Femenino

¿En que región vive??
☐ Región Central del Valle
☐ Región del Desierto/ Montaña
☐ Región Este del Valle /San Bernardino
☐ Región Oeste del Valle

¿Cuál edad de planeamiento esta más interesado?
☐ Niños
☐ Jóvenes en Transición (TAY)
☐ Adultos
☐ Adultos Ancianos

¿Qué edad de planeamiento esta más interesado?

¿Que Grupo usted representa?
☐ Miembro familiar de un consumidor
☐ Consumidor de servicios de Salud Mental
☐ Departamento de Policía
☐ Personal de la escuela
☐ Agencia en la Comunidad
☐ Comunidad Religiosa
☐ Empleado del condado
☐ Servicios Humanos
☐ Proveedor de Servicios de Salud
☐ Miembro de la Comunidad

¿Qué Grupo usted representa?

¿Cuál es su Identidad Étnica?
☐ Latino/ Latina
☐ Africano-Americano
☐ Euro-Americano
☐ Asiático -Americano
☐ Nativo Americano
☐ Otro (especifique) ______________

¿Cuáles son sus sentimientos generales acerca del CSS plan del condado de San Bernardino?

☐ Muy satisfecho ☐ Un poco Satisfecho ☐ Satisfecho ☐ Insatisfecho ☐ Demasiado insatisfecho

Por favor díganos las cosas que usted encontró ser positivas en el CSS plan. Por favor haga nota de las edades específicas o programas afectados, si es relevante. (Si necesita más espacio, puede usar la parte de atrás de esta forma)

¿Qué recomendaciones tiene usted para mejorar el CSS plan? Por favor haga nota de las edades específicas y programas afectados, si es relevante. (Si necesita más espacio, puede usar la parte de atrás de esta forma)

Gracias de nuevo, por tomarse el tiempo de revisar y dar recomendaciones acerca de la propuesta de expansión del presupuesto para establecer un Plan comunitario de Servicios y apoyo. ¡Esperamos que usted continué su participación en el esfuerzo de mejorar los servicios de salud mental para los residentes en nuestro condado!
MHSA Overview—PowerPoint Presentation
Mental Health Commission Public Hearings

San Bernardino County
Department of Behavioral Health
Mental Health Services Act (MHSA)
Overview

Mental Health Services Act (MHSA)

- Proposition 63, the MHSA, became law January 1, 2005
- Provides funding to transform local mental health systems
- Population Served: Seriously Mentally Ill & Seriously Emotionally Disturbed
- Goal: To improve resiliency and recovery

Mental Health Services Act (Cont’d)

- Six components for funding
  - Community Public Planning
  - Community Services and Supports
  - Capital Facilities and Technology
  - Education and Training
  - Prevention/Early Intervention
  - Innovative Programs
- Requires local public planning process
- Requires development of three-year plan
San Bernardino County MHSA

W&I 5848. (a) A draft plan and update 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 of such plans.

San Bernardino County MHSA

W&I 5848. b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30–day comment period required by subsection (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

MHSA Funding for San Bernardino County

- $17,168,200 million/year for community services and supports
- Total of 51,504,600 million over first three years
- Funding will continue as long as MHSA is law
- Funding expected to increase in future
San Bernardino County MHSA Planning Process and Results

- Open, inclusive process
- Community Outreach
- 3000 attendees participated
- 21 Training Workshops
- 4 Age Specific Workgroups
- 79 Member Community Policy Advisory Committee (CPAC)
- 120 Focus & Stakeholder groups
- 6 Public Forums
- 1863 (to date) Community Stakeholder Surveys

San Bernardino County MHSA Issues and Needs

- 54,893 persons in the county are in need of some level of mental health intervention and services.
- Significant racial and ethnic disparities exist among the number of persons unserved, underserved, or inappropriately served

San Bernardino County MHSA Issues and Needs (Continued)

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<td>Homelessness</td>
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<td>Access to care</td>
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<td>Institutionalization and incarceration</td>
<td>Frequent hospitalizations and emergency room visits</td>
<td>Frequent hospitalizations, episodes of emergency care, and incidents of relapse to previous behavior</td>
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<td>Inability to work</td>
<td>Inability to manage independence</td>
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<tr>
<td>Alcohol and drug problems experienced by youth and families dealing with mental illness</td>
<td>Inability to work</td>
<td>Inability to manage independence</td>
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<tr>
<td></td>
<td>Institutionalization and incarceration</td>
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<td>Isolation</td>
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San Bernardino County MHSA
Values and Outcomes

- Culturally competent
- Client/family-driven services
- Wellness/Recovery/Resilience focused
- Reduce disparities in access to care
- Measurable positive outcomes: decrease in hospitalizations, incarcerations, homelessness, and out-of-home placements
- State Department of Mental Health will provide statewide criteria

San Bernardino County MHSA New Programs

- One-Stop Transitional Age Youth Centers
- High Hospital User Assertive Case Management Team
- Circle of Care: Mobile Outreach & Intensive Case Management

San Bernardino County MHSA Expanded Programs

- Comprehensive Child & Family Support System
- Children Crisis Response Teams
- Consumer-Operated Peer Support Svs & Clubhouse Expansion
- Forensic Integrated Mental Health Services
- Crisis Walk-in Centers
- Psychiatric Triage Diversion Team at Arrowhead Regional Medical Center
- Circle of Care: System Development
San Bernardino County MHSA Programs Potential Program Providers

- Some services will be contracted out
- Department of Behavioral Health (DBH) will use Request for Proposal Process
- DBH will select appropriate community providers
- Some Services will be provided by DBH

San Bernardino County MHSA Budget by Age Group and Administration Costs

- Children $2,722,710
- TAY $3,528,712
- Adults $6,349,921
- Older Adults $2,022,972
- Administration $2,543,884

San Bernardino County MHSA Number of Clients to be Served

Estimated over the next three years (not unduplicated)

- 1285 Full Service Partnerships, including housing if needed
- 8848 System Development
- 2248 Outreach and Engagement
### One Time Only Funding

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### San Bernardino County MHSA Next Steps

- **Mental Health Commission endorses Plan** - February 2, 2006
- **Board of Supervisors approves Plan** - February 7, 2006
- **Submit Plan to State** - February 13, 2006
  - Proposed time for State approval of the CSS Plan is 90 days. Implementation is estimated to begin in late spring or early summer.

### Conclusion

The Department of Behavioral Health would like to thank the many individuals who provided the feedback that was instrumental in forming the foundation of the CSS Plan.

Additionally, a special thank you is extended to the work group chairs and members who utilized this public feedback to develop the CSS Plan and the various program proposals for each specified age range.
COMMUNITY SERVICES AND SUPPORTS PLAN
EXECUTIVE SUMMARY

Background
In November 2004, California voters passed Proposition 63, which imposed a 1% tax on adjusted annual income over $1,000,000. The proposition was enacted into law as the Mental Health Services Act (MHSA) effective January 1, 2005. According to the language in the MHSA, the overall purpose and intent is “to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...to insure that all funds are expended in the most cost effective manner...to ensure accountability to taxpayers and to the public”. This purpose of the Act is to be accomplished by providing funding that would adequately address the mental health needs of the unserved and underserved populations by expanding and developing the types of services and supports that have proven to produce successful outcomes, considered to be innovative, cultural and linguistically competent, community-based, consumer and family centered, and consistent with evidence-based practices. The Vision, as established by the State Department of Mental Health who has the responsibility to implement the MHSA through the state, is to “create a state-of-the-art, cultural competent system that promotes recovery/wellness for adults and older adults with serious mental health illness and resilience for children and youth with serious emotional disorders and their families”. The State Department continues that the focus of this vision is to go beyond “business as usual” approaches, and to transform from a “fail-first to help-first” system of public mental health services at the county level. The MHSA calls for five essential elements that are necessary in California to transform the public mental health system which are: community collaboration, cultural competence, client/family driven system of care, wellness focus, and integrated seamless service experiences for clients and families. The MHSA also requires each county to implement programs that achieve the following outcomes from the services provided:

- Decrease racial disparities, hospitalization, and incarceration
- Increase in timely access to care and treatment
- Decrease out-of-home placements
- Decrease homelessness
- Meaningful use of time and capabilities

The MHSA identifies six primary program components for funding that are critical in rooting this transformational process. These components are:

- Local/County Community Planning
- Community Services and Supports
- Capital (buildings and housing) and Informational Technology
- Education and Training (human resources)
- Prevention and Early Intervention
- Innovation

The County's Three-Year Community Services and Supports Plan (CSS) is the second component to be implemented by the State Department of Mental Health (SDMH). Through a very comprehensive community planning process, San Bernardino County Department of Behavioral Health (DBH) has completed its CSS Plan that is consistent with the intent and essential elements as required by the Mental Health Services Act of 2005.

As required by the Local/County Planning program component under the MHSA, $557,746 in planning funds was distributed to San Bernardino County from the SDMH to implement a community planning process to develop a three-year comprehensive plan for improving mental health services and supports for specific target populations (children, transitional age youth, adults, and older adults) identified in the Act. The Board of Supervisors approved submission of the DBH’s “Plan to Plan” to the SDMH on February 15, 2005.

The SDMH, in their instructions, proposed a planning model in which counties would: (1) identify issues resulting from untreated mental illness, (2) analyze the mental health needs in the community, (3) identify populations for Full Service Partnerships, (4) identify program strategies to meet the needs, (5) assess
capacity to expand current programs and implement new strategies, and (6) develop work plans with timeframes and budgets/staffing. The San Bernardino County CSS Plan employed this approach in conducting its planning process.

San Bernardino County’s unprecedented county-wide collaborative planning effort over the last number of months has reached out to approximately 3,000 county residents in order to engage their thoughts, beliefs, concerns, needs, preferences, and creativity ideas on the types of programs and services that would address the mental health needs of our communities. This planning activity was accomplished through the completion of need assessment surveys (English, Spanish, and Vietnamese), participating in community public forums, focus groups, age specific work groups, and a mental health stakeholders advisory group. The County’s community planning process was developed and accomplished according to the instructions and requirements provided by the SDMH.

However, there were specific guidelines that SDMH imposed on the content of the plans prepared by all counties. For example, SDMH requires that more then 50% of the funding be used for Full Service Partnerships (FSPs). FSPs are programs where a small caseload of clients are assigned to a single case manager who is responsible for ensuring that the clients have access to “whatever it takes” to foster resiliency and recovery. Clients in an FSP have access to someone to provide assistance 24 hours a day, seven days a week. The County’s CSS Plan meets that requirement. SDMH also established two other funding categories under the MHSA, Systems Development and Outreach and Engagement. Systems Development Funds may be used to improve programs, services, and supports; Outreach and Engagement funds maybe used to conduct activities to reach unserved populations to engage them into services.

The three fiscal years covered by the County’s CSS Plan are 2005-06, 2006-07, and 2007-08. It is expected that San Bernardino County will receive approximately $17.2 million in each of these years. Because a substantial part of the first year was needed for completing the required planning process, SDMH has allowed counties to prorate the program funding for Year 1, based on the actual number of months that services will be offered. The DBH is estimating only three months of program costs for services provided under this CSS Plan. However, counties may request the remainder of the first year funding as one-time-only funds to be used for additional planning efforts and system improvement activities (contract development, staff, consumer and family training, housing development, and work force development) to prepare for implementation of the programs and services as proposed in the CSS plan. On January 24, 2005, the Board of Supervisors approved DBH’s proposal to the SDMH for use of these one-time-only funds.

The MHSA CSS Plan was endorsed by the stakeholder group, the Community Policy Advisory Committee (CPAC), on December 8, 2005. As part of the planning process, through consensus, the CPAC agreed on the percentage allocation of this year’s MHSA funds for each of the four age groups. The distribution is 19% for Children and Youth, 24% for Transitional Age Youth, 43% for Adults, and 14% for Older Adults.

The MHSA CSS Plan was posted for public comment on December 13, 2005. Copies of the Plan were placed at all the DBH clinics and programs and distributed to all the public libraries throughout the county. After the required thirty-day public comment period, the San Bernardino County’s Mental Health Commission held three public hearings: one in Victorville (January 17th), one in Yucca Valley (January 18th), and one in the San Bernardino area (January 19th) on the CSS Plan. The Mental Health Commission will conduct their final review of the CSS Plan on February 2, 2006, and on February 7th, 2006 the San Bernardino County Board of Supervisors will have their final review.

