Mental Health Services Act

Annual Report FY 2016-2017

HOPE. HEALING. LIFE.

KERN **BEHAVIORAL HEALTH** & **RECOVERY** SERVICES

Executive Summary

The Mental Health Services Act
The Mental Health Services Act (MHSA) was passed via Proposition 63 in November 2004 and enacted in 2005. The purpose and intent of the Act was to reduce negative outcomes and prolonged suffering associated with mental illness. By passing of the Act, a one percent tax was imposed on Californians with adjusted annual incomes over $1 million. Funding provided to each County is dedicated to preventing and reducing homelessness, suicide, incarceration, unemployment, school failure or dropout and the removal of children from their homes due to untreated mental illness. Mental Health Services Act programs are created in five components; Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training and Capital Facilities and Technological Needs.

Changes during the FY 14/15-16/17 Three-Year Plan
The three-year plan included two programs since removed from the Kern MHSA roster: Student Assistance Programs and the completed Innovative Freise Hope House project. Both programs completed during FY14/15 with all other programs remaining active. Three Prevention and Early Intervention programs were added to the FY 16/17 Annual Update (mentioned below) and Kern is currently in the process of drafting three potential new Innovative programs.

Newly Added Regulations
In October 2015, regulations pertaining to two components; Prevention and Early Intervention and Innovation were passed. There is ongoing conversation between counties and the Mental Health Services Oversight and Accountability Commission to determine best practices in implementing the regulations locally. Both sets of regulations require extensive demographic reporting; which may require additions and/or modifications to Electronic Health Record upon implementation.

The Prevention and Early Intervention regulations identify programs in additional components, which include:

- Prevention
- Early Intervention
- Access and Linkage to Treatment
- Stigma and Discrimination Reduction
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Suicide Prevention (Optional)

As many counties have expressed, and Kern is no different, many required programs under the Prevention and Early Intervention umbrella have been active in our Community Services and Supports component for several years. Our Access to Care team provides a front door to access screening, assessment and linkage to care services. The Crisis Hotline team serves as a referral source for those seeking services, who may be referred to the Access to Care team; additionally, this program also provides copious outreach efforts to reduce stigma and discrimination related to mental illness. Recently, the Suicide Outreach Team, composed of Crisis Hotline staff, began collaborative efforts with the Kern County Coroner's office to provide support for families who have lost loved ones to suicide.

Three new Prevention and Early Intervention programs have been added to the roster for FY 2016/2017:

- Risk Reduction Education and Engagement Accelerated Alternative Community Behavioral Health (REACH): An Access and Linkage to Treatment field-based program to provide engagement and linkage to treatment for those who may be resistant or reluctant to begin mental health and substance use disorder care.
- Youth Juvenile Justice Engagement: A collaborative effort between the Youth Wraparound Team and the Kern County Probation Department. Youth Wraparound will work with Probation staff identify youth with experience in the juvenile justice system at risk of prolonged suffering due to mental illness, or developing mental illness. Once identified, youth would receive screening, assessment and linkage to mental health care.

- Foster Care Engagement: Created based on suggestion during the Community Planning Process in FY 2015/2016, the Foster Care Engagement program will be a collaborative effort with the Department of Human Services to provide psychoeducation for recognizing signs of mental illness and trauma among youth. Identified youth would be provided annual screening and assessment to ensure necessary mental health care is provided.

Potential Innovative Programs were determined during the FY 2015/2016 Community Planning Process. From eight programs originally proposed, three were chosen to be developed into programs which will be proposed to the MHSOAC for approval:

- Special Needs Registry – Smart 911: Highly favored among stakeholders in the public safety community, this program would be designed for Recovery Specialists to work with clients to create a special needs registry based on individual mental, physical and other health needs. The premise of the program is to provide pertinent information to first responders so that should an emergency arise, special needs which clients have identified may be met.

- The Healing Project – A Recovery Station and Housing First Program: This program is a dual-element project. The Recovery Station aims at reducing the number of arrests, emergency room and psychiatric evaluation center visits by those who are under the influence, while providing a safe place to become sober. Once sober, guests of the Recovery Station would be provided Motivational Interviewing, screening/assessment and linkage to care as needed. The Housing First aspect provides housing for those who may be active in their addiction and at risk for homelessness. Access and linkage to mental health and co-occurring substance use disorder care would be provided on site. The essential piece of the project is the incorporation of peer support; learned to be effective to break barriers to engagement during the initial Kern Innovative program, Freise HOPE House.

- Recovery Supports Transportation: A program built designed to provide ongoing support while developing empowerment and independence among clients accessing mental health services. The program employs peer and non-peer staff to provide scheduled transportation for therapy, psychiatry and group care services. Clients are able to navigate their own transportation needs and are provided support through Recovery Specialists who work with them to engage during transportation.

Changes to Existing Programs

Following stakeholder feedback supporting increased peer support services, Kern County Mental Health and the Self-
Following stakeholder feedback supporting increased peer support services, Kern County Mental Health and the Self-
Empowerment Team developed a System Improvement Project centered on creating better support during access and linkage to treatment. The Peer Navigation project provides peer support for clients linked to services with System of Care Teams. Peers engage clients during the interim period between referral and the start of services (orientation) to keep clients engaged and active in preparing to receive care. Services under the Peer Navigation project began in March 2016 and within the last quarter of FY 2016, 70 percent of those referred for the Peer Navigation services had attended their initial team orientation. Peer Navigation will continue in FY2016/2017 and anticipates adding staff to better support the program.

Older adults continue to be a population identified as underserved in Kern County. To better serve our older adult population, the WISE (Wellness, Independence and Senior Enrichment) program expanded services in Delano, the second largest city in the county. According to Census data from 2015, residents in Delano over the age of 65 totaled nearly 15 percent of the population. WISE services in Delano will bring full service partnership level mental health care specially designed for seniors. Services will begin during FY 2016/2017.

Access to Care – Access and Assessment Center will increase access and linkage for services to those in the East Kern area in FY 2016/2017 by providing Crisis Stabilization Unit services in Ridgecrest. Ridgecrest is the third highest populace in Kern County, following Bakersfield and Delano.

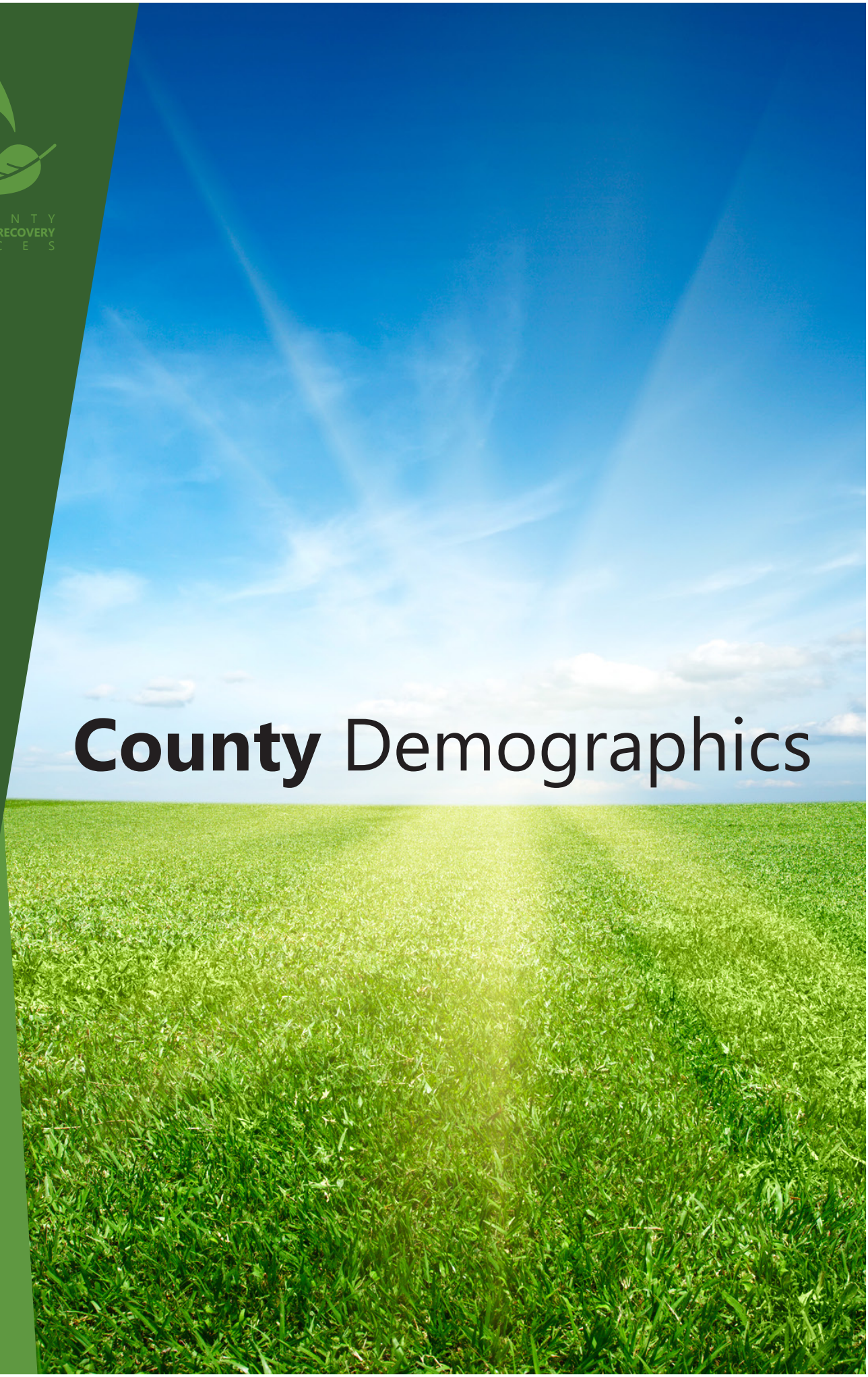
New Additions
Under the Capital Faculties and Technological Needs component, two IT programs are currently in development:

- Patient Portal: Designed to be provided in an in-clinic kiosk, the Patient Portal would be accessed by clients wishing to view pertinent information in their electronic health record. This information may also be reviewed with the Recovery Specialist (Personal Service Coordinator).

- Ultra-Sensitive Exchange: Also in development, the Ultra-Sensitive Exchange would provide a secure network in which Kern Medical and Kern Behavioral Health and Recovery Services would be able to exchange information important to providing care to shared clients who have been hospitalized.

Fiscal Year 2016/2017 Allocations
Kern County estimates $40,657,632 in allocations for MHSA programs and services. In addition, funds unspent from prior fiscal years continue to be appropriated to cover future costs which exceed each yearly estimated allocation.

KERN COUNTY
BEHAVIORAL HEALTH&RECOVERY
SERVICES



County Demographics

County Demographics

Geography

Kern County is located on southern edge of the San Joaquin Valley. With 8,163 square miles of mountains, valleys, desert and the ag-yielding valley, Kern County is geographically the third largest county in California. Bordered by eight counties, Kern lays neighbor to Kings, Tulare, Inyo, Ventura, San Bernardino, Los Angeles, Santa Barbara and San Luis Obispo. Located within the Central Valley, Kern County and primarily Bakersfield, is a thoroughfare for travelers and commuters as it connects many on the north-south route via Interstate-5 and Highway 99.

Economy

Major industries include oil and agriculture, with Kern County producing over 70 percent of oil in California. With the overwhelming decrease of oil prices in the last several years, Kern County has felt the heat, as jobs in one of the two leading industries have decreased substantially. Likewise, local economy has suffered as a result of revenue sources being directly linked to property taxes associated with oilfields. Another Kern County leading industry, agriculture has had economic effects due to drought, which is an ongoing concern for animal and crop-based ag. Military-based industry, primarily located within East Kern, with Edwards Air Force Base and the China Lake Naval Air Weapons Station which provides jobs to many within the Ridgecrest, Mojave and Rosamond area. Solar and Wind energy have also been growing industries over the last several years, generating construction and operational jobs throughout Kern, with wind energy based jobs provided primarily in the Tehachapi mountain area.

The unemployment rate as of July 2016 was 10.6 percent, up from 10.2 percent the year prior. Across all industries, there was a 6,900 job increase in July 2016; with decreases seen mostly in mining and logging from 2015 to 2016. Unemployment rates for June 2016 ranked as follows:

Arvin 12.5%

Bakersfield 9.6%

Delano 12.9%

Lake Isabella 9.3%

Lamont 7.2%

Mojave 19.3%

Ridgecrest 7.3%

Rosamond 9.0%

Shafter 9.2%

Taft 7.0%

Wasco 14.2%

Demographics

Bakersfield has an estimated population of 379,110 people, which is approximately 43 percent of the county's total population of 886,507 (2016 Department of Finance). Around 88 percent of the county's total population resides in or around various urbanized areas, while the remaining 12 percent live in more undeveloped, rural areas. Approximately 35 percent of the population in Kern County is aged 35-64. Children under 10 also make up a substantial portion of the population, approximately 25 percent, and 15-34 year-olds occupy approximately 31 percent of the Kern County population. According to the California Economic Forecast report, Kern will continue to attract new residents over the forecast horizon and the growth of population will modestly accelerate. By 2018, the total population is anticipated to reach 943,800 individuals, and exceeding 1 million in 2020.

English and Spanish are the primary threshold languages in Kern County. Hispanic/Latin persons constitute 51.5 percent of the population, which is also made up of White, non-Hispanic (36 percent), African American/Black (4.9 percent), Asian (4.4 percent), multi-racial (3.5 percent), Native American (0.4 percent) and Native Hawaiian/Pacific Islander (0.1 percent).

Governance

The County of Kern is one of 58 counties established by State of California statute. A county is the largest political division of the state which has corporate powers. Counties, like Kern, which adhere to state laws regarding the number and duties of other elected officials and officers, are called general law counties. State law requires every county to be governed by a five-member Board of Supervisors. Counties are authorized to make and enforce any number of local ordinances as long as they do not conflict with general laws. The Board of Supervisors must follow the procedural requirements in state statutes or its actions will not be valid.

The powers of a county can only be exercised by the Board of Supervisors or through officers acting under and on behalf of the board or by the authority which is specifically conferred by law. Kern County's Board of Supervisors oversees 37 departments, with a staff of 6,461 full-time employees. The Board of Supervisors sets service and program priorities, establishes County policies, oversees most County departments, annually approves all department budgets, controls all County property, and appropriates and spends money on programs and services in order to meet the needs of its residents.

KERN COUNTY
BEHAVIORAL HEALTH&RECOVERY
SERVICES

Community Planning
Stakeholder Feedback

2016 Community Planning and Stakeholder Feedback Schedule

Sept. 1, 2016: Central Avenue Senior Apartments, Wasco, Calif.

Sept. 6, 2016: NAMI General Board Meeting, KBHRS Adult System of Care Building, Bakersfield, Calif.

Sept. 9, 2016: Bakersfield Homeless Center Stakeholder Meeting, Bakersfield Homeless Center, Bakersfield, Calif.

Sept. 14, 2016: Consumer Family Learning Center Advisory Committee, KBHRS Adult System of Care Building, Bakersfield, Calif.

Sept. 21, 2016: Crisis Intervention Team Stakeholder Meeting, KBHRS Kern Linkage Program Building, Bakersfield, Calif.

Sept. 22, 2016: Transitional Age Youth Stakeholder Meeting, KBHRS Children's System of Care Building, Bakersfield, Calif.

Oct. 7, 2016: 10th Annual Recovery Conference, Bakersfield Marriott Hotel, Bakersfield, Calif.

Oct. 8, 2016: Good Neighbor Festival, Martin Luther King, Jr. Park, Bakersfield

Oct. 11, 2016: Mojave Stakeholder Meeting, Mojave Veteran's Hall, Mojave, Calif.

Oct. 13, 2016: Wasco Community Collaborative Meeting, Sunset Apartments, Wasco, Calif.

Oct. 13, 2016: Tehachapi Stakeholder Meeting, Tehachapi Veteran's Hall, Tehachapi, Calif.

Oct. 14, 2016: Kern Behavioral Health and Recovery Services Stakeholder Meeting, KBHRS Westchester North Tower, Bakersfield, Calif.

Oct. 17, 2016: Delano Stakeholder Meeting, Clinica Sierra Vista Adult Services Clinic, Delano, Calif.

Oct. 18, 2016: Kern River Valley Stakeholder Meeting, Kern River Valley Veteran's Hall, Lake Isabella, Calif.

Oct. 20, 2016: Lamont Stakeholder Meeting, Clinica Sierra Vista Clinic, Lamont, Calif.

Oct. 21, 2016: Frazier Park Stakeholder Meeting, Frazier Park Recreation Center, Frazier Park, Calif.

Nov. 15, 2016: Ridgecrest Stakeholder Meeting, CCS HOPE Center, Ridgecrest, Calif.

Nov. 17, 2016: Kern County Network for Children Collaborative, Bakersfield, Calif.

The 2016 Community Planning and Stakeholder Feedback process included community members, clients, family members, law enforcement, transitional age youth, parents of children, educators, representatives from the Department of Human Services and community organizations, NAMI, Older Adults and mental health providers.

Stakeholder meetings involved providing training which included a history of the Mental Health Services Act in Kern County. Stakeholders also learned which programs work within the five components and how MHSA is built to reduce homelessness, suicide, prolonged suffering, arrests and incarcerations and mental health stigma.

"The general public should be more involved, both in employment and education. If more people are aware of mental health services, there would be less stigma, more understanding and more people willing to get involved with Mental Health."

-Stakeholder Feedback

Presentations outlined the importance of stakeholder participation, providing highlights of feedback given during the 2015 stakeholder process, which helped develop new Prevention and Early Intervention programs for children. Feedback from stakeholders in 2015 provided Kern Behavioral Health and Recovery Services with guidance needed to develop potential Innovative Programs.

"The programs and organizations should be advertised to the community. I received services because someone told me about them. I would not have known otherwise."

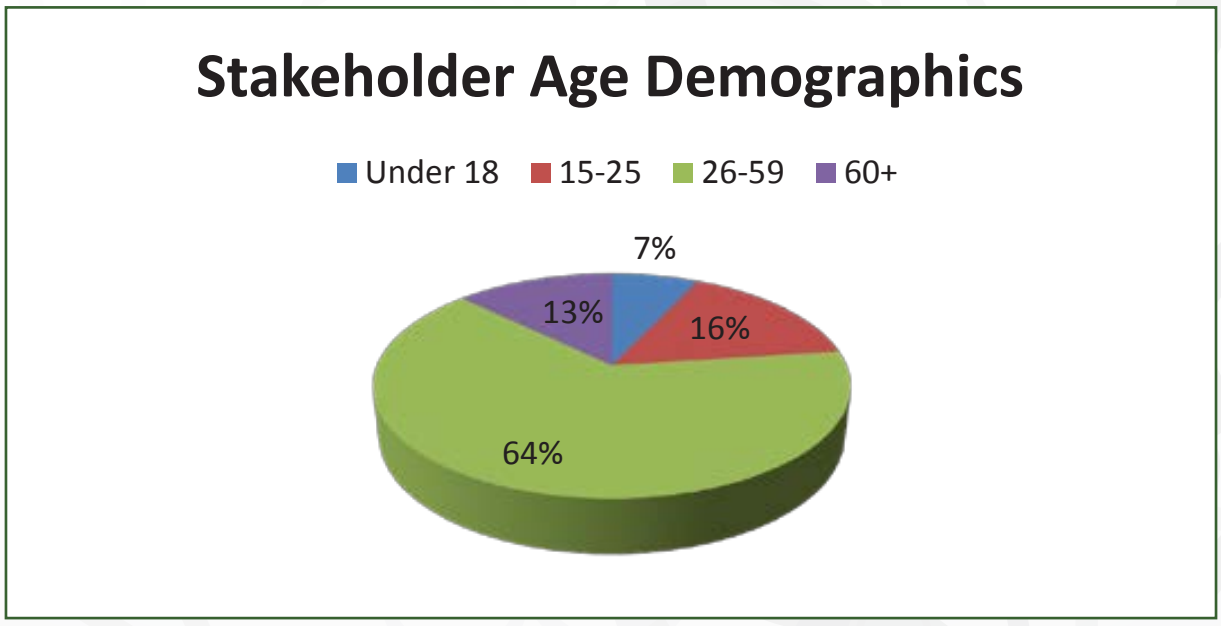
-Stakeholder Feedback

Feedback identified populations including Foster Youth, Seniors, Homeless persons, single parents, LGBTQ, mothers suffering from post-partum depression and those who are privately insured. Recommended services, supports and resources recommended more services for outlying areas, emergency housing, more social groups and activities for those with mental illness, transportation for appointments and an increase in services targeted at transitioning clients with mental illness to independent living.

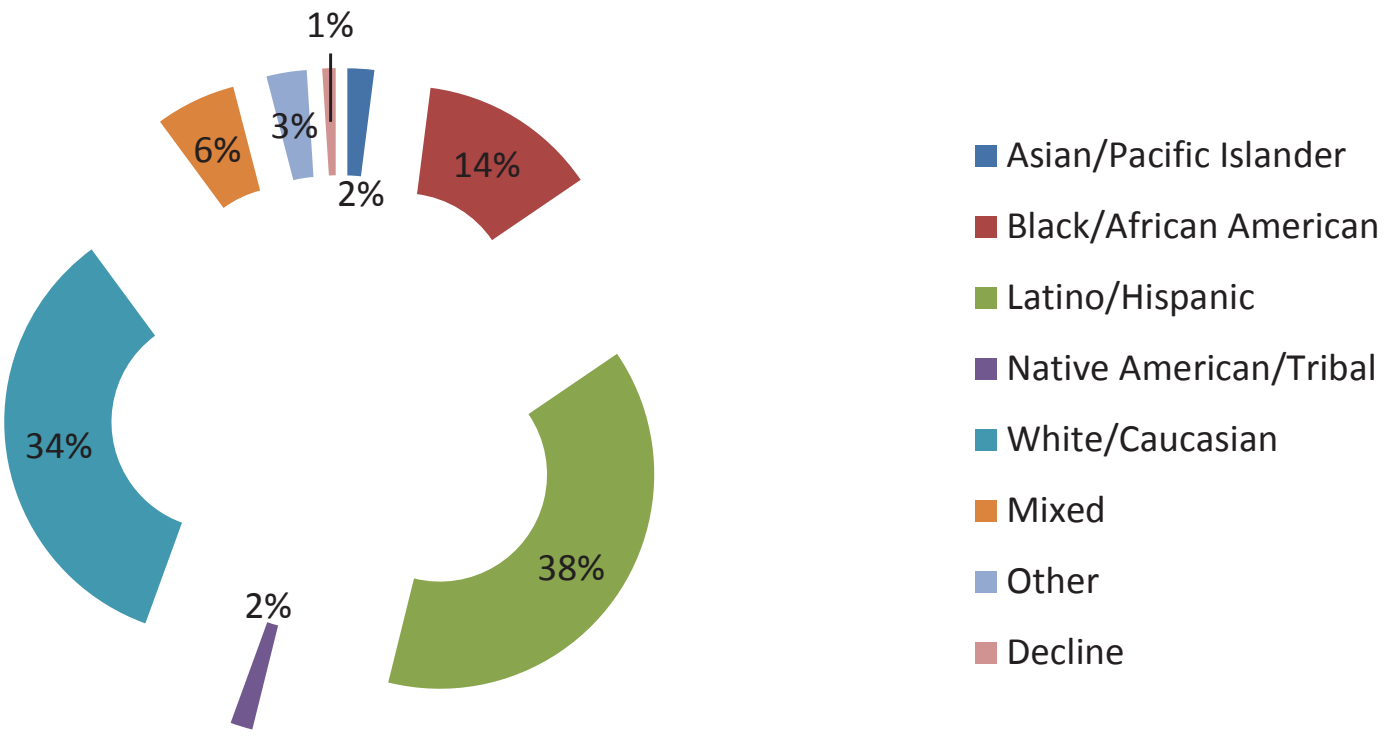
Stakeholder feedback meetings included a presentation on past and developing Innovative programs. Innovative feedback supported past and potential new programs, adding that services through these programs would be beneficial to the community and to clients receiving services. The Special Needs Registry – Smart 911 program received extensive feedback about the positive impact to emergency situations, "We can possibly reduce the use of force in some responses by having additional information when responding." Additional comments reinforced the idea that it is beneficial for law enforcement to have as much information about an emergency situation as possible prior to arrival on scene. There was also support for this program which could be utilized by the community as a whole, including others with special needs, including autism.

Regarding the Recovery Supports Transportation program, "We can learn about specific underserved populations that have not previously had access for transportation." Other comments centered on how the program will increase access to services for those struggling to fully engage in mental health care.

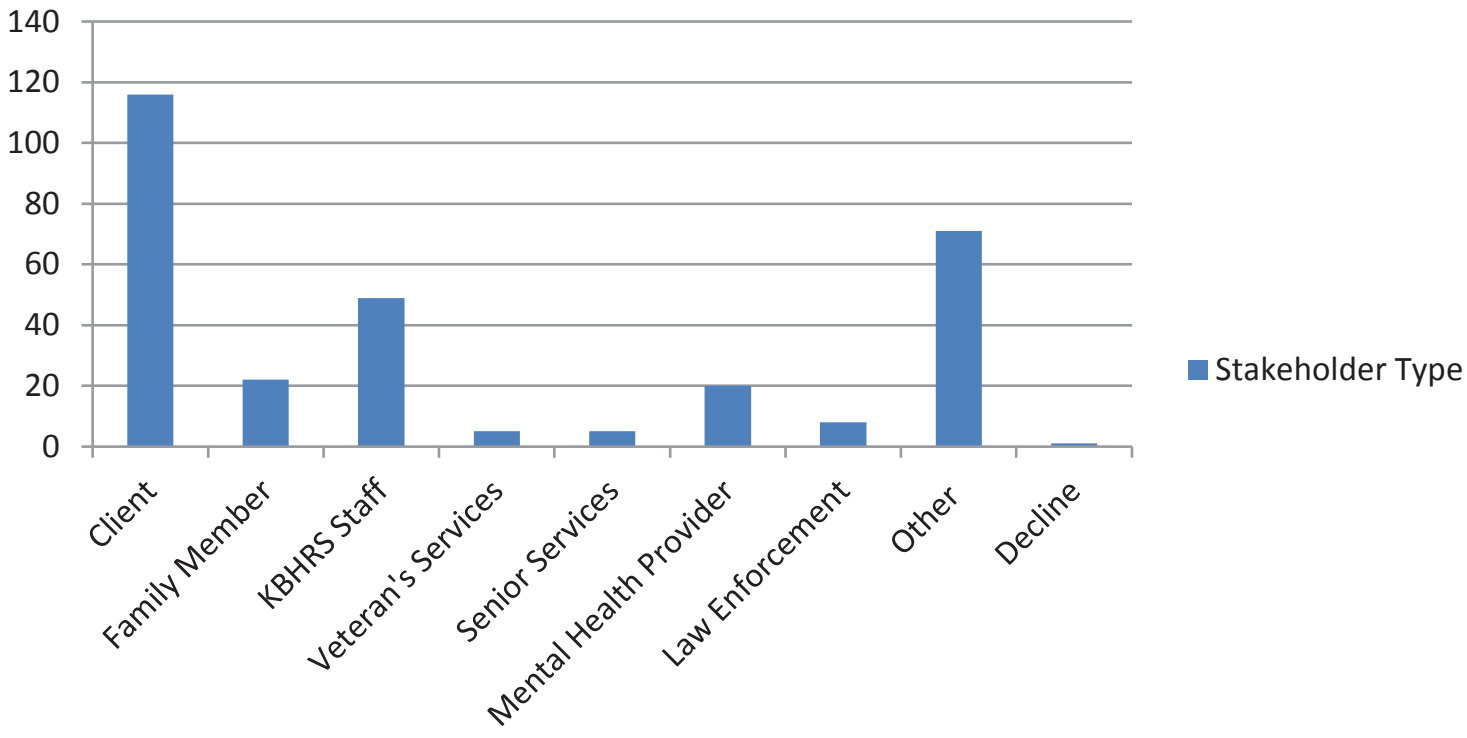
The Housing First and Recovery Station program, The Healing Project was deemed necessary in providing a new and necessary type of housing in Kern County, "The Healing Project will help the Department learn whether the recovery station reduces the impact on jail and emergency room use and whether a peer-involved program results in individuals becoming more successful in their sobriety. Also, the housing first project would bring the first of its kind to Kern County, providing a much needed housing component in the homeless housing continuum of care."

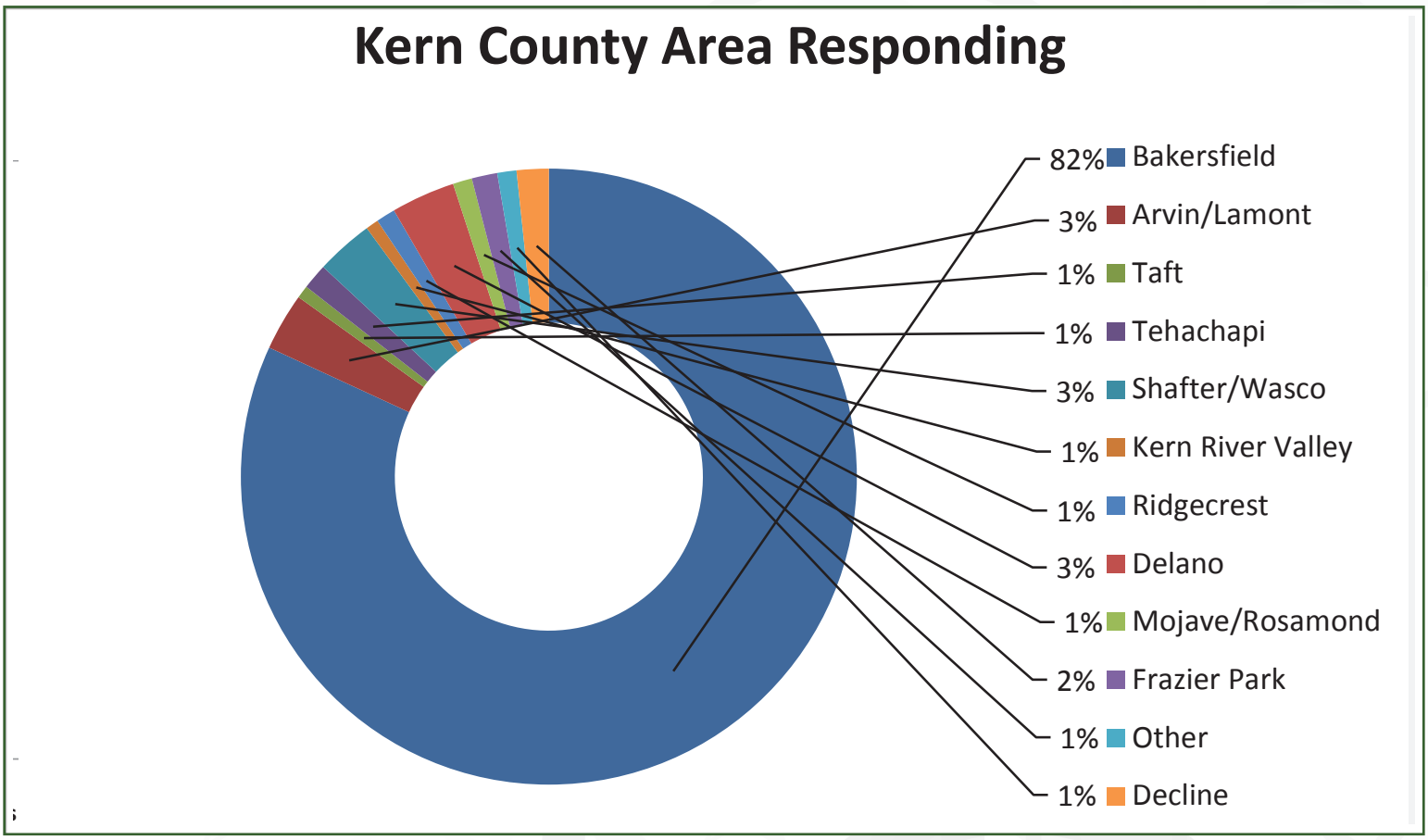


Race/Ethnicity



Stakeholder Type





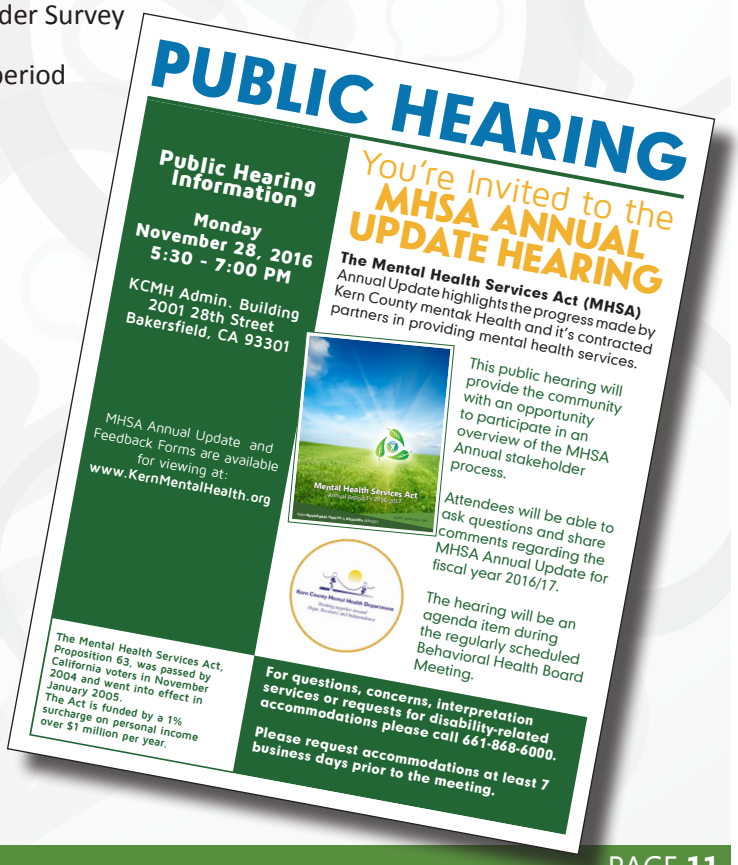
Behavioral Health Board Public Hearing, November 28, 2016

Kern County Mental Health posted the MHSA Annual Update FY 2016/2017 on their public website from Oct. 28, 2016 to Nov. 28, 2016. On Nov. 28, 2016, the Behavioral Health Board approved the annual report after the public hearing presentation. Recommendations included:

- Including Educators on the selections portion of the Stakeholder Survey
- Study ways to increase responses during the 30-day Review period
- Better identifying services for treatment-resistant clients
- Develop and report on nontraditional efforts to reach the Hispanic/Latino population

"I believe that it would be great for those living with a mental illness to get more involved with the community. For example, planning outings to volunteer with clean ups, planning events to teach the community about mental illness and even things that involve listening to guest speakers."

-Stakeholder Feedback



KERN COUNTY
BEHAVIORAL HEALTH&RECOVERY
SERVICES

Community Services and Supports

Community Services and Supports

Full Service Partnership Programs
Kern Behavioral Health and Recovery Services (KBHRS) continued FY 2015/2016 with six (6) Full Service Partnership programs which make up 51 percent of budgeted funds for the Community Services and Supports component. Full Service Partnership (FSP) programs are designed to serve those with serious mental illness and/or severe emotional disturbance. Mental health care provided by our System of Care teams and providers working in FSP's provide "whatever it takes" services; meaning care is available 24/7 to assist with crisis intervention and other immediate needs.

Children, Transitional Age Youth, Adults and Older Adults receive care built to fit specific needs to reduce homelessness, suicide, incarcerations, school dropout or failure, unemployment and prolonged suffering. Full Service Partnership Teams are as follows

Adult Care
Assertive Community Treatment (ACT)
Adult Transition Team/ Homeless Adult Team (ATT/HAT)

Children's Care
Youth Multi-Agency Integrated Service Team (MIST)
Youth Wraparound

Transitional Age Youth (TAY) Care
Transitional Age Youth (TAY)

Older Adult Care
Wellness, Independence and Senior Enrichment (WISE)

"Services for mothers suffering from post-partum depression. I had problems with this after the birth of my son and became suicidal. This would have helped a lot to prevent feeling so alone and ashamed."

-Stakeholder Feedback

Highlights from FY 2015/2016

For those provided services by Full Service Partnership programs for two or more years:

- Homelessness was reduced 33 percent
- Arrests decreased 87 percent
- Independent residence increased 18 percent for TAY, Adults and Older Adults

General System Development Programs
General System Development programs continued without change in FY2015/2016. These programs include our Access to Care, Adult Wraparound, Recovery Supports and Outreach and Education programs. Access to Care is the front door the KBHRS – from our Crisis Hotline team to Access and Assessment, Access to Care teams are designed to provide linkage to both System and Community mental health care. Recovery Supports is a set of programs richly involved in peer support, either through peer-involved or peer-led programs. Adult Wraparound provides engagement and intensified care for those exiting inpatient (hospital) mental health care and entering outpatient treatment. Outreach and Education is a provided by many System of Care and community provider teams throughout Kern County. Information on mental health, stigma reduction, suicide prevention and programs available is disseminated through community events, health fairs, conferences and other venues to all ages and populations. General System Development programs are as follows:

TAY, Adult, Older Adult Care
Consumer Family Learning Centers (CFLC)
Access to Care – Access and Assessment Team
Access to Care – Crisis Hotline

All Ages
Outreach and Education

Adult Care
Recovery and Wellness Centers (RAWC)
Self-Empowerment Team (SET)
Adult Wraparound

Highlights from FY2015/2016
The Consumer Family Learning Center (CFLC) began collecting data on unduplicated members attending activities and events. From January – June 2016, 1,723 unduplicated members attended events. Additionally, team members were added to the CFLC team, which was able to begin providing evening and weekend activities for members.

The Self-Empowerment Team (SET) provides peer specialist support through ancillary services for clients receiving care from Kern Behavioral Health and Recovery System teams. In FY 2015/2016, the SET team implemented a Peer Navigation program, which engages clients who have been assessed and referred for treatment within the System of Care. During the interim period between the referral and orientation with the mental health care team, peer specialists through the Peer Navigation program provide support and prepare clients to move into outpatient treatment. The program became active in March 2016. During the last quarter of the fiscal year, 165 referrals for Peer Navigation services were received; 116 of these clients attended their care team orientation successfully. At the end of the fiscal year, 22 clients were still pending orientation. These additional services will be continued in FY 2016/2017.

Assertive Community Treatment

Location:
Kern Behavioral Health and Recovery Services Services
5121 Stockdale Highway Ste. 275
Bakersfield, CA 93309

Clients served in FY 2015/2016: 221
Goal number of clients served in 2016/2017: 230
Anticipated Cost per Client: $12,094.12

Program Description
The Assertive Community Treatment (ACT) Full Service Partnership team provides specialty mental health care to those with severe and persistent mental illness. The team provides intensified services to clients with mental health and/or substance use disorders. The ACT Team is comprised of Recovery Specialists and Aides, Therapists, Substance Abuse Specialists and a Mental Health Nurse. Psychiatrists work with multiple teams within the System of Care, dedicating shifts throughout the week for assessments and medication management appointments.

"Peer specialists to navigate through the Mental Health Court/STAR Program and the criminal justice process."

-Stakeholder Feedback

Clients are referred through the KCMH Access to Care Center, family members and lower level mental health teams when more intensive care is necessary. Those served by the ACT team have often had a lengthy history of mental health and/or substance use treatment. ACT provides the highest level of care available for outpatient treatment (Level 4). By nature of the program Recovery Specialists and Substance Abuse Specialists may meet with clients several times per week to maintain engagement in treatment and progress toward goals. Individualized care is provided by the therapists and is provided in the clients living environment. Consultation is done with the Staff Nurse for medication management and health education. For physical health care, clients are linked to a primary care provider with whom we coordinate services and ACT team members may take clients to medical appointments as needed.

The ACT model is evidence-based and is characterized as a "Hospital without walls." This team works intensively with individuals, in their home or other settings. This model yields positive outcomes in helping clients recover in the community rather than institutional settings. Clinical staff utilize techniques and skills developed from evidence-based practices including Cognitive Behavioral Therapy for Psychosis (CBTp) and Dialectical Behavioral Therapy (DBT). Those with co-occurring disorders also participate in Dual-Recovery Anonymous groups. Individual therapy is provided by Licensed Therapists and therapist interns. Clients are referred to the peer-run Community Family Learning Center (CFLC, page 60) within for pro-social and educational activities co-facilitated by peer volunteers. Crisis intervention and assessment for involuntary psychiatric hospitalization are performed as needed.

The ACT Team has also begun serving those assigned to Assisted Outpatient Treatment (AOT) following the approval of the Laura's Law in Kern County in October 2015. Laura's Law makes it possible that those who are resistant to treatment and suffer from serious and persistent mental illness be court ordered to participate in AOT services lasting up to 180 days. Several attempts at comprehensive outreach and intervention are completed prior to requesting court ordered treatment for those with a valid referral. Clients referred for AOT must meet stringent criteria including having been determined to be unlikely to survive safely in the community without supervision.

