



## **Crestwood Bakersfield Bridge Program**

### **CORE PROGRAM**

#### **Description of Services**

The Bridge Program's services allow clients to enter the program with a high level of support and supervision. The Bridge provides a comfortable homelike setting coupled with programming resources such as Cognitive behavioral therapy (CBT), Dialectical Behavior Therapy (DBT), medication education and support, Wellness Recovery Action Planning (WRAP), life skills training, peer support and dual recovery services. In addition to the psycho-social educational groups offered to clients for wellness and recovery, the Bridge Program offers services to assist the client with reintegration into the community. The majority of clients are admitted to the Bridge program from a higher-level of care (IMD) and need support with community integration. Our program offers bus mobility training to assist the client with becoming familiar with local community resources and effectively utilizing the local bus transit system.

Clients in the program are often LPS conserved and have traditionally been served in an IMD or underserved in a Board and Care setting. Many of these clients may have behavioral challenges such as aggressive behavior, social isolation, self-abuse and other destructive behaviors. They may need continued stabilization, medication education and support in developing and refining independent living skills. Discharge to independent living or supported housing within six to twelve months are the expectation of this enhanced program. The program allows a length of stay of up to 18 months, if needed. Clients utilizing the Bridge program services are expected to develop and demonstrate the skills needed to support independent living and gradually decrease their need for support as they transition toward personal independence.

#### **Scope of Services**

The purpose of the Bakersfield Bridge Program is to provide an effective rehabilitative program that will provide around the clock supervision, while empowering the client to take charge of their recovery process, to make good choices and eventually be able to live independently. The program is designed to serve individuals with severe and persistent mental illness with a dual diagnosis. Our primary objective is to provide the client with a safe, comfortable and homelike environment while they gain the necessary tools to manage their

symptoms in an independent living setting, while increasing knowledge of the disease process.

The program is built on the foundation that immersion into a homelike supportive setting will create an environment which promotes true recovery. The Program activities are entertaining, educational and are tailored to meet the clients' needs. Clients are expected to participate in the program during the day. The program includes, but is not limited to:

- Social rehabilitation training.
- Medication education and management.
- Psycho-social educational support groups led by trained staff.
- 1:1 progress review sessions led by trained Case Managers.
- Bus mobility training by trained staff.
- Peer mentoring and support.
- Pre-vocational and Vocational programs.
- Life skills education and training.
- WRAP and DBT skills.
- Dual-recovery support and education (community and in-house AA/NA).
- Continuing education support.
- Community-based support programs.
- Community-based social and recreational activities.
- Spiritual support.
- Resident Council.
- Nutritional training and individualized support.
- Family support and education.

### **Program Philosophy and Goals**

Our purpose is to provide clients with an effective social rehabilitation program that will empower clients to take charge of their recovery process. This program focuses on developing skills requiring acceptance of mental illness and willingness to learn how to manage the symptoms of chronic mental illness. This program is dedicated to offering a continuum of services that empowers clients to live and succeed in their communities. Our mission is to promote wellness and recovery by helping to reduce the stigma associated with mental health issues. This program is committed to providing a community-based mental health curriculum that supports self-nurturing dual diagnosis treatment, self-determination, peer support, education, community integration and a focus on relapse triggers that are part of the dually diagnosed client's recovery issues.

### **Population Served**

This program serves clients who are dually diagnosed, medication compliant and exhibit a desire to reintegrate into the community and acquire life skills needed to survive independently and remain clean and sober. The counties contracting

with the Bridge Program currently include Kern County, Riverside County and Santa Barbara County.

### **Mechanisms to meet client needs**

Program staff includes Service Coordinators and Rehabilitation Assistants working together under the supervision of the Program Director. Service Coordinators are trained to provide psycho-social educational support groups such as WRAP, DBT Skills, medication education, relapse prevention, substance abuse education and illness management education. Service Coordinators complete primary assessments upon admission to develop recovery service goals. Rehabilitation Assistants collaborate with Service Coordinators to provide clients with life skills education and support. Working together, staff encourages and motivates clients to focus on daily maintenance of personal hygiene, learning to cook, maintain clean living environment, and develop money management skills, medication education and community integration. Staff is available to meet clients' needs 24 hours a day. 7 days a week.

### **Entry, Transition and Discharge Criteria**

#### **Admission Criteria:**

The counties contracting with the Bridge Program authorize all referrals and subsequent admission. They also make an initial contact with the Bridge Program Director and stipulate:

1. Estimated length of stay (expected 6-18 months).
2. Participation in program/list of requirements.
3. Expected behavioral outcome.

Clients admitted shall have an admission agreement signed by the client or legal representative describing the services to be provided and the expectations and rights of the client regarding program rules, client empowerment and involvement in the program and fees. Clients are admitted to this program only upon the written referral of, and remain under the care of a psychiatrist licensed to practice in the State of California.