County/Community Public Planning Process (Part I, Section I)

San Bernardino’s County Department of Behavioral Health embarked on a very comprehensive community planning process which was open, participatory and inclusive of all major mental health stakeholders, including identified populations who are historically isolated, disenfranchised and underserved. The DBH will continue in reaching out and attempting to engage these populations. Special attention was directed by DBH to encourage the meaningful participation of consumers and family members, unserved racial/ethnic groups, and marginalized populations in the planning process. This effort was supported through a number of mechanisms, including stipends, transportation, childcare, translation services, and refreshments at meetings. The Co-Chair of the CPAC was a consumer and is a member of the County’s Mental Health Commission. In June, July, and August 2005 the DBH conducted six community public forums that were held in four major geographical regions of the county in order to publicize the “kick off” of the MHSA program planning process, orient the general public, distribute written materials, and invite further participation from the community.
Through a contractual agreement with the California Institute for Mental Health, planning process participants were provided broad-based training on topics including, but not limited to, the Mental Health Services Act, the current public mental health system, cultural competence, wellness/recovery/resilience, the local planning process, SDMH implementation guidelines, identification of service gaps, and evidence-based practices. In addition, a special one-day workshop on the role and responsibilities of the Mental Health Commission under the MHSA was conducted for the commissioners and staff.

Age Specific Workgroups were established for each of the SDMH required target populations, and a 79 member community stakeholder group was established in October that was composed of consumers, family members, community leaders, agency representatives, service providers and other interested parties (e.g. law enforcement, social services, education, the Office on Aging and the faith-based community) to provide leadership in the decision-making process. Input was provided by 120 focus and stakeholder groups and to date 1863 surveys have been received and analyzed from the community. In addition, MHSA outreach staff went to homeless shelters, clubhouses, and clinics to interview individuals and families. Again, a total of approximately 3,000 community residents participated in San Bernardino County’s MHSA planning activities, demonstrating strong public involvement and support for the CSS Plan.

County/Community Public Planning Process (Part II, Section I)

Through the community planning process, San Bernardino County identified priority community issues that formed the foundation for preparation of the CSS Plan and various program proposals for each specified age range. Although a comprehensive list of issues was identified by the community, the following table displays the critical issues to be addressed in the first three years by the County’s CSS plan:

**Priority Issues by Age Group**

<table>
<thead>
<tr>
<th>CHILDREN/YOUTH</th>
<th>TRANSITIONAL YOUTH</th>
<th>AGE ADULTS</th>
<th>OLDER ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. School failure</td>
<td>2. Institutionalization and incarceration*</td>
<td>2. Frequent hospitalizations and emergency room visits*</td>
<td>2. Frequent hospitalizations, episodes of emergency care, and incidents of relapse to previous behavior*</td>
</tr>
<tr>
<td>3. Involvement in the child welfare system and juvenile justice systems*</td>
<td>3. Frequent hospitalizations and emergency room visits*</td>
<td>3. Inability to work*</td>
<td>3. Inability to manage independence*</td>
</tr>
<tr>
<td>5. Alcohol and drug problems experienced by youth and families dealing with mental illness*</td>
<td>5. Inability to work*</td>
<td>5. Institutionalization and incarceration*</td>
<td>5. Isolation*</td>
</tr>
</tbody>
</table>

*Priority Issues to be addressed in the first three years.

**Mental Health Needs and Disparities (Part II, Section II)**

The Department of Behavioral Health prepared a detail analysis of available data to fully understand the scope of mental health needs among the four age specific target populations. The community workgroups reviewed and discussed the analysis, which included estimates of the unserved, underserved, and inappropriately individuals in the county. This analysis included the four regions that are part of the large geographical area of the San Bernardino County Mental Health System which are: Central Valley, Desert/Mountain, East Valley/San Bernardino, and West Valley.

The estimate of prevalence for severe mental illness in the population is 9% of those living under 200% of the federal poverty level, or 64,435 persons. Of these, approximately 29,635 persons from all age groups are
considered unserved by the public mental health system in San Bernardino County. However, of the 34,800 who are considered to be served in some capacity (fully served, underserved, or inappropriately served), only 9,542 are in the category of fully served. Thus it can be concluded that approximately 54,893 persons in the county remain in need of some level of mental health intervention and services.

Based on the prevalence for severe mental illness in the population of 9% who are under 200% of the federal poverty level (64,435), there are approximately 29,635 persons from all age groups who are considered unserved by the public mental health system in San Bernardino County. However, of the 34,800 who are considered fully served, underserved, or inappropriately served, only 9,542 are fully served by the system. It can be concluded that approximately 54,893 persons in the county are in need of some level of mental health intervention and services.

As discussed in Part II, Section II of the CSS Plan for each age category, significant racial and ethnic disparities exist among the number of persons unserved, underserved, or inappropriately served by the present public mental health system. To increase equal access to culturally competent mental health programs and service outcomes for racial and ethnic populations in the county is a critical service delivery issue for the DBH.

According to California Department of Finance estimates for 2005, San Bernardino County has a total population of 1,942,091 with a projected population in the next three years of 2,083,637 people in the county. The current breakdown of the population into racial and ethnic categories is: Euro Americans 30%, Latino Americans 50%, African Americans 10%, Asian Americans 7%, Native Americans 1%, and all others 2%.

In reviewing the racial and ethnic data for the 29,635 people presently not receiving any level of services from the mental health system, the percentage of Latino Americans is 44%, Euro Americans 28%, African Americans 17%, Asian Americans 6%, Native Americans 1% and all others 3%. In further analysis of the data for children and youth between 0 and 25 years of age, approximately 60% are Latino Americans who are considered unserved by the system.

Unserved populations in San Bernardino County

Children & Youth, ages 0 - 15
Refinements of these estimates indicate that 60% (5,314) of the children in need but unserved in our county are Latino Americans; 18% (1,567) are African-Americans, 10% (868) are Euro-Americans, and the remaining 12% (1,102) are of other or multiple ethnicities.

By region, 9% of the unserved children live in our central valley area, 11% in the deserts and mountains, 24% in the east valley and San Bernardino areas, and 56% in the county’s west valley.

Transition Age Youth (TAY), ages 16 - 25
About 63% (3,468) of the unserved TAY in our county are Latino Americans; 18% (1,006) are African-Americans, 7% (412) are Euro-Americans, and 12% (660) are of other or multiple ethnicities. By region, 6% of the unserved TAY are in our central valley area, 20% in the deserts and mountains, 12% in the east valley and San Bernardino city areas, and 62% in the county’s west valley.

Adults, ages 26 - 59
Among adults, 36% (3,312) are Euro-Americans, 34% (3,095) of the unserved in our county are Latino Americans; 20% (1,828) are African-Americans, and 10% (1,003) are of other or multiple ethnicities. By region, 8% of the unserved adults are in our central valley area, 13% in the deserts and mountains, 14% in the east valley and San Bernardino city areas, and 65% in the county’s west valley.

Older Adults, age 60 and over
For older adults who are unserved, 64% (3,833) in our county are Euro-Americans; 19% (1,129) are Latino Americans, 12% (716) are African-Americans, and 5% (322) are of other or multiple ethnicities. By region, 9% of the unserved older adults are in our central valley area, 32% in the deserts and mountains, 27% in the east valley and San Bernardino city areas, and 32% in the county’s west valley.

Identifying Initial Populations for Full Service Partnerships (Part II, Section III)
San Bernardino County’s CSS Plan is proposing Full Service Partnerships (FSP) for all age groups by the third year. In the third year (2007-2008), 71% of the County’s allocation of MHS funds will be directed to FSPs. Below is a brief description by age group of the situational characteristics of the priority populations to be served by the various mental health programs under the FSP funding category.
### Populations for Full Service Partnerships

#### Children and Youth (0-17)
- Those children and youth who have serious emotional disturbances
- Those children and youth having problems at school or at risk of dropping out
- Those children and youth at risk of, or are involved in the juvenile justice system
- Those children and youth in need of crisis intervention and/or at serious risk of psychiatric hospitalization
- Those children and youth at risk of residential treatment or are stepping down from residential treatment
- Those children and youth who are homeless or at risk of homelessness
- Those children and youth who are high users of service; multiple hospitalizations/institutions
- Those children and youth who are uninsured
- Those children and youth who are at risk due to lack of services because of cultural, linguistic, or economic barriers
- Those children and youth at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse.
- Those children and youth with co-occurring disorders

#### Transitional Age Youth (16-25)
- Those transitional age youth who have serious mental illness or serious emotional disturbances
- Those transitional age youth who have repeated use of emergency mental health services
- Those transitional age youth who have co-occurring disorders
- Those transitional age youth who are homeless or at risk of homelessness
- Those transitional age youth who are at risk of involuntary hospitalization or institutionalization
- Those transitional age youth who are involved in the juvenile justice system
- Those transitional age youth who are in out-of-home placement or aging out of the foster care system
- Those transitional age youth who are recidivists of the mental health system who have functional impairment

#### Adults (18-59)
- Those adults who are seriously mentally ill
- Those adults who are homeless or at risk of homelessness
- Those adults who have co-occurring substance abuse problems
- Those adults who are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system
- Those adults who are recently discharged from psychiatric hospitals
- Those adults who are frequently hospitalized or are frequent users of emergency room services for psychiatric problems

#### Older Adults (60 and older)
- Those older adults who have serious mental illness
- Those older adults who are homeless or at risk of homelessness
- Those older adults who are unserved, underserved, or inappropriately served in the mental health system
- Those older adults who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
- Those older adults who have reduced personal and/or community functioning due to physical and/or health problems
- Those older adults who have co-occurring substance abuse problems
- Those older adults who are isolated and at risk for suicide due to stigma surrounding their mental health problems

### Community Services and Supports Program Strategies (Part III, Section IV; Exhibit 4s)
The County’s CSS Plan contains nine separate programs that were developed based on the five planning elements required by the MHSA. There is the Comprehensive Child/Family Support System for Children and Youth which has four primary service areas; comprehensive Transitional Age Youth Center for Transitional Age Youth which has six major service components; four programs for Adults, two for Older Adults, and one program for the Crisis Walk-In Centers, that “cuts-across” all of the age groups in the county. It is being
planned by the DBH over the next three years that approximately **12,381** individuals will be served by the various programs and services.

The expected outcomes for these funded programs, which are consistent with the goals of the MHSA, are to:

- Reduce the subjective suffering of serious mental illness for adults and serious emotional disorders for children and youth
- Reduce homelessness; increase safe/permanent housing
- 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 the number of multiple out-of-home placement for foster care youth
- Reduce criminal and juvenile justice involvement
- Reduce frequent emergency room visits and unnecessary hospitalizations
- Increase a network of community support services

The CSS Plan also includes a description of “start-up funding” being requested from the 1st Year allocation for the activities that support the effective implementation of the programs (Housing, Information System Improvement, Program Start-up Costs, Capital Purchases, and Training and Education) under the CSS Plan. Below is a brief summary by age group of the programs for which MHSA funding is being requested. Although all of these programs will be provided in the first three years, because of the availability of one-time-only funds in the first year, program implementations may vary slightly in Years 2 and 3.

**Children & Youth (CY) – One Program**

1. **Children’s Wraparound Service Model**
   The Comprehensive Child/Family Support System (CCFSS) will establish a “seamless” system of care to children and families in San Bernardino County to negotiate multiple agencies and funding sources. The goal is to coordinate and access services for families with children that suffer with emotional disturbances. San Bernardino County currently works with the Department of Children’s Services, Juvenile Justice, schools, Regional Centers, Law Enforcement, faith-based agencies, community agencies and stakeholders. The CCFSS plans to broaden those relationships to include law enforcement, domestic violence shelters, and preschool programs. The CCFSS will work with the population, ages 0-15. The plan is to serve **270** children and, youth, plus their families over the three-year period. CCFSS will provide full service partnerships and 24/7 services for children, youth and families that have been unserved or underserved through a Wraparound service model.

**Transitional Age Youth (TAY) – One Program**

1. **One Stop TAY Integrated Services Center**
   The Transitional Age Youth Integrated Services Center will be a community-based, consumer-centered program where individualized, consumer-driven service plans are developed and implemented. It will focus on consumer strengths and meet the needs of transitional age youth and, in many cases, their families across life domains. This program will promote success in school or work, safety, wellness and recovery through a “whatever-it-takes” approach.
   The One Stop Transitional Age Youth (TAY) Centers will assist TAY towards becoming independent, staying out of the hospital or higher level of care, reduce involvement in the criminal justice system, and reduce homelessness. The Department will hire a TAY coordinator that will monitor and provide technical assistance to the centers. Consumers, youth, and their families will be an integral part in the development of age appropriate services that reflect developmental and specialized needs of the TAY population. Adolescents and young adults will be hired to provide services as peer counselors, mentors, and parent partners. The center will be modeled as a drop-in resource center in order to improve participation. The Centers will serve **345** consumers over the three-year period.

