SAN BERNARDINO COUNTY

Behavioral Health

Mental Health Services Act

Annual Update for Fiscal Year 2024/2025 Outcomes and Fiscal Year 2025/2026 Updates

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Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Community Program Planning

Overview of San Bernardino County

San Bernardino County is located in Southeastern California, approximately 60 miles inland from the Pacific Ocean. It is the largest county in the continental United States in terms of land mass, covering over 20,000 square miles. There are 24 cities in the county and multiple unincorporated and census-designated places.

Over 81% of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). The county has four (4) active military bases, utilizing 13% of the land. These include Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

According to the United States Census Bureau, the estimated population is 2,195,611 (*Source*: US Census -2023). Approximately half of the county's population resides in the West Valley (32%) and East Valley (23%) regions, accounting for only 2.5% of the land. The remaining population resides in the Central Valley (20%) and Desert or Mountain regions (25%).

The residents of San Bernardino County fall into the following age groups: 45% are adults between the ages of 26 and 59 years old, 22% are children under the age of 15, 19% are older adults (age 60 and over), and the remaining 15% are between the ages of 16 and 25 years old.

San Bernardino County is the fifth largest county in California in terms of population and ethnic diversity. The largest ethnic population in the county is Latinx/Hispanic (56%), followed by Caucasian/White (24%), Asian/Pacific Islander (9%), African American/Black (8%), and Native American (0.3%). The remaining 4% is unknown.

The gender breakdown is even, with 50% male and 50% female.

Geographic Region	
20% Central Valley	**23%** East Valley
25% Desert/Mountain	**32%** West Valley

Age	
22% Children (0-15)	**45%** Adults (26-59)
15% TAY (16-25)	**19%** Older Adults (60+)

Race/Ethnicity	
8% African American/Black	**56%** Latinx/Hispanic
9% Asian/Pacific Islander	**<1%** Native American
24% Caucasian/White	**4%** Other/Unknown

Gender Identity	
50% Female	**50%** Male

N=2,195,611 **Note**: not all numbers add to 100 due to rounding.

Source: U.S. Census - 2023: ACS 1-Year Estimates Data Profiles

Community Program Planning

Introduction

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse consumers, family members, stakeholders, and community members from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. DBH's Community Program Planning (CPP) process encourages community engagement to empower the community to generate ideas, contribute to decision making, and engender a county/community partnership that improves behavioral health outcomes for San Bernardino County residents. These efforts include informing stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities and obtaining feedback. DBH is committed to incorporating best practices in our planning processes, allowing our consumer and stakeholder partners to participate in meaningful discussions around critical behavioral health issues. DBH considers community program planning a constant practice. As a result, this MHSA component has become a robust year-round practice incorporated into standard operations throughout the department. Like the other MHSA components, the Community Program Planning Process undergoes review and analysis that allows us to enhance and improve engagement strategies.

DBH's CPP protocol includes a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning, implementation and evaluation, and financial resources affiliated with behavioral health programs. This practice has allowed DBH to:

- Be responsive to changes and concerns in the public behavioral health environment.
- Establish and maintain a two-way communication pathway for community identified areas of improvement, which are introduced into DBH's larger process improvement efforts and results are reported back to the larger community.
- Encourage community involvement in DBH's planning beyond the typical "advisory" role.
- Educate consumers and stakeholders about the MHSA behavioral health resources and topics, including the public behavioral health system as a whole.

DBH ensures attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of community partners and contracted vendors. To ensure participation from diverse stakeholders, meetings include interpreter services, or as the occasion dictates, meetings held in languages other than English.

Community Program Planning

WIC § 5963.03 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental health and substance use disorder policy
- Program planning
- Implementation
- Monitoring
- Quality improvement
- Evaluation
- Budget allocations

9 CCR § 3300(c) states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process.

Meeting locations are coordinated in all regions of San Bernardino County, and virtual meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format.

Meetings are documented through agendas, sign-in sheets, virtual meeting chat feature, and minutes and include the following regularly scheduled meetings:

- Behavioral Health Commission (BHC): 10 annual meetings held monthly
- District Advisory Committee meetings: 5 monthly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 10 - 12 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate culturally specific subcommittees: approximately 15 monthly meetings
- Transitional Age Youth (TAY) Advisory Boards
- MHSA Executive Committee meetings

Note: A regularly scheduled meeting may be rescheduled or cancelled by the attendee's collective agreement.

Additional regular stakeholder engagement and education meetings include:

- Quarterly Prevention and Early Intervention (PEI) Provider Network meetings
- Clubhouse Governing Board meetings
- DBH Peer and Family Advocate employee meetings
- Substance Abuse Provider Network (SAPN) meetings
- Association of Community Based Organizations (ACBO)

Stakeholder attendance is recorded through meeting sign-in sheets and stakeholder feedback forms. These forms also document the attendance of underserved, unserved, and inappropriately served populations as outlined in Welfare and Institutions Code - WIC § 5963.03.

Cultural Competency

DBH has a commitment to cultural competency and ensuring this value is incorporated into all aspects of DBH policy, programming, and services, including planning, implementing, and evaluating programs. To ensure cultural competency in each of these areas, DBH has established the Office of Equity & Inclusion (OEI) which reports to the Equity Cultural Competency Officer (CCO), DBH Director, a Cultural Competency Advisory Committee, and 14 monthly cultural subcommittees.

These elements are an essential part of the stakeholder process including the use of the regularly scheduled committee and subcommittee meetings to obtain feedback and input on services and programs. The CCO and the OEI work in conjunction with MHSA program leads to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. The CCO or OEI staff regularly sit on boards or committees to provide input or affect change regarding program planning or implementation. OEI also provides support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meeting, and training events.

Language regarding cultural competence is included in all department contracts with community-based organizations and individual providers to ensure contract services are provided in a culturally competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation (WPE).

DBH is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. Our mission has been to include consumers and family members in an active system of stakeholders. Outreach to consumers and family members is performed through the Department's Public Relations and Outreach Services (PROS), DBH's seven TAY centers and DBH's ten consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA activities.

Consumer engagement occurs through regularly scheduled Community Program Planning Process meetings, community events, department activities, and committee meetings. Consumer participation in department committees includes meetings in which meaningful issues are discussed and decisions are made. Consumer input is always considered when making MHSA-related system decisions in DBH. Consumer feedback is used to inform decision-makers such as the Director, Assistant Directors, Chief Psychiatric Medical Director, Deputy Directors, Program Managers, Clinic Supervisors, medical staff, clinicians, and administrative/clerical staff.

Public Relations and Outreach Services (PROS)

The Public Relations and Outreach Services (PROS) division promotes services to people who have experienced mental illness or substance use disorders. PROS works to reduce stigma through education, awareness, and outreach. Utilizing strategic communication and community engagement, they advocate for all people to enjoy optimum wellness. PROS hosts employee wellness events and community events at no cost.

PROS organizes free, community-centered events designed to foster connection, well-being, and awareness. These gatherings provide safe spaces for community members to decompress while also learning about the wide range of services offered by the County of San Bernardino. Each event blends engaging, family-friendly activities with educational opportunities, ensuring participants not only enjoy themselves but also leave empowered with valuable resources and support.

PROS partners and sponsors many events during the year to offer support to local nonprofit organizations. These events are held throughout San Bernardino County to reach as many people as possible. Targeted populations include African American/Black, Latinx/Hispanic, faith-based, youth, TAY, LGBTQ+, reentry, and unhoused populations. During FY 2024/25, PROS coordinated more than 15 sponsorships and hosted webinars featuring self-care and money management classes, all offered free of charge to DBH employees.

Additionally, the outreach team identified opportunities to strengthen efforts in engaging the County's growing and diverse population. As the number of individuals served continues to grow, maintaining personalized and effective communication has become increasingly complex. This is because larger, more diverse groups may have varying preferences, languages, or accessibility requirements, making it difficult to craft inclusive and engaging invitations that resonate with everyone.

As outreach expands to more people, tracking contacts, RSVPs, and attendance has become increasingly complex, making it more challenging to follow up with participants and accurately measure event success. PROS staff have increased outreach efforts to engage a larger and more diverse population, including historically underserved ethnic groups. Additionally, PROS is translating all invitations into Spanish to reach a broader audience. To help streamline the complex process of tracking contacts, RSVPs, and attendance, PROS is working on maintaining a database to track attendance and is following up with attendees to receive feedback.

Public Relations and Outreach Services (PROS), cont.

In addition to the resource fairs and tabling events, PROS conducted the following outreach and engagement activities during FY 2024/25:

Activity Type	Number of Activity Type	Total Number of Participants
Summer Wellness Extravaganza	1	2,500
International Overdose Awareness Day Film Screening	1	150
Recovery Happens	1	3,000
Sound of Recovery	1	300
Behavioral Health Commission Winter Wonderland Tea	1	300
2nd District Reel Reality Fentanyl Awareness	1	102
4th District Reel Reality Fentanyl Awareness	1	55
Meet the Artist Exhibition	1	166
May Resilient and Real Summit	1	147
Directing Change	1	143
Total	**10**	**6,863**

MHSA Annual Update: Community Program Planning Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Annual Update included meetings hosted in multiple county and community venues in person and on virtual platforms. A total of **10** scheduled meetings were held throughout San Bernardino County.

To meet the requirements of the MHSA, outreach was conducted to promote the MHSA Annual Update Community Program Planning (CPP) process. Various methods were used to allow all stakeholders, including consumers, family members, community members, and partner agencies to have their feedback included and their voice heard. This included distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees, and regularly scheduled stakeholder meetings, such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to representatives of our diverse population. Social media sites, such as Facebook, YouTube, X, and Instagram, were also used to extend the department's reach in connecting interested community members with the stakeholder process. DBH's social media outlets can be accessed by clicking the icons below from the electronic version of this report.

The MHSA Administrative Manager and Component Leads, in conjunction with the OEI and Public Relations and Outreach Services (PROS), are responsible for coordinating and managing the CPP process. This process was built upon existing stakeholder engagement components, mechanisms, and collaborative networks within the behavioral health system and evolved out of the original CPP initiated in 2005.

MHSA Annual Update CPP Demographics

Age

0% 0-15
16% 16-25
72% 26-59
10% 60+
3% Prefer not to answer

Gender Identity

27% Male
69% Female
4% Other

Race/Ethnicity

17% African American/Black
27% Caucasian/White
1% American Indian/Alaskan Native
1% Asian/Pacific Islander
32% Latinx/Hispanic
21% Multi-race/ Other/Unknown

N=71 **Note**: Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

MHSA Annual Update: Community Program Planning Process, cont.

Participation by key groups of stakeholders included, but were not limited to:

- Individuals with serious behavioral health illness, children with serious emotional disturbance, and/or substance use disorder and/or their families.
- Providers of mental health, substance use disorder treatment services, physical health, and/or social services.
- Representatives from the education system.
- Representatives from local hospitals, hospital associations, and healthcare groups.
- Victims of domestic violence and/or sexual abuse.
- Veteran/military population of services organizations.
- Other organizations that represent the interests of individuals with serious behavioral health illness, children with serious emotional disturbance, and/or substance use disorder and/or their families.

This schedule ensured representation and participation in each geographic region of San Bernardino County. To ensure the participation of underserved, unserved, or inappropriately served cultural groups, the OEI provided stakeholder engagement meetings for the MHSA Annual Update for their Cultural Competency Advisory Committee and select subcommittees. To further include community involvement, sessions were held in collaboration with the Department of Aging and Adult Services Senior Affairs Commission and with the Behavioral Health Commission District Advisory Committee in each of the five districts. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Annual Update, and proposed program changes, as well as obtain feedback and recommendations for system improvement.

To ensure that stakeholders could fully benefit from the community meetings, OEI staff were available to arrange interpretation services, upon request, at each meeting. No requests for interpretation services were received.

MHSA Annual Update CPP Demographics

Primary Language

85% English

6% Spanish

10% Other/Prefer not to answer

Region

6% Central Valley

30% East Valley

37% Desert/Mountain

3% West Valley

1% Out of county

24% Prefer not to answer

N=71 **Note**: Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

MHSA Annual Update: Community Program Planning Process, cont.

At the end of the presentations, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question-and-answer session concluded, participants were advised about additional opportunities to provide feedback. The link to the survey was provided in the presentation, and participants were also provided information for alternative methods to provide input and feedback, including the email address, phone number for the MHSA Administration staff, and a link to the MHSA Issue Resolution that can be accessed at: https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

The MHSA Annual Update was presented at the Cultural Competency Advisory Committee on Thursday, November 20, 2025, to ensure additional opportunities to stakeholders to interact with decision making staff.

To further support this Community Planning Process effort, a special Community Policy Advisory Committee (CPAC) session was hosted on Thursday, December 18, 2025.

Attendees at all stakeholder engagement meetings were allowed to provide feedback and input into the MHSA Annual Update via verbal comment and a post-meeting survey in which stakeholders could provide written comments. Surveys were available in both English and Spanish and accessible by a direct electronic survey link or QR code directly linked to the electronic survey.

A total of 300 stakeholders attended this year's Community Program Planning stakeholder sessions, and DBH received 71 completed stakeholder comment forms from those sessions. Of the those who completed a survey, 78% were either satisfied or very satisfied with the CPP meeting and its goals.

MHSA Annual Update: Community Program Planning Process, cont.

MHSA Annual Update CPP Demographics

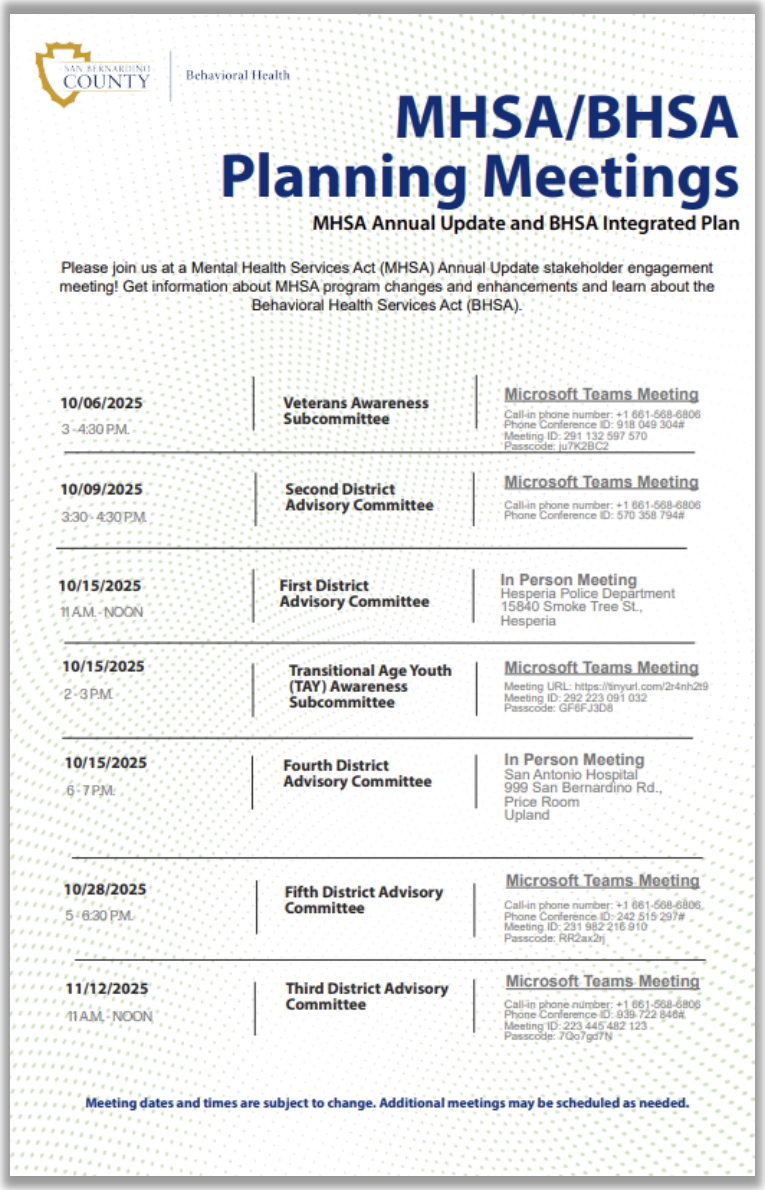
Stakeholder Groups Represented

7% Alcohol and Drug Service Program Providers	**6%** Veterans Organizations	**11%** Faith-Based Organization
9% Education/Students	**58%** Family Member or Loved One	**49%** Consumer of Mental Health Services
3% Social or Human Service Program/Agency	**30%** Federal, State, County, or City Government	**4%** Consumer of Substance Use Disorder Services
31% Healthcare – Behavioral/Mental Health	**7%** Healthcare – Physical Health	**10%** Youth or Youth Mental Health/ Substance Use Disorder Organization
14% Non-Profit Organization	**4%** Veterans	**4%** Regional Centers
7% Area Agencies on Aging	**4%** Substance Use Disorder Treatment Services provider	**38%** Self Employed/Not Employed/Other
13% Community-based organization	**3%** Continuum of Care	**1%** Disability Insurers
1% Education - Early Childhood Organizations	**3%** Education - K-12 (direct child services)	**3%** Education - Higher Education Partners, Colleges, Trade Schools
6% Education - School Districts, Local Education Agencies (LEA), and other Agencies (no direct child services)	**1%** Labor Representative Organizations	**1%** Healthcare service plans, including Medi-Cal managed care plans (MCPs)
9% Victims of domestic violence and/or sexual abuse	**31%** Experienced Homelessness	**14%** Prefer not to answer

N=71 **Note**: Total does not equal 100% since some respondents represent multiple groups.

Community Program Planning

The following pages provide the flyers distributed to the community to promote the MHSA Annual Update CPP process:



SAN BERNARDINO COUNTY | Behavioral Health

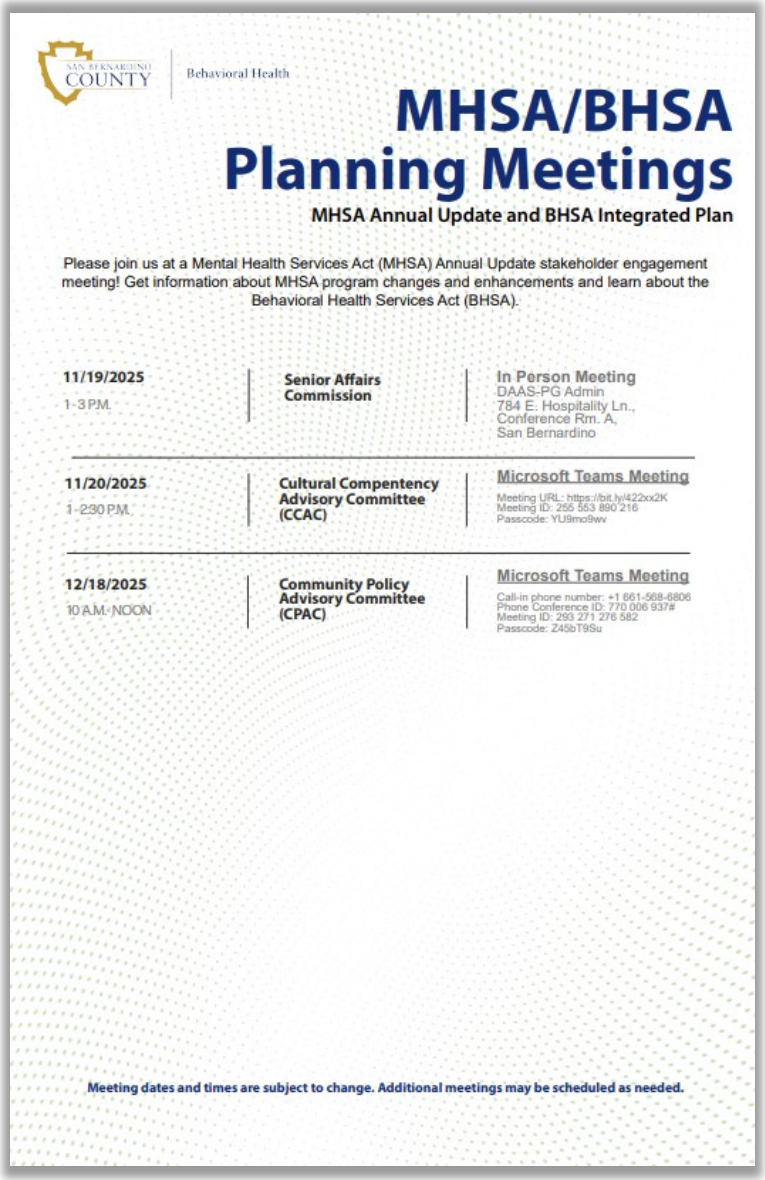
MHSA/BHSA Planning Meetings

MHSA Annual Update and BHSA Integrated Plan

Please join us at a Mental Health Services Act (MHSA) Annual Update stakeholder engagement meeting! Get information about MHSA program changes and enhancements and learn about the Behavioral Health Services Act (BHSA).

10/06/2025 3 - 4:30 P.M.	**Veterans Awareness Subcommittee**	**Microsoft Teams Meeting** Call-in phone number: +1 661-568-6806 Phone Conference ID: 918 049 304# Meeting ID: 291 132 597 570 Passcode: ju7K2BC2
10/09/2025 3:30 - 4:30 P.M.	**Second District Advisory Committee**	**Microsoft Teams Meeting** Call-in phone number: +1 661-568-6806 Phone Conference ID: 570 358 794#
10/15/2025 11 A.M. - NOON	**First District Advisory Committee**	**In Person Meeting** Hesperia Police Department 15840 Smoke Tree St., Hesperia
10/15/2025 2 - 3 P.M.	**Transitional Age Youth (TAY) Awareness Subcommittee**	**Microsoft Teams Meeting** Meeting URL: https://tinyurl.com/2r4nh2t9 Meeting ID: 292 223 091 032 Passcode: GF6FJ3D8
10/15/2025 6 - 7 P.M.	**Fourth District Advisory Committee**	**In Person Meeting** San Antonio Hospital 999 San Bernardino Rd., Price Room Upland
10/28/2025 5 - 6:30 P.M.	**Fifth District Advisory Committee**	**Microsoft Teams Meeting** Call-in phone number: +1 661-568-6806 Phone Conference ID: 242 515 297# Meeting ID: 231 982 216 910 Passcode: RR2ax2rj
11/12/2025 11 A.M. - NOON	**Third District Advisory Committee**	**Microsoft Teams Meeting** Call-in phone number: +1 661-568-6806 Phone Conference ID: 939 722 846# Meeting ID: 223 445 482 123 Passcode: 7Qo7gd7N

Meeting dates and times are subject to change. Additional meetings may be scheduled as needed.



SAN BERNARDINO COUNTY | Behavioral Health

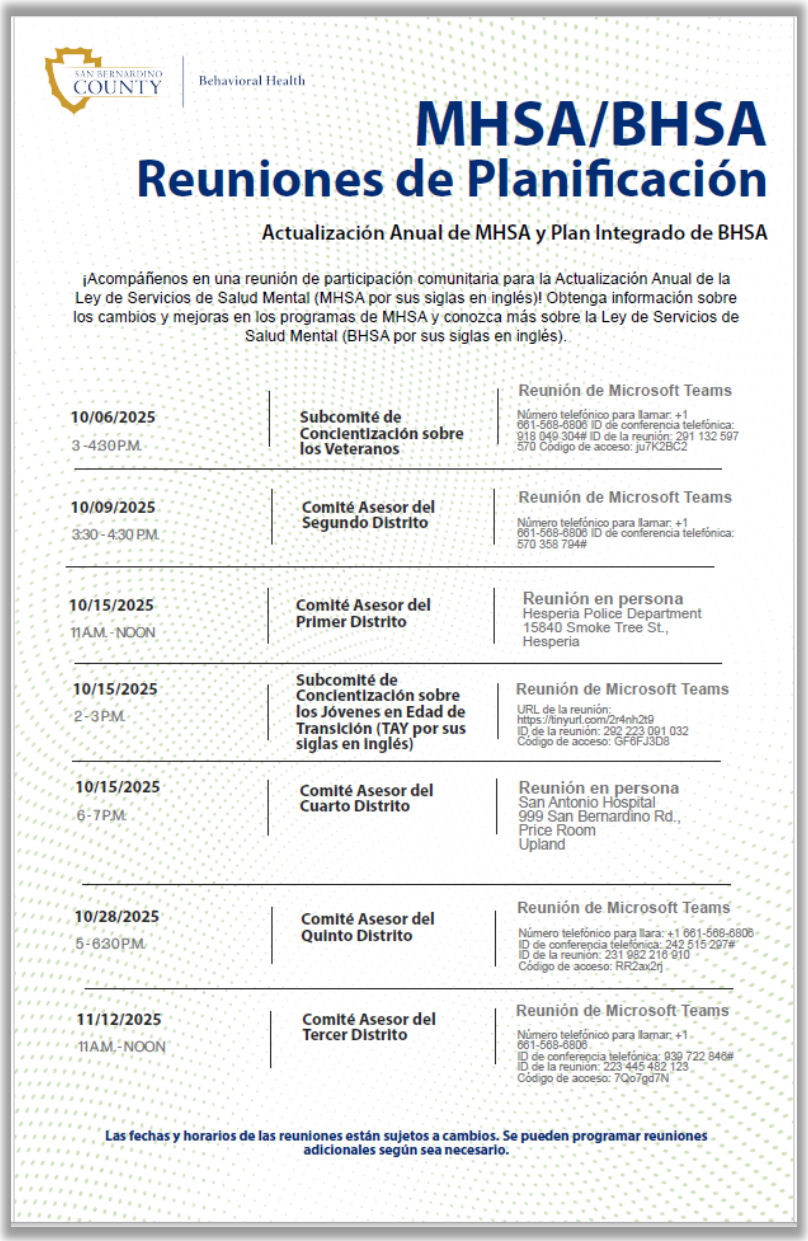
MHSA/BHSA Planning Meetings

MHSA Annual Update and BHSA Integrated Plan

Please join us at a Mental Health Services Act (MHSA) Annual Update stakeholder engagement meeting! Get information about MHSA program changes and enhancements and learn about the Behavioral Health Services Act (BHSA).

11/19/2025 1 - 3 P.M.	**Senior Affairs Commission**	**In Person Meeting** DAAS-PG Admin 784 E. Hospitality Ln., Conference Rm. A, San Bernardino
11/20/2025 1 - 2:30 P.M.	**Cultural Compentency Advisory Committee (CCAC)**	**Microsoft Teams Meeting** Meeting URL: https://bit.ly/422xx2K Meeting ID: 265 553 890 216 Passcode: YU9mo9wv
12/18/2025 10 A.M. - NOON	**Community Policy Advisory Committee (CPAC)**	**Microsoft Teams Meeting** Call-in phone number: +1 661-568-6806 Phone Conference ID: 770 006 937# Meeting ID: 293 271 276 582 Passcode: Z45bT9Su

Meeting dates and times are subject to change. Additional meetings may be scheduled as needed.



SAN BERNARDINO COUNTY | Behavioral Health

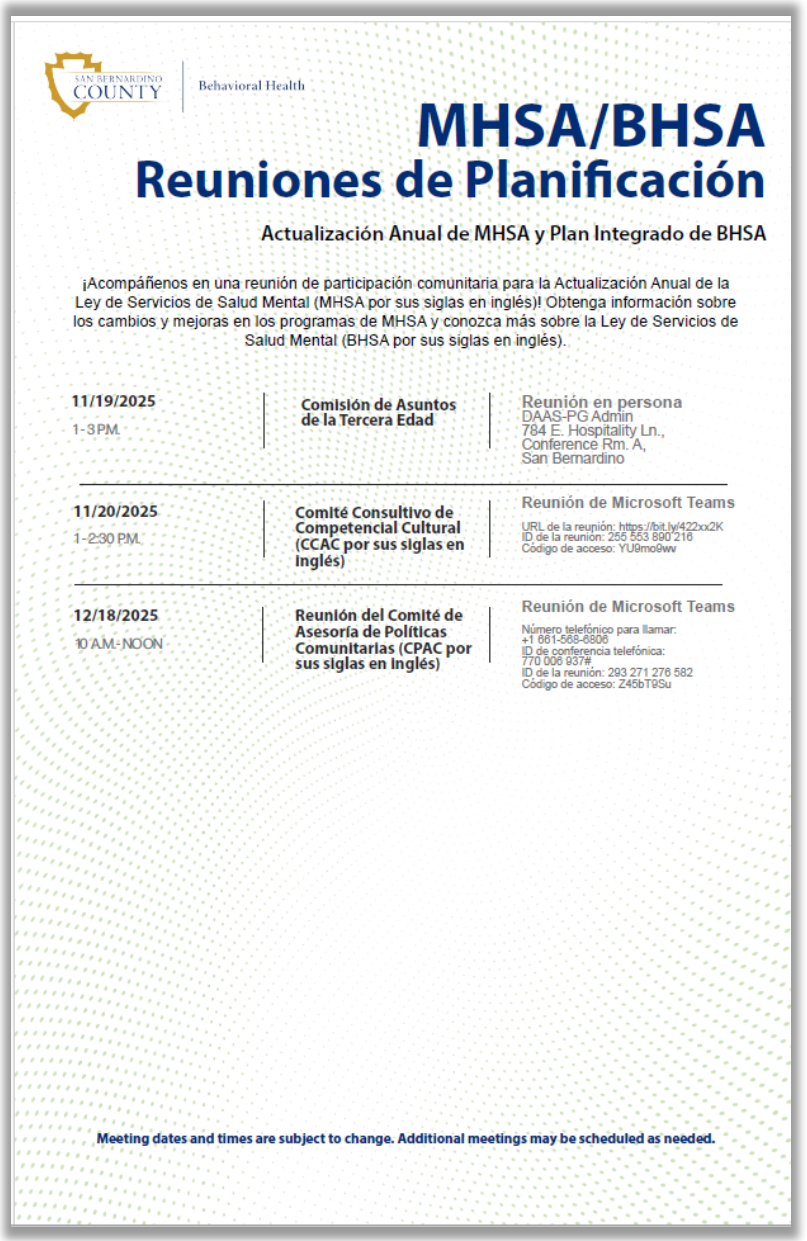
MHSA/BHSA
Reuniones de Planificación

Actualización Anual de MHSA y Plan Integrado de BHSA

¡Acompáñenos en una reunión de participación comunitaria para la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)! Obtenga información sobre los cambios y mejoras en los programas de MHSA y conozca más sobre la Ley de Servicios de Salud Mental (BHSA por sus siglas en inglés).