Clients shall not be denied admission by reason of race, color, religion, ethnic background, sex, age or physical disability. Clients are assigned rooms within the house without regard to race, color, religion, ethnic background or disability. Assessment documentation will consist of comprehensive assessments.

The following is included in this assessment phase of admission:

- Primary Assessment Admission
- Interpretive Summary
- Pre-Vocational Assessment
- Psychiatric Assessment

- History and Physical
- Functional Impairment checklist
- Activities Assessment
- Initial Discharge Appraisal

The following criteria have been established for admission:

1. The client may have a dual diagnosis.
2. The client must be medication compliant.
3. The client must exhibit a desire to reintegrate into the community and acquire life skills needed to survive independently and remain clean and sober.

### **Transition Plan:**

Upon admission, a basic orientation will be initiated that focuses on introducing the client to the Bridge Program. The main areas of concentration during the clients first week will be program structure, house rules, client responsibilities and facility layout. The comprehensive treatment team plan will be completed within the first week of the client's admission and the Program Director will have the responsibility of assuring its accuracy and completion. This treatment plan will be developed with the client in collaboration and will include feedback from other treatment team members (i.e. Staff, County case managers, Conservator and family or significant other).

### **Discharge Criteria:**

Our program starts the discharge process at the time of referral. The interdisciplinary team, including the county case manager, begins the discussion on possible placement prior to admission. At the time of admission, the service coordinator and client complete a Discharge Appraisal that identifies the successful past placements, condition to ensure success, resources needed and support required to minimize the likelihood of relapse and readmission.

The following criteria are the basis for the plan of discharge, however, each client's situation is unique and each person's eligibility for discharge shall be reviewed by the team.

1. Program compliance during stay in program.
2. Graduation from required groups.
3. Team referral for discharge to a specific place.
4. Fulfillment of treatment contract.
5. Three months prior to discharge, actively participating in a Community-based Dual Recovery Program.

The client transition plan will be completed upon discharge and all Recovery Service Plans will have a discharge disposition. A final discharge summary will be done upon completion of program.

**Setting:**

The Bakersfield Bridge Program is located at 6744 Eucalyptus Dr. in Bakersfield California. The facility location is accessible to community resources and public transportation and services. The Bridge Program is developed with guidance of Department of Mental Health, Department of Social Services and CARF regulations as the guide to treatments.

The Bridge Program provides 7 double bedrooms and 1 single bedroom, for a total of 15 beds. There are 3 full bathrooms available for client use and spaced out evenly throughout the home, making access readily available. There is a kitchen, allowing for both meal service and client teaching. There is a laundry room with a washer and dryer, enabling client teaching and promoting independence. The upkeep of the site is collaborative, utilizing client vocational training and staff resources as needed.

**Frequency of services:**

The Bridge Program is a Transitional Residential Facility for adults and is staffed 24/7, 7 days a week, 360 days a year.

The following is a sample of the daily schedule:

6:15-7:00am	Morning medications
7:00-8:00am	Breakfast/AM Social
8:00-9:00am	Life Skills (i.e. Daily chores, personal care)
9:00-10:00a	Group/Exercise (i.e. WRAP, community walk)
10:00-11:00a	Group/Community (i.e. Solutions for Wellness, Recovery Seekers, Schizophrenics Anonymous, in-house or community)
11:00-12:00p	Lunch prep/Lunch/Clean-up
12:45-1:45p	Group (in-house or community, i.e. Vocational Training, Socialization Training, Medication Education, Creative Expressions)
2:00-3:00p	Group (in-house or community, i.e. DBT skills, Money Management, Resident Council, Anger Management)
3:00-3:30p	Evening Social/Snack
3:30-4:00p	Break
4:00-6:00p	Dinner prep, dinner and cleanup
6:30-8:00p	Socialization and Free time, Community Outings, Recreational Activities, Arts & Crafts, Games
8:00-9:00p	Medication Supervision and education, Snack
9:00-10:00p	Relax, TV, Prepare for bed

### **Payer Services/Fees:**

Upon admission, the Program Director and/or Service Coordinator meet with the client to review the admission agreement.

#### **1) BASIC GENERAL SERVICES:**

- a. Lodging: double room
- b. Food Services:
  - 1. Three nutritious meals daily and between meals nourishment and snack.
  - 2. Special diets if prescribed by a doctor.
- c. Laundry service.
- d. Cleaning of the client's room.
- e. Comfortable and suitable bed including fresh linen weekly or more often, if required.

#### **2) PROGRAM SERVICES:**

- a) Continuous observation, care and supervision, as required.
- b) Assistance with bathing and personal needs, as required.
- c) Assistance in meeting necessary medical and dental needs.
- d) Assistance, as needed with taking prescribed medication in accordance with physician's instructions unless prohibited by law or regulations.
- e) Plan, arrange and/or provide for transportation to medical and dental appointments.
- f) A planned activity program including arrangement for utilization of available community resources.
- g) Notification to family and other appropriate person/agency of client's needs.