Service Goals

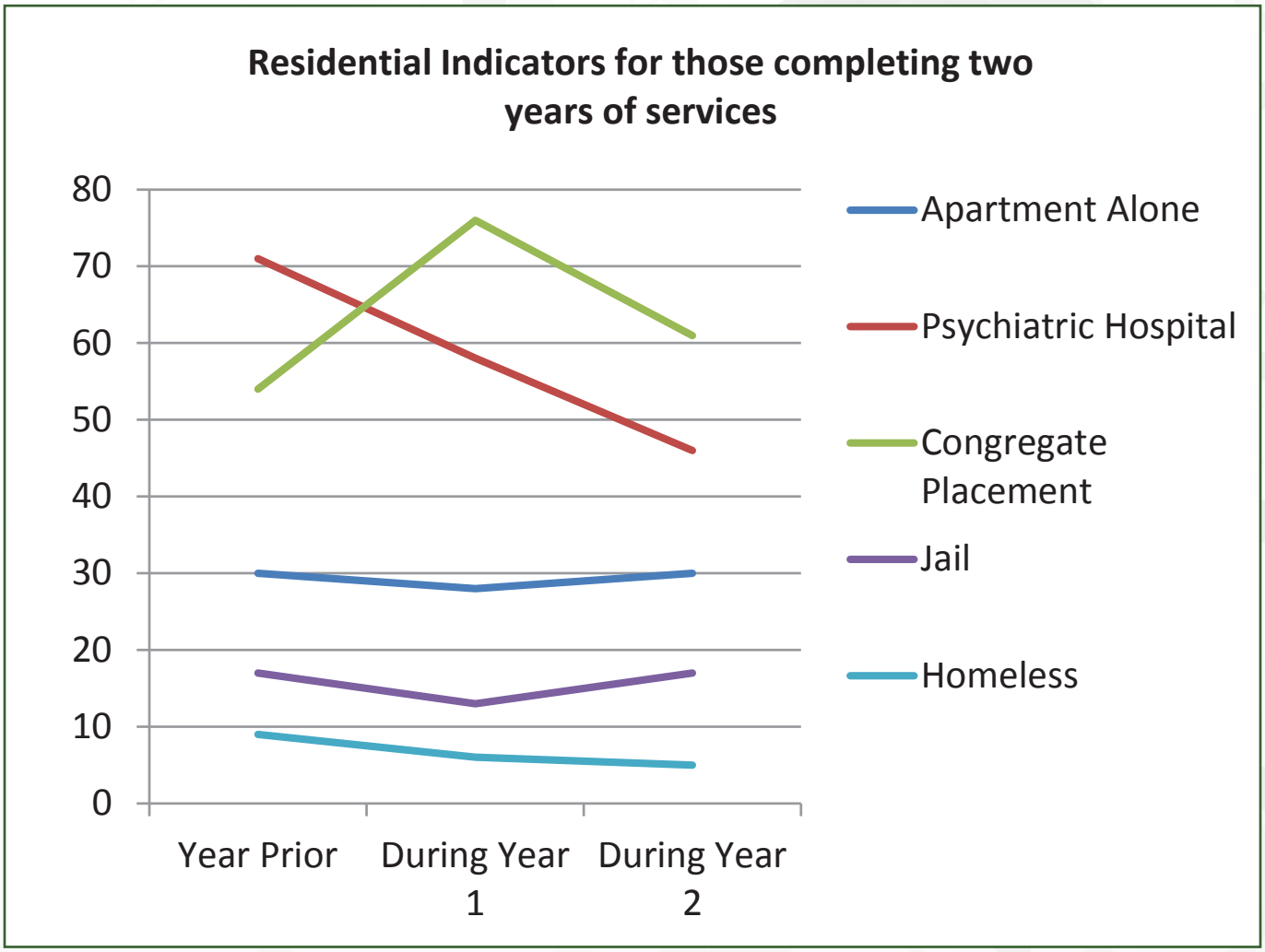
- Reduce the need for crisis services for clients living with severe and persistent mental illness.
- Provide AOT outreach and engagement to individuals with severe and persistent mental illness, who are not receptive to traditional mental health and substance use disorders treatment due to their symptoms and impairments.

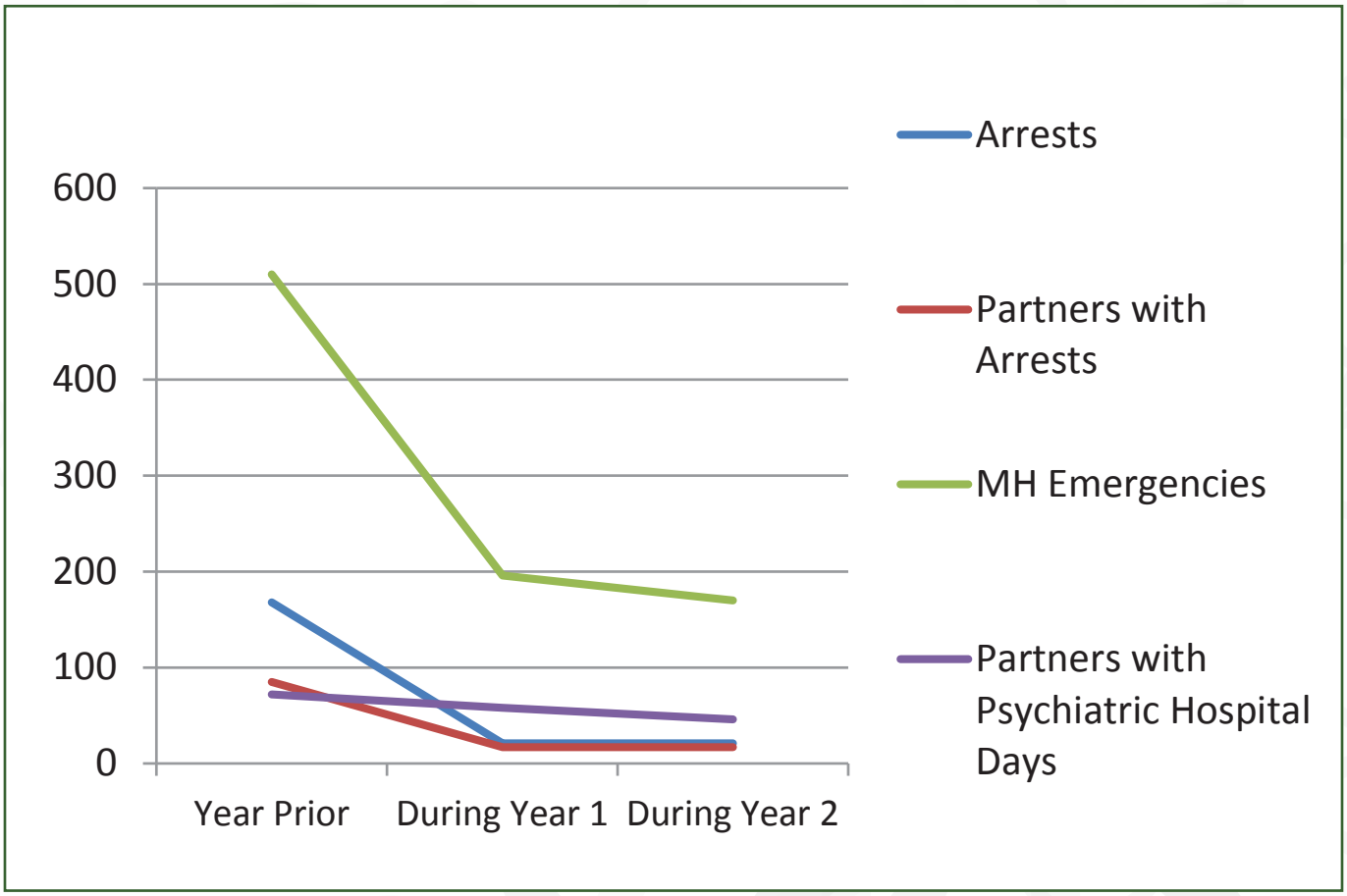
- Provide intensive services out in the community to facilitate mental health stability as well as a meaningful role in the community.
- Promote voluntary participation in services and increasing insight related to the benefits of mental health treatment.
- Reduce long term care placements.
- Treat clients with the goal of overcoming challenges related to grave disability leading to LPS Conservatorship.

Program Data

Data reflects clients who received services for at least two years:

- During year one of services:
    - 72 percent decrease in the number of clients experiencing arrest; 85 percent decrease in the number of arrests
    - 19 percent decrease in the number of clients admitted into a psychiatric hospital
    - 32 percent decrease in clients experiencing incarceration
    - 62 percent decrease in the number of mental health emergencies





- Overall for those completing at least two years of services:
  - Community Care residence increased 13 percent
  - Residential treatment decreased 46 percent.
  - Independent living increased in the following areas:
    - Single Room Occupancy increased 114 percent
    - Congregate Placement nearly tripled
    - Individual placement increased 14 percent
  - Clients experiencing mental health emergencies decreased 37 percent; the number of mental health emergency events decreased 67 percent
  - Incarcerations and those experiencing incarceration decreased nine percent
  - Arrests decreased 84 percent; the number of those experiencing arrest decreased 69 percent
  - 17 percent of clients discharged met program goals

Making a Difference

"Jane" began mental health services during her stay at an inpatient psychiatric facility due to inability to provide for her own basic needs. The severity of Jane's mental health symptoms caused challenges with her past goals of living independently, attending college and eventually gaining employment. Through the collaboration of the inpatient clinical staff, community support persons and the positive interactions with the ACT team, Jane has been able to move forward with her recovery goals. Currently, Jane has graduated to a lower level of mental health care. She is actively pursuing her goals of returning to college, living independently and attending a local church. Most importantly, Jane has been able to regain family relationships – she is visiting family members weekly and enjoys the time spent with them, laughing and looking at old photographs.

Jane continues to collaborate with her current mental health team; she is accessing community resources and celebrates her recovery by leading groups at her church. Jane has developed a sense of community and continued mental health recovery as she looks forward to attaining her next dream of being an advocate for those suffering from mental illness.

Challenges

- Extending coverage to include weekend and after hours coverage. ACT offers on-call phone consultation and support, but will be expanding coverage to include weekend and evening services.

Solutions in Progress

- An outreach worker will be accepting more referrals from law enforcement and other sources, in addition to referrals from the family advocate.
- ACT is increasing services to family members, other natural supports and placement operators when appropriate to increase the level of support to clients.

Adult Transition Team/Homeless Adult Team – Full Service Partnership

Location:
Kern Behavioral Health and Recovery Services Services
2525 N. Chester Avenue
Bakersfield, CA 93308

Clients Served in 2015/2016: 251
Goal number of clients served in 2016/2017: 438
Anticipated Cost per Client: $12,986.00

Adult Transition Team
The Adult Transition Team (ATT) is a Full Service Partnership focusing reduction and elimination of re-entry into jail/prison while providing specialty mental health treatment for severe and persistent mental illness.

Adult Transition Team clients have traditionally suffered a lengthy legal history, some including multiple incarcerations over a span of years. Referrals come from a number of sources, including in-jail assessments, hospitals or as walk-in self-referrals. An ATT team member provides screening and referral at the local jail individuals who may be in need of services. Active clients of the KCMH Correctional Mental Health Team may also transition to ATT as they exit incarceration.

Many ATT clients suffer from co-occurring disorders, requiring dual recovery services. The goal in treating the client is to help them address mental health and/or dual recovery needs, managing symptoms in such a way that they can successfully transition to less intensive services with a non-specialty mental health team or provider.

The ATT is comprised of a Clinical Psychologist, Therapists and Recovery Specialists, who provide treatment and support with the client. As clients are often reluctant to seek physical care and will often traverse between medical and psychiatric hospital settings, the ATT Staff Nurse is able to provide basic care including medication management, wound dressing and education on diabetes and hepatitis C.

Evidence-based programs and modalities are utilized when treating clients, including: Cognitive Behavioral Therapy (CBT), CBT specialized for psychosis (CBTp) and Dialectical Behavioral Therapy (DBT) and Aggression Replacement Training (ART). Seeking Safety and Matrix groups are utilized for those requiring treatment for co-occurring disorders. Recovery Specialists engage clients in the field for case management while individual therapy sessions and groups are provided on-site.

In August 2015, the Sustained Treatment and Recovery Court (STAR Court) was implemented. As a multi-agency collaboration, the STAR Court partners county agencies including; Probation, Behavioral Health and Recovery Services, District Attorney, Public Defender and the Superior Court. Clients with severe mental illness are referred after one or multiple serious crimes have been committed. The 18-to-36-month program is designed to reduce or eliminate recidivism while providing necessary mental health care, which is closely monitored by mental health Recovery Specialists and the client's probation officer. STAR Court status hearings are regular and should clients fail to appear or continue fidelity to treatment plans, their eligibility in the STAR Court may be suspended or revoked. The program also ensures proper linkage to resources including housing, transportation and benefits. Since its inception, STAR Court has referred ( ) participants, ( ) of which have remained active.

Homeless Adult Team
The Homeless Adult Team (HAT) is a program expansion of the ATT. The HAT works with clients who are homeless or at risk of becoming homeless, who also require specialty mental health treatment.

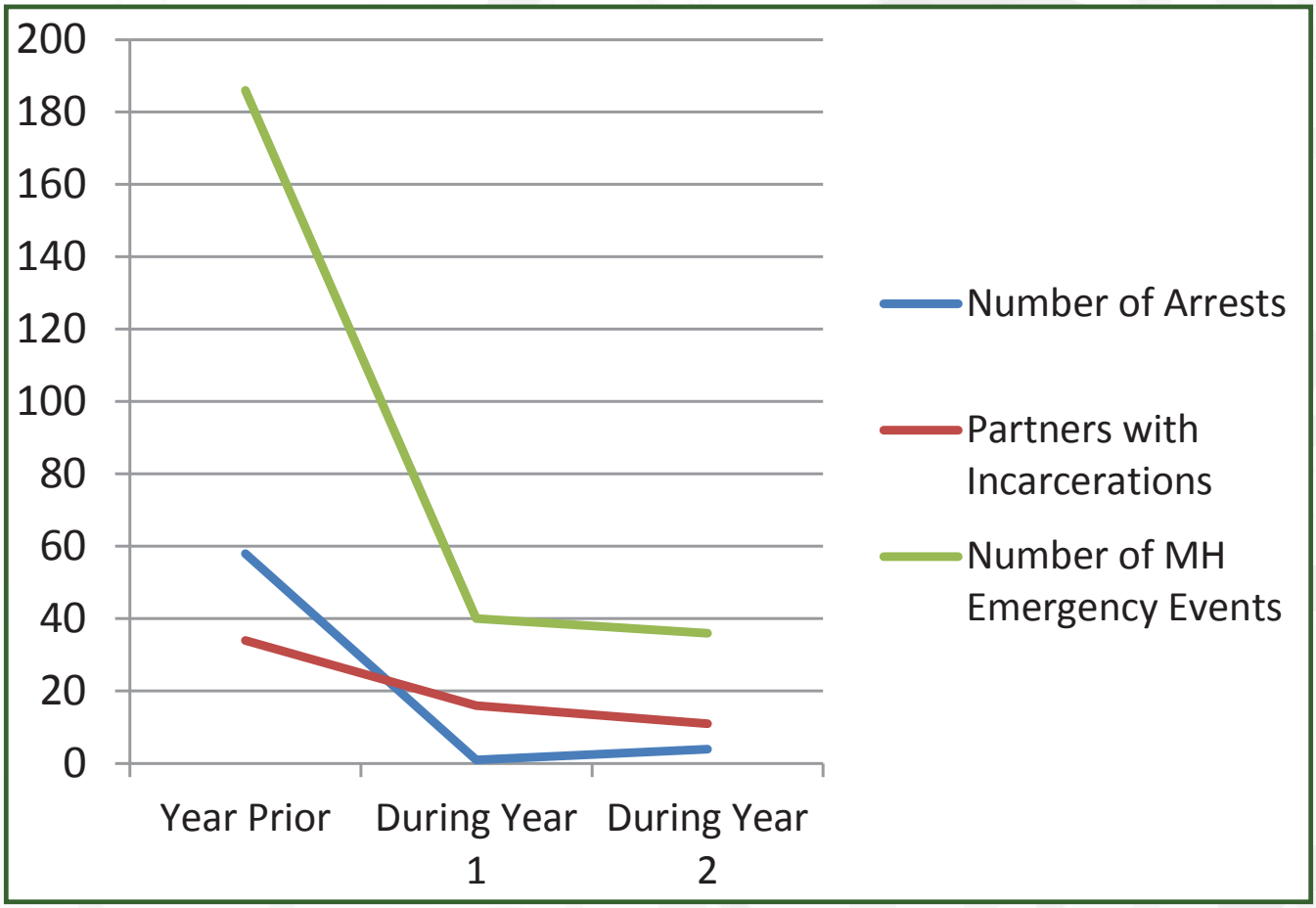
Linkage to resources and housing is an essential piece for clients of HAT. Team members are adept in assisting with the application process for acquiring Medi-Cal and Social Security benefits. Housing is acquired by team collaboration with the homeless shelter and like organizations as well as contracted and community housing providers. Vouchers may also be obtained for clients who may be eligible for various housing programs. Stable and permanent housing is a crucial part of ensuring the client remains stable and engaged in treatment goals. To aid in ensuring housing resources are available, ATT/HAT funds half of the salary for a Homeless Resources Director with the Kern County Homeless Collaborative.

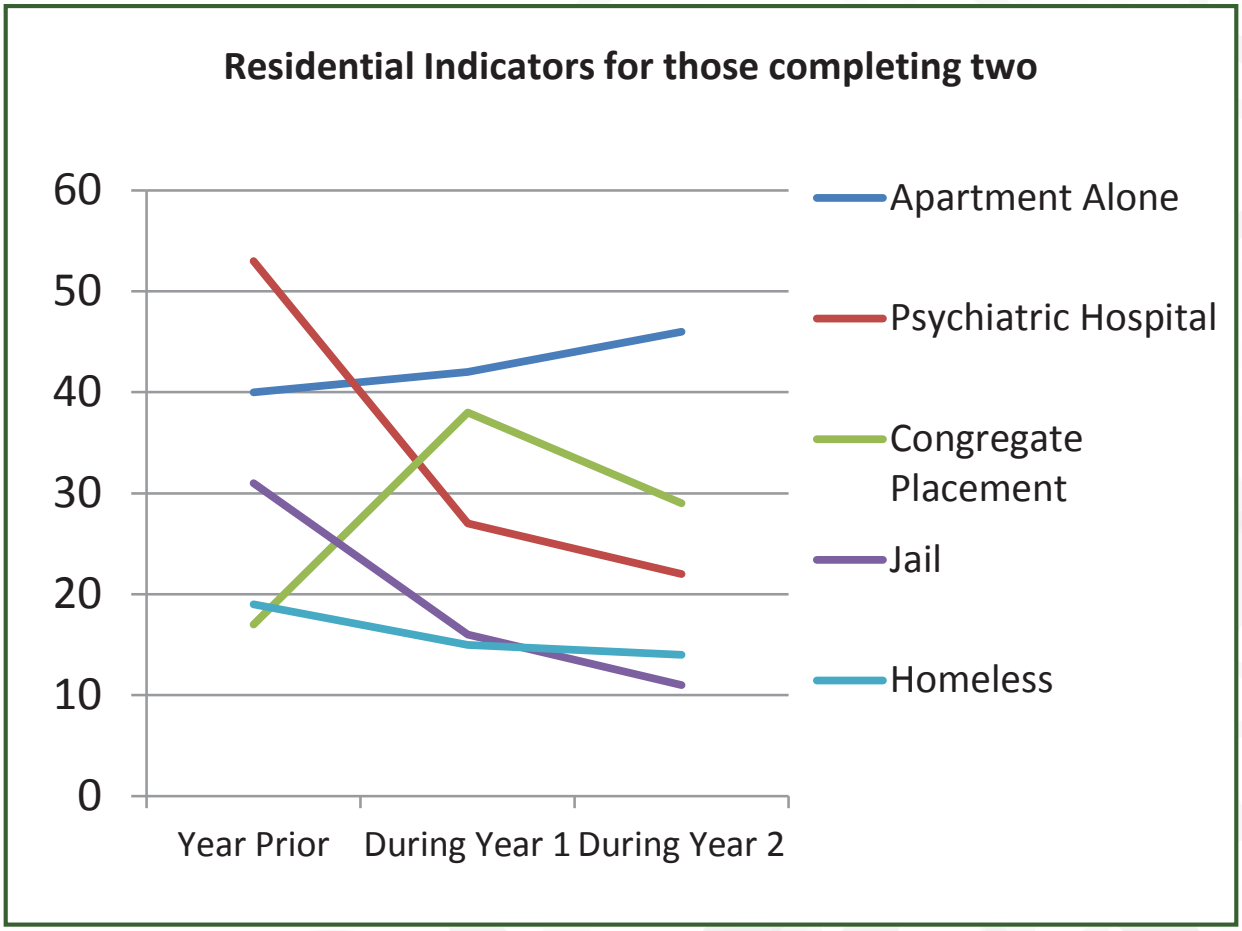
HAT clients do not traditionally carry a lengthy legal history. Much like its counterpart, ATT, the HAT works diligently eliminate the barriers to housing, benefits and community resources. In its partnership with the Kern County Homeless Collaborative, many staff members participate in the annual Homeless Census. The Homeless Census is a requirement of the U.S. Department of Housing and Urban Development (HUD), from which data is used when applying for additional grant funding. The census is completed over a 24-hour period in which the sheltered and unsheltered homeless population are counted and surveyed throughout Kern County. Funding from the HUD is utilized in the Kern County Homeless Collaborative Continuum of Care, which provides for projects to assist the homeless. ATT/HAT also collaborates with public agencies and community organizations working with the homeless, including; Veterans Administration, payee service providers, legal assistance programs, sober living environments and additional agencies providing affordable housing.

Service Goals

- Reduce likelihood of recidivism in incarcerations, hospitalizations and homelessness by providing specialty mental health services to at-risk clients
- Increase independent living through single room occupancies, apartment residence and congregate placement.

Program Data:
Clients completing at least two years of services





- First year of services:
    - Arrests decreased 97 percent
    - Homelessness decreased 21 percent
    - State Psychiatric residence was eliminated in the first year of services
    - Clients experiencing incarceration decreased 53 percent
    - Clients experiencing mental health emergency events decreased 69 percent; the number of mental health emergency events decreased 79 percent
    - Clients spending days in a psychiatric hospital decreased 46 percent; the number of days spent in a psychiatric hospital decreased 31 percent

- Overall outcomes for those completing at least two years of services:
    - Arrests decreased 94 percent
    - Homelessness decreased 26 percent
    - Clients residing in an apartment alone increased 15 percent
    - The number of clients residing in a single room occupancy quadrupled
    - Community Care residence increased 33 percent
    - Congregate placement (room and board) residence increased 71 percent

- Mental health emergency events decreased 81 percent; Clients experiencing mental health emergencies decreased 77 percent
- The number of clients admitted to psychiatric hospitals decreased 58 percent; Days residing in a psychiatric hospital decreased 17 percent
- Clients incarcerated decreased 39 percent; additionally, the number of clients experiencing arrest decreased 92 percent,
- 27 percent of clients discharged had met program goals

Making a Difference

During the start of her services, Bambi utilized crisis services. She began developing a level of understanding of her mental health. She has persevered through troubles with managing basic living needs including housing, self-care, etc. She was able to overcome by focusing on her educational goals, her faith and hope for a better future. She has lived independently with her children for over three years. She has an eagerness to learn, and regularly attends the Community Family Learning Center sewing classes.

Bambi has become a perfect example of an individual with self-determination, resilience and courage. Throughout her recovery, Bambi learned the importance of self-care. In order for her to take care of her children, provide stability and be a good mother, she had to first learn to care for herself. Her self-care included meeting with her psychiatrist regularly, managing her medications, learning about mental health, participating in group consistently, being an advocate for Spanish speakers and utilizing the public transportation system to attend scheduled appointments. Bambi was able to determine her limitations and be the become the best version of herself.

Challenges:

- Lack of Board and Care is difficult for clients who are uninsured because there is a lack of interim care while clients await benefits. This leaves few housing options and often leads to prolonged homelessness.
- Maintaining and having a continuum of housing; The majority of clients are homeless and tend to lose housing often due to behavioral problems and/or multiple relapses.
- Engagement: Individuals who are not aware of their dependence on substances or their mental illness tend to not engage in mental health services, and as a result cycle in and out of psychiatric hospitals or jail.
- One housing contract was discontinued in 2015-2016, which was one of few providing housing to female clients.

Solutions in Progress:

- Provide training to help housing providers acquire skills in working with challenging co-occurring clients.
- ATT liaison works with the purchasing manager and contract supervisor to develop ongoing requests for specialty housing vendors throughout the year. It has become increasingly difficult to secure County certified housing.
- ATT/HAT staff meets weekly with staff at Sober Living Environments (SLE) to case conference common clients and develop plans to help maintain housing. Staff also keep an open dialogue with SLE staff as needed to discuss any issues arising with clients who appear to need additional care. Early Intervention can help maintain housing.
- ATT/HAT staff work with probation officers to help clients comply with probation terms and conditions.
- Correctional Mental Health staff utilize the Stages of Change model and evidence-based group therapies including seeking safety, MRT, DBT, motivational interviewing and solution focused brief therapy to engage individuals who are incarcerated.
- Staff collaborates with the Self-Empowerment Team (SET), a team comprised of hired peers with lived experience to engage clients in their residence.
- ATT/HAT staff participate in with the Kern County Homeless Collaborative to provide resources for homeless

individuals and link them to housing services.

- ATT/HAT staff provide Assertive Community Treatment style wrap around services in which the whole team works with an individual to maintain stability. “On call” staff follow up with clients after hours as needed.
- KCMH has contracted an additional Sober Living Environment (SLE) for clients with co-occurring disorders.

Youth Multi-Agency Integrated Service Team - Full Service Partnership

Location:
Kern Behavioral Health and Recovery Services Services
3300 Truxtun Avenue
Bakersfield, CA 93301

Client's served in 2015/2016: 47
Goal number of clients served in 2016/2017: 50
Anticipated Cost per Client: $34,498.84

Program Description:
The Youth Multi-Agency Integrated Service Team (MIST) provides specialty mental health care for children and families. Referrals for care come from former or active foster parents, parents/families, group homes, other Kern Behavioral Health and Recovery Services teams and public agencies including; Kern County Probation, Public Health and Human Services departments.

Clients of the MIST team have been identified as having serious emotional disturbance, severe mental illness or behavioral issues. Many of the youth have been separated from their families and reside in group homes or foster care settings. The Youth MIST team is certified in reunifying families who have experienced separation. Another effort of the team involves placing youth in foster families, who may have previously resided in group homes. There is a constant need for foster families to provide homes for the adolescent population. The team advertises as recruitment potential foster parents for adolescents aged 12-18 in local publications. Ongoing training and 24-7 support is offered through the MIST team for foster parents of clients.

Youth MIST provides individual, group and family therapy using evidence-based programs including Dialectical Behavioral Therapy (DBT) and skills training, Anger Replacement Training, Matrix for co-occurring disorders, Positive Behavioral Interventions and Support (PBIS) and Therapeutic Foster Care. The team is comprised of Psychiatrists, Therapists, Recovery Specialists, Substance Abuse Specialists, a Probation officer, Social Worker and Parent Partner. The staff Parent Partner works with parents using the Educate, Equip and Support: Building Hope program. This program provides parents with psychoeducation and insight into their child's mental health diagnosis, medication, child welfare and school information including the special education and IEP process. This team works with families on the whole as needed, providing services in the same location to help keep family mental health care centralized. Parents are provided family therapy and meet with the therapist or psychiatrist as necessary. Additionally, the team provides medication management, crisis intervention and comprehensive case management.

Service Goals

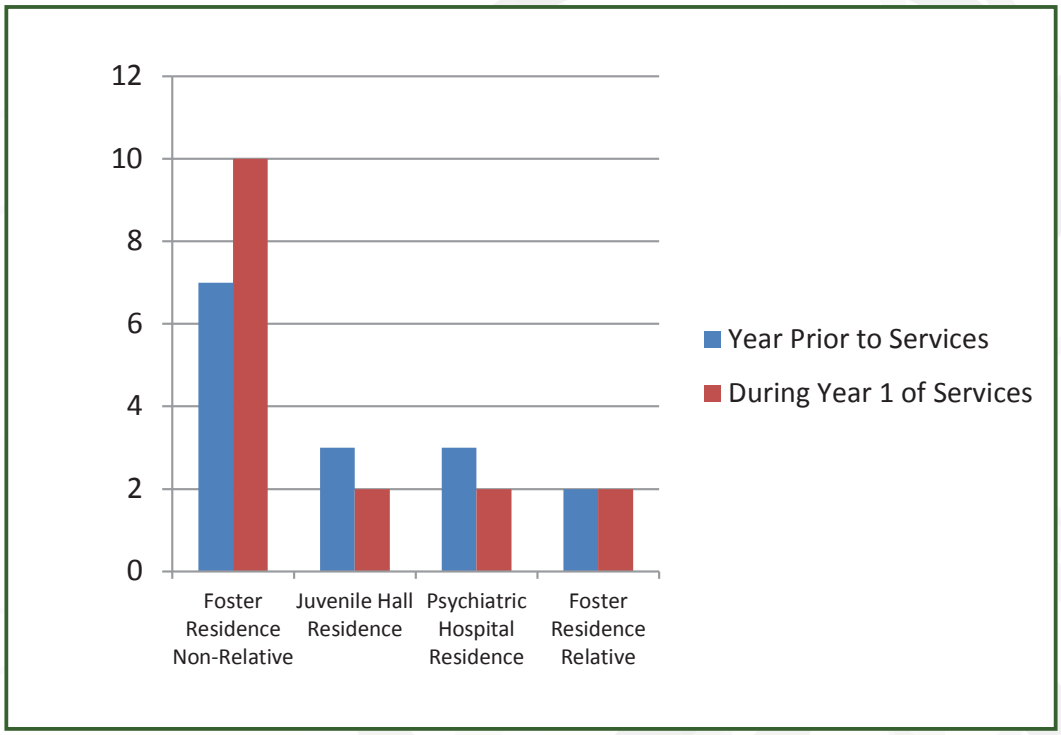
- Provide individualized recovery-based services with the firm belief that recovery is possible for everyone.
- Provide a full continuum of intensive mental health services which include a parent partner, Probation officer, Social Worker, individual and family counseling, group counseling, skills training, family and other collateral services including assessments, co-occurring disorder treatment, medication and medication support, crisis intervention, case management and treating clients in the field to accommodate service needs.
- Provide culturally competent, effective and appropriate services for individuals and families, inclusive of all racial and ethnic groups, genders and sexual orientation.

Program Data

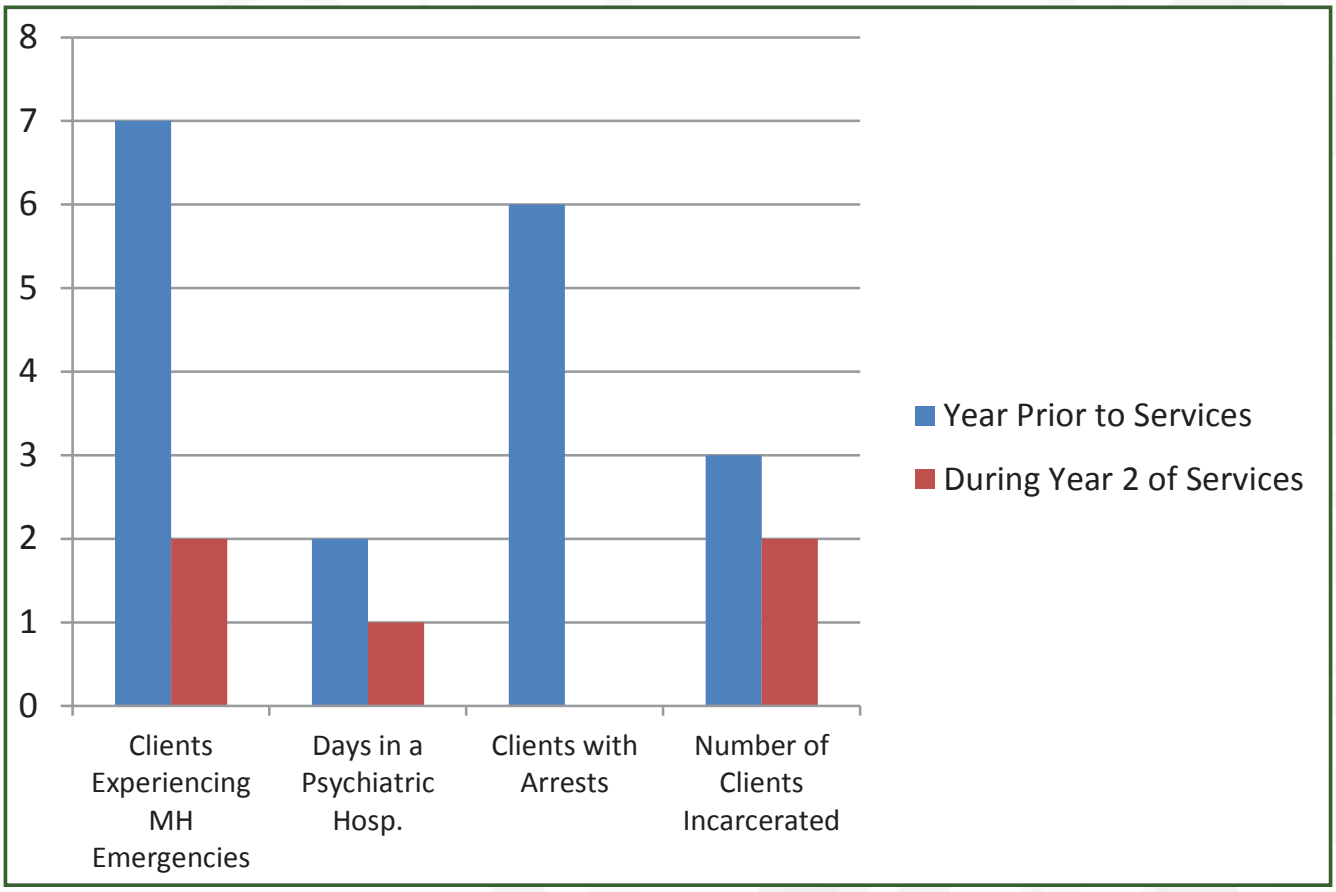
Data reflects those completing one and two years of services

- During the first year of services:
    - Arrests decreased 76 percent; Clients experiencing arrest decreased 67 percent
    - Clients experiencing mental health emergencies decreased 29 percent; the number of mental health emergencies decreased 25 percent
    - 80 percent of reporting youth showed 'Always, Most or Improved' attendance

- 40 percent of reporting youth showed 'Good, Very Good or Improved' grades
- Clients admitted into psychiatric hospital care decreased 50 percent; the number of days admitted to psychiatric hospital care decreased 98 percent



- Overall results for those completing at least two years of services:
  - Arrests were eliminated during the second year of services
  - 33 percent decrease in group home (0-11) residence; 17 percent decrease in foster residence, non-relative
  - At the end of two years, a total of two clients reported homelessness for a total of 28 days during the second year of services
  - The number of clients reporting residence in juvenile hall decreased 33 percent
  - Clients with mental health emergencies decreased 71 percent; the number of mental health emergency events decreased 92 percent



- Forty-two percent of youth discharged in FY 15/16 had met program goals

Making a Difference

MIST received a referral for 10 year old "Danny." Danny had lived with his mother and sister in homeless shelters and motels off and on for the past three years; that is, when he wasn't on the run. He was referred to the MIST team due to his many extreme behaviors such as temper tantrums, kicking and hitting. Additionally, he was failing school, and sent home almost daily for attacking teachers and other students. When Danny first started to receive services from a MIST therapist and skills trainer, he was very angry and reluctant to participate in treatment. Over time, he slowly began to open up and trust his mental health team. Danny's therapist and skills trainer used skill building interventions and anger replacement training to help him cope with his anxiety and anger. Currently, Danny is exceling at school and has made honor role. He is now able to express his feelings appropriately, and is getting along much better with his family, school staff and peers. MIST staff were also able to assist Danny's mom with applying for housing assistance and they now have a home to call their own.

Challenges

- The foster care system continues to experience a decrease in available foster homes while the need for quality foster care increases. The Kern County Foster Care Oregon (KCTFCO) cannot exist without quality foster families.
- Many single parent families exist in poverty with minimal support from extended family and lack of resources in the community. Lack of transportation to appointments is an on-going issue.
- Lack of positive enrichment and on-going consistent pro-social activities after school and during the summer for children and youth coming from low income and improvised homes creates risk factors that increase the likelihood that youth will partake in risky behaviors.

- Heightened awareness of human trafficking has increased the need for services among those who have been victims of sexual exploitation.
- Children/youth on the run for various reasons including sexual exploitation, chronic runaways and running from abusive situations have few 'safe house' options. Lack of 'safe house' puts these children/youth at risk of abuse and exploitation.
- Lack of job readiness programs in place prevent youth from having the opportunity to work toward independence.
- Accessibility of educational support including tutoring.

Solutions in Progress

- Ongoing creative efforts to recruit new foster parents while supporting existing foster parents and providing ongoing training and support to keep them engaged, skilled and effective.
- Continue to increase mental health and substance use disorder services and utilizing services such as Therapeutic Behavioral Services, WRAP 163 and food banks.
- Continue to provide mental health services in the field, home, community and school as needed. Providing transportation as needed.
- Utilizing "No Wrong Door." Collaborating efforts with community partners and providing care to families in a centralized location.
- MIST is a multi-disciplinary team, which works to create a comprehensive service delivery system between agencies working with children and families to access resources by eliminating barriers.

Youth Wraparound – Full Service Partnership

Location:
Kern Behavioral Health and Recovery Services
Children's Services
3300 Truxtun Avenue
Bakersfield, CA 93301

Henrietta Weill Child Guidance Clinic
3628 Stockdale Highway
Bakersfield, CA 93309

1430 6th Avenue
Delano, CA 93215

Clinica Sierra Vista
1400 S. Union Avenue, #100
Bakersfield, CA 93307

College Community Services
29325 Kimberlina Road
Wasco, CA 93280

Client's served in 2015/2016: 271
Goal number of clients served in 2016/2017: 300
Anticipated Cost per Client: $5,817.83

Program Description:
Youth Wraparound are Full Service Partnership teams which provides intensive services for youth who are at risk of hospitalization or in frequent need of crisis intervention. The goal of the Youth Wraparound teams are to ensures that youth and families receives the support needed to stabilize the child in their home, reduce crisis and hospitalization and decrease mental health symptoms and high risk behaviors.

In order to ensure that services are readily available the Youth Wraparound Teams are located within the Children's Geographical Providers service areas. Referrals to the Youth Wraparound team come from a variety of sources, including but not limited to self-referrals to geographical providers, the Mobile Evaluation Team, the Psychiatric Evaluation Center, and Bakersfield Behavioral Health Hospital. In order to provide immediacy to families and youth during times of crisis Staff are available after-hours, on weekends and holidays.

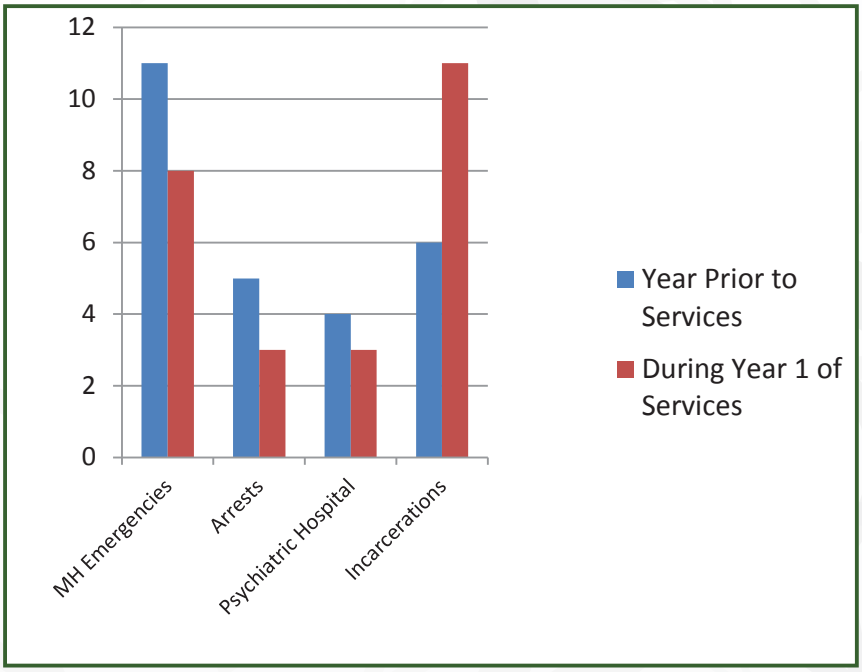
Throughout the county, Youth Wraparound provides intensified treatment services, including but not limited to; individual and family therapy, psychiatric services, with the psychiatrist and therapist, medication management, TBS and other specialized groups such as Anger Replacement Training, Dialectical Behavioral Therapy (DBT), A DBT group for parents of youth in DBT and the Discovering Respect Empowerment Strength Skills (DRESS) Group. Treatment plans for Youth Wraparound services are created in a collaborative treatment team, with the focus on meeting the specific needs of the youth and family. The treatment team involves the client, therapist, recovery specialist, parents/guardians, third-party supports (friends, advocates) as available, and clinicians for specialty services including substance use disorder treatment. Youth Wraparound works with the parents/caretakers and other community partners such as Human Services, and Probation. Parents requiring mental health treatment services may also meet with the Youth Wraparound clinicians as necessary.