10/06/2025 3 - 4:30 P.M.	**Subcomité de Concientización sobre los Veteranos**	**Reunión de Microsoft Teams** Número telefónico para llamar: +1 661-568-6806 ID de conferencia telefónica: 918 049 304# ID de la reunión: 291 132 597 570 Código de acceso: ju7K2BC2
10/09/2025 3:30 - 4:30 P.M.	**Comité Asesor del Segundo Distrito**	**Reunión de Microsoft Teams** Número telefónico para llamar: +1 661-568-6806 ID de conferencia telefónica: 570 358 794#
10/15/2025 11 A.M. - NOON	**Comité Asesor del Primer Distrito**	**Reunión en persona** Hesperia Police Department 15840 Smoke Tree St., Hesperia
10/15/2025 2 - 3 P.M.	**Subcomité de Concientización sobre los Jóvenes en Edad de Transición (TAY por sus siglas en inglés)**	**Reunión de Microsoft Teams** URL de la reunión: https://tinyurl.com/2r4nh2t9 ID de la reunión: 292 223 091 032 Código de acceso: GF6FJ3D8
10/15/2025 6 - 7 P.M.	**Comité Asesor del Cuarto Distrito**	**Reunión en persona** San Antonio Hospital 999 San Bernardino Rd., Price Room Upland
10/28/2025 5 - 6:30 P.M.	**Comité Asesor del Quinto Distrito**	**Reunión de Microsoft Teams** Número telefónico para llara: +1 661-568-6806 ID de conferencia telefónica: 242 515 297# ID de la reunión: 231 982 216 910 Código de acceso: RR2ax2rj
11/12/2025 11 A.M. - NOON	**Comité Asesor del Tercer Distrito**	**Reunión de Microsoft Teams** Número telefónico para llamar: +1 661-568-6806 ID de conferencia telefónica: 939 722 846# ID de la reunión: 223 445 482 123 Código de acceso: 7Qo7gd7N

Las fechas y horarios de las reuniones están sujetos a cambios. Se pueden programar reuniones adicionales según sea necesario.



SAN BERNARDINO COUNTY | Behavioral Health

MHSA/BHSA
Reuniones de Planificación

Actualización Anual de MHSA y Plan Integrado de BHSA

¡Acompáñenos en una reunión de participación comunitaria para la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés)! Obtenga información sobre los cambios y mejoras en los programas de MHSA y conozca más sobre la Ley de Servicios de Salud Mental (BHSA por sus siglas en inglés).

11/19/2025 1 - 3 P.M.	**Comisión de Asuntos de la Tercera Edad**	**Reunión en persona** DAAS-PG Admin 784 E. Hospitality Ln., Conference Rm. A, San Bernardino
11/20/2025 1 - 2:30 P.M.	**Comité Consultivo de Competencial Cultural (CCAC por sus siglas en inglés)**	**Reunión de Microsoft Teams** URL de la reunión: https://bit.ly/422xx2K ID de la reunión: 255 553 890 216 Código de acceso: YU9mo9wv
12/18/2025 10 A.M. - NOON	**Reunión del Comité de Asesoría de Políticas Comunitarias (CPAC por sus siglas en inglés)**	**Reunión de Microsoft Teams** Número telefónico para llamar: +1 661-568-6806 ID de conferencia telefónica: 770 006 937# ID de la reunión: 293 271 276 582 Código de acceso: Z45bT9Su

Meeting dates and times are subject to change. Additional meetings may be scheduled as needed.

Summary and Analysis of Stakeholder Comments

During the Community Program Planning meetings, DBH received several inquiries on the stakeholder comment forms asking what services are available in their region, especially in rural areas, how to access additional information on available behavioral health services in San Bernardino County, and where to find out more information on Substance Use Disorder and Recovery Services (SUDRS). Please see below for additional information on services and programs.

Services and programs by region

The DBH Services Guide is located at https://wp.sbcounty.gov/dbh/resources/, under the Services Guide, Handbooks, and Provider Directories section, and includes service providers in the East Valley, West Valley, Desert/Mountain, and Morongo Basin. It is available in English, Spanish, Mandarin, and Vietnamese. The DBH Services Guide is a summary of DBH and DBH contract provider services and is not inclusive of all services and/or providers.

Organizations that provide services

DBH's Provider Directories, which include each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed with or contracted by DBH to deliver Medi-Cal services, may be viewed at https://wp.sbcounty.gov/dbh/resources/ under the Services Guide, Handbooks, and Provider Directories section.

Substance Use Disorder and Recovery Services (SUDRS) Resources

The DBH SUDRS providers can be found in the DBH Services Guide, and additional SUDRS resources can be found at https://wp.sbcounty.gov/dbh/resources/#SUDRSresources

Summary and Analysis of Stakeholder Comments, cont.

During stakeholder meetings, community members also asked how they might participate in the CPP process and find additional information on upcoming meetings.

Community Program Planning Meetings

Throughout the year, regular stakeholder meetings include:

- Behavioral Health Commission (BHC)
- District Advisory Committee (DAC)
- Community Policy Advisory Committee (CPAC)
- Cultural Competency Advisory Committee (CCAC), along with 14 Culturally Specific Subcommittees
- Association of Community Based Organizations (ACBO)
- Prevention and Early Intervention (PEI) Provider Network

The schedule of upcoming DBH meetings and events can be found at https://wp.sbcounty.gov/dbh/events/.

Feedback from regularly occurring meetings is compiled throughout the year(s) and included with feedback from any special sessions that are held to review the Annual Plan Update. DBH encourages and supports community collaboration in all aspects of the MHSA programs provided.

To address concerns related to DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating to the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Annual Update and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087.

Community members do not have to wait for a meeting to provide feedback to the Department. Feedback can be provided anytime via email at MHSA@dbh.sbcounty.gov or by calling 1-800-722-9866. As program data, outcomes, statistics, and ongoing operations are discussed regularly, regular attendance at one or more meetings is encouraged. The Community Policy and Advisory Committee (CPAC) specifically addresses MHSA programs, which occur monthly. If you would like to be added to the invite list for CPAC meetings, please email MHSA@dbh.sbcounty.gov.

Summary and Analysis of Stakeholder Comments, cont.

When the MHSA Annual Update is written and posted, feedback is regularly solicited on the content of plans/programs while plans are posted for public review.

Feedback/comments can be submitted via email at MHSA@dbh.sbcounty.gov or by phone at 1-800-722-9866. If feedback is received, it may be incorporated into the new MHSA Annual Update or, if not incorporated, addressed in the final MHSA Annual Update as to why it was not incorporated.

As feedback is collected from the community, it is analyzed with county demographic information, prevalence and incidence rates for behavioral health services, specific treatment information collected by programs, consumers served, number and types of services provided, geographic regions served by zip code, data provided to the department by state agencies evaluating access to county services, cultural and linguistic needs, poverty indexes, current program capacity, and demonstrated needs in specific geographic regions and areas within the system of care (e.g., inpatient, residential, long term care, day treatment, intensive outpatient, general outpatient care), and program needs are considered.

Additional information about past MHSA-approved plans can be accessed at the following link: https://wp.sbcounty.gov/dbh/programs/bhsa/. If you have any questions about MHSA programs in general or programs as detailed in this MHSA Annual Update, please email or call the department at MHSA@dbh.sbcounty.gov or 1-800-722-9866.

During Community Program Planning meetings, community members asked how they might be considered to become a new DBH provider or provide new or expanded services.

DBH clinics or organizational contract providers can provide new program proposals and/or program enhancement services. Programs are often implemented using DBH clinics and organizational contract providers working together to provide services in a system of care framework. A request for proposal (RFP)/procurement process is required for services provided by organizational providers. The RFP process can be accessed via the link here, which is as follows: https://wp.sbcounty.gov/purchasing/.

Summary and Analysis of Stakeholder Comments, cont.

During stakeholder meetings, community members asked how they will be informed about the Behavioral Health Services Act (BHSA) regulatory changes and how it might potentially affect their programs.

Community Program Planning Meetings
Throughout the year, as DBH is apprised on BHSA updates, they will share this information with stakeholders through the Community Program Planning meetings.

Special BHSA Integrated Plan meetings were held throughout January 2026 to provide an overview of what is included in the first BHSA Integrated Plan. An additional meeting is tentatively scheduled for March 2026 to discuss the BHSA Integrated Plan for FY 2026/27 through FY 2028/29 in more detail.

During stakeholder meetings, community members asked about programs for specific populations.

Categories of programs for specific populations
The Community Services and Supports component comprises programs designed to support a continuum of services that support the mental health needs of diverse children, TAY, Adults, and Older Adults according to need.

The Prevention and Early Intervention component is comprised of culturally specific programs, children and youth programs, and specialty programs that are designed to prevent mental illness from becoming severe and disabling with an emphasis on improving timely access to services for underserved populations.

For a description of MHSA programs, please refer to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/24 through Fiscal Year 2025/26.

During the stakeholder meetings, community members requested additional information regarding the following topics. In reviewing this feedback, DBH would like to respond to these areas already being addressed within our current system of care or by other community resources.

Assistance for Disabled Individuals

For individuals with developmental disabilities and intellectual disabilities, DBH collaborates and works with First 5 (https://first5sanbernardino.org/initatives/early-learning/) and the Inland Regional Center (https://www.inlandrc.org/). Both programs specifically work

Summary and Analysis of Stakeholder Comments, cont.

with this population (Developmental Disabilities and Intellectual Disabilities) and ensure that the individual and families are referred to the appropriate resources (i.e., Early Head Start/Head Start).

A good resource for finding services to support developmentally and physically disabled adults would be the utilization of the 2-1-1 service. The 2-1-1 service is free and confidential, available 24-hours a day, providing information and resources for health and social services in San Bernardino County. Call 2-1-1 or visit the website at inlandsocaluw.org to find resources nearby.

Reduction of Discrimination and Stigma

Prevention and Early Intervention (PEI) programs focus on reducing stigma and discrimination. The programs are tailored to be culturally and linguistically competent and meet the identified needs of the communities they serve. Services offered include prevention services and leadership programs for children, youth, transitional-age youth, adults, and older adults. Services include behavioral health education workshops, community counseling, adult skill-based education programs, and parenting support. Additional information regarding PEI programs can be obtained by calling 1-800-722-9866.

Support for Parents and Caregivers

The Family Resource Centers (FRC) offer programs tailored to be culturally and linguistically competent and meet the identified needs of the communities they serve, including parents and caregivers. Services offered include prevention and leadership programs for children, youth, transitional age youth, adults, and older adults. Services include behavioral health education workshops, community counseling, adult skill-based education programs, and parenting support. Additional information regarding FRC programs can be obtained by calling 1-800-722-9866.

Crisis Services

The Crisis Stabilization Units (CSU), including those formerly known as Crisis Walk-In Center (CWIC), programs are staffed with available nurses, and services are available to the community 24 hours per day, 365 days a year. Further, the DBH Crisis Contact Center (CCC) operates 24 hours per day, 365 days a year, offering text message, telephone, and telehealth support countywide to individuals in crisis. The CCC is able to dispatch mobile crisis response services 24 hours per day, 365 days a year, when safe and appropriate, to the West Valley, East Valley, and High Desert regions.

Summary and Analysis of Stakeholder Comments, cont.

Community-based mobile crisis response teams are available 24 hours per day, 365 days a year to provide services in all languages for individuals of any age experiencing a mental health crisis. Call 1-800-398-0018 or text 1-909-420-0560.

Shelter Beds and Homeless Assistance

The Office of Homeless Services (OHS) plays a vital role in the San Bernardino County Homeless Partnership as the administrative support unit for the organization. OHS ensures that the partnership's focus is to develop a countywide public-private partnership and to coordinate services and resources that are carried into effect. Homeless services information and resources can be found at the San Bernardino County Homeless Partnership website: https://sbchp.sbcounty.gov/.

The 2-1-1 website offers a guide for homeless service providers and a list of homeless resource centers. For specific areas in need that may not be available on the website resources, dial 2-1-1 to access the most comprehensive database of free and low-cost health and human services available in the county. Call 2-1-1 or visit the website at inlandsocaluw.org to find resources nearby.

In addition to the available resources from the OHS regarding homeless services, DBH provides services from the Recovery-Based Engagement Support Teams (RBEST), Community Crisis Response Team (CCRT), the Crisis Stabilization Units (CSU), Innovative Remote Onsite Assistance Delivery (InnROADs), and Triage, Engagement, and Support Teams (TEST) programs throughout San Bernardino County.

These programs are intended to reduce:

- Incidents of acute involuntary psychiatric hospitalization
- The number of calls to law enforcement for psychiatric emergencies
- The number of psychiatric emergencies in hospital emergency departments
- The number of consumers seeking emergency psychiatric services from hospital emergency departments
- The amount of time a consumer with a psychiatric emergency spends in hospital emergency departments and increase consumer access to services

Additional information regarding Community Crisis Response Team (CCRT) and Crisis Stabilization Units (CSU) can be obtained through the access unit hotline, which offers 24-hour crisis and referral information and can be reached at 1-888-743-1478.

Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and its system of care services. This MHSA Annual Update reflects program changes under the Community Services and Supports (CSS) and Innovation (INN) components. There are no planned program changes under the Prevention and Early Intervention (PEI) component.

The following are proposed changes in programs and components:

Community Services and Supports

Enhanced Board and Care – Budget Increase

Helping Hearts California, LLC, an established San Bernardino County contractor providing Adult Residential Facility services, is transitioning one of their active Social Rehabilitation sites with 10 beds into an Adult Residential Facility (ARF) and adding two additional 10-bed sites, for a total of 30 ARF beds for Enhanced Board and Care. The 30 Enhanced Board and Care beds will be located in San Bernardino.

- With this addition, DBH will be able to provide for a total of 235 ARF beds with enhanced support and will look to serve a total of 325 consumers annually across all enhanced board and care contracted partners funded within the Adult Transitional Care Programs (A-13) component of MHSA.

Funding Sources: The total increase to the CSS A-13 Adult Transitional Care Programs, Enhanced Board and Care section across the 5-year contract period, effective October 1, 2025, is $17,803,500 and is broken down as follows:

Fiscal Year	Amount
2025/26 October – June (9 months)	$2,669,062.50
2026/27	$3,558,750
2027/28	$3,568,500 (allows for leap year)
2028/29	$3,558,750
2029/30	$3,558,750
2030/31 July – September (3 months)	$889,687.50

Thirty (30) beds at a cost of $325 per bed per day. The contract will serve 30 consumers annually at an approximate cost of $118,625 per consumer.

This increase is supported by stakeholder's feedback to increase appropriate residences and department need. Enhanced board and care is an expanded MHSA program to enhance the residential support of adult consumers experiencing complex, challenging, and/or chronic mental health conditions and severe co-occurring disorders, including the provision of treatment services specializing in hearing and communication impairments. This level of care provides the consumer with a community step-down opportunity, when clinically appropriate, into an unlocked setting with enhanced staffing to ensure a seamless transition back into the community.

Summary of Program Changes, cont.

Social Rehabilitation – Budget Increase

The Department of Behavioral Health (DBH) currently contracts for Adult Residential Facilities with Social Rehabilitation Treatment Services (ARF with SRTS) for a total of 66 beds. This change will increase that number by six (6), to 72 total beds, with an increased annual amount of $1,478,250 (from $10,446,300 to $11,924,550). These six additional ARF Social Rehabilitation beds will be located in Redlands.

- This increase will allow DBH to continue to provide this vital step-down level of care to San Bernardino County consumers. Additionally, the increase to available beds allows additional opportunity for placement at this step-down level of care. These additional beds will reduce costly wait times in higher levels of care.
- This increase is supported by stakeholder's feedback to increase appropriate residences. ARF with SRTS provides 24/7 nonmedical care and supervision to residents. The particular ARFs funded through MHSA are also licensed and certified through the state to deliver social rehabilitation services, which are provided in a long-term or transitional residential setting for adult consumers.

Funding Sources: The total increase to the MHSA CSS A-13 Adult Transitional Care Programs, Social Rehabilitation Model services is $1,478,250, for a total annual amount of $11,924,550, effective July 1, 2025. The following is a breakdown of the increases approved by DBH:

- Rate increase –
  - Helping Hearts approved for 54 beds at $485 per bed per day (an increase of $35 per bed per day). Annual amount is now $9,559,350. This is a $689,850 increase over the original annual approved amount of $8,869,500. This change will cover the increased cost per bed per day, increase of $35 per bed per day for 54 beds.
- Bed increase –
  - Amethyst approved for 18 beds at $360 per bed per day (six additional beds). Annual amount is now $2,365,200. This is a $788,400 increase over the original annual approved amount of $1,576,800.

Summary of Program Changes, cont.

Continuation of Joxel Support for myAvatar System Improvements

The Department of Behavioral Health (DBH) is approving the four-year contract with The Joxel Group, LLC (Joxel) to ensure continued specialized support for DBH's electronic health record (EHR) system, myAvatar.

- A continued partnership with Joxel is essential as California advances the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, including Payment Reform, which supports counties and healthcare providers in delivering value-based care to improve Medi-Cal beneficiaries' quality of life. Enhancing patient outcomes through improved data sharing and integration of health information systems (interoperability) is increasingly vital for patient care and regulatory compliance. Joxel's specialized expertise ensures DBH can effectively adapt myAvatar to meet these evolving state requirements and interoperability standards.

Funding Sources: The total amount of MHSA funding across the four-year contract period, effective October 1, 2025, is $1,200,000 and is broken down as follows:

Fiscal Year	Amount
25/26 October – June (9 months)	$240,000
26/27	$320,000
27/28	$320,000
28/29	$320,000

Continuation of this contract will help to support the BHSA data sharing requirement for the local planning process with the Medi-Cal Managed Care Plans (MCPs) and local health jurisdictions (LHJs), and it will support data sharing for the increased accountability and transparency under Behavioral Health Transformation.

Innovation

Eating Disorder Collaborative – Project Sunset

The Eating Disorder Collaborative (EDC) project is designed to support treatment for eating disorders and care coordination. The project is scheduled to sunset December 31, 2025. The Department of Behavioral Health (DBH) is reviewing project data and outcomes to explore options to continue the project after sunset.

Cracked Eggs – Project Sunset

The Cracked Eggs project will sunset June 30, 2026, and will not continue as a standalone program. The project is currently conducting its final cohorts, which highlights art as a therapeutic tool. Low enrollment rates combined with the substantial operational costs have rendered it unsustainable. DBH will explore integrating select art-based strategies into its system of care where appropriate. The final project report is expected in FY 2026/27.

Summary of Program Changes, cont.

Innovation

Progressive Integrated Care Collaborative (PICC) – Project Update

The Progressive Integrated Care Collaborative Project is developed to deliver integrated behavioral and physical health services to Medi-Cal enrollees at Apple Valley Community Clinic. The Department of Behavioral Health is developing an arrangement with Arrowhead Regional Medical Center to deliver the project's physical health services.

Public Review and Comment Period

Placeholder for 30-day Public Review and Comment Period; to be completed following close of 30-day posting.

Improvements in Progress

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT).

The Department of Health Care Services (DHCS) is enacting changes resulting from Proposition 1 through the Behavioral Health Transformation project and are providing guidance to counties. As the Department of Behavioral Health (DBH) is apprised on BHSA updates, they will share this information with stakeholders through the Community Policy Advisory Committee (CPAC) meetings and other Community Program Planning (CPP) meetings throughout this fiscal year.

The current MHSA programs and services will continue as approved through June 30, 2026. The first BHSA Integrated Plan for FY 2026/27 through FY 2028/29 is due by June 30, 2026, and will be effective on July 1, 2026. The BHSA Integrated Plan is currently being developed, and DBH is continuing to engage stakeholders and obtain feedback through the Community Program Planning (CPP) process during development of the Plan.

To ensure as smooth a transition from MHSA to BHSA as possible, DBH is currently engaged in the following activities:

- Expanding stakeholder engagement by identifying and connecting with new partners to ensure inclusive participation in the CPP process and program planning.
- Educating stakeholders on Proposition 1, discussing its program impacts, and soliciting actionable feedback to address community needs and guide future planning during monthly CPAC meetings and CPP meetings.
- Continuing to meet with county partners and discuss program impacts.
- Developing mitigation plans to ensure a smooth transition to funding structures and service models.
- Maintaining a proactive role in the BHSA transition, engaging in Behavioral Health Transformation (BHT) listening sessions led by the state, and staying up-to-date on evolving policies and regulations to ensure informed decision-making and community alignment.

Additional information on stakeholder engagement can be found on the Department of Health Care Services (DHCS) website using the following link: Stakeholder-Engagement.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: PEI Component including Annual Prevention and Early Intervention Report

Introduction

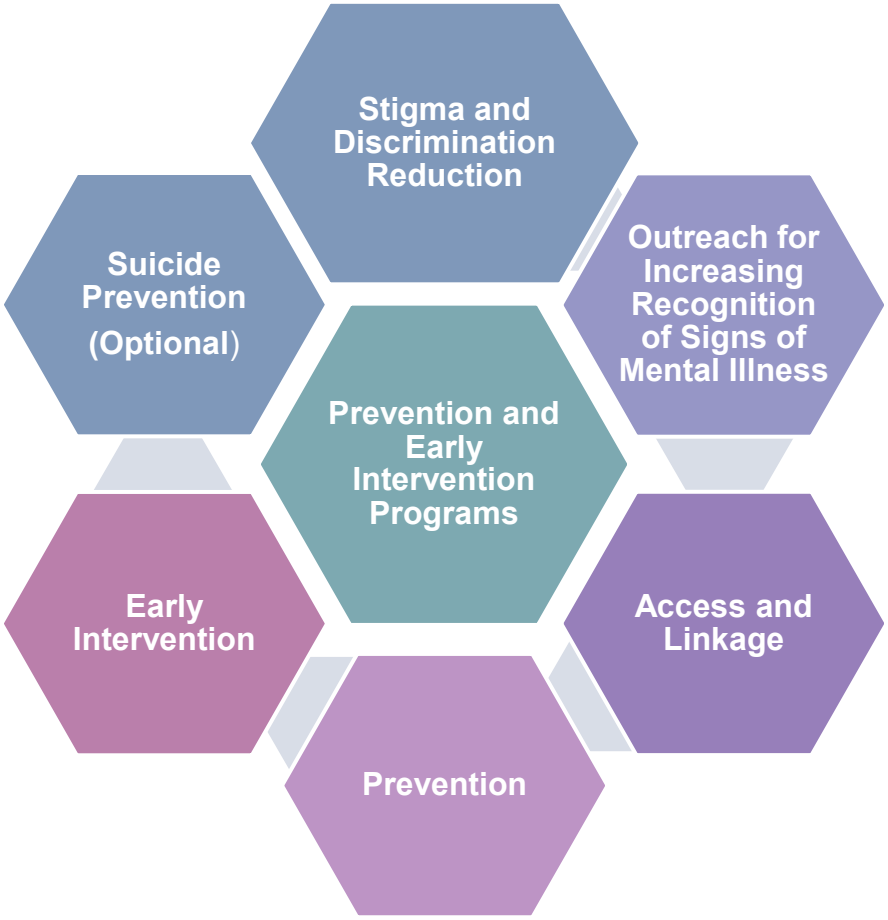
The Prevention and Early Intervention (PEI) program was developed to prevent mental illness from becoming acute and disabling. PEI approach is the promise to improve timely access to services, particularly for populations that have historically been underserved or unserved.

PEI programs are grounded in the principles of cultural competence, community empowerment, collaboration, and inclusion. These values guide the delivery of services that foster recovery, wellness, and resilience for individuals and families. Through strong partnerships with schools, justice systems, primary care, and a wide range of community organizations, PEI initiatives are able to identify individuals at risk and connect them to appropriate resources and support.

PEI programs are dedicated to addressing the priority needs identified by diverse local community stakeholders, fulfilling the critical community and priority population needs delineated in the Mental Health Services Act (MHSA) and effecting transformation within the public mental health system.

There are six (6) State-Defined PEI Programs. These State-Defined programs are Stigma and Discrimination Reduction, Outreach for Increasing Recognition of Signs of Mental Illness, Access and Linkage to Services, Prevention, Early Intervention, and Suicide Prevention, shown in the adjacent image.

State-Defined Prevention and Early Intervention Programs



Introduction, cont.

County PEI programs operate under the State-Defined Prevention and Early Intervention reporting construct as illustrated in the following table.

Local PEI Construct

Stigma and Discrimination Reduction

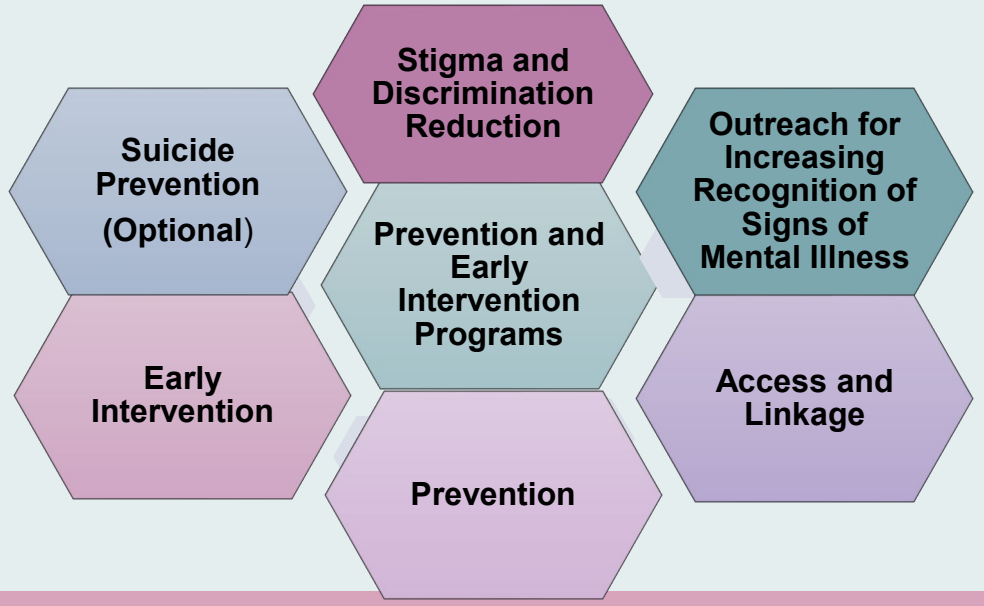
- Native American Resource Center (NARC)

Outreach for Increasing Recognition of Signs of Mental Illness

- *Promotores de Salud* (PdS)
- Community Health Workers (CHW)
- Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)

Access and Linkage to Treatment

- Child and Youth Connection (CYC)



Prevention

- Preschool PEI Program (PPP)
- Resilience Promotion in African American Children (RPiAAC)
- Lift Program (LP)
- Coalition Against Sexual Exploitation (CASE)
- Older Adult Community Services (OACS)

Early Intervention

- Family Resource Center (FRC)
- Military Services and Family Support (MSFS)
- Community Wholeness and Enrichment (CWE)
- Student Assistance Program (SAP)
- Improving Detection and Early Access (IDEA)

Suicide Prevention (Optional)

- Office of Suicide Prevention (OSP)

Introduction, cont.

MHSA Legislative Goals and Key Outcomes	Local Program
Increase early access and linkage to medically necessary care and treatment:	
• Connect children, adults, and seniors with serious mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.	- CYC -OACS - SAP - LP
Improve timely access to service:	
• Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.	- OACS - PPP - MSFS - SAP
Promote, design, and implement programs in ways that reduce and circumvent stigma:	
• Reduce and circumvent stigma, including self-stigma. • Reduce discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. • Increase service accessibility.	- NARC
Prevent suicide as consequence of mental illness:	
• Improve attitudes, knowledge, and/or behavior regarding suicide related to mental illness.	- MSFS - OSP - CWE - OACS

Acronym	Program	Acronym	Program
NARC	Native American Resource Center	CYC	Child and Youth Connection
SAP	Student Assistance Program	PPP	Preschool PEI Program
CHW	Community Health Workers	LP	Lift Program
OSP	Office of Suicide Prevention	OACS	Older Adult Community Services
MSFS	Military Services and Family Support		

Introduction, cont.

MHSA Legislative Goals and Key Outcomes	Local Program
Increase recognition of early signs of mental illness:	
• Increase identification of early signs of potentially severe and disabling mental illness for potential responders. • Increase support to individuals with mental illness. • Increase referrals for individuals who need treatment or other mental health services.	- CHW/PdS - OSP - SUPPOrT - OACS
Reduce prolonged suffering associate with mental illness:	
• Reduce risk factors. • Reduce indicators. • Increase protective factors that may lead to improved mental emotional and relational functioning. • Reduce symptoms. • Improve recovery, including mental, emotional, and relational functioning.	- OACS - CYC - SAP - FRC - PPP - LP - CASE - MSFS - RPIAAC - IDEA
Reduce stigma and discrimination associated with mental illness:	
• Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.	- RPIAAC - CWE - CHW/PDS

Acronym	Program	Acronym	Program
NARC	Native American Resource Center	CYC	Child and Youth Connection
PdS	Promotores de Salud	PPP	Preschool PEI Program
CHW	Community Health Workers	LP	Lift Program
SUPPOrT	Substance Use Prevention & Pathways to Outreach and Treatment	RPiAAC	Resilience Promotion in African American Children
CASE	Coalition Against Sexual Exploitation	OACS	Older Adult Community Services
OSP	Office of Suicide Prevention	FRC	Family Resource Center
MSFS	Military Services and Family Support	CWE	Community Wholeness and Enrichment
SAP	Student Assistance Program	IDEA	Improving Detection and Early Access

Introduction, cont.

SB 1004 PEI Program Priority Areas
All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004, which requires counties to specify how they are incorporating the following six program-identified priorities in the FY 2025/26 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transition-age youth, prioritizing partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health needs of older adults.
6. Early identification programming of mental health symptoms and disorders, including but not limited to anxiety, depression, and psychosis.

These priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies, consistent with our community planning process (see subsequent totals for details).

Per WIC section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following provides these estimates:

	SB 1004 PEI Program Priority Categories:	Percentage of Funding Allocated to Priority:
1.	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs	68%
2.	Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan	2%
3.	Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs	13%
4.	Culturally competent and linguistically appropriate prevention and intervention	7%
5.	Strategies targeting the mental health needs of older adults	3%
6	Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	7%

Introduction, cont.

PEI Component	Local Program Name	SB 1004 Priority Category					
		1 Child Trauma	2 Early Psychosis	3 Youth Outreach	4 Cultural Comp	5 Older Adults	6 Early ID
Prevention	PEI SI-2: Preschool PEI	x					x
	PEI SI-3: Resilience Promotion in African American Children			x	x		
	PEI SE-1: Older Adult Community Services					x	
	PEI SE-5: Lift						x
	PEI SE-6: Coalition Against Sexual Exploitation (CASE)	x		x			
Prevention and Early Intervention	PEI CI-2: Family Resource Center	x					x
	PEI SE-3: Community Wholeness and Enrichment		x	x			
	PEI SE-4: Military Services and Family Support				x		x
	PEI SI-1: Student Assistance Program	x		x			
	PEI SE-7: Early Psychosis Program/IDEA		x				

Introduction, cont.

