SAN BERNARDINO COUNTY: DATA NOTEBOOK 2015

FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Mental Health Boards/Commissions

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FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS

County Population (2014): 2,091,618

Website for County Department of Mental Health (MH) or Behavioral Health:

http://www.sbcounty.gov/dbh/index.asp

Website for Local County MH Data and Reports:

http://www.sbcounty.gov/dbh/index.asp

Website for local MH Board/Commission Meeting Announcements and Reports:

http://www.sbcounty.gov/dbh/mhcommission/mhcommission.asp#

Specialty MH Data[1] from 2013: see Archives folder at http://www.caleqro.com/

Total number of persons receiving Medi-Cal in your county (2013): **697,392**

Average number Medi-Cal eligible persons per month: **560,224**

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: **55.1** %

Adults, 18 and over: **44.9** %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2013): 29,077

Percent of Specialty MH service recipients who were:

Children, ages 0-17: **46.9** %

Adults, 18 and over: **53.1** %

[1] Downloaded July 2014 from the former APS Healthcare website, www.caeqro.com.
[2] Serious Mental Illness, term used for adults 18 and older.
[3] Severe Emotional Disorder, term used for children 17 and under.

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Introduction: Purpose, Mandates, and Data Resources

What is the "Data Notebook?"

It is a structured format for reviewing information and reporting on the mental health services in each county. For some questions, the Data Notebook supplies data for each county from public resources (e.g., mental health (MH) data from the External Quality Review Organization[4] and Substance Use Disorders (SUD) treatment reports). For other questions, we request that local mental health boards obtain information from their county behavioral health department because there is no public source.

The Data Notebook is designed to meet these goals:

- Assist local boards to meet their legal mandates[5] to review the local county mental health services and report on performance every year,
- Function as an educational resource about mental health data for local boards,
- Enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

Every year, the mental health boards and commissions are required to review data about the services for mental health in their county. The local boards are required to report their findings to the CMHPC every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information. The Data Notebook is organized to provide data and solicit responses from the mental health board regarding specific topics so that the information can be readily analyzed and reported by the CMHPC each year. These data are compiled in a report to inform policy makers, stakeholders and the general public.

The CMHPC serves under the umbrella of the Department of Health Care Services (DHCS) and must fulfill certain legal mandates to report on the public mental health system every year. We analyzed all Data Notebooks received in 2014 from the mental health boards and commissions; information which represented 41 counties that comprised a geographic area containing 83% of this state's population.[7] Our analyses produced the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Documents/CMHPCCSIDataNBReport2015.pdf

[4] See www.CALEQRO.com for county level data. Select the Archives folder containing reports for each county MH Plan, or check "New Reports" as available for the most recent year data.
[5] W&IC. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W&IC. 5772 (c), requires annual reports from the California Mental Health Planning Council.
[7] An additional six counties submitted their documents after our report was completed, for a total participation of 47 counties in partnership with their local advisory boards.

Other recent reports from various committees of the CMHPC can be found at: http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function.

Data Resources for the Data Notebook

Selected questions request input from members of the local boards. Your experience and perspectives are valuable, and that is one reason these boards exist. Most important, stakeholder input is taken into account by legislators and agency policy makers when they design and implement programs.

Some information is available from your local Department of Behavioral Health. Besides your county's Director of Behavioral Health or the staff for MH board liaison, other key contacts may include the Administrator for Alcohol and other Drug Programs, your Quality Improvement Coordinator or the Mental Health Services Act (MHSA) Coordinator. For your questions about healthcare disparities and related outreach efforts, you may wish to contact the county's Cultural Competence Coordinator or the related committee.

Data about local specialty MH services may be found in reports from the external quality review organization (EQRO) (www.CALEQRO.com). Check the "Archives" file for "Reports." Select the most recent "EQRO MHP Report" for your county. For detailed numbers, see "Appendix D" in the report. For an estimate of the percent of clients with serious mental illness (SMI) who also have Substance Use Disorders (SUD), consult the section titled "Information Systems Review."

Finally, we are very excited about a new data resource for your reports. We have arranged with DHCS to obtain Substance Use Disorders treatment data to share with you. These data are made available for publication by the CalOMS-Tx[8] group at the Office of Applied Research and Analysis after review by the office charged with protecting patient privacy and Health Insurance and Portability Accountability Act (HIPAA) compliance.

We have customized each report by placing the data for your county within the Substance Use Disorders section, followed by discussion questions on this topic. We also provide statewide reference data so that you can compare it to the information for your own community.

[8] CalOMS-Tx herein refers to both the "outcomes management system" for data about substance use treatment (Tx), and to the DHCS unit that performs the data collection, analyses, and reporting.

Instructions for Completing the Data Notebook 2015

Most county Departments of Mental Health are now Departments of Behavioral Health. Many local advisory boards have re-named themselves in terms of behavioral health, not just mental health boards or commissions. Some define their mission in more specific terms, as "Mental Health and Drug and Alcohol Boards." However, not all groups are ready to make such changes at this time.

Additionally, in terms of resources, some counties have inpatient facilities and/or crisis response teams to meet the needs of individuals experiencing a mental health crisis. Some counties have just one such resource available and some counties have none.

In respect of all these differences, we are presenting topics covering two critical issues for review by the local advisory boards in this year's Data Notebook. Please review the data we provide within the report. Of course, you are welcome to consult other resources for further background if you so choose.

Please discuss and answer the questions for these topics:

A. Strategies to Meet the Needs of Persons Experiencing Mental Health Crises: Treatment Options and Alternatives to Locked (Involuntary) Facilities

B. Integrated Care: Treating Individuals with both MH and SU Disorders

Please submit your completed Data Notebook report to the CMHPC at:

DataNotebook@CMHPC.ca.gov

For more information, please call (916) 449-5249, or email the address above.

Thank you for participating in our project.

Strategies to Meet Needs of Persons Experiencing a Mental Health Crisis

Treatment Options and Alternatives to Locked (Involuntary) Facilities

While every effort is made to notify Californians of the availability of services and to encourage individuals to seek services early, sometimes a crisis occurs and immediate intervention is needed. In a worst case scenario, law enforcement is called to respond but in a better case scenario, a multi-disciplinary team that includes a mental health professional and a peer will meet with the individual in crisis. The toll and costs of hospitalizations and incarceration of individuals experiencing a mental health crisis are high on both the individual and public system. Many counties have implemented diversionary programs to help persons in crisis manage the situation, de-escalate their symptoms and recover without having to enter an institution.

We are seeking to identify the resources and options that are available to promote the least restrictive environment that will help individuals experiencing a MH crisis to stabilize and move toward recovery. Our goal is to highlight effective programs that meet this essential need on the continuum of services. Effective programs are an excellent way to reduce stigma, and to reduce costs allowing those savings to be used in other areas of the service system. By sharing information about programs with a substantial track record, we wish to promote programs of quality, excellence and safety.

Continuum of Care for SMI in your Community

County of San Bernardino, Department of Behavioral Health (DBH) would like to thank the California Mental Health Planning Council, as well as the California Association of Local Mental Health Boards/Commissions for the opportunity to present data to both the councils and our local stakeholders in this report.

DBH would also like to provide positive feedback on the strategies used in this year's report of focusing on specific program areas, i.e., emergency/crisis services and Integrated Substance Use Disorder Treatment. While both service areas are very dynamic and critical to our county Mental Health Plan system of care, they are two robust programs topically.

Each area as a single focus/topic could be extensively discussed and presented on. If the approach of addressing specific program topics is to be used again next year we would ask the planning council and affiliated stakeholder groups who are planning the report structure, consider focusing on one program subject area at a time.