Service Goals:

- Ensuring prompt linkage to mental health services.
- Decrease mental health symptoms and high-risk behavior among youth.
- Reduce crises, hospitalization and incarceration.
- Stabilize and maintain children in the least restrictive safe environment.
- Retain children in their homes or as close to a home-like setting as possible.

Program Data:
Data reflects those completing at least one year of services

- Arrests decreased 60 percent; Clients experiencing arrest decreased 33 percent
- Clients experiencing mental health emergencies decreased 31 percent
- All reporting youth showed 'Always, Most or Improved' attendance
- 59 percent of reporting youth showed 'Good, Very Good or Improved' grades
- Clients admitted into psychiatric hospital care decreased 25 percent; the number of days admitted to psychiatric hospital care increased 76 percent
- Homelessness was eliminated during the initial year of services
- Residence in juvenile hall decreased 145 days
- Residence with parents decreased 14 percent
- Client's residing in a Group Home (0-11) increased 40 percent and 33 percent (group homes 12-14), respectively



Making a Difference:

A 17 year old female presented for services at the beginning of the school year in 2014. She was going into her senior year. She had recently started cutting herself, isolating in her room and became very defiant in regards to her family members living in the home. The triggering event was a breakup she was going through with a boyfriend of two years. Client was diagnosed with Major Depressive Disorder. She was informed about Dialectical Behavioral Therapy and asked if she was interested in participating in the program. Client was interested and started going to groups weekly and individual sessions weekly. In addition, she was given a psychiatric evaluation and began taking an antidepressant medication.

Within a very short period of time, this client began to blossom and move forward. She was very skillful, took advantage of the services offered and it was apparent. Her grades rose. She made new friends. She got along better with the people in the house and had the courage to use her skills to improve the relationship with her mother. She completed DBT skill building. She was able to graduate high school on time with good grades. She went on to a private technical institute, which was her dream.

Challenges:

- Continued need for ongoing collaboration within the system of care as well as with community partners to ensure that services are closely coordinated
- A need to identify other no- mental health needs (ie: developmental delays, educational needs, physical health needs) to ensure that comprehensive services are provided and appropriate linkages are completed.
- Engagement of client and families is key successful outcomes. Youth Wraparound teams will need to continue to explore alternative modes of engagement with families.

Solutions in Progress:

- Working with providers to intensify crisis intervention services immediately.
- Exploring transportation options with families, providing bus passes as needed; meeting with clients in their homes and in the community to increase engagement.
- Increase use of warm handoffs to ensure that as youth has successfully completed wraparound services that they are stepped down to the appropriate level of care.

Transitional Age Youth (TAY) – Full Service Partnership

Location:
Kern Behavioral Health and Recovery Services
Children's Services
3300 Truxtun Avenue
Bakersfield, CA 93301

Client's served in 2015/2016: 104
Goal number of clients served in 2016/2017: 200
Anticipated Cost per Client: $14,752.07

Program Description
The Transitional Age Youth (TAY) team is a full service partnership serving young adults aged 16 to 25, providing a full spectrum of services using a client-driven approach. TAY clients receive outpatient treatment services of varying degrees of intensity based on mental health needs. The TAY team is the only team serving this age-specific population in Kern County; as a result, case management services are provided geographically to fit the needs of their clients. TAY provides assessments, psychiatric care and individual therapy, group therapy, counseling for mental health and/or co-occurring disorders, medication management, linkage to community resources including physical health care, housing and pro-social opportunities. The Substance Use Disorder has also recently begun making a Substance Abuse Specialist available to the team for substance use disorder assessments.

The youth entering the TAY program are transitioning from the Children's System of Care, self-referring, or have been referred by the Kern County Department of Human Services, Probation Department, KCMH Access to Care Center, group homes, schools, hospitals or contract providers. The majority of TAY youth reside in apartments, foster care, in group homes, with parents or other family members.

Youth in this transitional age are often reluctant to begin services. Many have had prolonged interaction with social services and other agencies throughout their childhood. Historically, youth turning 18 were no longer eligible for services, and as a result were at a higher risk for becoming homeless, unemployed, incarcerated, addicted and exploited. Services for TAY clients are catered to their developmental needs and interests. As permitted, youth are encouraged to include supportive persons in their treatment plan, including parents and other family members, friends and like supports.

The TAY team works with clients toward recovery and independent living by utilizing the Transition to Independence Process (TIP) treatment model. This evidence-supported model is designed for use with the 14-to-29 age bracket. The TAY team became certified trainers of the TIP model in 2015. As a result, they have been able to train partnering community agencies and contract providers working with clients using consistent practice. TIP is a client-driven approach, focused on working with youth to set and obtain career and educational goals, self-manage behaviors and substance use issues as well as creating and maintaining supportive relationships. Client-based goal development helps further foster trust and self-sufficiency in creating and reaching personal, educational and professional goals. The TIP model operates using five domains: Employment and Career, Educational Opportunities, Living Situation, Personal Effectiveness and wellbeing and Community-Life Functioning. One unique aspect of the TIP model is In-vivo teaching, which coaches youth in learning and applying skills through role play in a variety of settings (i.e. home, school work and community).

Independent living is a pivotal goal for TAY youth. In 2013, Kern Behavioral Health and Recovery Services, with partners Golden Affordable Housing, Inc. and the Housing Authority of Kern began a permanent supportive housing project, the Residences at West Columbus (RWC). The RWC dedicates 20 one-bedroom rent subsidized units for TAY youth or other clients aged 18-25 who have a mental health disorder and are at risk for homelessness. The TAY team provides case management and treatment services are on-site to youth residing at RWC. A contract provider is on site to assist clients with obtaining community resources and to report on any issues that arise at the complex. The Residences at West Columbus features a computer lab, multi-purpose room for group activities, two offices for on-site treatment services and a basketball court. Units are furnished with a sofa, dining set, bedroom set and appliances as most of these youth are unable to afford apartment furnishings. Housing may be provided outside of the designated units for those who exceed the age limit, but a different Section 8 voucher would be obtained.

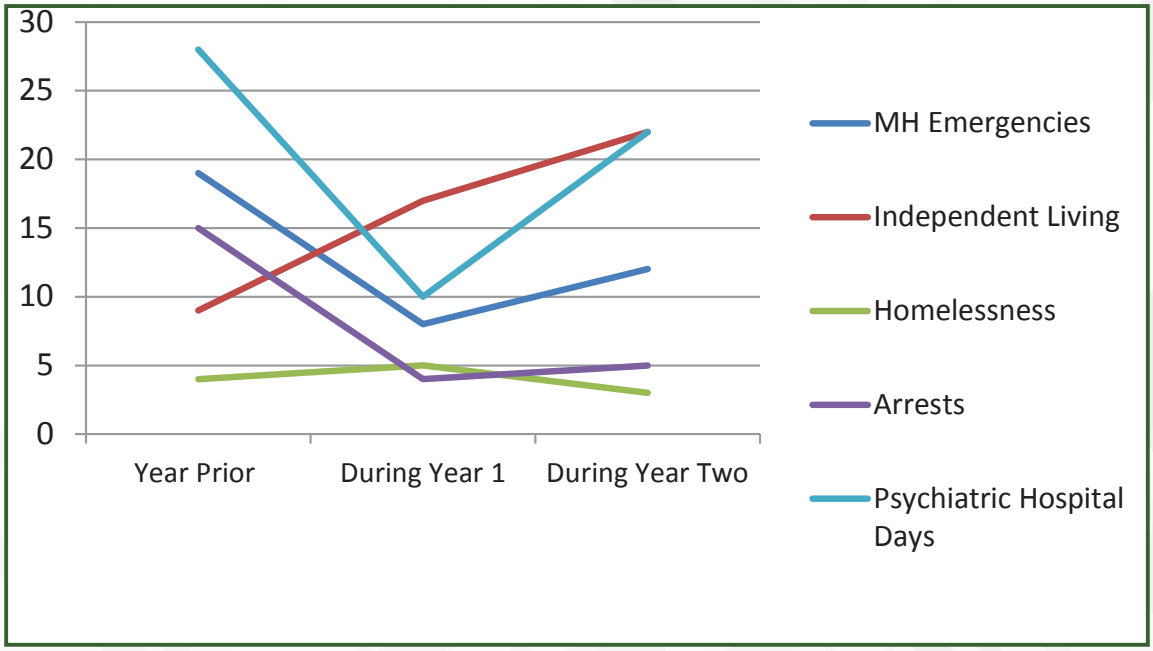
The TAY team relocated offices during the FY 15/16. This provided the team the opportunity to dedicate a new space for their Drop-In Center. Unlike the previous Drop-In Center, the new location will provide an open space for youth who come to relax, do school work, paint or spend time alone. The psychiatrists office will be located within the Drop-In Center.

The Dream Center, created in 2008, is a collaboration of agencies including Kern Behavioral Health and Recovery Services, the Department of Human Services, the Kern County Network for Children, Kern High School District and the Department of Probation. The premise of the Dream Center is to create a positive, pro-social atmosphere for foster youth and transitional foster youth, while providing access to resources. Staff on site work with youth to assist in advocating for needs, ensure appropriate placement if needed and work with youth on educational and vocational goals. Youth visiting the Dream Center can meet with a TAY staff therapist, if needed. They also have access to a computer lab, snacks, hygiene packs and are provided a locker for storage and mail services, if needed. Those seeking AB12 services for extended foster care past age 18 are assisted with the application process. There are pro-social events and activities, and groups such as the LGBTQ group are offered on site. The goal of the Dream Center is to provide a comfortable non-stigmatizing space, rich in resources for youth who needing assistance navigating the foster care system.

Service Goals:

- Decrease incarcerations and arrests
- Improve self-sufficiency, self-efficacy among TAY youth
- Incorporating parent support skill building with partnering agencies and TAY parents
- Decrease mental health symptoms and high-risk behaviors among youth
- Reduce crises and hospitalizations
- Increase financial self-sufficiency of youth, through attainment of educational and vocational goals
- Reduce homelessness and substance abuse among youth
- Eliminate barriers to community services and resources including housing
- Address co-occurring disorders

Program Data:
Data reflects those completing at least two years of services



- During the first year of services:
    - Arrests decreased 67 percent; Clients experiencing arrest decreased 50 percent
    - Clients experiencing mental health emergencies decreased 64 percent; the number of mental health emergencies decreased 58 percent
    - All reporting youth showed 'Always, Most or Improved' attendance
    - 60 percent of reporting youth showed 'Good, Very Good or Improved' grades
    - Clients admitted into psychiatric hospital care decreased 40 percent; the number of days admitted to psychiatric hospital care decreased 72 percent
- Overall results for those completing at least two years of services:
    - 31 percent decrease in residence with parents; 46 percent decrease in group home (12-14) residence; 17 percent decrease in foster residence, non-family
    - Congregate placements doubled; Residence in an apartment alone increased 17 percent
    - Homelessness decreased 25 percent
    - Juvenile Hall residence decreased 67 percent
    - Residential treatment quadrupled
- Forty-three percent of youth discharged in FY 15/16 had met program goals

Making a Difference
When 'Sally' began services with the TAY team, she was transitioning out of a three-year relationship in which drug use and domestic violence were present. She said that she used drugs to cope with pain and block out the dark lifestyle she was living. With no support, Sally faced the challenge of losing her children, due to the choices she was making. After her children were taken out of her care, she felt depressed, overwhelmed, hopeless and a lack of motivation. For two years she was homeless, couch surfing and often spending the night in the park.

Upon being placed with the TAY team, Sally was able to engage and connect with her therapist, who encouraged her to set goals for her future. Sally was motivated, honest, and future oriented as she came to terms with the mental health symptoms and substance use disorder for which she needed treatment. She became determined to achieve her goals, referring often to her therapists motivation, "I'm going to sink or swim." Sally chose to swim without turning back. With her therapists support she received case management and substance use treatment. She set educational and vocational goals for herself. She completed substance use disorder treatment, received her high school diploma, began vocational school and regained housing.

Sally has now been sober for over a year. She has regained custody and secured a home for her children. She is also working toward her career goal of becoming a massage therapist. She says that she is a better mother now that she is aware of her self-worth, life goals and road to recovery, "I know that anything I put my mind to can be conquered. I will continue to make right choices in my life with the support of the TAY team to provide a better future for me and my children."

Challenges:

- The TAY population continues to grow and with those applying for continued foster care through AB12, there are many more referrals of TAY youth requiring services anticipated in the future. TAY is currently receiving approximately 25-30 referrals monthly.
- Clients of TAY can begin services at 16-years-old. But many are not referred until 18, when they are or are nearly emancipated. Beginning services with youth at an earlier age can provide a better chance at engaging them in the treatment process, help them build trust and eliminate barriers once they reach emancipation age.

- The team is currently understaffed to fit client needs. The TIP model traditionally encourages smaller caseloads of 15 or fewer youth clients.
- Homelessness creates a challenge with lack of short-term and long-term housing resources available.

Solutions in Progress:

- The TAY team continues to reach youth in the community and on-site in the office, with 85 percent of work being done in the field. The team will potentially be adding a psychiatrist who will provide services to youth in the community.

WISE (Wellness, Independence and Senior Enrichment) – Full Service Partnership

Locations:
Kern Behavioral Health and Recovery Services – Adult System of Care
5121 Stockdale Highway, Ste. 275
Bakersfield, CA 93309

Client's served in 2015/2016: 78
Goal number of clients served in 2016/2017: 80
Anticipated Cost per Client: $13,726.78

Program Description
The Wellness, Independence and Senior Enrichment (WISE) Full Service Partnership team provides mental health services to the older adult population. Older adults were recognized by stakeholders in 2006 as an un-served or underserved population. WISE Clients experience serious mental illness and require services that are delivered through this "whatever it takes" approach. Many clients of WISE have transitioned from adult (aged 18-59) service teams and require continued mental health care. Referrals to the WISE team will come from mental health teams serving adults, the Volunteer Senior Outreach Program, the Access to Care Center or through the Mobile Evaluation Team. Clients may also be referred from psychiatric or medical hospital settings.

The team is mobile, providing services in the seniors homes, as many lack transportation. This also allows the team members to engage the client where they are most comfortable or natural.

The WISE team includes a geropsychiatrist, therapist, nurse and recovery specialists. Clients are provided evaluation, medication management, therapy, case management and assistance with obtaining resources. The geropsychiatrist may also evaluate and provide integrated care when symptoms are present, offering referrals for physical health care as needed. Team members have received specialized training in working with the older adult population. There is often a strong need among seniors to retain independence; this can often lead to resistance in acceptance of mental illness requiring treatment. The team provides individual rehabilitation, skill building and uses therapy including the evidence-based practices: Cognitive Behavioral Therapy (CBT), Experimental Dynamic Therapy (EDP) and Problem Solving Therapy (PST). Clients are also screened for neurocognitive impairment, which can occur with age and may increase the chances of progression into dementia.

The WISE team also assists clients who are in need of help accessing resources. Many of those served are coming to an age to receive Social Security, and require help through the sometimes cumbersome application process. Team members may also help to secure housing. Fixed incomes and availability can have an effect on the type of housing seniors obtain. Many cannot afford retirement homes, and room and board facilities often have long wait lists.

Maintaining or gaining independence is a primary goal for seniors in treatment. As such, WISE works with clients to incorporate activities designed to engage clients with the community. Seniors may attend classes at the Community Family Learning center or visit Community Centers or Senior Centers and will also visit the Mercy Hospital Art and Spirituality Center.

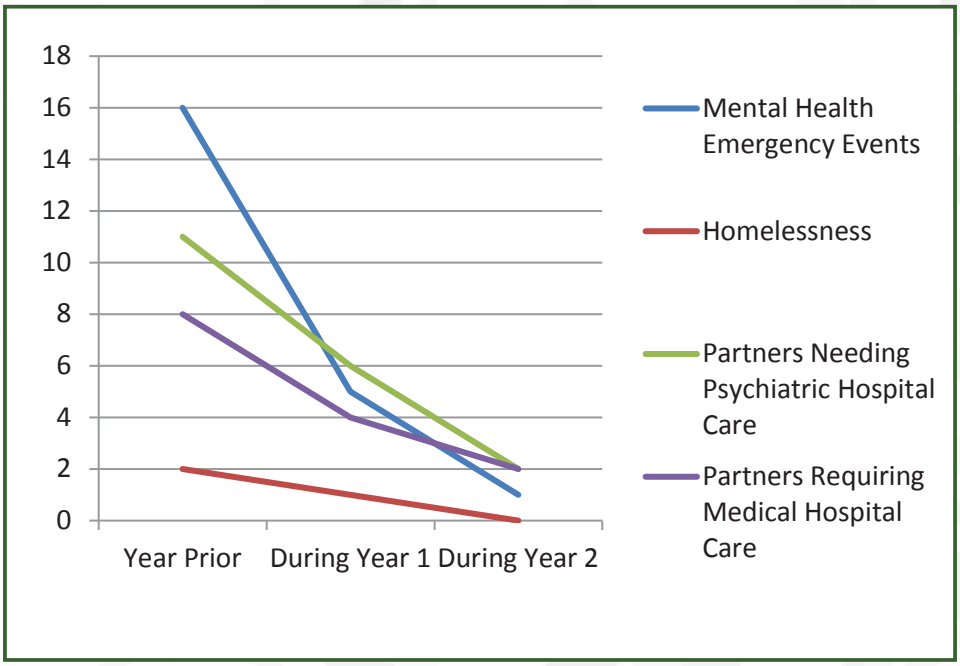
Volunteers through the Volunteer Senior Outreach Program also work to engage seniors in their home setting, and assist them with maintaining connected to the community through activities which foster independence and incorporate meaningful activity. Volunteers are provided training for their role including: Psychology of Aging, Case Linkage and ASIST Suicide Prevention Training.

Service Goals

- Help seniors establish a sense of belonging while incorporating meaningful activities
- Reduce crisis incidents and hospitalization
- Increase outreach and treatment for underserved populations
- Continue to eliminate barriers to community resources

Program Data
Data provided is based on those who completed at least two years of services. Clients in this data set did not experience arrest or incarceration.

- During first year of services:



  - Clients experiencing mental health emergencies decreased 69 percent; mental health emergency events decreased 69 percent
  - Homelessness decreased 50 percent and was subsequently eliminated during the second year of services
  - State Psychiatric residence and long-term care were all eliminated within the first year of receiving services
  - Clients requiring psychiatric hospital care decreased 40 percent
- Overall data for two years of services:
  - Medical hospital residence decreased 75 percent
  - 82 percent fewer clients required psychiatric hospital care; 91 percent fewer days were spent in psychiatric hospital care
  - During the second year of services those experiencing mental health emergencies decreased 93 percent; the number of emergency events decreased 96 percent
  - Clients experienced an 5 percent decrease in residence in an apartment alone; Community care residence increased 17 percent; Congregate placement decreased 25 percent; Residence with other family decreased 60 percent
- Discharge reports indicate that 53 percent of those discharged in FY 2015/2016 met program goals.

Making a Difference

'Joy' moved to California having lived her entire life in another state. The decision was based on the desire to live closer to her son and grandchildren. Shortly after her move, family troubles ensued and she soon found herself living in a new place with no friends, family or source of support. She was devastated, hopeless and began to believe there was little future for her. She questioned whether she should continue living.

Through her despair she found the courage to seek help. Joy began services with the WISE team and soon began implementing coping skills she was taught. She also attended social groups and outings and engaged in therapy sessions where she shared her personal struggles and triumphs; including the ability to manage difficult emotions and improve interpersonal relationships.

Joy reunited with her family and reported that she is a better mother and grandmother. She has completed a year of services and currently lives in her own apartment, is an active member of her church and volunteers with multiple agencies, including the VSOP program with Kern Behavioral Health and Recovery Services, where she is able to share her own story, proving recovery is possible.

Challenges

- Clients may be reluctant to transition to a lower level of care when intensified services are no longer necessary.
- Uninsured clients may have a greater struggle with maintaining secure housing.

Solutions in Progress

- WISE receives annual training to provide information on holistic methods to address symptoms including pain and depression.
- WISE collaborates with Kern County Aging and Adult Services to connect those clients who may be at risk or need continued support.
- Team members attend multi-disciplinary meetings to stay abreast of those who may need services and advice on how to work with older adult clients.

Access to Care Center - Access and Assessment Team – System Development

Location:
Kern Behavioral Health and Recovery Services Services
Mary K. Shell Building
2151 College Avenue
Bakersfield, CA 93305

Clients Served in 2015/2016: 4248
Goal number of clients to be served in 2016/2017: 4250
Anticipated Cost per Client: $542.75

Program Description
The Access to Care Center acts as an entry point for those who need screening and assessment after experiencing mental health related symptoms. The majority of clients entering the Center self-refer as walk-ins, or are brought in by family members. At the time of screening or assessment, clients meet with a Therapist, Recovery Specialist and/or third-party supports, including family members, friends, etc., as permitted. Any previous mental health history, if applicable, is reviewed during the assessment process.

The clinician works with the client and supports closely to determine, by their symptoms and history, whether and to what degree mental health care may be needed. Urgent and emergent assessments may be conducted with clients who have experienced acute crisis or are at risk for a crisis event. These clients are met as soon as possible but no later than within two business days; any needed services are provided in the interim. Based on mental health care needs identified in the assessment, the client will be referred for specialty or non-specialty services. Specialty mental health care is offered to those with severe impairment who require more intense mental health care, meaning more frequent interventions and other services. Should the client not require specialty mental health care, they are referred to a non-specialty team, community based provider or their primary care provider.

Clients presenting with co-occurring mental health and substance use disorder symptoms may be assessed for treatment by a Substance Use Specialist assigned from the Substance Use Disorders System of Care to work within the Access to Care Center. Clients with co-occurring disorders would be referred to a team providing dual-recovery (mental health and substance use disorder) services.

Clients experiencing suicidal or homicidal feelings, or who have attempted suicide or homicide are provided immediate Harm Reduction Therapy (HaRT) Program services. This program uses the Cognitive Behavioral Therapy (CBT) designed for short-term, immediate use to reduce suicidal ideation. When referred to continuing outpatient services, the therapist providing HaRT will collaborate with the primary treatment team to incorporate interventions to be used as necessary in conjunction with the treatment plan.

The team has six staff certified to provide referral for involuntary psychiatric detainment. Involuntary psychiatric detainment is used only when the client presents as a danger to themselves or others or are gravely disabled due to mental illness. This detention period allows clinicians within the PEC/CSU time to provide psychiatric evaluation and stabilize symptoms. Clients may be released at any point during the 72-hour period if symptoms are found to be non-emergent.

Located in the same building, the PEC/CSU provides services to those experiencing a mental health emergency or mental health crisis. Mental health emergencies are identified as life threatening situations including suicide attempt, homicidal behavior or threats, self-injury requiring medical attention, severe alcohol and/or other drug impairment or showing highly erratic or unusual behavior possibly leading to an inability to care for oneself. Mental health crisis is serious, but non-life threatening. Examples of a mental health crisis include making threats to harm self or others, other erratic and unusual behavior, self-injury not requiring immediate medical attention and emotional distress including severe depression or anxiety. After completing involuntary psychiatric detainment within the PEC/CSU, clients may be referred to the Access to Care Center for a screening and assessment.

On site classes and groups are offered free of charge for those who are in the interim period between screening and assessment to encourage continued engagement and shorten the duration of untreated mental illness. Clinicians facilitate groups including; Depression Group, Attempters Recovery and Mentor Support (ARMS) for those who have attempted suicide, Anger Management and Conflict Resolution. Also recently added was an Emotional Regulation and Assertive Communication (ERAC) class, designed by clinical staff.

During the 2015-2016 year, Access to Care was able to add an additional 61 assessment appointment slots to their schedule, shortening the duration of untreated mental illness. Wait times for those being screened has decreased and maintained an average below 30 minutes. Those utilizing Access Center services had been waiting 90-120 minutes in previous years.

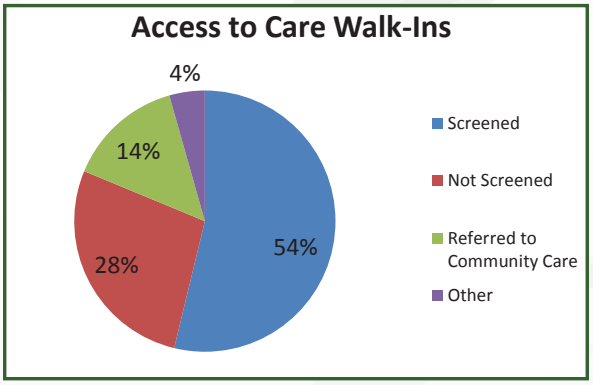
To address the needs of clients who may require crisis intervention, access and linkage to mental health care in the underserved East Kern County desert area, Kern Behavioral Health and Recovery Services opened a Crisis Stabilization Unit in Ridgecrest, the most populace East Kern city.

Service Goals

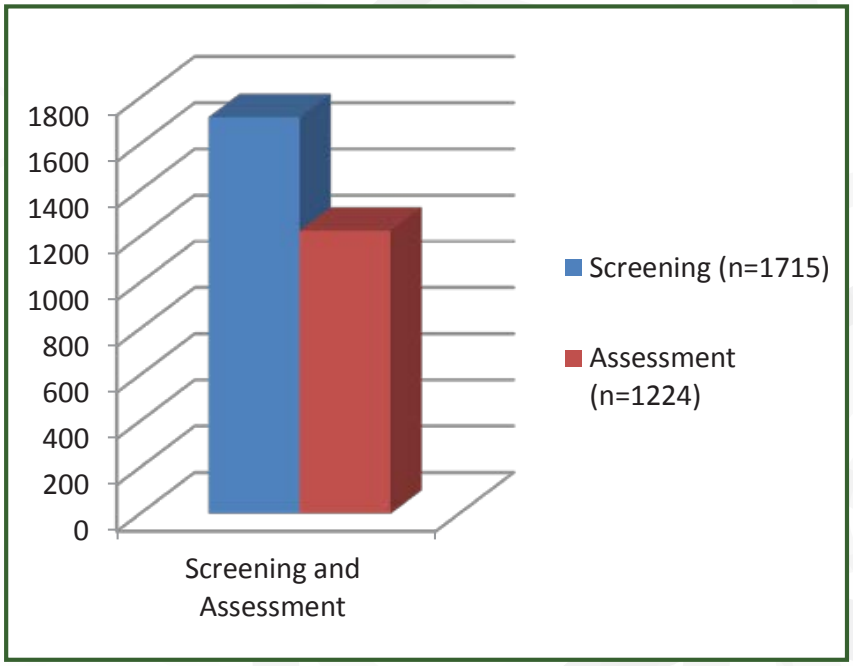
- Ensure each individual finds services to be easily accessible.
- Provide emergent, urgent, priority and routine assessments to individuals in acute crisis within 24 hours – 10 business days and connect them with interim services as necessary.
- Complete a culturally sensitive mental health assessment, in the preferred language of the client.
- Identify consumers in need of specialty mental health services and link to the appropriate service provider within seven business days of assessment.
- Reduce interim period between assessment and first team service to reduce the duration of untreated mental illness.
- Schedule first team service appointments within 14 days of the initial contact with mental health services for those requiring outpatient specialty mental health services.
- Link individuals who are in need of non-specialty mental health services with a community provider and/or with the Care Coordination Unit within 10 business days.
- Simplify the assessment forms to help make the process more efficient while eliminated unnecessary redundancy.
- Reduce individual's problematic symptoms and behaviors.
- Prevent hospitalization through access to outpatient services.
- Increase social contacts and professional and collaborative community interactions.
- Satisfaction with treatment services.
- Increase linkage and facilitate coordination of outpatient and community resources.
- Reduce no show rates for assessment appointments.

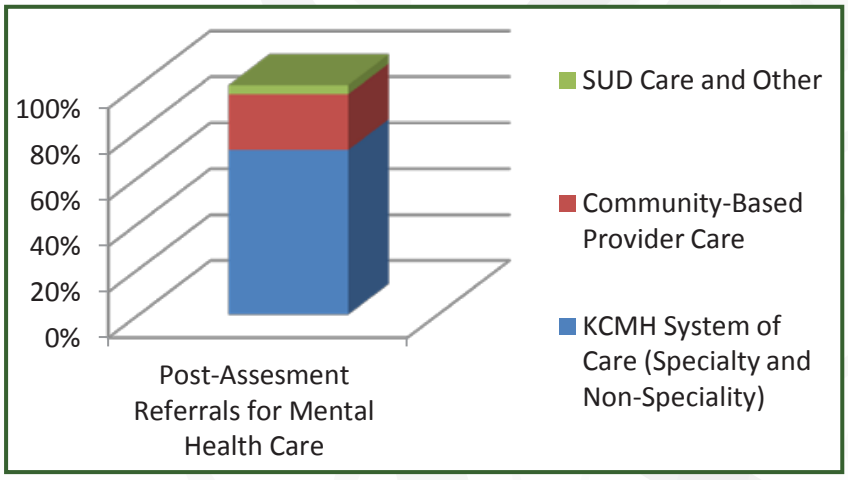
Program Data

Due to a system virus, the System of Care network server lost several months of data for the Access to Care team. Data for May 2016 was unable to be salvaged across most measured data points. Screening data for July and August 2015 and May 2016 was also unable to be recovered. Due to the data loss, numbers for Access to Care service totals are not fully reflected. Data is based on recovered information.



Access to Care Center total walk-ins = 3,034
Total Screenings = 1715
Total referred for community-based mental health care: 268
Total not requiring screening or referred directly for assessment = 876
Total 'Other' services (i.e. Requests for Directions, appointment scheduling, System of Care inquiries, etc.) = 140





Of those served, 53 were better served in a language other than English (1.8 percent). Fourteen individuals were referred to the Children's System of Care for screening and referral services (0.04 percent).

Making a Difference
'Betty' came into the Mary K. Shell building disorganized, unaware of how she arrived or from where she came. After spending time with Betty, she reported that she left Utah with her boyfriend, who dropped her off at the Greyhound bus station.

Due to the bizarre behavior she exhibited, law enforcement was contacted and they delivered her to the Mary K. Shell Center. Betty arrived with no money, minimal clothing and wore a pair of flip-flops. Her screener contacted several Sober Living Environment's and Room and Board facilities, but without income, there was no availability. When asked about her families, she reported that she had a mother and father in Utah. After obtaining a release of information to contact the parents, the screener made contact with Betty's father, who stated that he had been worried and looking for her.

The screener contacted the local Greyhound and got the ticket prices for a ticket that would take Betty back to Utah. Since she did not have identification, the local Greyhound employee asked that when her father bought the ticket, that he provide a code for her to obtain the ticket. The screener was able to coordinate Betty's departure and arrival between Bakersfield and Utah. Betty was also provided with tennis shoes and a sweater. Betty was given a food basket and snacks to take with her on her trip home. Within a few days, Betty's father contacted the screener to thank them for the service and effort provided in having Betty returned home safely.

Challenges

- Continually reducing the time needed to transition the client between assessment and orientation with treatment provider.
- No show rates for scheduled assessments are high and affect timely access to an assessment.
- Lack of transportation for clients shows a direct correlation with the number of no show events.
- Longer wait times for scheduled appointments increase no show rate and impact timely access to service.
- Warm hand-offs when transitioning clients between teams and/or systems of care.
- Outreach and education is needed to better inform the community at large of the Access to Care services available through both the Access Center and Assessment Center, as well as services offered throughout Kern County.
- Facility signage is ill placed and can deter potential clients from going to the appropriate office.
- There is not currently a sobering station or detox center on site for those suffering from alcohol and other drug intoxication.
- There has been a need for interpretation for potential clients presenting who communicate through American Sign Language.
- Successful engagement and smooth transitioning clients between levels of mental health care minimizes crisis episodes.
- The current screening tool is long and asks many of the same questions presented in the assessment form.
- Lack of access to mental health emergency services in outlying or rural areas.

Solutions in Progress

- Screeners identify individuals who may be able to fill no show slots on an on-call basis. A call back list has been in operation as a means of trying to bring clients awaiting assessment in earlier when the opportunity allows.
- No show appointment slots are also filled with clients seen directly from crisis services including those from the PEC/CSU and Mobile Evaluation Team (MET).
- Clinicians have increased booking slots to address high no show rates.
- Interim services are offered that include free group classes and the HaRT program.
- The team plans to do more outreach and education in the community to provide information on Access to Care services. They will include information on geographic service providers throughout the county.
- Screeners will work to create a tool that gathers critical information, but is not redundant with information gathered during the assessment process.
- Peer Navigators provide interim services and warm handoffs to specialty mental health providers.
- The recently introduced Med Clinic speeds access to emergency psychiatric appointments for medication evaluation and management, both for clients of Access and Assessment and for clients of outpatient teams/providers.
- During FY 2016/2017, Access and Assessment will be expanded in East Kern County with the opening of the

Ridgecrest Crisis Stabilization Unit (CSU). The Ridgecrest CSU will provide access to and capacity for community-based mental health care and crisis intervention services which offer alternatives to hospitalization and incarceration by providing access and linkage to mental health care.

Access to Care - Crisis Hotline – System Development

Location:
Kern Behavioral Health and Recovery Services Services
2525 North Chester Avenue
Bakersfield, CA 93308

Clients Served in 2015/2016: 23,670
Goal number of clients served in 2016/2017: 25,000
Anticipated Cost per Client: $37.47

Program Description
The Kern Behavioral Health and Recovery Services Crisis Hotline began in 2006 and has, since its inception, expanded to become a resource center, stigma and discrimination reduction program and suicide prevention program.

Prior to the start of the Crisis Hotline, stakeholders reported access issues when referred directly to the Crisis Stabilization Unit, rather than being provided crisis interventions via telephone. Callers actually called and talked to someone in the Crisis unit but the unit was very busy and staff weren't able to effectively serve caller. CSU/PEC staff continued to answer calls after 11pm until the Hotline became a 24/7 team. The Hotline team started in 2006 with paid permanent and extra-help staff. The volunteer program began in 2010.Volunteers continue to be an essential piece of the Crisis Hotline team. Some remain short term while many have been longer-term over the years. Some members of the permanent and extra help staff began as volunteers. Many Hotline volunteers have become employees in different divisions of Kern Behavioral Health and Recovery Services The Hotline was, and continues to be dedicated to providing; crisis intervention, suicide risk assessment and intervention, referrals for services, information about community based resources, problem solving and coping skills, mental health and substance use disorder related support and referral and outreach and education.

The Kern Behavioral Health and Recovery Services Crisis Hotline is accredited through the American Association of Suicidology and just received a 5 year re-accreditation and is also part of the National Suicide Prevention Lifeline (NSPL). As such, they accept Lifeline calls from around the world. During the 2015/2016 year, Crisis Hotline staff and volunteers answered 6,953 NSPL calls. In 2014, the team began the Suicide Prevention Advisory Council (SPARC). As such, they engage the community through Facebook and publish a bi-monthly newsletter aimed at educating and de-stigmatizing mental health and suicide prevention.

Outreach and education is provided within the system of care and to the public through Question, Persuade, Refer (QPR) trainings. The training is required for non-direct service staff of the System of Care and offered to the public as an educational piece designed as a suicide prevention and stigma reduction tool. The QPR training provides education on how to recognize the warning signs of suicide, to persuade and refer one to seek help. A total of 381 individuals were provided QPR training in 17 classes offered throughout FY 2015/2016. The team, with other mental health staff, also provides Applied Suicide Intervention Skills Training (ASIST) to direct staff, and community members which is refreshed every two years. The ASIST training is essentially a suicide first aid designed to help individuals learn to intervene and help prevent suicide. Additionally, the Crisis Hotline team provided outreach at 128 community events with 7087 attendees, 1,637 of which were identified as members of underserved populations.

As a community support, the Survivor Outreach Team (SOT) was created. This prevention/postvention program, modeled after the Active Postvention Model, created to help survivors of suicide loss through the grief process. The SOT consists of one staff member and volunteers who work directly with the Kern County Coroner and is called when a suicide within the county occurs. After a referral is received, the SOT contacts the family, and if allowed, will engage and assist with normalizing grief, reduce trauma and provide comfort and resources. During 2015/2016, SOT received 45 referrals, met with 18 families and served 366 persons through their Survivors of Suicide support group. Hotline staff developed and wrote a manual, in conjunction with the California Suicide Prevention Network (CalMHSA) on how to start a Survivor Outreach Team that has been placed on the Suicide Prevention Resource Center as a Best practice and presented at the American association of Suicidology Conference in 2015. To date, there have been over 75 requests for the manual.

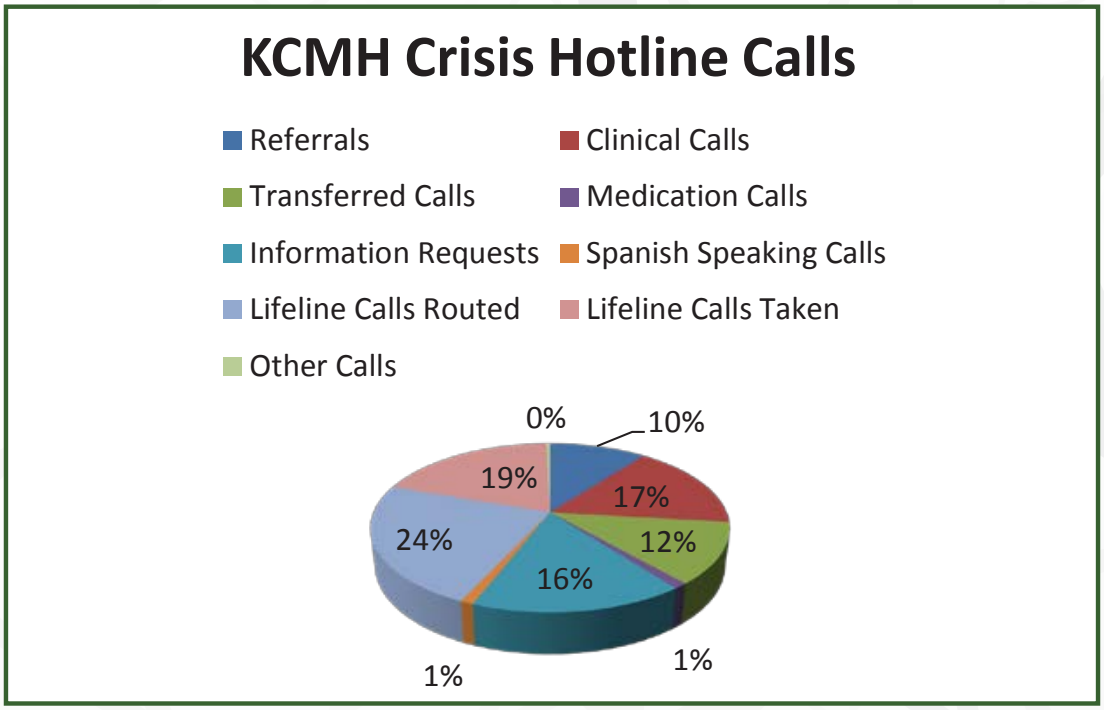
The Crisis Hotline team also began sending "Caring Notes" as part of their Inpatient Follow-up efforts. Inpatient Follow-up began after staff attended an American Association of Suicidology Conference. It was learned that many suicide occur after patients leave an in-patient facility. The team organized an effort to reach out to those served upon exiting hospital care for follow-up. Three attempts are made to contact and "Caring Notes" are sent to the patient. During follow-up, team members ensure that the client's transition to home is smooth, checking to see if they are making necessary appointments and remaining responsible with medications. Crisis Hotline staff also link clients to necessary resources to meet basic needs. Clients are also provided Crisis Hotline information, should they need to talk.