PEI Component	Local Program Name	SB 1004 Priority Category					
		1 Child Trauma	2 Early Psychosis	3 Youth Outreach	4 Cultural Comp	5 Older Adults	6 Early ID
Stigma and Discrimination Reduction	PEI-CI-3: Native American Resource Center				x		
Outreach for increasing recognition for early signs of Mental Illness	PEI CI-1: Promotores de Salud/Community Health Worker				x		
	PEI CI-5: Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)						x
Access and linkage to treatment	PEI SE-2: Child and Youth Connection	x					

Introduction, cont.

PEI Community Program Planning

Description of PEI CPP Process: This includes an explanation of how stakeholders contributed to PEI priorities and the allocation of funding for priorities.

A series of District Advisory Committee (DAC) meetings were held in FY 2024/25. There are five distinct districts within San Bernardino County, each very unique and different. PEI met with each district during their DAC meetings to share specific district information about MHSA, including PEI. Each engagement consisted of a presentation via Webex to reach a broader audience.

- District 1 – January 15, 2025
- District 2 – January 9, 2025
- District 3 – February 12, 2025
- District 4 – January 15, 2025
- District 5 – January 28, 2025

In addition to the District Advisory Committee meetings, PEI presented a comprehensive overview of its programs to the Community Policy Advisory Committee (CPAC) on October 17, 2024.

Invites were sent to the general public, stakeholders, Community Policy Advisory Committee (CPAC), Behavioral Health Commission (BHC), PEI providers, and Office of Equity and Inclusion (OEI).

Committee meetings were advertised on all DBH social media platforms, including Facebook, Instagram, and X.

Key findings as a result of the feedback from these stakeholder engagement meetings identified the following priorities:

The top three priorities for PEI efforts within our community:

- Childhood trauma early intervention to address early origins of mental health and substance use disorder needs.
- Strategies targeting mental health and substance use disorder needs of older adults.
- Strategies addressing needs of individuals at high risk of crisis.

Some of the PEI priorities within our community that are already being met:

- Culturally competent and linguistically appropriate.
- Strategies targeting mental health needs of older adults.
- Childhood trauma early intervention to deal with early origins of mental health and substance use disorder needs.
- Early psychosis and mood disorder detection and intervention and mood disorder programming across the lifespan.

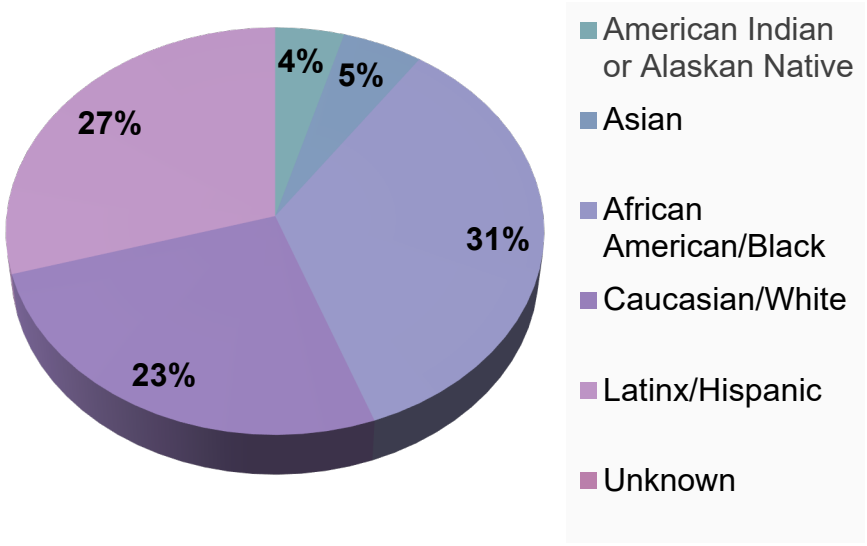
Introduction, cont.

PEI Community Program Planning, cont.

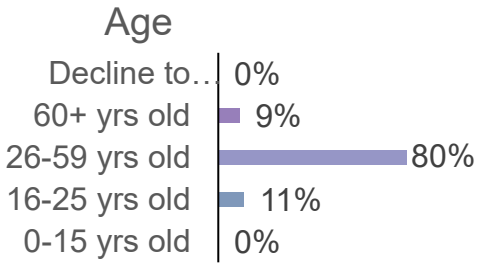
The following graphs show the community demographics of the stakeholders who attended the meetings.

The rich racial diversity of San Bernardino County was reflected in the demographic data of the participants, with 31% identifying as African American/Black, 5% Asian, 23% Caucasian/White, 27% Latinx/Hispanic, and 4% Native Hawaiian/Pacific Islander. In addition, 10% of participants indicated that they identify with more than one race.

Race

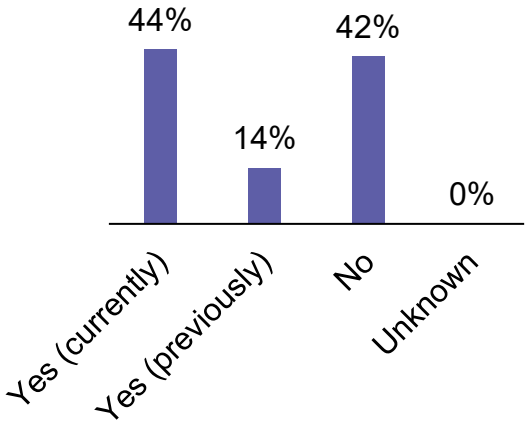


The majority of participants were adults, with 80% reporting that they were between 26-59 years old, 9% were older adults over 59, and 11% TAY-aged youth 16-25.

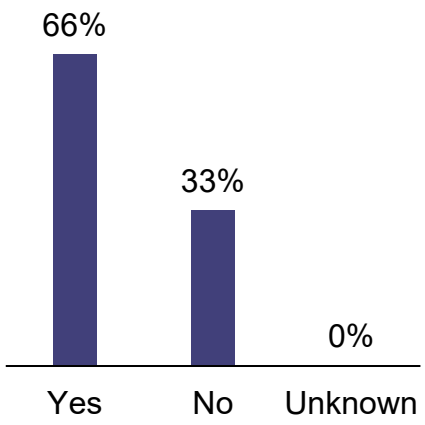


Participants comprised of a mix of individuals with 44% reporting that they are either a current or previous consumer of mental health services and 66% reporting that the are related to a consumer of either mental health or substance use disorder services.

Consumer of Mental Health Services



Related to Consumer of Mental Health and/or Substance Use Disorder Services



Introduction, cont.

PEI Data Collection

Data is collected for PEI programming in various ways throughout the reporting cycle. Program providers enter data into the Data Collection System (DCS) 2.0 portal for activities related to prevention, outreach for increasing recognition of early signs of mental illness, access and linkage, improving timely access, and stigma and discrimination reduction. DBH's Electronic Health Record (EHR) and billing system is myAvatar and will be presented as myAvatar throughout the document. PEI program providers use the myAvatar database to enter data associated with early intervention services.

In addition, PEI outcomes and successes related to increasing knowledge and changes in beliefs and perceptions are measured using tools such as the PEI Outreach Survey and the PEI Stigma and Discrimination Reduction Survey.

Other methods used to collect data include feedback from Community Program Planning meetings, PEI quarterly meetings, and bi-annual and annual reports submitted by the PEI program providers.

Additional information about the data collection methods is described in greater detail in the following sections.

Introduction, cont.

PEI Statewide Projects

PEI Statewide Projects are intended to build PEI capacity across the state and locally via the California Mental Health Services Authority (CalMHSA), a joint powers authority working on behalf of California Public Behavioral Health plans. The effort was jointly initiated with other California counties to make a statewide and local impact by expanding awareness of mental health needs and supports, reducing stigma, preventing suicides, and teaching individuals how to achieve mental wellness.

Participating California counties work with CalMHSA to support the statewide implementation of the Prevention and Early Intervention (PEI) Project through the Take Action for Mental Health initiative, advancing prevention, stigma reduction, suicide prevention, and mental wellness for all Californians.

During FY 2024/25, Take Action for Mental Health reached 2.3 million Californians through media, delivered nearly 9,000 mental health resources to California counties, and supported communities statewide in building cultures of wellness and prevention.
Take Action for Mental Health encourages individuals to take proactive steps for their own mental health and the mental health of others through three core pillars:

- **Check In** – Promoting connection and open conversations about wellbeing.
- **Learn More** – Increasing access to mental health education and information.
- **Get Support** – Encouraging help-seeking behaviors and connection to resources.

Building Engagement Through Social Media
Throughout FY 2024/25, organic social media channels maintained consistent visibility for Take Action for Mental Health, laying the groundwork for deeper engagement during strategic campaign moments:

- Total Reach: 30,868
- Total Engagement: 1,046

Engagement includes interactions such as likes, shares, comments, and other platform-based actions. This steady presence ensured Take Action for Mental Health remained visible to our county between major campaigns such as May is Mental Health Matters Month and Suicide Prevention Week, for those ready to take action.

Introduction, cont.

Training	Description
Directing Change Judges Training	Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, giving volunteer judges criteria to apply in evaluating student-submitted Directing Change videos.
Each Mind Matters Insiders Newsletter	A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
Suicide Prevention 101 for Parents: Recognizing Signs and What to Do	Webinar series providing information for parents including: • Recognizing warning signs for suicide. • How to have a conversation with your teen. • Actions to take if your teen is having suicidal thoughts. • Tips and resources to support emotional and mental health. • Information about raising resilient teens.
Suicide Prevention Week: Share Hope Together for Suicide Prevention	Through sharing of experiences and stories we can connect with and inspire one another. Sharing can create a sense of belonging while also reducing the weight of our burdens – allowing us to take action for suicide prevention together.

Native American Resource Center (NARC)

Program Description and Target Population

The Native American Resource Center (NARC) is a Stigma and Discrimination Reduction program that functions as a one-stop center offering prevention and early intervention services designed to reduce stigma and discrimination surrounding behavioral health services for Native American community members of all ages. They use holistic approaches, recognizing that the mental, physical, spiritual, and emotional self are all interconnected.

NARC provides culturally-based behavioral health services and education through historical and cultural contexts. They use traditional and strength-based Native American practices in their service delivery model. The use of cultural methods in prevention activities such as beading, sewing, herbal medicines, and sharing a meal together helps to ease the discomfort of having conversations about mental illness and reduces the stigma attached to mental illness and accessing mental health services.

The tables below provide an overview of the program's target population, service locations, annual budget allocation, and the types of services offered. The NARC program continually assesses the needs of its participants and responds by updating the services they offer.

Services Offered	• Talking Circles • Wellness Circles • Drumming Circles • Daughters of Tradition • Cultural education and awareness • Cultural arts therapy • Cognitive therapy groups

Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Counseling Centers

Native American Resource Center (NARC), cont.

State Program Positive Results

NARC provides a variety of activities rooted in tradition. The program aims to reduce stigma around mental illness and accessing behavioral health services by emphasizing culturally-focused preventative measures. For instance, using Talking Circles in place of traditional group therapy helps alleviate the stigma associated with engaging in behavioral health activities. Additionally, incorporating traditional Native practices such as beading, art, and storytelling demonstrates how cultural norms can be seamlessly integrated with therapeutic approaches.

Stigma & Discrimination Reduction

Recognizing and acknowledging the behaviors and actions that have caused emotional harm to the Native American community is a crucial first step towards healing and transformation. Educating the community about historical and intergenerational trauma helps in addressing the unique needs of this underserved group.

To assess progress in reducing stigma and discrimination, NARC measures changes in attitudes, knowledge, and behaviors. This is done through surveys that evaluate how participants' perceptions of mental illness have evolved as a result of the activities or presentations they engaged in.

The table below shows a significant increase from FY 2023/24 to FY 2024/25 in both the number of unduplicated participants and the services provided. NARC played a key role and was present at the 2024 San Manuel Pow Wow, a multi-day event that drew thousands of attendees from multiple states.

Number of Participants / Number of Services			
	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	5,566	3,334	33,777
Number of Services	5,972	4,153	33,810

Native American Resource Center (NARC), cont.

State Program Positive Results, cont.

Access & Linkage to Services

NARC provides access and linkage to additional services and higher levels of care for participants who need treatment beyond early intervention. Participants needing higher levels of care receive referrals to providers who can appropriately meet their needs.

NARC works closely with Riverside San Bernardino County Indian Health, Inc. (RSBCIHI). RSBCIHI supports NARC with linkage to RSBCIHI's Behavioral Health Services Department or to an outside agency.

FY 2023/24 saw a significant increase in referrals, a trend which continued to FY 2024/25. This rise in referrals is linked to a growing demand for mental health services that exceed basic care.

The adjacent table shows the number of participants who were linked to referrals during the three previous fiscal years.

Access and Linkage to Services Referrals			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals Provided	4	20	166
Number of referrals to County-funded / administered programs	0	0	0
Number of referrals to other programs	4	20	0
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	0*	0*	0*

*All participants engaged in treatment with the non-county administered service providers to whom they were referred.

Native American Resource Center (NARC), cont.

State Program Positive Results, cont.

Improving Timely Access

NARC enhances timely access to behavioral health services for members of historically underserved populations. They facilitate referrals to appropriate prevention, early intervention, and higher-level care services. This includes individuals who are unserved, underserved, or inadequately served within the care system, who face higher risks of homelessness, institutionalization, incarceration, or out-of-home placements.

NARC also serves ethnic, racial, cultural, and linguistic groups lacking access to mental health programs. Barriers such as misidentification of mental health needs, insufficient engagement and outreach, limited language access, and a lack of culturally competent services make it challenging for these individuals to obtain care.

NARC actively identifies and engages with individuals to assess their needs and provides culturally relevant referrals to meet their behavioral health care requirements.

The data for measuring Improving Timely Access is gathered from referrals to prevention services, early intervention treatment, and higher levels of care. The table below represents those who were referred and identified as part of an unserved/underserved population.

The improvement in Timely Access is due to NARC's use of the Screendox electronic health record system, which tracks risk factors related to substance use, mental health, domestic violence, and gambling. This system has enhanced NARC’s ability to collect Timely Access data more accurately.

Improving Timely Access Referrals			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals Provided	247	313	166

Native American Resource Center (NARC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	3%	6%	12%	3%	76%
FY 23/24	9%	8%	34%	9%	40%
FY 24/25	10%	9%	20%	6%	56%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 22/23	1%
FY 23/24	2%
FY 24/25	3%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 22/23	<1%
FY 23/24	0%
FY 24/25	0%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 22/23	3%
FY 23/24	6%
FY 24/25	4%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	8%	17%	<1%	75%
FY 23/24	15%	49%	0%	36%
FY 24/25	15%	39%	0%	46%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	14%	<1%	<1%	86%
FY 23/24	59%	2%	<1%	39%
FY 24/25	99%	<1%	0%	0%

Native American Resource Center (NARC), cont.

Demographics, cont.

Demographic Observations

- NARC continues to provide culturally appropriate services to the Native American community.
- Due to the increased number of in-person activities, participants were offered the opportunity to complete paper surveys instead of only electronic surveys.
- The program has faced challenges in collecting certain demographic data, citing respondents' hesitance to share this information. Regardless, the program remains committed to providing services even when demographic details are not disclosed.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	2%	8%	<1%
American Indian/Alaska Native	10%	21%	37%
Asian	1%	2%	<1%
Latinx/Hispanic	7%	8%	2%
Native Hawaiian or Pacific Islander	<1%	<1%	<1%
Caucasian/White	3%	4%	3%
More than One Race	2%	6%	6%
Other Race	82%	58%	52%

Native American Resource Center (NARC), cont.

Demographics, cont.

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	0%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	0%
Latinx/Hispanic	7%	0%	0%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other	93%	100%	100%
More than one ethnicity	0%	0%	0%

Native American Resource Center (NARC), cont.

Program Goals

The goals of the Native American Resource Center are to:

- Reduce stigma,
- Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, and
- Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.

The chart below provides information on the metrics used to meet these goals. The Native American Resource Center utilizes two primary surveys to measure outcomes related to reducing stigma and discrimination.

By administering these surveys, they can measure changes in attitudes, knowledge, and behaviors related to behavioral health services. Challenges such as technology issues and cumbersome paper-based methods have been identified as barriers to effectively administering the surveys. Collaborative efforts between PEI and the provider are underway to design a more effective method of survey distribution.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Historical Trauma Survey	Mixed-use survey designed to measure changes in attitudes, knowledge, and behavior through a combination of survey questions, storytelling, and artistic expression	Post-activity	FY 22/23: 0* FY 23/24: 0* FY 24/25: 0*
Stigma Reduction Questionnaire (SRQ) Survey	Survey to measure changes in attitudes, knowledge, and behavior related to mental health services	Post-activity	FY 22/23: 147* FY 23/24: 1,757 FY 24/25: 88*

*Shows areas for improvement in survey distribution.

Native American Resource Center (NARC), cont.

Outcome Discussion

Historical Trauma and Reduction of Stigma

Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants. Historical trauma responses are the biological, societal, and psychological symptoms which include changes in the traditional ways of child rearing, family structure, and relationships. These learned behaviors, coping skills, and general mistrust of outside agencies effects help seeking of mental health services. Intergenerational trauma is the transference of emotional, physical, or social pain from one person to their descendants. Survivors of trauma may hold stereotypes about mental health treatment and may be unfamiliar with mental health services which can minimize the need for services. As a result of historical trauma and policies of governmental agencies, Native Americans report fears of removal of their children, forced hospitalization in mental health institutions, and general mistrust.

Stigmatizing ideas stemming from historical trauma are reduced through providing education regarding trauma and the effects on individual, family, and the community which allows for the process of healing unresolved grief and the loss of cultural identity. Through increased awareness of and returning to traditional laws, principles, and values are preventative measures for at risk behaviors.

NARC program participated in Cultural Competency Trainings which discussed how historical and intergenerational trauma effects the family systems and how those families navigate through systems of care. Events such as Native American Heritage Month celebrations have also been a way to share about historical trauma.

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

Stigma Reduction Surveys

In FY 2023/24, NARC began collecting data on stigma-related outcomes through its independent data system, Screendox. The transition to Screendox has led to a rise in the number of identified respondents. NARC observed that the increasing demand for mental health services suggests a decline in the stigma associated with mental health.

By using both paper and electronic surveys, along with the Screendox system in FY 2024/25, NARC was able to add additional questions to the Stigma Reduction Surveys to better capture respondents' attitudes toward mental health. Efforts are ongoing to explore ways to expand survey distribution and increase response rates.

Percentage of participants who agreed that they would be more likely to engage or support someone living with a mental health challenge			
	FY 22/23 N=147*	FY 23/24 N=1,757*	FY 24/25 N=88*
More likely to seek mental health support if needed	87%	100%	65%
More likely to talk to a friend or family member about mental health needs	84%	0*	73%
More likely to take action to prevent mental health discrimination	83%	0*	71%
More likely to actively and compassionately listen to someone in distress	89%	0*	75%

*Shows areas for improvement in survey distribution.

Promotores de Salud/Community Health Worker (PdS/CHW)

Program Description and Target Population

The Promotores de Salud/Community Health Workers (PdS/CHW) program is categorized as a State Outreach for Increasing Recognition of Early Signs of Mental Illness. The PdS/CHW program is designed to increase awareness of community-based prevention and mental health services in culturally diverse communities. The program promotes mental health awareness, education, and available resources for members of culturally-specific populations throughout the county. Services are designed to increase awareness of and access to the behavioral health system of care. The program targets five specific cultural populations identified by community stakeholders as having the highest need: Latinx/Hispanic, African American/Black, Asian/Pacific Islander, LGBTQ+, and Native American.

The program provides field-based outreach and education to all age groups in many areas of the County. The chart below provides an overview of the program services.

Services Offered	• Mental Health and Substance Use Screenings and Assessments • Mental Health Educational Presentations • Case Management • Resource Referrals • Peer Counseling

Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Community based

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results

The PdS/CHW program provides community education on mental health and substance use disorder topics, promotes behavioral health prevention and wellness, and connects community members to local resources within San Bernardino County. The populations served include Latinx/Hispanic, African American/Black, Asian/Pacific Islander, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ+), and Native American communities.

The PdS/CHW program utilizes evidence-based methods to engage the target populations. An effective strategy is recruiting PdS/CHW workers with many of the same social, cultural, and economic characteristics as the target population. This increases the probability that communities will engage with Promotores de Salud or Community Health Workers.

The program relies heavily on recruiting and training community members with lived experience or family members to become PdS and CHW staff and deliver services.

As an extension of Community Health Workers, Peer Providers draw upon their lived experience to help individuals access mental health services and navigate the mental health system.

This peer perspective also helps to reduce stigma associated with accessing services. Due to providers participating in large-scale events drawing people from multiple neighboring states, CHW saw a sharp increase in the number of unduplicated individuals reached in FY 2024/25.

Number of CHW Individuals / Number of Services

	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	24,083	37,584	69,645
Number of Services	24,764	37,755	73,338

Number of PdS Individuals / Number of Services

	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	40,570	36,949	31,645
Number of Services	47,925	45,833	26,364

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Outreach

The PdS/CHW program uses a variety of culturally specific strategies to engage new individuals and train potential responders about the signs and symptoms of mental illness. This information includes recognizing their symptoms and seeking help if necessary. These outreach activities build the capacity of entire communities to identify potential mental health concerns and increase help-seeking behaviors.

During the last three fiscal years, the PdS/CHW program has served 214,700 unduplicated individuals. This figure includes potential responders in the community; these are people in the community who can identify early signs of mental illness and refer individuals to behavioral health services. The PdS/CHW program continues to exceed their annual total of projected unduplicated individuals.

The PdS/CHW program captures information on the number of potential responders trained each year. This enables tracking of the increase in mental health awareness in the community. Between FY 2022/23 and FY 2024/25, the program engaged an average of 71,500 potential responders per year.

Potential Responders			
	Number of Potential Responders		
	PdS	CHW	Total
FY 22/23	34,426	23,800	58,226
FY 23/24	24,279	37,218	61,497
FY 24/25	25,060	69,917	94,977

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Outreach, cont.

Potential responders may include, but are not limited to, family members, employers, primary health care providers, school personnel, community service providers, peer providers, law enforcement personnel, and many others. Below are some of the specific potential responders who participated in the program.

- Consumer Family Members
- Families
- Employers
- Leaders of Faith-Based Organizations
- School Personnel
- Child Protective Services
- Peer Providers

Promotores de Salud and Community Health Workers naturally become trusted and reliable members of their communities. These relationships enable them to serve as community liaisons and contribute to the successful delivery of culturally-appropriate services. As cultural brokers in the community, they may also serve as advocates, educators, mentors, and interpreters.

PdS/CHWs engage individuals in both traditional and non-traditional settings to build trust and reduce stigma in their targeted populations. The most commonly used settings to engage potential responders for the PdS/CHW program are listed below.

Types of Settings	
• Cultural Organization • Virtual Platforms • Community Event • Community-Based Organization • Church • School	• Residence • Family Resource Center • Recreation Center • Behavioral Health Clinic • Faith-Based Organizations

PdS/CHWs are engaging with individuals in a variety of cultural and community spaces that range from schools, to homes, to hair salons. PdS/CHWs are constantly discovering new ways to connect with potential responders and community members in their own environments.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Improving Timely Access to Underserved Populations

An additional PdS/CHW program strategy is to improve timely access to services. PdS/CHWs are trained and equipped with the necessary resources to link individuals to possible mental health services as soon as possible and provide support.

Improved data collection efforts have allowed the program to better track referrals to other services. The PdS/CHW program successfully connects underserved populations to timely services. PdS/CHW program providers have improved their efforts in increasing and tracking referrals to prevention, early intervention, and treatment beyond early onset of serious mental illness.

The reduction in referrals provided in FY 2024/25 as compared with the two prior fiscal years is associated with persistent barriers in collecting data and survey completion, which has limited the PdS/CHW program to effectively tailor services. The PdS/CHW program is addressing the challenges and has implemented several strategic solutions at strengthening staffing, rebuilding partnerships, and improving data collection.

Improving Timely Access Referrals			
	FY22/23	FY 23/24	FY 24/25
# of Referrals Provided	15,006	9,004	401
Referred To	• Prevention • Early Intervention • Treatment Beyond Early Onset		

The PdS/CHW program made referrals for the following underserved populations:

- African American
- Asian and Pacific Islander
- Children & Youth at risk of school failure
- Individuals experiencing onset of serious psychiatric illness
- Latinx/Hispanic
- LGBTQ+
- Native American
- Trauma-exposed

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics

Fiscal Year	CHW Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	2%	3%	5%	2%	88%
FY 23/24	2%	3%	7%	2%	85%
FY 24/25	>1%	1%	5%	8%	84%

Fiscal Year	PdS Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	8%	16%	63%	10%	3%
FY 23/24	7%	13%	64%	11%	4%
FY 24/25	3%	8%	34%	2%	0%

Fiscal Year	CHW Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	PdS Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	0%

Fiscal Year	CHW Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	3%	7%	<1%	90%
FY 23/24	5%	10%	<1%	85%
FY 24/25	5%	9%	0%	86%

Fiscal Year	PdS Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	3%	93%	<1%	4%
FY 23/24	14%	22%	<1%	65%
FY 24/25	33%	55%	0%	12%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

Fiscal Year	CHW Veteran Status
% of consumers who identified as a veteran	
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	PdS Veteran Status
% of consumers who identified as a veteran	
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	CHW Disability
% of consumers who identified a physical disability	
FY 22/23	<1%
FY 23/24	1%
FY 24/25	2%

Fiscal Year	PdS Disability
% of consumers who identified a physical disability	
FY 22/23	<1%
FY 23/24	1%
FY 24/25	<1%

Fiscal Year	CHW Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	6%	<1%	1%	92%
FY 23/24	15%	<1%	1%	84%
FY 24/25	5%	<1%	<1%	82%

Fiscal Year	PdS Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	3%	93%	<1%	4%
FY 23/24	2%	94%	<1%	3%
FY 24/25	10%	37%	0%	0%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

CHW Demographic Observations

- CHW demographic data includes all target population programs for the African American/Black, Latinx/Hispanic, Asian, Pacific Islander, LGBTQ+, and Native American communities.
- CHWs continue their efforts to reach additional members of the African American/Black community.
- There is an upward trend in the response rate for collecting data over the last three years. CHWs continue to discover creative strategies and opportunities for improvement when engaging with members of all the target communities served.

CHW Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	27%	2%	<1%
American Indian/Alaska Native	1%	2%	4%
Asian	1%	1%	13%
Latinx/Hispanic	3%	2%	<1%
Native Hawaiian or Pacific Islander	<1%	<1%	0%
Caucasian/White	1%	4%	<1%
More than One Race	2%	2%	0%
Other Race	66%	88%	<1%

CHW Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	<1%	0%	0%
Asian Indian/South Asian	<1%	0%	0%
Cambodian	<1%	0%	<1%
Chinese	4%	6%	9%
Eastern European	0%	0%	0%
European	<1%	<1%	0%
Latinx/Hispanic	1%	21%	<1%
Filipino	<1%	<1%	<1%
Japanese	<1%	0%	<1%
Korean	<1%	<1%	<1%
Middle Eastern	<1%	0%	0%
Vietnamese	2%	3%	4%
Other	92%	64%	0%
More than one ethnicity	<1%	<1%	0%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

PdS Demographic Observations

- The PdS component of the program continues to successfully capture demographic data. This is in part due to the relationships and trust built within the community.
- The primary language for participants for all three years was identified primarily as Spanish, which aligns with the PdS/CHW program.

PdS Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	<1%	<1%	0%
American Indian/Alaska Native	<1%	0%	0%
Asian	<1%	0%	0%
Latinx/Hispanic	95%	62%	43%
Native Hawaiian or Pacific Islander	<1%	0%	0%
Caucasian/White	1%	1%	5%
More than One Race	36%	<1%	0%
Other Race	24%	37%	0%

PdS Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	0%	<1%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	0%
Latinx/Hispanic	39%	68%	46%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	<1%	0%
Middle Eastern	0%	0%	0%
Vietnamese	0%	0%	0%
Other	99%	32%	0%
More than one ethnicity	0%	0%	0%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Program Goals

The goals of the PdS/CHW program are:

- Increase recognition of early signs of potentially severe and disabling mental illness,
- Provide support to individuals with mental illness,
- Refer individuals who need treatment to other mental health services, and
- Provide outreach to individuals to recognize and respond to their symptoms of potential mental illness.

The goals are achieved by deploying trained PdS/CHW into targeted communities. They train community members to recognize and respond effectively to early signs of potentially severe and disabling mental illness and to provide health promotion, education services, alternative activities, or identify risk factors that can contribute to the development of a behavioral health condition. Communities learn about the risk factors that contribute to developing a behavioral health condition.

The effectiveness of the program is evaluated through reflective surveys, which yield a sufficient measurement of improved learning. Surveys are provided after the activity and allow individuals to gauge their level of change in knowledge and comfort level. The table on the following page provides a summary of the tools used and a brief description.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Stigma Discrimination Reduction Surveys	Refers to a compilation of surveys used by the Department of Behavioral Health – PEI programs designed to capture outcomes from Stigma and Discrimination Reduction activities. Examples of surveys used by PdS/CHW programs are the Modular presentation Survey, Measures, Outcomes, and Quality Assessment (MOQA) Survey, and the Stigma Reduction Questionnaire (SRQ).	Post – after each Stigma Reduction presentation	FY 22/23: 828 FY 23/24: 102 FY 24/25: 144
PEI Outreach Survey	The PEI Outreach Survey has 13 questions. The first 9 collect PEI demographic information, and the last 4 gather information on individuals' confidence in recognizing potential mental health challenges and seeking services if needed.	Pre and Post each educational Outreach activity	FY 22/23: 1,571 FY 23/24: 6,759 FY 24/25: 5,707

Outcome Discussion

The PdS/CHW program planning revolves around ensuring the community has access to linguistically and culturally competent mental health information. The program uses evidence-based strategies to reach out to community members and offers a variety of opportunities to learn more about behavioral health concerns surrounding their cultural communities.

Strategies for engagement vary between cultural groups. Some cultural groups are comfortable with utilizing technological tools, while others prefer traditional in-person strategies. Not all cultures experience the same level of comfort with the same approaches. The program continues to explore the most effective methods for delivering culturally appropriate services in their communities and maximizing engagement efforts.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

An objective of this program is to train potential responders and other members of the community to recognize behaviors or symptoms that may indicate someone who is suffering from a mental health challenge. Furthermore, the program helps people become more comfortable supporting those individuals. That support can include informing individuals of the risks surrounding untreated mental illness and reducing the stigma surrounding accessing services.