**Adult (ADL) – 4 Programs**

1. **Consumer – Operated Peer-Support and Clubhouse Expansion**
   A countywide peer support recovery program will utilize peer education, advocacy, counseling, social and recreational activities, and life skills development to serve **300** adults annually. Two Consumers will be hired to serve as Peer Support Coordinators and coordinate the Office of Consumer and Family Affairs with the long term goal of supporting, coordinating and advocating for system wide Recovery Model planning and implementation.
   Clubhouse Enhancement and Expansion
The clubhouses in San Bernardino and Victorville will expand the social and community rehabilitation activities for 300 consumers annually. The expansion will be coordinated from the San Bernardino and Victorville clubhouse sites with outreach to all clubhouses.

2. Forensic Integrated Mental Health Services

Forensic services proposes the expansion of the Crisis Intervention Training Program, the expansion of Mental Health Court treatment to serve an additional 70 consumers annually, and the implementation of a Forensic Assertive Community Treatment program to serve 40 consumers annually. These specialized mental health services will be provided to Severely and Persistently Mentally Ill (SPMI) individuals who are involved with the criminal justice system. The Forensic Assertive Community Treatment (FACT) team will partner with the San Bernardino County Sheriff's Department West Valley Detention Center (WVDC), San Bernardino County Department of Behavioral Health (DBH), Mental Health Court and the Probation Department. The Team will be a 24/7, multi-disciplinary team and provide crisis response, case management, peer support, alternatives to hospitalization and incarceration, and housing and employment support and do what ever it takes to assist the consumer in maintaining their independence in the community. The FACT Team will work closely with the Jail Mental Health Services Clinic in WVDC and Mental Health Court to expedite the voluntary participant's release from WVDC to community treatment resources.

3. Assertive Community Treatment Team (ACT) for High Users of Hospital and Jail Services

The program is designed to annually serve sixty (60) SPMI adults who are identified as high users of acute hospital services. The program will provide crisis response, peer support, clinical interventions by staff and consumers, psychiatric services, housing support, employment services and training, and will utilize the "whatever it takes" approach which typifies the Assertive Community Treatment model of community services. Transitional housing, sober living, safe haven housing, and permanent housing will be provided as appropriate.

4. Psychiatric Triage Diversion Team at County Hospital

At San Bernardino County's psychiatric hospital, the Department of Behavioral Health (DBH) will provide culturally competent screening and diversion of 300 clients annually who present at the hospital's emergency room in crisis due to homelessness, co-occurring disorders, recent release from incarceration, and medical conditions and who may not be in actual need of hospitalization. A preliminary screening of clients will be provided as they enter the Behavioral Health Unit's ER and the reason for the client's coming to the ER will be determined. The program will divert the client and link the client with existing community resources, which are most appropriate for the client's condition, and ongoing mental health needs.

Older Adults (OA) – 2 Programs

1. CIRCLE OF CARE: System Development-Expansion of Agewise Senior Peer Counseling Program

Extend mental health treatment and case management services to older adults in all regions of San Bernardino County. Enhance existing Senior Peer Counseling program with a focus on wellness and recovery that will annually assist 145 older adults in remaining independent and active in their communities and pursuing individualized personal goals for as long as possible. Develop a capacity building component that ensures that staff volunteers and community partners provide client centered and culturally competent services, education and assistance to older adults.

2. CIRCLE OF CARE: Mobile Outreach and Intensive Case Management

The CIRCLE OF CARE, Mobile Outreach and Intensive Care management plan is comprised of two components that will provide services to older adults in the high desert area, which is an area that has a high percentage of unserved and underserved older adults. The Mobile Outreach program will be comprised of two field-capable multidisciplinary teams, both of which will provide crisis response and crisis prevention services. To launch Intensive case management services to seriously mentally ill older adults, a “Full Service Partnership” (FSP) will be developed for the high desert area. The FSP will annually provide services for 13 unserved and underserved SMI older adults who are isolated, have the most severe conditions, have a history of repeated emergency health services or several admissions to inpatient services, are at risk for institutionalization, or have been or are at risk of becoming, homeless.

All Ages - One Program

1. Crisis Walk-In Centers

Annually, Crisis Walk-In Centers will provide urgent mental health services 24/7 for 3,000 seriously and persistently mentally ill (SPMI) persons of all age groups – children, TAY, adults, and older adults –
needing immediate access to crisis mental health services. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and this program will provide integrated substance abuse treatment services for dually diagnosed clients. These centers will offer urgent mental health services to the acute and sub-acute mentally ill individuals including crisis intervention, crisis risk assessments, medications, substance abuse counseling, case management, referrals to DBH and contracted clinics, family support and education, transportation, 23-hour crisis stabilization and when required 5150 evaluations.

**Start-Up Activities and One-Time Only Initiatives**

1. **Housing Development Initiative**

   Safe and affordable housing is one of the basic requirements needed in order to promote recovery/wellness for individuals (and their families) with severe mental illness or serious emotional disturbance. Appropriate housing is crucial to maintaining stability in the community for all age specific target populations. For those with very low income and who are homeless, finding safe and affordable housing in San Bernardino County is a real challenge. This housing program will include a flexible pool of money in a housing trust fund to support the members of full service partnerships. A continuum of housing will be developed that will include short-term transitional, supportive, and permanent housing. One-time funds ($3,975,000 over three years) will be used for short term lodging in shelter beds, motel vouchers, transitional housing, shared group housing, augmented residential care facilities, rental subsidies for permanent supportive housing, security deposits and other potential housing assistance. Funds will be available for housing specialists that can assist in locating housing resources and successfully obtaining housing for individuals and families. Housing will be developed and provided in a culturally sensitive manner, with special attention paid to language, ethnicity, gender, and client culture.

2. **Training and Education**

   San Bernardino County is requesting a total of $2,213,533 for a comprehensive staff development program. Staff development is essential for any system of care that aspires to provide treatment services that are culturally appropriate, mindful of the interaction between substance abuse and psychological problems and based in true recovery principles.

   A comprehensive staff development program is proposed that will enhance the quality of services and activities on behalf of: Existing departmental staff, interns in psychology, social work, marriage and family therapy, occupational therapy, nurses, psychiatric technicians, and psychiatrists in training as well as consumers who are hired by the MHP as consumer employees or consumers who volunteer to participate in client activities in a leadership roles on various departmental committees.

   Research shows that clinician bias and stereotyping leads to misdiagnosis, discriminatory practices and inappropriate or inadequate treatment. Services that are delivered by a well trained, culturally empathic and recovery principled manner will result in greater treatment outcomes for a greater number of clients. The ability of the MHP to train the new and existing workforce to utilize evidence-based practices will increase the likelihood of:
   - Increased employee job satisfaction
   - Increased consumer satisfaction with improved treatment outcomes
   - Positive employee morale
   - Increased public trust
   - Increased departmental integrity
   - Increased community respect
   - Positive employee morale leading to a culturally diverse workforce of competent and highly trained employees

3. **Information System Improvement**

   San Bernardino County is requesting a total of $2,264,916 for improvements and extensions of our information system are necessary under the MHSA in order to adequately support the development, operation, and accountability of new and expanded programs. The Department plans to improve data collection, access, and storage capabilities by implementing an electronic behavioral health record system and information analysis software, and will set up user-friendly information collection and feedback points at various service locations in the county. The data specifically required by the State will include the reporting of key events such as hospitalizations, significant changes of housing or caretaker relationships, etc. In addition, a major upgrade of the existing services and episodes database is anticipated within the next two years.
4. **Program Start-Up**

San Bernardino County is requesting a total of $1,267,311 in the following two areas of funding under the start-up funding available as outlined by the California Department of Mental Health (DMH):

1. Extension of Community Planning
2. System Improvement Funding

The Extension of Community Planning and System Improvement funding requests are as follows:

**I. Additional Community Program Planning Funding ($858,410):**

On September 2, 2005, DMH informed counties that they could request additional planning funds of up to 5% of the counties initial 2005-06 estimated program allocation. The additional funds would finance continued planning activities during the 3-month State review and approval process following the county’s submission of its 3-year CSS plan. San Bernardino County’s 2005-06 program allocation estimate is $17,168,200; therefore, DBH may apply for an additional $858,410 in planning funds.

When the State approves DBH’s request for additional planning funds, DBH will provide continued coordination of the MHSA planning process, coordinate and implement our housing initiative, develop statistical information for determining outcomes, provide fiscal and administrative support, develop consumer training modules, and provide outreach services.

Planning funds will continue to fund other operating costs associated with outreach, training, focus groups, public forums, surveys, statistical analysis, and to reimburse travel, meals, conference and other costs for consumers and other stakeholders participating in the planning process.

**II. System Improvement Funding ($408,901):**

On September 2, 2005 DMH also informed counties that they could request funding for system improvements and other expenditures necessary to support the CSS plan. This funding can be utilized during the State’s review and approval process of DBH’s 3-year CSS plan. It is anticipated that San Bernardino County’s 3-year CSS plan will be submitted to the State in February after Board approval.

Types of allowable system improvement activities include, but are not limited to: RFP development, issuance, & review, & all necessary HR activities to recruit personnel for the proposed MHSA programs and services.

DBH is requesting $408,901 in system improvement funds. These funds will be used to hire staff to begin developing, reviewing, and issuing RFPs for new and expanded contracted services, provide outcome development and planning, develop training modules for resilience and recovery, expand cultural competency training, and create and coordinate an internship program with local universities. In addition to staffing, the system improvement funding will be used to fund HR costs to recruit service personnel needed for the proposed MHSA programs and services. These costs could include advertising, HR staff time, possible hiring incentives, nationwide recruitments, etc.

5. **Capital Purchases**

San Bernardino County is requesting $4,013,800 to be utilized for capital purchases for all nine programs to be funded and implemented under the MHSA. Capital Purchases include items such as cars, copiers, computers, furniture, office rents, etc. that are required tools to operate the programs requested in the county’s three year CSS.

**Conclusion**

The development and preparation of the San Bernardino County’s Community Services and Supports Plan resulted from a very concentrated planning process and intense effort by a large group of consumers, family members, service providers, county agencies, and representatives of interested organizations throughout the county. The primary objective of this planning effort was to develop community mental health program strategies that would expand and increase services for those individuals and families who are the most unserved and underserved by the present public mental health system, especially those who have not traditionally had access to the existing programs.

The CSS Plan being proposed to the SDMH for funding under the MHSA cannot meet the increasing demand for services and backlog of unmet mental health needs in our communities. However, it can begin to “jump-start” the transformation process in San Bernardino County by enhancing the continuum of services currently available and increasing access to care for racial and ethnic populations that have traditionally been unserved or underserved. The community planning process and the County’s CSS Plan for using the MHSA funding has also brought intangible benefits to the local community and its residents. Renewed hope has been created for individuals and families affected by mental illness because they have been empowered to having a more meaningful voice in the planning and development of the needed programs and services.
their loved ones. Another major benefit resulting from this process has been the involvement among the various community stakeholders in the county who came to the table to contribute their knowledge, experience, creativity and support for the collaborative development of the CSS Plan. This involvement will further the goals and intent of the MHSA for our county and provide the necessary impetus to transform the mental health system from a “fail first to help first” public system of care that truly addresses the mental health needs of the entire community. The future will look different because it is not “business as usual”!

January 17, 2006
Exhibit 4
Program Work Plan Name: Comprehensive Child/Family Support System (CCFSS)
Work Plan Number – C-1
Description of Program:
San Bernardino County has developed an array of services for children that struggle with Severe Mental Illness (SMI). These services include:
- School based
- Home based
- Hospital and crisis responses
- Wraparound

The Comprehensive Child/Family Support System (CCFSS) will establish a “seamless” system of care to children and families in San Bernardino County to negotiate multiple agencies and funding sources. The goal is to help families with children that suffer with SMI get their needs met and move toward recovery and increased resilience.

Services will be provided in collaboration with:
- Department of Children’s Services
- Juvenile Justice
- Schools
- Regional Centers
- Law Enforcement
- Faith-based agencies
- Community agencies and stakeholders

The CCFSS will work with the population, ages 0-17. CCFSS will provide full service partnerships and 24/7 services for youth and families that have been unserved or underserved through a Wraparound service model.