Service Goals

- Offer telephone-based counseling, crisis intervention and information and referral services
- Provide a 24/7 support alternative to crisis stabilization or emergency medical/law enforcement services when possible
- Increase access to care for individuals in Kern County communities
- Increase follow-up with callers to encourage engagement in mental health services

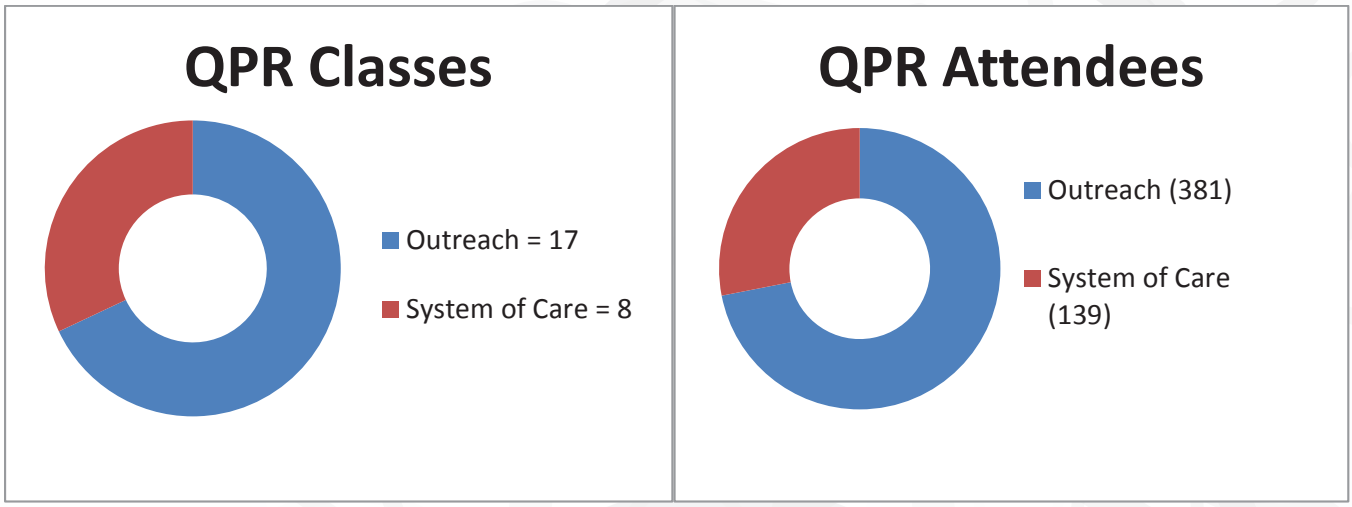
Program Data
Total Calls: 25,749
Referral Calls: 3,760
Clinical Calls: 5,931
Transferred Calls: 4,271
Medication Calls: 388
Information Requests: 5,881
Spanish calls: 356

Lifeline Calls:
Taken: 6,953
Routed: 8,454



Survivor Outreach Team Info:
Referrals: 45
Visits to families: 18
Survivors of Suicide Group Attendance: 332

Question, Persuade, Refer (QPR) Training:



Total Outreach Events: 128
Total Attendees: 7,087
Community Events: 50
Attendees: 3,322
Underserved population(s): 1,637

Making a Difference

A caller phoned the Crisis Hotline, wanting to thank Kern Behavioral Health and Recovery Services's staff for being a support to her daughter. She said during the call that her daughter felt that the Hotline was just like her family, because she depended greatly on the support she found. Daily she would call the Hotline to check in; it had become an important part of her life. The client phoned the Crisis Hotline the night before she decided to die by suicide. Her first call into the Crisis Hotline was at least nine years prior, when calls were routed to the Crisis Stabilization Unit. As time went by, it appeared the conversations, which had begun with recounting the substances used and consequences when intoxicated, had shifted to treatment, sobriety and finding peace with her past. There were times when the client would call twice, three times daily. She never indicated that she was going to die by suicide. The Crisis Hotline staff use this lesson to remember to always be welcoming, caring and compassionate, always taking a moment to ensure that all is said and done to prevent another death by suicide.

Challenges

- Half of staff are extra help (temporary), leaving personnel gaps throughout the year, creating greater turnover
- Prank phone calls can diminish morale, causing staff burnout

Solutions in Progress

- Peers monitor each other; volunteers monitor staff and vice versa to keep track of progress and how well staff remains engaged. The goal is to maintain a safe, caring environment.

Adult Wraparound – System Development

Location:
Kern Behavioral Health and Recovery Services Services
Kern Linkage Program Office
2525 N. Chester Avenue
Bakersfield, CA 93308

Clients Served in 2015/2016:
Adult Wraparound Core Team: 68
Dialectical Behavioral Therapy: 64

Goal number of clients served in 2016/2017:
Adult Wraparound Core Team: 42
Dialectical Behavioral Therapy: 70

Anticipated Cost per Client: $24,636.78

Program Description
Adult Wraparound Core Team
Adult Wraparound services are provided through two different programs which offer intensive mental health services for adults referred upon exiting psychiatric care in hospitals or who require additional services to intervene with behaviors that prevent the client from succeeding in treatment.

The Adult Wraparound Core Team (AWA) is a subset of the KCMH Crisis Case Management Outreach team (CCMO). This core team works with adults who are referred for additional intensive services beyond outpatient treatment offered through the primary mental health team; or those who have not entered the Mental Health System of Care. These services include meeting with the client frequently throughout the week and providing additional supports such as locating and obtaining housing, attending groups or appointments, etc. Other necessary interventions may be implemented by AWA staff and the referring case manager.

If a referred client is receiving inpatient services in a hospital, the Adult Wraparound Team can assist in discharge planning to prepare them for future outpatient services. Upon discharge, the AWA team member would work with the client, providing intensive outpatient treatment services. If the client has never been open to the system of care, they would be referred to a KCMH System of Care team or geographic service provider. For those with an existing treatment provider and active treatment plan, the Adult Wraparound services augment services in progress.

Adult Wraparound provides services for approximately four-to-six weeks, up to eight weeks if necessary. Wellness Recovery Action Plan (WRAP), an evidence-based recovery system is utilized and is based on the client's self-determination to reach and maintain mental health wellness. The system is utilized with four goals; decrease and prevent troubling behaviors or feelings, increase personal empowerment, improve quality of life and achieve personal goals. Using the WRAP process, the client is able to exercise control in developing long-term recovery goals and begin the implementation process while receiving intensified services with the AWA team.

Outside of treatment-specific interventions, AWA will assist with those who may have issues with medication compliance, housing, attending sessions, groups or primary care doctor appointments and encourage substance use treatment for those with co-occurring disorders. Adult Wraparound staff has also provided transportation for clients who attend Dual-Recovery Anonymous, Alcoholics Anonymous and Narcotics Anonymous meetings. While providing interventions, a goal of the AWA staff is to ensure that there is no disruption in the client's treatment plan, or the trust that has been built with the primary treatment team and case manager. Adult Wraparound team members will communicate regularly with the primary team case manager, encouraging frequent visits with the client. The primary team may also be involved in the coordination of the client's WRAP, helping to encourage the client's goals and overall wellness. The AWA team has recently held services due to staffing and is anticipated to begin ancillary services again in FY 2016/2017.

Dialectical Behavioral Therapy Team (DBT Core Team)
The Dialectical Behavioral Therapy (DBT) Team program is a highly intensive 12-18 month program, using the DBT treatment model, traditionally offered to those diagnosed with Borderline Personality Disorder (BPD). Those referred have been diagnosed or exhibit behaviors reflective of those suffering from BPD. Clients, most of who are diagnosed with Borderline

Personality Disorder, tend to experience a higher likelihood of attempted suicides or self-harm, intense emotional responses and often times suffer from co-occurring or co-morbid disorders, including substance use or physical health issues.

The DBT core team accepts referrals from all Adult System of Care teams referring clients for the DBT program. The program is ancillary, providing services in addition to the primary treatment team and plan. Services are provided on-site, rather than in the community, and clients are accountable for attendance. The team also provides coaching within the department for those providing DBT skills with clients and, when necessary, works with the Youth DBT team. Outreach and education provided by the DBT Core Team centers on eliminating stigma associated with the borderline personality disorder diagnosis both in the community and within the clinical teams.

Clients entering the program are informed of the service plan and complete a period of pre-commitment, prior to signing the agreement for services. Like a traditional DBT program, the team provides weekly group DBT skills and individual rehabilitation sessions. A 24-hour DBT coach phone line is incorporated into the treatment model to act as a preventative measure when clients are tempted to self-harm or other potential crisis situations arise. Group and individual sessions focus on four main skills; mindfulness, distress tolerance, interpersonal effectiveness and emotion regulation. Treatment targets include working to address life-threatening, therapy-interfering and quality of life behaviors as well as acquiring skills needed to achieving goals.

As part of the comprehensive program, the DBT Core Team meets with a therapist consultation team, intended act as therapy for the clinicians. This is a standard of practice within DBT. Other modes of practice include the DBT Core Team reviewing fellow team member session recordings to ensure fidelity to the model is preserved. The team also requests client feedback through a Client Satisfaction Survey, with data collected quarterly.

After successful completion of the DBT program, clients are encouraged to develop and practice hobbies that continue to enrich their lives. The DBT Core Team also provides an Alumni Group, designed for clients who have completed, but can still benefit from use of DBT skills.

Service Goals:

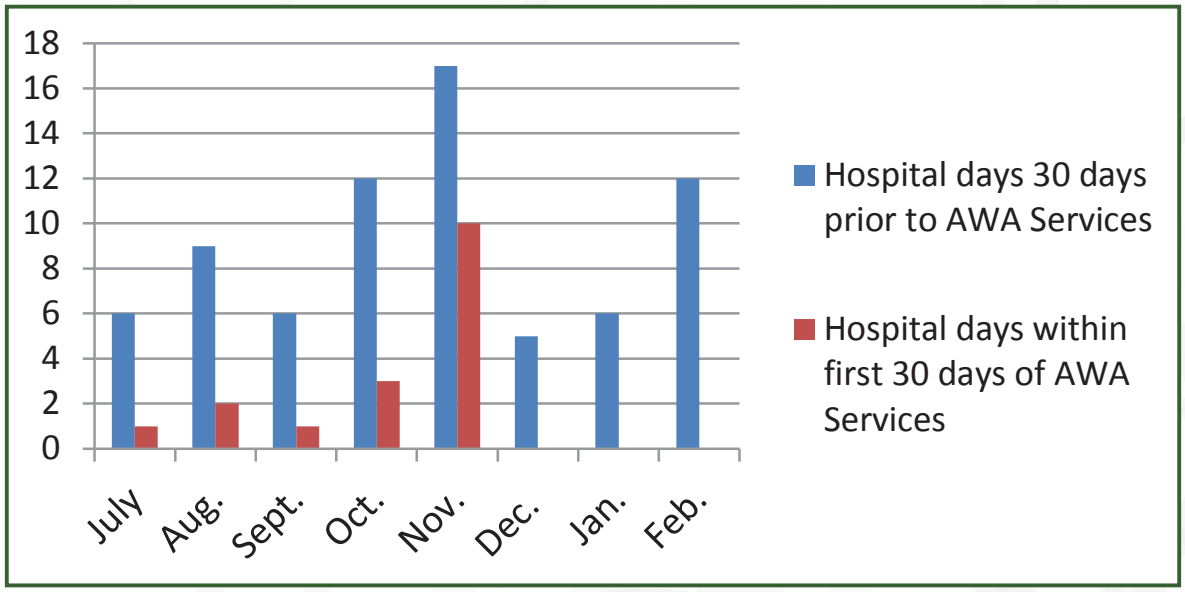
- Reduce or prevent hospitalization
- To reduce symptomology related with mental illness
- To assist clients in accessing necessary mental health and substance use services as well as utilizing community resources

Making a Difference

'Marie' suffered from a history of unstable relationships, severe depression and substance use, was engaged for services while in the hospital, due to a suicide attempt. Members of the Adult Wraparound Core Team began building a rapport with Marie, who agreed to begin outpatient treatment services upon discharge. The Adult Wraparound team secured housing and made an appointment with both a therapist and psychiatrist for Marie to begin her evaluation and medication management. During transition to her outpatient mental health team, she was provided access to her therapist, recovery specialist/case manager, substance abuse specialist and necessary community resources.

Marie was able to begin building coping skills, manage her mental health symptoms and build personal relationships. Through the process she was able to learn to identify any triggers associated with her previous substance use. She developed and began working toward several goals including education, housing and treatment goals toward recovery and maintaining sobriety. She said that upon transitioning to her treatment team, she felt that her depression was manageable and she had regained hope for the future and her ability to maintain stable and work toward recovery.

Program Data
Adult Wraparound Core Team:



- The Adult Wraparound Core Team opened 68 clients in FY 2015/2016
- Kern Behavioral Health and Recovery Services Teams served primarily included North Bakersfield RAWC, Southeast Bakersfield RAWC and West Bakersfield RAWC
- Of those clients who with psychiatric hospital care 30 days prior to beginning services; 83 percent did not require psychiatric hospital care within 30 days of completing services
- Approximately 77 percent of clients served showed improved MORS (Milestones of Recovery Scale) scores at completing of Adult Wraparound services
- 85 percent of those served had acquired stable housing within 30 days of completing services

DBT Core Team:

- Number of Clients Served in FY15/16: 64
- Race/Ethnicity: 80 % Non-Hispanic White; 20 % Hispanic
- Sex/Gender: 85% Female; 15% Male
- Crisis utilization post-DBT treatment was reduced 54 percent
- Client participation satisfaction rating remained high at 93 percent
- Graduation rates decreased 13 percent

Challenges
Adult Wraparound Core Team

- Quality and availability of housing. Housing resources in the community are limited, and the quality of available housing can be subpar
- Meeting the staffing needs for optimal servicing of the program

DBT Core Team

- Since DBT Core Team services are provided in the office, staff does often have the opportunity to engage the community. A primary functions of the DBT team to provide community outreach and education.
    - While traditionally the DBT Core Team does not add personnel, upon recommendation and approval of supervisor and administrator, KCMH team members can become DBT Consultation team members.

Solutions in Progress

Adult Wraparound Core Team

- Adult Wraparound continues to work with treatment teams in the system of care to promote its use with individuals who could benefit from services
- To address the challenge of meeting staffing needs, Adult Wraparound Core team continues to search for new hires to maintain optimal staffing to meet client needs

DBT Core Team

- DBT Core team continues to make every effort to increase exposure of available services within the System of Care. This is done through attendance at team meetings, providing education on services available and streamlining the referral process. During the FY 2015/2016 the team has seen an increase in referrals for program clients.
- DBT Core Team members recently had the opportunity to provide psychoeducation and DBT skills based education for staff of a local room and board facility. This effort was made to improve the quality of care for clients as well as assist with housing retention for clients.
- The team is currently recruiting for DBT Consultation Team members to assist with expanding the quantity of DBT services and allow for further engagement, system and community training.

Recovery and Wellness Centers (RAWC) – System Development

Clients Served in 2015/2016:
Stockdale RAWC: 419
North Bakersfield RAWC: 352
Southeast Bakersfield RAWC: 530
West Bakersfield RAWC: 419

Goal number of clients served in 2016/2017:
Stockdale RAWC: 375
North Bakersfield RAWC: 375
Southeast Bakersfield RAWC: 450
West Bakersfield RAWC: 390

Anticipated Cost per Client: $4,514.88

Program Description
The Recovery and Wellness Centers (RAWC) share a common goal of delivering client-driven mental health care focused on recovery goals set by the client. Team members and peer specialists work with clients to create a Wellness and Recovery Action Plan (WRAP), a self-management and recovery system focused on improving quality of life based on the clients personal recovery goals. Recovery and Wellness Center teams are located throughout metropolitan Bakersfield and provide care to those with both specialty and non-specialty mental health needs. Southeast, North and West RAWC teams traditionally provide care to those who have either stepped down from intensified Level 4 services with the ACT team, or have a need for more intensified services from non-specialty care teams, including the Stockdale RAWC. Some referrals will come from the Crisis Case Management Outreach Team for those exiting the psychiatric hospital setting. Client's may also be referred from the Access to Care Center. Common modalities utilized in treatment with RAWC teams include: Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT) skills, Motivational Interviewing and Solution Focused Brief Therapy.

RAWC teams provide similar services including peer support, primary health care linkage, medication management, linkage to community resources and individual therapy with some variation based on needs of the client population. Peer specialists assist each of the RAWC teams to work with clients in building confidence while acquiring skills associated with activities of daily living (ADL). Incorporation of meaningful activities is another primary goal of the RAWC teams in working with clients toward recovery. Clients are encouraged to attend group classes and recreational activities at the peer-run Consumer Family Learning Center (CFLC). Incorporating peers into the recovery-focused setting provides an opportunity to show wellness and recovery in action. For clients experiencing co-occurring mental health and substance use disorders, peer-run Dual Recovery Anonymous groups are made available.

Transitioning clients to non-specialty community-based mental health care or medication management is a universal goal of the RAWC teams. Upon successful program completion, clients are provided referrals for medication management with a primary care provider or psychiatric care for those with more complex medication needs.

As clients reach the point in recovery where they are ready to begin seeking employment, they are referred to Vocational Services programs, which assist with learning interview skills, resume writing, job searching, etc. Clients may be referred to Vocational Services through the Department of Rehabilitation.

West RAWC and Stockdale RAWC
Kern Behavioral Health and Recovery Services
Adult System of Care Building
5121 Stockdale Highway
Bakersfield, CA 93309

Stockdale RAWC
The Stockdale RAWC provides non-specialty services with the goal of transitioning clients to community-based care within six months. The majority of services are provided in the office and include case management, medication management and individual therapy. The primary treatment modality is Brief Intervention. A nursing assessment is also completed to identify any physical health concerns which may need to be addressed. Once service goals are met, clients are transitioned

to community providers, who assist with medication management and interventions as necessary. Ideally, clients who meet service goals from higher level RAWC and other service teams would transition into the Stockdale RAWC or other non-specialty care.

Developing supports and incorporating social engagement and meaningful activity into recovery goals is a priority; SET team peer specialists often introduce clients to the CFLC to assist with incorporating classes into their weekly schedule. This provides client's an opportunity to build skills, and develop a support system of peers with lived experience. Other peer guided activities may include navigating the public transportation system and self-advocacy with medical appointments.

West RAWC

Upon referral to the West RAWC team, orientation with a therapist will be scheduled, at which time the treatment plan is determined the client is connected with case management services. Case management linkage is provided as soon as possible to begin the engagement process with clients to determine any needs and to determine the client's personal recovery goals. When a client requires benefits acquisition, team members will assist with the application process for Medi-Cal, social security or general assistance and housing when necessary. Case managers provide services in the field and in-office. Team members work with clients instilling basic rehabilitation skills to teach them how to work, communicate and act in the community.

Psychiatrists meet with clients to discuss mental health and medication needs. Therapists provide individual therapy and nursing staff provide medication monitoring, including education on medication side effects and potential reactions. A nursing assessment is administered during intake to obtain a baseline of information regarding physical health needs. Information collected may help in determining whether clients, who may be reluctant to seek physical care, will be in need of a referral.

West RAWC also treats clients with co-occurring disorders, providing group rehabilitation interventions including Coping Skills classes, Seeking Safety and psychoeducation classes. Additional group classes may be added to augment activities which will become less accessible after the relocation of the Consumer Family Learning Center (CFLC). Currently clients receive service with the West and Stockdale RAWC teams as well as participate in CFLC activities in the same building. The CFLC will relocate in early 2017.

North Bakersfield RAWC

Kern Behavioral Health and Recovery Services
Kern Linkage Program Building
2525 N. Chester Avenue
Bakersfield, CA 93308

The goal of the North RAWC team is to provide specialty mental health care with a goal of graduating clients to non-specialty care with a community-based mental health provider. A high percentage of North RAWC clients experience co-occurring mental health and substance use disorders. Group classes, including co-occurring classes are coordinated with other Kern Behavioral Health and Recovery Services teams on and off-site. Commonly referred classes include: Depression Group, Seeking Safety, Anger Management and Conflict Resolution. Clients may also be referred to peer-run Dual Recovery Anonymous classes. Team therapists provide individual therapy for mental health and substance use disorders. Additionally, trauma-focused therapy is often provided as many clients present with trauma in their history and experience Post-Traumatic Stress Disorder or anxiety.

Ancillary services are provided by the SET Team peer specialists, Adult Wraparound, All Aboard vocational services, benefits acquisitions and payee services. Team members participate in Interdisciplinary Team Meetings (IDT) to coordinate with fellow providers to address potential barriers and concerns. The team also works with conservators in determining service needs for those under LPS conservatorship.

Health education and information on the benefits of medication responsibility are a focus to prevent stoppage in medication use, which can increase symptomology. The team nurse works with primary care providers when a client is near completion of treatment with North RAWC to ensure a seamless transition to community non-specialty services.

Southeast Bakersfield RAWC
Kern Behavioral Health and Recovery Services
1600 E. Belle Terrace Avenue
Bakersfield, CA 93307

The Southeast Bakersfield RAWC team provides specialty care focusing on assisting clients in developing the independence to reach meaningful goals. Services include: case management, medication management, individual, group and family systems therapy including structural, strategic and intergenerational approaches. Those with co-occurring mental health and substance use disorders are provided Seeking Safety and Coping Skills group classes.

The team also works with linking clients to resources. A Substance Abuse Specialist is onsite two days each week to provide assessments for SUD services. Southeast RAWC commonly receives ancillary services from Kern Behavioral Health and Recovery Services teams including: Patient's Rights Advocates and Family Advocates, Vocational Services and the CFLC. Southeast RAWC also refers clients to services provided by community organizations including Alliance Against Family Violence and Greater Bakersfield Legal Assistance.

Should a client begin preparation to transition to community-based mental health care, team members will prepare psychiatric and therapy referrals, to ensure clients have the mental health resources they need.

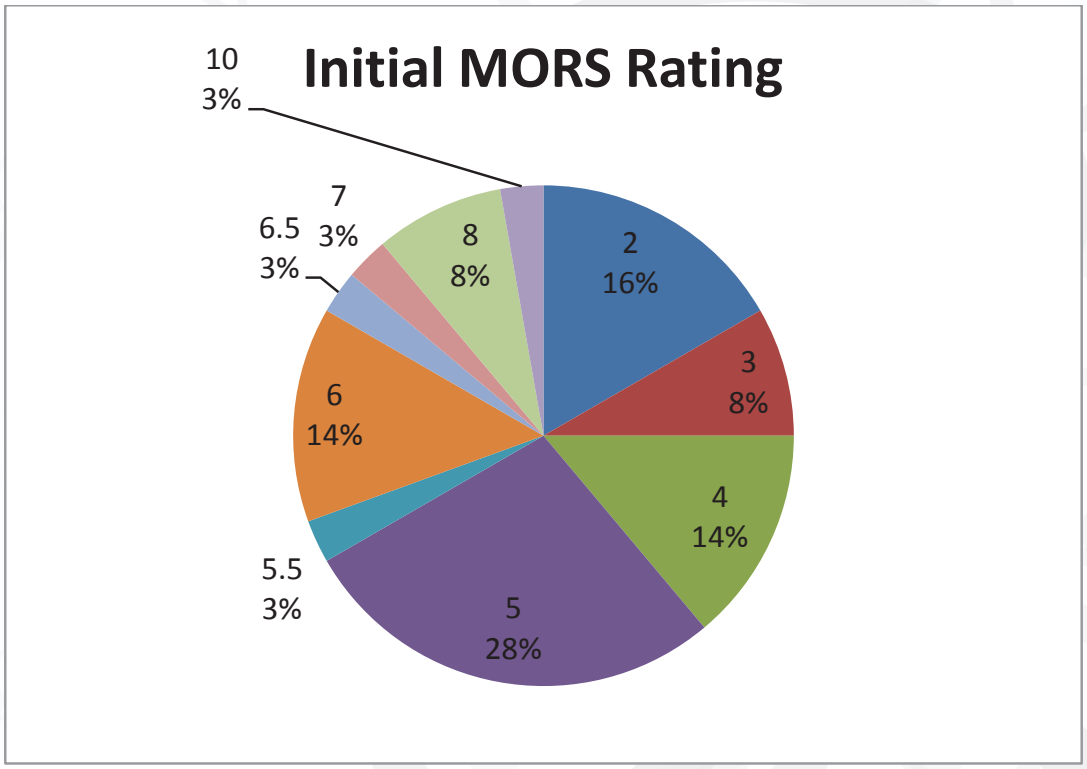
Service Goals:

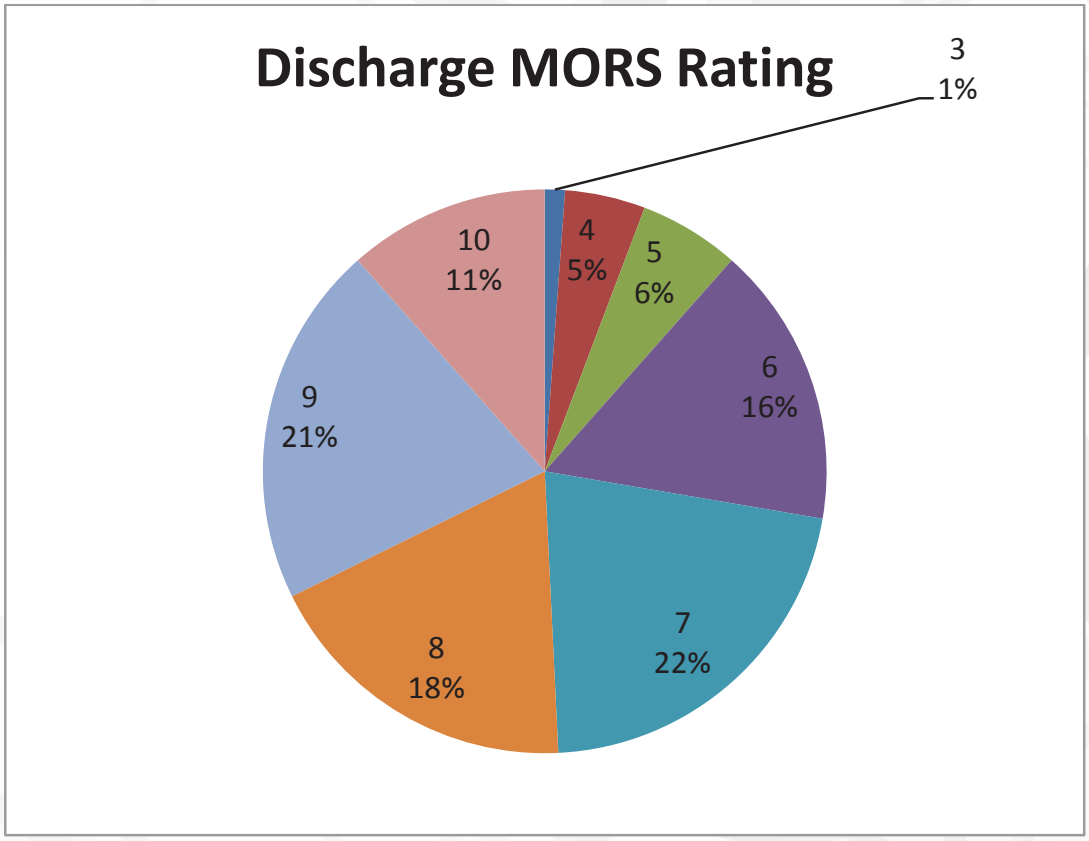
- Provide recovery-focused mental health care to those with mental health and or co-occurring disorders.
- Assist client in growing in responsibility, hope and self-empowerment.
- Work with SET peer staff in assisting clients with building skills needed to perform activities of daily living (ADL).
- Promote and encourage incorporation of wellness and self-management activities including CFLC classes and activities, volunteerism, vocational programs and peer support.
- Work with clients to attain recovery goals which allows for transition to non-specialty community-based mental health care.

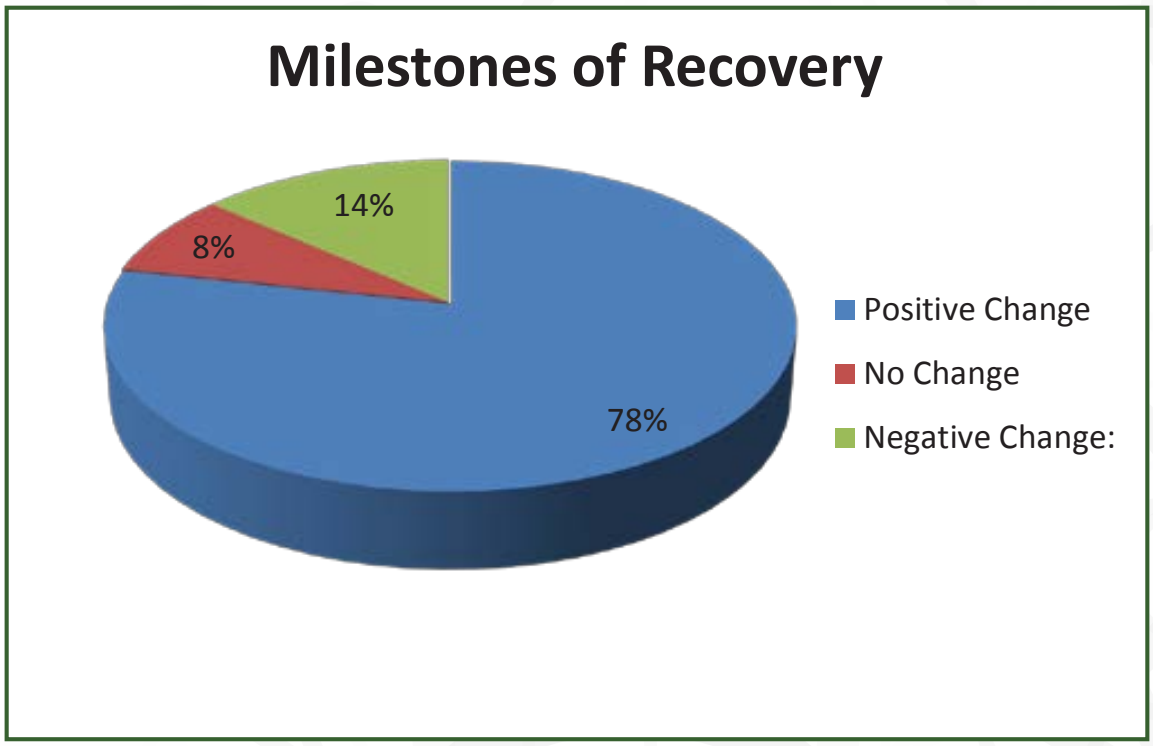
Program Data:
Stockdale RAWC provides lower level mental health care designed to transition clients to community based mental health care within a shorter period of time (6-8 months) than would traditionally happen with a specialty mental health care team. Clients are screened to determine readiness to receive care from a community health provider, which requires less monitoring than System of Care treatment. Those prepared to receive care from a community provider would receive more infrequent visits with their doctor, who would help to monitor any medications prescribed.

Clients receiving more specialized mental health care through geographical RAWC teams are provided treatment plans which help them work toward recovery. When ready for transition, these clients are assigned to a lower level team, like the Stockdale RAWC to receive services which prepare for community care.

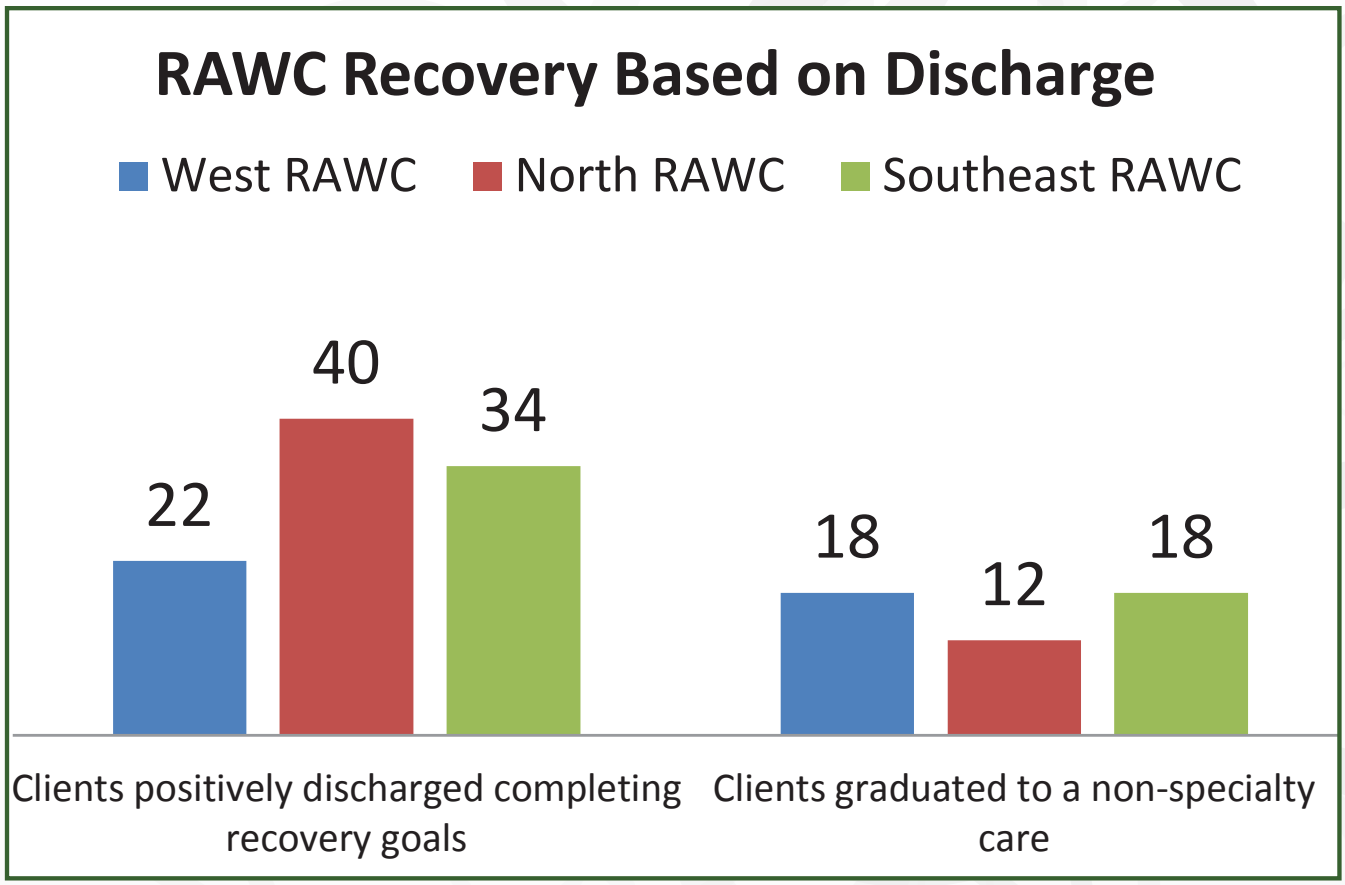
Stockdale RAWC Positive Completion Data based on MORS Scale:







Geographical RAWC Specialty Teams:



Making a Difference:
Stockdale RAWC
Amy has been with the Stockdale RAWC team since August 2015, but has been in treatment with outside providers since 1994. She has maintained her sobriety from substance use since 2009. After years of inconsistent mental health care, homelessness, jail and substance use, Amy has thrived in the past year since being with Stockdale RAWC. She has overcome barriers including social anxiety and paranoia, which previously prevented her from interacting with others and having meaningful relationships. By utilizing her anxiety management skills, she was able to attend the Recovery Conference in Nov. 2015, something she never would have considered prior to beginning care with Stockdale RAWC.

Amy is now actively involved in her church, where she does public speaking and has participated in classes at the Consumer Family Learning Center (CFLC). She is also currently working with Vocational Services and the Department of Rehabilitation to reduce her criminal charges so she can go back to work. Amy is now receiving her medications through a community provider and will soon be a Stockdale RAWC graduate.

Challenges:

Universal:

- Primary care and other community providers are not able to provide adequate monitoring of certain medications. If a client is ready to transition to community care, they either cannot be served by community care or require a change in medication.
- Clients may be ready for transition to community care, but feel reluctant for fear of losing their benefits
- Lack of regular on-site psychiatrists creates long periods between initial and follow-up appointments
- Lack of transportation can create a disruption in services if clients are missing appointments

Stockdale RAWC:

- Clients using Affordable Care Act require a different treatment schedule than is commonly used due to requirements of the carrier
- Co-occurring clients are not easily transferred to community-based services. Those in need of continued SUD support are referred to groups at the CFLC, Narcotic's Anonymous or Alcoholics Anonymous groups. If symptoms are persistent and in need of more specialized care, clients may be referred for a Kern Behavioral Health and Recovery Services substance use assessment with the GATE team

West RAWC:

- The number of clients without income is higher than it has been historically. This creates a precarious situation where clients are vulnerable to lose their housing. Loss of stable housing can result in increased symptomology, mental health crisis, etc.
- The number of clients presenting with co-occurring mental health and substance use disorders has created a need for more SUD care

North RAWC:

- Client's reluctant to beginning services could be better engaged with more staff to provide intensive services

Southeast RAWC:

- Developing a base of community primary care providers who can provide for mental health needs for client transition
- A Spanish-Speaking therapist would benefit the team to better provide services for monolingual clients

Solutions in Progress:

- For clients who are reluctant to transition to community-based care, Stockdale RAWC will provide information on multiple community resources for continued engagement
- The SET Team added a Substance Abuse Specialist to their team to better engage co-occurring clients through peer support
- When clients using Affordable Care Act coverage need to be transitioned to community care, Stockdale RAWC ensures a warm handoff to community based care, which can have a six week wait for initial appointment
- The newly-added Care Coordination Unit assists in transitioning clients to community based care including primary care providers
- Telepsychiatry availability is increasing. When necessary, psychiatrists will provide services for teams who may not have an available doctor
- Some RAWC teams will be adding additional staff to better their opportunity to engage clients who may be reluctant to begin services
- Stockdale RAWC will be developing flow data to improve services

Self-Empowerment Team – System Development

Location:
Kern Behavioral Health and Recovery Services Services
Recovery Services Administration
5121 Stockdale Highway, Ste. 150
Bakersfield, CA 93309

Client's served in 2015/2016: 126
Goal number of clients served in 2016/2017: 100
Anticipated Cost per Client: $7,337.69

Program Description
The Self-Empowerment Team (SET) was created as a program which utilizes the skills of those with lived experience to assist clients in transitioning to outpatient mental health care. Originally staffed with extra help positions, the SET team was provided Peer Employment Training (PET) facilitated by Recovery Innovations, Inc. The PET training teaches peer specialists how to utilize their lived experience in a client-focused manner to assist those entering into mental health care services. At the program's inception, SET peer specialists were assigned to work with clients exiting psychiatric hospital settings, entering outpatient mental health care. Peer staff provide advocacy on behalf of the client, attending Interdisciplinary Team Meetings, assisting with linkage to psychiatric and other service appointments and act as part of the treatment team to determine recovery goals.

Utilizing Dialectical Behavioral Therapy (DBT) skills and Solution-Focused Therapy techniques help the peer specialists and clients develop a set of personal goals. These goals are also set for mental health care; the peer specialist informs the client's Recovery Specialist of any goals or concerns and coping skills are used during treatment. As part of transitioning and building coping skills, peer specialists also help clients successfully utilize public transportation. Other daily functions of life, including grocery shopping or certain errands may present a challenge for clients who may feel anxious; peer specialists can use these opportunities to further help build coping skills. The SET team also assists clients in incorporating social, educational and otherwise meaningful activities into their schedule by introducing them to the peer-run Consumer Family Learning Center (CFLC).

Recently, the SET team peer specialist positions from temporary/extra help to permanent, providing consistent staff without a break in schedule due to the required period removed from employment annually.

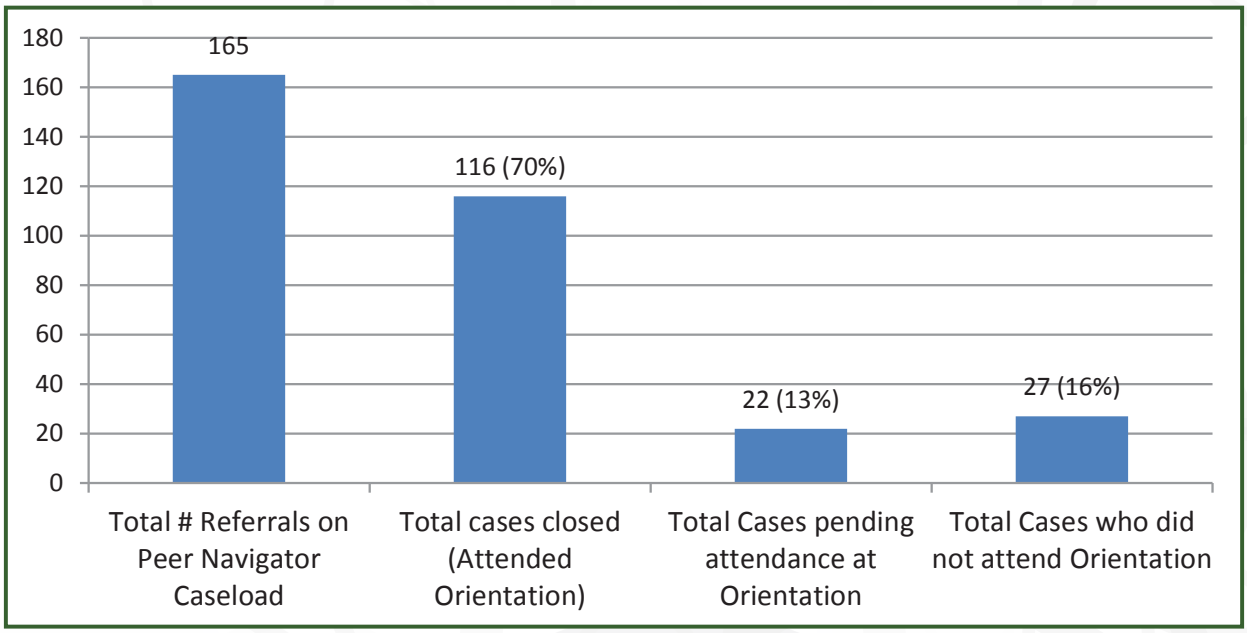
As part of a System Improvement Project (SIP), SET began a Peer Navigator project. The SIP began in March 2016 with a goal to increase access to mental health services for those receiving screening and/or assessment with the Access to Care Team. Peer Navigators engage clients in the time between assessment and initiation of services with a mental health care team. Peers lived experience to assist with clients early in their recovery. By engaging clients prior to services beginning, the Peer Navigators help clients who may be apprehensive or anxious about initiating treatment.