The program evaluates success by administering surveys and questionnaires that capture changes in learning, perception, and help seeking behaviors. To measure stigma reduction following engagement, PdS/CHWs utilize the Stigma Reduction Questionnaire (SRQ) to capture individual changes in how they feel after participating in an event or activity. Sample questions include:

As a direct result of this program, I am MORE likely to…

- Socialize with someone who had a serious mental health condition.
- Take action to prevent discrimination against people with mental health conditions.
- Actively and compassionately listen to someone in distress.
- Seek support from a mental health professional if I thought I needed it.
- Talk to a friend or a family member if I am experiencing emotional distress.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

FY 2024/25 saw providers expressing concern about the challenges of obtaining data. Many reported that participants are hesitant to share any information due to fears around how the data might be used. PEI advises providers to inform participants that any information collected remains with DBH and is used solely for data purposes, not for identification. While PEI encourages collecting demographic data from willing participants, it emphasizes that services and resources should be provided regardless of whether participants provide information.

	As a direct result of this training, I am MORE likely to…	FY 22/23	FY 23/24	FY 24/25
PdS	…talk to a friend or a family member if I was experiencing emotional distress	98%	98%	94%
	…seek support from a mental health professional if I thought that I needed it	97%	97%	94%
	…actively and compassionately listen to someone in distress	98%	98%	94%
	…take action to prevent discrimination against people with mental health…	98%	98%	95%
	…socialize with someone who had a serious mental health condition	96%	96%	94%

	As a direct result of this training, I am MORE likely to…	FY 22/23	FY 23/24	FY 24/25
CHW	…talk to a friend or a family member if I was experiencing emotional distress	72%	72%	*
	…seek support from a mental health professional if I thought that I needed it	73%	73%	*
	…actively and compassionately listen to someone in distress	80%	80%	*
	…take action to prevent discrimination against people with mental health…	86%	75%	*
	…socialize with someone who has a serious mental health condition	88%	72%	*

*Reflects difficulty in obtaining data

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

Additional stigma survey results below demonstrate a change in attitude of the individuals who received a stigma-reduction activity. FY 2024/25 data shows that as a direct result of PdS activities, 94% of individuals agree or strongly agree that they are likely to feel and view people experiencing mental health challenges in a positive light. Promotores have successfully engaged with community members and provided responders with the resources and the ability to assist friends, family, and community members facing mental health challenges.

	As a direct result of this training, I am MORE likely to…	FY 22/23	FY 23/24	FY 24/25
PdS	…often have unique strengths	98%	91%	94%
	…work hard to be healthy	97%	95%	94%
	…have valuable perspectives and wisdom to share	98%	96%	94%
	…contribute valuable and important things to their family and friends	98%	95%	94%
	…contribute valuable and important things to our community & neighborhood	98%	94%	94%
	…are a valuable and important part of my community & neighborhood	98%	92%	94%

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)

Program Description and Target Population

The Substance Use Prevention & Pathways to Outreach and Treatment program (SUPPOrT), previously known as the Inland Empire Opioid Crisis Coalition (IEOCC), is a PEI program categorized as Outreach for Increasing the Recognition of Early Signs of Mental Illness. SUPPOrT is comprised of over forty (40) member organizations participating since 2017. It encompasses a multidisciplinary mix of partners working across sectors that include county agencies, community agencies and institutions, professional partners, and residents working together to educate one another, support, and develop strategies to combat the opioid crisis. SUPPOrT works with the Department of Behavioral Health's Substance Use Disorder Recovery Services (SUDRS) and Public Relations and Outreach Services (PROS) in providing outreach activities.

The SUPPOrT program aims to continue supporting the community by delivering outreach activities to provide access and linkages to prevention, early intervention, and substance use treatment. The SUPPOrT program seeks to collaboratively work on bringing and maintaining community partners, agencies, and professionals together to generate strategies to reduce opioid use and opioid related deaths. In addition, the SUPPOrT program will conduct outreach to raise awareness, provide resources and support, and educate the individuals in the community.

Services Offered	• **Medication Assisted Treatment (MAT) Referrals** • **Substance Use Disorder Services Referrals** • **Behavioral Health Services Referrals** • **Community Education and Awareness**

Program Serves	**Children** **TAY (16-25)** **Adults** **Older Adults (60+)**
Location of Services	School Campuses, Behavioral Health Clinics, In-home

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

State Program Positive Results

The SUPPOrT program delivers outreach activities to provide access and linkages to substance use prevention, early intervention, and treatment. In addition, the program raises awareness by educating individuals in the community and through training on the use of Naloxone/Narcan.

In FY 2024/25, the program increased its outreach efforts to raise awareness and provide substance use and mental health resources at community fairs, workshops, and conferences. The table on the right shows that SUPPOrT engaged 2,259 unduplicated participants at 154 community health fairs.

The SUPPOrT program outreach efforts reached out to 2,472 potential responders in the community. Potential responders are people in the community who can identify early signs of mental illness and refer individuals to Behavioral Health services. Examples of potential responders include community service providers and school personnel.

The SUPPOrT program has successfully distributed the following: 1,695 Naloxone Medication; 1,720 Deterra Medication disposal pouches; and 2,070 Fentanyl test strips. Out of the Naloxone distributions, one report was submitted of an overdose reversal due to the participant receiving training on how to administer Naloxone and save someone's life.

Number of Participants / Number of Actual Services			
	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	212	3,662	2,259
Number of Services	216	4,333	4,518

Number of Potential Responders		
FY 22/23	FY 23/24	FY 24/25
212	3,338	2,472

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	0%	19%	10%	1%	70%
FY 23/24	1%	8%	24%	3%	64%
FY 24/25	2%	17%	64%	15%	2%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	<1%
FY 23/24	2%
FY 24/25	4%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	7%
FY 23/24	3%
FY 24/25	2%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	8%
FY 23/24	6%
FY 24/25	15%

Fiscal Year	Gender Identity			
				UNK
FY 22/23	7%	22%	1%	70%
FY 23/24	12%	24%	0%	64%
FY 24/25	28%	70%	1%	1%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	30%	<1%	0%	70%
FY 23/24	33%	3%	<1%	64%
FY 24/25	95%	3%	1%	<1%

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Demographics, cont.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	2%	6%	15%
American Indian/Alaska Native	0%	1%	1%
Asian	1%	6%	4%
Latinx/Hispanic	24%	18%	42%
Native Hawaiian or Pacific Islander	<1%	1%	<1%
Caucasian/White	3%	10%	27%
More than One Race	1%	1%	1%
Other Race	1%	1%	<1%
Declined to Answer	69%	56%	4%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	2%	6%	11%
Asian Indian/South Asian	1%	1%	<1%
Cambodian	1%	<1%	<1%
Chinese	0%	<1%	<1%
Eastern European	1%	<1%	2%
European	2%	7%	15%
Latinx/Hispanic	22%	19%	42%
Filipino	1%	1%	2%
Japanese	0%	0%	0%
Korean	0%	1%	0%
Middle Eastern	1%	<1%	<1%
Vietnamese	0%	<1%	<1%
Other	2%	5%	15%
More than one ethnicity	2%	2%	1%
Declined to Answer	65%	54%	<1%

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Program Goals

- Reduce prolonged suffering associated with untreated mental illness:
  - Reduce risk factors.
  - Reduce indicators.
  - Increase protective factors that may improve mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.
- Increase recognition of early signs of mental illness:
  - Potential Responders:
    - Identify early signs of potentially severe and disabling mental illness.
    - Provide support to individuals with mental illness.
    - Refer individuals who need treatment or other mental health services.
  - Individuals:
    - Recognize your own symptoms.
    - Respond to symptoms.

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number completed
Outreach Survey	The Outreach Survey has13 questions. The first 9 are used to collect PEI demographic information, and the last 4 are used to gather information on participants' confidence in recognizing potential mental health challenges and seeking services if needed.	After each outreach activity	FY 22/23: 68 FY 23/24: 1,580 FY 24/25: 2,326

Outcome Discussion

The Department of Behavioral Health's Office of PEI, SUPPOrT, and Research and Evaluation teams collaborated in creating an outreach survey that gathers information on participant's knowledge of substance use disorders following an engagement activity. Sample outreach survey questions include:

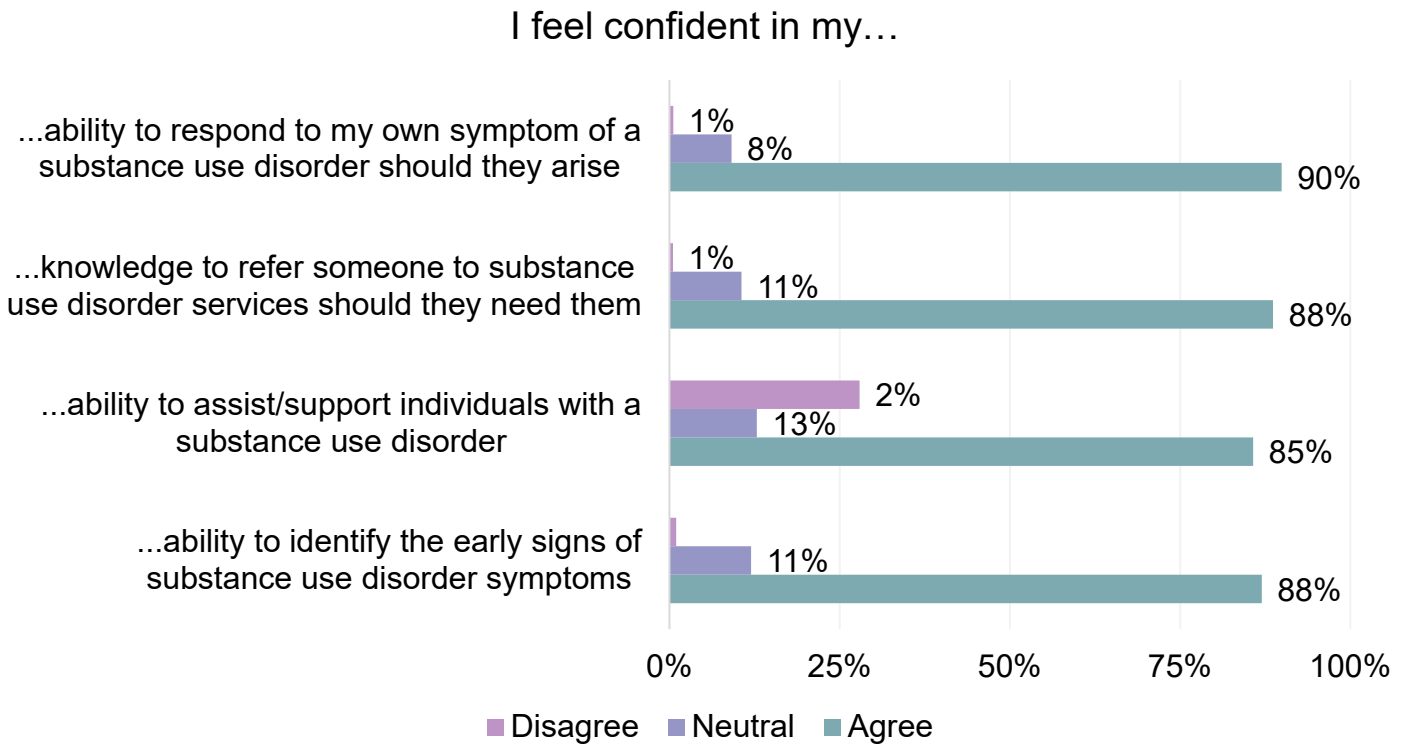
I feel confident in my…

- Ability to identify the early signs of substance use disorder symptoms.
- Ability to assist/support individuals with a substance use disorder.
- Knowledge to refer someone to substance use disorder services should they need them.
- Ability to respond to my symptoms of a substance use disorder should they arise.

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Outcome Discussion, cont.

Outreach survey data illustrates that 90% of participants who completed the survey agree that they successfully increased their ability to respond to their symptoms of a substance use disorder, should they arise. Also, following their activities, 88% of participants agreed that they were more confident in their ability to identify early signs of substance use disorder symptoms and, in their knowledge, to complete a referral for substance use disorder service. The overall outcomes demonstrate that SUPPOrT outreach and educational activities are successfully meeting the intended goals of the program.



Child and Youth Connection (CYC)

Program Description and Target Population

CYC is a State Access and Linkage to Treatment program that connects children suffering from severe emotional challenges to medically necessary care and treatment. CYC is comprised of several components:

- **Screening, Assessment, Referral, and Treatment (SART):** Offers complete treatment for children ages 0 to 6 suffering from social, physical, behavioral, developmental, and/or physiological problems. It's a comprehensive program for at-risk children, many of whom have been subjected to abuse, neglect, or prenatal exposure to hazardous substances.
- **Early Identification and Intervention Services (EIIS):** EIIS provides assistance to children aged 0 to 8 who have social, physical, behavioral, developmental, and/or psychiatric difficulties but do not require the intense therapies provided by SART. Children who participate in EIIS do not always have a history of trauma, and they are usually referred from SART after being examined.
- **Children's Assessment Center (CAC) Pre-Forensic Examination Counseling Services:** The Children's Assessment Center (CAC) is a partnership between Loma Linda University Children's Hospital (LLUCH) and the County to serve children and families who are in need of services in a child-friendly environment. The CAC provides a safe location for the LLUCH physicians and nurse practitioners to perform the necessary forensic medical examinations on children who are victims of sexual and physical abuse. This contract allows the LLUCH medical staff to perform the pre-forensic examination counseling service prior to the exam to reduce the trauma to child victims and their families referred. It is in the best interest of the child to have the LLUCH medical staff provide the pre-forensic examination counseling service since they will be conducting the medical exam.

SART and EIIS Services Offered	• **Assessments** • **Comprehensive Treatment Services** • **Case Management Services** • **Mental Health Education**

The SART and EIIS Programs Serve	**Children**
Location of Services	Desert/Mountain, East Valley, Central Valley, West Valley

Child and Youth Connection (CYC), cont.

Program Description and Target Population, cont.

- **Juvenile Public Defender's Office:** In-home screenings for adolescents involved in the juvenile justice system are provided by the Department of Behavioral Health in collaboration with the Public Defender's Office Juvenile Division.
- **Mentoring Network:** DBH collaborates with Children's Network to conduct mentoring needs assessments of at-risk youth through a collaborative effort of several County departments including the Public Defender's Office, Children's Network, and Children and Family Services. The Mentoring Network identifies new and existing mentoring organizations, links system-involved youth with appropriate agencies and collects and provides mentoring resources.

Program Highlights

The CYC program focuses on access and linkage to treatment where children are assessed and provided the appropriate level of care. In addition to these services, the program also offers prevention and outreach services to increase awareness and access to services.

CYC offers education, outreach, case management, resource referrals, and mentoring as part of the prevention services. These assist in reducing the stigma surrounding mental health services and connecting communities to appropriate resources.

The program's overall success can be measured by the number of participants listed below. Each year, the number of unique participants surpassed our contractual requirements.

Number of Participants / Number of Services			
	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	7,111	8,325	12,027
Number of Services	86,701	103,926	57,399

Prevention:

The risk factors for CYC program participants can include neglect and abuse, attachment difficulties, and exposure to substance use disorder.

Prevention activities within the program help to address these risk factors by boosting protective factors such as supportive parenting and education, healthy communication, and social support.

Some of the prevention activities offered include parenting support groups, substance use disorder workshops, multidisciplinary collaboration, and case management.

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Early Intervention:

SART and EIIS are CYC programs that provide early intervention services, such as treatments and interventions, for children who have been exposed to trauma and/or have impaired functioning but do not require a wide range of ongoing services.

Parent-Child Interaction Therapy (PCIT) and Infant Massage are examples of the treatments administered by this program. The table below illustrates the total number of sessions opened, the number of sessions closed, and the proportion of participants who met their treatment goals for each fiscal year.

The participants are engaged in the program up to 6 years of age for SART and up to 9 years of age for EIIS. If the child still requires additional support, they are transitioned to the appropriate level of care.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 22/23	2,538	2,042	23%
FY 23/24	2,408	2,044	39%
FY 24/25	4,391	2,285	52%

A key indicator of effective prevention efforts is how often participants access services. Regular return visits show comfort with the offerings and a willingness to engage in group activities. This ongoing engagement is crucial for fostering a supportive environment that promotes learning and growth.

The following table provides a detailed breakdown of the unduplicated number of participants who utilized prevention services, along with the total number of services provided. This data offers valuable insights into participation trends and the effectiveness of outreach strategies, highlighting the importance of continued support and accessibility in preventive programs.

Prevention	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	2,349	5,079	5,282
Total Services	3,262	4,028	2,534

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Outreach:

The outreach component of the CYC program provides services to participants to engage, encourage, educate, and/or train potential responders on how to recognize and respond effectively to early indicators of potentially severe and disabling mental illness. These services reach a variety of potential responders in an equally variable number of settings, as detailed below.

Potential Responders Reached			
	FY 22/23	FY 23/24	FY 24/25
Potential Responders	1,037	1,231	1,788

Outreach Types of Responders / Settings	
Types of Responders	**Settings**
• Community service providers • Child protective services personnel • Consumer family members • School personnel • Peer providers • Students and educators • Law enforcement	• Community-based organizations • Community events • Schools • Health centers • County offices • Behavioral health clinics • Hospitals • Various outreach events

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Access and Linkage to Treatment:

Children needing mental health services are identified through either the Referral, Screening, Assessment, and Treatment (RSAT) assessment process or the full Clinic Day referral to the Screening, Assessment, Referral, and Treatment (SART) centers.

The RSAT process is a collaboration between the Department of Behavioral Health (DBH), Children and Family Services, and the SART providers.

Those children ages 0-5 are referred to SART while children ages 6-17 are referred to DBH's Juvenile Court Behavioral Health Services (JCBHS) program. Both programs offer each referred child a full psycho-social assessment to determine eligibility and need for services.

Through a trans-disciplinary process known as "Clinic Day," each SART center has a public health nurse, pediatrician, occupational therapist, speech and language therapist, and psychologists who can provide additional assessments for other needs. In many cases, the public health nurse functions as case manager by assisting families in reaching appropriate resources.

Children needing ongoing care are referred to appropriate resources provided either through the SART center directly or through partners such as the Inland Regional Center (IRC), medical services, or educational services.

The Healthy Homes Program, a clinical unit with JCBHS, has clinicians who are co-located at the Children and Family Services (CFS) offices throughout the county. The Healthy Homes clinicians conduct assessments for children involved with CFS.

If these children and youth need ongoing services, they are referred to local service providers and programs.

Sometimes, these clinicians will provide short-term mental health services to prevent involvement in a long-term program.

Child and Youth Connection (CYC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 22/23	36%	3%	26%	1%	34%
FY 23/24	83%	11%	5%	<1%	1%
FY 24/25	4%	5%	45%	3%	3%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	0%
FY 23/24	0%
FY 24/25	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	0%
FY 23/24	0%
FY 24/25	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	0%
FY 23/24	<1%
FY 24/25	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	1%	8%	0%	90%
FY 23/24	46%	54%	0%	0%
FY 24/25	21%	58%	0%	76%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	78%	9%	<1%	12%
FY 23/24	89%	10%	<1%	0%
FY 24/25	25%	38%	<1%	37%

Child and Youth Connection (CYC), cont.

Demographics , cont.

Demographic Observations

The CYC program served the largest proportion of children, meeting its target participant age. In some categories, a large proportion of those declined to answer. Often, this is because it has been deemed inappropriate to ask this age group.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	16%	34%	2%
American Indian/Alaska Native	<1%	<1%	0%
Asian	<1%	2%	2%
Latinx/Hispanic	39%	31%	52%
Native Hawaiian/Pacific Islander	0%	<1%	<1%
Caucasian/White	12%	27%	5%
More Than One Race	1%	6%	0%
Other Race	3%	1%	0%
Declined to Answer	28%	1%	41%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	1%	6%	1%
Asian Indian/South Asian	0%	0%	1%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	0%	0%	3%
Latinx/Hispanic	0%	4%	4%
Filipino	0%	<1%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	<1%	0%
Vietnamese	0%	<1%	0%
Other	4%	25%	0%
More Than One Ethnicity	0%	0%	0%
Declined to answer	9%	9%	34%

Child and Youth Connection (CYC), cont.

Program Goals

Increase early access and linkage to medically necessary care and treatment:

- Connect children, adults, and older adults with serious mental illness to care as early in the onset as practical to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Improve timely access to services for underserved populations:

- Increased the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receive appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Reduce risk factors,
- Increased protective factors that may lead to improved mental, emotional, and relational functioning,
- Reduced symptoms, and
- Improved recovery, including emotional and relational functioning.

Reduce stigma and discrimination associated with mental illness:

- Reduced negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

Child and Youth Connection (CYC), cont.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	Intake, 6 months, Discharge, Significant life events	FY 22/23: 1,045 FY 23/24: 1,339 FY 24/25: 1,409

Outcome Discussion

The CYC program uses the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to measure outcomes of the early intervention treatments and develop treatment plans and goals. Children and TAY receive the initial CANS-SB assessment within the first 30 days of receiving assistance. Every three to six months, follow-up assessments are conducted. A final assessment is completed after services.

The focus of the early intervention treatment for the CYC program includes:

- Life Functioning is described as the various areas of social interaction present in the lives of children, teenagers, and their families. This domain assesses their performance in the areas of self, family, peers, school, and community.
- The Behavioral/Emotional Needs domain identifies the child’s behavioral health needs.
- The Ages 0-5 Early Childhood domain focuses on elements of a young child’s functioning that are prominent during the first five years of development.

Each CANS-SB assessment domain includes sub-domains that measure more micro-level improvements.

Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

The Life Functioning domain consists of the following sub-domains utilized to measure a participant's needs in this area: school behaviors, family functioning, and living situation. Each sub-domain has the following explanation:

- School behaviors rate the child's behavior in a school or similar setting.
- Family functioning rates the child's relationships with those in their family. Family should be defined from the child's perspective and who they identify as family.
- Living situation refers to how the child functions in their current living arrangement, which could be with a relative, in a foster home, etc.

The Behavioral/Emotional Needs sub-domains include the following:

- Depression: This rates the symptoms of the child, such as irritable or depressed mood, social withdrawal, and loss of motivation.
- Anxiety: This rates the symptoms of the child, such as excessive fear and anxiety and related behavioral disturbances. Panic attacks can be a prominent type of fear response.
- Anger Control: This refers to the child's ability to identify and manage anger when frustrated.

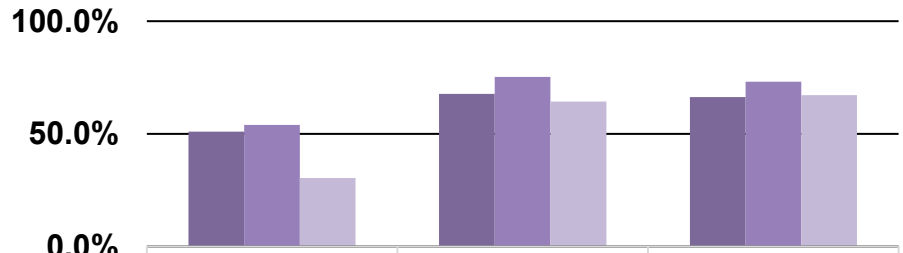
The Ages 0-5 Early Childhood module rates the same sub-domains as the Life Functioning Domain; however, these sub-domains are rated through a lens more focused on the stages of development from ages 0-5 rather than the participant's overall life functioning.

Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

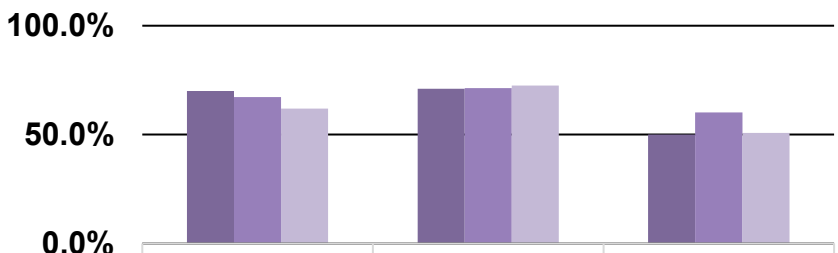
These graphs demonstrate global improvement in life functioning, behavioral/emotional needs, and ages 0-5 early childhood for both EIIS and SART participants of the CYC program. Both programs have maintained an average of 46% improvement in the life functioning domain, 50% improvement in the behavioral/emotional needs domain, and 28% in the ages 0-5 early childhood domain.

CYC SART % Improved by Fiscal Year



	Life Functioning	Behavioral/ Emotional Needs	Ages 0-5 Early Childhood
FY 22/23	51.0%	67.8%	66.3%
FY 23/24	53.9%	75.3%	73.2%
FY 24/25	30.4%	64.3%	67.2%

CYC EIIS % Improved by Fiscal Year



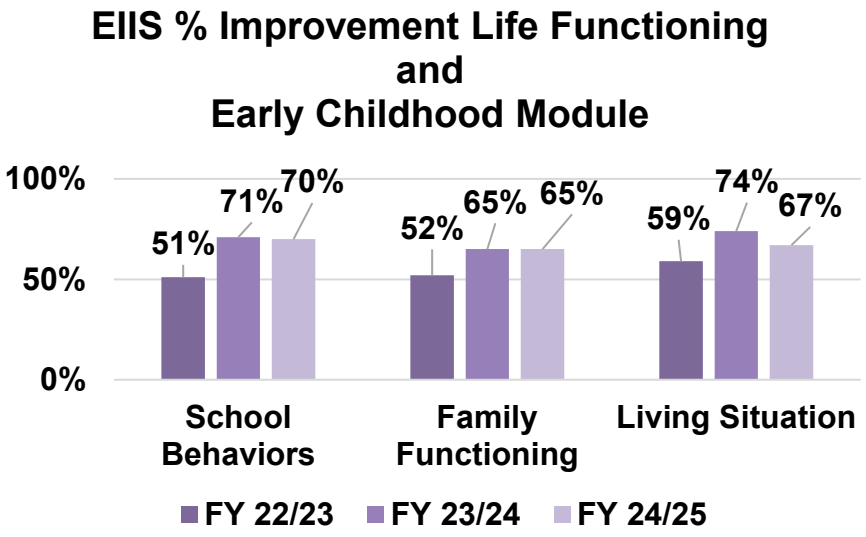
	Life Functioning	Behavioral/ Emotional Needs	Ages 0-5 Early Childhood
FY 22/23	70.0%	71.0%	50.0%
FY 23/24	67.3%	71.3%	60.2%
FY 24/25	61.9%	72.6%	50.8%

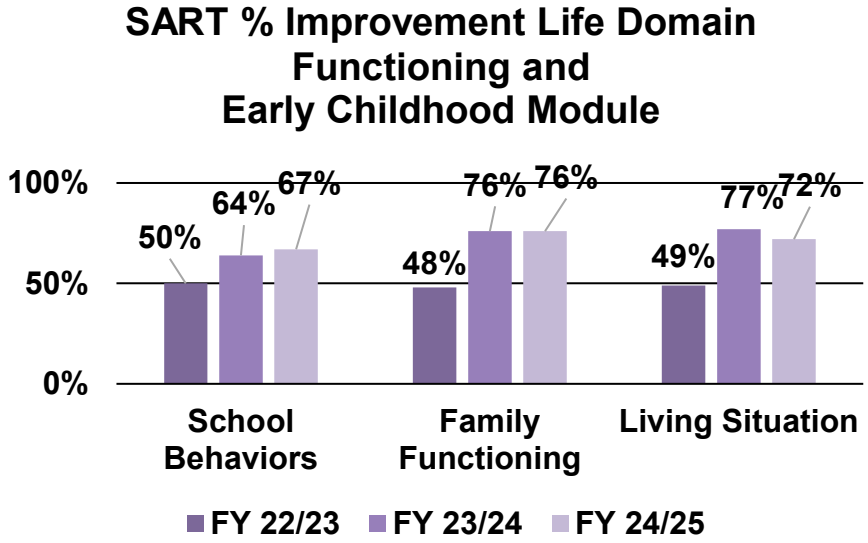
Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

The following graphs demonstrate the participants' improvement in these sub-domains over the last three fiscal years. The EIIS Program outcomes saw significant improvements from FY 2022/23 to FY 2023/24, particularly in School Behaviors and Living Situation. However, progress plateaued in FY 2024/25, with Family Functioning stabilizing and Living Situation declining.

SART outcomes show strong and sustained improvements across all areas, with notable gains in Family Functioning and Living Situation, though continued focus is needed to sustain progress in Living Situation and further strengthen School Behaviors.

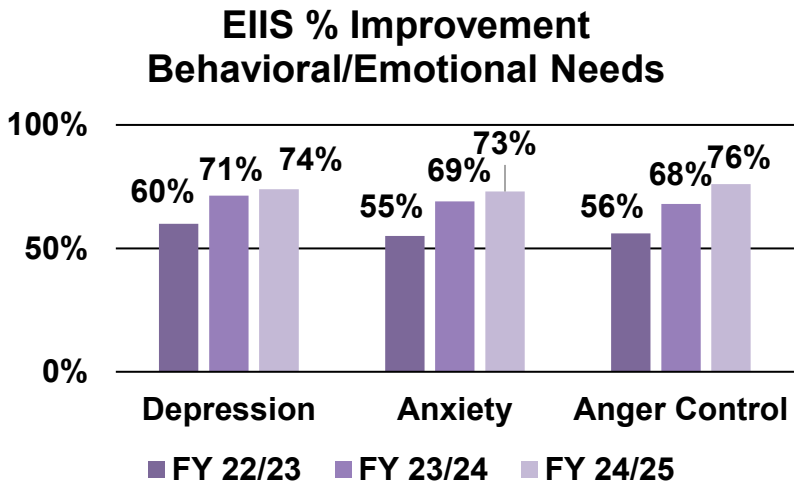


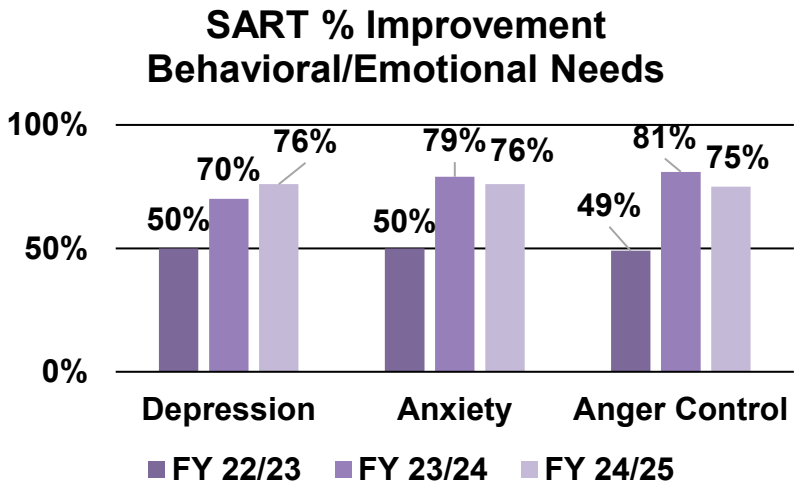


Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

Depression can be a significant barrier to child development. Both programs have been successful in maintaining an average of 70+% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 75%. Reducing anxiety leads to improved behavioral and emotional functioning. The program has seen an improvement of 73%+ within the three-year review period.