In completing this year's report, based on structure and number of questions, we found that we dialogued extensively on crisis/emergency services and had to intentionally devote the same amount of effort to Substance Use Disorder Treatment, which is an equally important topic for discussion.

We believe this is due in part to how the report questions were structured, as well as the significant breadth and depth of both of the program topics themselves.

Thank you for your consideration of our input and feedback on the structure of the data notebook, and the strategies used to structure it. We are happy to provide any additional clarification you would like on this topic, and/or participate as a stakeholder in any future planning meetings for the Data Notebook 2016.

DBH would also like to note that the crisis/emergency system of care, although already robust in San Bernardino County, is undergoing additional program planning during the period of this report. There are several grant related efforts as well as the implementation of a Mental Health Service Act (MHSA) Innovation Project that are in various stages of operations. As this report is reviewed, it is important to note that several programs as discussed are new and in the planning stages, while others are newly implemented within the last year, and others have been operating for several years and are longstanding programs.

A major goal of DBH over the next several years in building out the continuum of care for crisis/emergency services is to continue to work to coordinate/integrate crisis programs in various stages of development not only with each other, but with community partners like Law Enforcement, Fire Services, Judicial and Legal Partners, Medi-Cal Managed Care, General Health Practitioners, Hospitals, Commercial Insurance Providers, and other cross sector partners such as Education, Housing and Development, and Workforce Development.

Therefore, strategies to meet the needs of persons experiencing mental health crisis and individuals needing integrated care go far beyond the influence/capacity of the Department of Behavioral Health alone. These are community and policy level issues that require collective partnership and cross sector dialogue of multiple private and public partners. Additionally, efforts will require the integration of not only mental health practices, but effective partnership among other major public/private community workflows, policies, procedures and alignment of large, disintegrated, separate systems into an interconnected, regional, global health related strategy.

The leadership of multiple sectors in San Bernardino County is aware of the scope of this work, and the Behavioral Health Commission, in the completion of this report, would like to acknowledge the importance of community level strategic planning and express its commitment and ownership as a critical partner in these efforts.

1. Do you have these types of facilities <u>in</u> your county? Please check all that apply. Please mark 'Other' (and describe) if your county contracts for beds <u>outside</u> of your county.

San Bernardino County Response:

☒ IMDs (Institutions for Mental Diseases, used often for placement of MH clients who are under conservatorship and others)

☐ PHFs (Psychiatric Health Facilities)

☐ SNF with PTP (Skilled Nursing Facility with Psychiatric Treatment Program)

☒ State Hospital beds

☒ Psychiatric hospital beds

☐ None of the above

☒ Other, please describe:

Psychiatric Health Facilities (PHFs), Psychiatric Hospital beds, State Hospital, Fee-for-Service (FFS) Hospital beds and Adult Residential Facilities.

For each of the categories marked above, the Department contracts for beds both inside and outside of San Bernardino County.

2. If you do not have any of the above facilities in your county and you have a need that goes beyond crisis intervention, how do you handle a need for a longer term hospitalization (14-90 days)?

☐ Transport to out-of-county psychiatric care facility

☐ Crisis intervention services

☐ Licensed adult residential facility (board and care home) that receive extra funding from the county (or placing agency) for additional MH-related services

☐ Other, please describe_____

3. What alternatives to a locked facility do you have for those experiencing an immediate MH crisis? Please check all that apply.

San Bernardino County Response:

- ☒ Crisis Stabilization Service (23 hours)
- ☒ Crisis Residential
- ☒ Mobile Crisis Intervention Teams
- ☐ Transport to another county for treatment
- ☐ Transport to another state for treatment
- ☐ Assisted Outpatient Treatment (AOT) teams (Laura's Law type programs)
- ☒ Licensed adult residential facility (board and care home) that receives extra funding from the county (or placing agency) for additional MH-related services
- ☒ Other, please list or describe:

a. The Recovery Based Engagement Support Team (RBEST):

The RBEST project is an Assisted Outpatient Treatment alternative that began 10/01/2014, and is funded by Mental Health Services Act as an Innovation Project. MHSA Innovation Projects allow Mental Health Plans (MHP), such as DBH, to test, evaluate or determine new, creative or novel approaches to behavioral health care. The RBEST project provides community (field-based) services throughout San Bernardino County for those individuals living with behavioral health issues who are not engaged in medically necessary psychiatric care in an effort to voluntarily "activate" the individual into the behavioral health system to receive appropriate services.

The multi-disciplinary nature of the engagement teams presents a holistic approach to the needs of consumers and their families. In an attempt to mirror Laura's Law, RBEST works on an inclusionary basis, eliminating program qualifiers that may act as a barrier to individuals participating in necessary care. It should be noted that consumers that participate in RBEST still meet medical necessity criteria for Specialty Mental Health Services (SMHS), but that the structure of the program is non-traditional in its approach. The RBEST program response is fluid and changes it's parameters in real time to best serve the consumer where ever they are. It does not require consumers to come anywhere, go through any structured clinic or program based steps, is provided in the field, has a heavy focus on transportation and assisting individuals navigating the public systems that are meant to assist them with basic needs. The program also heavily

focuses on consumer support systems, specifically families and care givers of individuals living with mental illness, and is similarly flexible. Services are provided in the field, in homes, in homeless shelters, and issues being addressed are specific to that family, their loved ones needs, and building capacity within the supportive structure to understand, navigate, and successfully access the systems in place meant to support both family members, and their loved one. From October 2014 through May 2015, ***300*** *individuals were served in RBEST, with an expectation that approximately* ***300*** *individuals will be served per year.*

b. Comprehensive Children and Family Support Services (CCFSS):

The CCFSS program is comprised of a continuum of services targeting three primary populations for Full Service Partnerships (FSP) to provide wraparound services to diverse children and youth with emotional disturbances and co-occurring disorders. The populations served include children and youth involved with the child welfare system, the juvenile justice system, and those at-risk of out of home placement due to the severity of their behavioral health condition. These services have proven to be an effective means by which children and youth receive assistance and avoid out-of-home placements or loss of current placements.

Wraparound is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes. Services are "wrapped around" the child and family in their natural environments. Wraparound is community-based (using a balance of formal and informal supports), culturally relevant, flexible, and coordinated across agencies; it is outcome driven, and provides unconditional care (SAMHSA, 2008). In Fiscal Year (FY) 2013/14, ***1,205*** *individuals were served by the CCFSS program.*

4. Does your county have a MH court, jail diversion program, or similar mechanism to help individuals whose MH crisis or illness contributed to their involvement with the criminal justice system? Please check all that apply.

San Bernardino County Response:

- ☒ MH court
- ☒ Drug Court (some counties have combined into "problem-solving courts")
- ☒ Jail diversion program (a court-ordered MH program where client avoids jail)
- ☒ Re-entry programs with MH/BH services to assist persons released into the community after leaving a correctional facility (e.g. programs funded by AB 109, Proposition 47, or related services)
- ☒ Other, please describe:

As described in the introduction of this report, a major goal of DBH over the next several years in building out the continuum of care for crisis/emergency services is to continue to coordinate/integrate crisis programs in various stages of development not only with each other but with community partners like Law Enforcement, Fire Services, Judicial and Legal Partners, Medi-Cal Managed Care, General Health Practitioners, Hospitals, Commercial Insurance Providers, and other cross sector partners such as Education, Housing and Development, and Workforce Development.

Therefore, strategies to meet the needs of persons experiencing mental health crisis and individuals needing integrated care go far beyond the influence/capacity of the department of behavioral health alone. These are community and policy level issues that require the partnership and cross sector dialogue of multiple private and public partners, and the integration of not only mental health practices, but effective partnership among other major public/private community workflows, policies, procedures and alignment of large, disintegrated, separate systems into an interconnected, global health related strategy.