Service Goals

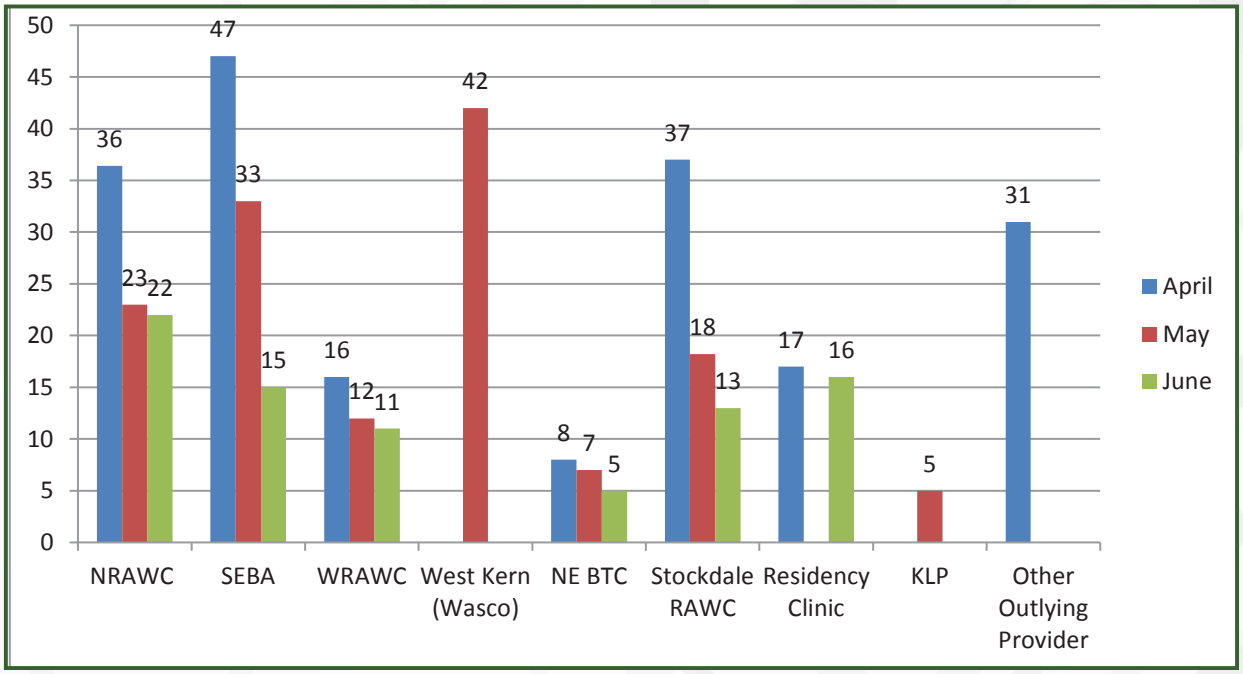
- Successful help 50 clients in learning the public transportation system
- Successfully assist 50 clients in incorporating of social, educational and other wise meaningful activity into their schedule through CFLC activities
- Successful initiation of mental health care using Peer Navigators

Program Data
Since beginning the System Improvement Project implementation, 165 total referrals have been made for Peer Navigation services. Of those, 116 cases were closed, as clients completed their first service with their treatment team; 22 clients were pending orientation at the end of June 2016 and 27 clients did not attend orientation. Linkage to treatment and engagement services were provided to teams by Peer Navigators across the Adult System of Care. Of the five treatment teams which utilized services in April, May and June, each program saw a decrease in the number of days from assessment to team orientation.

Total Number of Referrals and Orientation attendees:



Average number of days from client assessment to orientation by System of Care team:
North Bakersfield RAWC: 39 percent (36 to 22 days)
Southeast Bakersfield RAWC: 68 percent (47 to 15 days)
West RAWC: 31 percent (16 to 11 days)
Northeast Brief Therapy Clinic: 38 percent (8 to 5 days)
Stockdale RAWC: 65 percent (37 to 13 days)



The SET team successfully trained 25 clients in utilizing public transportation in FY 2015/2016. Additionally, 24 clients were integrated into the CFLC.

Making a Difference

When Bob began receiving services with SET, he was on conservatorship and struggled with grandiose delusions, disorganization, anger outbursts, ruminated on negative events in his past, felt isolated, lived with suicidal ideation and social isolation at his senior board and care. After building a rapport with Bob, the SET peer began using solution-focused counseling to aid him in exploring recovery goals. Throughout the process, Bob's peer specialist was able to use shared experience of Schizoaffective Disorder Bipolar Type including symptoms; auditory hallucination, medication side effects and benefits and some learned coping skills. This helped his specialist build a therapeutic alliance and answer questions related to his mental health experiences.

Once ready, Bob and his peer specialist began building his recovery plan. He was linked to a Consumer Family Learning Center (CFLC) crafts class, "Creative Expressions." While Bob attended regularly with support, his peer specialist was able to work with his Recovery Specialist to determine a service focus. His peer specialist was able to utilize Dialectical Behavioral Therapy skills as well as continued solution-focused counseling in aiding mental health symptoms. His participation in CFLC activities increased and he soon began using the Consolidated Transportation Service Agency to attend classes independently.

Soon after, Bob continued gaining independence as he advocated for himself in changing residence from his previous senior board and care, where he did not feel safe. Bob was recently released from conservatorship. He continues to enjoy classes at the CFLC, socializes with staff and peers and advocates for his recovery needs.

Challenges

- As the SET team continues to grow, they continue to receive referrals, and staff needs increase
- Staff maintaining an active workload while splitting time between caseload and Peer Navigator project
- Cognizance within the system of care of the role SET peers play in the services client's receive

Solutions in Progress

- It is anticipated that by mid FY2016/2017, the SET team will be allocated more positions to ensure coverage of the continued Peer Navigator project, providing the ability to accept referrals for services
- Data collection for Peer Navigators and SET is in development to ensure that outcomes are accurate and consistent with System Adult service teams
- Staff continue to be provided Peer Employment Training in addition to other peer-involved trainings to improve peer-to-client care
- SET has added a team supervisor who has been guiding the team through the Peer Navigation project and process and continues to improve SET services

Consumer Family Learning Center (CFLC) – System Development

Locations:
Consumer Family Learning Center
Kern County Mental Heath
2001 28th Street, South Tower
Bakersfield, CA 93301

HOPE Center
College Community Services
1400 N. Norma Street, Ste. 137
Ridgecrest, CA 93555

The Learning Center
College Community Services
107 S. Mill Street, Ste. B
Tehachapi, CA 93561

Clients Served in 2015/2016: 2130
Goal number of clients served in 2016/2017: 3200
Anticipated Cost per Client: $472.38

Program Description
The Consumer Family Learning Center, HOPE Center and The Learning Center provide a welcoming environment to the community and especially to those who have experience with mental illness, either as clients or family members of those with mental illness.

The goal of the centers is to engage those experiencing mental illness and their supports with pro-social, educational and skill building activities that promote wellness, hope and enrich the lives of its members. The peer-led centers also help in reducing self-stigma and family stigma. Several of the CFLC team are peer specialists, many of whom share their recovery by empowering members to work toward personal recovery goals.

In the 2015-2016 year, the Consumer Family Learning Center began providing evening and weekend classes, to further engage members outside of normal business hours. This involved expanding the program to include additional staff. As of April 2016, this included an additional 22 classes for the month. The CFLC is currently preparing for relocation. Renovation will begin at the beginning of fiscal year 2016/2017, with tentative move dates in early 2017.

Peers are an essential piece of the consumer centers; where members are can act as both attendee and co-facilitator for classes and activities. Each of the centers provide a variety of options including; arts, crafts, music, physical activity, support groups, field trips, health classes, movie nights, etc. Support groups are peer-led, offering attendees the opportunity to build supports with those who have shared experiences. Support groups for families are also held in Spanish. The CFLC also partners with NAMI (National Alliance on Mental Illness) to provide a 'Family to Family' group, to better help families understand mental illness.

Clients may also be referred to the center as a way of including meaningful activities to their daily lives while active in their mental health or substance use treatment. Members are not questioned on their mental health status or diagnosis. Those who choose to share, do so willingly, and are met with the support of those who have a similar understanding. The centers can be especially beneficial for those who have few supports in family or friends. The centers are safe places, where close attention is paid to members who may have an increase in mental health symptoms.

The CFLC also has an advisory committee, which meets twice monthly. The board of nine members is annually elected by CFLC members. Along with elected board members, the committee includes the volunteer coordinator. CFLC members also participate as stakeholders, participating on boards for the Adult Treatment and Recovery meetings, Behavioral Health Board and Subcommittees, the Suicide Prevention Advisory Resource Council (SPARC) and the System Quality Improvement Committee. Member satisfaction surveys are completed annually, to gauge interest and gather feedback. Members are also allowed to provide suggestions on classes and activities through the onsite suggestion box.

Class calendars for all three centers are posted on the Kern Behavioral Health and Recovery Services public website each month and distributed through KCMH and provider clinics and various other sites throughout the county. Community

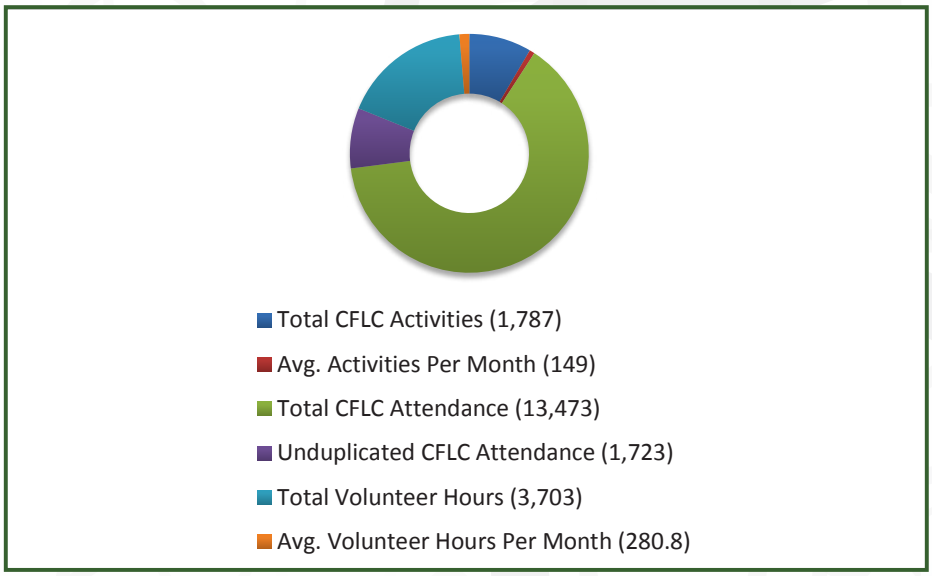
collaboratives also distribute information through countywide e-mail lists connected to community based organizations and agencies.

Service Goals

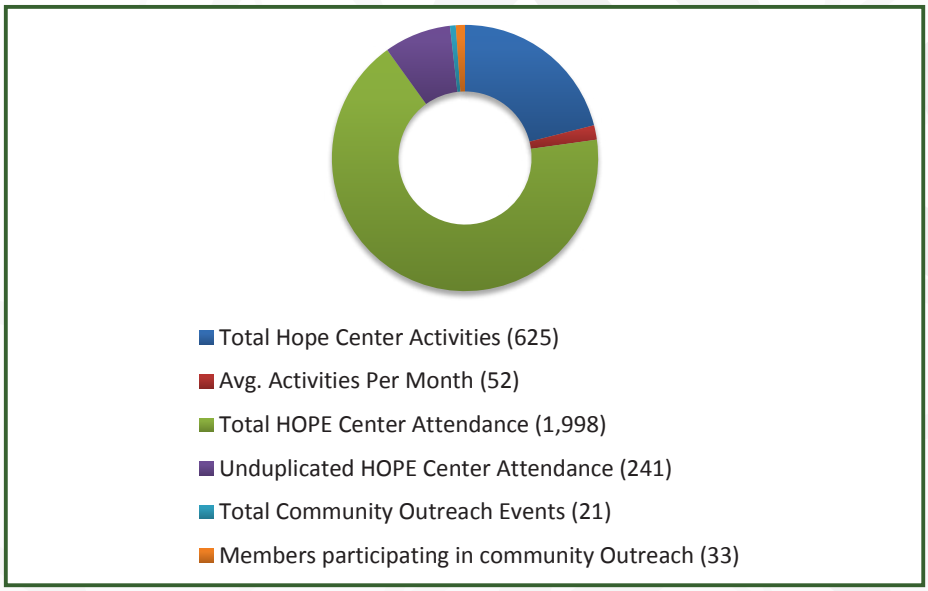
- Decrease the need for crisis services
- Increase participation of client and family members in groups and classes.
- Increase volunteerism in the community
- Increase participation of clients in system of care committees and evaluations
- Increase community outreach to reduce stigma about mental illness and recovery
- Equipping volunteers/members to facilitate or co-facilitate classes

Program Data

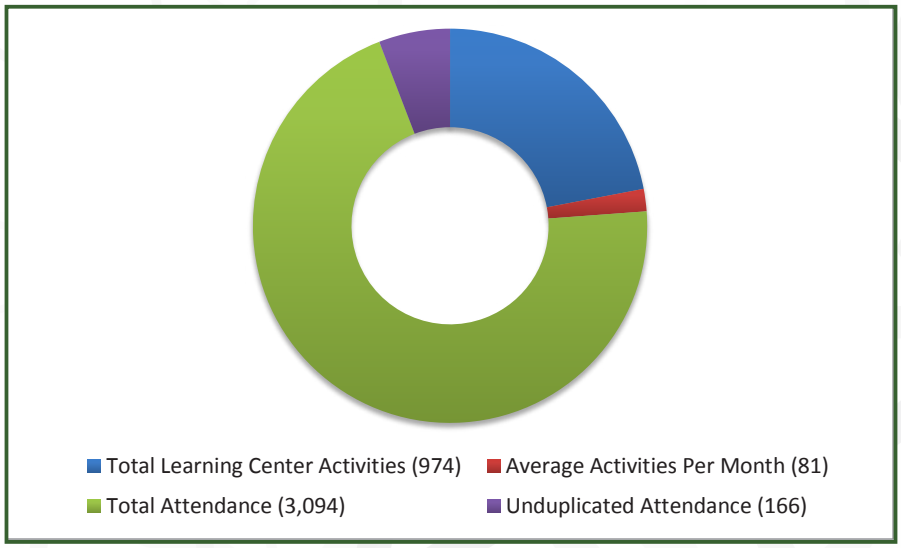
CFLC:



HOPE Center:



The Learning Center:



Making a Difference

'Lisa' has attended CFLC for over five years. Her road to recovery began after receiving a diagnosis of Clinical Depression, Borderline Personality Disorder and Post Traumatic Stress Disorder from years of molestation by her adopted father.

The stress from finding out that her own daughter was being molested and pressing charges on her husband caused what she described as a 'mental breakdown.' This was followed by numerous hospitalizations and eventual custody loss of her children. When released from the hospital, she was moved into a board and care facility and had lost her children, financial independence, home, possessions and driving privileges. She was suicidal and exhibiting self-mutilating behavior.

With encouragement and support from the Self-Empowerment Team (SET) peers, she learned to navigate the public transportation system and gained the courage to attend CFLC. Initially, she would sit in a corner reading. She gradually began opening up and making friends. Lisa and a CFLC staff member shared their mutual interest in sewing. She credits the patient and support provided by this staff member as an integral part of her recovery.

Lisa is now sewing, reading, baking and cross-stitching again. She facilitates her own class and co-facilitates another class. She is the CFLC Advisory Committee Chairperson and participates in CFLC's "Voices of Recovery" by sharing her recovery journey with other clients and to graduate-level social work students to educate and reduce stigma about mental illness. She enjoys giving back by regularly volunteering where she encourages and supports others in their own recovery. She has regained her driver's license, lives in her own apartment and no longer requires a payee. She is connected with family and enjoys her life and independence.

Challenges

- The relocation of the CFLC will inhibit ease of access for those accessing public transportation.
- Creating opportunities for members who are interested in volunteering.
- Due to the non-clinical nature of activities at the CFLC, data is not collected through traditional means.

Solutions in Progress

- Three staff members were added to the CFLC team to provide classes in the evenings and on weekends. As of May 2016, 25 additional classes were added to the calendar for the month.
- Self-Empowerment Team members also assist in co-facilitating classes.
- CFLC members complete Consumer Recovery Survey's, which have shown a high satisfaction rating among those attending classes and activities

- CFLC has begun tracking a series of data to improve the effectiveness of CFLC services
- Quarterly meetings between CFLC, HOPE Center and Learning Center staff occur to improve services offered at all sites

Outreach and Education – System Development

Location:
Kern Behavioral Health and Recovery Services Services
2001 28th Street
Bakersfield, CA 93301

Client's served in 2015/2016: 22,559
Goal number of clients served in 2016/2017: 23,500
Anticipated Cost per Client: $8.08

Program Description:
The Outreach and Education Program represents the Mental Health Services Act Prevention and Early Intervention requirement for an Outreach for Increasing Recognition of Early Signs of Mental Illness Program. The program was created based on a need found to increase services to underserved populations. Various MHSA programs work to educate, train and provide information throughout Kern County.

The Promatoras and Community Health Workers Network, a group of representatives from agencies or community based organizations which advocates for or provides services to the Latino community in California were an active partner with Kern Behavioral Health and Recovery Services (KCMH). During 2015/2016 KCMH and a liaison for Each Mind Matters and Know the Signs and Vision y Compromiso to train the Promatoras in Safe Talk and Know the Signs curriculum. The training will further assist in outreaching to the Spanish-monolingual population in Kern County.

Implementation of the Survivor Outreach team took place in 2015/2016, providing postvention services to those who have lost a loved due to suicide. If allowed, the family will be provided support and offered a referral or Survivor Outreach Team groups to assist with grieving. To assist with this effort, Crisis Hotline staff work directly with the Kern County Coroner in the event of a suicide. This engagement is only done as families allow.

Question, Persuade, Refer (QPR) trainings were provided to System of Care and the community-at-large. This suicide-prevention and stigma reduction course provides education on how to recognize the warning signs of suicide, persuade and refer one to seek help. There were 520 QPR training session attendees in 2015/2016.

Outreach to older adults was provided throughout Bakersfield, Wasco, Lake Isabella and Tehachapi. During outreach events for seniors, information on mental health care was distributed and attendees were provide information on services and the opportunity to take part in mental health screenings and referrals as necessary. Staff attended health fairs and visited Senior Centers, retirement homes, assisted living facilities and events designed for older adults, including the annual Healthy Harvest. Screening tools utilized during the events included the Patient Health Questionnaire (PHQ-9), which screens for symptoms related to depression; the Generalized Anxiety Disorder Questionnaire (GAD-7) and the AUDIT-C which screens for alcohol misuse. Additionally a screening for cognitive mental status (SLUMS) can be done to determine whether neurocognitive disorders are present. Socialization groups were created at two senior apartment complexes in Wasco, which meet weekly; one is bilingual, one is for monolingual Spanish speaking seniors.

Youth and family outreach was done via the Strategic Training for Effective Parenting (STEPS), Communication Skills and Social Skills parenting groups implemented at the Bakersfield Homeless Center. Outreach was also provided to schools throughout Kern County by System of Care and community provider staff. The teams also provide outreach at community events including the 2015 Back to School Health Fair and Third Thursday community street fair. Community events provide a venue to disseminate program information and educate the public on the importance of mental health care while reducing stigma. Coordination with area schools was continued in metro Bakersfield and outlying areas to provide mental health care information and availability of services for youth.

The May is Mental Health Awareness Month 2016 theme, "When Illness Becomes Wellness" surrounded Department and provider activities, which kicked off with the annual Art Shows in Bakersfield, Ridgecrest and Tehachapi. Events featured artwork created by those identifying as experiencing mental illness as well as community members passionate about recovery. The art show in Bakersfield featured 36 artists with 110 art pieces. Eight artists with 32 pieces were represented at The Hope Center in Ridgecrest. Art shows were also coordinated at partnering locations in Tehachapi and Ridgecrest. Events also included the screening of "Call Me Crazy," a film centered on showing how mental illness can affect individuals and families, while showing that recovery is possible. Approximately 45 people attended the event and pre and post tests were provided to gain understanding of whether mental health stigma was reduced among those in attendance.

Perception change was identified among ten percent of mental health providers, 20 percent of community members and 25 percent of family members in attendance.

The 17th Annual Academy Awards Luncheon was attended by 232 clients, providers and family members. Awards recognize those making strides in promoting recovery principles either by being active in their recovery or providing recovery-focused services for those receiving care. Fifty-one nominations were accepted in five categories: Incredible Youth, Recovery and Wellbeing, Outstanding Advocate and Mental Health Professional of The Year.

Kern Behavioral Health and Recovery Services partnered with NAMI for the annual Walk at the Park event in Bakersfield. The event draws in clients, service providers, family members and the community to promote mental health awareness, resources and raise funds for the local NAMI organization. Stigma and Discrimination Reduction materials were provided as well as information on System of Care and geographical provider service information.

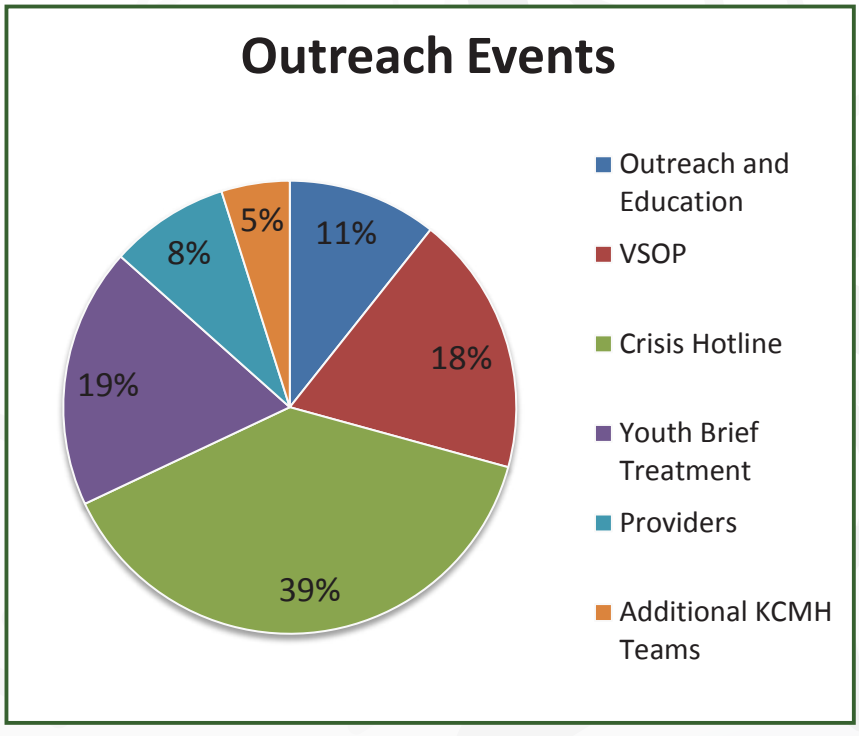
CalMHSA sponsored "Every Mind Matters" and "Know the Signs" materials were provided at health fairs, trainings, community events and Department-sponsored events throughout 2015/2016. These materials are utilized as tools to educate and reduce stigma in the community surrounding mental health and suicide.

For FY 2016/2017, Kern Behavioral Health and Recovery Services will strengthen efforts in starting La CLAVE, a public campaign focusing on recognizing symptoms of serious mental illness. La CLAVE has been an active campaign throughout areas of Southern California, focusing on bringing relevant information on signs and symptoms to Latino families. Information can be provided using resources including an online toolkit featuring classes and workshop materials.

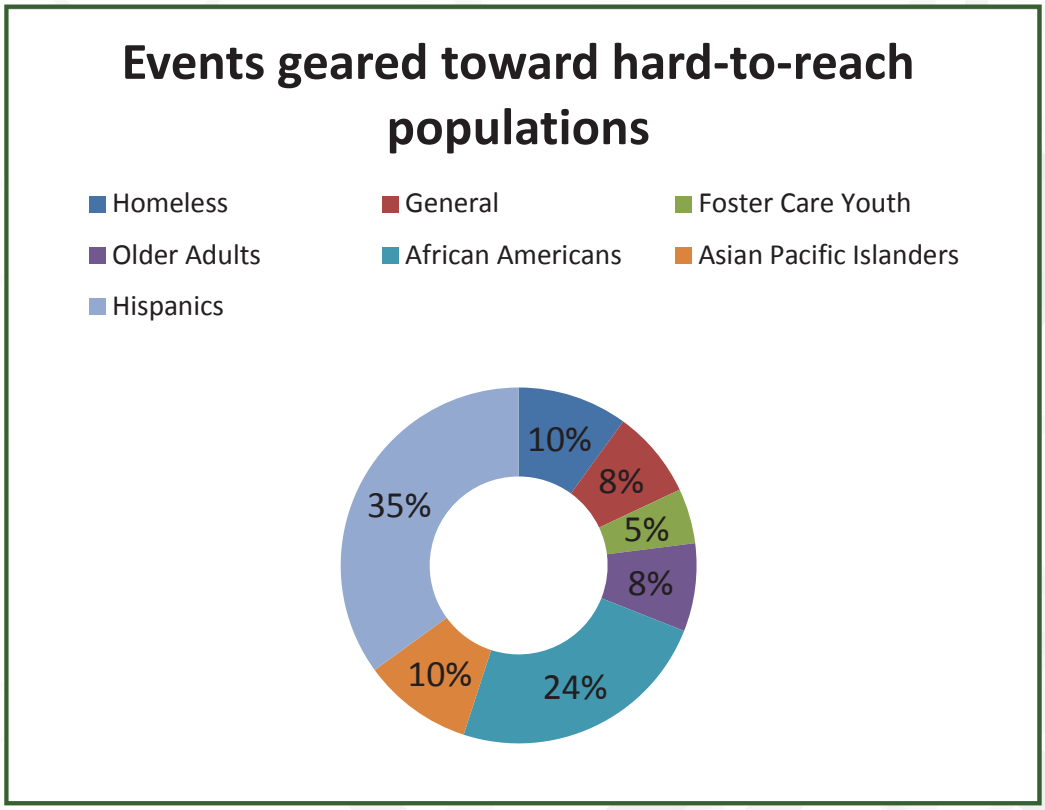
Service Goals

- Continue to collect stakeholder feedback to identify potential unserved and underserved populations
- Incorporate La CLAVE public outreach to Kern County in metro and rural areas to reduce mental health stigma and assist families in identifying mental health care needs
- Increasing recognition of early mental illness among youth, TAY, adults and older adults
- Utilize state-funded campaign information and materials focused on suicide prevention and stigma reduction
- Begin online stigma reduction and suicide prevention efforts through Department website re-launch, occurring in FY 2016/2017

Program Data



Kern Behavioral Health and Recovery Services outreach and education events totaled 223 for 2015/2016, spread across 17 System of Care and community provider teams.



Kern Behavioral Health and Recovery Services Open House, May is Mental Health Awareness 2016

May is Mental Health Awareness Month 2016 Art Show

Challenges

- Engaging underserved populations in stigma reduction efforts

Solutions in Progress

- Identifying populations with which to work and locating organizations currently in existence within populations groups to attempt to engage and educate on the importance of mental health

Prevention and Early Intervention

In October 2015, regulations pertaining to Prevention and Early Intervention programs were revised. These revisions

included adding a series of components and strategies within the program structure. Originally solely either prevention, early intervention or a combined program, these programs may continue as such but additional components are required to suit specific PEI needs, including: Access and Linkage to Treatment, Outreach for Increasing Recognition of Early Signs of Mental Illness, Stigma and Discrimination Reduction and an optional Suicide Prevention program.

Kern Behavioral Health and Recovery Services has historically provided many of these services within the Community Services and Supports System Development component. The Access to Care - Access and Assessment Team is the front door to mental health care, providing access and linkage for mental health care both within the System of Care and to community providers. The Crisis Hotline and Outreach and Education programs provide Stigma and Discrimination Reduction and Outreach for Increasing Recognition of Early Signs of Mental illness services. The Crisis Hotline, a suicide prevention program also received its five year re-accreditation through the American Association of Suicidology and is part of the National Suicide Prevention Lifeline. During 2015/2016, the Crisis Hotline also implemented the Suicide Outreach Team, which works with the Kern County Coroner to identify and provide support for families who have lost a loved one to suicide.

Prevention and Early Intervention programs within the Kern Behavioral Health and Recovery System of Care and its providers have been developed to serve all age groups; children, TAY, adults and older adults. In FY 2016/2017, the Department will add three PEI programs; two providing services for children, one for adults.

REACH (Risk Reduction Education and Engagement Accelerated Community Behavioral Health) is an Access and Linkage to Treatment program. The focus is to provide outreach and education with the goal of engaging those who have not previously been successful in engagement in mental health care. The REACH team will be primarily field-based, providing services throughout Kern County.

Foster Care Engagement is a Prevention, Early Intervention and Access to Linkage program developed based on feedback gathered during the FY 2015/2016 Community Planning Process. Kern Behavioral Health and Recovery Services will partner with the Department of Human Services to identify youth who may be at risk for mental illness. Identified youth will be provided assessment and referral to early intervention or specialty mental health care as needed and re-assessed annually.

Youth Wraparound Engagement follows in a similar vein; based on collaboration and education of Kern County Probation staff in identifying at-risk youth, the Youth Wraparound Engagement team will provide Prevention, Early Intervention and Access and Linkage to Treatment for those youth exiting the juvenile justice system who are at risk for mental illness.

Youth Juvenile Justice Engagement – Prevention-NEW

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 93301

Anticipated number to be served in FY2016/2017: 100
Anticipated Cost per Client: $833.73

Program Description
The Youth Wraparound Engagement Prevention and Early Intervention program is designed to engage those youth who have been active in the juvenile justice system. Youth exiting juvenile hall are often unserved, underserved and undiagnosed. By collaborating efforts with the Kern County Probation Department, this team will provide consultation regarding engagement of youth who may require mental health care. Further consultation will be done with the Juvenile Probation Psychiatric Services team to identify youth in need of assistance with access to services. These youth would also be referred for prevention/relapse prevention activities through the Unspoken Words Art Program.

Prevention Activities

- Continued consultation with partnering agencies and mental health care teams to identify and engage youth with potential treatment needs
- Increase access to mental health care for unserved and underserved youth and families
- Reduce duration of untreated mental illness
- Provide outreach to increase recognition of early mental illness
- MATRIX relapse prevention groups

Evaluation Tools

- Data will be collected for outreach and education events, engagement with clients, number of referrals, demographics and the number of prevention activities provided
- Report data on successful completed MATRIX relapse prevention program

Youth Juvenile Justice Engagement – Early Intervention

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 93301

Anticipated number to be served in FY2016/2017: 40
Anticipated Cost per Client: $833.73

Program Description
The Youth Wraparound Engagement Program early intervention services provide treatment for those with mild to moderate mental health care needs involved in the juvenile justice system. This population is often unserved, underserved and/or undiagnosed. Consultation and engagement through collaboration with partnering Kern County Probation Department will allow an opportunity to provide access and linkage to treatment programs for those in need of mental health care. Providing mental health treatment to these youth increases the likelihood of reduced repeat incarceration, school failure and/or dropout and reduced or eliminated instances of suicidal ideation and self-harm.

Early Intervention Activities

- Screening, assessment and treatment planning for those youth requiring mental health care
- Child PTSD Symptom Scale (CPSS-V) to identify treatment needs
- Functional Family Therapy, evidence-based practice

Evaluation Tools

- Functional Family Therapy generated outcomes (OQ, YOQ, YOQ-SR, FSR, TSR) self-report measures to assess family and individual functioning at the beginning middle and end of treatment to help gage effectiveness and benefits of therapy
- Analysis of Child PTSD Symptom Scale (CPSS-V) identifying treatment needs of youth between the ages of 8-18
- Pre/Post client status reports from MATRIX implementation

Foster Care Engagement – Prevention-NEW

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 93301

Anticipated number to be served: 100
Anticipated Cost per Client: $3,843.08

Program Description
Kern Behavioral Health and Recovery Services's Foster Care team will begin providing Prevention and Early Intervention services in FY 2016/2017. The premise of these services is to actively engage youth active in the Foster Care system who have not been engaged in mental health services. Many Foster Care Youth have a history with the public system, but are often underserved and/or undiagnosed. By providing annual Trauma-Informed assessments for youth residing in foster care, this team will actively provide access to ongoing preventative care. Providing needed care to this underserved population could decrease the number of placement changes, allowing for maintained secure, safe homes for youth. Other potential positive outcomes include; decreasing school failure, self-harming behaviors, suicidal tendencies and strengthening collaborative outreach between agencies.

Prevention Activities

- Psychoeducation to the Department of Human Services (DHS) social workers on the impact of trauma on foster youth and stigma reduction. This would be done through regular and quarterly staff meetings with DHS teams
- Assist DHS social workers in identifying, screening and referral for foster youth with potential mental health care needs
- Utilization of a pre and post trauma screening tool
- Timely access to mental health care as necessary
- Assist to bridge DHS social workers to mental health staff
- Work in collaboration with DHS to provide Special Increment training to foster parents
- Provide 10-Week CBT-Trauma Informed promising practice Bounce Back Group

Evaluation Tools

- Reports generated from the Cerner Electronic Health Record will keep track of the number of youth assessed and the number and type of prevention activities provided. This will include the number of social workers and caregivers impacted by outreach for increasing recognition of early signs of mental illness events

Foster Care Engagement – Early Intervention-NEW

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 93301

Anticipated number to be served in FY2016/2017: 40
Anticipated Cost per Client: $3,843.08

Program Description
Foster youth are among the recognized underserved and unserved populations. Many youth active in foster care have experienced trauma and have been left unserved and undiagnosed. As part of the Foster Care Engagement Prevention and Early Intervention program, social workers will be provided psychoeducation on the importance of engaging foster youth for potential undiagnosed mental health care (prevention). Those youth recognized as requiring potential mental health care will be provided assessment services (early intervention). Assessment will continue annually for referred youth. Providing mental health assessments annually will assist Kern Behavioral Health and Recovery Services staff in helping those youth in need better access to treatment.

Early Intervention Activities

- Annual administration of youth through the Child PTSD Symptom Scale (CPSS-V) to identify mental health care needs of foster youth aged 8-18 years
- Annual administration of Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) to identify developmental delays and/or behavioral concerns of foster youth up to 66 months.
- Bounce Back, a cognitive behavioral trauma approach designed for youth, grades kindergarten through fifth

Evaluation Methods

- Annual analysis of youth through the Child PTSD Symptom Scale (CPSS-V) to identify mental health care needs of foster youth aged 8-18 years
- Annual analysis of Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) to identify developmental delays and/or behavioral concerns of foster youth up to 66 months.

Youth Brief Treatment – Prevention

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 933001

Henrietta Weill Memorial Child Guidance Clinic
3628 Stockdale Highway
Bakersfield, CA 93309

2001 N. Chester Avenue
Bakersfield, CA 93308

1430 6th Avenue
Delano, CA 93215

Clinica Sierra Vista
3105 Wilson Road
Bakersfield CA, 93304

3717 Mt. Pinos Way
Frazier Park, CA 93225

7839 Burgundy Avenue
Lamont, CA 93241

College Community Services
29325 Kimberlina Road
Wasco, CA 93280

Clients served in 2015/2016: 4421
Goal to be served in FY2016/2017: 4863
Anticipated Cost per Client: $273.78

Program Description
The Youth Brief Treatment Prevention and Early Intervention program works with System of Care and provider-based teams to provide stigma reduction materials and outreach designed to allow for ease of access and linkage to treatment for those with mental health care needs.

The Kern Behavioral Health and Recovery Services children's teams provided Youth Brief Treatment services at the Bakersfield Homeless Center. Among services provided, the teams educated parents on treatment services available for youth and a series of parenting classes including: Empowering Parenting, STEPS (Strategic Training for Effective Parenting), Parent Process group and Communication Skills groups. Parents were also provided resources and information on treatment services, and the option for onsite screening, assessment and brief intervention for children.

Program staff throughout the county also participated in outreach events at school fairs, health fairs, through presentations at school parent and family events and other public entities including County Departments that work with children and parent populations.

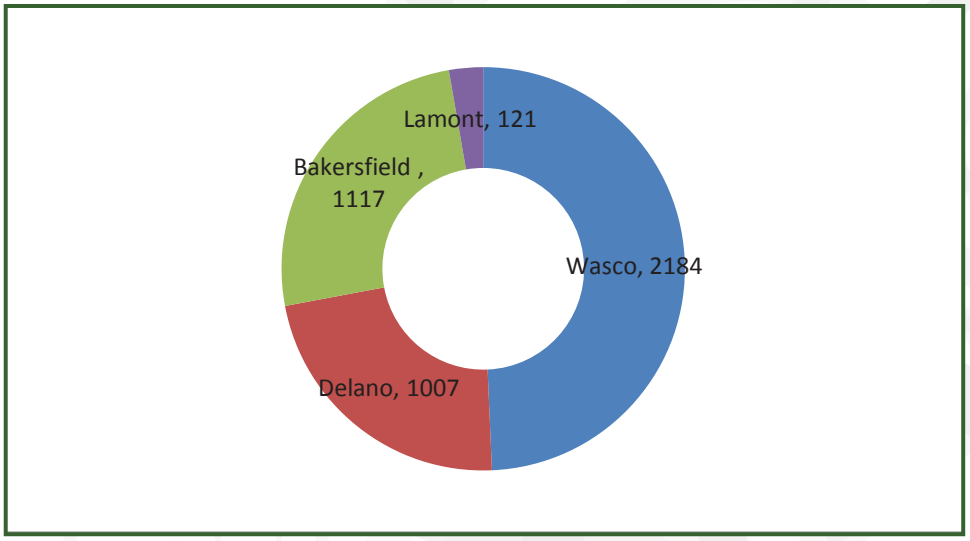
Children's service providers for the Youth Brief Treatment program in Delano have continued a project from FY2014/2015, in which they engaged public schools throughout Delano to provide information on access and linkage to treatment. Providing school site-based outreach, program staff met with principals and school officials at each site to provide information on available mental health care and potential on-site screening, assessment and brief treatment.

Prevention services offered within metro Bakersfield in 2015/2016 have involved participation in School Attendance Review Board meetings to engage youth and families potentially requiring care.

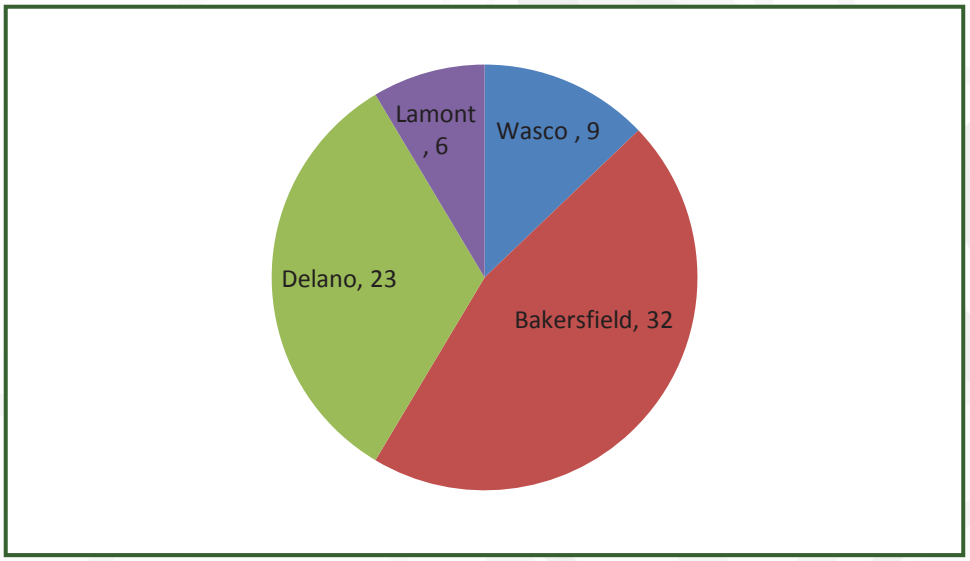
Service Goals

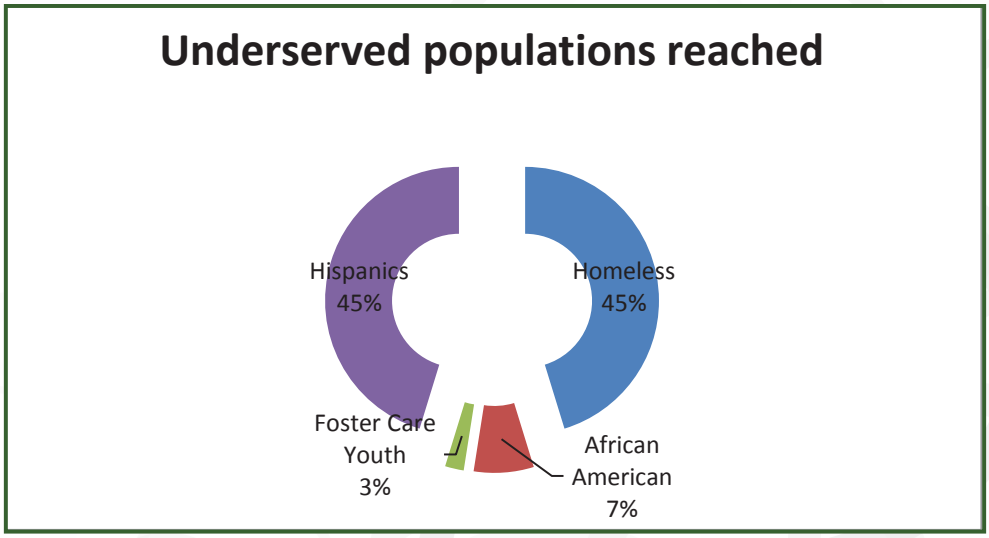
- Provide information on geographic services available through the Youth Brief Treatment program
- Increase knowledge and supportive attitudes about mental health care (Stigma Reduction)
- Outreach to traditionally underserved families and youth
- Conduct public education campaigns to engage stressed youth and their families
- Provide community support groups/workshops

Program Data
Number reached in community outreach efforts



Number of community outreach events





Making a Difference

During Fiscal Year 2015-16, an ongoing Empowering Parenting six week class was provided at the Bakersfield Homeless Shelter to underserved families with the goal of educating and bringing awareness of the available resources within the community. We continue to receive ongoing positive feedback from the families and the staff at the Bakersfield Homeless Shelter. The families made several comments about how the parenting class was helpful and it provided them with the opportunity to learn new parenting tools and ongoing support from the mental health staff. After the parenting classes were offered at the shelter, the PEI staff provided same day screening and assessment options. The staff at the shelter worked collaboratively with the mental health staff in order to have access to private offices. Families expressed appreciation as mental health services were easily accessible at the shelter as it is difficult for them to seek mental serviced due to their limitations in resources (transportation, financial hardship, etc.).