Preschool PEI Program (PPP)

Program Description and Target Population

Preschool PEI Program (PPP) is a Prevention program that is a collaborative effort between the Department of Behavioral Health and the Preschool Services Department to serve students enrolled in the County's Head Start program. The PPP supports preschool children ages two through five and educates their parents, caregivers, and teachers. The program is designed to help children learn to understand and manage their emotions. It also promotes and improves participants' academic competence in areas such as language, reading, and social skills.

Program eligibility is based on an enrolled preschool child demonstrating self-regulation or social behavior that potentially affects the child's ability to engage in educational or social experiences effectively.

Services Offered	• **Social-emotional development** • **Screenings & assessments** • **Trauma support** • **Resources and referrals** • **Behavioral health plan development** • **Family support**

Program Serves	**Children, TAY (16-25), Adults, Older Adults (60+)**
Location of Services	Preschool, In Home, and Counseling Centers

Preschool PEI Program (PPP), cont.

Program Highlights

The PPP provides services to preschool-aged children, their parents, and their caregivers. In addition, the PPP provides education and classroom strategies to develop secure and consistent interactions between home and school settings.

As a prevention program, PPP seeks to provide activities and classroom instruction that promote protective factors such as:

- Supportive nurturing and attachment,
- Improving cognitive development,
- Developing social connections with peers, and
- Developing social and emotional competence.

Risk factors typically seen within PPP include ineffective parenting, which results in a lack of attachment, nurturing, and supportive relationships.

The PPP seeks to reduce these risk factors by:

- Assisting parents in better understanding their children's needs and development,
- Fostering stable attachments with parents and caregivers, and
- Developing supportive connections with other significant adults.

Research shows that promoting protective factors and reducing risk factors increase children's and families' mental health and well-being and are associated with a lower likelihood of negative outcomes.

Number of Participants / Number of Services			
Actual			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	409	354	457
Number of Services	1,358	1,075	1553

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Building social-emotional skills in preschool-aged children helps them learn to recognize, understand, and manage powerful feelings and helps them to develop empathy for others. These skills are important to developing their mental health and well-being. In addition, the family support component helps families create an environment where the children can develop a sense of predictability and safety through nurturing, stable, and consistent relationships with adults. This sense of predictability is further developed in the classroom with regular routines and consistent positive behavior management strategies.

The PPP develops protective factors of emotional self-regulation, positive coping skills, effective problem-solving skills, peer engagement, supportive relationships with family members, and predictability in the home and school environment.

Teacher Training

Teachers within the PPP are trained in classroom management to support children's developmental milestones, emotional literacy, friendship skills, self-regulation, and problem-solving. The teacher education component builds skills to promote children's social, emotional, and academic growth, while encouraging parent involvement to align home and school.

Ongoing evaluations confirm proper use of these strategies, reflected in improvements on the Desired Results Development Profile (DRDP). In FY 2022/23, a drop in preschoolers' self-regulation prompted PSD Class Teacher Coaches to introduce intervention strategies and Second Step curriculum training, alongside Behavioral Health Specialists receiving Teaching Pyramid training.

Support for both curriculums continued in FY 2023/24, with additional training and integrated coaching provided. In FY 2024/25, teachers reported success in classroom management and behavior regulation amongst the students, attributing improvements to the curriculums implemented in the prior fiscal years.

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Bereavement and Loss

In addition to the social-emotional development strategies that are used within the classroom, this group assists children who have experienced trauma, loss, or separation from a parent or significant care provider in their lives.

This may include a parent, grandparent, or other person close to the child. The loss may be due to death, divorce, separation, foster care, military deployment, homelessness, or parent incarceration.

In previous years, PPP utilized the Trauma, Loss, and Compassion (TLC) model to improve child/family outcomes. The TLC activities help children self-regulate, practice social behavior in a safe space, and to develop healthy coping skills, which decrease aggressive, internalizing, self-isolation, and other self-harming behaviors.

In FY 2023/24, PPP transitioned to a new program to address loss. The Living in Grief Healing Together (L.I.G.H.T.) Program is an eight-week workshop for enrolled PSD children, facilitated by MFT Interns and supervised by a Clinical Supervisor where the team focuses on discussing loss, fostering hope, and understanding emotions. The program works with children who have experienced trauma, specifically grief and loss.

Number of Children Participating in the TLC Group		
FY 22/23	FY 23/24	FY 24/25
76	0	0

Number of Children Participating in the L.I.G.H.T. Program		
FY 22/23	FY 23/24	FY 24/25
0	43	84

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Access & Linkage to Services

Behavioral Health Specialists within the San Bernardino County Preschool Services Department identify children struggling with learning, behavioral, or emotional challenges, and refer their families to SART (Screening Assessment Referral Treatment) centers and psychological treatment centers to access additional services to support the child and their caregivers.

The program is intended to engage with young children and their families at a very early age. The percentage of families who declined or did not engage in services is indicative of the stigma that still exists in accessing mental health services for young children.

Needs Assessment

PPP, PSD, and their partnering agencies collaboratively identify children ages 0-5 enrolled in preschool classrooms where there are concerns related to self-regulation and social-emotional challenges.

To assess and evaluate at-risk children, the tools Ages and Stages Questionnaire-Social Emotional 2 (ASQ-SE2) and the Desired Results Developmental Profile (DRDP) are used. These assessment tools provide valuable data that helps in identifying children who may need additional support. The data-driven approach ensures that interventions are both relevant and effective.

The partnering agencies lend support by offering direct home and classroom assistance for the children and their families. These partnerships enable PPP to reach a broader segment of the population, particularly those who may not have had access to resources otherwise.

Preschool PEI Program (PPP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	51%	4%	26%	1%	18%
FY 23/24	54%	5%	33%	1%	7%
FY 24/25	54%	4%	32%	1%	8%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	0%
FY 23/24	0%
FY 24/25	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	0%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	5%
FY 23/24	4%
FY 24/25	4%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	32%	38%	0%	30%
FY 23/24	19%	34%	<1%	46%
FY 24/25	22%	29%	0%	49%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	79%	7%	1%	0%
FY 23/24	84%	6%	1%	9%
FY 24/25	82%	10%	1%	7%

Preschool PEI Program (PPP), cont.

Demographics, cont.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	21%	24%	22%
American Indian/Alaska Native	<1%	1%	<1%
Asian	2%	0%	2%
Latinx/Hispanic	1%	<1%	11%
Native Hawaiian or Pacific Islander	1%	1%	0%
Caucasian/White	4%	28%	31%
More than One Race	31%	6%	3%
Other Race	40%	40%	32%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	2%	<1%	<1%
Asian Indian/South Asian	0%	0%	<1%
Cambodian	0%	0%	0%
Chinese	3%	0%	<1%
Eastern European	0%	0%	0%
European	2%	0%	<1%
Latinx/Hispanic	21%	18%	52%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	1%	1%	0%
Vietnamese	0%	0%	0%
Other	90%	80%	45%
More than one ethnicity	3%	0%	<1%

Preschool PEI Program (PPP), cont.

Demographics, cont.

Demographic Observations

The PPP program has consistently served the targeted demographics over the last three fiscal years.

- The majority of the population served is preschool-aged children.
- The program is designed to support parents and caregivers in providing a nurturing and supportive environment for the children's social-emotional development. As a result, the PPP serves the adult population (TAY, adult, and older adult) and the children who receive services.

Questions related to gender and sexual orientation have a high rate of "Unknown" responses.

- Questions regarding sexual orientation are considered inappropriate to ask for the primary target population of preschool-aged children and contribute to lack of responses in this area.

The overall diversity of the participants within the PPP reflects the diverse community of San Bernardino County.

Preschool PEI Program (PPP), cont.

Program Goals

The PPP aims to reduce risk factors and promote protective factors. Protective factors are associated with lower likelihoods of problem outcomes. Risk factors are associated with a higher likelihood of problem outcomes. Specific objectives of the PPP are to reduce the occurrence of aggressive and oppositional behavior, increase social competency to support overall school functioning, increase overall family functioning, and increase mental and emotional health. Strategies used within the PPP promote positive cognitive, social, and emotional development and encourages a state of well-being that allows the individual to function well in the face of ongoing changing and sometimes challenging circumstances.

Program Outcomes

The instrument employed to assess outcomes within the PPP is the Desired Results Developmental Profile (DRDP). This tool is designed to evaluate various developmental domains, providing valuable insights into the progress of students. By systematically measuring outcomes, the DRDP tracks growth over time and enables PPP to identify areas for improvement.

The Desired Results Developmental Profile

The Desired Results Developmental Profile (DRDP) is an assessment tool used to determine whether the preschool-aged child is at or above the California Foundations age expectations in social-emotional development. Building meaningful and rewarding relationships with others is a part of a child's social-emotional development. Children begin to manage their emotions and acquire a sense of predictability, safety, and responsiveness in their social contexts when they have nurturing, stable, and consistent relationships with adults.

Method use to collect outcome	Description of method	Frequency of use	Number completed
The Desired Results Developmental Profile (DRDP)	Designed for teachers to observe, document, and reflect on the learning, development, and progress of children who are enrolled in early care and education programs and before-and after-school programs.	Fall, Winter, and Spring	FY 22/23: 1,290 FY 23/24: 1,219 FY 24/25: *

*Indicates no data available new program launch

Preschool PEI Program (PPP), cont.

Outcome Discussion

The DRDP assessment is completed in the fall, winter, and spring using observations of the children's work by the children's families and teachers.

Desired Results Developmental Profile									
Social-Emotional Development Domain	FY 22/23			FY 23/24			FY 24/25		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Identity of Self in Relation to Others	48%	70%	76%	52%	79%	66%	63%	69%	8%
Social and Emotional Understanding	48%	67%	75%	48%	75%	67%	65%	67%	3%
Relationships and Social Interactions with Familiar Adults	52%	70%	80%	54%	81%	67%	73%	75%	3%
Relationships and Social Interactions with Peers	58%	76%	82%	59%	84%	70%	66%	68%	3%
Symbolic and Sociodramatic Play	33%	44%	59%	*	*	*	*	*	*

*Not included in DRDP assessment

The results of the assessment shown in the table illustrate the increase in children's development in five key social-emotional development dimensions of Identity of Self in Relation to Others, Social and Emotional Understanding, Relationships and Social Interactions with Familiar Adults, Relationships and Social Interaction with Peers, and Symbolic and Sociodramatic Play across the previous three years.

Preschool PEI Program (PPP), cont.

Collaborative Partners

- Fatherhood FIRE Program
- 211 Inland SoCal United Way- PSD 211 Specialist
- Cal Baptist University MFT Intern Program
- County Library
- First 5
- Transitional Assistance Department
- Children's Fund
- Victor Community Support Services
- Christian Counseling Services
- Desert Mountain
- Lutheran Social Services
- Foster & Kinship CARE Education
- Childcare Resource Center
- Inland Regional Center
- Dr. Bergin
- Fontana Unified School District
- Colton Bloomington School District
- Needles School District
- West Valley SART

Program Updates

The Preschool PEI Program concluded on June 30, 2025, and was succeeded by the Preschool Building Blocks to Success Program, which launched on July 1, 2025.

Resilience Promotion in African American Children (RPiAAC)

Program Description and Target Population

The Resilience Promotion in African American Children (RPiAAC) program focuses on prevention and early intervention for African American/Black children and youth. The program embraces African American/Black values, beliefs, and traditions, incorporating them into educational and behavioral health services. The program's goal is to promote resilience in African American/Black children to reduce the risk factors that lead to the development of a mental illness and/or substance use disorder behaviors.

Services Offered	• Cultural awareness and empowerment workshops • Professional development presentations • Mental health/SUD screenings • Mental health/SUD education • Counseling services • Case management • Homework assistance • Parenting Workshops

Program Serves	**Children** **TAY (16-25)** **Adults**
Location of Services	School campuses, Family Resource Centers, Community organizations

Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results

The RPiAAC program works in collaboration with local schools to provide programming and activities at school sites that are convenient for students and their families. Individuals undergo screening for risk factors that may result in mental health symptoms and the likelihood of developing an early-onset mental illness. The concerns of impairment and safety are further evaluated to establish the degree of the individual's need of additional services.

RPiAAC providers involve students and parents in planning culturally appropriate and engaging activities for the target audience. Trends from screening tools and survey feedback determine the offered activities.

The RPiAAC program is categorized as a State Prevention and Early Intervention program. The program aims to reduce risk factors such as school failure, dropout, and juvenile justice involvement. It increases protective factors such as positive coping skills, increased knowledge, access to services, and positive self-image. RPiAAC provides a variety of prevention activities and social skill groups through evidence-based curriculums, Peacemakers, and National Curriculum and Training Institute (NCTI) Youth Crossroads.

Services are intended for children who are identified as struggling with behavior in class, maintaining passing grades, absenteeism, and tardiness.

Students are provided a variety of workshops to aid them with time management, conflict resolution, coping with challenges, and managing emotions. These services incorporate culturally specific strategies and approaches.

Number of Individuals / Number of Services Projected vs Actual

	Projected	Actual		
		FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	4,753	1,076	1,464	3,067
Number of Services	8,339	7,474	9,136	6,659

Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results, cont.

Prevention

The RPiAAC program implements a variety of prevention services and social skill groups through evidence-based curriculums and activities, such as:

- Peacemakers,
- Meet A Pro,
- Effective Black Parenting Curriculum, and
- NCTI Youth© Crossroads Curriculum.

The Peacemakers and NCTI Youth© Crossroads curricula are used for grades K-12 on school campuses and delivered during school hours and in after-school programs. The students participate in weekly training on varying topics throughout the school year. RPiAAC students that participate in these curriculums learn how to make better choices, resolve disputes through conflict resolution, and learn to have positive peer interactions.

Through the Meet A Pro activities, African American/Black professionals talk with students about their careers, personal experience of racism and discrimination, and how they overcame obstacles to succeed. These activities are intended to influence favorable perceptions of professional accomplishment for African American/Black children and TAY and encourage them to follow their desired career pathways.

The RPiAAC program also provides cultural awareness group sessions for children and TAY. In these sessions, individuals are allowed to share their own background, which allows them to understand cultural differences and similarities in attitudes, beliefs, and values.

Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results, cont.

Early Intervention

RPiAAC utilizes various screening and assessment tools to ensure individuals receive treatment services as soon as mental health concerns are identified.

The RPiAAC program utilizes the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) to measure the outcomes of the early intervention treatments and assist in developing the mental health treatment plan.

The program also uses the Pediatric Symptom Checklist (PSC) at intake to assess emotional and behavioral problems in children. The tool assists in recognizing cognitive, emotional, and behavioral problems so that program staff can initiate the appropriate interventions.

The table below shows the number of early intervention services as reported by the RPiAAC program.

Early Intervention Individuals / Services			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	42	75	82
Number of Services	908	1950	855

RPiAAC providers established relationships with school districts to resume on-campus services. Services are initiated via referral from school staff. The program continues to expand its services to the high desert region of the county.

Early intervention services include mental health screenings and assessments, individual and group therapy, and case management. Successful treatment indicates that the individual has met all their treatment goals when the case has closed. The information in the table below illustrates the program's early intervention data for the last three fiscal years.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 22/23	335	51	38%
FY 23/24	467	5	73%
FY 24/25	1,919	1,846	96%

Resilience Promotion in African American Children (RPiAAC), cont.

Outreach

RPiAAC's outreach and education services are designed to incorporate cultural and historical education for African American/Black student populations. This promotes positive social identity and raises awareness among all students about the importance of mental health and wellness. RPiAAC providers build relationships that allow them to integrate themselves into the culture of schools. They engage with school leadership, teaching staff, and students to reduce the stigma associated with mental health services, which allows for services to begin rapidly.

Collaborations with different agencies and stakeholders have allowed the program to identify and target the at-risk African American/Black population. One of the largest barriers faced was the decrease in in-person participation and change in engagement due to the virtual platform presented to students. The table to the right illustrates the number of potential responders reached during each of the three previous fiscal years.

Potential Responders Reached			
	FY 22/23	FY 23/24	FY 24/25
Potential Responders	992	932	1,635

Outreach Settings

- Schools
- Community events
- Community based organization facility

Types of Potential Responders

- Families
- School Personnel
- Community Service Providers
- Peer Providers
- Employees

Resilience Promotion in African American Children (RPiAAC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	12%	6%	0%	0%	83%
FY 23/24	40%	15%	17%	6%	22%
FY 24/25	18%	5%	0%	0%	78%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	0%
FY 23/24	<1%
FY 24/25	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	0%
FY 23/24	6%
FY 24/25	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	30%	46%	0%	22%
FY 23/24	34%	52%	<1%	14%
FY 24/25	88%	13%	0%	76%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	89%	1%	<1%	10%
FY 23/24	76%	5%	<1%	19%
FY 24/25	42%	<1%	<1%	57%

Resilience Promotion in African American Children (RPiAAC), cont.

Demographics, cont.

Demographic Observations

- The RPiAAC program has consistently supported the target population over the past three fiscal years, with 32% of those served being children and TAY aged 0-25 years old in FY 2024/25. The changes in the proportion of the target population served underscore the opportunities for improving data collection.
- Although the program focuses on African American/Black students, RPiAAC continues to successfully reach individuals who identify as Latinx/Hispanic.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	70%	59%	56%
American Indian/Alaska Native	0%	0%	0%
Asian	<1%	<1%	<1%
Latinx/Hispanic	25%	12%	25%
Native Hawaiian or Pacific Islander	<1%	<1%	0%
Caucasian/White	2%	17%	8%
More than One Race	6%	2%	4%
Other Race	12%	9%	6%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	74%	41%	49%
Asian Indian/South Asian	<1%	<1%	0%
Cambodian	0%	<1%	0%
Chinese	0%	0%	0%
Eastern European	7%	1%	<1%
European	0%	6%	5%
Latinx/Hispanic	25%	39%	36%
Filipino	1%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	<1%	0%	0%
Vietnamese	0%	<1%	1%
Other	10%	9%	7%
More than one ethnicity	7%	3%	1%

Resilience Promotion in African American Children (RPiAAC), cont.

Program Goals

Reduce prolonged suffering associated with untreated mental illness by:

- Reducing risk factors,
- Reducing indicators,
- Increasing protective factors that may lead to improved mental, emotional, and relational functioning,
- Reducing symptoms, and
- Improving recovery, including mental, emotional, and relational functioning.

Reduce stigma and discrimination associated with mental illness by:

- Reducing negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	Intake, 3 - 6 months, Discharge, Significant life events	FY 22/23: 32 FY 23/24: 80 FY 24/25: 89
National Curriculum & Training Institute (NCTI)	A complete behavioral change system delivered in a group format, following a precise sequence that leads individuals from a general level of discussion to a specific behavioral commitment.	2 times Initial & completion	FY 22/23: 377 FY 23/24: 689 FY 24/25: 403

Resilience Promotion in African American Children (RPiAAC), cont.

Outcome Discussion

RPiAAC intends to influence the following outcomes with its myriad of services by:

- Improving resilience and feelings of self-efficacy,
- Reducing truancy, drop-outs, suspensions, expulsions,
- Increasing knowledge of risk and resilience/protective factors,
- Reducing family stress/discord,
- Reducing violence,
- Improving school performance, and
- Reducing involvement with law enforcements and courts.

The adjacent chart shows the percent improvement by individuals before and after participation in the NCTI curriculum.

The knowledge gained in the Cognitive Life Skills courses intends to establish positive, goal-directed behaviors that increases protective factors.

NCTI Youth Crossroads				
Curriculum	Results	FY 22/23	FY 23/24	FY 24/25
Cognitive Life Skills	Average Pre-Test	*	1.25	4.80
	Average Post-Test	*	8.25	8.98
	Percent Improvement	*	70%	42%
Alcohol and Substance Use	Average Pre-Test	*	3.70	4.07
	Average Post-Test	*	3.80	4.70
	Percent Improvement	*	2%	9%
Anger Management	Average Pre-Test	*	3.57	3.23
	Average Post-Test	*	3.83	3.50
	Percent Improvement	*	5%	5%

*No data available for comparison

Older Adult Community Services (OACS)

Program Description and Target Population

Older Adult Community Services (OACS) program is categorized as a State Prevention program that provides early intervention services. OACS program services target older adults (ages 60+) who are at risk for developing mental health concerns.

The program was created to address important indicators that can contribute to mental health issues such as depression, isolation, chronic physical health conditions, and lack of family support.

- The Mobile Resource Unit provides mental health and substance use screenings to seniors who live in rural or economically depressed areas.
- Older Adult Wellness Services provides various services to older persons, including transportation to and from medical appointments, basic life functioning requirements, and physical and mental health education programs tailored to their needs.
- The Older Adult Home Safety program assists older adults in maintaining the appropriate personal and home safety level. Older adults receive services and education in personal safety, home safety, preventing falls, and medication management.
- The Older Adult Suicide Prevention program provides suicide prevention education, screenings, and direct support services. These services are delivered to the program's target demographic in a culturally acceptable manner. Those who are experiencing the onset of a mental illness and/or relapse episodes related to a pre-existing psychiatric disorder can benefit from early intervention treatments.

Services Offered	
	• Mental Health Education • Mental Health/SUD Screenings • Case Management Services • Home Safety Screenings • Transportation Assistance for High Desert Residents • Counseling Services • Physical Fitness/Wellness Activities • Suicide Prevention

Program Serves	**Older Adults (60+)**
Location of Services	In-home, Senior Centers, Mobile Services, Mental Health Care Facilities

Older Adult Community Services (OACS), cont.

Program Highlights

The curriculum focuses on the causes and risk factors that can lead to suicide and/or suicidal ideation, as well as individuals who have been exposed to trauma or are grieving. Older Adult Peer Counselors, who have been trained in suicide prevention and have access to licensed suicide prevention resources, are also used in the program.

The OACS program is intended to promote healthy aging and assist in maintaining mental health wellness. OACS services must be delivered conveniently and engagingly for participants. It is classified as a prevention program because it aims to strengthen protective factors and decrease risk factors associated with mental health challenges. On the following page, you'll find a list of prevention activities and the associated risk and protective factors.

OACS providers collaborate closely with service coordinators at local senior centers and apartment complexes to design and implement presentations, workshops, and/or groups aimed at addressing the mental health symptom prevention needs within the community.

Participants are screened for mental health symptoms and early onset diagnosis possibility. Impairment and safety issues are evaluated to determine the participant's need severity.

OACS providers, in collaboration with their peer family advocates and program participants, utilize a variety of methods such as suggestion boxes, polling, and analysis of screening tools to assess and determine the activities to be offered.

The table below provides the numbers of participants and actual services rendered by the OACS program over the past three fiscal years.

The implementation of virtual services has notably mitigated transportation-related obstacles. Furthermore, the program consistently meets participation targets, aligning with the prevailing trends in mental health services.

Number of Participants / Number of Services			
	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	8,957	8,534	11,773
Number of Services	5,755	4,443	9,154

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Prevention Activity	Description	Risk Factors Addressed	Protective Factors Addressed
Wellness Activities • Socialization • Fitness • Nutrition • Craft/Art • Group Meals	• Senior social support groups, activities, and education designed to engage seniors in wellness activities to increase social engagement, decrease isolation/loneliness, and foster healthy personal and community interactions to prevent further escalation of mental health symptoms.	• Prolonged isolation • Ongoing stress • Chronic health conditions • Onset of mental illness	• Socialization • Education on mental wellness • Knowledge of physical health • Nutrition education • Improved flexibility and balance • Knowledge and access to services • Positive coping skills
Fall Prevention/Home Safety	• Older adults receive services and education in personal safety, home safety, disaster planning, preventing falls, and medication management.	• Prolonged isolation • Chronic health conditions • Ongoing stress • Lack of family support • Onset of mental illness	• Identification of potential household hazards • Increased safety in home • Knowledge and access to services
Step Down Groups	• Relapse prevention for consumers who have received or are receiving mental health services.	• Onset of mental illness • Depression • Severe trauma • On-going stress	• Positive coping skills • Socialization • Knowledge and access to services

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Prevention Activity	Description	Risk Factors Addressed	Protective Factors Addressed
Tai Chi for Arthritis	• To help seniors improve mental and physical balance, reduce accidental falls, and increase strength, mobility, and heart/lung/muscle function. Reducing pain and stiffness, protecting joints, and improving relaxation, vitality, posture, and immunity.	• Reducing mental illness factors • Access to physical and mental health care • Depression • Chronic physical health conditions	• Screenings for mental health and substance use • Knowledge and access to services • Socialization • Positive coping skills
Transportation Reimbursement Escort Program (TREP)	• Transportation reimbursement program provided to seniors in the High Desert communities for their medical appts, medication pick-ups, and errands.	• Prolonged isolation • Access to physical and mental health care	• Transportation assistance • Socialization • Knowledge and access to services
Home Safety Program	• To assist seniors in maintaining personal and home safety through education and services covering personal safety, home safety, fall prevention, and medication management assistance.	• Poverty - Insufficient food, shelter, healthcare • Ongoing stress • Preventive measures	• Access to mental and physical health care • Knowledge and access to services

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Outreach

Outreach is a primary strategy in the OACS program for increasing recognition of early signs and symptoms of mental illness. As a result of successful outreach efforts, OACS has reached out to over 20,000 participants, also known as potential responders, between fiscal years 2022/23, 2023/24, and 2024/25.

Potential Responders Reached			
	FY 22/23	FY 23/24	FY 24/25
Potential Responders	8,988	8,534	10,450

Potential participants in this program will be involved in various activities. They attend educational presentations to learn about the signs and symptoms of mental illness and age-related difficulties. They also work in multidisciplinary teams with responders/providers from different fields to enhance the team's capabilities. Through collaboration, they gain a better understanding of age-related difficulties, mental health issues, and other challenges affecting older adults.

Responders are well equipped to engage with older adults personally and provide advice on age-related or mental health-related difficulties.

OACS provides education and outreach services in areas where potential responders for this population can be engaged. These include senior centers and primary healthcare facilities. Potential responders come from all types of roles. The table below provides a full list of outreach settings and types of potential responders.

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Community Members • Community Service Providers • Healthcare Providers • Faith-Based Organization Leaders • Family Members • Government Service Staff • Primary Health Care Facilities • Law Enforcement Personnel	• Community Events • Community-Based Organizations • Government Service Offices • DBH Community Clubhouses • Faith-Based Organizations • Senior Centers • Primary Health Care Facilities

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

The early intervention services (EIS) provided by the OACS program offer a comprehensive approach to supporting older adults with emerging mental health concerns. These services are designed to identify mental health issues early and provide timely interventions to prevent the escalation of symptoms. The core components of EIS include:

- Mental Health Screenings and Assessments: Screenings are the first step in identifying potential behavioral health concerns. Licensed professionals conduct thorough evaluations for symptoms of anxiety, depression, and other behavioral health conditions.
- Individual Therapy: One-on-one therapy sessions provide a safe, confidential space for individuals to explore their emotions, challenges, and mental health concerns. Therapy is personalized to meet the emotional and psychological needs of each older adult.
- Group Therapy: Group therapy provides individuals the opportunity to connect with others facing similar challenges. These sessions promote peer support and open communication and help to reduce feelings of isolation.
- Case Management: OACS case managers offer holistic support, coordinating care, making referrals to mental health providers or community resources, and assisting with logistical needs such as transportation or medication access.
- The data on the following pages illustrates the impact of these services over the past three fiscal years, highlighting trends such as the number of individuals served, types of services utilized, and the success rates of early intervention efforts. This information is critical for evaluating program effectiveness and identifying areas for improvement.

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Early Intervention Services

Early Intervention Services provided by the OACS program include mental health screenings and assessments, individual and group therapy, and case management. The table below illustrates the Early Intervention data for the last three fiscal years.

Number of Open Episodes by Fiscal Year			
	FY 22/23	FY 23/24	FY 24/25
Open Episodes at any time during fiscal year	62	22	47

Early Intervention Services for homebound elders primarily shifted to virtual due to COVID-19's long-term effects. However, telehealth isn't favored among older adults due to limited resources and unfamiliarity with technology. Many lack access to computers or smartphones. Early intervention services have increased since providers returned to in-person services, and seniors have become more comfortable with technology.

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Early Intervention Services

Treatment Success by Fiscal Year			
	FY 22/23	FY 23/24	FY 24/25
Treatment Successful	15%	32%	43%
Treatment Partially Successful	33%	29%	27%
Treatment Not Successful	44%	36%	27%
Missing or Other	7%	7%	<1%

The above table illustrates the discharge status after treatment. Many episodes opened, resulting in participants meeting their treatment goals successfully. The OACS program assesses the success of the Early Intervention treatment by the following:

1. Treatment Successful: The participant's treatment plan goals were met and/or they received successful treatment.
2. Treatment Partially Successful: Progress was made, but the participant did not meet all the requirements in their treatment plan.
3. Treatment Not Successful: The individual did not make progress or did not complete the treatment.

The "treatment successful" data contains some episodes that may have been opened in a previous fiscal year.

Older Adult Community Services (OACS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	0%	0%	<1%	29%	71%
FY 23/24	1%	0%	<1%	20%	73%
FY 24/25	<1%	0%	<1%	22%	78%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	<2%
FY 23/24	<1%
FY 24/25	1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	<1%
FY 23/24	5%
FY 24/25	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	3%
FY 23/24	26%
FY 24/25	1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	13%	35%	0%	52%
FY 23/24	18%	50%	0%	32%
FY 24/25	10%	57%	0%	85%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	12%	3%	<1%	85%
FY 23/24	27%	3%	<1%	70%
FY 24/25	84%	2%	<1%	26%

Older Adult Community Services (OACS), cont.

Demographics, cont.

Demographic Observations

Historically, older adults have been hesitant to engage in services and share personal information. This reluctance is often rooted in experiences from past eras when government and institutional practices were harmful toward individuals with mental health challenges, members of the LGBTQ+ community, and people from ethnic and minority groups.

This deep-seated mistrust has made capturing accurate demographic data more challenging. In recent years, there has been a decline in participants identifying as male. There has also been an increase in individuals choosing not to answer gender-related questions, reflecting evolving attitudes toward gender identity and privacy.

This trend is particularly concerning given that research shows older adult males, specifically Caucasian/White and Native American men, have some of the highest rates of suicide attempts and deaths. Engaging this demographic remains a priority for the OACS program, which will continue to monitor these trends in the coming years and adapt outreach efforts accordingly.

Additionally, there has been a noticeable decrease in participants identifying as having a physical disability. This decline may be linked to the expansion of telehealth services, which allowed many individuals to receive care from home.

All current OACS providers are committed to continuing the offering of telehealth services, ensuring that participants who require technological assistance receive the support they need to access these services effectively.

Older Adult Community Services (OACS), cont.