Services will include:
- Case management
- Family driven treatment services
- Flexible funding
- Service coordination
- Respite care
- 24/7 crisis phone and mobile crisis intervention services
- Co-occurring treatment
- Psychiatric services
- Family advocacy, and parent partnerships

In the past fiscal year the Wraparound Program has expanded to each region of San Bernardino County and includes 200 slots for youth that meet the SB163 criteria. The CCFSS program will allow children and youth to be enrolled that do not meet the SB163 criteria, although the child is in need of services to prevent them from out-of-home (Foster Care, group homes, institutionalized) placement. These services will be provided to help reduce hospitalizations and out-of-home placements and to help children and youth return to their families. The program services will increase stabilization, help families identify community supports, and encourage resiliency and wellness.

Priority Population:
According to prevalence data, Latino children make up the most underserved population. African American children, although utilizing more services, are inappropriately served. The number of clients projected to receive services annually is 163 under Full Service Partnerships, 40 under System Development, and 67 under Outreach and Engagement for a total of 270.

<table>
<thead>
<tr>
<th>Children</th>
<th>Unserved, Underserved or Inappropriately Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>18%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>1%</td>
</tr>
<tr>
<td>Euro-American</td>
<td>36%</td>
</tr>
<tr>
<td>Latino</td>
<td>39%</td>
</tr>
<tr>
<td>Native-American</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

The priority population will include children and youth ages 1-17 who:
- Struggle with serious emotional illness and/or co-occurring disorders
- Are identified as unserved and/or underserved
- Have experienced inappropriate service delivery in culturally diverse communities.

Many of these families struggle with their children at school and in the community. They may have alcohol and or drug problems, family issues, are homeless or are at risk of being homeless.

**Strategies:**

<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Fund Type</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FSP</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Comprehensive child/youth and family support system</strong></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Integrated mental health services, which includes co-location and/or collaboration with multiple providers (Department of Children’s Services, Probation Department, schools) to provide individualized, multi-disciplinary, coordinated services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wraparound service model to provide strength based, family driven services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services and supports provided at school, in the community, and in the child/youth’s home.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Values-driven, evidence-based, and promising clinical services that are culturally and linguistically competent.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crisis services including 24-hour phone line, mobile crisis intervention, respite care for children and families, and crisis and transitional residential treatment alternatives.</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Co-occurring services which, at a minimum, will include screening and assessment for substance abuse and mental illness, history of trauma and family violence. There will be a single individualized service plan.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Partnership Programs are operated by family members and include strategies to engage racially and ethnically diverse families.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff training in developmental and cultural needs of children and families.</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
Exhibit 4
Program Work Plan Name: One Stop TAY Center
Work Plan Number – TAY - 1

Description of Program:
The One Stop TAY Center will provide integrated services to the unserved, underserved, and inappropriately served TAY (16-25 years) who are:

- Severely and Persistently Mentally Ill (SPMI)
- High users of acute facilities
- Homeless
- Have co-occurring disorders
- Incarcerated
- Institutionalized
- Recidivists with significant functional impairment

Services will include 24/7 access to:

- Mental health services
- Medical support
- Educational/vocational services
- Intensive case management
- After care services
- Supportive housing

Services provided will address the transitional domains of employment, educational opportunities, housing and community life necessary for wellness and recovery of young SPMI. All services will be provided in a culturally competent manner that is age and developmentally appropriate.

San Bernardino County Department of Behavioral Health has a Cultural Competency plan that reflects our commitment to ongoing training of staff, recruitment and retention. Consumers, youth, and their families will be an integral part in the development of age appropriate services that reflect developmental and special needs of TAY. The One Stop TAY Center will include peer and mentoring support services. County agencies and community partners will be co-located to provide a comprehensive service for TAY in order to reduce out-of-home and high levels of placement, incarceration, and institutionalization.

Development and implementation of One Stop TAY Centers

<table>
<thead>
<tr>
<th>Year</th>
<th>TAY Center</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>First TAY Center</td>
<td>West Valley/Central Valley Region</td>
</tr>
<tr>
<td>2006-07</td>
<td>Second TAY Center</td>
<td>East Valley/San Bernardino Region</td>
</tr>
<tr>
<td>2007-08</td>
<td>Third and Fourth TAY Centers</td>
<td>High Desert and Mid Desert Regions</td>
</tr>
</tbody>
</table>

There will be a menu of available recovery services at the centers including, but not limited to:

- 24/7 access to behavioral health/peer counselors
- Easy access to all needed services from community partner agencies
- Housing support
- Educational/vocational training
- Job search and coaching
- Skill building necessary for community life
- Recovery and co-occurring specialized programs
Recreation activities
Email/internet access
Other necessary referrals for community integration

Services that are both culturally and linguistically appropriate will be provided to TAY and their families. Behavioral Health staff, peer counselors, parent partners, adjunct agency staff, and peer volunteers will receive cultural competency training in order to provide linguistically and culturally appropriate services.

Priority Population:
TAY (16-25 years) will be served at the One Stop TAY Center. This is a new program.
Existing limited programs addressing the needs of TAY include case management, client run clubhouse, and other mental health services. San Bernardino County has not been successful in outreaching to TAY as most services do not address their situational characteristics, developmental needs, and are not tailored to the specific needs of TAY.

Significant efforts will be made to work with Latino and African-American youth who are disproportionately over-represented in the Justice System and out-of-home (Foster Care, group homes, institutions) placements. TAY with co-occurring (mental health and drug/alcohol) disorders, SPMI, unserved, uninsured, and homeless or at risk of becoming homeless due to exiting out-of-home placement, high utilizers, and recidivists will be targeted.

The number of clients projected to receive services annually is 242 under Full Service Partnerships, 69 under System Development, and 34 under Outreach and Engagement for a total of 345.

<table>
<thead>
<tr>
<th>TAY</th>
<th>Unserved, Underserved or Inappropriately Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>18%</td>
</tr>
<tr>
<td>Asian-American</td>
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<tr>
<td>Euro-American</td>
<td>35%</td>
</tr>
<tr>
<td>Latino</td>
<td>37%</td>
</tr>
<tr>
<td>Native-American</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

Strategies:
- Stakeholder collaborative services with multiple community based organizations co-located in the center for easy access.
- Early identification and assessment of underserved TAY populations and their families who are SMI, homeless or at risk of out-of-home placement, experience co-occurring disorders and residivists with significant functional impairment will be targeted for services.
- 24/7 access to supportive services will be available at the One Stop TAY Center to underserved TAY and their families to prevent and/or reduce homelessness, abuse, and re-incarceration.
- Care Coordination, skill development supportive housing, and supported education and employment will be available in the community, at home or at the One Stop TAY Center.
• Referral services, transportation and discretionary funds will be available.
• African-Americans and Latino TAY in out-of-home placement or involved in the Juvenile Justice System, who are underserved or inappropriately served in the mental health programs will be a priority for service of this program.
• TAY will be trained and educated on co-occurring disorders by trained staff and peer counselors through psycho-educational groups
• Engagement outreach and services that are culturally and linguistically appropriate will be provided at the One Stop TAY Center, which is reflected in DBH Cultural Competency Plan.
• Assertive Community Treatment (ACT) teams will help TAY stay out of the hospital and to develop skills for living in the community, so that their illness is not the driving force in their lives. These services are customized to the individual needs of the consumer and are provided 24 hours a day seven days per week.
• Services which are values driven and evidenced-based will be provided to TAY to support their recovery process in the community.
• Supportive housing will be provided to meet short term and long term needs of TAY and their families.
• Peer and mentoring subsidized positions will be available to TAY and families members to provide services at the One Stop TAY Center and in the community.
• DBH will collaborate with Department of Children Services, Probation Department, and other adjunct agencies to work with families to meet the needs of their TAY who are placed out-of-home (Foster Care, group homes, institutionalized). These efforts will enhance the reunification and return of TAY to their families.
• The One Stop Center will have a subsidized peer/family support component that will be part of the intensive case management team to provide services to TAY.
• Individual integrated consumer driven service plans will be developed for each TAY within 30 days of enrollment.
• Scholarships will be identified and developed with educational, vocational and technical institutions.
• Indoor and outdoor recreational activities will be available including, but not limited to basketball, pool table, video and television.
• Enterprise development to support self-sufficiency will be developed. The TAY Coordinator will reach out to the business community and work with staff, peer counselors and parent partners to develop a plan for the business venture.
• Current and effective TAY housing models in the county will be utilized for consultation to help establish further development of the continuum of housing.
• An integrated, collaborative multi-agency, multi-provider systematic approach will be established to determine client/case selection for continuum of housing.
• Paid mentors will provide TAY Peer Mentoring.
• Services and supports provided in non-traditional settings, such as malls, video and game stores, local eateries, and places where TAY frequent.
• Education for TAY and family or other caregivers about mental health diagnosis and
assessment, medications, services and supports planning, treatment modalities, and
other information related to TAY’s mental health services and needs

- Emphasis on decreasing level of care or placement for TAY from incarceration,
  residential care to either independent living or returning to live with family/care
  providers.
- Values-driven, evidence-based and promising clinical services that are integrated
  with overall service planning and which support youth/family selected goals.

San Bernardino County CSS WORK PLAN

Exhibit 4
Program Work Plan Name: Adult - Consumer-Operated Peer-Support Services and Clubhouse Expansion
Work Plan Number – A-1
Description of Program:
1. Consumer Operated Peer Support Services: A countywide peer support recovery program utilizing:
   - Peer education
   - Peer advocacy
   - Peer counselors/specialists
   - Employment support services
   - Life skills development classes
   - Social/recreational activities

   This will be an independent program utilizing two consumers hired as Mental Health Specialists and serving as Peer Support Coordinators. They will have office space located in the clubhouses in the San Bernardino and Victorville regions and service these centralized regions. All services will be age, gender and developmentally appropriate. This will be accomplished by hiring culturally diverse staff through a process of outreach into the ethnic communities and identifying training opportunities specific to the populations being served.

2. Clubhouse Enhancement: Provides expanded capacity for social and community rehabilitation activities for 600 total, 300 additional underserved seriously mentally ill (SMI) adults per site in two regionally centralized locations, beginning in the City of San Bernardino and enhancing services in the High Desert region of San Bernardino County (Victorville); thus providing the integrated services of a “Fountain House” clubhouse model within these regions.

   The clubhouse will become central training sites for both consumers and staff implementing and disseminating the recovery model philosophy throughout the San Bernardino County Department of Behavioral Health (DBH). DBH will have trainers and consultants with consumer and recovery experience to develop and provide formal and informal internships and mentor programs. Funding will be specifically budgeted for this purpose (see exhibit 5a. under A. Expenditures, line item d., Employment and Education Supports.) All regional clubhouses will be affected through enhancement and outreach activities.

3. Clubhouse Expansion for Services: Provides underserved seriously mentally ill (SMI) adults with:
   - Increased social and recreational activities
   - Supported employment and housing
   - Health and psychiatric services
   - Programs for co-occurring disorders
   - Crisis response and respite services
   - Expanded hours of operation within the County’s existing clubhouse system to include mentor and internship programs
Clubhouses will demonstrate 90% consumer operation by 07-08. Consumer operation will be defined by the fact that 90% of the operations:

- Clerical
- Maintenance
- Group facilitation
- Recreational Activities

will be performed by consumer participants. There will only be 3.5 paid staff assigned to each clubhouse site; and they will function in consultant/advisory/supervisory role, which will diminish as consumers become more capable and experienced. In addition, every effort will be made to hire consumers for paid staff positions in the clubhouses by identifying and recruiting consumers who meet the employment requirements for the DBH positions. It should also be noted that consistent with clubhouse philosophy, a consumer council or governing board would oversee and decide on all clubhouse activities and policies utilizing the “nothing about us without us” strategy of client empowerment movement.

There will also be an Office of Consumer and Family Affairs that will be staffed by two (2) paid consumers, hired under the Peer Support Services program and budget that will identify all relevant resources for training, curriculum and consultation in Recovery Model programs. Trainers, consultants and training modules from a nationwide search of resources will be utilized to train an ever-expanding number of consumers who will be able to increase their responsibility and leadership roles in the clubhouses and move on to mentoring their peers.

**Priority Population:**
Persons between age 18 - 65 with a diagnosis of severe mental illness (SMI) who are interested in support, rehabilitation and recovery services provided by peers, thus increasing their ability to function in the community.

The number of clients projected to receive services annually is 300 under System Development and 300 under Outreach and Engagement for a total of 600.