At the end of the six weeks of the parenting class, not only did one parent, but several parents approached KCMH staff indicating their interest in pursuing prevention and early intervention services for their children, but asked about resources for themselves. One parent reported concerns about her child's behaviors. KCMH provided support and educated the mother on the services available in the community which could benefit her child. She was thankful to have the opportunity to participate in the parenting classes because she learned different tools to address her child's misbehaviors. She shared she felt overwhelmed, but has been using the parenting techniques learned in the class and has made a significant difference in the parent-child relationship.

Challenges

- Program goals and benchmarks that are clear and measureable
- Ongoing training and support
- Staff requirements for additional training on how to be effective communicators and presenters
- Turnover of Therapists due to extra help (temporary) positions

Solutions in Progress

- Approved two permanent Mental Health Therapist positions to add to the program
- Considering ways to adapt the pre and posttests to collect data for parenting programs
- Create standardized tracking to obtain data collection
- Continue to provide required training for staff, to improve communication and presentation skills for outreach delivery

- Continue to engage and support families and youth to further building rapport and engagement in prevention parenting groups provided in the clinic and community settings
- Create outreach efforts and surveys about prevention services offered for families and participants

Youth Brief Treatment – Early Intervention

Location:
Kern Behavioral Health and Recovery Services
Children's System of Care
3300 Truxtun Avenue
Bakersfield, CA 93301

Henrietta Weill Memorial Child Guidance Clinic
3628 Stockdale Highway
Bakersfield, CA 93309

1430 6th Avenue
Delano, CA 93215
Clinica Sierra Vista
3105 Wilson Road
Bakersfield CA, 93304

7839 Burgundy Avenue
Lamont, CA 93241

College Community Services
29325 Kimberlina Road
Wasco, CA 93280

Client's Served in 2015/2016: 628
Goal number of clients served in 2016/2017: 690
Anticipated Cost per Client: $547.00

Program Description
The Youth Brief Treatment program's Early Intervention services include offering same day walk-in mental health screening, assessment and brief interventions for those in need. Brief intervention services follow the Solution-Focused Brief Therapy approach. These services are designed to teach youth communication, social and coping skills**.** Adapting to use of skills learned through early intervention services help prevent mental health symptoms from becoming severe and persistent and improve quality of life.

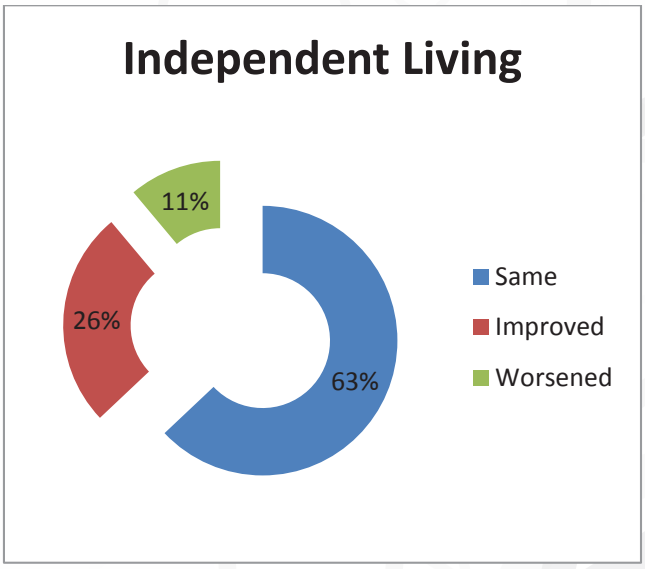
Youth Brief Treatment program mental health care is geared toward working with those who have not been active in the mental health system of care, but rather have had recent onset of mental health symptoms. Clinicians and Recovery Specialists work with youth and their parents, foster parents and school supports as necessary to address symptoms in a timely matter. Treatment typically lasts six-to-nine months for youth in this program. Should parents also require brief treatment, modalities like Functional Family Therapy may be indicated in the treatment plan. Parenting classes and groups are offered at community sites and within the clinic as well.

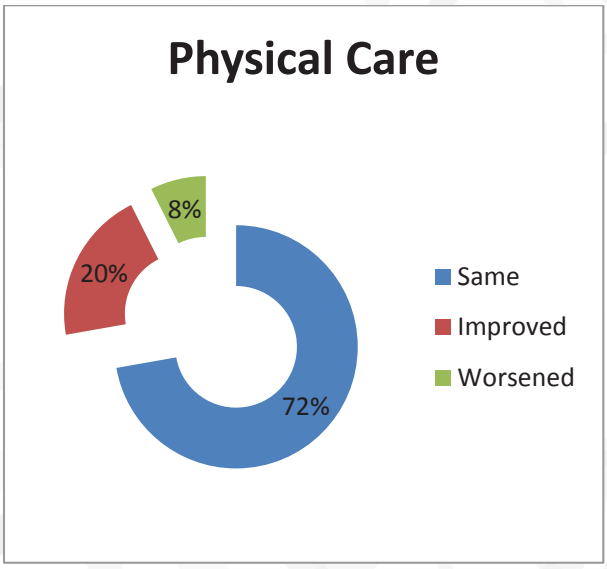
Service Goals

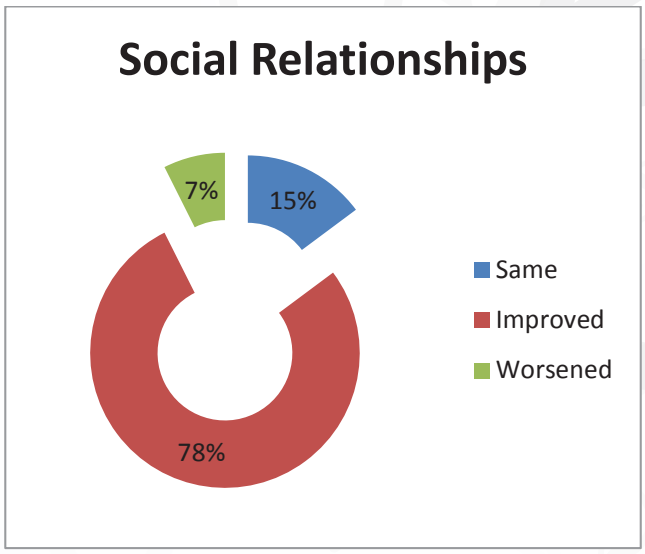
- Offering same day, walk-in screening and assessment
- Offering immediate brief care
- Increase effective coping and communication skills to improve social relationships and other areas of functioning
- Prevention prolonged suffering due to mental illness

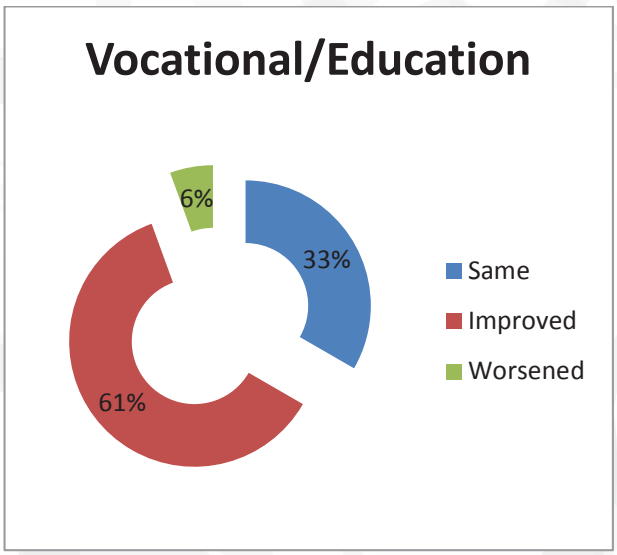
Program Data
Clinical outcomes were measured on a series of impairments as well as children-specific indicators of academic outcomes and behavior outcomes. Measurements show whether after care was received, if symptoms or behaviors improved, remained unchanged or worsened.

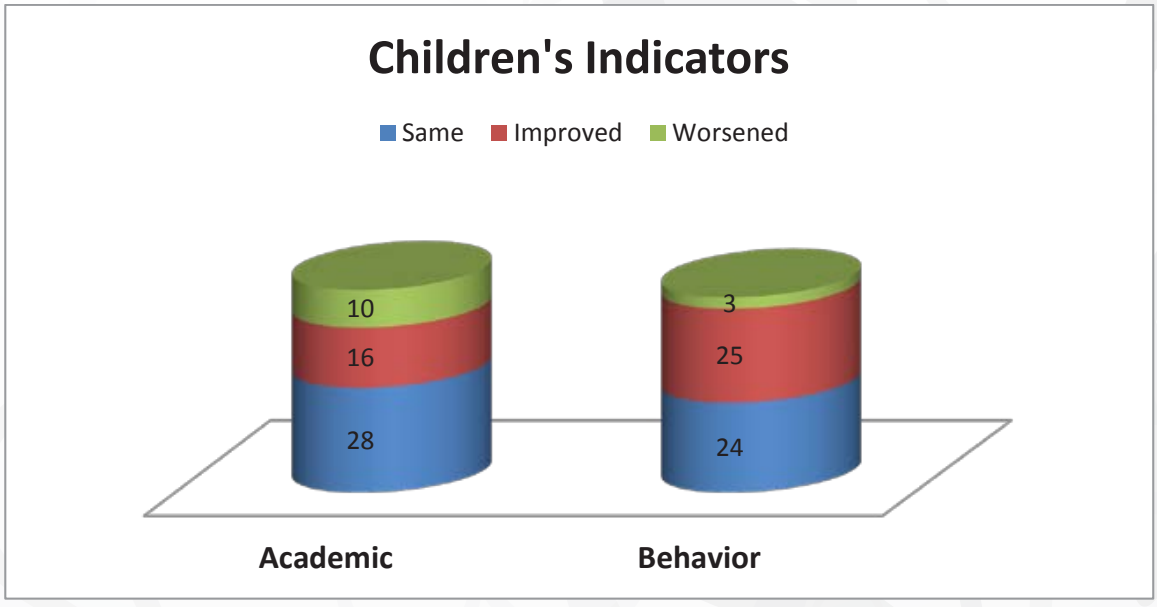
Kern Behavioral Health and Recovery Services Children's System of Care Teams:



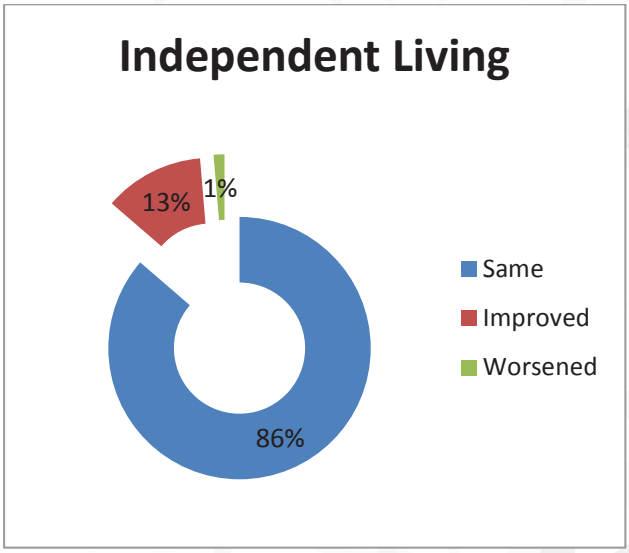


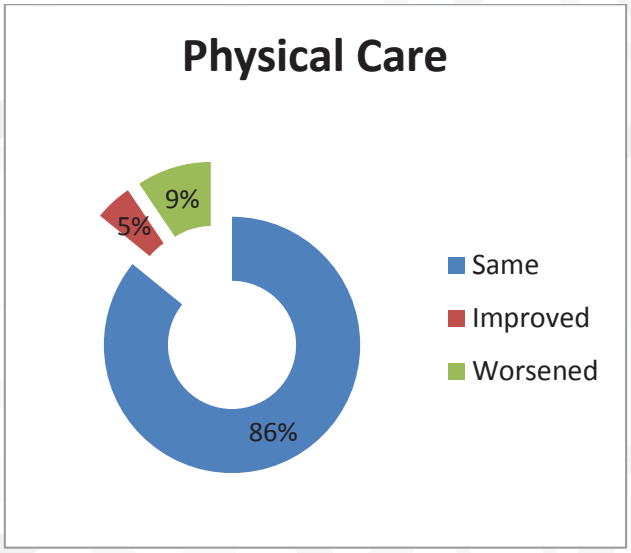


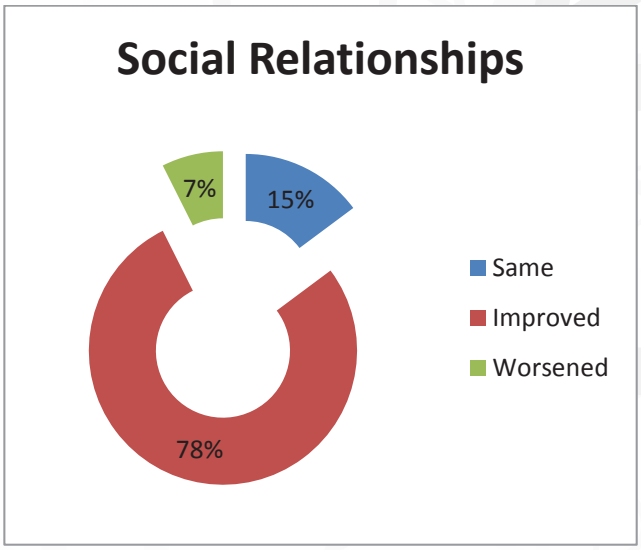


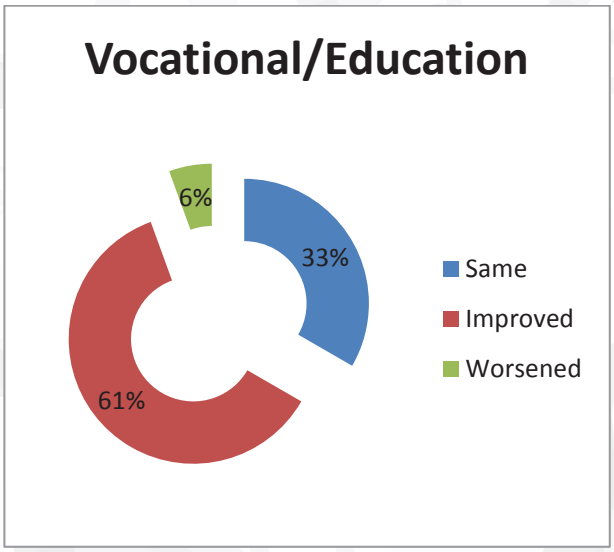


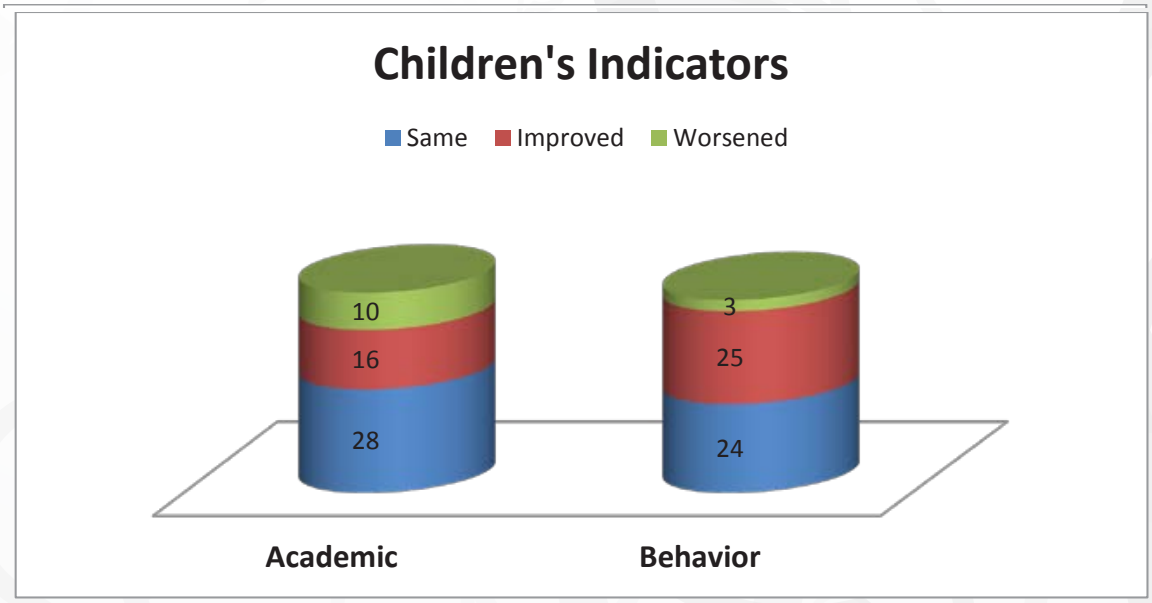
Henrietta Weill Child Guidance Center – West Bakersfield Care Team:



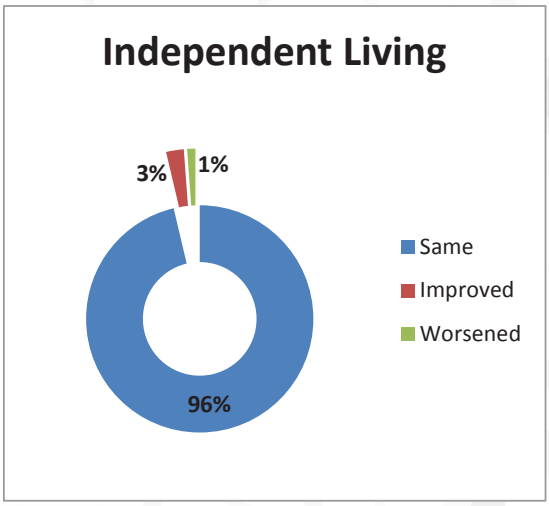


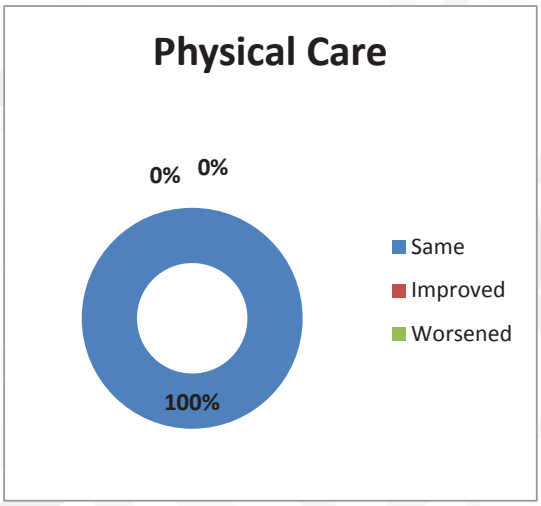


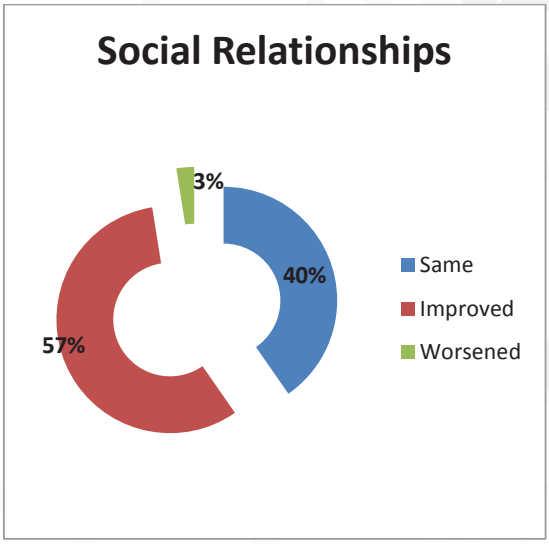


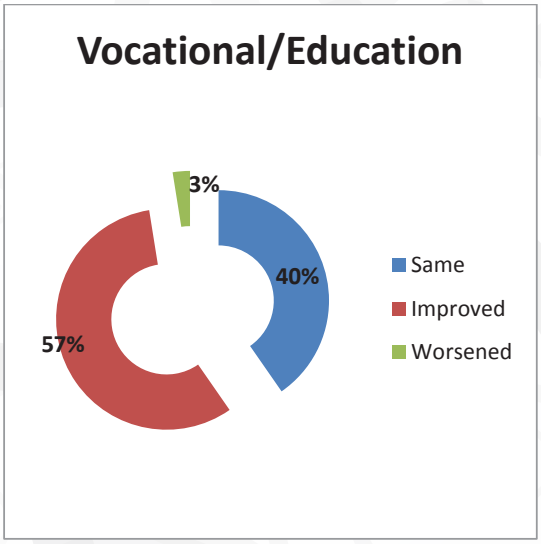


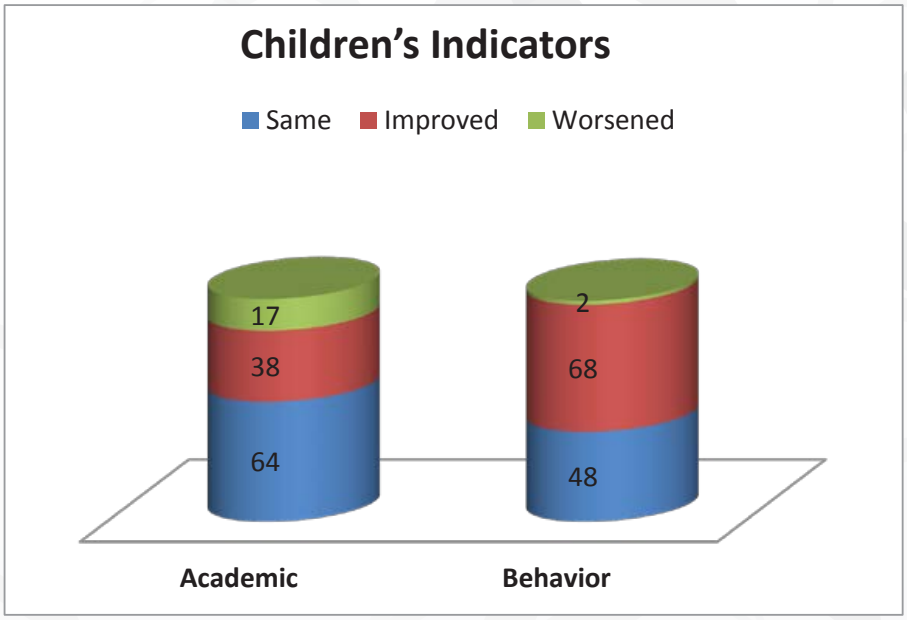
Henrietta Weill Child Guidance Clinic – Delano Team:



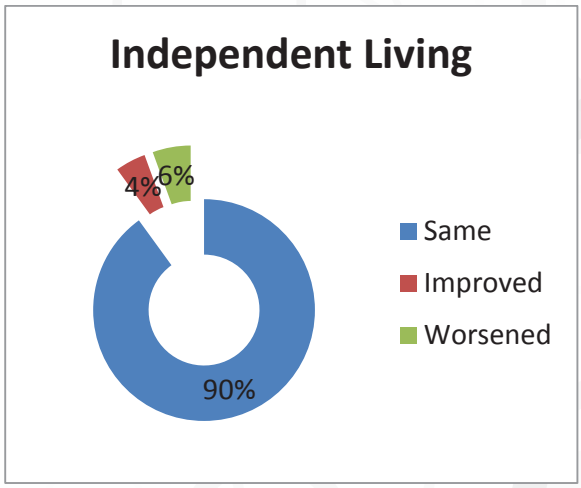


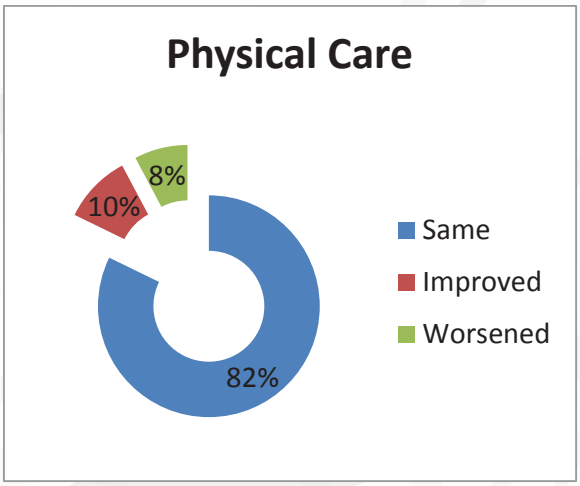


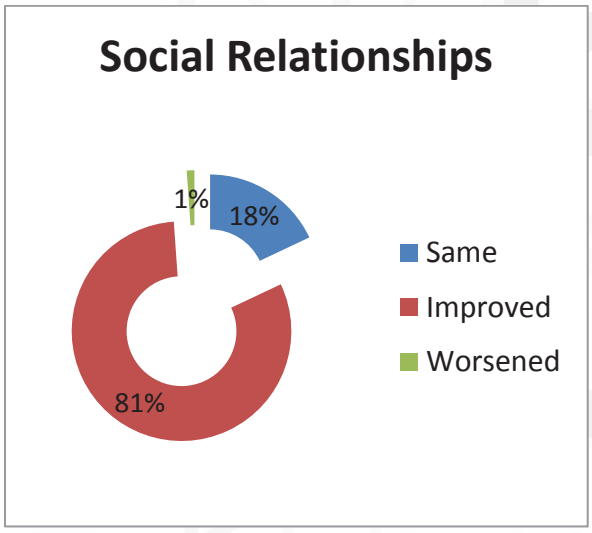


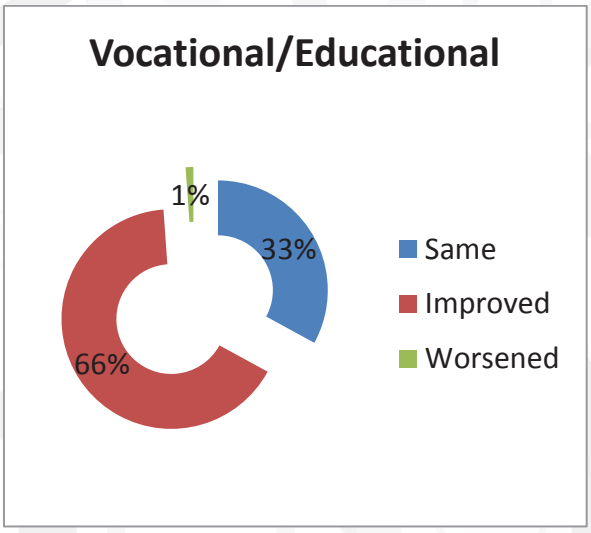


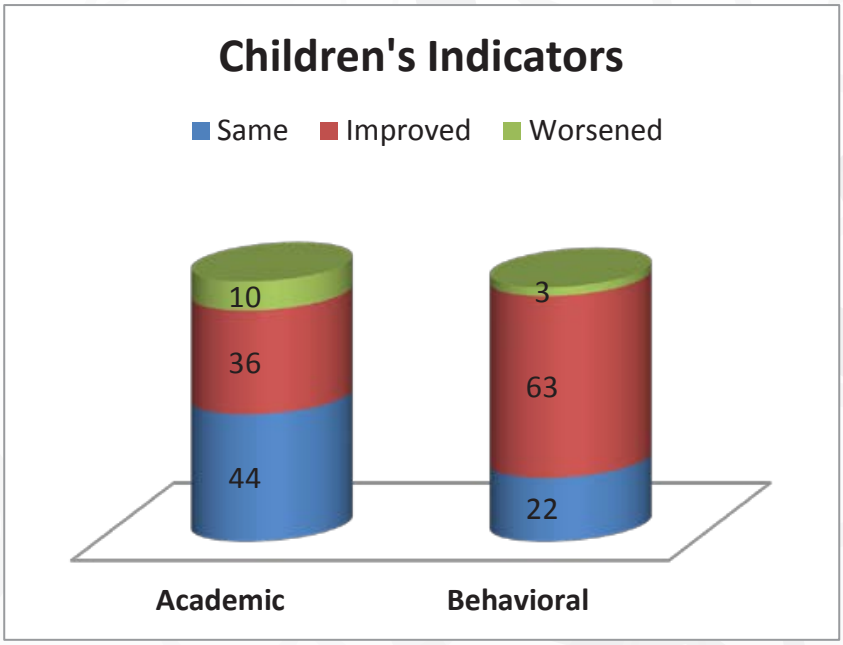
Clinica Sierra Vista Arvin/Lamont Team:



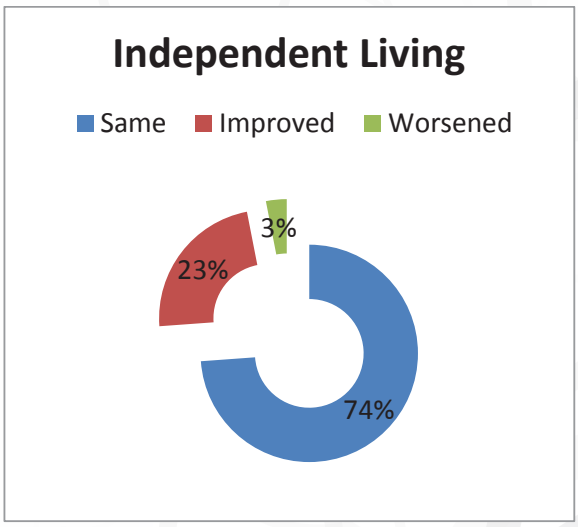


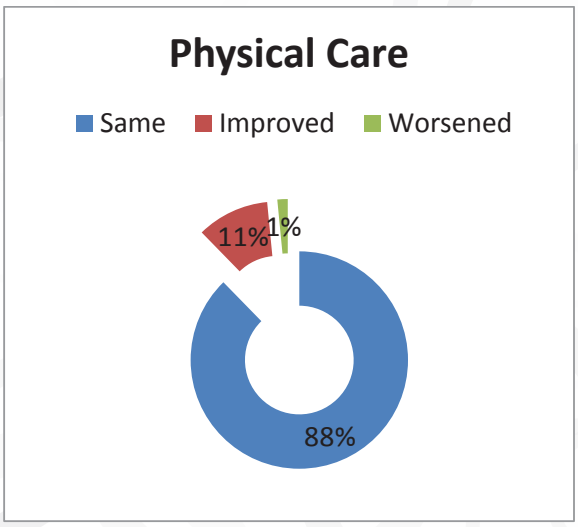


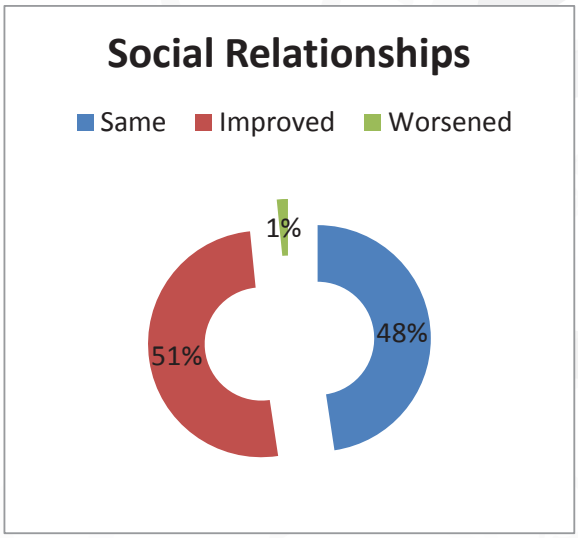


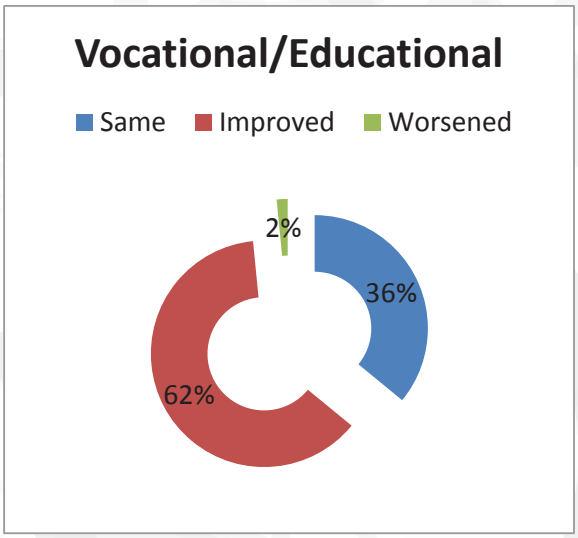


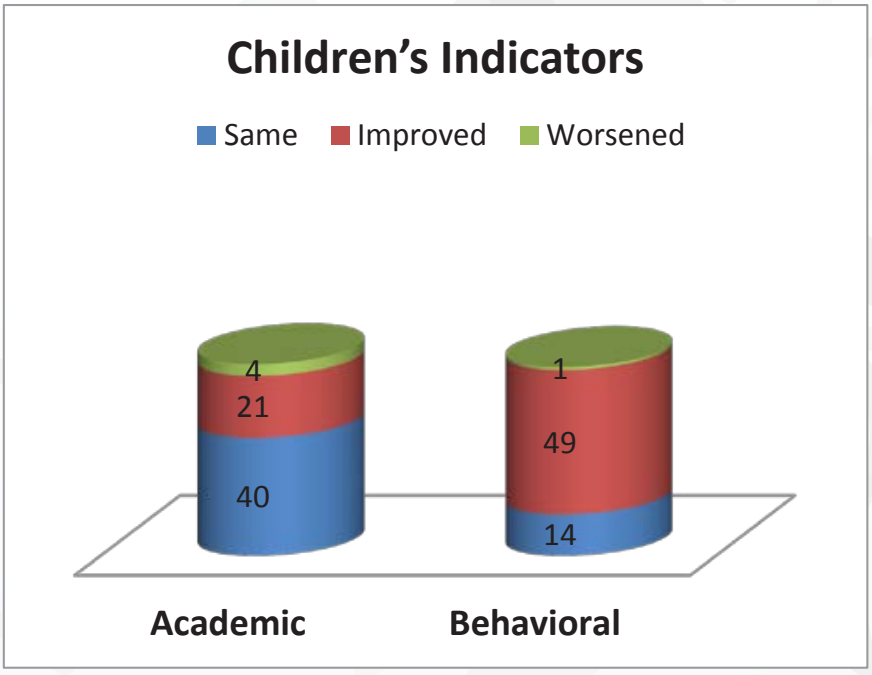
College Community Services Wasco Team:

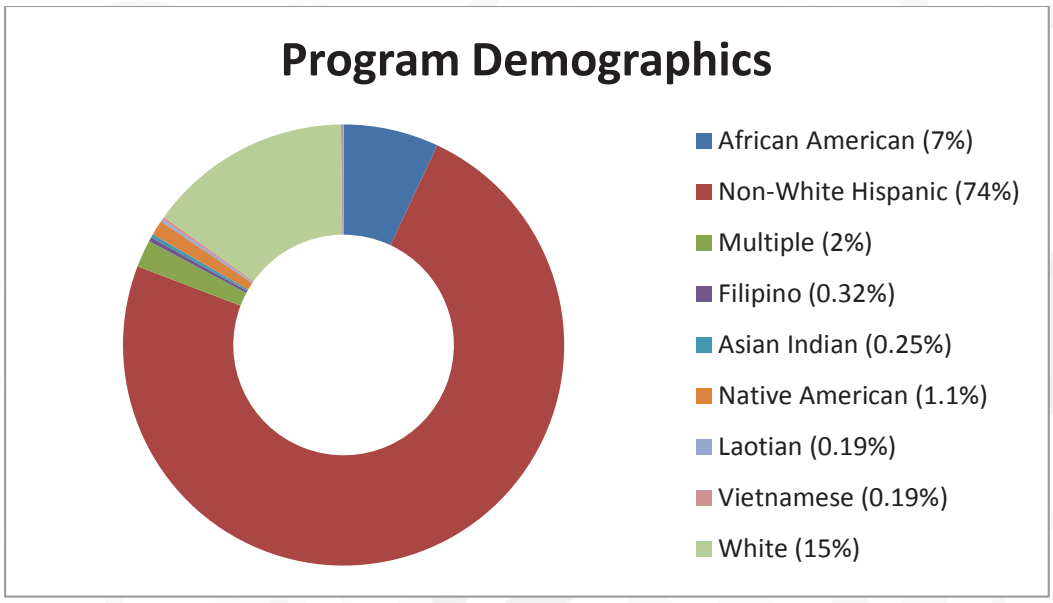












Challenges

- Effectively and efficiently implementing the program with new staff
- Training new staff on goals, objectives, target populations and increasing caseloads for the program
- Training new staff on evidence-based, culturally appropriate services
- Ongoing training for veteran and new staff to accurately and systematically assess and reflect initial reported symptoms and behaviors for outcome measure data, and collection of self-report ratings from youth and their families; collecting self-report data at intake and discharge to measure program effectiveness

Solutions in Progress

- Regular meetings with staff to track data
- Develop a "Decision Tree" of specific criteria to qualify for the program versus youth who may require a higher level of mental health care as the Youth Brief Treatment program is designed those determined to be able to complete a six-to-nine month treatment plan
- Develop a survey for participants to provide feedback on potential program improvement
- Provide clinical skills training for staff to ensure treatment effectiveness
- Review and monitor outcome data reports quarterly

Transitional Age Youth Career Development – Prevention

Location:
America's Job Center of California
1600 E. Belle Terrace Avenue
Bakersfield, CA 93307

Client's served in 2015/2016: 23
Goal number of clients served in 2016/2017: 40
Anticipated Cost per Client: $595.55

Program Description
The Transitional Age Youth (TAY) Career Development Program provides TAY (aged 16-25) a unique opportunity to address personal barriers including stressors while developing the skills necessary to successfully engage in gainful employment. The program was developed for transitional aged youth who are either new to the TAY mental health services program or who have transitioned from mental health care.

TAY team members work with youth to promote social skills, self-empowerment and reduce any psychosocial, adjustment or situational stressors through use of coping skills. This is designed to reduce risk factors which could further inhibit their ability to successfully perform in the workforce. The program primarily serves youth who have a history with foster care or probation. Successful participation and completion of the program provides this population the ability to further attain independence financially, eliminating the need for public assistance.

As a collaborative effort, TAY works with the Kern High School District, America's Job Center and the Employment Development Department on the 12-week program. Broken down into four phases, the Career Development program includes a job training portion (four weeks), volunteer period (two weeks), paid externship (six weeks) and finally job search and placement. Participants are provided an opportunity to benefit from experience of peers who have completed through program during Fun Friday's. Peers speak on their experience and offer mentoring for youth active in the program. The Kern High School District provides an allowance for a professional outfit and the Employer's Training Resource also provides a closet of gently used clothing for youth beginning their job search and placement process.

Challenges arising from the length of time between program cohorts resulted in the cohort schedule changing to every four months. Youth waiting to begin the program are provided interim services to keep them engaged, or if the full cohort is deemed unnecessary.