However, leadership in multiple sectors in San Bernardino County are aware of the scope of this work, and the Behavioral Health Commission, in the completion of this report, would like to acknowledge the importance of community level strategic planning and express its commitment and ownership as a partner in these efforts.

a. Triage Engagement and Support Teams (TEST):

*The Triage Engagement and Support Teams (TEST) is a state wide grant opportunity for The Department of Behavioral Health's staff to work in collaboration with other agencies to meet the needs of individuals living with behavioral health issues in the field. The TEST program is a community-based program comprised of Department of Behavioral Health professionals and paraprofessionals located in partnered sites across the county that began in 2014. The program is in the early stages of implementation and the goal is to co-locate TEST staff in two detention facilities, seven (**7**) Sheriff stations county-wide, Public Defender's office and California State University Campus Police Department. Consumers in need of services that present at any of the co-location sites will meet with a TEST staff to determine what the needs are and provide linkage to resources. TEST offers crisis intervention and intensive case management to connect consumers with many resources such as mental health services, substance use services, homeless and employment services with the purpose to reduce hospitalization and incarceration. The goals of the program include offering early intervention, strengthening the opportunity for recovery and wellness, expanding the crisis continuum of care, providing a warm hand-off to resources and services, providing timely and effective engagement, and reducing hospital and jail recidivism. From March 2015 through July 2015, **119** Individuals received services from the TEST program, with an expectation that **2,000** individuals will be served annually.*

b. Homeless Outreach Support Teams (HOST):

The Department of Behavioral Health's (DBH) Homeless Outreach Support Team (HOST) and Housing and Employment Programs, in collaboration with the Housing Authority of the County of San Bernardino (HACSB), receive funding from the Department of Housing and Urban Development (HUD) to assist homeless individuals with mental illness and their families into permanent supportive housing under the Homeless Assistance Shelter Plus Care grant. HACSB is the primary recipient of the HUD funding and provides the housing vouchers. DBH staff provides service match in the form of wrap-around case management services.

HOST is an outreach based program providing services in the field to engage those chronically homeless individuals living with behavioral health issues into permanent supportive housing. HOST collaborates with the Sheriff's Homeless Outreach Proactive Enforcement (HOPE) team to conduct outreach events, go out into the field, and engage the most difficult and hard to reach clients. HOST staff works with qualified individuals to complete the necessary applications and assessments in the field and, upon receipt of housing voucher, will assist the individual to locate and move into housing. HOST continues to offer recovery-based services, such as intensive case management, advocacy and empowerment for self-sufficiency as well as linkage and

*referrals, in an effort to assist the individual to recover, gain wellness, and reintegrate into the community with the ultimate goal of independence and self-sufficiency. Currently, HOST assists approximately **200** individuals to maintain permanent supportive housing, and works with multiple cross sector partners to support consumers in these efforts. In FY 2013/14, **175** individuals were served by the HOST program.*

c. Integrated New Family Opportunities (INFO):

INFO is a National Association of Counties Achievement (NACo) award-winning program using intensive Probation supervision and evidence-based Functional Family Therapy (FFT). The goal is to provide and/or obtain services for children/youth and their families that are unserved or underserved. The program is inclusive of culturally and linguistically diverse juvenile justice populations, ages 13-17, and their families.

*Youth in the San Bernardino County Central Juvenile Detention and Assessment Center (JDAC) receive mental health and Substance Use Disorder services through a joint effort between San Bernardino County Probation and the Department of Behavioral Health (DBH). The services provided through this program increase stabilization, help families identify community supports, encourage recovery, wellness, and resiliency to reduce psychiatric hospitalizations, out of home placements, and assist children/youth in remaining with their families. Due to the intensive nature of the services and wrap around multi-systems approach, the case load is meant to be focused and inclusive of youth and their supports. In FY 2013/14, **46** juveniles received services from the INFO program.*

d. Choosing Healthy Options to Instill Change and Empowerment (CHOICE):

*The CHOICE Program offers intensive case management and behavioral health treatment services to consumers who are on formal supervision with the San Bernardino County Probation Department, as established by the Assembly Bill (AB) 109 statute. This program offers three outpatient mental health clinics and one outpatient Substance Use Disorder clinic, which are co-located at the Probation Day Reporting Centers (DRC) in Rancho Cucamonga, Victorville, and San Bernardino. Additionally, an intensive outpatient mental health treatment clinic is located in Colton where medication support services are also accessible. In FY 2013/14, **1,786** probationers were referred to the CHOICE program at the DRC's, with **1,265** voluntarily engaging in the screening and referral process to acquire treatment services and community resources to behavioral health services.*

5. <u>Creative Solutions.</u> Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?

San Bernardino County Response:

☒ Yes ☐ No

If yes, please list and describe:

a. California Health Facilities Financing Authority (CHFFA) Grants:

San Bernardino County has been awarded two (2) Investment in Mental Health Wellness Act of 2013 (SB 82) grants for the development of Crisis Residential Treatment programs. One will be located in San Bernardino, and the other in Victorville.

A second Grant opportunity from CHFFA allows the department to purchase and/or develop property (i.e., a building) including covering limited costs related to start-up, expansion, construction or renovation, as well as costs of project planning or project management, appraisals, inspections, and pre-construction.

Between the two grant awards, San Bernardino County DBH will implement programs that enhance our current continuum of emergency psychiatric services such as additional behavioral health urgent care centers like DBH's current Crisis Walk-In Centers (CWICs), Crisis Stabilization Units (CSU's), and crisis residential programs (CRP's). Currently, DBH operates a Crisis Residential Program for Transitional Aged Youth (TAY) 16-25, however the new CRP's will be focused on Adults aged 18 and older.

Mental Health Urgent Care, such as DBH CWICs and CSU's are intended to help consumers suffering with a psychiatric emergency that do not need to be hospitalized. Services are brief and intensive, are aimed at addressing the behavioral health emergency and stabilizing the individual within 24-hours. If an individual does need to be hospitalized, the CWIC's and CSU's work like a primary care urgent care, partnering with local hospitals for appropriate care. However, in the event an individual does not need to be hospitalized, the CWIC and CSU treat the individual and assist with connecting them with regular, non-emergency outpatient mental health providers, or assist them in finding a provider if they do not have one for ongoing outpatient care. These types of services are short term emergency services that are not intended to treat individuals' long term, similar to emergency rooms and traditional urgent cares.

In some cases, those who access emergency psychiatric services need longer term stabilization than an outpatient or intensive outpatient program can provide.

For individuals requiring longer-term stabilization, CRPs are a lower-cost, community-based treatment option in home-like settings, available 24-hours a day seven days-per-week, that provide treatment services aimed at rehabilitative and psychiatric stabilization and allow consumers to stay up to 30-days to be stabilized.

The key difference between a CRP program and other programs, is the intensive treatment provided in a residential environment in which the consumer lives, versus a housing environment that has added case management services, with the individual accessing a lower level, but still intensive, treatment service that are not provided in the residence.

Both of these programs as described in this section are new, and will address psychiatric emergencies.

*It is estimated that **4,600** individuals will be served in behavioral health urgent cares provided annually per Crisis Stabilization Units (CSU's) and **275** new, individual admissions of crisis residential treatment annually per Crisis Residential Program (CRP).*

b. Psychiatric Triage Diversion:

This program is located within the Psychiatric Emergency Room of the county hospital, Arrowhead Regional Medical Center (ARMC). It is important to note that a psychiatric hospital emergency room has several points at which consumers are evaluated and assessed for admission. Some consumers are brought to the hospital on an involuntary hold (5150) and others are not. If an individual is brought the hospital on a hold, there is a specific process that must be used to evaluate if the consumer will be admitted to the hospital, or treated and released.