Demographics, cont.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	1%	<1%	<1%
Native American or Alaskan Native	<1%	<1%	<1%
Asian	<1%	<1%	1%
Latinx/Hispanic	4%	4%	2%
Native Hawaiian/Pacific Islander	0%	<1%	<1%
Caucasian/White	8%	12%	19%
More than One Race	<1%	<1%	4%
Other	<1%	1%	<1%
Declined to Answer	84%	82%	73%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	<1%	<1%	<1%
Asian Indian/South Asian	0%	<1%	<1%
Cambodian	0%	0%	<1%
Chinese	<1%	<1%	1%
Eastern European	0%	0%	<1%
European	20%	18%	44%
Latinx/Hispanic	4%	1%	6%
Filipino	<1%	<1%	<1%
Japanese	0%	0%	0%
Korean	0%	<1%	<1%
Middle Eastern	0%	0%	<1%
Vietnamese	0%	0%	<1%
Other	2%	1%	1%
More than One Ethnicity	1%	3%	11%
Declined to answer	75%	75%	34%

Older Adult Community Services (OACS), cont.

Program Goals

The State Prevention Program aims to alleviate prolonged suffering from untreated mental health issues. This is achieved by:

- Reducing risk factors and early indicators of mental illness.
- Enhancing protective factors that promote better mental, emotional, and relational health.
- OACS Program - Promoting Healthy Aging.

The OACS Program serves adults aged 60 and above, aiming to foster a healthy aging process through the following initiatives:

- Facilitating access to activities that encourage connections among older adults.
- Providing education and promoting participation in behavioral and physical wellness activities.
- Enhancing personal safety, home safety, and fall prevention measures, while supporting medication management.
- Encouraging older adults to participate in suicide and depression screenings.
- Expanding access to therapy services and promoting early engagement in treatment for mental health conditions.

Older Adult Community Services (OACS), cont.

Program Outcomes

Method used to collect outcomes	Description of method	Frequency of use	Number completed
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met.	• Intake • 3 Months • Discharge • Significant Life Events	FY 22/23: 35 FY 23/24: 21 FY 24/25: 20
Satisfaction Survey	Survey that reflects on the usefulness of the service/presentation and the speaker's ability to deliver information. An additional space was provided for narrative feedback.	• Post Service and/or Presentation	FY 22/23: 42 FY 23/24: 828 FY 24/25: *
Outreach Questionnaires	A seven-item questionnaire that assesses a participant's improved knowledge of signs and symptoms that can lead to a potentially severe mental illness.	• Pre/Post Mental Health Education Presentation and/or Activity	FY 22/23: 73 FY 23/24: 347 FY 24/25: *
PHQ-9	Nine-question instrument given to patients in a healthcare setting to screen for the presence and severity of depression.	• Intake • 6 Months	FY 22/23: 30 FY 23/24: 37 FY 24/25: 18

Note: *Indicates data unavailable

Older Adult Community Services (OACS), cont.

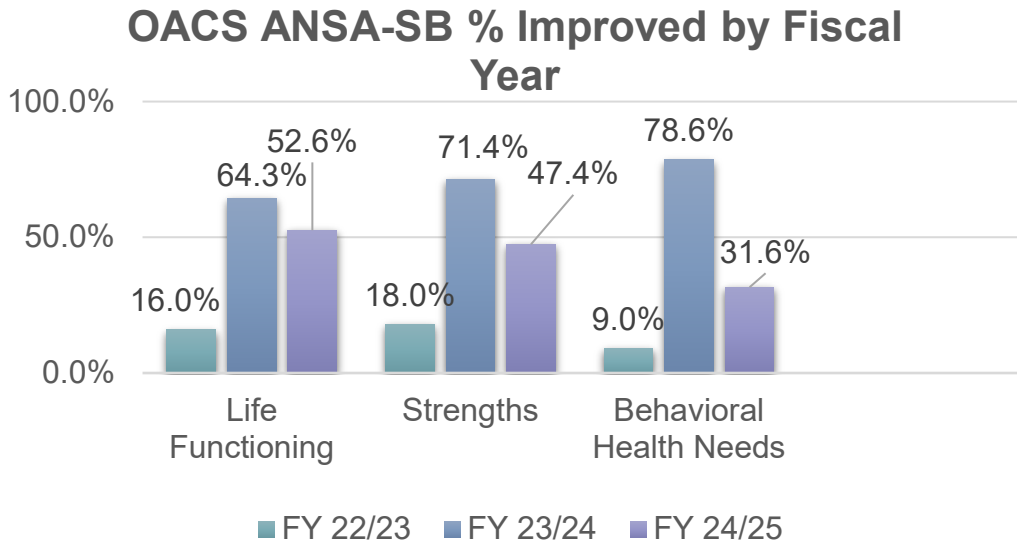
Outcome Discussion

The OACS program uses the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) to measure the outcomes of the early intervention treatments. ANSA-SB is an information integration tool for adults with behavioral health challenges. The tool is used to support individual case planning and the planning and evaluation of service systems. Each dimension is rated on its four-point scale when the ANSA-SB is administered. The ANSA-SB is administered at intake and at three-month intervals until discharge.

The data shows that individuals in early intervention services saw improvements in Life Functioning, Strengths, and Behavioral Health Needs. However, in FY 2023/24, all three areas saw declines, likely due to the lingering impact of COVID-19. Providers are working on innovative strategies to engage older adults and improve outcomes.

The focuses of early intervention treatment for the OACS program are:

- Life Functioning domain evaluates factors like an individual's family relationships, social functioning, residential stability, self-care, and transportation.
- Strengths domain evaluates factors like family support, optimism, talents and interests, spirituality, relationship permanence, community connection, and resourcefulness.
- Behavioral Health Needs, which evaluate factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma, and substance use.



Older Adult Community Services (OACS), cont.

Outcome Discussion, cont.

Outreach Survey Results

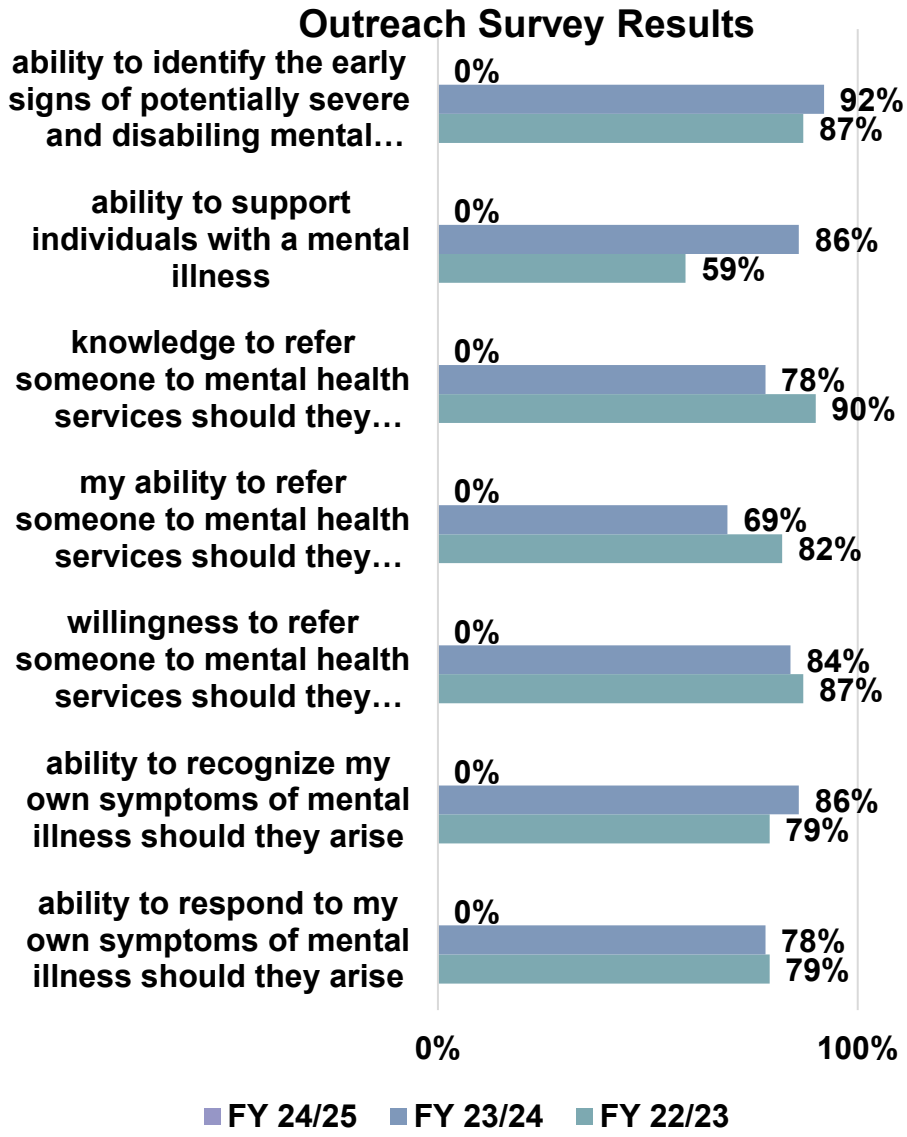
The OACS Program conducts various outreach activities, including:

- Educational sessions for the community to learn more about mental health and wellness.
- Information dissemination events focused on the signs and symptoms of mental illness, as well as age-related challenges.
- Participants in mental health information events complete a survey to evaluate their understanding, comfort level in assisting others, and post-event feelings. The graph on this page displays survey questions and responses from the past three years.

Key findings include:

- Increased confidence: In FY 2023/24, 88% of survey respondents felt confident in recognizing and assisting individuals with mental illness.
- Improved referral knowledge: The survey results show an overall improvement in participants' understanding of the mental health referral process and their intent to seek mental health services if needed.
- These results underscore the success of education and behavioral health promotion strategies in increasing community awareness of mental health issues and available resources.

Note: *Indicates data unavailable



Lift Program

Program Description and Target Population

The Lift Program is a prevention initiative developed through a collaborative effort between the Department of Behavioral Health and the Preschool Services Department. It is designed to enhance the health, well-being, and self-sufficiency of pregnant and parenting mothers, their children, and families.

Priority enrollment is given to first-time pregnant mothers who meet specific guidelines, as well as those facing additional risk factors such as homelessness, teenage pregnancy, child welfare involvement, risk of juvenile justice involvement, or signs of depression.

Pregnant mothers receive in-home visits from registered nurses who provide education on the connection between physical and mental health and the developmental stages of their children. These nurses offer supportive strategies to help ensure that both children and families thrive in their environments.

Referrals to the Lift Program come from a variety of sources, including community hospitals, local high schools, pregnancy resource centers, homeless shelters, faith-based organizations, the Black Infant Health program, and Women, Infants, and Children (WIC) centers.

Services Offered	• **Parent education and support** • **Post-natal depression screenings** • **Nurturing activities to increase maternal attachment** • **Developmental milestones education** • **Life and employment skills development** • **Community referrals**

Program Serves	**Children, Youth, TAY, Older Adults**
Location of Services	In-home

Lift Program, cont.

Program Positive Results

The Lift Program nurses use a variety of tools and assessments that identify potential risk factors and protective factors. These tools and assessments are designed to quickly identify indicators of areas of need, such as depression and nicotine dependency. The tools and assessments used are:

- Edinburgh Postnatal Depression Scale
- Fagerstrom Test for Nicotine Dependency
- Maternal Fetal Attachment Scale
- Life Skills Progression
- Father Skills Assessment
- Teeth for Two

Typically, these screenings take the form of a survey or a conversation. Lift nurses make referrals to partner agencies that specialize in these types of supportive services. These services contribute to the development of protective factors by providing tangible support during times of difficulty and by providing participants with information tailored to their specific needs.

Additionally, this strengthens feelings of social connection as Lift nurses provide support and reassurance. As a result of the early screening and identification process, participants better understand parenting and child development. They discuss the effects of smoking, attachment, and depression on the mother-child bond and the developing child.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	120	52	65	67
Number of Services	1,728	360	511	586

Lift Program, cont.

Program Positive Results, cont.

Edinburgh Postnatal Depression Scale

Lift nurses use the Edinburgh Postnatal Depression Scale as an assessment to recognize signs that might indicate a new mother may be experiencing postnatal depression. Scoring between 10 to 30 points on this 10-question scale signifies a high likelihood of participants experiencing clinical depression.

The Lift nurse administers the Edinburgh Postnatal Depression Scale within eight weeks after birth. Based on the assessment results, nurses and Marriage and Family Therapists (MFTs) provide the appropriate interventions, services, and resources.

When a participating mother is identified as experiencing possible postnatal depression, nurses provide early support, education, and resources to help new mothers navigate through their symptoms. Nurses are trained at recognizing signs and continually assess during home visits.

Most new moms in the Lift program who exhibit symptoms improve through working with their Lift nurses, as observed in ongoing assessments conducted by the nurses. If a participating mother is identified as experiencing possible depression, a referral is generated and an MFT is assigned to work collaboratively with the participant and nurse to provide the necessary resources and services.

The chart below presents data on Depression Related Mental Health Needs from the past three years. In the most recent fiscal year, FY 2024/25, 30 mothers were screened for signs of depression with 2 identified as displaying symptoms and subsequentially receiving mental health services.

Identification of Depression Related Mental Health Needs			
	FY 22/23 (N=52)	FY 23/24 (N=65)	FY 24/25 (N=30)
Exhibited signs of depression	6	22	2
Received mental health supportive services	6	6	2
Required clinical intervention	4	0	0

Lift Program, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 22/23	63%	0%	37%	0%	0%
FY 23/24	0%	8%	32%	0%	60%
FY 24/25	0%	40%	40%	0%	20%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	0%
FY 23/24	0%
FY 24/25	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	2%
FY 23/24	6%
FY 24/25	5%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	6%
FY 23/24	3%
FY 24/25	0%

Fiscal Year	Gender Identity			
				UNK
FY 22/23	20%	69%	0%	11%
FY 23/24	0%	74%	0%	26%
FY 24/25	0%	88%	0%	12%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	78%	9%	10%	4%
FY 23/24	74%	5%	6%	15%
FY 24/25	75%	9%	7%	9%

Lift Program, cont.

Demographics, cont.

Demographic Observations

The Lift program primarily targets first-time pregnant women, new mothers, and families. Most participants are TAY and adult women. However, there is a small percentage of male participants, which reflects services provided to fathers who are participating in the family services program.

The ethnic/racial diversity of the participants generally reflects the diversity of the population of San Bernardino County.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	0%	18%	27%
American Indian/Alaska Native	3%	3%	0%
Asian	0%	0%	0%
Latinx/Hispanic	0%	0%	6%
Native Hawaiian or Pacific Islander	0%	0%	0%
Caucasian/White	10%	29%	35%
More than One Race	10%	0%	5%
Other Race	50%	50%	27%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	9%	2%	8%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	0%
European	10%	29%	2%
Latinx/Hispanic	52%	18%	64%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	3%	5%
Vietnamese	0%	0%	0%
Other	80%	72%	18%
More than one ethnicity	50%	50%	2%

Lift Program, cont.

Program Goals

The goal of the Lift Program is to promote healthy outcomes for at risk mothers and their infants by providing home visitation services. Registered nurses provide education and resources to reduce risk factors and promote protective factors.

The goals of the Lift program are as follows:

- Support prenatal care and reduce cigarette, alcohol, and illegal drug use to improve pregnancy outcomes.
- Educate on healthy nutrition to enhance mental health for mother and child.
- Promote child health by guiding parents in care during the first two years of life.
- Provide parenting guidance on nurturing and safe, consistent discipline.
- Help mothers develop future goals, plan pregnancies, build healthy relationships, pursue education, and seek employment.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Maternal Fetal Attachment Scale	The Maternal Fetal Attachment Scale is a tool used to determine the attachment between a mother and her unborn child.	1x at the beginning of services	FY 22/23: 52 FY 23/24: 65 FY 24/25: 30
Life Skills Progression Tool	The Life Skills Progression is a tool used to monitor participants' strengths and needs.	1x at the beginning of services	FY 22/23: 52 FY 23/24: 65 FY 24/25: 30

Lift Program, cont.

Outcome Discussion

Nurturing & Attachment			
	FY 22/23	FY 23/24	FY 24/25
I desire this baby / I'm not sorry I became pregnant	100%	90%	97%
I am willing to give up certain things to protect my baby	94%	85%	97%
I read to my baby / unborn child	53%	48%	50%

Family Supports			
	FY 22/23	FY 23/24	FY 24/25
My mate wants this pregnancy	0% No	17% No	3% No
My pregnancy interferes with my relationship with my mate	22% Yes	20% Yes	3% Yes
My family supports my pregnancy	63% Yes	77% Yes	97% Yes
My family will help in caring for my baby	82% Yes	77% Yes	93% Yes

Family support is an important protective factor. New and expectant mothers rely heavily on the encouragement and care they receive from close family and friends throughout pregnancy and during the early years of their newborn's life.

The Family Supports chart reveals a decline in respondents reporting that their partner did not want the pregnancy, along with a significant drop - from 20% in FY 2023/24 to just 3% in FY 2024/25 - in those who felt the pregnancy interfered with their relationship.

Feelings of family support for the pregnancy have steadily increased over this three-year period. Engaging all family members in the Lift program's interventions further strengthens the support network for expectant mothers throughout their pregnancy journey.

The Nurturing and Attachment charts show a consistent increase in indicators of parental bonding across all measures over the past three fiscal years.

Lift Program, cont.

Outcome Discussion, cont.

Life Skills Progression (LSP) Tool

The LSP tool captures a portrait of the behaviors, attitudes, and skills of mothers enrolled in the Lift program. It helps to establish a baseline of participant profile, identify strengths and needs, plan interventions, and monitor outcomes to show that interventions are working.

In the Lift program, the LSP is used to assess needs related to education and employment. As seen in the table below, there is a strong correlation between the education level and stable employment. In FY 2024/25, the percentage of participants with less than a high school education significantly decreased from the past year.

Stable employment lowers risk factors associated with poverty and unemployment while enhancing protective factors related to economic security. The Lift Program supports participants by providing referrals to high school diploma completion programs. Earning a diploma boosts protective factors, including future opportunities, and increases self-esteem through accomplishment.

Additionally, the program offers referrals to the Preschool Services Department Apprenticeship program and other career training options. By securing stable employment, families improve self-esteem, self-efficacy, and overall economic security.

Participant Education Level and Employment Stability

	FY 22/23	FY 23/24	FY 24/25
Less than high school education	2%	17%	7%
Unemployed / work occasionally	69%	72%	7%
Some college	46%	34%	17%
Stable employment	31%	17%	17%

Program Updates

The Lift Program concluded on June 30, 2025, and was succeeded by the Preschool Building Blocks to Success Program, which launched on July 1, 2025.

Coalition Against Sexual Exploitation (CASE)

Program Description and Target Population

CASE of San Bernardino County is a county-wide partnership dedicated to combating the commercial sexual exploitation of children (CSEC). The coalition focuses on educating the community, intervening with at-risk youth, and providing essential services and support to children and teens affected by commercial sexual exploitation. Through education and training, CASE raises awareness about the issue, teaches how to recognize the signs of exploitation, and ensures youth have direct access to resources and treatment.

The CASE team is a multidisciplinary group that includes Child and Family Services (CFS), the Public Defender's Office, Behavioral Health, as well as attorneys from the District Attorney's Office. Probation officers, public health nurses, and advocates from Court Appointed Special Advocates (CASA) and Open Door also contribute to this collaborative effort. Together, these professionals provide comprehensive support to youth identified as victims of commercial sexual exploitation.

CASE's primary goal is to reduce both the number of exploited youth and the risk factors that contribute to exploitation. By emphasizing prevention, the coalition works to decrease vulnerabilities while strengthening protective factors for at-risk children and teens. This multi-agency model aligns with state-level prevention initiatives, aiming to protect vulnerable youth and ultimately prevent commercial sexual exploitation.

Services Offered
• Mental health assessments • Crisis Intervention • Case Management including linkage and referrals • School enrollment assistance • Therapeutic interventions • Transportation assistance • Placement consultation • Outreach and community awareness training

Program Serves	**Children, Youth, TAY**
Location of Services	Foster care placements, hospitals, schools, community settings

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results

The CASE program aims to reduce prolonged suffering from untreated mental illness by identifying signs of CSEC involvement early and connecting youth to needed services. Its goals include:

- Training agency staff to recognize CSEC,
- Raising public awareness,
- Increasing knowledge of community resources, and
- Ensuring access to treatment for potential victims.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	1,500	1,661	1,626	1,728
Number of Services	1,500	2,044	1,971	736

Key risk factors among CASE participants include running away, trauma, school challenges, poverty, substance use, and exposure to violence. Protective factors focus on positive adult relationships, community involvement, resilience, peer support, optimism, leadership, and life skills. CASE prevention activities seek to address the risk factors and protective factors with the following services:

- Placement assistance, advocacy, safety planning, and CASE Youth Resource cards to reduce risks for homeless/runaway youth.
- Support, consultations, and advocacy from schools, probation, and the District Attorney to address truancy, curfew, and juvenile justice involvement.
- Safety plans, CFS Social Worker assignment, Child Family Team meetings, mentors, public health, and therapy services for youth facing abuse and neglect risks.

While there appears to be a decrease in the number of services provided in FY 2024/25 in the table to the left, CASE has noted challenges in accurately tracking the number of individuals receiving services. This highlights an opportunity for improvement in their data tracking processes.

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

Prevention activities focus on ongoing, individualized engagement between CSEC youth and the multidisciplinary team. In FY 2024/25, there were 61 total CASE participants. The steady increase in participant numbers over the past three fiscal years, as shown in the table below, reflects CASE's continued dedication to serving its target population.

Number of Prevention Participants			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	35	42	61
Number of participants continuing from previous year	24	25	30
Percentage of continuing participants	69%	60%	49%

Girls' Court

A key prevention initiative for CASE is Girls' Court, a program designed for at-risk females ages 12 to 17 who are involved in the legal system. Girls' Court emphasizes building self-esteem and empowerment, helping young women develop the skills they need to succeed. Successful completion of the program results in the sealing of their criminal records before they turn 18, reducing the stigma associated with prior juvenile justice involvement.

Graduation from Girls' Court requires participants to demonstrate progress by meeting program benchmarks and supervision goals. The program supports better outcomes by encouraging continued school enrollment, promoting academic achievement, reducing dropout rates, and working to lower recidivism and incarceration. In FY 2024/25, the program achieved a 33% completion rate, up from 26% in FY 2023/24, reflecting a 27% increase.

Girls' Court Completion Rate			
	FY 22/23	FY 23/24	FY 24/25
Completion Rate	41%	26%	33%

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

Outreach for Increasing Recognition of Early Signs and Symptoms of Mental Illness

CASE follows the state strategy of outreach to increase recognition of early signs and symptoms of mental illness as a key approach to engaging child-serving agencies and the community. This strategy helps identify children who may be at risk of sexual exploitation and provides crucial information and resources to support their safety.

The outreach and education efforts focus on training agency staff to recognize signs of commercial sexual exploitation (CSE) in youth, raising public awareness of CSEC issues, enhancing knowledge of available community resources, and improving the ability to identify potential victims. These efforts ensure that youth receive timely access to necessary resources and treatment.

During FY 2024/25, the CASE program delivered educational outreach to 2,060 potential responders. This audience included staff from law enforcement agencies, probation departments, attorneys, school personnel, health care providers, and local community service organizations, demonstrating broad and impactful engagement across multiple sectors.

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

When it comes to identifying youth who may be potential CSEC victims, 100% of participants reported being able to recognize key terms related to CSEC victims and the trafficking subculture. Additionally, 100% demonstrated an increased understanding of trauma bonds and the signs of CSEC involvement. This not only highlights the effectiveness of the CASE program's outreach efforts but also reflects the eagerness of the target audience to receive and engage with this information. Early Intervention services are available to CASE participants. However, the CASE team members do not directly provide these services. The multidisciplinary team assesses, refers, and links children identified as needing early intervention support.

Program Goals	
Goal: Raise awareness of CSEC issues	
Ability to define / describe human trafficking	100%
Increased knowledge and awareness of recruiting tactics and locations	100%
Goal: Raise knowledge of available community resources	
Knowledgeable about available resources for CSEC youth	100%
Goal: Identify youth who are potential CSEC victims	
Able to recognize key terms relating to CSEC victims and the subculture of trafficking	100%
Understanding trauma bonds / identifying signs of CSEC involvement **N**=640	100%

Coalition Against Sexual Exploitation (CASE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	4%	24%	56%	4%	12%
FY 23/24	3%	27%	52%	2%	3%
FY 24/25	6%	32%	51%	4%	7%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22 /23	3%
FY 23/24	2%
FY 24/25	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	4%
FY 23/24	3%
FY 24/25	6%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	4%
FY 23/24	4%
FY 24/25	6%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	16%	33%	1%	50%
FY 23/24	14%	28%	0%	58%
FY 24/25	28%	67%	1%	3%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	100%	0%	0%	0%
FY 23/24	48%	2%	1%	49%
FY 24/25	84%	4%	2%	10%

Coalition Against Sexual Exploitation (CASE), cont.

Demographics, cont.

Demographic Observations

- CASE has consistently served the targeted demographics over the last three fiscal years. Females between 16 - 50 are among the highest recipients of CASE services. The demographic totals represent both Prevention and Outreach service demographics.
- The completion of the "CASE Database" allowed the program to begin entering consumer information monthly starting in FY 2023/24, providing a more comprehensive and accurate picture of their data through FY 2024/25.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	13%	10%	8%
American Indian/Alaska Native	1%	<1%	<1%
Asian	4%	6%	2%
Latinx/Hispanic	10%	42%	35%
Native Hawaiian or Pacific Islander	<1%	<1%	0%
Caucasian/White	20%	20%	10%
More than One Race	0%	4%	3%
Other Race	6%	18%	6%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	0%	0%	0%
Asian Indian/South Asian	46%	<1%	0%
Cambodian	0%	<1%	0%
Chinese	6%	0%	0%
Eastern European	0%	<1%	0%
European	0%	0%	0%
Latinx/Hispanic	10%	41%	0%
Filipino	26%	<1%	<1%
Japanese	1%	0%	0%
Korean	0%	0%	0%
Middle Eastern	1%	0%	<1%
Vietnamese	0%	<1%	0%
Other	9%	58%	99%
More than one ethnicity	10%	<1%	0%

Coalition Against Sexual Exploitation (CASE), cont.

Program Goals

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors,
- Reduce indicators, and
- Increase protective factors that may improve mental, emotional, and relational functioning.

Increase recognition of early signs and symptoms of mental illness:

- Raise public awareness of CSEC issues,
- Raise knowledge of available community resources, and
- Identify youth who are potential CSEC victims.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Continuing Engagement	Determine percentage of CSEC youth remain active on the CASE MDT roster from one year to another, demonstrating continuing engagement in the program.	1x at beginning of new year	FY 22/23: 24 FY 23/24: 25 FY 24/25: 30
Girls' Court	Girls' Court completion requires meeting program requirements including demonstration of healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being.	1x at completion of Girls' Court program	FY 22/23: 21% FY 23/24: 26% FY 24/25: 33%
Outreach Survey	Use survey to gauge effectiveness of educational outreach events designed to increase recognition of indicators of CSEC involvement, including understanding and awareness of trauma bonds and the effect on mental health	1x completed at educational outreach events	FY 22/23: 335 FY 23/24: 275 FY 24/25: 384

Coalition Against Sexual Exploitation (CASE), cont.

Outcome Discussion

Continuing Engagement

One of the ongoing challenges in working with CSEC youth is maintaining their continued engagement. A key indicator of success is building trust and rapport, which encourages youth to remain connected to essential services. Continued participation in the CASE program serves as a valuable measure of this success. In FY 2022/23, 69% of youth continued with the program from the previous year. While participation adjusted to 60% in FY 2023/24 and 49% in FY 2024/25, these figures reflect the program's sustained commitment to supporting youth through meaningful engagement over time.

Girls' Court

Girls' Court defines successful program completion as achieving established goals, demonstrating healthy lifestyle choices, self-empowerment, pro-social behavior, educational engagement, and overall well-being. In FY 2022/23, 21% of participants graduated from the program, increasing to 26% in FY 2023/24, with FY 2024/25 seeing the highest completion rate of 33%.

Outreach Surveys

Outreach surveys designed to assess the impact of meeting educational goals are conducted during CASE outreach presentations. These surveys evaluate whether participants have gained knowledge and awareness on key topics covered in the presentation, such as increased understanding of CSEC issues, recognizing signs of commercial sexual exploitation (CSE) in youth, awareness of available community resources, and enhanced ability to identify potential CSE victims and connect them with necessary resources and treatment. In FY 2024/25, CASE saw a 40% increase in survey responses compared to the previous FY 2023/24.

Family Resource Center (FRC)

Program Description and Target Population

Family Resource Centers (FRCs) offer a variety of Prevention and Early Intervention services supporting the health and wellness of individuals and families. FRC locations allow services to be tailored to individualized communities' specific needs and cultural requirements. Services and activities are offered at non-traditional locations, such as community centers, where other collateral services are also provided. This reduces the stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

The earlier people seek mental health intervention, the less intense treatment will be needed. People who receive early intervention learn to apply healthy coping skills and avoid reliance on unhealthy and sometimes dangerous coping mechanisms.

Family Resource Centers offer participants options to participate in activities that foster mental health, such as: raising self-awareness and practicing healthy coping skills in prevention activities; learning about signs and symptoms of mental illness to self-identify early signs; offering individual and family counseling sessions to work on problems and challenges; and allowing recovery to be less difficult and time-consuming.

Services Offered	• After school youth projects and activities • Behavioral health education workshops • Maternal mental health • Personal development • Skills-based education for adults • Family counseling • Individual therapy

Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Community

Family Resource Center (FRC), cont.

State Program Positive Results

FRCs offer a range of Prevention and Early Intervention activities to support mental wellness. Prevention efforts focus on reducing risk and building resilience through parenting classes, NCTI Crossroads© workshops, art and computer programs, job readiness support, and basic needs assistance—all designed to strengthen relationships, foster engagement, and promote healthy lifestyles.

Outreach services educate community partners, such as families, service providers, law enforcement, and schools, on early signs of mental illness through events like film screenings and expert Q&A sessions.

Early Intervention focuses on recovery through individual, family, and group counseling, as well as relapse prevention. The accompanying tables show projected vs. actual participation.

In FY 2024/25, the number of potential responders reached rose sharply, in part due to provider involvement in large-scale community events.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	32,090	36,383	43,992	42,694
Number of Services	51,011	47,207	35,971	25,784

Potential Responders Reached

	FY 22/23	FY 23/24	FY 24/25
Number of Potential Responders Reached	16,927	8,795	20,600

Family Resource Center (FRC), cont.

State Program Positive Results, cont.

Access & Linkage to Services

FRCs offer access to and connections with services for participants requiring treatment beyond early intervention. Those needing more intensive care are referred to appropriate service providers that can address their needs. Many FRCs facilitate “warm hand-offs” to higher-level providers by making advance calls or providing in-person introductions, ensuring participants can easily connect with their referral partners.