<table>
<thead>
<tr>
<th>Adults</th>
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</thead>
<tbody>
<tr>
<td>African-American</td>
<td>18%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>3%</td>
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<tr>
<td>Euro-American</td>
<td>34%</td>
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<tr>
<td>Latino</td>
<td>40%</td>
</tr>
<tr>
<td>Native-American</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
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</table>

Some un-served people are expected to be served for the first time through this program, although most will have had contact with County Department of Behavioral Health (DBH), yet with little or no prior experience with peer-provided services.

Transitional Age Youth (TAY) clients between the ages of 18-25 who are interested or in need of additional supports may also utilize the services of the TAY One-Stop Centers that are being developed in DBH through MHSA funding in coordination with the overall MHSA plan.

<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Fund Type</th>
<th>Budget</th>
</tr>
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<tbody>
<tr>
<td><img src="image.png" alt="Image" /> Consumer-Operated Peer-Support: Consumers and Family Members will be recruited as Mental Health Specialists (MHS) who will be assigned to provide a full array of culturally and linguistically appropriate peer recovery and support services throughout San Bernardino County. The six Mental Health Specialists will be divided between two programs with two MHS positions, utilizing consumers only to staff the Peer Recovery Support Program and be the main staff for the Office of Consumer and Family Affairs. Four MHS positions assigned to the clubhouses in San Bernardino and Victorville.</td>
<td>X</td>
<td>$935,691 $53,029 $882,662</td>
</tr>
</tbody>
</table>
These six paid positions will form an initial base of consumer/family member employees who will be used to role model and train other consumers. All efforts will be made to hire culturally diverse consumers for these positions through recruitment and outreach to increase services to underserved ethnic populations. Funding has been allocated to provide the initial consumer employees with training, consultation and support to insure their success. Expansion of additional trained consumers will be an ongoing goal with additional paid positions developed as funding allows. The consumers hired for the Peer Support Program, implemented through the Office of Consumer and Family Affairs, will serve 200 consumers in the community by the end of fiscal year 07-08 through outreach into the community, i.e. board and care facilities, IMD’s, community centers, churches, etc.

- Mental Health Specialists and Occupational Therapists will assist and support 300 members to engage in paid vocational activities by fiscal year 07-08. Currently, with limited employment services available through DBH, up to thirty (30) unduplicated consumers monthly, request vocational support services and whose needs cannot be adequately met.
- An Office of Consumer and Family Affairs will be established in two central and strategic locations in San Bernardino County to establish, support, coordinate and advocate for system-wide planning and implementation of the Recovery Model programs. The staff will be funded through the budget for the Consumer-Operated Peer Support Services program.
- Two Occupational Therapist positions will be recruited for consumer/volunteer training and program support. Every effort will be made to hire consumers with the appropriate credentials for this program.
- One (1) clerical staff will provide administrative/clerical support.
- Hired consumers will be strategically based each in one of the three clubhouses, West Valley, East Valley/San Bernardino, and High Desert. However, outreach will be provided in all regions throughout the county.
- Expand the number of trained consumers, provide peer recovery services, have regular in-service meetings and follow-up with all consumers to provide ongoing support. The goal will be to train fifty (50) consumers by the second year of program implementation through outside training and mentor programs to provide leadership in the peer recovery and clubhouse programs.
- “Fountain House” model clubhouse programs will be International Center for Clubhouse Development (ICCD) certified and will follow the 36 standards of practice from the ICCD (including the training of all consumer staff in recovery principles). All remaining clubhouse programs will employ many ICCD standards along with engagement strategies.
- In-service training will be provided to paid staff to access supported housing resources and employment supports, such as California Department of Rehabilitation CO-OP programs and Housing Authority subsidized apartment rentals.
- Structured educational activities on a variety of topics will be implemented. These will
include, but will not be limited to, adult education, GED classes, symptom
management, life skills, etc. These activities will be offered, promoting rehabilitation
goals, through staff, peers, and community resources.

- Consumers Advocating Recovery through Empowerment (CARE), arts and crafts,
sport activities, recreational outings, self-help advocacy group, etc.
- Structured educational activities on a variety of topics will be implemented. These will
include, but are not limited to, adult education, GED classes, symptom management,
life skills, etc. These activities, promoting rehabilitation goals, will be offered through
staff, peers, and community resources.
- Use/develop curriculum to include promising and best practices to include: SAMHSA’s
Illness Management & Recovery Toolkit, NAMI’s Peer-to-Peer Recovery Program,
NEC’s PACE Plan, and/or other approaches (WRAP planning, employment
development, housing and educational goal setting, advocacy strategizing, and peer
support training, etc.).
- The DBH-run clubhouses that will be operated by primarily consumer-run activities will
provide opportunities for social rehabilitation and symptom management through an
array of peer-led, gender and cultural-specific educational, and leisure groups and
community activities such as Dual Diagnosis Anonymous, Inland Network of
Community Clubhouses, Pathways to Recovery, NAMI Consumers Advocating
Recovery through Empowerment (CARE), arts and crafts, sport activities, recreational
outings, self-help advocacy groups, etc. Consistent with Clubhouse philosophy, all
activities will be self-directed by consumer choice and overall groups, activities and
clubhouse structure and policies will be determined by consumer representation in
collaboration with paid staff through a consumer council or governing board.
- The DBH-operated clubhouses that utilize consumer/member involvement in providing
daily programs and utilizing the “Fountain House” model will provide employment
screening and job placement through onsite and/or offsite volunteer and/or paid
vocational opportunities, e.g. in the areas of clerical, facilities maintenance, retail food
preparation, etc. for overall daily operations. The program will also provide ongoing job
supports via activities within a network of supportive relationships of peer staff,
members who are employed and others who are seeking employment.
- Consumer-operated services will focus on rehabilitation; recovery; and
increased community integration, individualized for each participant while fostering
partnership, thus establishing measurable outcomes. Every consumer will be offered to
develop a WRAP Plan in helping them achieve their goals for success.
- Culturally competent services will be provided and community outreach initiated
consistent with availability of linguistically and culturally capable staff. Every effort will
be made to utilize MHSA funding to identify and recruit culturally appropriate staff to
serve the unserved and underserved ethnic populations. This will involve contacting
community leaders, schools and agencies providing services currently to the ethnic
populations identified. Outreach services will be provided to sites including but not
limited to clubhouses, outpatient clinics, Board & Care facilities, NAMI affiliates, IMD’s.
and other community sites, i.e., churches, etc.

- Ethnic populations of adults as well as those with special needs (hearing and sight impaired) who are underserved, unserved, or inappropriately served will be the priority for services in this program.
- Engagement, outreach and services that are culturally and linguistically appropriate as well as gender-specific will be provided through Consumer-Operated Peer-Support Services.
- Expanded space and equipment, including vans for transportation, will allow for expansion and increased utilization of social and recreational activities such as sports, outings, etc.
- Evening and weekend hours will allow for social events such as dances, holiday celebrations, coffee house and entertainment activities.
- Two (2) six-slot transitional housing programs within easy commuting distance of each clubhouse to increase permanent housing options for SMI adults with little history of independent living.
- Expanded networking/collaboration will be implemented through the use of MOU’s, written referral and interagency cooperation agreements and development of specific protocols with a wide variety of agencies that serve the mentally ill population and can provide resources and support. Currently the clubhouses have contracts, on a limited basis, with food banks, Goodwill for clothing exchanges, and the District Attorney, the Public Defender, the San Bernardino Police Dept., and the Superior Court for an innovative Homeless Court that is held at the San Bernardino clubhouse site. Building on the experience that DBH already has in developing and implementing MOU’s and contracts with numerous agencies such as California Department of Rehabilitation, the Probation Dept., Mental Health and Drug Courts, etc., this networking and collaboration will be expanded and formalized.
- Track services, sites, and the number of consumers being served.

San Bernardino County CSS WORK PLAN

Exhibit 4
Program Work Plan Name: Adult – Forensic Integrated Mental Health Services
Work Plan Number – A-2
Description of Program:
Specialized mental health services provided to Severely and Persistently Mentally Ill (SPMI) individuals who are involved with the criminal justice system. An integrated treatment team will partner with:
- San Bernardino County Sheriff's Department
- San Bernardino County Department of Behavioral Health (DBH)
- Mental Health Court
- Probation Department
The Team will be a 24/7, multi-disciplinary team and provide:
- Crisis response
- Case management
• Peer support
• Alternatives to hospitalization and incarceration
• Housing and employment support

The team will do whatever it takes to assist the consumer in maintaining their independence in the community. The emphasis in this program will be to advance the goals of the Mental Health Services Act:
(1) To divert appropriate consumers away from the criminal justice system
(2) To expand both types and capacity of forensic-specific mental health service modalities, especially the formation of an Assertive Community Treatment (ACT) Program and the expansion of Mental Health Court and Crisis Intervention Training to law enforcement, and
(3) To integrate these consumers more effectively into existing services.

This will result in a reduction in homelessness, incarceration, hospitalization, emergency room care, involuntary mental health care, and an increase in the consumer’s ability to work and manage their independence in the community.

**Priority Population:**
Severely and Persistently Mentally Ill (SPMI) individuals who are incarcerated or at risk for incarceration and who are recidivistic for consumption of high cost institutional services.

The number of clients projected to receive services annually under Full Service Partnerships is 110.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>African-American</td>
<td>18%</td>
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<tr>
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<tr>
<td>Euro-American</td>
<td>34%</td>
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<tr>
<td>Latino</td>
<td>40%</td>
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<tr>
<td>Native-American</td>
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<tr>
<td>Other</td>
<td>4%</td>
</tr>
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</table>

**Strategies:**

<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Fund Type</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand the Crisis Intervention Training program with the Sheriff’s Department by hiring a Forensic Mental Health Education Consultant to provide mental health training to law enforcement, including the Sheriff’s Department, Community Police Departments, the Probation Department, the District Attorney’s Office, the Public Defender’s Office, Superior Court and other law enforcement partners.</td>
<td>X</td>
<td>$2,533,903 $609,663 $1,924,240</td>
</tr>
<tr>
<td>Expand Mental Health Court from San Bernardino City to outlying courts in the High Desert, Mid Desert, and West Valley regions by adding Case Managers to serve 40 additional consumers’ mental health case management needs in conjunction with the judicial system and add a Mental Health Specialist to act as a liaison to provide support to the expanded Mental Health Court.</td>
<td>X</td>
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<tr>
<td>Assertive Community Treatment (ACT) Team to serve 40 consumers, to include peer support and a Probation Officer that focuses on case management that will provide 24/7 support and intensive community services and supports.</td>
<td>X</td>
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</tbody>
</table>
• Provide a continuum of housing for 66 forensic mental health consumers, including augmented board and care, regular board and care, sober living housing and independent permanent housing based on the consumers’ needs.
• Increase capacity of current Mental Health Court treatment programs, as follows:
  – Increase capacity of Day Rehabilitation Program from 30 to 40 consumers, and
  – Increase capacity of Outpatient Case Management from 40 to 60.
• Coordinate with 24/7 Drop Off Centers to increase utilization by law enforcement personnel when dealing with mental health consumers.

San Bernardino County CSS WORK PLAN

Exhibit 4
Program Work Plan Name: Adult – Assertive Community Treatment (ACT) Team for High Utilizers of Hospital and Jail Services
Work Plan Number – A-3
Description of Program:
This program will be modeled after San Bernardino Department of Behavioral Health’s (DBH) successful ACT program, started in January of 2003. However, the target population will be different for the current program. Where the first ACT program was designed to assist clients transitioning from locked facilities (IMDs, state hospitals) and Augmented Board and Care facilities into the community and support their independent living, the current program is designed to provide community-based assertive case management and support, 24 hours a day, to 60 seriously and persistently mentally ill (SPMI) clients who are frequent users of acute psychiatric hospitalization and/or who are caught in the cycle of arrest for minor crimes - jailed - released - re-offend - jailed again, etc. Many of these clients are homeless and have co-occurring disorders.
The program will provide:
• Crisis response
• Peer support
• Clinical interventions by staff and consumers
• Psychiatric services
• Housing support
• Employment services and training
and will utilize the "whatever it takes" approach which typifies the ACT model of community services. Transitional housing, sober living, safe haven housing, and permanent housing will be provided as appropriate.
The goals of the program are to:
• Reduce homelessness in the county's mentally ill population
• Reduce frequency and length of incarceration (reduce recidivism)
• Reduce frequency and length of acute psychiatric hospitalization
• Increase clients' involvement in their recovery plans
• Increase clients' ability to find and hold meaningful employment
• Increase independent decision-making
• Provide our clients with a durable sense of hope about their futures

Attachment AF
**Priority Population:**
The program is designed to serve SPMI adults who are identified as high users of acute hospital services and/or who are cycling in and out of jail. This population is characterized by crisis-only contact with the mental health system, homelessness, co-occurring disorders, and minimal skills with which to manage their lives.