While the Diversion program is co-located within ARMC and works very closely with their programs, it is not to be confused with the ARMC triage unit, which is the main admissions unit to the acute psychiatric inpatient unit. Both individuals who are brought on a 5150 and an individual who has come voluntarily can be admitted to the hospital through the ARMC triage unit if needed.

However, just as is the case in general emergency rooms, in many cases individuals brought to the hospital can be treated at other levels or types of psychiatric care. The DBH Psychiatric Triage Diversion program is designed to screen individuals who do not need to be hospitalized to determine if their behavioral health needs can be met in behavioral health settings outside of an acute psychiatric inpatient treatment unit.

The Diversion Staff assess individuals to determine how to best meet their needs outside of the hospital environment. Services provided include crisis assessment, crisis intervention, case management, collateral contacts, transportation assistance, housing assistance, linkage with outpatient resources and providers, referrals to medical and social service agencies, family and caretaker education, and consumer advocacy.

Both ARMC inpatient and the DBH Diversion program work with the newly implemented Access Coordination and Service Enhancement (ACE) program to secure follow-up appointments within 7-days to outpatient services, post hospitalization.

*FY 2013/14, **4,014 i**ndividuals received services from the Psychiatric Triage Diversion program, with a diversion rate of **70**% of total consumers served.*

c. Transitional Age Youth Behavioral Health Hostel (STAY):

The STAY is a crisis residential treatment program (CRP) that focuses on youth between the ages of 18-25 and allows consumers to stay up to 30-days for stabilization. The STAY is a MHSA Innovation Project, which allows Mental Health Plans (MHP) such DBH to test, evaluate or determine new, creative or novel approaches to behavioral health care. The STAY serves those that are experiencing an acute psychiatric emergency or crisis and are in need of a higher level of care than intensive outpatient but a lower level of care than psychiatric hospitalization, and are not yet ready to transition to traditional FSP or outpatient programs.

*STAY services provided are **80**% peer run and are designed to be culturally and linguistically appropriate with an emphasis on diverse former system-involved youth.*

*STAY Services include therapeutic and psycho-educational groups and rehabilitative activities that include daily living skills-training, individual and group counseling, crisis intervention, medication support, Substance Use Disorder treatment, recreational therapy, educational assistance, and pre-release and discharge preparation and planning. Services are comprehensive and are designed to improve consumers functioning through their acquisition of skills essential for successful independent or semi-independent living in the community with FSP or other outpatient behavioral services. In FY 2013/14, **88** TAY received services from the STAY project.*

d. Community Crisis Response Teams (CCRT):

The CCRTs provide urgent behavioral health services to residents of San Bernardino County in the field. The team responds to homes, community locations, hospitals, law enforcement and individuals at various locations in the community. CCRT utilizes specially trained mobile crisis response teams to provide crisis interventions, assessments, linkage to resources and medication referrals. Additional services include

linkage to resources through collaboration with law enforcement, hospitals, the San Bernardino County Departments of Children and Family Services, Adult Protective Services, schools and other community organizations. In FY 2013/14, ***4,518*** *individuals received services from the CCRT program.*

e. Crisis Walk-In Center (CWIC):

The CWICs provide urgent behavioral health services to San Bernardino County residents located in the Morongo Basin, High Desert and the Central Valley regions of the county. These clinics work similarly to primary care urgent cares, and conduct urgent psychiatric assessments and crisis stabilization for those clients who are in acute psychiatric distress, and are experiencing a behavioral health emergency. Services are culturally and linguistically competent and are provided by a multi-disciplinary team that focuses on stabilizing those in crisis and providing linkage to resources within the community for psychiatric follow-up. In collaboration with the Community Crisis Response Teams, the CWICs work to reduce psychiatric hospitalizations. Additional services include crisis intervention, crisis risk assessments, medications, education, and when necessary, evaluations for hospitalization. In FY 2013/14, ***8,149*** *individuals received services from the CWIC program.*

f. Managed Care

The provision of inpatient care and emergency behavioral health services is also provided through working with local partners such as hospitals, and the local managed care plans, Inland Empire Health Plan (IEHP) and Molina. In the County of San Bernardino, the Medi-Cal insurance benefit is provided under a geographic two-plan model, with the Department of Behavioral Health (DBH) providing coverage for the Medi-Cal Tier III benefit (severe), for individuals suffering from Severe and Persistent Mental Illness. DBH provides a benefit package, which is enhanced by Mental Health Services Act funding, of Specialty Mental Health Services (SMHS), which includes inpatient psychiatric acute care, crisis stabilization, intervention, as well as crisis residential treatment. For beneficiaries who have Medi-Cal, coordination with their health plans and their primary care providers/medical homes is critical to their overall health, with inpatient and crisis services being a significant clinical event in a person's life.

Over the past two years DBH has worked in partnership through our MOUs with IEHP and Molina to develop protocols and procedures around coordination and transitional care when a person has experienced a psychiatric emergency. While program efforts are still under development, to date significant progress has been made in complex care coordination efforts for those individuals suffering with both chronic medical and psychiatric needs. The program planning in this area will continue to be heavily focused

on care coordination as the transformation required for healthcare reform continues to be carried out, and true care coordination across multiple levels of services, providers, programs, and systems begins to occur.

g. Arrowhead Regional Medical Center (ARMC) Collaboration

*The Department of Behavioral Health (DBH) has a longstanding collaborative relationship with the county hospital, Arrowhead Regional Medical Center (ARMC), which provides the majority of inpatient psychiatric care in this county for consumers with Medi-Cal, Medicare and no insurance, with **5,215** admissions in FY 2013/14.*

In an effort to continue to enhance coordination of acute psychiatric inpatient care, an Executive Operation Collaborative/Workgroup was established to readily identify operational and systemic issues and explore performance improvement opportunities in ARMC's acute inpatient Behavioral Health Unit. The Collaborative has been instrumental in addressing the behavioral health needs of individuals served as well as identifying the capacity challenges that have implications on the delivery of inpatient services. A formal Discharge Planning Committee was developed to facilitate linkages and referrals to outpatient care in an effort to ensure timely, appropriate and successful discharges of consumers from ARMC inpatient psychiatric services. Additionally, an Early Warning System was instituted to trigger an immediate triage for individuals that arrive at ARMC who do not warrant inpatient hospitalization to provide a seamless transition to the appropriate level of non-hospital care.

To address county-wide issues beyond ARMC, the Hospital Association of Southern California recently developed a regional collaboration/workgroup which is composed of key leaders and stakeholders from both Riverside and San Bernardino Counties. The purpose of the workgroup is to address involuntary hold issues that result in inpatient hospitalization, as well as the wait time individuals experience in the Emergency Departments throughout the local hospitals. This particular collaboration has been charged with identifying creative solutions to very complex issues that has substantive impact on emergency care, the provision of behavioral health services delivered while in inpatient care, as well as the overall system of care.

6. <u>Prevention</u>. Does your county have any programs implemented specifically as alternatives to locked facilities that haven't been addressed above? This is an open question that could include MHSA-funded prevention programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). This question could also be addressed by other strategies that engage public (county) and private partnerships, regardless of funding sources.

San Bernardino County Response:

*The San Bernardino County Department of Behavioral has thirteen (**13**) Prevention and Early Intervention (PEI) program services that are intended to implement strategies to prevent mental illness from becoming severe and disabling, emphasizing improvement in timely access to services for underserved populations. Strategies and activities are implemented early on to deter the onset of mental health conditions or relapse among individuals and to change community conditions that contribute to risk factors for developing behavioral or mental health issues. An early intervention program is defined as a program providing "treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness."*

All PEI programs are categorized under three initiatives or "access points".

a. School Based Initiative:

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

An example of a School-Based Initiative is the Student Assistance Program (SAP). SAP is a school-based approach that focuses on services for diverse students (grades K-12) and their families who are in need of prevention education and early interventions for substance use, mental health, emotional and social issues. This program connects behavioral health, educators, programs and services to create a network of supports between schools and community based organizations, supporting students and their families.