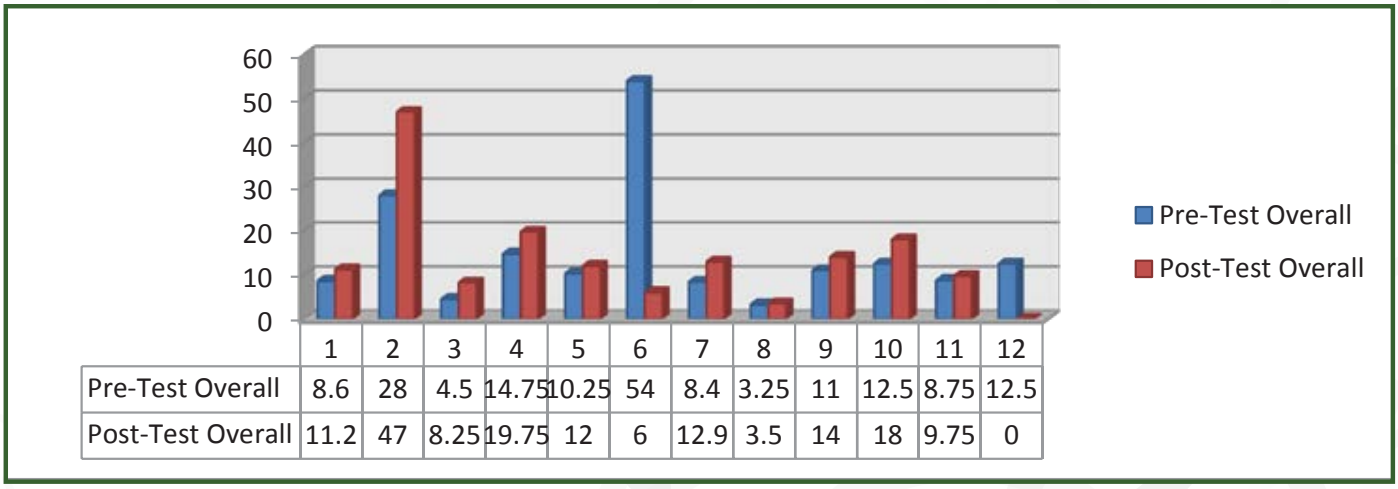
The TAY Career Development program was highlighted during a workshop session at the 2016 Recovery Workforce Summit hosted by the Psychiatric Rehabilitation Association in Boston, Mass. The annual four-day summit incorporates a breadth of topics related to recovery and wellness, with presenters representing programs and practices across the United States

Service Goals

- Build self-work, confidence and continued wellness
- Prevent unemployment among transitional age youth
- Prevent psychosocial, situational and adjustment stressors that impair transition age youth from finding and maintaining employment
- Promote effective communication both socially and professionally
- Complete job readiness, utilizing a pre and post-test to measure confidence in the program

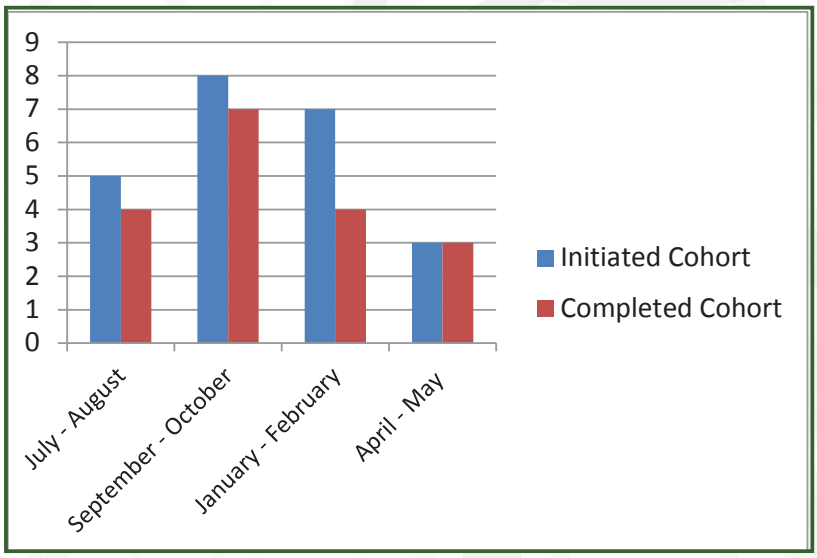
Program Data

This chart indicates the overall scores for pre-test and post-tests of cohorts during the FY15/16 year. The overall score average for pre-tests was 14.71; the overall score average for post-tests was 13.53. If youth did not complete the cohort class, a score was not provided for the post-test.



	1	2	3	4	5	6	7	8	9	10	11	12
Pre-Test Overall	8.6	28	4.5	14.75	10.25	54	8.4	3.25	11	12.5	8.75	12.5
Post-Test Overall	11.2	47	8.25	19.75	12	6	12.9	3.5	14	18	9.75	0

Twenty-three youth initiated the cohort in 2015/2016, 18 youth completed the job readiness cohort.



Challenges

- Some youth do not complete the job training portion or upon completion do not complete their paid externship due to increased mental health symptoms or substance use
- Youth lose motivation when it comes time to begin job searching
- Homelessness or lack of stable housing can create reduced attendance or failed completion of the job training cohort
- Some youth may experience mental health symptoms which inhibit their ability to complete the program; these symptoms are addressed in treatment prior to re-engaging them in Career Development

Solutions in Progress

- Interim services provided to those not requiring the full cohort; this will expedite the job searching process and allow youth to secure employment and other resources more efficiently
- For youth who are at risk of discontinuing the program, TAY team members work with the youth and Employers Training Resource staff to help in securing employment
- Re-evaluate the job search and placement portion of the program to better engage youth in using resources available to seek and attain employment.

Transitional Age Youth Career Development – Early Intervention

Location:
America's Job Center
1600 E. Belle Terrace
Bakersfield, CA 93307

Client's served in 2016/2017: 122
Goal number of clients served in 2016/2017: 120
Anticipated Cost per Client: $4,601.47

Program Description
Youth participating in the TAY Career Development Program experiencing increased mental health symptoms may be provided treatment and support throughout the process. This includes youth with increased anxiety which may prevent them from seeking employment or successfully completing the program.

For these youth, therapists provide individual therapy interventions and group rehabilitation using the Transition to Independence Process (TIP) model. Case managers work with issues that arise, including barriers to resources. Substance Abuse Specialists work on relapse prevention and provide youth an opportunity to re-submit their drug screen if willing and necessary, to continue in the program. Additionally, early intervention services are provided to TAY who have completed treatment in the Full Service Partnership, but have experienced recent increase in symptoms. Clinical staff at the Dream Center and Employers Training Resource address the needs of these youth in non-clinical settings.

Using TIP, TAY staff focus the treatment aspect and goals to the work force setting. By this, treatment will focus on strength discovery, coping skills and In Vivo, a role play which allows clients to practice interviewing scenarios. To better prepare them for an externship, clients receiving early intervention services will shadow Employer's Training Resource staff at America's Job Center, where they are prompted to and reminded of appropriate behavior in the workplace.

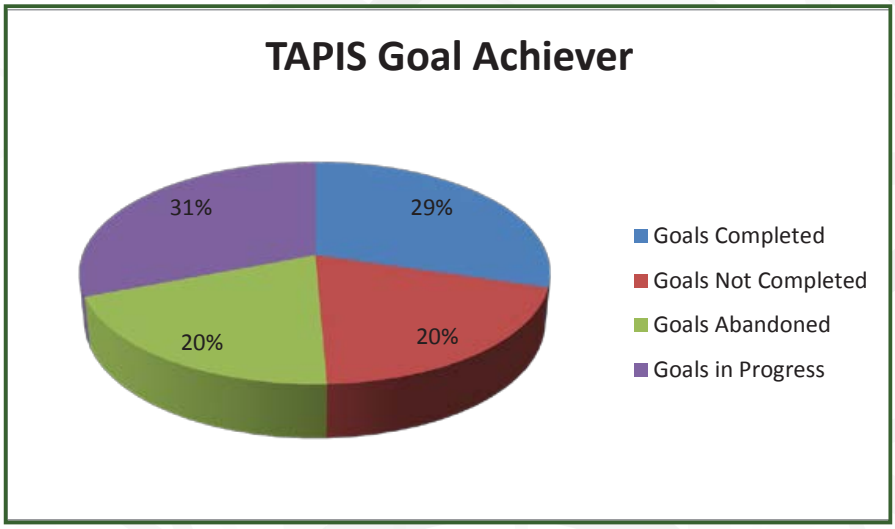
Continuing the hands-on approach, after job shadowing, clients practice submitting resumes and requesting applications from retail and food service establishments, and practice properly inquiring about job openings. The activity assists youth in managing anxiety, while the treatment team provides feedback and support throughout the activity. Once confidence in treatment interventions having reduced symptomology is established, clients rejoin the cohort to continue the program externship and internship.

Service Goals

- Decrease anxiety and depression by providing youth In Vivo role-play training to assist in finding and maintaining employment
- Assist transition age youth in learning to self-manage their mental health symptoms while simultaneously developing the necessary skills to enter the workforce
- Reduce homelessness by promoting independence

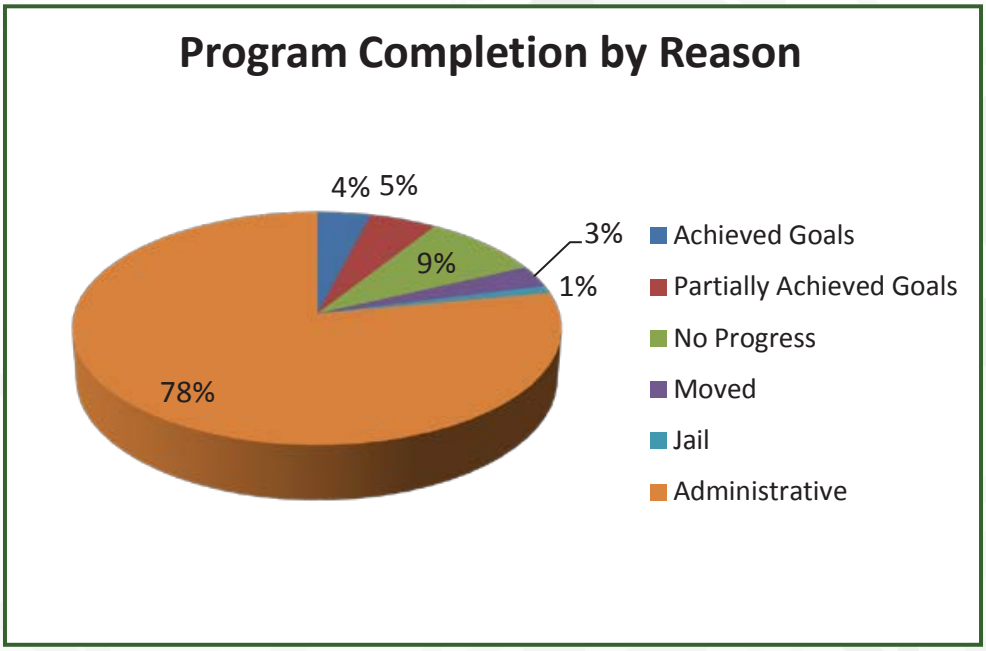
Program Data

In FY2015/2016, the TAY Career Development Early Intervention program began utilizing TAPIS, a goal and achievement based outcome system. Tracking begins with an initial 41-question assessment which determines goals. The assessment is conducted quarterly thereafter. Due to the nature of the reporting program, any changes in goals are reflected as new goals; which automatically indicates that the previous goal may not have been completed.

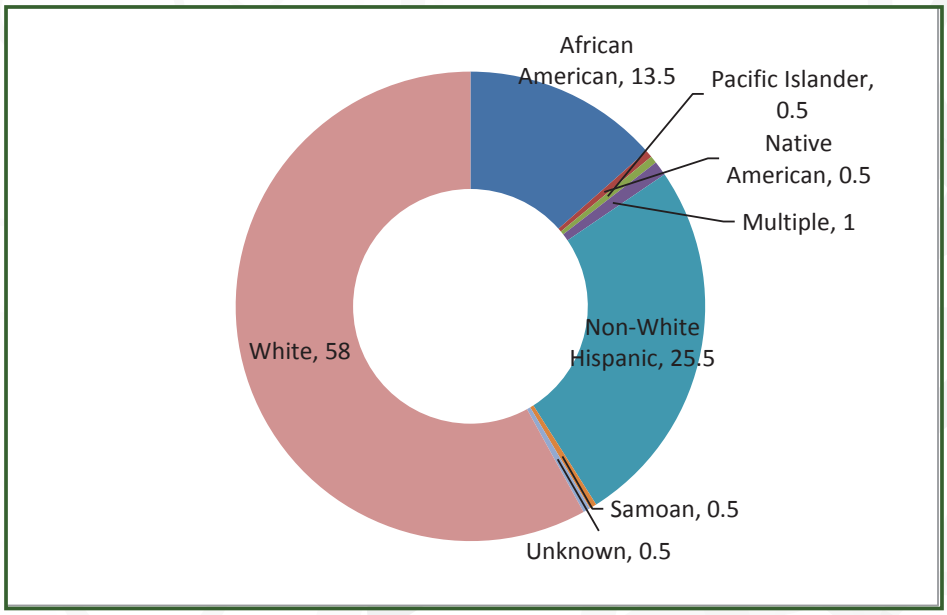


The above results of goals achieved were determined from the progress for each client set by personal goals. Clients are given a date for each goal to determine follow through of tasks in a timely manner. Clients may have multiple goals set at any given time. Goals are set in various categories including employment, educational, reduction in symptoms and may include items like obtaining a driver's license.

Clients completing services with TAY Career Development Early Intervention were discharged either by plan when completing service goals or unplanned. If a client required a higher level of care they were provided transfer to a specialty care team as necessary. Due to a move in March 2016, clients were moved changed in subunit, which is reflected by the Administrative discharges. Those clients served were subsequently reopened to the relocated subunit assigned with the treatment team.



Demographics percentages of those served during the FY 2015/2016



Challenges

- Many youth are transitioning from foster care to independent living. If not prepared, this can lead to homelessness and increased risk for drug use, lack of support and unemployment
- Many TAY youth struggle with depression, low motivation, distrust, anxiety and impulsivity; they are not structured to a traditional work week, which can cause premature exit from the program
- Co-occurring substance use disorders can prevent youth from participating in paid externships and ultimately increase likelihood of homelessness

Solutions in Progress

- Providing skills necessary to develop independence
- Support youth with transportation during externship
- Pre-placement job practice and coaching to ensure readiness prior to entering a paid position
- Implementation of a prevention planning, goal-oriented substance use disorder group to foster an increase in self-efficacy
- Maintain connection to potential employment opportunities

Risk Reduction Education & Engagement Accelerated Alternative Community Behavioral Health (REACH) –NEW

Estimated number to be served in FY 16-17: 100
Estimated cost per client: $2,812.85

Program Vision
Prevent mental illnesses from becoming severe and disabling, by engaging hard-to-reach, at risk individuals who do not respond well to traditional behavioral health services, and successfully linking them with treatment.

Program Description
The Risk Reduction Education & Engagement Accelerated Alternative Community Behavioral Health (REACH) Program will provide community outreach, education, and engagement services. Outreach and education services will be provided to community members and partner agencies, with the focus of identifying and engaging at risk adults who are experiencing challenges in accessing and/or remaining engaged in traditional mental health and substance use disorder services. Once identified and referred, the REACH Program will deliver temporary case management services, with a primary focus of engagement, to assist individuals in getting successfully linked with ongoing outpatient treatment.

REACH Program staff will be trained annually in mental health and substance use disorder skills from the following evidence-based practice models: Motivational Interviewing, Solution Focused Brief Therapy, Dialectical Behavior Therapy, AEGIS, and Applied Suicide Intervention Training. The staff will work in teams of two, and will embrace a "whatever it takes" model of service delivery. Typical services during the engagement phase will include will include: psycho-education, engagement, skill acquisition/building, crisis intervention/response, accelerated access and linkage to mental health and substance use disorder services, and post-linkage follow-up. These services will be provided in attempt to reduce negative outcomes that often result from ongoing, untreated mental health and substance use disorders, including: incarceration, involuntary psychiatric hospitalization, and homelessness.

Referrals to the REACH Program will be provided by, but not limited to, the following: Family Members/Persons of Support, Hospitals, Inpatient Psychiatric Units, Crisis Walk in Center, Family Advocate, Contract Providers, Public Health, Law Enforcement, Detentions Personnel, National

Alliance on Mental Illness, Aging and Adult Services, Kern County Mental Health Teams, other community supports. A 24-hour referral line, which will be answered by staff Monday thru Friday, 0800-1700, will be available for referring parties.

There is a significant need for behavioral health outreach services in the metropolitan and outlying areas of Kern County. The REACH Program will provide an alternative, non-traditional type of behavioral health services, with an emphasis on engaging individuals in a patient manner and providing accelerated access to ongoing treatment. REACH Program staff will continue to follow-up with individuals and the outpatient treatment team for at least 1 year to evaluate the flow and disposition of the individuals' services. Ongoing program evaluation, data collection, and data analysis will assist in the further development of the REACH Program.

Service Goals

- Improved connection of care as evidenced by the number of unduplicated individuals linked with ongoing outpatient services
- Increase in the number of unduplicated individuals remaining engaged in services as evidenced by time increment reports
- Decrease the number of monthly law enforcement contacts as evidenced by data collected by the law enforcement communications centers
- Decrease the number of monthly crisis/emergency behavioral health services as evidenced by recidivism reports and data tracking by the mobile evaluation team and psychiatric evaluation center

Program Data

- It is anticipated the REACH Program will serve at least 100 unduplicated individuals during the first year of operation
- The number of referrals
- The number of unduplicated individuals with serious mental illness referred to treatment.
- The type of treatment individuals with serious mental illness were referred to

- How long the individual experienced symptoms of mental illness prior to becoming involved in the REACH Program, based on the first face-to-face engagement with REACH Staff
- The number and frequency of outreach worker contacts with the individual
- The number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participate at least once in the program to which they were referred
- The focus of the outreach worker contacts with the individual
- The number of cases with family/supports involved
- The number of contacts/interventions the outreach worker has with family members/supports
- The number of contacts per month delivered by the geographical service provider
- The number of law enforcement contacts the individual has per month.
- The number of MET, PEC-CSU, and Inpatient Psychiatric Hospitalizations per month
- Quarterly community stakeholder meetings about REACH Program per geographic region
- Dispositions of individuals who have been served by the REACH Program. At monthly intervals until 1 year after being successfully linked with services
- Client and Family Satisfaction Surveys

Challenges

- The availability of Evidence Based Practices Skills training for the REACH Program staff.
- Successfully engaging service resistant individuals.
- Accurately reflecting services delivered in documentation.
- Referring community members/partner agencies wanting information regarding the individuals they refer.

Solutions in Progress

- Working with the training department to prioritize and plan trainings.
- Working with the AZ/QI work group regarding documentation. Will request specific documentation training for REACH Program staff.
- Will have a tri-fold informational brochure that explains the program's vision, goals, objectives, and the confidentiality of the individuals who are referred to the program.

Program and Evidence-Based Practice Skills Monitoring

- Weekly team meetings
- Bi-weekly supervision
- Supervisor shadowing staff at least once per quarter
- Ongoing evaluation of data patterns
- Peer feedback surveys

Project Care – Prevention

Locations:
Clinica Sierra Vista
Delano Community Health Center
1408 Garces Highway
Delano, CA 93215

Clinica Sierra Vista
Arvin Community Health Center
1305 Bear Mountain Blvd.
Arvin, CA 93203

Clinica Sierra Vista
Lamont Community Health Center
8787 Hall Road
Lamont, CA 93241

Clinica Sierra Vista
McFarland Community Health Center
217 W. Kern Avenue
McFarland, CA 93250

Client's Served in 2015/2016: 1,064
Goal number of clients served in 2016/2017: 5,000
Anticipated Cost per Client: $106.68

Program Description
The Project Care program began in 2011. Kern Behavioral Health and Recovery Services contracted with community healthcare providers to integrate behavioral health in a primary care setting. Project Care services are currently available at four community health care centers in traditionally underserved areas of Kern County: Delano, Lamont, McFarland and Arvin.

Project Care is a Prevention and Early Intervention program, working to reduce stigma associated with mental illness while normalizing the necessity of mental health care. The SBIRT (Screening, Brief Intervention and Referral to Treatment) model is utilized in the primary care sites to serve the prevention and early intervention purpose. The prevention aspect of the program utilizes three screening tools to determine levels of potential anxiety, depression and substance use disorder.

Within the clinic, behavioral health staff assist primary care providers in identifying mental health symptoms to address concerns during routine visits. This collaboration is designed to reduce stigma associated with mental illness and substance use disorder and provide a comfortable place for patients to address needs in a familiar environment.

The primary care provider utilizes the General Anxiety Disorder seven item scale (GAD -7) to screen anxiety symptoms, Patient Health Questionnaire nine item scale (PHQ-9) for depression symptoms and the Alcohol Use Disorders Identification Test (Audit C+) for alcohol and drug use. Clients screening results in any of these areas determine whether and what concerns may need to be addressed during their primary care visit.

Service Goals

- Increase capacity of the community health centers to address mental health and substance use disorders for unserved or inappropriately served individuals
- Increase knowledge among primary care providers to understand the interplay between primary and specialty care
- Increase the level of comfort for primary care providers to discuss these issues with patients, as a large portion of those in need of mental health care will more often utilize the medical care system
- Identify mental health and substance use disorders and prevent them from worsening by addressing them as

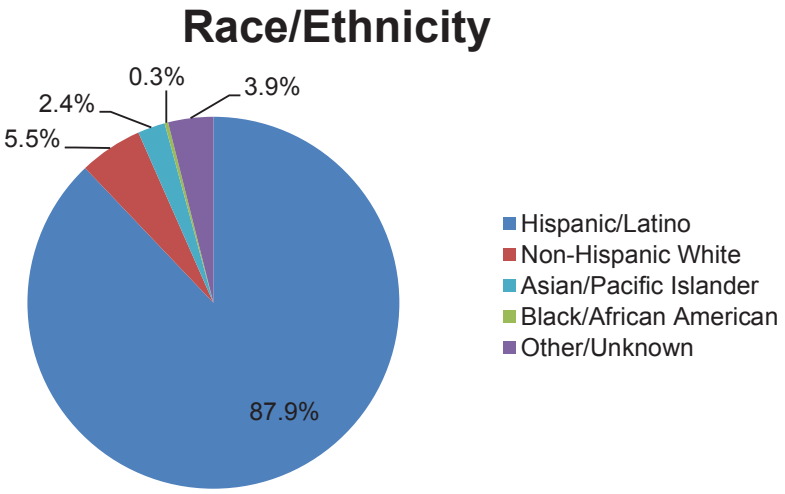
part of routine medical care

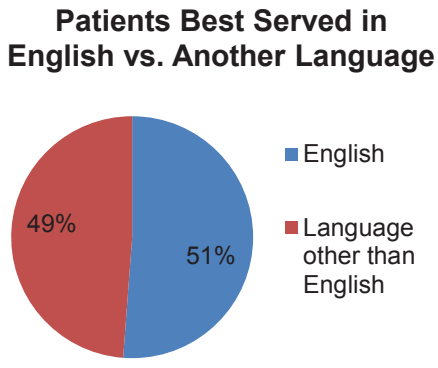
Program Data
Evaluation for Project Care is provided by University of California, Los Angeles (UCLA) researchers. Program administrators, provider leadership and the evaluator meet monthly. UCLA has also provided training and technical assistance. In January 2016, training was provided to 78 participants on "Engaging Primary Care Patients in Behavioral Health Conversations."

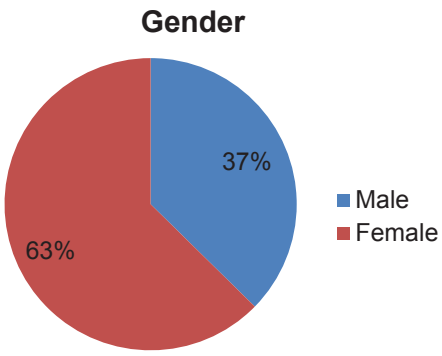
Data collected by UCLA includes demographic data, information on services provided, summarized data on screening results and the change between initial screening and post-intervention screening. Datasets differ due to a change in reporting systems on the part of the provider. In August 2015, the service provider began utilizing Cerner/Anasazi, the electronic medical record used by Kern Behavioral Health and Recovery Services.

Demographics:

- 37 percent male; 63 percent female
- 87.9 percent Hispanic/Latino; 5.5 percent Non-Hispanic White; 2.4 percent Asian/Pacific Islander; 0.3 percent Black/African American; 3.9 percent Other
- 51 percent of clients were served in English; 49 percent were best served in another language

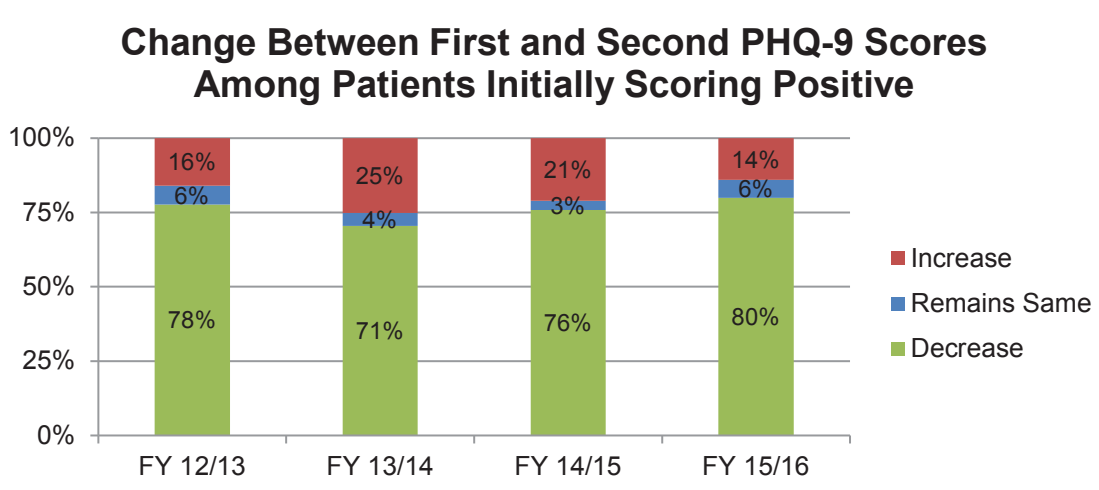


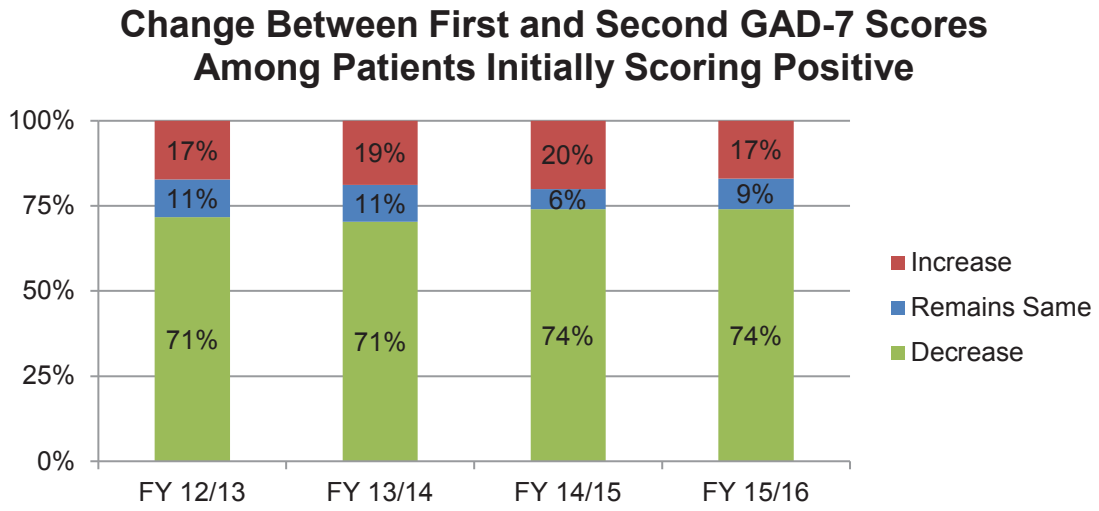


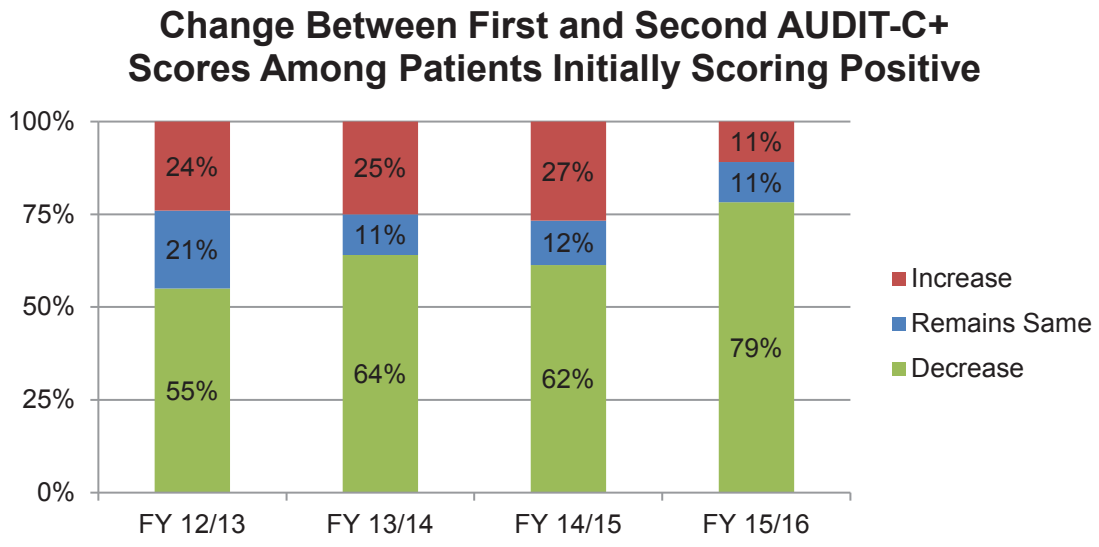


Total Project Care visits: 1,563
Total number of patients screened: 839
Number of new screenings performed: 488
Number of new patients screened 412

Change in screening scores for those patients initially scoring positive on Depression (PHQ-9), Anxiety (GAD-7) or Alcohol and Substance Use (Audit –C+):







Of the Project Care patients receiving at least two screenings, 57 percent screened positive for possible depressive disorder; 54 percent screened positive for possible general anxiety disorder and 22 percent screened positive for possible substance use disorder. Screening results showed decreased scores in each of the categories. Eighty percent of patients had decreased PHQ-9 scores; 74 percent had decreased GAD-7 scores; 79 percent had decreased Audit-C+ scores.

Making a Difference
Jimmy, a 23-year-old, has been diagnosed with Asperger's Syndrome. He has been seen 14 times, but I have worked with him longer. This client struggled with obtaining regular employment and was managing symptoms of depression all while having difficulty communicating his needs.

He had encountered several years of sexual abuse by a family friend. He continues to see the perpetrator within his neighborhood. With all of this, he continues to strive for better. During our time working together, Jimmy has taken up crocheting; he has bought himself a saxophone, which he practices. He has appealed his case with Kern Regional Center, and though he did not win, this was a challenge for him.

He now has full time employment with a local pizza restaurant, gets along well with his co-workers and socializes with family and friends.

Challenges

- Introduction of the behavioral health staff into the medical setting by primary care staff, including office and medical staff lead to some apprehensiveness from the primary care staff
- A reduction in clinics assigned to the program resulted in additional planning to take place to ensure geographical areas continued to have representation in the project

Solutions in Progress

- Building relationships with staff at all levels in the medical clinic through increased interactions and collaborative training
- Additional staff resources focused on relationship building and oversight of referrals between specialty care and primary care.

Project Care – Intervention

Locations:
Clinica Sierra Vista
Delano Community Health Center
1408 Garces Highway
Delano, CA 93215

Clinica Sierra Vista
Arvin Community Health Center
1305 Bear Mountain Blvd.
Arvin, CA 93203

Clinica Sierra Vista
Lamont Community Health Center
8787 Hall Road
Lamont, CA 93241

Clinica Sierra Vista
McFarland Community Health Center
217 W. Kern Avenue
McFarland, CA 93250

Client's served in 2015/2016: 1,275
Goal number of clients served in 2016/2017: 1,200
Anticipated Cost per Client: $532.67

Program Description
The Project Care integrated health program intervention piece, like its prevention counterpart, utilizes the Screening, Brief Intervention and Referral for Treatment (SBIRT) model. This early intervention effort is designed to provide short-term treatment for clients exhibiting mild mental health and substance use symptoms.

During the course of the primary care visit, the physician will review any positive screening results from the General Anxiety Disorder seven scale questionnaire (GAD -7), Patient Health Questionnaire nine item scale (PHQ-9) and the Alcohol Use Disorders Identification Test (Audit C+) and discuss with the patient any concerns. As needed, the physician will provide introduce the behavioral health clinician and begin conversation to address mental health and substance use concerns.

Brief interventions for clients include education on mental health and or substance use, coping skills, referrals for community resources and support. Patient's requiring brief interventions may also be encouraged to schedule treatment with behavioral health staff, for continued services. The patient may also be referred for an appointment with a psychiatrist. If medication is needed, the psychiatrist and physician will consult to discuss any barriers to medication, including an existing regimen.

If a patient's mental health care needs exceed those provided by the early intervention program, their physician, clinician or psychiatrist can refer them to specialty mental health care at any time during the course of treatment. The patient will then be referred to a Kern Behavioral Health and Recovery Services System of Care program or geographic service provider based on need and service availability.

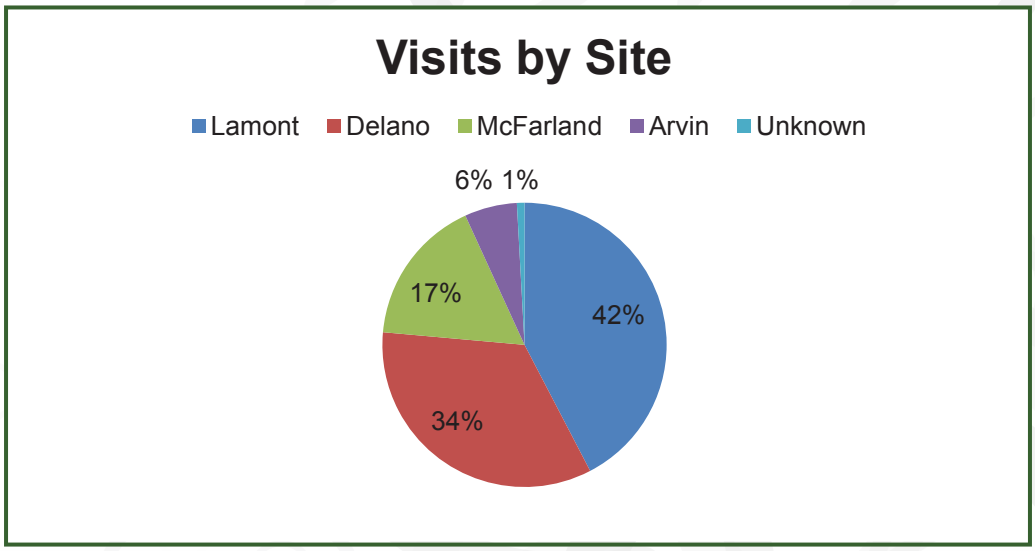
Service Goals

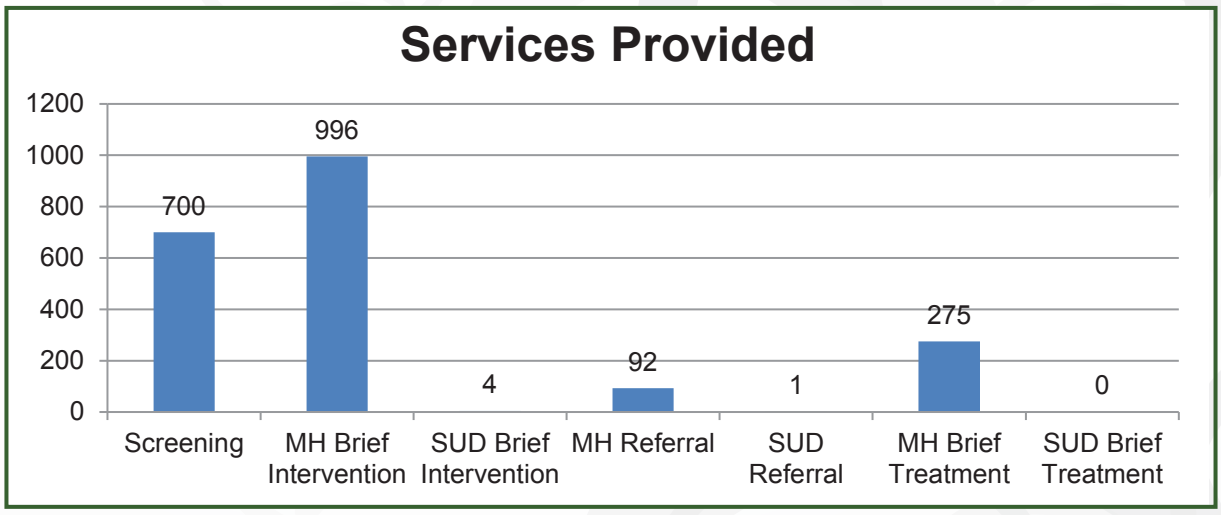
- Provide brief interventions for mental health and substance use disorders in a primary care setting
- Broaden access to care for individuals that may not access necessary services due to stigma or lack of resources
- Facilitate referrals to specialty mental health and addiction treatment when services that are more intensive are deemed appropriate

Program Data

Evaluation for Project Care is provided by University of California, Los Angeles (UCLA) researchers. Program administrators, provider leadership and the evaluator meet monthly. UCLA has also provided training and technical assistance. In January 2016, training was provided to 78 participants on "Engaging Primary Care Patients in Behavioral Health Conversations."

Data collected by UCLA includes demographic data, information on services provided, summarized data on screening results and the change between initial screening and post-intervention screening. Datasets differ due to a change in reporting systems on the part of the provider. In August 2015, the service provider began utilizing Cerner/Anasazi, the electronic medical record used by Kern Behavioral Health and Recovery Services. For additional information on Project Care screenings, please refer to the Project Care Prevention program description.





In an effort to broaden access to care, Project Care services were provided at Clinica Sierra Vista Community Health Center's in rural/outlying areas of Kern County. Lamont Community Health Center had the largest share of visits (837), followed by Delano (673), McFarland (331) and finally Arvin which had the fewest (118).

Data sets report 996 mental health brief intervention services and 275 brief treatment services provided. Additionally, 92 referrals for mental health care were provided. Four brief intervention for substance use services and one referral for substance use disorder care were also provided.

For those who received brief interventions through Project Care were surveyed to determine whether they felt improved confidence in their ability to manage mental health and/or substance use disorder symptoms. Data was reported for three clinics: Lamont, Delano and McFarland. An average of 75 percent of participants reported improved or maximum confidence.

Making a Difference

A 48-year-old client presented to the clinic with symptoms of worrying, being easily angered, anxiety and inability to sleep. During her initial mental health care visit, she was highly anxiety and reported being unable to control feelings of worry. She was worried about her terminally ill father, her marriage and children. The patient learned meditation and relaxation technique strategies and was encouraged to improve communication with her family in the initial visit. In follow up sessions, Cognitive Behavioral Therapy was used to help her learn 'thought stopping' techniques and to replace anxious provoking thoughts with pleasant, reassuring thoughts. Utilizing her new skills, she reported improved symptoms and that her relationship with her husband and children had improved. She had reported that she was taking it one day at a time with her father. A follow up was provided after she had decided that her symptoms were such that she could terminate services. During follow up, her mental health care provider shared techniques to help her let go of things she cannot control. The patient reported that services helped her to focus on her family.

Challenges

- Based on client interviews, some patients felt the questions were unusual and did not like that they were referred to a 'drug counselor'
- The inability to see all patients that screen positive in the same day of the visit. This comes from not being made aware that the screening is positive before the patient is discharged, or being with another patient at the time of the screening
- Primary care clinic reception staff being apprehensive in working with clients who have returned for an appointment with behavioral health staff

Solutions in Progress

- Patient perception surveys will be conducted periodically to identify barriers to treatment and illicit recommendations from patients to overcome these barriers
- Aid the staff to meet patients during the course of their medical visit
- Consultation with clinic staff is highly valued, as they will recommend better and more efficient processes for screening and contact with behavioral health staff
- Continued education with primary care staff and strengthening of relationships between behavioral and primary care staff through collaborative training

Volunteer Senior Outreach Program – Prevention

Locations:
Kern Behavioral Health and Recovery Services – Adult System of Care
5121 Stockdale Highway, Ste. 275
Bakersfield, CA 93309

Kern Behavioral Health and Recovery Services – West Kern
930 F Street
Wasco, CA 93280

College Community Services
113 F Street
Tehachapi, CA 93561

College Community Services
2731 Nugget Avenue
Lake Isabella, CA 93240

Client's Served in 2015/2016: 4060
Goal number of clients served in 2016/2017: 4000
Anticipated Cost per Client: $189.20

Program Description
The Volunteer Senior Outreach Program (VSOP) prevention component utilizes trained volunteers, who work alongside clinicians and case managers to outreach older adults throughout Kern County. The program was designed to educate and engage seniors who are homebound or living independently and at risk of isolation. Referrals for VSOP services may come from Kern Behavioral Health and Recovery Services teams, including the Access to Care Center, from family members, hospitals, home health care and as self-referrals. Older adults who seem at risk for isolation are typically referred for VSOP services address potential mental health symptoms which can exacerbate as seniors continue to isolate. The VSOP program has been implemented in Bakersfield, Tehachapi, Lake Isabella, Shafter and Wasco, reaching seniors in both metro and rural areas.

The Prevention component provides public education to seniors through health fairs, senior living facilities, churches and community collaborative meetings. Program staff provide information on the program as well as signs and symptoms of mental illness. This effort helps to dispel stigma and create access for services for those in need. Seniors engaged during outreach events may be referred for screening, if found to show symptoms. Screening is done using multiple tools, which measure the activities of daily living, anxiety, depression and mental health status. For those referred by family, friends or other sources to VSOP; staff will make multiple attempts to contact and engage the senior. Staff meet the senior in their homes, as transportation can often be difficult to obtain. Upon engaging a senior, staff members will provide information and screening and refer for services as necessary.