The number of clients projected to receive services annually under Full Service Partnerships is 60.

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<td>Asian-American</td>
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<tr>
<td>Euro-American</td>
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<tr>
<td>Latino</td>
<td>40%</td>
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<tr>
<td>Native-American</td>
<td>1%</td>
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<tr>
<td>Other</td>
<td>4%</td>
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**Strategies:**

- **Fund Type**
- **Budget**

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<thead>
<tr>
<th>Name and Description</th>
<th>Fund Type</th>
<th>Budget</th>
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<tbody>
<tr>
<td>Provide community-based ACT-type aggressive case management and wrap-around services.</td>
<td>X</td>
<td>$864,227</td>
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<tr>
<td>Services to be provided to consumers 24/7, ratio of consumers to staff will not exceed 15 to 1.</td>
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<td>$59,209</td>
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<tr>
<td>Services to include needed mental health interventions, aggressive case management and the full range of community-based services consistent with the Recovery Mode. (“Whatever it takes.”)</td>
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<td>$805,018</td>
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<tr>
<td>Services to be provided in partnership with families, Probation Dept., Parole Department private medical and psychiatric providers, and providers of acute care.</td>
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<td>Services will include education and employment preparation, training and support.</td>
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<tr>
<td>Support for sober living, safe havens, transitional shelter, single room occupancy and permanent housing, as appropriate, will be included.</td>
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<tr>
<td>Case management services will include substance abuse interventions and will provide access to substance abuse services, including detox.</td>
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<tr>
<td>Psychiatric services will be provided by program staff.</td>
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**San Bernardino County CSS WORK PLAN**


**Exhibit 4**

**Program Work Plan Name:** Adult – Crisis Walk-In Centers

**Work Plan Number – A-4**

**Description of Program:**
San Bernardino County Department of Behavioral Health (DBH) is proposing a redesign and expansion of DBH’s current walk-in clinics into countywide system of three 24/7 Crisis Walk-In Centers (CWIC). Currently DBH has fragmented and incomplete urgent care coverage that mainly operate during weekday business hours and evenings. DBH’s Crisis Response Teams provide limited weekend and geographical coverage, but
suspend services at 9:00 or 10:00 pm. Thus clients have had to utilize inpatient units, emergency rooms, and law enforcement for urgent mental health services when DBH clinics are not open. When responding to sub-acute mentally ill persons in the community after DBH business hours, law enforcement personnel are left few resource options beyond involuntary holds or arrest.

The proposed CWIC program will provide urgent mental health services 24/7 for seriously mentally ill (SMI) persons of all age groups – children, TAY, adults, and older adults – needing immediate access to crisis mental health services. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and this program will provide integrated substance abuse treatment services for dually diagnosed clients. These centers will offer urgent mental health services to the acute and sub-acute mentally ill individuals including:

- Crisis intervention
- Crisis risk assessments
- Medications
- Substance abuse counseling
- Case management
- Referrals to DBH and contracted clinics
- Family support and education
- Transportation
- 23-hour crisis stabilization
- 5150 evaluations when required

Direct linkage to the high users’ team, the proposed Assertive Community Treatment (ACT) program, residential drug/alcohol programs for dually diagnosed person, DBH and DBH contracted mental health clinics, and housing and employment programs will be made by CWIC staff. All services will be provided in a culturally, linguistically, and developmentally competent manner.

The goals for this program are soundly based in recovery principals by using less restrictive settings, client driven treatment delivery, and client support systems. The goals are to:

- Maintain mentally ill persons in the community with familial and social support.
- Reduce utilization of emergency rooms by mentally ill persons for mental health needs.
- Reduce hospitalizations, incarcerations, and residential placements.
- Provide access to crisis mental health and substance abuse services to previously unserved and underserved persons through the use of outreach presentations to community stakeholders.

**Priority Population:**
Inappropriately served, underserved, and unserved seriously mentally adults and children who frequently use acute care hospitals or jails care services for their mental health, substance abuse treatment, and shelter needs.

The number of clients projected to receive services annually is 1875 under System Development and 1125 under Outreach and Engagement for a total of 3000.

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<td>African-American</td>
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<td>Latino</td>
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<td>Native-American</td>
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<tr>
<td>Other</td>
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</table>
Three (3) Crisis Walk-In Centers (CWIC) will be strategically located throughout the county such that they will be readily accessed by this population. Proposed locations are the Morongo Basin, Rialto, and Victorville.

All services will be community-based, developmentally and culturally competent, and focused on maintaining clients within the community. This will reduce reliance on acute care settings and incarceration.

Linkage to local mental health clinics and/or intensive case management services will be made when clients are stable.

Referrals to physical health care and housing programs.

Peer advocates, as paid staff and volunteers, will provide hospitality, support, and guidance to clients receiving services. Peer advocates will be recruited from DBH’s current consumer run programs and clubhouses such as the Pathways to Recovery consumer group and the T.E.A.M. House clubhouse.

A “warm line” will be created and manned by trained peer advocates.

Families and friends of clients will be included in the crisis interventions and will be educated and supported to assist them in better intervening and supporting the clients in the community.

Collaboration and local law enforcement agencies, local school districts, children service agencies, homeless shelters, community health care providers, clubhouses, faith-based organizations will be an essential aspect of this program.

Services will be individually provided and will include crisis intervention, risk assessment, emergency medication, medical screening (nursing assessments), substance abuse counseling, and 23-hour crisis stabilization. There will be separate sections for treating children and adults in the 23 crisis stabilization unit.

Presentations and written materials on the CWIC program will be provided to clubhouses, physical health care providers, local hospitals, homeless shelters and programs, NAMI, faith-based organizations and local law enforcement agencies.
• Prescription refills
• Resolution of homelessness
• Resolution of crisis
• Assistance with substance-abuse crises
• Hunger
• Seeking information regarding mental health services

It is also the department’s experience that approximately 40% of those going to the ER can be provided services which will meet their needs in a less restrictive environment and that will give them opportunities to increase their coping skills and decrease their reliance on hospitalization.

The proposed program will provide a preliminary screening of clients as they enter the Behavioral Health Unit’s ER and will determine the reason for the client’s visit to the ER. The program will divert the client and link them to existing community resources most appropriate for their condition and ongoing mental health needs.

Preventing unnecessary acute hospitalizations promotes recovery and resiliency, decreases dependency on “the system”, and promotes responsible wellness.

**Priority Population:**
The priority population to be served is adults who are presenting at the psychiatric ER in crisis due to homelessness, co-occurring disorders, recent release from incarceration, and medical conditions. The target population will include clients who are uninsured, and who will most likely represent the full range of racial, cultural and ethnic diversity found in the county.

The number of clients projected to receive services under System Development is 300.

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<td>Native-American</td>
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<tr>
<td>Other</td>
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**Strategies:**

- Provide integrated case management services at the psychiatric triage location in the county hospital, in collaboration with outpatient clinics, primary care providers and housing providers. Clients who are frequently hospitalized in acute psychiatric care will be linked to existing intensive community-based case management services and with existing outpatients clinics.
- After stabilization, provide facilitation of community placement at the lowest appropriate level of care.
- Advocate for and facilitate the client’s negotiations to return to their previous location if at all possible.
- Advocate for clients with family and caregivers to support recovery and aftercare.
- Advocate for clients to have access to treatment for co-occurring disorders and link with

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<tr>
<td>FSP</td>
<td>SD</td>
<td>OE</td>
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<tr>
<td>X</td>
<td>$465,549</td>
<td>$163,150</td>
<td>$302,400</td>
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residential treatment or transitional housing as needed.

- Clients will be encouraged and empowered to actively participate in their diversion and recovery plan. Options regarding mental health care and housing will be presented; with clients being encouraged to make choices that will promote their long-term recovery goals.
- Transportation assistance will be made available to clients to facilitate their return to community-based recovery. Again, clients will be encouraged to make their own decisions as much as possible.
- Advocate for clients’ use of existing community support and self-help services that will simultaneously enhance their recovery goals.
- Clients who do not speak English or who are hearing-impaired will be provided with linguistic services that will allow for immediate access to mental health services.
- Provide education and consultation to clients and families regarding community services and facilitate their engagement in and accessing of those services.

attachment af

San Bernardino County CSS WORK PLAN

Exhibit 4
Program Work Plan Name: CIRCLE OF CARE: SYSTEM DEVELOPMENT
Work Plan Number - OA-1
Program Description:
San Bernardino County has developed an array of services for Older Adults that struggle with severe mental illness (SMI). These services include:
- Expand mental health treatment and case management services
- Expand the Senior Peer Counseling program
- To provide treatment, education and assistance
- Enhance existing Senior Peer Counseling program
  - With a focus on wellness and recovery
  - To assist older adults in remaining independent and active
  - To pursue individualized personal goals

This program is to lay the foundation for the Full Service Partnership (Plan 2) to be implemented in Year 2.

Priority Populations:
- Unserved and underserved Older Adults (60 years and older)
  - Who are isolated and may be in declining health
  - Because of stigma,
  - Lack of transportation
  - Lack of awareness of availability of services

According to prevalence data, Euro-Americans and Latino older adults make up the most underserved population. Significant efforts will be made to work with these identified groups.

The number of clients projected to receive services annually is 90 under System Development 55 under Outreach and Engagement for a total of 145.

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<td>African-American</td>
<td>11%</td>
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### Strategies:

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<tr>
<th>Name and Description</th>
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<tbody>
<tr>
<td>Increase staff to extend to diverse populations of older adults not currently receiving mental health and case management services.</td>
<td>X</td>
<td>$1,277,199</td>
</tr>
<tr>
<td>Provide services to all who meet the unserved/underserved criteria. Assure that mental health services will be delivered in a manner that is culturally, racially, ethnically, and age-cohort appropriate.</td>
<td>X</td>
<td>$350,696</td>
</tr>
<tr>
<td>Provide ongoing education, linkage and consultation related to insurance and SSI benefits for the Transitional Age Older Adult population (ages 55-59) and for those Older Adults 60-65 years that may need assistance in obtaining benefits.</td>
<td></td>
<td>$926,503</td>
</tr>
<tr>
<td>Link those interested in employment to programs, such as Vocational Rehabilitation, DAAS Senior Employment Program, and State of California Employment Development Program.</td>
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<tr>
<td>The <strong>AGEWISE</strong> Senior Peer Counselor Program provides facilitation of peer support groups in the High Desert and East Valley regions of San Bernardino County. Expand the existing Senior Peer Counseling Program to provide mental health counseling with the focus on wellness and recovery and to include the following: outreach and engagement to groups in communities throughout the county, facilitation of support groups for consumers, families, and caregivers, social service referrals, advocacy, telephone support and referral with implementation of a “Warm Line” (telephone program to those who are isolated and in need of emotional support) and provide education to the community regarding older adult mental health issues to reduce the stigma about mental illness.</td>
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<tr>
<td><strong>AGEWISE</strong> Senior Peer Counselors will provide in-home supportive peer counseling to older adults suffering from situational difficulties related to aging (i.e. bereavement, caregiver stress, grandparent raising grandchildren, coping with physical decline, etc.). Will recruit and train volunteers form vari9ous geographical regions with special attention to racial, ethnic, and cultural representation. Bilingual volunteers will be recruited.</td>
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<td><strong>AGEWISE</strong> Training for Primary Care Physicians on evidence-based and promising clinical practices for coordination and integration of mental health and primary care, covering clinical practices guidelines, screening and assessment protocols (particularly for depression and suicidality), chronic disease management, and cultural competence. Use of evidence-based treatment models such as the IMPACT model, which identifies and treats in primary care physicians” offices those</td>
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### Demographics:

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<td>Native-American</td>
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<tr>
<td>Other</td>
<td>7%</td>
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older adults with depression, who may be particularly at high risk for suicidality, and Promotores Model, a healthy aging program targeting Latino populations.

- Capacity-building component in which specific modules of training, consultation, and mentoring regarding important areas related to older adult mental health concerns will be provided by community agencies with specific expertise (e.g. Alzheimer’s Association, Inland Caregiver Resource Center, Department of Aging and Adult Services (DAAS)). Training that is responsive to the needs of new and existing staff, volunteers, and community partners will be developed by DBH to identify the most urgent areas of training needed. A technical assistance network comprised of community experts in the field of geriatric mental health and older adult issues will act as consultants and mentors to individual staff with challenging care cases and participate in multidisciplinary team meetings.
- Develop/purchase a range of information and educational tools for distribution to users of AGewise services, their families, and other support persons and for distribution to professionals in allied health fields (i.e. M.D.’s, clinics, Public Health, churches, etc.)
- Link with respite care vendors/providers, as needed, by referral.