The SAP program aims to minimize barriers to learning, supports students in developing academic and personal successes, and shortens the duration of untreated behavioral health concerns. At the core of the program is a professionally trained team that includes school staff and staff from community behavioral health agencies. SAP team

members are trained to identify problems and make recommendations to assist both the student and parents, provide services to improve student wellbeing, and provide follow-up services. When the problem lies beyond the scope of the program, the SAP team will refer the student and parents to resources and services within the community. In FY 2013/14, ***38,672*** *students were served by SAP.*

b. Community Based Initiative:

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

One example of Community Based initiative is the Family Resource Centers (FRC). FRCs offer various culturally and linguistically competent services tailored to meet the identified needs of the communities they serve. This program serves all ages and includes the following: personal development activities; parent/caregiver support and education; behavioral health education workshops; after school programs for children/youth/transitional age youth; health education workshops; adult skill-based education (e.g. education and employment assistance); counseling and therapy for all ages. Services are delivered in the local FRCs and are also deployed into the communities they serve, increasing the likelihood that community members will use the services while reducing stigmatizing attitudes associated with behavioral health services.

In FY 2013/14, ***31,425*** *individuals were served by the FRCs.*

c. System Enhancement Initiative:

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

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

The OACS program works to reduce the stigma associated with mental illness and behavioral health problems in the older adult community by providing services in natural, community based settings. This program increases knowledge about mental health and access to free and confidential mental health services which allows older adults to seek services, if needed.

*In FY 2013/14, **5,453** individuals were served by the OACS program.*

d. Access Coordination and Enhancement (ACE):

ACE seeks to improve the timeliness of access to Department of Behavioral Health (DBH) outpatient services for those recently discharged from an acute inpatient psychiatric hospital, and began in 2014. The ACE program specifically seeks solutions to improve the linkage from psychiatric hospital to an outpatient clinic within 7-days of discharge from an acute psychiatric hospital. A centralized case management and referral workflow is being implemented to achieve this goal, and the ACE team will work with the Recovery Based Engagement Support Teams (RBEST) program to help improve the number of consumers attending their outpatient behavioral health appointments. Services provided include mental health assessments, psychiatric evaluations, Substance Use Disorder screenings, referrals and linkage and access to appropriate ongoing outpatient services. For the first two quarters of FY 2014/15 the number of assessments to outpatient care that have been completed per month are below:

- *1st Quarter FY 2014/15 average of **409** intake assessments per month.*
- *2nd Quarter FY 2014/15 average of **520** intake assessments per month*

e. Long Term Adult Residential Treatment Programs:

DBH is in the process of establishing two long term adult residential treatment programs in the county of San Bernardino. Long term adult residential treatment programs are rehabilitative services provided in a home-like residential setting for consumers who are at risk for hospitalization if they were not in the adult residential treatment program.

*Services are provided by behavioral health professionals in the residence and consumers can stay up to 18-months to be stabilized. Services include a range of activities that support the consumer in their efforts to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Services are available in the residence 24-hours-a- day, 7-days-a-week and include assessment, therapy, rehabilitation and collateral. Access to these services is coordinated by the Department of Behavioral Health and will serve up to **30** adults per year.*

Once an individual is stabilized in a long term adult residential treatment environment, they can transition with the assistance of DBH to permanent supportive housing such as described in the HOST program, with Full Service Partnership (FSP) and case management services provided on an outpatient basis and not in the residence.

7. <u>Unmet needs</u>. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

San Bernardino County Response:

The County of San Bernardino Department of Behavioral Health has identified a variety of unmet needs and pursued several specific strategies to meet these needs. The STAY, a crisis residential treatment facility for transition-aged youth, was created to meet a treatment gap for this age group. Due in part to the success of this program, DBH has been awarded two grants under SB82, the Investment in Mental Wellness Act of 2013, to address unmet crisis needs. With these grants, DBH is developing two new crisis residential treatment facilities for adults. Some of the goals of these projects include reducing the impact of psychiatric conditions on hospital emergency departments as well as reducing unnecessarily lengthy psychiatric hospital stays. The crisis residential facilities will help provide a new level of care between inpatient hospitalization and outpatient care that did not previously exist, therefore providing an additional option for more appropriate care. Another grant application is being developed, proposing a crisis stabilization unit for both adults and adolescents, further helping to close the gap of crisis services.

DBH and the Sheriff's Department have been collaborating since 2008, providing Crisis Intervention Training (CIT) to Sheriff's Deputies to support their skill sets in effectively navigating psychiatric crises. DBH's Community Crisis Response Team (CCRT) is often called upon by law enforcement to assist in such situations, as well. Further, under a different component of SB82, DBH was awarded an additional grant to develop a new mobile triage service, called TEST, which is described in prior sections of this report. Some of the personnel are co-located with law enforcement to provide immediate support for psychiatric crises, but also provide longer-term follow-up and care coordination to help community members effectively and appropriately engage in behavioral health care.

*Another recognized unmet need is individuals who have not yet been activated into the best level/type of behavioral health services for them. DBH has recently begun a new program, RBEST, to test new ways of activating consumers and their families into treatment. This mobile team has already engaged **300** individuals, helping link them into appropriate levels of care, understanding the true nature of barriers to treatment, and*

reducing need for emergency services. One significant lesson from the project in the first year is the high rate of need for concurrent Substance Use Disorder services in this population. San Bernardino County operates and manages a continuum of SUD services; however, the SUD benefit has been significantly underfunded for decades, both by Medi-Cal and other funding sources. DBH is engaging in the Drug Medi-Cal Waiver which will allow the department to focus expanding the level of care for Substance Use Disorders. DBH is also engaged in the development of co-occurring disorders specific programming.

While DBH provides a wide array of needed and effective services, we recognize there are still significant unmet needs in our communities. One of the significant challenges for our County is related to its size and geographical diversity. Much of the County is a managed care geographically excluded area, which means insurance companies and managed care plans have different requirements for building networks of providers in some zip codes, versus others. The result is that County programs have built provider panels in these geographic areas for SMHS, which are also recognized as health professional shortage areas, creating an available network of behavioral health providers, with general health care provider networks being much more impacted, or in some cases not present at all.

Over the next several years, DBH will be working extensively with the managed care plans in our region, IEHP, IEHP-Kaiser and Molina on implementation of multiple strategies impacting health care coordination and access to care.

Members of the Behavioral Health Commission and DBH staff are involved with the County's Community Vital Signs project, which is exploring ways of coordinating countywide strategy and approaches to improving overall health and w ellness in the County. This project has taken a strengths-based approach, exploring what various sectors in our County have done well, but also acknowledging where there are areas of improvement. A consistent topic of focus is in the need to coordinate efforts and strategies, as a community, across sectors. Programs like those mentioned above, including CIT, CCRT, and TEST, are examples of such partnership in action. Continued work that improves close collaboration and partnership between County departments as well as other organizations across the County will further help close gaps in unmet needs.

8. If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

San Bernardino County Response:

While San Bernardino County has identified many top priorities, the following three are submitted for the purposes of this report.