Those who show mild symptoms are referred for early intervention treatment services. Should specialty treatment be necessary, a senior may be referred to a higher level of care provided through the Kern Behavioral Health and Recovery Services WISE program. Screening to measure prescription drug and alcohol use determines if Substance Use Disorder care is needed. Clients may be referred for SUD classes held at the Mary K. Shell Building as needed.

Because VSOP strongly incorporates its volunteers, VSOP works through the outreach process to both recruit and train participants. During the training process, volunteers act as observers and collaborate with the clinical and case management staff to help in reducing isolation of clients while creating new relationships and building interest in activities of daily living. Success in engaging seniors can help prevent hospitalization or institutionalization of seniors and improve overall quality of life.

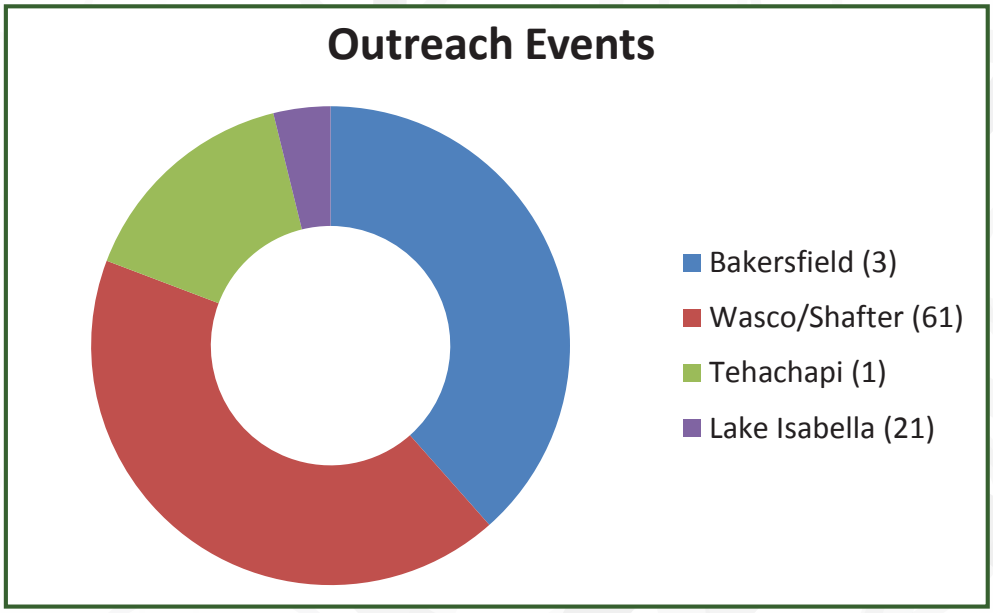
Service Goals

- Provide information on mental illness to older adults in the community
- Increase access and linkage to treatment for older adults, including those in underserved populations

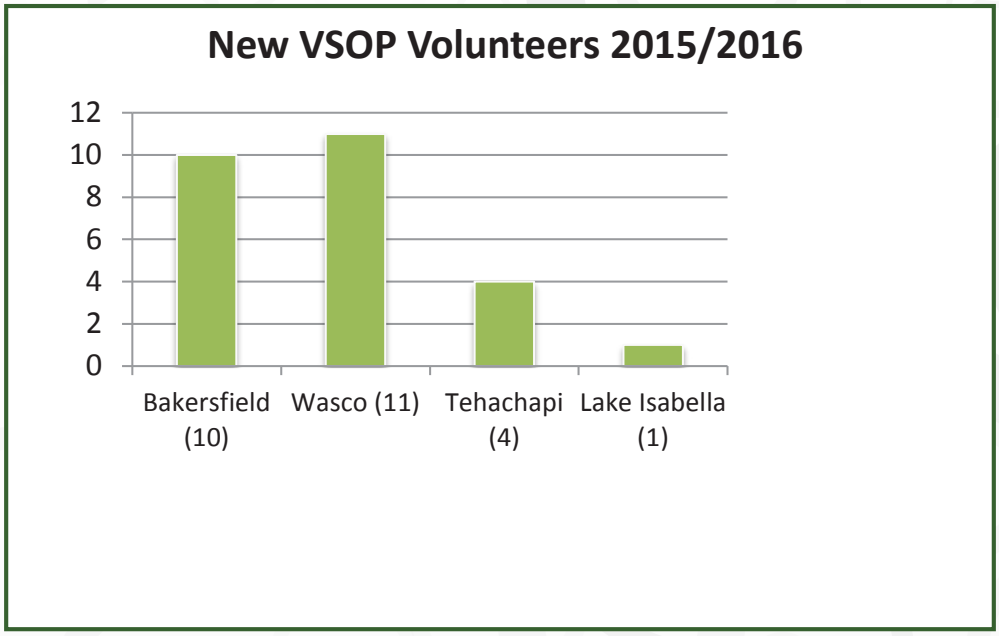
- Provide support for older adults by increasing social interaction and meaningful activity in their daily lives
- Identify clients who are in the mild stages of mental illness

Program Data

Volunteer Senior Outreach Program (VSOP) provides information on mental health program and services throughout Kern County. Outreach events serve to remove stigma associated with mental illness and provide an opportunity for those who may be experiencing symptoms to gather information and receive screening services. A total of 86 outreach events were provided through the VSOP program in the communities of Shafter, Wasco, Tehachapi, Lake Isabella and Bakersfield.

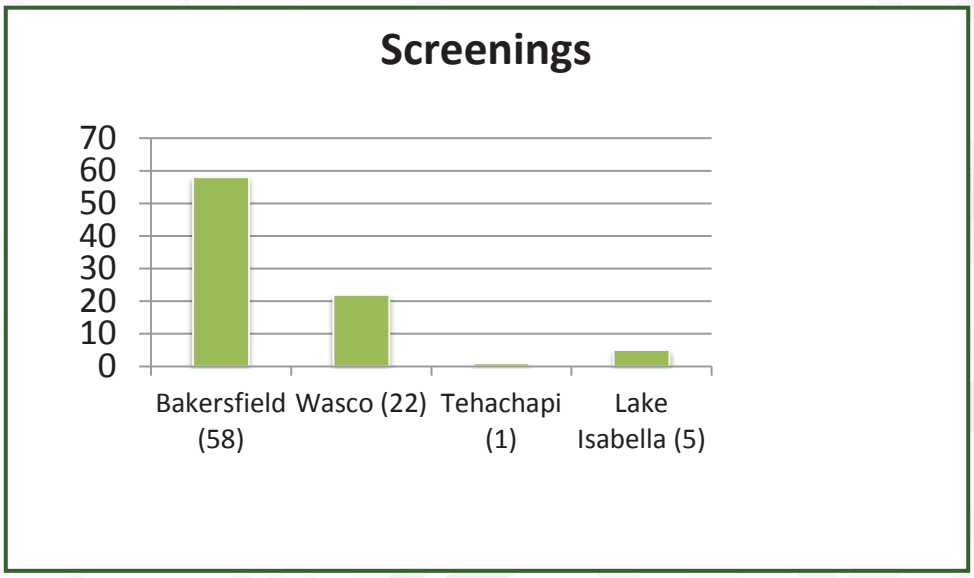


Volunteers are trained throughout the year to assist with engaging older adults referred for VSOP services. A total of 26 newly recruited volunteers were added to VSOP programs throughout Kern County. These, along with existing volunteers completed a total of 348 hours of volunteer training in 2015/2016.



A total of 86 screenings were provided by VSOP staff throughout Kern County. Screenings are provided to determine whether mental health symptoms of anxiety (GAD-7), depression (PHQ-9) and/or alcohol misuse (AUDIT-C) are present. Additionally, older adults screened are provided a SLUMS (Saint Louis Mental Health Status) screening to determine

whether neurocognitive disorders are present.



Challenges

- Transportation for seniors
- Food insecurities
- Lack of socialization, engagement in senior housing, board and care and assisted living facilities
- Recruiting and maintaining volunteers
- Seniors residing in unsafe living environments
- Inappropriately referred clients – many require specialty mental health care, not early intervention services

Solutions in Progress

- Collaboration with public transportation entities.
- Coordination with Meals on Wheels, grocery delivery, food baskets and resource information about senior center lunch and food stamp programs. Adult and Aging Services also provides coupons for the Farmer's Market.
- Staff work with housing providers to assist with barriers to secure housing
- Volunteers have been added to the program in rural communities as well as metro Bakersfield from; California State University, Bakersfield, The Center for Education and Community Engagement and former VSOP clients.

Volunteer Senior Outreach Program (VSOP) – Early Intervention

Location:
Kern Behavioral Health and Recovery Services – Adult System of Care
5121 Stockdale Highway, Ste. 275
Bakersfield, CA 93309

Kern Behavioral Health and Recovery Services – West Kern Office
930 F Street
Wasco, CA 93280

College Community Services
113 F Street
Tehachapi, CA 93561

College Community Services
2731 Nugget Avenue
Lake Isabella, CA 93240

Clients served in 2015/2016: 68
Goal number of clients served in 2016/2017: 100
Anticipated Cost per Client: $151.36

Program Description
The Volunteer Senior Outreach Program (VSOP) utilizes mental health staff and volunteers to provide outreach, education and early intervention as needed to seniors throughout the Kern County community. With teams providing VSOP in Bakersfield, Wasco/Shafter, Tehachapi and the Kern River Valley, seniors are engaged in both metro and outlying areas of the county.

The Volunteer Senior Outreach Program's Early Intervention component provides treatment for seniors who screen positive for mild mental health symptoms. Treatment is provided using motivational interviewing and evidence-based behavioral activation through Healthy IDEAS (Identifying Depression Empowering Activities for Seniors) for treatment of depression. Most typically, seniors are treated for symptoms related to depression, anxiety, grief and trauma. Those experiencing substance or medication misuse are provided information on substance use disorder groups available. The Older Adults screened through this program are also provided a Saint Louis University Mental Status (SLUMS) examination, which determines neurocognitive impairment up to and including Dementia.

The teams consist of mental health clinicians, recovery specialists or case managers and volunteers who assist with client engagement and act as social and peer support. Often times there are challenges in engaging this population to feelings of "not wanting to be a burden on others." This can cause many older adults to minimize feelings of loneliness or cause apprehension to seek treatment services. As the program is voluntary and those referred may be reluctant to begin treatment services, the team will make several attempts to engage and build a rapport with the client as needed.

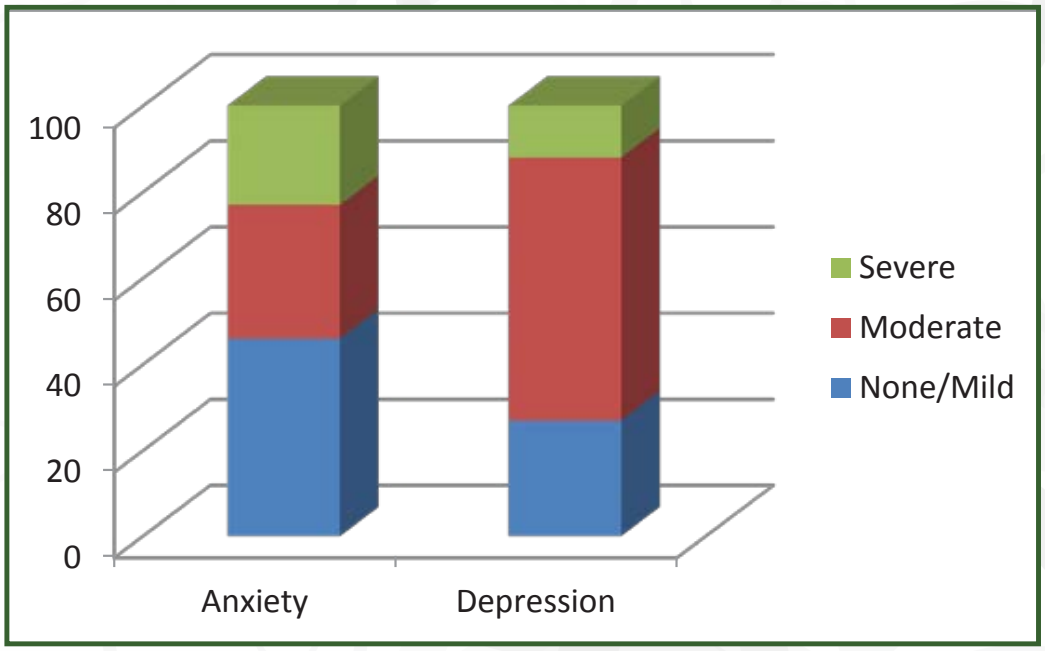
Referrals for service can come after engagement at outreach events, through personal referrals or from agencies including Aging and Adult Services. Seniors are recommended for treatment based on a series of screenings to assess depression, anxiety, mental health status, activities of daily life and other indicators. Case management is provided in the senior's home, preventing transportation from being a barrier to treatment. Seniors are further supported by the VSOP community volunteers, who are trained to work with the clinical staff in being a support to seniors both socially and as peers. Through regular contact with the older adult clients, volunteers help to foster autonomy and independence.

Service Goals

- Linkage to appropriate resources including benefits acquisition and mental health services
- Provide early intervention activities which improve the mental health status of older adults
- Improve daily functioning level of older adult clients
- Mild-to-moderate mental health symptom management

Program Data:
Bakersfield VSOP symptoms at start of services
GAD -7 (Anxiety):
None/Mild = 46%
Moderate = 31%
Severe = 23%

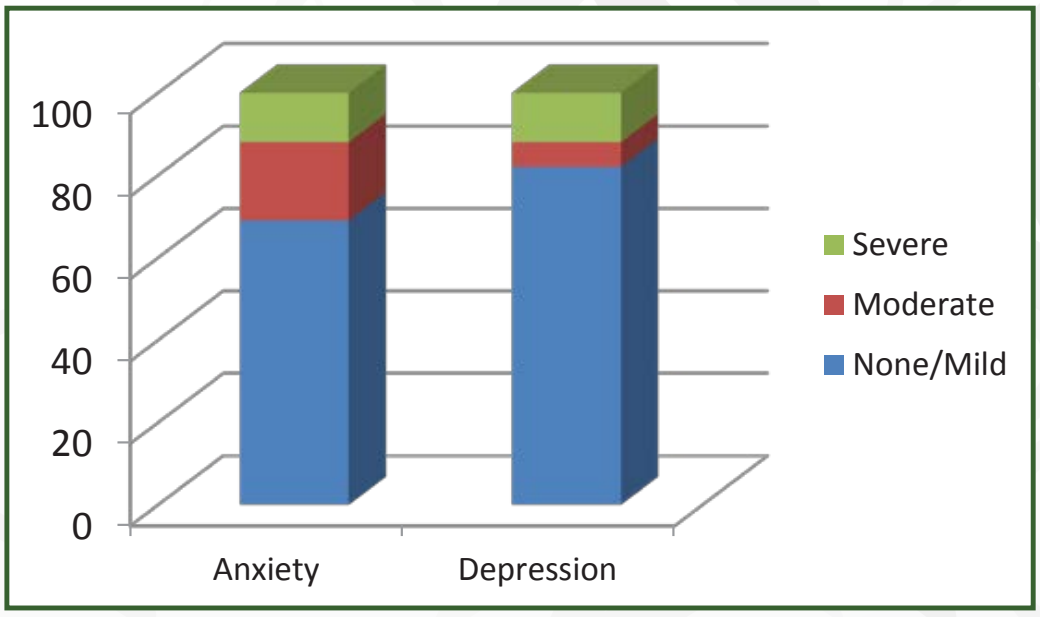
PHQ-9 (Depression):
Minimal/Mild = 27%
Moderate or Moderate/Severe = 61%
Severe = 12%



Bakersfield VSOP symptoms at end of services:

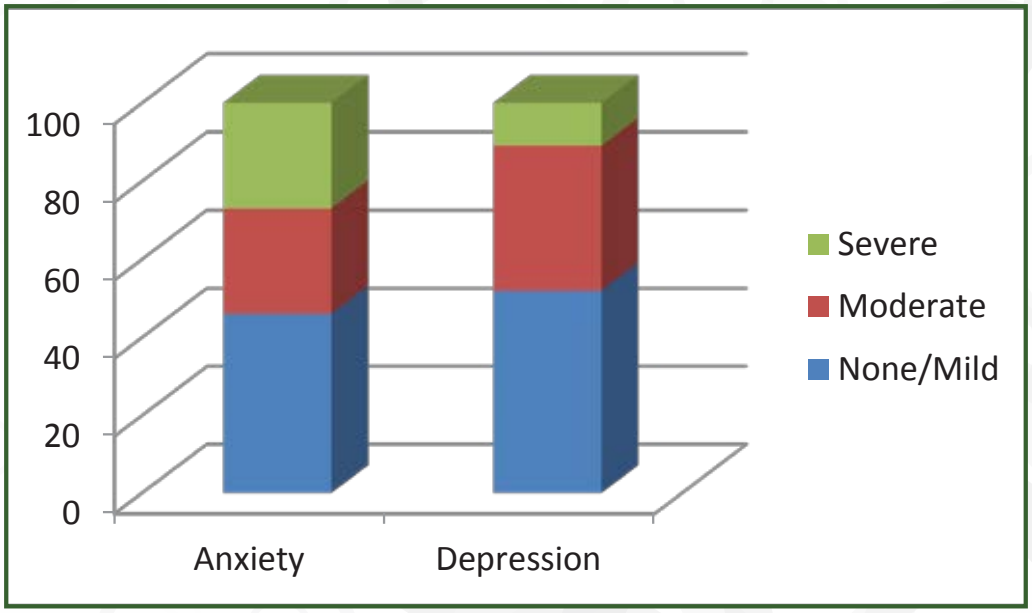
GAD -7 (Anxiety):
None/Mild = 69%
Moderate = 19%
Severe = 12%

PHQ-9 (Depression):
Minimal/Mild =82%
Moderate or Moderate/Severe = 6%
Severe = 12%



Wasco VSOP symptoms at start of services:
GAD-7 (Anxiety):
None/Mild = 46%
Moderate = 27%
Severe = 27%

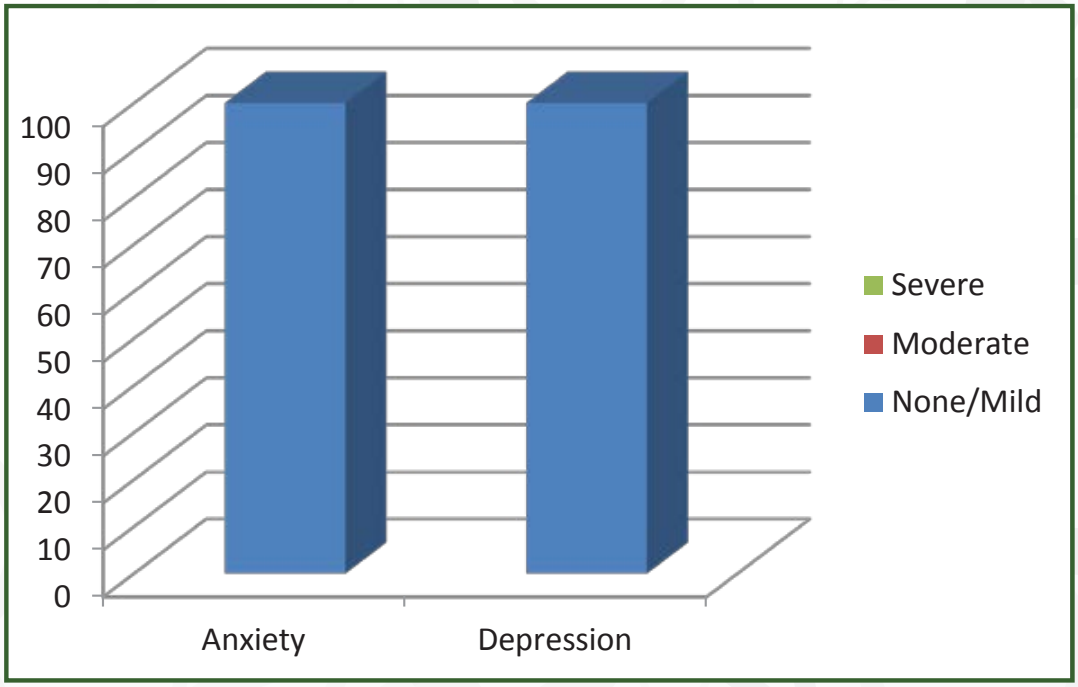
PHQ-9 (Depression):
Minimal/Mild = 52%
Moderate or Moderate/Severe = 37%
Severe = 11%



Wasco VSOP symptoms at end of services:

GAD-7 (Anxiety):
None/Mild = 100%

PHQ-9 (Depression):
Minimal/Mild = 100%



Tehachapi VSOP added four clients in 2015/2016, one did not receive screening. No clients were discharged. Data at the beginning of services shows:GAD-7(Anxiety):
None/Mild = 0
Moderate = 2
Severe = 1

PHQ-9 (Depression):
Minimal/Mild = 1
Moderate or Moderate/Severe = 2
Severe = 0

Lake Isabella VSOP added five new clients in 2015/2016. There was one discharge, who screened mild for symptoms of anxiety and depression. Data at the beginning of services was as follows: GAD-7 (Anxiety):
None/Mild = 3
Moderate = 1
Severe = 1

PHQ-9 (Depression):
Minimal/Mild = 4
Moderate or Moderate/Severe = 1
Severe = 0
Total Number referred for higher level of mental health care: 6

Demographics based on total number served in VSOP Programs:
Veteran Status:
Veterans: 10%

Gender:
Male: 59%
Female: 40%
Other: 0.03%

Race:
White: 68.5%
Hispanic: 24.3%
Black/African American: 5%
Native American: 0.06
Other: 1%

Challenges:

- Clients minimizing symptomology can create difficulty in determining whether they require specialty mental health care
- Requests for increased VSOP services county wide is difficult due to staffing
- Due to staffing, goals to provide services to underserved populations are often unmet

Solutions in Progress

- VSOP is collaborating with additional mental health providers to serve the older adult population

Innovative Programs Summary

During the 2015 Stakeholder Process, eight programs were identified for potential development and proposal to the Behavioral Health Board, Kern County Board of Supervisors and Mental Health Services Oversight and Accountability Commission (MHSOAC). From the eight, three were chosen to continue in the program development process and are currently in the drafting phase.

At the end of Fiscal Year 2014/2015, Kern Behavioral Health and Recovery Services completed the five-year termed Freise Hope House. Final year data is included in the following program description. The program has continued through non-MHSA funding.

Special Needs Registry – Smart 911:

Many jurisdictions utilize a created special needs registry for their community which identifies any illnesses, mobility limitations, cognitive disabilities and like information. However, there has not been a community effort or a mental health care provider effort previously to identify the special needs of those with mental illness. This program proposes engaging clients to identify special needs and allowing them, either independently or with their Recovery Specialist, identify special needs as it pertains to their mental health and related needs so that information can be provided to first responders in the event of an emergency. This program seeks to engage emergency responding agencies to determine whether fewer first responder-involved tragedies occur as a result of law enforcement, emergency medical and fire services having more information before arriving on scene.

The Healing Project – A Recovery Station and Housing First Program:

The Healing Project brings two aspects of mental health and co-occurring substance use care to Kern County. Developed as a peer-involved program to provide access and linkage to treatment for those experiencing mental health and co-occurring substance use care needs, the Healing Project provides Housing First project which involves peer support to provide care to clients who may have a difficult time engaging in care. Peer-involved Recovery Stations would provide an alternative to arrest for public intoxication and seeks to reduce the number of intoxicated persons entering emergency rooms and the psychiatric evaluation center (PEC).

Recovery Supports Transportation Project:

The Recovery Supports Transportation Project works to empower clients while developing independence through scheduling of mental health care transportation for care appointments with psychiatrists, medication management and therapists. Peer and non-Peer Recovery specialists will work with clients to provide support and engagement and care navigation. This Uber-type program allows clients the opportunity to use services based on their scheduling needs.

Freise HOPE House - Final Report

Program Description

Freise HOPE (Helping Others through Peer Empowerment) House opened in September 2011. The innovative project goal was to contribute to learning by introducing change to an existing mental health practice or approach; and introducing a new application to the mental health system. This project, funded was funded as an innovative project which completed its term in June 2015. The concept of adding peer specialists to manage and facilitate programs within the adult crisis residential program provided the new concept or approach. Those with lived experience are able to assist consumers in crisis during their stay with the Freise HOPE House. The environment strives to be comfortable, welcoming and those who stay are referred to as "guests."

Recovery Specialists on staff have completed an 80-hour training program designed for those working with others who have lived experience with mental illness. The recovery model used was adopted from Recovery Innovations, a subcontracted organization with experience developing peer-operated programs. The model focuses on the recovery principles of hope, encouragement and empowerment while focusing on the strengths of the individual and community integration. Additionally, program personnel include a Licensed Marriage and Family Therapists, Clinical Social Worker or Psychologist and psychiatrists to address physical and mental health needs. The program allows for up to 14 guests to have 24/7 care for up to 30 days, unless extended, which is done as needed. Access and linkage to treatment may also be provided as well as aftercare.

Recovery Specialists work with guests to develop their Wellness Recovery Action Plan (WRAP). Guests also participate in a variety of educational classes, workshops and groups which promote skill building. Freise HOPE House fosters health and recreational activities through indoor gym and outdoor recreational activities and weekly outings. Linkage to community and employment resources offers guests the opportunity to begin their future planning. Each morning and evening, guests are invited to join House Meetings and offer suggestions on activities, meals, beautification, etc. Weekly meetings allow for discussion in progress of personal goals, as guests discuss their plans centering on permanent housing and employment and other personal goals.

Program Data

The consistent key learning goal for the program included the impact of a peer-managed crisis residential program. Additionally, the program collected information related to the number of days in psychiatric hospital care prior to and after receiving services with Freise HOPE House. Satisfaction surveys were utilized, from which the goal was 80 percent satisfaction. Average positive responses remained well over 80 percent in the 2014 and 2015 calendar years based on the following questions:

When I first arrived at Freise HOPE House, I got a feeling that I'd be comfortable here. Positive Response: 91.78%

There were staff or Peer Supporters at Freise HOPE House that related to my experiences. Positive Response: 93.86%

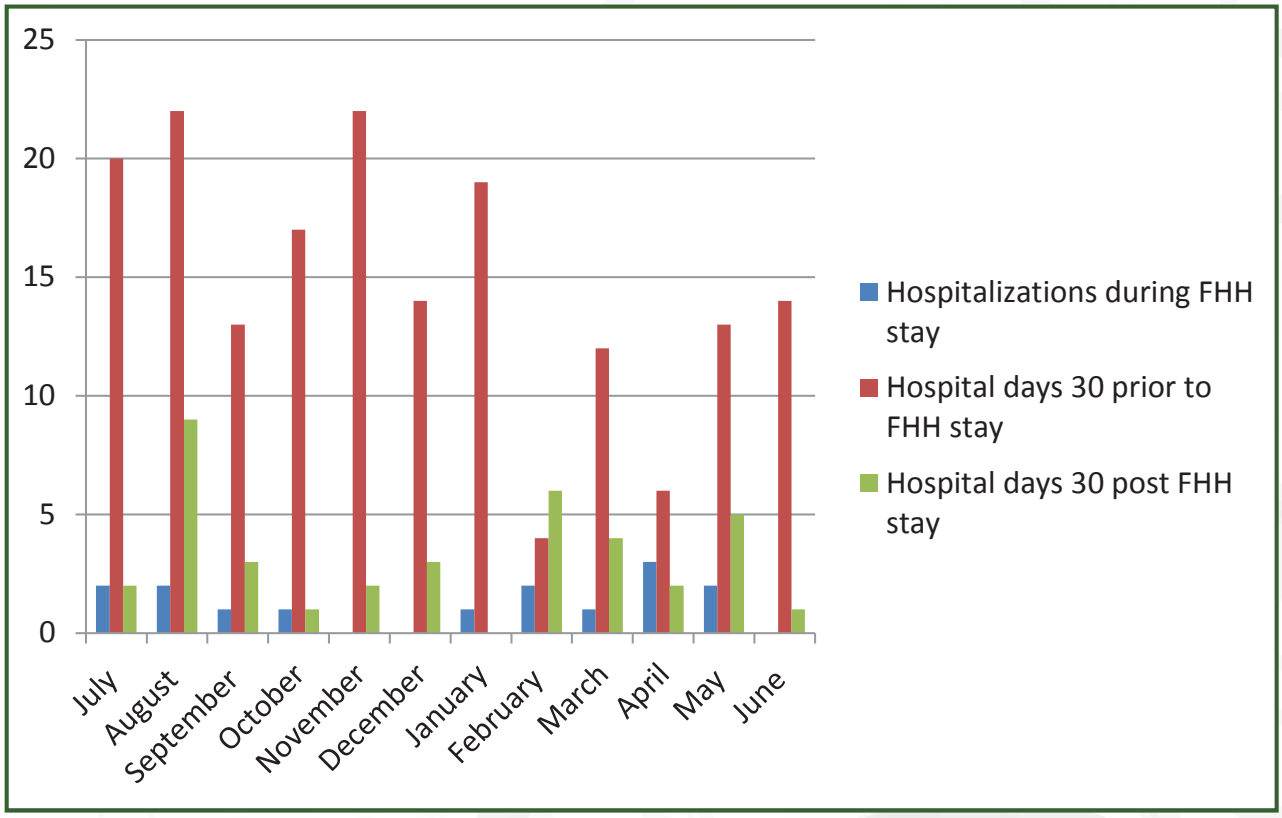
When we talked about what was happening in my life, I felt like the staff understood what I was saying, or was trying to understand. Positive Response: 94.33%

During your stay it was helpful to recieve receovery coaching/support from a staff member that had lived experience? Positive Response: 92.63%

The Freise HOPE House helped me feel good about who I am. Positive Response: 85.56%

The Freise HOPE HOuse helped me understand people better. Positive Response: 86.33%

In FY 2014/2015, there was a 75 percent reduction in the number of days clients received psychiatric hospital care after receiving Freise HOPEHope House services.



Lessons Learned

During the course of the Freise HOPE House project, it was learned that recovery coaching/support from those with lived experience played an integral role in providing services to those who were experiencing or post-mental health crisis event. This has helped in the developing of a potential new innovative program, The Healing Project. If approved, The Healing Project would allow KBHRS to continue to build on lessons learned from Freise HOPE House; to learn whether utilizing peer support in a different treatment environment further helps to engage those who may be reluctant to begin services.

Workforce Education and Training

Mental Health Interpreter Training
In February 2016, Kern Behavioral Health and Recovery Services hosted two training Mental Health Interpreter Training sessions. The sessions were included in the Southern California Regional Partnership FY 15/16 plan, approved by the Office of Statewide Health Planning and Development. The Mental Health Interpreter Training sessions were provided to Kern Behavioral Health and Recovery Services and community provider staff. The training series was created to address language gaps associated with deficiency in the ability to properly provide mental health care to individuals with limited or no English proficiency. The premise of the training is to help clients and providers better communicate, increasing the accuracy of diagnosis, treatment and intervention. Improvements of quality of care and efficiency in providing services are other benefits associated with proper interpretation. Mental Health Interpreter Training series was developed by the National Latino Behavioral Health Association (NLBHA) and National Asian American Pacific Islander Mental Health Association. Satisfactory ratings were high for both trainings, between 4.79 and 4.97 of a possible score of 5. The SCRP is negotiating providing trainings for FY2016/2017.

The first session, *Training Providers Who Use Interpreters in Mental Health Settings* is a seven hour training session with works with mental health care providers who use interpreters and/or interpreter services. The training teaches clinicians utilizing interpreting services to be more culturally competent, providing accurate terminology, providing better care. Attendees included 25 clinical direct and non-direct service staff providing mental health care to children, adults and transitional aged youth across the system of care. Kern Behavioral Health and Recovery Services's Ethnic Services Coordinator also attended the training to provide continual coaching to those who attended as well as instruction to those unable to attend the session. Recommendations for future trainings included incorporating information on play therapy, art therapy and parent/child interactive therapy.

The second trainings series was the *Training of Interpreters.* This three-day, 21 hour series worked with 35 certified bilingual direct and non-direct service staff providing mental health care. The training series was proposed for those interested in becoming a trained interpreter. The mean score change between pre and post tests showed a 19 point increase. Recommendations included adding content regarding specific mental health disorders and symptoms.

Mental Health First Aid
The Southern Counties Regional Partnership facilitated three Mental Health First Aid (MHFA) Train-the-Trainer series in September and October 2016. Series were available in both Youth and Adult Mental Health First Aid. The benefit of the course is for attendees to learn about recovery and resiliency by creating and utilizing an action plan which can be used in a variety of mental health symptom situations. Through role play, scenarios and activities, those participating in training learn to apply learned skills in the event of: panic attacks, suicidal ideation or behaviors, self-injury, acute psychosis events, etc. Part of intervention is to provide support and encourage mental health care. Four Kern Behavioral Health and Recovery Services staff attended the MHFA series to acquire certification in providing MHFA courses for mental health care professionals and community members for both youth and adults. Certified are required to provide at least three training sessions annually.

Southern Counties Regional Partnership Conference
Members of the Southern Counties Regional Partnership began planning a conference in FY 2015/2016 to be held in March 2017.

The SCRP Regional Conference will provide space for 10 staff from each county to attend and anticipates providing workshop sessions on a variety of topics, from Anasognosia, Cultural Competency, Motivational Interviewing, Integrating Peers and Incarcerated Youth and Adults.

Internship Support Program

Clinical staff completing internship of post-graduate and practicum of pre-graduate for their discipline are provided hours of clinical supervision through the Internship Support Program. Kern Behavioral Health and Recovery Services licensed clinical staff who have retained their license at least two years. Clinical supervision is provided in one hour increments for every ten hours of clinical treatment provided. Licensed Clinical Social Workers must have had their license for two years and have completed 15 hours of clinical supervision training to provide supervision. Licensed Marriage and Family Therapists must have completed two years of clinical work post-licensure and six hours of Continued Education Units prior to providing clinical supervision.

Core Competency Training Series

Kern Behavioral Health and Recovery Services is in the process of developing a series of trainings based on the Core Competency framework developed by Loma Linda University for the Southern Counties Regional Partnership. The first series of course will include a Universal Core Competency Training, which will be provided for all staff. Specialized trainings will be further developed based on staff classification and core competencies compatible with job duties. Skills provided at these training series will create rating used in developing employee performance reviews.

Westchester System of Care Offices

Kern Behavioral Health and Recovery Systems began assessing space needs in 2012 via survey to each system of care. Included within the options identified was a centrally-located, dual tower building, purchased for $4.7 million of a $6.2 million fund balance in 2014. Construction began in 2015 to renovate the north tower, which houses: Executive Administration, Finance, Human Resources, Information Technology Systems, Electronic Health Record (Cerner/Anasazi) Support, Facilities Management and a portion of the Substance Use Disorders Administration. The 2015 renovation costs totaled $2.6 million; with $1.5 million exhausting CFTN balances and using an additional $1.1 million in Realignment funding. This completed use of the original CFTN fund balance.

During renovation, the building was outfitted with television monitors and computer systems in each of the conference rooms to help eliminate paper waste. Each office includes dimming motion sensor lights which automatically turn off after a period of vacancy to reduce energy waste. Additionally, the building is in the process of installing audio visual capability which will allow for trainings to be provided in-house, reducing travel costs. Other costs savings included decreased lease expenditures. Staff began work in the new building in March 2016.

The south tower begins construction in July 2016. Construction costs associated with the renovation of the south tower were paid via MHSA funding allocated to Capital Facilities and Technology Needs component. The south tower will house the: Recovery Supports Administration, Consumer Family Learning Center, Self-Empowerment Team, Housing Division and Substance Use Disorders Administration. Additionally, an office will be allocated for a representative of the National Alliance on Mental Illness (NAMI) Kern County. Original plans included relocating the Quality Improvement Division Administration to the south tower; as this division works closely with the newly assigned Managed Care Division, they will continue in their current location. Relocation of these teams is currently planned for November 2016.

Ultra-sensitive Exchange

The Ultra-sensitive Exchange project allows Kern Behavioral Health and Recovery Systems and other care providers, including primary care provider and the county hospital, Kern Medical to share information on common clients. Should a System of a Care client visit the hospital or other care setting, there may be a secured exchange between the hospital and KCMH about the visit. Kern Behavioral Health and Recovery Systems would also be able to provide information to the hospital with the proper Release of Information. The Ultra-sensitive exchange project incorporates HL-7 (Health Level 7), a program which is designed to work securely between medical health records. The project has been in development over the past five years and anticipates being implemented in FY 2016/2017.

Patient Portal

The Patient Portal is also currently pending implementation. The Patient Portal allows the client, through internet access to view and schedule appointments with their Recovery Specialist. Through the Intelichart feature, the Recovery Specialist and the Client can review areas of the chart accessible to the client to discuss any concerns, progress or other topics of interest.

Crisis Stabilization Unit, Ridgecrest

To help meet the need for crisis stabilization, access and linkage to treatment, Kern Behavioral Health and Recovery Systems expanded the Access to Care – Access and Assessment Center program to east Kern County by adding a Crisis Stabilization Unit to the Ridgecrest area. Ridgecrest is the highest populace area in eastern Kern County with 28,780 residents. The Crisis Stabilization unit will provide; crisis assessment and evaluation for mental health and substance use disorder care needs, brief crisis interventions, referral and linkage to community care and resources, coordination of admission to inpatient mental and medical care facilities when necessary and peer mentoring.

KERN COUNTY
BEHAVIORAL HEALTH&RECOVERY
SERVICES

BUDGET SUMMARY

FY 2016/17 Mental Health Services Act Annual Update
Funding Summary

County: Kern Date: 10/27/16

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	32,077,521	15,953,030	6,714,737	292,987	67,397	
2. Estimated New FY 2016/17 Funding	29,851,600	8,471,400	2,017,000			
3. Transfer in FY 2016/17[a/]	(5,973,650)			624,432	1,965,000	3,384,218
4. Access Local Prudent Reserve in FY 2016/17	0	0				0
5. Estimated Available Funding for FY 2016/17	55,955,471	24,424,430	8,731,737	917,419	2,032,397	
B. Estimated FY 2016/17 MHSA Expenditures	24,116,622	6,876,257	6,714,737	917,419	2,032,397	
G. Estimated FY 2016/17 Unspent Fund Balance	31,838,849	17,548,173	2,017,000	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	12,497,960
2. Contributions to the Local Prudent Reserve in FY 2016/17	3,384,218
3. Distributions from the Local Prudent Reserve in FY 2016/17	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	15,882,178

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Kern Date: 10/27/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Assertive Community Treatment	2,781,648	1,605,210	1,176,438			
2. Adult Transition Team	3,718,660	2,613,532	1,105,128			
3. Homeless Adult Team	1,969,207	1,010,323	958,883			
4. Youth Multi-Integrated Service Team	1,724,942	868,235	856,707			
5. Youth Wraparound	1,745,350	1,149,914	595,436			
6. Transitional Age Youth (TAY)	2,950,414	1,529,635	1,420,779			
7. Wellness, Independence and Senior Enrichment (WISE)	1,372,678	900,475	472,203			
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS - System Development						
1. Access and Assessment	2,306,706	1,136,975	1,169,731			
2. Crisis Hotline	936,679	936,679	0			
3. Adult Wraparound Core Team	2,297,075	1,229,903	1,067,172			
4. Dialectical Behavioral Therapy Core Team	462,244	247,296	214,948			
5. Stockdale RAWC	1,262,294	596,603	665,691			
6. West Bakersfield RAWC	1,986,426	1,159,467	826,959			
7. North Bakersfield RAWC	1,553,208	819,485	733,722			
8. Southeast Bakersfield RAWC	2,376,739	1,301,931	1,074,808			
9. Self-Empowerment Team	733,769	514,376	219,393			
10. Community Family Learning Centers	1,511,627	1,511,363	263			
11. Outreach and Education Coordination	189,828	189,828	0			
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	4,795,392	4,795,392	0			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	36,674,884	24,116,622	12,558,262	0	0	0
FSP Programs as Percent of Total	67.4%					

FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Kern Date: 10/27/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Youth Juvenile Justice	88,373	88,373				
2. Foster Care Engagement	384,308	384,308				
3. Youth Brief Treatment	1,331,399	1,331,399				
4. TAY Career Development	299,822	299,822				
5. Project Care	533,423	533,423				
6. Volunteer Senior Outreach Program	756,815	756,815				
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Youth Juvenile Justice	35,349	35,349				
12. Foster Care Engagement	153,723	153,723				
13. Youth Brief Treatment	1,089,326	1,089,326				
14. TAY Career Development	1,104,352	552,176	552,176			
15. Project Care	639,205	639,205				
16. Volunteer Senior Outreach Program	15,136	15,136				
17.	0					
PEI Programs - Access and Linkage to Tx						
Risk Reduction Eduction and Engagement Accelerated Alternative Community						
18. Behavioral Health (REACH)	281,285	178,948	102,337			
19.	0					
20.	0					
PEI Administration	818,254	818,254				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	7,530,771	6,876,257	654,513	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Kern Date: 10/27/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. To Be Determined	6,714,737	6,714,737				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	6,714,737	6,714,737	0	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Kern Date: 10/27/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training Expansion/Enhancement	332,028	332,028				
2. Internship Support Program	585,392	585,392				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	917,419	917,419	0	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Kern Date: 10/27/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Westchester South Tower	1,767,397	1,767,397				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Ultra-Sensitive Exchange	189,286	189,286				
12. Patient Portal	75,714	75,714				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	2,032,397	2,032,397	0	0	0	0