### San Bernardino County CSS WORK PLAN


**Exhibit 4**

**Program Work Plan Name:** OLDER ADULT FULL SERVICE PARTNERSHIP

**Work Plan Number - OA-2**

**Program Description:**
San Bernardino County has developed an array of services for Older Adults that struggle with severe mental illness (SMI). These services include:

- Provide mobile outreach for crisis response
- Provide crisis prevention and comprehensive mental health and substance abuse screening
- Integrate geriatric assessment, benefits eligibility, and information
- Linkages and referrals to clients, family, and care providers
  - Through outreach to isolated seniors in their homes
  - To the homeless in vivo settings, including on-site services such as senior centers, nutrition sites, churches, and other community settings.
- A transportation component
  - Includes the purchase of two (4-wheel drive) vans to facilitate team mobility and reach geographically isolated Older Adults in the High Desert region.
- Full Service Partnership (FSP) system of care
  - Goals of the FSP would be to increase access to care and the ability to manage independence while reducing episodic institutionalization and incidents of relapse.

**Priority Populations:**
- Unserved and underserved Older Adults who are homeless or at risk for homelessness.
- Priority will be given to those with the most severe conditions, with the highest incidence of emergency, and with inpatient services utilization, or those having the most difficulty accessing care due to system barriers.

In the Full Service Partnership component, the priority population will be 13 SMI Older Adults with the most severe conditions,
I.e. clients who have
  o a) History of repeated emergency health services;
  o b) Several admissions to inpatient services or are at risk for institutionalization;
  o c) Been homeless or at risk for homelessness.

Services may be extended to adults, ages 55 – 59 years, whose service needs are likely to extend into older adulthood.

According to prevalence data, Euro-Americans and Latino older adults make up the most underserved population. Significant efforts will be made to work with these identified groups. The number of clients projected to receive services is 13 under Full Service Partnerships, 450 under System Development, and 300 under Outreach and Engagement for a total of 763.

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<td>Other</td>
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**Strategies:**

- Senior Peer Counselors will receive initial orientations and training, which will include information about the unique mental health needs of older adults and evidence-based and culturally and linguistically appropriate crisis intervention and prevention strategies. The Senior Peer Counselors will receive ongoing supervision and in-service trainings.
- Identify appropriate supplemental housing for older adults; provide referrals as needed.
- Support and education, and sharing of knowledge, to clients and families about navigating the mental health system, and understanding older adult mental health issues in general; support and education for families and caregivers who are housing and/or supporting those with serious mental illness (i.e. grandchildren, adult children, spouses, other family members, etc.)
- Utilize a capacity building program to ensure client-centered and culturally competent services are provided by staff, volunteers and community partners in the CIRCLE OF CARE program. Individuals will participate in knowledge and skills building seminars throughout the County. A needs assessment will identify the most urgent areas of training needed to ensure linguistically appropriate, generational and sexual orientation sensitivity, and understanding of an optimal client/provider relationship. Utilize community experts, mentors and train-the-trainer programs to create a positive team atmosphere, respect for others and prevention of barriers to a successful CIRCLE OF CARE program.
- Certificated training in geriatric mental health for mental health professionals and other aging network service providers (i.e. Senior Peer Counselors, all volunteers, staff,
- Outreach to skilled Nursing Facilities (SNF’s), convalescent hospitals, and physicians offices to educate about and assist in identification of older adult mental health issues.
- Assist those interested in employment opportunities by referral to programs, such as Vocational Rehabilitation, Department of Aging and Adult Services (DAAS) Senior Employment Program, State of California Employment Development Program, and other community agencies such as faith organizations.
- Contract with community services for episodic transportation needs.
- Share responsibility for treatment, support and referrals for any rehabilitation services.
- Provide 24/7 multidisciplinary teams services. Multifaceted interventions to be provided wherever needed. Teams work in partnership with collaborative services. There are no time limits for appropriate services for those clients and families participating in the Full Service Partnerships.
- Provide intensive case management and treatment follow-up for FSP clients. Sustained management is focused on self-directed client goals, comprehensive planning with community/family support to reach optimal mental and physical health.
- Utilize existing Residential Care Facilities for the Elderly (RCFEs) and assisted living facilities for placement, as needed. Provide for residential care that has an augmentation for special care to provide modified older adult wraparound services with contracts for 9 units. The placement will enable the older adult to live at the lowest level of care for as long as possible. (See Housing Exhibit)
- FSP staff ratio of 1:10. CIRCLE OF CARE team members and Senior Peer counselors specifically trained to work with SMI older adults. Mobile team members share responsibility for treatment, support and referrals for any rehabilitative services.
INTEROFFICE MEMO

DATE: February 2, 2006

FROM: ALLAN RAWLAND, Director
Department of Behavioral Health
LISA McGINNIS, MHSA Program Manager
Department of Behavioral Health

TO: MEMBERS, Mental Health Commission

SUBJECT: REPORT ON THE PUBLIC REVIEW PROCESS FOR THE MENTAL HEALTH SERVICES ACT (MHSA COMMUNITY SERVICES AND SUPPORTS (CSS)) THREE-YEAR DRAFT PLAN

In accordance with Welfare and Institutions Code, Sections 5848 (a) and (b), each County submitting requests for MHSA funds is required to circulate the CSS Draft Plan for public review and comment for at least 30 days, followed by a Public Hearing conducted by the local mental health board or commission. The Plan was posted on the San Bernardino County Internet site Home Page, as well as the County’s and the Department of Behavioral Health’s (DBH) Intranet Home Page sites, beginning December 13, 2005 and ending on January 13, 2006.

Copies were also distributed to all County library branches, DBH Clinics and Contract Agencies. Newspaper public notices and a media advisory were sent out to all county residents regarding the Public Review Process and the Mental Health Commission Public Hearings. In addition flyers advertising the Public Hearings, which included the Plan’s viewing locations, were e-mailed to all County personnel, DBH contract agency providers and to the communities throughout San Bernardino County via the MHSA Outreach staff. On January 17, 18 and 19, 2006 three (3) Public Hearings were held in Victorville, Yucca Valley and Rialto to solicit public feedback on the MHSA CSS Draft Plan.

The following is a summary report on the 30-day Public Review Process and the Public Hearings:

- The Department only received three written comments during the 30-day Public Review Process of the CSS Draft Plan. One related to improvements in grammar. Another was from a community provider, a director of a domestic violence shelter, wanting to partner with DBH in providing services to this population. The other was a local psychiatrist who wanted to increase services to “troubled youth”. Both community service partners expressed a desire to be part of the ongoing MHSA planning and implementation process. They were contacted by the Department and invited to become members of our Community Policy Advisory Committee.

- The Public Hearings were well attended and included consumers, their families, service agency representatives, County program representatives, DBH
MEMO
REPORT ON THE PUBLIC REVIEW
PAGE 2

administrative personnel, Mental Health Commissioners and other community stakeholders. There seemed to be a general consensus for approval of the Plan and there were positive comments at all three Public Hearings regarding the inclusion of intensive case management, housing resources and crisis walk in services, which spanned all four age specific programs. A common theme in all three areas, but more so in the high and low desert regions, was a lack of transportation to enable consumers to access services and a need for more staff resources to adequately address the mental health needs of the consumer population. Although addressed in several of the work plans, there was a comment regarding the need for increased “paid consumer/family employment”. Increasing our consumer employment will continue to be a priority as the MHSA Community Services and Supports are implemented in San Bernardino County.

There were a total of eighteen (18) written comments from the three Public Hearings. Many other comments were addressed verbally at the Public Hearings and were responded to by our DBH Director and Deputy Directors for the Adult and Children’s Programs.

The following are the written comments broken down by specific location:

VICTORVILLE (January 17, 2006)
There were forty-nine (49) individuals in attendance at the Victorville Public Hearing and six (6) feedback forms were received.

- This comment was from the former supervisor of the Crisis Resolution Team in Riverside County: “I think it’s important to focus on 4 main groups: 1) substance abusers (who want 3 hots [meals] and a cot); 2) [those with] dual diagnoses; 3) [those with] personality disorders and 4) “police drop offs” [or those with mental illness who come to the attention of law enforcement].”

- Lack of staff resources to address mental health needs. “We need staff. I work in a clinic that has been without a therapist for six months.”

- Positive comments regarding the development of a “crisis walk-in center, intensive case management services and housing programs”.

YUCCA VALLEY (January 18, 2006)
There were 20 attendees at the Yucca Valley Public Hearing and two (2) feedback forms were received.

- “Helping the indigent population [which] seems to be a major concern in the high-desert area.”

- “Adequate plans for transportation – a major problem in the Morongo Basin.”

RIALTO (January 19, 2006)
There were 58 attendees at the Rialto Public Hearing and ten (10) feedback forms were received
MEMO
REPORT ON THE PUBLIC REVIEW
PAGE 3

- "Work Plan A-2 needs to be sure to address the provision of services to mentally ill individuals who do not voluntarily seek assistance but indicate through actions and conditions that help is needed".

- "The work plans, Numbers A-1 and A-3 are much needed. A-2 is an excellent extension to the current Mental Health Court which inadequately serves a population in much need."

- "All 3 Programs need to include service to more individuals."

- "I am most interested in the effectiveness of housing and employment support that will be offered to African-American adult males with mental illness."

- A recommendation: "Counselors/case managers working in FSP must have training and sensitivity to work with individuals in a caring and empathic manner. To date, services received have been less than favorable. Hopefully, smaller yet full service case loads will improve the quality of services."

- "While it is important to address the threshold population; it is just as important to address the concerns/issues and treatment needs of other cultures and ethnicities as well."

- "Increase paid consumer/family member employment in lieu of volunteer work. Prepare consumers for the County’s hiring process."

- "I appreciate the recognition that we must transform our service-delivery system rather that just put more money in current clinics, etc."

- "Looking forward to RFP for program development, helping and building the community, and growing the opportunity for clients."

- "Collaborate with other agencies to help all members of the family from 0-5, children, adolescents and adults."

- "Helping the homeless is a very positive thing."

- "Recommendations" "Help out the adult group because they are raising the children who may be mentally ill."

While the written feedback outlined here is significant, it did not warrant any substantive changes to the overall CSS Plan. These comments/suggestions will be incorporated in the ongoing planning and implementation process so as to further enhance services offered under the Mental Health Services Act.

We wish to acknowledge the Mental Health Commission (MHC) for conducting these Public Hearings along with Margot Varden, Secretary to the MHC, for all her hard work,
time and effort to ensure that the Public Hearings were a success. We look forward to an ongoing collaborative working relationship as we continue to implement the Mental Health Services Act in San Bernardino County.