1. *Support the elimination of the IMD and managed care geographic exclusions.*
2. *Comprehensive, recovery-oriented approach to justice involved individuals suffering with behavioral health issues.*
3. *Increased capacity for enhanced services such as:*

    a. *Crisis stabilization and crisis residential beds/facilities.*
    b. *Integrated Health strategies to address physical health, mental health, Substance Use Disorder, and complex care coordination without limits to number of day visits.*
    c. *Family education and support programs.*

Integrated Care: Treating Individuals with both MH and SU Disorders[9]

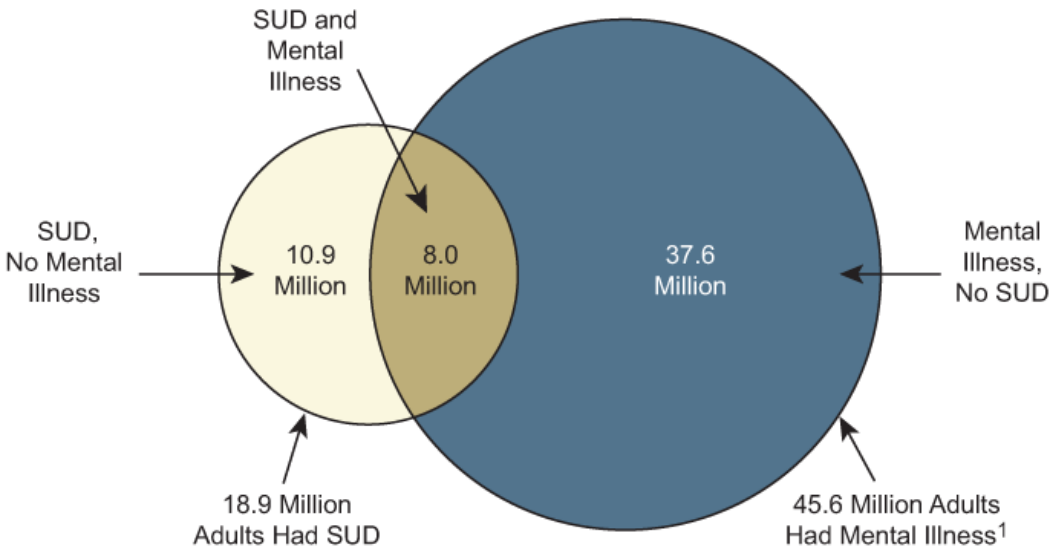
Understanding the Scope of the Problem using National Statistics

We show examples of national data from the NSDUH[10] survey to give perspective on the data for our local communities and state. Many experts believe these data are an under-estimate of the true scope of the problem. All figures in this introduction are from this NSDUH survey report. We ask: how many people are affected by these disorders?

The report describes adults who had any mental illness, or a Substance Use Disorder, or both problems in 2011, the most recent year for which there is national data.

- A total of 45.6 million adults had a mental illness. Of that group, 8 million (17.6 percent of total) also had a Substance Use Disorder.
- Among the 18.9 million adults with Substance Use Disorder, 8.0 million (42.3 percent) also had a mental illness.

Past Year Substance Dependence or Abuse and Mental Illness among Adults Aged 18 or Older: 2011



The problem is even more serious as we consider the risks for those with severe mental illness (SMI), a subset of those with "any" MH disorder shown above.

[9] SU = substance use. SUD= Substance Use Disorders, referring to problems with abusing drugs, alcohol, or both. Drugs refer to both illegal substances and prescription drugs used for purposes other than those legally prescribed or intended. See www.drugabuse.gov for more information.

[10] **NSDUH**: The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. population. See more information at: http://archive.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.htm

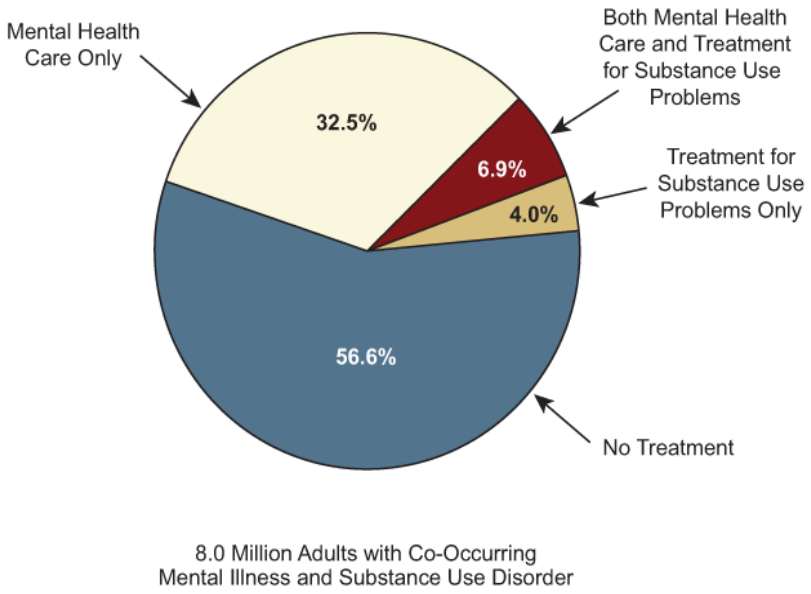
Who received treatment, and what kind? In the co-occurring disorder population, we would expect better recovery outcomes for those who receive treatment for both disorders. However, such integrated treatment may be difficult to access.

For the 8.0 million adults with co-occurring disorders, how many received treatment in the last year for MH disorders, SUD, both, or neither? Data from the NSDUH show that:

- 43.4 percent received some kind of treatment for either SUD or mental illness during the past year, however:
  - 32.5 percent received MH care only,
  - 4.0 percent received SUD treatment only, and
  - Just 6.9 percent received treatment for both disorders.

- But more than half -- 56.6 percent received no treatment at all for either disorder.

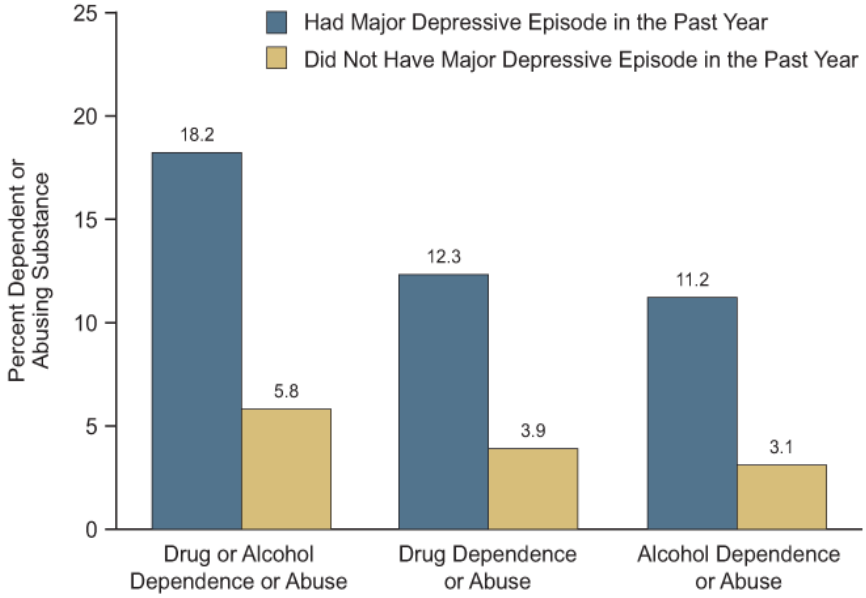
Figure 4.12 Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older with Both Mental Illness and a Substance Use Disorder: 2011



Note: Mental health care is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Treatment for substance use problems refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Children and youth under 18 are also affected. Those who had a major depressive episode were three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who did not have depression. Such episodes may be an early indicator of risk for more severe emotional disorders.

Figure 4.15 Past Year Substance Dependence or Abuse among Youths Aged 12 to 17, by Major Depressive Episode in the Past Year: 2011



The NSDUH report also found that youth with a major depressive episode had an increased risk for use of any type of illicit drug. A related but very serious concern is the increased risk for abuse of prescription drugs (when taken for non-prescribed uses).