During FY 2023/24, FRCs saw a notable rise in referrals, a trend that continued into FY 2024/25. This increase is tied to the growing demand for mental health services beyond basic care, along with expanded provider outreach within the community. The table below shows the number of participants who received access and linkage referrals in the past three fiscal years.

Access and Linkage to Services Referrals			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals Provided	46	162	774
Number of referrals to County-funded / administered programs	8	117	91
Number of referrals to other programs	38	45	683
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	18	66	65

Family Resource Center (FRC), cont.

State Program Positive Results, cont.

Improving Timely Access

FRCs help improve timely access to mental health care for historically underserved populations by providing referrals to prevention, early intervention, or higher-level services as needed. These populations may face risks like homelessness or incarceration, and often experience barriers such as limited language access, lack of culturally competent care, and poor outreach. FRCs actively identify and engage individuals, connecting them to services in a culturally responsive way.

In FY 2022/23, an FRC service provider introduced an alternative method for collecting referral data, which significantly contributed to a rise in referrals aimed at improving timely access to services. Continued use of this method in FY 2023/24 led to more accurate reporting and further increases in referrals. In FY 2024/25, a sharp increase in referrals was linked to providers' expanded presence at community events.

Improving Timely Access Referrals			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals Provided	1,318	1,635	2,008

Family Resource Center (FRC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	21%	7%	35%	3%	95%
FY 23/24	17%	8%	27%	7%	41%
FY 24/25	18%	4%	25%	5%	48%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	2%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	2%
FY 23/24	3%
FY 24/25	2%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	17%	31%	<1%	52%
FY 23/24	18%	33%	<1%	49%
FY 24/25	22%	11%	<1%	66%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	65%	18%	<1%	17%
FY 23/24	68%	11%	<1%	28%
FY 24/25	63%	11%	<1%	20%

Family Resource Center (FRC), cont.

Demographics, cont.

Demographic Observations

The FRC program has consistently served the targeted demographics over the last three fiscal years.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	7%	6%	13%
American Indian/Alaska Native	2%	1%	5%
Asian	2%	1%	<1%
Latinx/Hispanic	31%	28%	26%
Native Hawaiian or Pacific Islander	<1%	<1%	<1%
Caucasian/White	3%	21%	17%
More than One Race	19%	4%	2%
Other Race	54%	40%	42%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	3%	2%	2%
Asian Indian/South Asian	1%	<1%	<1%
Cambodian	0%	<1%	0%
Chinese	<1%	<1%	<1%
Eastern European	<1%	<1%	<1%
European	10%	9%	14%
Latinx/Hispanic	31%	10%	20%
Filipino	<1%	<1%	<1%
Japanese	<1%	<1%	<1%
Korean	<1%	<1%	<1%
Middle Eastern	<1%	<1%	<1%
Vietnamese	<1%	<1%	<1%
Other	81%	67%	60%
More than one ethnicity	4%	2%	3%

Family Resource Center (FRC), cont.

Program Goals

The goal of the FRC program is to alleviate prolonged suffering from untreated mental illness. Prevention efforts focus on identifying risk factors, lowering indicators, and enhancing protective factors to improve mental, emotional, and relational functioning. Early intervention provides counseling and treatment that reduces symptoms and supports recovery. Additional objectives include reducing stigma around mental illness and enhancing access to services by connecting participants with severe mental health needs to necessary care, particularly for historically underserved populations.

Method used to collect outcome	Description of method	Frequency of use	Number completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision-making, including level of care and service planning.	Intake, 3 months, Discharge, Significant life events	FY 22/23: 312 FY 23/24: 348 FY 24/25: 321
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met.	Intake, 3 months, Discharge, Significant life events	FY 22/23: 237 FY 23/24: 241 FY 24/25: 134
NCTI Crossroads ©	A complete behavioral change system delivered in a group format, following a precise sequence that leads participants from a general level of discussion to a specific behavioral commitment.	2 times Initial & completion	FY 22/23: n/a* FY 23/24: 102 FY 24/25: 92
Life Skills Progression (LSP)	Assesses the strengths and needs of families participating in the Family Support Program. The LSP measures 35 parental skills in areas such as relationships, resources, medical health, mental health, and basic essentials.	2 times Initial & completion	FY 22/23: 193 FY 23/24: 228 FY 24/25: 228

*No data is available for FY 2022/23 due to licensing issues.

Family Resource Center (FRC), cont.

Outcome Discussion

Early Intervention activities such as individual and family counseling offer therapeutic services such as cognitive behavioral therapy and solution-focused therapy. Outcomes are measured using the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) Assessments and Adult Needs and Strengths Assessments – San Bernardino County (ANSA-SB).

Child and Adolescent Needs and Strengths Assessment (CANS)

The Child and Adolescent Needs and Strengths (CANS) assessment is an evidence-based, multi-purpose tool that helps develop the level of care and service planning and allows for the monitoring of outcomes of services. The table below shows that children and youth participating in FRCs early intervention activities have made improvements in these domains.

Children and youth availing of FRC resources face a variety of challenges. The following tables show some of the most prevalent subdomains and the corresponding rates of improvement. FY 2024/25 showed improvement across all Domains.

Child and Adolescent Needs and Strengths Improvement in Primary Domains			
	FY 22/23	FY 23/24	FY 24/25
Life Functioning Domain	43.1%	44.2%	51.1%
Strengths Domain	79.1%	78.9%	86.0%
Behavioral Health Needs Domain	37.4%	43.9%	49.2%

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Child and Adolescent Needs and Strengths Assessment (CANS), cont.

Child and Adolescent Needs and Strengths Improvement in Subdomains			
	FY 22/23	FY 23/24	FY 24/25
Life Functioning Domain			
Family Functioning	61%	74%	70%
Social Functioning	80%	80%	76%
School Achievement	72%	61%	46%
Strengths Domain			
Family Strengths	59%	50%	59%
Interpersonal	69%	63%	64%
Resiliency	76%	68%	76%
Resourcefulness	61%	64%	65%
Behavioral Health Needs			
Depression	74%	70%	73%
Anxiety	68%	77%	72%
Anger Control	63%	71%	72%
Risk Behaviors			
Suicide Risk	71%	86%	55%
Non-Suicidal, Self-Injurious Behavior	72%	75%	61%

Adult Needs and Strengths Assessment (ANSA)

The ANSA is a multi-purpose tool developed for adult behavioral health services to support decision-making, including the level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA helps care providers decide which of an individual's needs are the most important to address in a treatment plan. The ANSA also helps to identify strengths.

Accurately measuring participant progress relies on completing the ANSA both before and after treatment. In FY 2024/25, a decrease in reported improvement was noted, with providers attributing this to consumers withdrawing from treatment before completion.

Adult Needs and Strengths Improvement in Primary Domains			
	FY 22/23	FY 23/24	FY 24/25
Life Functioning Domain	76.8%	83.4%	65.7%
Strengths Domain	74.2%	80%	53.7%
Behavioral Health Needs Domain	73.2%	79.4%	67.2%

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Adult Needs and Strengths Assessment (ANSA), cont.

Further analysis of the ANSA domains remains consistent in the decrease of improvement for FY 2024/25. Providers are actively looking into ways to enhance participant engagement and increase completion rates to support better outcomes.

Adult Needs and Strengths Improvement in Subdomains

	FY 22/23	FY 23/24	FY 24/25
Life Functioning Domain			
Family Functioning	71%	81%	62%
Social Functioning	77%	85%	78%
Decision-Making/Judgment	89%	90%	83%
Parenting Roles	83%	88%	84%
Strengths Domain			
Family Strengths/Family Support	66%	60%	45%
Community Connection	76%	85%	68%
Natural Supports	73%	78%	56%
Resiliency	79%	84%	86%
Resourcefulness	77%	89%	71%
Behavioral Health Needs Domain			
Depression	84%	91%	84%
Anxiety	80%	86%	75%
Adjustment to Trauma	82%	88%	67%
Eating Disturbances	89%	91%	85%

National Curriculum and Training Institute (NCTI)

Participants engaged in a variety of NCTI courses with topics including anger management, cognitive life skills, substance use and alcohol, and parenting.

The knowledge gained in courses such as cognitive life skills and parenting intends to improve communication and family relationships, which results in increased protective factors.

The knowledge gained in the alcohol and substance use courses intends to reduce use and dependence on substances, resulting in a reduction of risk factors.

NCTI Percent Improvement All Courses

	Average Pre-Test	Average Post-Test	Percent Improvement
FY 22/23	n/a*	n/a*	n/a*
FY 23/24	5.11	19.62	41.46%
FY 24/25	8.8	9.41	52.95%

*No data is available for FY 2022/23 due to licensing issues.

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

LSP surveys collect detailed family information through interviews and observations, measuring growth in key areas such as relationships, resources, medical and mental health, and basic essentials that support mental well-being.

To effectively monitor progress, the LSP must be completed at intake and again at the end of services. The outcomes in the adjacent table show a decline in FY 2024/25 across all measured categories, which providers attribute to consumers not completing the program or the post-service assessment.

To improve outcomes, providers are exploring strategies to boost engagement and completion.

Life Skills Progression Percent Improvement			
	FY 22/23	FY 23/24	FY 24/25
Relationships	13.5%	23%	9%
Resources	18.1%	44%	12%
Medical	8.5%	15%	7%
Mental Health	18%	36%	3%
Basic Essentials	12.8%	14%	8%

Community Wholeness and Enrichment (CWE)

Program Description and Target Population

The CWE program is categorized as a Prevention and Early Intervention program. CWE identifies and helps to manage the early onset of mental health symptoms in transitional age youth (TAY) ages 16-25 and adults ages 26-59 who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder.

The primary goal of the CWE program is to address mental health disorders early in their onset, utilizing the prevention and early intervention services to prevent the onset or reduce the severity of a mental illness. Although prevention and early intervention can be implemented over the lifespan, the benefits are maximized when people are targeted at or around the time of onset of a mental disorder. Utilizing stakeholder feedback and community needs assessments, CWE providers work closely with their communities to understand their needs and ensure they are met. CWE services include screenings, assessments, therapeutic treatment, resources, and education.

TAY, adults, and/or their family members are considered eligible for CWE programs based on risk factors for developing a potentially serious mental illness. CWE providers can evaluate a participant's risk factors using various screenings, including the immediate needs screening tool. The screenings also address experience with mental health, including past services received, to determine the participant's current mental health needs.

Services Offered	• **Screenings/Assessments** • **Case Management, Linkage and Referrals** • **Support Groups (includes suicide bereavement)** • **Mental Health Education** • **Early Intervention Counseling Services**

Program Serves	**TAY (16-25)** **Adults (26-59)**
Location of Services	Central Valley, Desert/Mountain, East Valley, West Valley

Community Wholeness and Enrichment (CWE), cont.

Program Highlights

CWE is a program focused on prevention and early intervention, offering suicide prevention and outreach education. It enhances access to services through assessments and case management, ensuring participants are connected to the appropriate resources. The CWE program seeks continuous solutions, such as telehealth services, to boost the percentage of participants achieving their treatment goals.

The tables below show the number of individuals receiving Prevention and Early Intervention services over the past three fiscal years and the total services provided. CWE faced significant challenges in delivering these services due to immigration raids, which caused hesitation in treatment. Staffing shortages complicated the provision of services.

Number of Participants/Number of Services			
Prevention	**FY 22/23**	**FY 23/24**	**FY 24/25**
Unduplicated Participants	2,091	2,572	2,960
Number of Services	8,306	5,668	2,094

Early Intervention	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	2,429	1,372	1,915
Total Services	853	3,248	3,097

Prevention

Early onset of mental illness can be linked to risk factors such as trauma, stressful life events, and isolation. The CWE program focuses on prevention through supportive groups and offers topics like relapse prevention, depression, anxiety, and suicide bereavement support.

Early Intervention

The CWE program provides early intervention services, including evidence-based treatments, therapies, and relapse prevention services, to promote early recovery and functional outcomes for mental illness. The table on the next page displays the number of episodes opened and closed, as well as the proportion of participants who met their treatment goals for each fiscal year.

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Outreach

The CWE engages new participants and educates potential responders about the signs and symptoms of mental illness, as well as to recognize their symptoms and seek services if needed. These outreach services allow individuals to identify signs and symptoms in their friends, family, and themselves, leading to a greater likelihood of seeking services for behavioral health needs.

The following table illustrates the number of potential responders reached and the types of settings where outreach occurred over the last three fiscal years. The community continues to adjust and show increased engagement, as illustrated in the data for FY 2024/25

Potential Responders Reached

	FY 22/23	FY 23/24	FY 24/25
Potential Responders	1,648	1,033	1,828

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 22/23	430	289	67%
FY 23/24	352	187	42.25%
FY 24/25	313	185	59.11%

Outreach
Types of Responders / Settings

Types of Responders	Settings
• Community service providers • Families • Employers • Primary health care providers • School personnel • Leaders of faith-based organizations • Peer providers • Consumer family members	• Community events • Community-based organizations • Social media outreach • County facilities • Family resource centers • Faith-based organizations • Schools • Virtual platforms

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Access & Linkage

The CWE program is designed for individuals with early-onset behavioral illnesses, as well as those with severe mental illnesses. While the program employs the Access and Linkage to Treatment strategy, CWE providers sometimes need to refer participants to a higher level of care when necessary. Over the past three fiscal years, the CWE program has made several referrals to treatments beyond early-onset conditions. All of these individuals were actively engaged in the program.

Improve Timely Access to Treatment

The CWE program occasionally provides referrals as part of the Improve Timely Access to Services strategy. Over the past three years, CWE providers have made referrals for early intervention or treatment beyond early onset services. Like Access and Linkage, CWE providers make relatively few referrals for Improve Timely Access, as their agencies can deliver these services within their programs.

Improve Timely Access to Services			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals	0	10	7
Participants Engaged	0	10	7
Average # of Days Participant Engaged	0	0	0

Underserved Populations	
• Trauma-exposed	• LGBTQ+
• Co-occurring	• Homeless
• Justice-involved	• African American/Black
• TAY-age foster children	• Latinx/Hispanic
• Military/Veteran	• Pacific Islander

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Suicide Prevention

The CWE program places a strong emphasis on providing support for suicide prevention. Its primary goal is to deliver services aimed at reducing the incidence of suicide within the community. The program actively distributes information to raise awareness about the signs and symptoms that may indicate someone is at risk for suicide.

The CWE program organizes a variety of educational opportunities focused on suicide prevention. One of the key components includes offering gatekeeper training programs such as Applied Suicide Intervention Skills Training (ASIST), Safe TALK, and Question, Persuade, Refer (QPR). These trainings are designed to enhance the community's ability to respond to suicide-related crises effectively.

The program tailors training sessions to meet the specific needs of diverse communities. Organizations are encouraged to contact the program to request specialized training sessions. Over the past three fiscal years, a total of 1,735 individuals have received training in suicide prevention through the CWE program. This demonstrates the program's commitment to equipping the community with essential skills and knowledge in this crucial area.

Suicide Prevention Training			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	304	345	1,086

Community Wholeness and Enrichment (CWE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	<1%	14%	40%	<1%	45%
FY 23/24	<1%	16%	55%	<1%	27%
FY 24/25	<1%	7%	32%	<1%	59%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Disability
	% of consumers who identified a physi1.35cal disability
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	10%	23%	1%	66%
FY 23/24	17%	38%	4%	41%
FY 24/25	16%	32%	<1%	52%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	76%	15%	0%	9%
FY 23/24	68%	29%	0%	3%
FY 24/25	82%	6%	<1%	12%

Community Wholeness and Enrichment (CWE), cont.

Demographics, cont.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	2%	5%	4%
America Indian/Alaska Native	<1%	<1%	0%
Asian	<1%	<1%	4%
Native Hawaiian/Pacific Islander	<1%	<1%	<1%
Latinx/Hispanic	15%	42%	19%
Caucasian/White	12%	14%	17%
More than One Race	2%	7%	3%
Other	3%	11%	1%
Declined to Answer	65%	36%	56%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	<1%	3%	<1%
Asian Indian/South Asian	0%	<1%	<1%
Cambodian	0%	0%	0%
Chinese	0%	<1%	<1%
Eastern European	<1%	<1%	<1%
European	10%	14%	13%
Latinx/Hispanic	15%	42%	12%
Filipino	<1%	<1%	0%
Japanese	0%	0%	0%
Korean	0%	0%	<1%
Middle Eastern	0%	<1%	<1%
Vietnamese	0%	<1%	<1%
Other	3%	11%	55%
More than One Ethnicity	7%	7%	2%
Declined to Answer	79%	36%	17%

Community Wholeness and Enrichment (CWE), cont.

Program Outcomes

Program Goals

The primary objective of the CWE program is to address mental health disorders early on in their development by utilizing prevention and early intervention services to avert or lessen the severity of mental disorders.

Prevention and Early intervention throughout a person's lifetime can yield the greatest benefits, particularly when young people are at or near the onset of mental health disorders. To identify and help manage early mental health symptoms, the CWE program uses collaborative approaches and short-term interventions.

The CWE program services reduce and prevent crises by providing support early in the emergence of a mental health concern.

They also provide support and education to the families. These services include information on how to support a family member who is experiencing a mental health crisis.

Respite care is an important element of this program. Family members are provided with information on identifying the signs and symptoms of a potential mental health concern. They have access to services that can help reduce the stressors associated with caring for a loved one suffering from mental disorders.

Method used to collect outcome	Description of method	Frequency of use	Number completed
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors is used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making, level of care and service planning, and ensuring projected goals are being met.	• Intake • 3 months • Discharge • Significant life events	FY 22/23: 244 FY 23/24: 171 FY 24/25: 173

Community Wholeness and Enrichment (CWE), cont.

Outcome Discussion

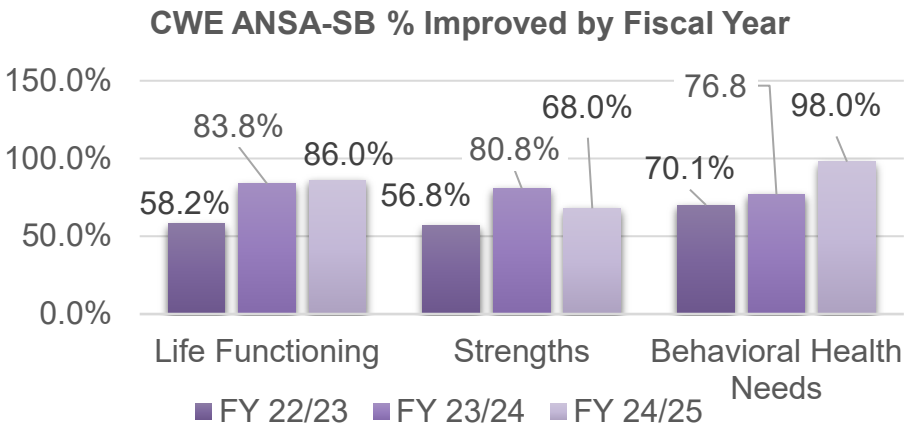
The CWE program uses the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) to measure the outcomes of early intervention treatments.

ANSA-SB is an information integration tool for adults with behavioral health challenges. It supports individual case planning and the evaluation and development of service systems. The ANSA-SB assessment involves rating each dimension on a four-point scale. This assessment is conducted upon intake and at three-month intervals until discharge.

The ANSA-SB measures the readiness of early intervention participants to engage in services. CWE focuses on three primary domains:

- The Life Functioning domain evaluates factors like an individual's family relationships, social functioning, decision-making, self-care, and knowledge of illness.
- The Strengths domain evaluates family support, optimism, interpersonal and social connectedness, relationship permanence, vocational skills, and resilience.
- Behavioral Health Needs, which evaluates factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma, and substance use.

Fiscal Year 2024/25 demonstrates remarkable advancements in Life Functioning. Behavioral health needs saw the most improvement between the fiscal years 2023/24 and 2024/25, while Strengths experienced the largest improvement in FY 2023/24. This data will be used to enhance future programming.



Community Wholeness and Enrichment (CWE), cont.

Outcome Discussion, cont.

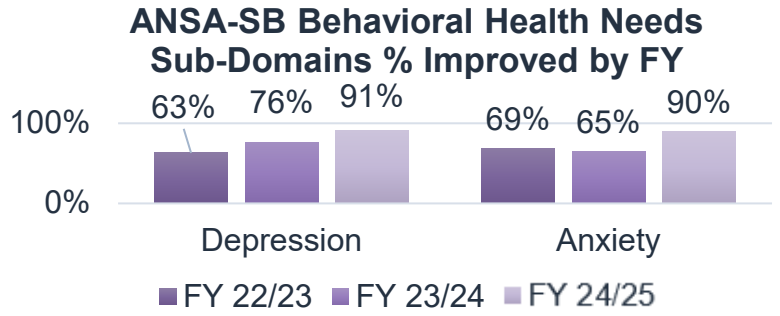
Each domain contains sub-domains that measure:

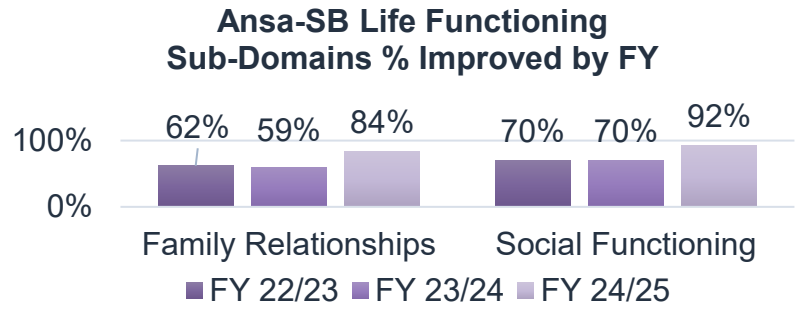
- Depression,
- Anxiety,
- Family Relationships,
- Social Functioning,
- Interpersonal/Social Connectedness, and
- Resilience.

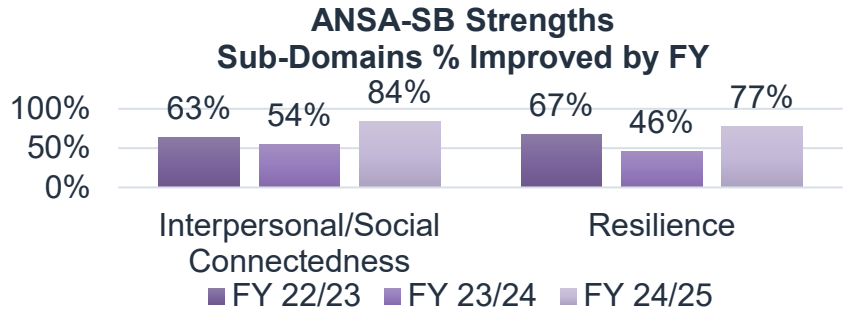
Overall, the data indicated variable improvements across fiscal years, with notable progress in addressing Depression and Anxiety in FY 2024/25.

The data indicated that there was an initial decline in improvement for both sub-domains; however, Social Functioning improved in FY 2024/25, while Family Relationships continued to show progress.

Additionally, the data revealed a trend of improvement in both Interpersonal/Social Connectedness and Resilience, with a particularly notable increase in Resilience in FY 2024/25.







Military Services and Family Support (MSFS)

Program Description and Target Population

The Military Services and Family Support (MSFS) program is a Prevention and Early Intervention program that targets active-duty military service members of all branches, veterans, and retired military personnel and their families.

This program addresses the challenges military members and their families face due to circumstances unique to military life. Due to the stigma of mental health discussion in the military community, it can be difficult for those experiencing a mental health concern to seek help as they fear retaliation, loss of job/status, or embarrassment.

Through mental health promotion activities and building relationships with the military communities, the MSFS program can offer and assure confidential services. Services are offered in any setting that makes the individual comfortable, including the individual's homes or nearby public places.

Utilizing stakeholder feedback and community needs assessments, MSFS providers work closely with their communities to understand their needs and ensure they are met.

MSFS services include screenings and assessments, therapeutic treatment, resources and education.

Services Offered	• Mental Health Education • Mental Health/Substance Use Disorder screenings • Case Management and Referrals • Psychoeducation • Counseling Services • Suicide Prevention

Program Serves	**Children** **TAY (16-25)** **Adults** **Older Adults (60+)**
Location of Services	Central Valley, Desert/Mountain, East Valley

Military Services and Family Support (MSFS), cont.

State Program Positive Results

The MSFS program is classified as a Prevention and Early Intervention initiative. In addition to providing prevention and early intervention services, the program also offers outreach education and suicide prevention. MSFS employs the Access and Linkage, as well as Improve Timely Access strategies, to ensure individuals are connected with the appropriate services to meet their needs.

In FY 2024/25, the number of services provided declined in comparison to previous fiscal years due to ongoing challenges faced by providers, including staffing transitions and vacancies in critical positions such as licensed clinicians, which created a gap in services provided.

Number of Individuals / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	3,605	3,480	3,917	2,238
Number of Services	6,990	7,118	7,701	653

Prevention

The risk factors associated with military service include experience of trauma, isolation, moral injury, substance use, and stress.

To combat these risk factors, prevention services seek to build protective factors in individuals, including supportive care, inclusion, and services relevant to military experience.

The following table illustrates the number of prevention participants and the number of services received by fiscal year. The program depends on local military bases for access to service members and military families. The program continues to build rapport with new military base leadership.

Prevention Individuals / Services			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Individuals	414	400	1,908
Number of Services	1,344	1,350	1,720

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

Outreach

The MSFS program provides engaging outreach services that educate and train potential responders to recognize and respond to early signs of potentially severe and disabling mental illness.

Providing outreach services to this at-risk group helps responders recognize signs in themselves and others. Recent leadership transitions at military installations have limited access to service areas, reducing opportunities for outreach. MSFS providers continue to find ways to collaborate with all community and military partners. The table below shows the number of potential responders reached.

Potential Responders Reached			
	FY 22/23	FY 23/24	FY 24/25
Potential Responders	2,533	2,869	1,741

The following table summarizes the responder types and the settings where they were engaged.

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Community service providers • Military Personnel or Veterans • Peer Providers • School Personnel • Employers • Families • Law Enforcement Personnel • Cultural Brokers	• Community Events • Community-Based Organizations • Faith-Based Organization • Schools • Recreation Center • Virtual Platforms

Early Intervention

Early intervention services, treatments, and interventions are aimed at addressing and promoting recovery and related functional outcomes for a mental illness early in its emergence. Services are provided to individuals identified as experiencing the first onset of a serious mental illness. These treatment services include developing a treatment plan with goals that are meaningful to the individual.

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

Early Intervention, cont.

The table below illustrates the total number of early intervention episodes opened in each fiscal year, the number of episodes closed in the fiscal year, and the percentage of individuals who met their treatment goals. FY 2022/23 saw a decrease in overall episodes and the percentage of individuals who met their goals.

The decrease is attributed to many individuals not completing their early intervention treatment plan. Changes in the leadership at the military base limited access to military families engaged in services. There has been progress in reestablishing those relationships to gain access.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 22/23	88	51	18%
FY 23/24	42	40	65%
FY 24/25	38	*	*

*No data available for FY 2024/25.

Access & Linkage to Treatment

Access and Linkage to Treatment services are integrated into the MSFS program to connect individuals and/or their family members with severe mental health concerns to care and treatment that will meet their needs as early as possible in the onset of these conditions.

The table below illustrates the number of referrals made to a higher level of care each fiscal year. It also includes those referred to a County or non-county funded entity and those that were referred and engaged in treatment. MSFS providers can provide referrals to County-funded programs and occasionally to a non-county funded provider, such as a private physician.

Access and Linkage to Services Referrals

	FY 22/23	FY 23/24	FY 24/25
Number of Referrals	21	30	30
County-Funded	7	14	2
Non-County Funded	8	11	28
Individuals Engaged	15	30	30

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

Improve Timely Access to Treatment

The Improve Timely Access to Treatment strategy focuses on providing appropriate services based on accessibility, cultural and language appropriateness, transportation, family focus, available hours, and cost of services to increase access to appropriate mental health services for underserved populations.

The MSFS program services are available in whatever setting is most comfortable to an individual, whether it is virtual, in a clinical setting, or in-home. The Improve Timely Access to Services strategy aims to refer individuals of underserved populations to prevention, early intervention, or higher level of care services.

The program aims to serve underserved populations which include active military troops, recently retired military/veterans, and their families. The adjacent table provides a sample of the underserved populations serviced this past fiscal year.

Over the last three fiscal years, individuals were engaged within an average of eight days from the date of referral. The Improve Timely Access to Services table illustrates the number of individuals who were given a referral to a prevention, early intervention, or higher level of care service, the number of those referred who engaged in services, and the average number of days from date of referral to date involved in services. This displays the ability of the MSFS program to provide linkage and referrals in a timely manner to individuals with needed services as soon as possible.

Improve Timely Access to Services			
	FY 22/23	FY 23/24	FY 24/25
Number of Referrals	96	53	154
Individuals Engaged	19	4	53
Average # of Days Individual Engaged	6.89	8.7	*

*Indicates no data available.

Underserved Populations	
• Trauma-exposed	• African American
• Co-occurring	• Military/Veterans
• At risk children and youth	• Pacific Islander
• Latinx/Hispanic	• Individuals experiencing onset of serious psychiatric illness
• LGBTQ+	

Military Services and Family Support (MSFS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 22/23	12%	8%	35%	6%	39%
FY 23/24	18%	12%	45%	14%	11%
FY 24/25	12%	11%	54%	11%	3%

Fiscal Year	Veteran Status
	% of Individuals who identified as a veteran
FY 22/23	13%
FY 23/24	14%
FY 24/25	21%

Fiscal Year	Sexual Orientation
	% of Individuals who identified as LGBTQ+
FY 22/23	2%
FY 23/24	1%
FY 24/25	11%

Fiscal Year	Disability
	% of Individuals who identified a physical disability
FY 22/23	0%
FY 23/24	0%
FY 24/25	10%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	30%	46%	<1%	24%
FY 23/24	36%	54%	<1%	10%
FY 24/25	30%	49%	<1%	20%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	98%	<1%	0%	2%
FY 23/24	98%	1%	<1%	0%
FY 24/25	89%	<1%	<1%	0%

Military Services and Family Support (MSFS), cont.

Demographics, cont.