AR:LM

cc: Members of the Board of Supervisors
    Mark Uffer, CAO
    Dean Arabatzis, Assistant CAO
    DeAnna Avey-Motikeit, Assistant Director, DBH
    Ralph Ortiz, Deputy Director, DBH
    Kimm Hurley-Smith, Deputy Director, DBH
MHSA-CSS SUBJECT REFERENCES BY AGE GROUPS (*)

CHILDREN

School Dropout Rates, Performance, Test Scores, and Student Demographics:
California Department of Education
http://data1.cde.ca.gov/Dataquest

Children in out-of-home placement by counties:
California Department of Social Services
http://www.dss.cahwnet.gov/research/cws-cms1-c_408.htm

Juvenile Felony Arrests by County, Juvenile Misdemeanor Arrests by County, 2002-2003:
California Legislative Analyst’s Office
www.lao.ca.gov/1995/050195_juv_crime/kkpart2.html

Inpatient Care, Hospitalizations:
County of San Bernardino, Department of Behavioral Health
Treatment Authorization Reports, County of San Bernardino, DBH databases

Substance-related Services Provided:
County of San Bernardino, Department of Behavioral Health
Direct Services and Client Services, County of San Bernardino, DBH, Research & Evaluation databases

Illicit Drug and Alcohol Abuse and Dependence:
Office of Applied Studies, SAMHSA, National Survey on Drug Use & Health 2002-2003
http://oas.samhsa.gov/2k3state/appB.htm

Drug & Alcohol Abuse & Mental Health:
National Mental Health Association
http://www.nmha.org/substance/advocate.cfm

Foster Care Placement in RCL 12-14, Number of Children Placed in RCL 12-14, Number of Medi-Cal Eligibles:
State of California Department of Mental Health
www.dmh.ca.gov/SADA/docs/EmilyQ/FosterCarePlacement_RCL_12-14_2002&2003.pdf

Severely Mental Ill Rates:
California Department of Mental Health, Statistics & Data Analysis
http://www.dmh.ca.gov/SADA/SDA-Prevalence_Rates.asp

Center for Substance Abuse Prevention:
U.S. Department of Health and Human Services
http://prevention.samhsa.gov

Center for Substance Abuse Treatment:
U.S. Department of Health and Human Services
http://csat.samhsa.gov/

National Institute on Drug Abuse:
National Institutes of Health
http://www.nida.nih.gov

Demographic Information:
California Department of Finance, Demographic Research Unit

U.S. Census Bureau
http://www.census.gov

(*) References may be repeated by Age Group
TRANSITIONAL AGE YOUTH (TAY)

Inpatient Care, Hospitalizations:
County of San Bernardino, Department of Behavioral Health
Treatment Authorization Reports, County of San Bernardino, DBH databases

Juvenile Felony Arrests by County, Juvenile Misdemeanor Arrests by County, 2002-2003:
California Legislative Analyst’s Office
www.lao.ca.gov/1995/050195_juv_crime/kkpart2.html

Substance-related Services Provided:
County of San Bernardino, Department of Behavioral Health
Direct Services and Client Services, County of San Bernardino, DBH, Research & Evaluation databases

Illicit Drug and Alcohol Abuse and Dependence:
Office of Applied Studies, SAMHSA, National Survey on Drug Use & Health 2002-2003
http://oas.samhsa.gov/2k3state/appB.htm

Transitional Age Youth (TAY) in the Juvenile/Adult Justice System:
County of San Bernardino, Department of Behavioral Health
AB2034 Clients Reports Mental Health County of San Bernardino, DBH, Research & Evaluation databases

Transitional Age Youth (TAY) minorities in Juvenile/Adult Justice System:
State of California, Department of Justice, Office of the Attorney General
http://ag.ca.gov/cjsc/databats.htm

Inpatient Consolidation and Short Doyle Medi-Cal Inpatient Readmissions, 2002-2003:
State of California Department of Mental Health

Penetration Rates-Hospital Inpatient and RCL 12-14 Placements, 2002-2003:
State of California Department of Mental Health

Psychiatric Hospitalizations-California:
California Institute for Mental Health

Foster Care Placement in RCL 12-14, Number of Children Placed in RCL 12-14, Number of Medi-Cal Eligibles:
State of California Department of Mental Health
www.dmh.ca.gov/SADA/docs/EmilyQ/FosterCarePlacement_RCL_12-14_2002&2003.pdf

Severely Mental Ill Rates:
California Department of Mental Health, Statistics & Data Analysis
http://www.dmh.ca.gov/SADA/SDA-Prevalence_Rates.asp

Juvenile Hall: Mental Health Cases and Cases on Psychotropic Medications 2002-2003:
California Department of Mental Health

Substance Abuse Treatment Facility Locator:
U.S. Department of HHS, Substance Abuse & Mental Health Services Administration
http://www.mentalhealth.samhsa.gov/databases/

Center for Substance Abuse Prevention:
U.S. Department of Health and Human Services
http://prevention.samhsa.gov

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Center for Substance Abuse Treatment:
U.S. Department of Health and Human Services
http://csat.samhsa.gov/

National Institute on Drug Abuse:
National Institutes of Health
http://www.nida.nih.gov

Substance Abuse and Mental Health Administration (SAMHSA):
http://www.samhsa.gov

Homeless Young Adults Ages 18-24, Examining Service Delivery Adaptation:
National Health Care for the Homeless Council, September 2004
http://www.nhchc.org/publications.html

The prevalence of homelessness among adolescents in the United States.
American Journal of Public Health, 88(9).

Demographic Information:
California Department of Finance, Demographic Research Unit

U.S. Census Bureau
http://www.census.gov

ADULTS

Inpatient Care, Hospitalizations:
County of San Bernardino, Department of Behavioral Health
Treatment Authorization Reports, County of San Bernardino, DBH databases

Substance-related Services Provided:
County of San Bernardino, Department of Behavioral Health
Direct Services and Client Services, County of San Bernardino, DBH, Research & Evaluation databases

Illicit Drug and Alcohol Abuse and Dependence:
Office of Applied Studies, SAMHSA, National Survey on Drug Use & Health 2002-2003
http://oas.samhsa.gov/2k3state/appB.htm

San Bernardino County Homelessness Census & Survey:
Applied Survey Research/Community Action Partnership

Severely Mental Ill Rates:
California Department of Mental Health, Statistics & Data Analysis
http://www.dmh.ca.gov/SADA/SDA-Prevalence_Rates.asp

Adult Felony & Misdemeanor Arrests:
State of California, Department of Justice
http://stats.doj.ca.gov/cjsc_stats/prof03/36/3B.htm

Therapeutic Behavioral Services (TBS), Unduplicated Clients, Penetration Rates by County:
California Department of Mental Health
www.dmh.ca.gov/SADA/docs/EmilyQ/TBS-Penetration_2003.pdf

Substance Abuse Treatment Facility Locator:
U.S. Department of HHS, Substance Abuse & Mental Health Services Administration

(*) References may be repeated by Age Group
http://www.mentalhealth.samhsa.gov/databases/

Center for Substance Abuse Prevention:  
U.S. Department of Health and Human Services  
http://prevention.samhsa.gov

Center for Substance Abuse Treatment:  
U.S. Department of Health and Human Services  
http://csat.samhsa.gov/

National Institute on Drug Abuse:  
National Institutes of Health  
http://www.nida.nih.gov

National Institutes of Health:  
http://www.nih.gov

National Institute of Mental Health:  
http://www.nimh.nih.gov

Substance Abuse and Mental Health Administration (SAMHSA):  
http://www.samhsa.gov

Adult Protective Services, Open Cases:  
California Department of Social Services  
www.dss.cahwnet.gov/research/soc242-Adu_436.htm

Food Stamp Program Participation:  
California Department of Social Services  
http://www.dss.cahwnet.gov/research/DFA358F-Fo_425.htm

Below Poverty Level:  
California Department of Social Services  
www.dss.cahwnet.gov/research/GeneralInf_640.htm

Unemployment Rates:  
California Department of Social Services  

Demographic Information:  
California Department of Finance, Demographic Research Unit  
U.S. Census Bureau  
http://www.census.gov

OLDER ADULTS

Inpatient Care, Hospitalizations:  
County of San Bernardino, Department of Behavioral Health  
Treatment Authorization Reports, County of San Bernardino, DBH databases

Substance-related Services Provided:  
County of San Bernardino, Department of Behavioral Health  
Direct Services and Client Services, County of San Bernardino, DBH, Research & Evaluation databases  
Illicit Drug and Alcohol Abuse and Dependence:  
Office of Applied Studies, SAMHSA, National Survey on Drug Use & Health 2002-2003  
http://oas.samhsa.gov/2k3state/appB.htm

(*) References may be repeated by Age Group
Severely Mental Ill Rates:
California Department of Mental Health, Statistics & Data Analysis
http://www.dmh.ca.gov/SADA/SDA-Prevalence_Rates.asp

Isolated Older Adults and Mental Health:
Personality Research Organization
http://www.personalityresearch.org/papers/roy.html

National Institutes of Health:
http://www.nih.gov

National Institute of Mental Health:
http://www.nimh.nih.gov

Demographic Information:
California Department of Finance, Demographic Research Unit

U.S. Census Bureau
http://www.census.gov
### CSS Draft Plan Distribution List

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<td>Bob Sudol</td>
<td>TEAM House</td>
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<td>201 W. Mill St., San Bernardino</td>
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### Specific Requests for Copy of Draft CSS Plan

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<td>Ed Diksa/CIMH</td>
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<td>Shannon Steele</td>
<td>San Bernardino Co. Probation 21101 Dale Evans, Apple Valley</td>
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<td>405 14th St., 15th Floor, Oakland, CA 94612</td>
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<td>Niki Gofinch</td>
<td>1111 W. Chestnut St., San Bernardino, CA 92410 Mail returned 12/28-sent interoffice to TEAM House.</td>
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<td>Phyllis Dinwiddie</td>
<td>29272 Silverfern Place, Highland, CA 92346</td>
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<td>1/23/06</td>
<td>1-Bound</td>
<td>Kelly E. Arnold (MH Commission)</td>
<td>18966 Monterey Street, Hesperia, CA 92345</td>
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Dear County Library Staff:

Enclosed please find a copy of the Community Services and Supports (CSS) Proposal, currently available for public review. The Mental Health Services Act (MHSA), or Proposition 63, was passed by voters to expand funding for a comprehensive, community-based mental health system for Californians who need it most. The San Bernardino County Department of Behavioral Health has coordinated the development of the local plan for this program expansion throughout 2005. This proposal is the result of active community program planning among residents, consumers, public agencies, community organizations and other community members throughout San Bernardino County. This plan is now available for public review and comment.

We would greatly appreciate it if your library would make this document available to members of the community for review. Community residents may submit their comments by visiting the county’s website or by completing the enclosed comment form. In addition, the county’s Mental Health Commission will be holding Public Hearings for the review and discussion of the San Bernardino County MHSA Community Services and Supports (CSS) funding proposal on January 17, 18 and 19, 2006. County residents may submit their opinions at these events as well.

If you have any questions, feel free to contact Elizabeth Longfellow at (909) 387-7712 at the Department of Behavioral Health. Thank you for your assistance.

Sincerely,

Allan Rawland             Lisa McGinnis
Director                 Program Manager II
Department of Behavioral Health    Mental Health Services Act
Dear Clinic Supervisors:

Enclosed please find a copy of the Community Services and Supports (CSS) Proposal, currently available for public review. The Mental Health Services Act (MHSA), or Proposition 63, was passed by voters to expand funding for a comprehensive, community-based mental health system for Californians who need it most. The San Bernardino County Department of Behavioral Health has coordinated the development of the local plan for this program expansion throughout 2005. This proposal is the result of active community program planning among residents, consumers, public agencies, community organizations and other community members throughout San Bernardino County. This plan is now available for public review and comment.

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Sincerely,

Allan Rawland                    Lisa McGinnis
Director                        Program Manager II
Department of Behavioral Health  Mental Health Services Act

MARK UFFER
County Administrative Officer

Board of Supervisors
BILL POSTMUS .............First District
PAUL BIANE .............Second District
JOSIE GONZALES .......................Fifth District
DENNIS HANSBERGER ..........Third District
GARY OVITT .........................Fourth District
DBH
Access Unit
700 East Gilbert
San Bernardino, CA 92415

DBH
Boys' & Girls' Club
1180 W. 9th
San Bernardino, CA 92411

DBH
Hesperia Clinic
14628 Main St.
Hesperia, CA 92345

DBH
La Casa Ramona
1543 W. 8th St., Suite B
San Bernardino, CA 92411

DBH
Morongo Basin Mental Health Services
55475 Santa Fe Trail
Yucca Valley, CA 92286

DBH
Phoenix Clinic
700 East Gilbert, Bldg. 4
San Bernardino, CA 92415

DBH
Victor Valley Behavioral Health
12625 Hesperia Road
Victorville, CA 92392

DBH
Agewise
850 E. Foothill Blvd.
Rialto, CA 92376

DBH
Chino Multiple Diagnosis Clinic
6180 Riverside Drive, Ste. H
Chino, CA 91710

DBH
Homeless Program
237 W. Mill St.
San Bernardino, CA 92408

DBH
Lucerne Valley Clinic
32700 Old Woman Springs Rd., #C
Lucerne Valley, CA 92356

DBH
Needles Clinic
1300 Bailey Avenue
Needles, CA 92363

DBH
T.E.A.M. House
201 W. Mill St.
San Bernardino, CA 92408

DBH
Vista Counseling Center
17216 Slover Ave., Bldg. L
Fontana, CA 92337

Barstow Counseling & Mental Health Center
805 E. Mountain View
Barstow, CA 92311

East Valley Resource Center
820 East Gilbert St.
San Bernardino, CA 92415

Hospital Aftercare Services
850 E. Foothill Blvd.
Rialto, CA 92376

Mesa Counseling Center
850 E. Foothill Blvd.
Rialto, CA 92376

Nueva Vida
209 N. 10th Street
Colton, CA 92324

Upland Community Counseling
934 N. Mountain Ave., # C
Upland, CA 91783