Data: Understanding who Receives SUD Treatment in your County

The next two pages will show some county-level information supplied by the data specialists of CalOMS-Tx in the Office of Applied Research and Analysis at DHCS. Before release to us, these data were reviewed by the DHCS offices charged with protecting patient privacy and HIPAA compliance. These data are from Fiscal Year 2013/14.

Some data cells may not have any numbers, but instead are marked by an asterisk, "*****" which means that the numbers have been redacted (hidden) to protect patient privacy because the total number is too small. Counties with small populations may see many such asterisks, with the result that only limited data can be seen for those counties.

Access: Who Receives Services? The first part will present data for the demographics of those admitted for SUD treatment and the type of services. Demographics include age, gender, major race/ethnicity groups, and county. Service types in this dataset are outpatient, detox, or residential.

What are the Client Outcomes? The second part contains data regarding client outcomes. Discharge outcomes after thirty days include:

- return to substance use
- arrests
- employment
- housing situation (homeless vs. stable housing of any type)
- Social supports within the last 30 days (includes 12-step programs as well as general social support activities, more than 4 or fewer than 4).

You will see that there is a certain percentage of data assigned as "missing." These are not redacted (hidden) numbers. "Missing data" indicates the numbers of clients for which no further data could be obtained by the treatment program. Some clients are no longer reachable by program staff or are otherwise lost to follow-up.

Finally, please examine the California State Data reference pages at the end of this document. We live in a highly diverse state and so your county data may or may not resemble the statewide data. However, these data are worth review and discussion as you consider advocacy and policies regarding demographic disparities in service access and unmet needs.

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

County: SAN BERNARDINO

Service Type:

Outpatient	DETOX	Residential	Total
4,349	344	1,923	6,616
65.73%	5.2%	29.07%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
290	1,371	2,252	2,703	6,616
4.38%	20.72%	34.04%	40.86%	100%

Gender:

Male	Female	Total
3,870	2,746	6,616
58.49%	41.51%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
72	64	663	2,779	290	2,748	6,616
1.09%	0.97%	10.02%	42.00%	4.38%	41.54%	100%

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge

Discharges in FY 2013-2014

County: SAN BERNARDINO

Substance Use:

None	Use Data Missing	Use Documented	Total
1,533	1,211	795	3,539
43%	34%	22%	100%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
79	1,211	2,249	3,539
2%	34%	64%	100%

Employment:

Employed	Data Missing	None	Total
624	1,211	1,704	3,539
18%	34%	48%	100%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
92	1,211	2,236	3,539
3%	34%	63%	100%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
1,251	1,077	1,211	3,539
35%	30%	34%	100%

The Impact of Substance Abuse on the MH System of Care in your County

9. This next question may help define the nature and scope of the substance use problem in your community. Resources for such information may include the Alcohol and Other Drug Administrator for your county, your county Sheriff's Department, or the Behavioral Health Director.

What substances are the most commonly abused in your county? Please select the top three drug categories below (and indicate estimated percentage if known).

San Bernardino County Response:

- ***19%*** Alcohol
- ☐ Marijuana, hashish or synthetic marijuana-like drugs (e.g. 'spice', 'bath salts')
- ***48%*** Amphetamines, ***methamphetamine***, prescription stimulants (ADHD drugs)
- ☐ Cocaine, 'crack' cocaine
- ***13%*** Opioids (heroin, opium, prescription opioid pain relievers)
- ☐ Club Drugs (MDMA/Ecstasy, Rohypnol/Flunitrazepam, GHB)
- ☐ CNS depressants (prescription tranquilizers and muscle relaxants)
- ☐ Hallucinogens (LSD, Mescaline/peyote/cactus, Psilocybin/mushrooms)
- ☐ Dissociative Drugs (Ketamine, PCP/phencyclidine/angel dust, Salvia plant species, dextromethorphan cough syrup)
- ☐ Inhalants (solvents, glues, gases, nitrites/laughing gas)

10. With respect to SUD treatment in your county, what are the main barriers to access and engagement with treatment?

San Bernardino County Response:

- ☐ Transportation
- ☐ Wait list to enter treatment
- ☐ Language and/or cultural issues
- ☒ Client not ready to commit fully to stopping use of drugs and/or alcohol
- ☐ Failure to complete treatment program
- ☒ Lack of treatment programs or options locally
- ☐ Lack of workforce licensed/certified to treat clients who have co-occurring MH and SUD issues

☒ Stigma and prejudice regarding diagnosis or participation in treatment

☐ Reduced motivation of clients due to changes in court-required drug treatment programs (Proposition 47 reduced penalties for some substance use crimes, thus individuals may choose not to apply for drug court supervision of their case. Drug court is a way to reduce criminal penalties for some crimes in exchange for the client engaging in treatment for substance use).

☒ Other, please describe:

There is a lack of providers who are Drug Medi-Cal (DMC) certified, and low reimbursement rate for DMC services.

Addiction is a chronic disease, just like Diabetes, Cancer and Cardiovascular Disease that has both environmental and genetic influences as well as interactions between the two. As with other complex diseases, environmental risks and protective factors interact with genetics to determine the course and outcome of the disease.

Addiction is not a moral failing and should be treated as the chronic disease that it is, without a focus on "commitment to stopping use of alcohol and drugs." This type of non-recovery focused language further impacts an already stigmatized community. No one chooses to be an addict just like no one chooses to develop heart disease. And while personal responsibility and behavioral changes are important components of treatment services, one cannot forget that addiction is a real and complex chronic disease.

11. What could be done to increase successful outcomes for SUD recovery in your county? Choose the top three priorities.

San Bernardino County Response:

☒ Ongoing case management

☐ Support individuals to make necessary changes in social patterns (new neighborhood; change routes to home, school or work; change circle of friends)

☒ Medication services

☐ Family treatment/education

☐ Health and nutrition classes

☐ Parenting classes

☐ Onsite access or referrals for primary health care screening and treatment

☐ Vocational training and support, including employment readiness classes

☒ Other, please describe*:*

Increased knowledge of the Substance Use Disorder (SUD) system by Medi-Cal Managed Care Plans (MCP) for complex care management/coordination of care for medically fragile and psychiatrically complex individuals.

12. Have any SUD treatment strategies been shown to be especially successful in your county?

San Bernardino County Response:

☒ Yes ☐ None

If yes, please describe: *The Screening Assessment and Referral Center (SARC) model provides a comprehensive assessment of an individual's bio-psycho-social background as it relates to their SUD. The assessment captures a myriad of information necessary to provide a primary diagnosis to establish criteria and medical necessity to support the need of SUD treatment. The SARC then uses the assessment information to determine proper level of treatment based on American Society of Addiction Medicine (ASAM) criteria where the individual is referred to the properly identified level of treatment which will best address that person's needs. Additionally, interim case management services are provided for the individual until they are fully engaged in SUD treatment. All practices utilized in the SARC are evidence-based practices and supported by SAMHSA and DHCS.*

Co-Occurring SUD services are provided to individuals and utilize evidenced-based practices that address the challenges directly impacting clients who live with SUD and non-severe mental illness. This is achieved through the use of practices including motivational enhancement therapy, cognitive behavioral therapy and twelve-step facilitation curriculum which is recognized as an evidence-based practice for individuals who are engaged in co-occurring disorder programs.

13. How does your county support individuals in recovery to increase the rates of success? Please check all that apply in your county.

San Bernardino County Response:

- ☒ Transportation to outpatient treatment and therapy appointments
- ☒ Motivational interviewing
- ☒ Case management/aftercare/follow-up services and referrals
- ☐ Services more like FSP[11] or wrap-around services
- ☒ Family treatment and/or family education
- ☐ Medication services
- ☒ Teaching about activities of daily living
- ☒ Parenting classes
- ☒ Smoking cessation classes or treatment
- ☒ On-site health testing and treatment
- ☒ Linkage to primary care clinic for health tests and treatment
- ☒ Job readiness training, vocational services, GED/college classes
- ☒ Facilitate a change in the person's culture, to build new relationships, routines, patterns not linked to alcohol or drug use.
- ☒ Peer support, mentors or sponsors in the community
- ☒ Classes about nutrition, cooking, exercise, and care of one's own health
- ☒ Other, please describe:

Transportation for Perinatal clients, Recovery Centers (7 including 1 mobile unit for the Mountain region - Sky Forest).

In your opinion, which of the above are the four factors most essential to client success in SUD recovery?

- ✓ *Linkage to primary care clinic for health tests and treatment.*
- ✓ *On-site health testing and treatment.*
- ✓ *Case management/aftercare/follow-up services and referrals.*
- ✓ *Recovery Supports.*

[11] Full Service Partnership mental health services, programs funded by the Mental Health Services Act.

14. <u>Prevention</u>. This last question is about coordinating prevention efforts between different agencies and groups. We believe that prevention and education activities are important to help reduce the number of persons using drugs or abusing alcohol, especially for youth under 18 and young adults.

The evidence shows that prevention efforts are much more effective when coordinated across multiple service systems. Currently, funding for MH efforts have a different source than that for substance abuse prevention[12] and therefore must be devoted to mental health. This results in most programs being separate or "siloed" which risks producing fragmented, patchwork efforts and less than optimal outcomes for consumers.

Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?

San Bernardino County Response:

☒ Yes ☐ No

If yes, please provide a brief description of the program, target audience, and activities.

The department provides programming in MHSA funded programs such as Prevention and Early Intervention (PEI) and Community Services and Supports (CCS) via the Transitional Age Youth (TAY) centers, which include education, and access to 12 step recovery support and groups. However, DBH has implemented separate efforts to allow for more focus on Substance Use Disorder (SUD) prevention, which has very different social dynamics than mental health. There is far more stigma around addiction especially due to the large focus in the law enforcement arena on addiction and its relation to criminal behavior. This is a specialized field. DBH uses prevention targeted interventions derived from public health strategies by Community Based Organizations (CBO's) to assist in further community specific prevention efforts, which have been very successful.

*In the recent past, mental health and SUD were combined but funding specificity, especially with regards to prevention set aside funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Substance Abuse Prevention and Treatment Block Grant (SAPT) Block Grant, as well as the special nuances of both specialties resulted in the ability of DBH to focus **100**% of our prevention efforts on each specialty separately, so that neither mental health, nor SUD was short changed.*

[12] Examples of programs funded from different sources could include MHSA Prevention and Early Intervention programs or the substance Abuse Prevention and Treatment Block Grant. You may know of others in your community.

Addendum: Question #15

Resources for local Advisory Boards to carry out their Mandated Roles

These questions address the operations of county mental health boards, behavioral health boards, or mental health commissions, regardless of current title. These items have been included in partnership with the California Association of Local Mental Health Boards and Commissions.

San Bernardino County Response:

(a) What process was used to complete this Data Notebook? Please check all that apply.

- ☐ MH Board completed majority of the Data Notebook
- ☐ County staff and/or Director completed majority of the Data Notebook
- ☐ Data Notebook placed on Agenda and discussed at Board meeting
- ☒ Other; please describe:

*The Behavioral Health Commission and the San Bernardino County Department of Behavioral Heath work in collaboration with County Staff to complete research, discuss, provide data, and facilitate a comprehensive response to the questions posed in the Data Notebook**.***

(b) Do you have suggestions for future Data Notebook themes or topics?

☒ Yes ☐ No **If Yes, please list:**

Suggestions for future Data Notebook themes or topics include a broad suggestion that one topic area be selected and studied. Such topics include a focus on complex care coordination, or on the transition from inpatient care to outpatient care, or a continued focus on cultural competency and related penetration rates.

(c) Does your Board have a yearly budget to support its activities?

☒ **Yes** ☐ **No** **If Yes, please list:** *$15,000*

(d) Does your Board have designated staff to support your activities?

☒ Yes ☐ No **If yes, please provide their job classification:**

One (1) Behavioral Health Director, ***One (1) Executive Secretary II, One (1) Office Assistant III, and Four (4) Secretary I positions.***

Briefly describe their duties:

- ***One (1) Behavioral Health Director:*** *Provides new member orientation upon appointment by the Board of Supervisors; participates in monthly sessions of Executive Committee and Board meetings or delegates staff to participate in her absence; provides regular updates on Federal, State, County and other policy issues.*
- ***One (1) Executive Secretary II*** *- Ensures Board meetings comply with Brown Act; notifies stakeholders of meetings; works with the Chair and Director to set monthly agendas; transcribes meeting minutes; schedules educational presentations and mandatory trainings.*
- ***One (1) Office Assistant III*** *- Assembles meeting binders; transcribes meeting minutes, arranges travel and reimbursement.*
- ***Four (4) Secretary I – Provides support to District Advisory Committee (DAC) meetings; notifies stakeholders of meetings; transcribes minutes; schedules educa****tional presentations.*

The Behavioral Health Commission would like it noted that under the direction and leadership of the Behavioral Health Director, CaSonya Thomas, DBH staff are extremely responsive to the commission's requests, such as educational presentations, attendance at conferences/trainings, and support at community events. Interaction with the Director and DBH staff includes information sharing, open dialogue and transparency.

In addition to the above, staff have worked hard to partner with Behavioral Health Commissioners to identify and quantify behavioral health outcomes on an ongoing basis so that meaningful analysis and conversations can take place throughout the year.

(e) What is the best method for contacting this staff member or board liaison?

Name and County: ***Debi Pasco, Executive Secretary II, San Bernardino***
Email**:** ***dpasco@dbh.sbcounty.gov***
Phone #: ***(909) 388-0820***

(f) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: ***Debi Pasco, Executive Secretary II***
Email: ***dpasco@dbh.sbcounty.gov***
Phone #: ***(909) 388-0820***

Name and County: ***Susan McGhee Stehsel, Chair***
Email: ***dpasco@dbh.sbcounty.gov***
Phone #: ***(909) 388-0820***

CALIFORNIA State Reference Data for SUD Treatment and Outcomes

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

Totals are for all counties.

Service Type:

Outpatient	DETOX	Residential	Total
89,071	19,904	24,763	133,738
66.60%	14.88%	18.52%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
14,957	23,614	38,042	57,125	133,738
11.18%	17.66%	28.45%	42.71%	100%

Gender:

Male	Female	Total
84,615	49,123	133,738
63.27%	36.73%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
1,612	2,984	16,926	49,352	5,070	57,794	133,738
1.21%	2.23%	12.66%	36.90%	3.79%	43.21%	100%

CALIFORNIA State Data; includes all counties.

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge

For Discharges in FY 2013-2014

Substance Use:

None	Use Data Missing	Use Documented	Total
28,093	29,016	9,553	66,662
42.14%	43.53%	14.33%	100.00%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
1,160	29,016	36,486	66,662
1.74%	43.53%	54.73%	100.00%

Employment:

Employed	Data Missing	None	Total
10,596	29,016	27,050	66,662
15.90%	43.53%	40.58%	100.00%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
3,167	29,016	34,479	66,662
4.75%	43.53%	51.72%	100.00%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
19,306	18,340	29,016	66,662
28.96%	27.51%	43.53%	100.00%

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 449-5249

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413