Demographic Observations

- The MSFS program is successful in serving children, TAY, and adults at 12%, 11%, and 54%, respectively. This aligns with the program's goal of serving those with military service.
- The program increased service to veterans over the past year.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	11%	13%	13%
American Indian/Alaska Native	1%	<1%	1%
Asian	1%	2%	2%
Native Hawaiian or Pacific Islander	2%	1%	2%
Caucasian/White	6%	43%	46%
More than One Race	31%	6%	6%
Other Race	39%	19%	20%

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	2%	4%	5%
Asian Indian/South Asian	4%	1%	<1%
Cambodian	0%	1%	0%
Chinese	0%	3%	<1%
Eastern European	<1%	<1%	<1%
European	3%	3%	<1%
Latinx/Hispanic	10%	3%	<1%
Filipino	<1%	4%	<1%
Japanese	<1%	2%	0%
Korean	0%	2%	0%
Middle Eastern	<1%	6%	<1%
Vietnamese	0%	2%	0%
Other	73%	60%	24%
More than one ethnicity	17%	8%	36%

Military Services and Family Support (MSFS), cont.

Program Goals

Increase early access and linkage to medically necessary care and treatment:

- Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment, including, but not limited to, care provided by County mental health programs.

Improve timely access to services for underserved populations:

- Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Reduce risk factors.
- Increased protective factors that may lead to improved mental, emotional, and relational functioning.
- Reduced symptoms.
- Improved recovery, including emotional and relational functioning.

Reduce stigma and discrimination associated with mental illness:

- Reduced negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
- Increased acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Military Services and Family Support (MSFS), cont.

Program Outcomes

Method used to collect outcome	Description of method	Frequency of use	Number completed
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met.	Intake, 3 months, Discharge, Significant life events	FY 22/23: 36 FY 23/24: 27 FY 24/25: 41
PTSD Checklist for Active and Veteran Military (PCL-M)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met.	Every three months for duration of treatment	FY 22/23: 7 FY 23/24: 5 FY 24/25: 25

Outcome Discussion

The Adult Needs and Strengths Assessment - San Bernardino County (ANSA-SB) is a comprehensive assessment of psychological and social aspects used for treatment planning by MSFS early intervention providers. This assessment evaluates functioning in various essential life areas and aids in decision-making, level of care and service planning, and ensuring that planned goals are realized. Based on the individual's response, he/she receives a rating from 0 to 3, with 0 revealing there is no evidence of needs and 3 requiring immediate and/or intensive action.

The Life Functioning Domain focuses on the different areas of social interaction in an individual's life. This can include how they function individually, within family, peer, school, and community realms.

The Strengths Domain refers to the individual assets an individual can use to advance healthy development. Identifying areas where strengths can be built is a significant element of service planning.

Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

The Behavioral Health Needs Domain identifies the behavioral health needs of an individual.

The table below illustrates the percentage of individual improvement within the Life Functioning, Strengths, and Behavioral Health Needs domains.

Domain improvement leads to improved recovery including emotional and relational functioning. These improvements reduce the prolonged suffering related to an untreated mental health concern.

FY 2024/25 showed an increase in the Life Functioning domain, while decreases were observed in both the Strengths and Behavioral Health Needs domains. It is important to note that a gap in services has contributed to changes in assessment, monitoring, and effectiveness. As such, the percentages presented may not accurately reflect a decline in improvement.

	MSFS ANSA % Improved by FY	FY 22/23	FY 23/24	FY 24/25
Domains	Life Functioning	44.8%	66.7%	80%
	Strengths	34.5%	76.2%	60%
	Behavioral Health Needs	41.4%	76.2%	60%

Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

Each domain includes sub-domains that help to evaluate the individual's readiness to participate in early intervention services.

In the domain of Life Functioning, the sub-domain of Family Relationships evaluates and rates the individual's relationships with their family members: spouse/partner, children, and other family members. The sub-domain of Social Functioning rates social skills and relationships for an individual.

In the Strengths domain, the Interpersonal/Social Connectedness sub-domain measures an individual's social and relationship well being. The Resilience domain measures an individual's ability to recognize their internal strengths and use them to manage their daily life.

The percentages reported for the sub-domains in FY 2024/25 may appear inconsistent when compared to previous years due to a gap in therapeutic services. Providers also noted that many participants either did not complete the full course of therapy or did not complete the post-assessment following treatment.

	ANSA Life Functioning Sub-Domains % Improved by FY	FY 22/23	FY 23/24	FY 24/25
Domains	Family Relationships	44.8%	66.7%	50%
	Social Functioning	34.5%	76.2%	100%

	ANSA Strengths Sub-Domains % Improved by FY	FY 22/23	FY 23/24	FY 24/25
Domains	Interpersonal/ Social Connectedness	17%	67%	50%
	Resilience	56%	82%	50%

Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

The Behavioral Health Needs sub-domain of Adjustment To Trauma is used to help the individual define their difficulties related to a traumatic experience. Improvement in an identified need reflects that an individual has reduced a debilitating level of trauma symptoms. The Anxiety sub-domain measures improvement in an individual's anxiety symptoms such as excessive fear and anxiety related to behavioral disturbances. Improvement in the Depression sub-domain may indicate a decrease in symptoms such as an irritable or depressed mood, social withdrawal, and sleep disturbances.

The adjacent table illustrates the comparison of individual pre and post scores on the Post-Traumatic Stress Disorder (PTSD) Checklist for Active and Veteran Military members (PCL-M). The PCL-M uses 17 questions to assess the degree to which individuals experience symptoms of PTSD, such as trouble falling or staying asleep, being "hyper alert" or watchful and on guard, or feeling jumpy and/or easily startled. Higher scores indicate a greater intensity of PTSD symptoms.

	ANSA Behavioral Health Needs Sub-Domains % Improved by FY	FY 22/23	FY 23/24	FY 24/25
Domains	Adjustment to Trauma	47%	80%	0%
	Anxiety	50%	50%	0%
	Depression	50%	91%	50%

	PTSD Average Scores Pre and Post by FY	FY 22/23	FY 23/24	FY 24/25
Domains	Pre	63	65	*
	Post	46	52	*

*No data is available for FY 2024/25.

Student Assistance Program (SAP)

Program Description and Target Population

The Student Assistance Program (SAP) employs a school-based approach to provide targeted services to students in kindergarten through 12th grade who require interventions for substance abuse, mental health, academic, emotional, and/or social issues. SAP links education, programs, and services within and across school and community systems to form a support network for students.

SAP's target population consists of K-12 students and their families who have the following characteristics: trauma exposure, the onset of serious psychiatric illness for the first time, families in distress, at risk of dropping out of school, and/or becoming involved with the juvenile justice system.

The SAP program prioritizes schools and school districts with high rates of students from underserved ethnic/cultural groups, poverty, low academic achievement, suspension, expulsion, dropouts, children/youth in foster care, at risk of juvenile justice involvement, and/or community violence.

Services are not intended for those who have previously been diagnosed with a mental health condition, as well as students whose needs have been identified and should be met as part of an Individual Education Plan (IEP).

Services Offered	• **Mental Health and Substance Use Screenings and Assessments** • **Mental Health Educational Presentations** • **Critical Incident Stress Debriefing** • **Individual and Group Counseling** • **Alcohol and Drug Education and Intervention**

Program Serves	**Children, Youth, TAY (16-25)**
Location of Services	School Campuses, Mental Health Clinics, In-home

Student Assistance Program (SAP), cont.

Program Highlights

SAP uses a school-based approach to provide focused services to students needing interventions for substance use, mental health, academic, emotional, and/or social issues. It is a process that connects students to a network of supports. SAP identifies students in need and links them to services that can fully assess their needs. Once assessed, students are connected with the appropriate level of services and ongoing support.

The SAP falls into the State Prevention and Early Intervention Program reporting structure. The program includes both prevention and early intervention activities to provide students with a comprehensive system of care.

Prevention

SAP prevention activities offer education, outreach, and support to help students and school staff understand mental wellness.

Prevention activities are readily available to all students and staff. Referrals can be made to additional services such as screening and assessments. These referrals can be made by school counselors, teachers, and/or parents.

SAP delivers presentations at school assemblies and offers after-school group activities. They are provided with useful information on the signs and symptoms of mental illness as well as substance use disorders.

The following includes some of the topics that are presented by the SAP program:

- Substance Use Education and Interventions,
- Conflict Resolution,
- Self-Control/Anger Management,
- Healthy Dating and Relationships,
- Psychoeducational/Social Skill Building,
- Grief Processing/Critical Incident Debriefing, and
- Suicide Prevention.

Number of Participants / Number of Services			
	Actual		
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	50,221*	56,608	47,517
Number of Services	67,095*	58,432	44,893

*FY 2022/23: reported numbers were incorrect; actual numbers have been updated.

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Early Intervention

The program's core component consists of professionally trained teams. These teams are comprised of school personnel and staff from community behavioral health agencies.

SAP team members are trained to identify potential learning barriers and make recommendations that will benefit both the student and their families. They work collaboratively to meet the needs of the student most effectively and practically.

The SAP team plans and implements services to improve students' well-being. They include ongoing support to ensure the students are successful in their treatment program.

When a student's needs exceed the scope of the program, the SAP team connects the student and their families to additional community resources and services, including referrals to a higher level of care.

The following table includes data on the number of children and youth served by early intervention services.

Early Intervention Participants / Services			
	FY 22/23	FY 23/24	FY 24/25
Unduplicated Participants	570	905	6,387
Total Services	7,958	12,384	9,818

SAP early intervention services significantly depend on school site referrals from prevention services. When schools transitioned to distance learning, these prevention services were temporarily suspended. However, with children now returning to traditional learning sites, there has been an increase in the utilization of these services.

The table below presents an overview of consumer successes. Data indicates a slight decline in treatment plans over the past three fiscal years. During the pandemic, many consumers were displaced and moved out of their program service areas, leading to interruptions in their services. Additionally, some consumers lacked the necessary technology or adequate space for a successful transition to telehealth services.

Treatment Success by Fiscal Year			
	FY 22/23	FY 23/24	FY 24/25
Treatment Successful	38%	37%	28%
Treatment Partially Successful	18%	28%	15%
Treatment Not Successful	36%	23%	29%
Missing or Other	7%	12%	9%

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Outreach

The SAP program is intended to minimize barriers to learning, support students in developing academic and personal successes, and shorten the duration of untreated mental illness. To reach potential responders, the SAP program extends information and education in various settings. School staff meetings, community meetings, and schoolwide psychoeducation are used by all providers. The tables to the right show the settings in which Outreach is carried out and the types of potential responders who took part in the education activities.

San Bernardino County Superintendent of Schools, in collaboration with the DBH, host a multi-day Wellness Conference that trains and supports all those who work closely with children and youth. In July 2024, over 900 people attended the conference to learn about positive behavior interventions for the classroom, including identifying behavioral issues and referring to services. Through this partnership, schools also have access to year-round training and support for the implementation of the Positive Behavioral Intervention and Supports (PBIS) model on their school site campuses.

Outreach Settings
• Schools • Community Events • Health Fairs • Family Resource Center • Community Based Organization Facility • Faith-Based Organizations • Southern Region Student Wellness Conference • Behavioral Health Clinics • Student Attendance Review Board Meetings • Shelters

Types of Potential Responders
• Families • Parents • Community Members • School Officials/Staff • Community Service Providers • Law Enforcement • Peer Providers • Student Attendance Review Boards • Mediators • Prevention/Treatment Professionals • Social Service Providers

Student Assistance Program (SAP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 22/23	55%	17%	14%	<1%	13%
FY 23/24	29%	10%	6%	<1%	55%
FY 24/25	26%	10%	13%	2%	50%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 22/23	<1%
FY 23/24	2%
FY 24/25	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 22/23	<1%
FY 23/24	<1%
FY 24/25	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 22/23	5%	12%	0%	83%
FY 23/24	15%	22%	0%	63%
FY 24/25	20%	22%	0%	68%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 22/23	71%	5%	<1%	24%
FY 23/24	34%	2%	<1%	63%
FY 24/25	48%	4%	<1%	49%

Student Assistance Program (SAP), cont.

Demographics, cont.

Demographic Observations

- The SAP program has consistently served the targeted demographics over the last three fiscal years. Children and Youth are the significant participants.
- The SAP program serves high numbers of adults with the annual Wellness Conference.
- Family support services also contribute to the number of adults served by the SAP program.
- There has been a significant increase in participants declining to answer demographic questions partly due to the age of participants and some thinking the questions are inappropriate to ask.
- The ethnic and racial participation is consistent with the demographics of the general population of San Bernardino County.

Race	FY 22/23	FY 23/24	FY 24/25
African American/Black	9%	5%	11%
American Indian/Alaska Native	0%	<1%	<1%
Asian	4%	2%	2%
Native Hawaiian/Pacific Islander	1%	<1%	<1%
Caucasian/White	19%	7%	9%
Latinx/Hispanic	27%	16%	20%
More than One Race	5%	2%	4%
Other Race	<1%	<1%	3%
Decline to Answer	34%	66%	90%

Student Assistance Program (SAP), cont.

Demographics, cont.

Ethnicity	FY 22/23	FY 23/24	FY 24/25
African	<1%	1%	1%
Asian Indian/South Asian	0%	0%	<1%
Cambodian	0%	0%	0%
Chinese	0%	0%	0%
Eastern European	0%	0%	<1%
European	1%	1%	<1%
Latinx/Hispanic	4%	3%	1%
Filipino	0%	0%	<1%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	0%	0%	<1%
Vietnamese	0%	0%	<1%
Other	5%	3%	3%
More than One Ethnicity	3%	1%	<1%
Declined to answer	87%	91%	90%

Student Assistance Program (SAP), cont.

Program Outcomes

The State program is designed to reduce the impact of untreated mental illness by addressing risk factors and enhancing protective factors. The Early Intervention goal aims to alleviate symptoms and improve recovery outcomes. The SAP program contributes to these objectives by minimizing learning obstacles, promoting academic and emotional success, and reducing the duration of untreated mental illness. The effectiveness of the SAP program is assessed using specific measurement tools as detailed in the accompanying table. Challenges related to staff retention have impeded the timely updating of data.

Method used to collect outcome	Description of method	Frequency of use	Number completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision-making, including level of care and service planning.	Intake, 6 months, Discharge, Significant life events	FY 22/23: 465 FY 23/24: 595 FY 24/25: 516
Pediatric Symptom Checklist (PSC 35)	PSC is a 35-item parent-completed questionnaire that assesses a broad range of emotional and behavioral problems in children. It is used as a screen for psychosocial problems in pediatric well-child visits, school enrollment, and entry into other systems of care for children from 4 to 18 years of age. With repeat administrations, it is also used to assess changes in functioning over time.	Initial, 6 months, Discharge	FY 22/23: 737 FY 23/24: 466 FY 24/25: 555
Measurement Outcomes and Quality Assessment (MOQA_SP/SDR)	The MOQA surveys are used to gather information regarding the stigma associated with mental health needs. Forms of MOQA used are Stigma and Discrimination Reduction (SDR), Suicide Prevention (SP), and Outreach.	Completion of SDR, SP, or Outreach activity	FY 22/23: 229 FY 23/24: 66 FY 24/25: *
Client Satisfaction Survey	Client satisfaction surveys are used to determine whether the participants are gaining useful and valuable information from the program and to determine whether the participants are engaging in the program in a way that is satisfying and enjoyable.	Completion of services	FY 22/23: 162 FY 23/24: 188 FY 24/25: *

*Reflects difficulty in collecting data.

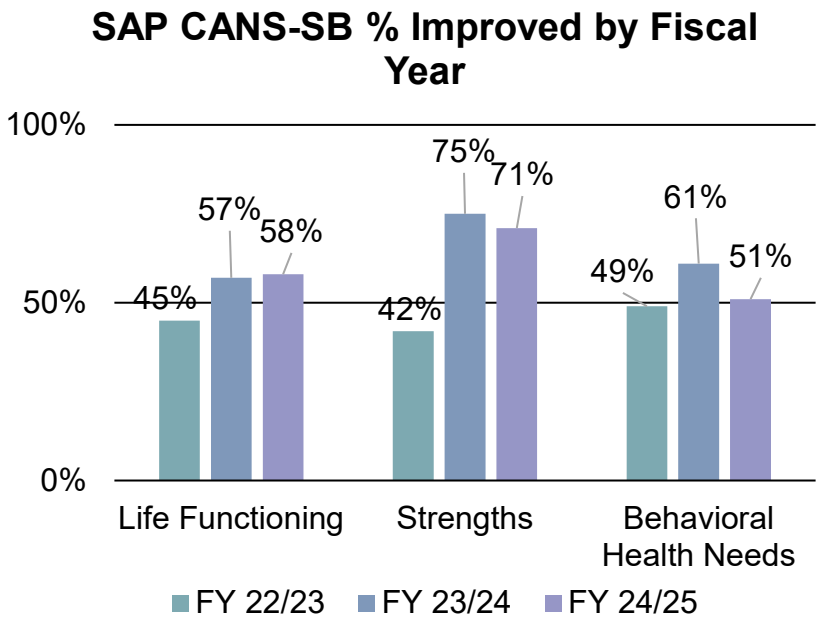
Student Assistance Program (SAP), cont.

Outcome Discussion

The SAP program uses the Children and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to measure outcomes of the early intervention treatments, as well as to develop treatment plans and goals. Within the first 30 days of receiving assistance, children and TAY receive the initial CANS-SB assessment. Every three to six months, follow-up assessments are conducted, and a final assessment is completed at the conclusion of services. The CANS-SB includes three primary domains used to evaluate early intervention needs. The domains utilized by the SAP program include:

- Life Functioning addresses various areas of social interaction present in the lives of children, teenagers, and their families. This domain assesses their performance in the areas of self, family, peers, school, and community.
- The Strengths domain describes the assets of the child/youth that can be used to advance healthy development. Addressing a child's strengths while also addressing their behavioral/emotional needs leads to better functioning and better outcomes.
- The Behavioral/Emotional Needs domain identifies the behavioral health needs of the child.

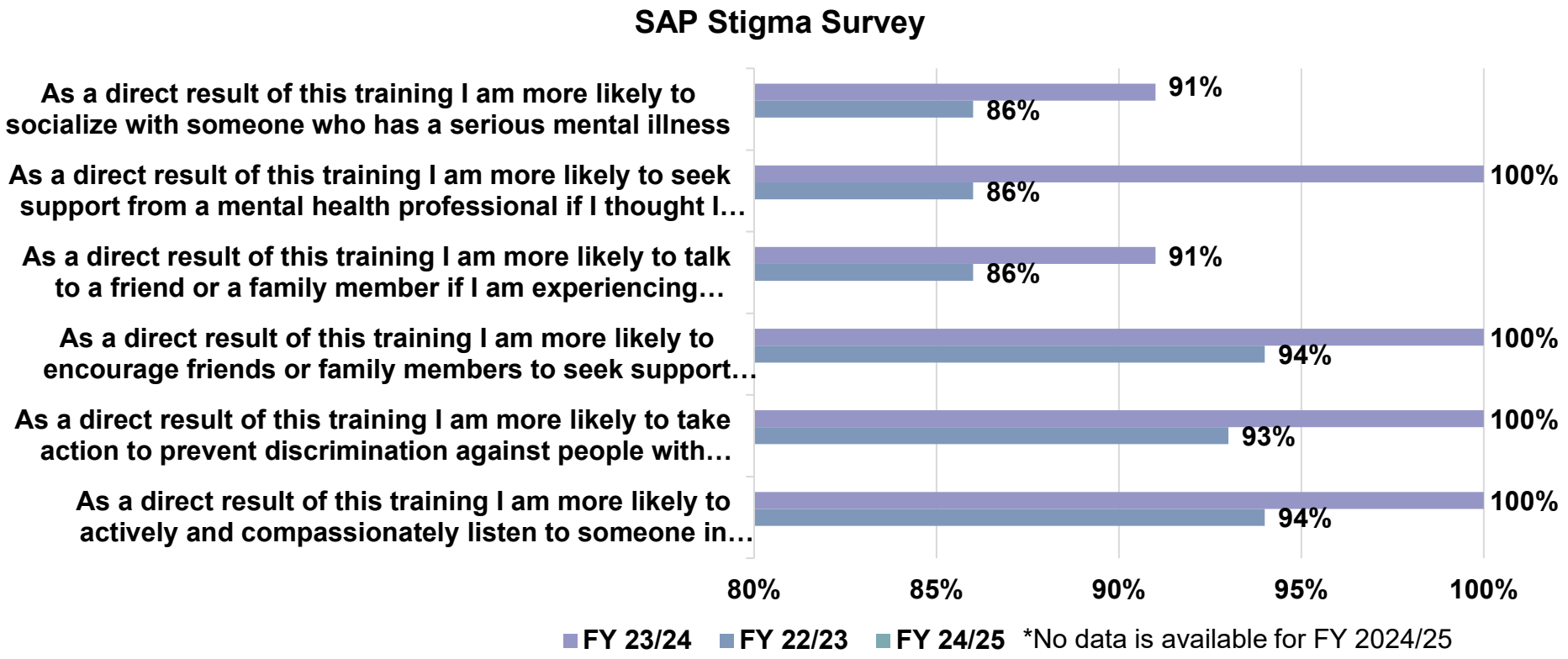
The following graph illustrates the overall improvement in the elements of Life Functioning, Strengths, and Behavioral/Emotional Needs among participants in the SAP program.



Student Assistance Program (SAP), cont.

SAP Stigma Surveys

Stigma surveys assess the impact of prevention efforts and curricula on youth's knowledge, attitudes, and behaviors regarding behavioral health. These surveys are conducted after activities aimed at reducing negative perceptions and discrimination against mental illness and promoting acceptance and inclusion for individuals with mental health challenges and their families. Staff retention issues have hindered data updates.



Improving Detection and Early Access (IDEA)

Program Description and Target Population

Psychosis is a serious mental health condition in which thought and emotion are so disrupted that one loses contact with external reality. Early warning signs and symptoms, which can last from a few days to several weeks or years, typically predict the start of a serious and long-lasting mental condition accompanied by psychotic symptoms. This phase of forewarning is a powerful point at which intervention can help to reduce worsening of mental symptoms, distress, and functional impairment. Individuals at this early stage are at a Clinical High Risk (CHR) of developing a serious illness.

The Improving Detection and Early Access (IDEA) Program supports Transitional Age Youth (ages 16–25) who are at high risk of developing psychosis or experiencing their first episode. Youth as young as 12 may be considered on a case-by-case basis. The program offers early intervention, treatment, and supportive services to help them and their families navigate challenges, build coping skills, and improve communication, to promote wellness and recovery during this important stage of life. The IDEA program aims to serve a total of 26 unduplicated participants annually through the TAY One-Stop Centers.

Services Offered	• **Mental Health and Substance Use Screenings and Assessments** • **Mental Health Educational Presentations** • **Individual and Group Counseling** • **Case Management** • **Family Education and Support** • **Supported Employment and Education**

Program Serves	**TAY (16-25)**
Location of Services	TAY Centers, Mental Health Clinics, Hospitals

Improving Detection and Early Access (IDEA), cont.

Existing Efforts

The Department of Behavioral Health (DBH) continues to offer a continuum of services that includes prevention and early intervention, crisis assistance, and a variety of outpatient and short-term residential treatments that vary in intensity based on the needs of consumers.

Phase I: Needs Assessment

The DBH Outpatient Clinics and DBH Specialty Programs were identified as initial locations to be trained in identifying Clinical High Risk. A training and education outreach strategy was implemented.

Phase II: Program Support Staff Recruitment

The IDEA Program is staffed with a coordinated specialty care team including: a clinic supervisor, clinical therapists, peer and family advocate, mental health specialist, social worker, and support staff.

Phase III: Clinical High-Risk Training and Education

IDEA program staff conducted training and education sessions at DBH Outpatient Clinics and DBH Specialty Programs throughout San Bernardino County.

These sessions focused on recognizing early signs and symptoms of psychosis and provided an overview of the new referral process to connect individuals experiencing their first episode of psychosis to the IDEA program. In the first year, these efforts reached over 270 staff, with additional sessions planned for community partners, schools, and other potential responders during the upcoming year.

Strategies for recruiting new participants:

- The IDEA clinic is located at the One Stop TAY Center in San Bernardino. This location ensures convenience and accessibility.
- Using existing system tools such as CANS/ANSA to identify participants within our own system of care.
- Conduct education and outreach to DBH clinics, DBH Community Crisis Response Team (CCRT), Community-Based Organizations (CBOs), schools, and medical facilities.
- Collaborate with other counties to manage Medi-Cal insurance changes for participants, thereby preventing gaps in service for participants switching from one county partner to another.

Improving Detection and Early Access (IDEA), cont.

IDEA Program Implementation

The IDEA program had a debut year receiving referrals from mental health clinics and community partners throughout the county. The IDEA program provided Coordinated Specialty Care services to a total of four participants.

Program participants this year ranged in ages from 14 to 23. The Coordinated Specialty Care team worked with participants and their families to identify their needs and worked on addressing their particular challenges. Clinical therapists provided individual counseling, while peer and family advocates and other team members provided individual support, family education, educational support services, as well as linkage and referral to needed resources.

Participants showed improvement in their respective CANS and ANSA scores in key areas such as daily functioning, emotional and behavioral needs, behavioral health, and risk factors. They also showed growth in strengths like optimism, community involvement, social connections, job readiness, resourcefulness, resilience, overall well-being, and goal progress.

Office of Suicide Prevention (OSP)

Program Description and Target Population

The Office of Suicide Prevention (OSP) is categorized as a stand-alone Suicide Prevention Program. As legislation evolves and suicide prevention efforts expand across the state, DBH has considered how to meet the changing needs of the communities. Recent community planning supports the need to strengthen the infrastructure surrounding suicide prevention by enhancing our current programming.

Our office has worked closely with Public Relations & Outreach Services (PROS), the Office of Equity and Inclusion (OEI), and the Community Education Program (CEP) to identify community needs, amplify messaging, and expand our reach. These partnerships have enabled us to develop strategies that are culturally responsive, community-informed, and effective in engaging new participants across San Bernardino County. In addition, we have aligned our efforts with the California Department of Public Health's Office of Suicide Prevention, using their Zero Suicide framework as a guiding model. Participation in the Striving for Zero Academy has further shaped our approach, equipping our team with evidence-based strategies to help in the reduction of suicide.

Services Offered	• **Suicide Prevention Outreach and Education** • **Critical Incident Stress Debriefing** • **Countywide Strategic Planning Coordination**

Program Serves	**Children, Youth, TAY, Adults, Older Adults**
Location of Services	Countywide
Unduplicated Participants	2,305

Office of Suicide Prevention (OSP), cont.

State Program Strategies

Prevention

OSP has implemented a range of practices and activities to raise awareness about suicide linked to mental illness. In collaboration with the Department of Behavioral Health (DBH) and the Public Relations and Outreach Services (PROS) team, the agency launched three public campaigns.

- “Promote Hope”
- “Let’s Talk”
- “Never a Bother”

The campaigns emphasize that mental health support is always accessible and that seeking help should never be a burden or inaccessible. These campaigns also enforce how anyone at any age can prevent suicide.

SafeTALK and Applied Suicide Intervention Skills Training (ASIST) are offered countywide to equip community members with the skills to recognize and respond to signs of suicidal ideation. Both of these trainings are Evidence-based. The Zero Suicide Academy is an initiative that aligns with the county’s “Striving for Zero” framework to promote a comprehensive, system-wide approach to suicide prevention.

Outreach

Our outreach efforts are designed to reduce stigma and promote help-seeking behaviors, while partnerships with schools, law enforcement, healthcare providers, and community organizations ensure that individuals at risk are identified and referred to appropriate treatment pathways. OSP conducted over 17 outreach presentations and 42 modular presentations. OSP also maintains a robust online presence and distributes educational materials that guide individuals and families on how to access mental health services, reinforcing a message of hope and recovery throughout the county. We also partnered with culturally focused agencies to tailor messaging and materials, making our services more accessible and relevant to diverse populations across San Bernardino County.

Office of Suicide Prevention (OSP), cont.

Program Highlights

Highlights

OSP reached a total of 2,305 participants through a combination of evidence-based trainings, including Mental Health First Aid, SafeTALK and ASIST, community presentations, tabling events, and awareness campaigns. These efforts, delivered in partnership with the DBH, Public Relations and Outreach Services (PROS) team, spanned all five districts within San Bernardino County and engaged a diverse range of individuals including our youth, educators, healthcare professionals, and residents from underserved communities.

OSP serves as a resource to ensure that individuals and families have access to timely, appropriate, and culturally relevant support. We've expanded our resource network through partnerships with Soluna Mental Health and other local agencies, offering referrals, printed materials, and digital directories. Our team also provides navigation support to help participants access services such as counseling, crisis lines, and peer support.

These efforts have proven effective in bridging gaps in care, improving service utilization, and fostering trust within the community, especially among populations historically underserved by mental health systems. These practices strengthen our outreach and recruitment strategies for suicide prevention, outreach, and education efforts for San Bernardino County.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Community Services and Supports

Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is mandated to be allocated to the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) and children with serious emotional disturbance (SED).

The CSS section is organized by programs with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component. There are nine Full Service Partnership (FSP) programs that provide intensive case management and treatment services for consumers. The Peer Support Programs section highlights consumer-driven programs that operate from a lived experience perspective.

The overarching goal of all CSS programs is to provide the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

Community Services and Supports Goals
• Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
• Reduce homelessness and increase safe and permanent housing.
• Increase in self-help and consumer/family involvement.
• Increase access to treatment and services for co-occurring problems, substance use, and health.
• Reduction in disparities in racial and ethnic populations.
• Reduce the number of multiple out-of-home placements for foster care youth.
• Reduce criminal and juvenile justice involvement.
• Reduce the frequency of emergency room visits and unnecessary hospitalizations.
• Increase a network of community support services.

Introduction, cont.

The table below lists the CSS programs:

Community Services and Supports Programs
Crisis System of Care • A-5: Triage Transitional Services • A-6: Community Crisis Services • A-16: Crisis Intervention Collaborative Programs
Crisis Stabilization System of Care • A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs) • A-10: Crisis Residential Treatment (CRT)
Peer Programs • A-1: Peer Programs
Outreach, Access, and Engagement Programs • A-9: Access, Coordination, and Enhancement (ACE) • A-15: Recovery Based Engagement Support Teams (RBEST)
Full Service Partnerships • C-1: Comprehensive Children and Family Support Services (CCFSS) • C-2: Integrated New Family Opportunities (INFO) • TAY-1: One Stop Transitional Age Youth (TAY) Centers • A-2: Forensic Services Continuum of Care • A-3: Assertive Community Treatment (ACT) Model Full Service Partnership Services • A-11: Regional Adult Full Service Partnership (RAFSP) • A-20: Collaborative Adult Full Service Partnership Services • OA-1: Age Wise
Homeless Services, Long-Term Supports, and Transitional Care • A-7: Housing and Homeless Services Continuum of Care Programs • A-13: Adult Transitional Care Programs

CSS Demographics for FY 2024/25

Age Group	
Children (0-15)	20%
TAY (16-25)	21%
Adult (26-59)	49%
Older Adult (60+)	9%

Gender	
Female	47%
Male	52%
Other	<1%

Race/Ethnicity			
African American/Black	19%	Latinx/Hispanic	42%
Native American or Alaska Native	<1%	Caucasian/White	27%
Asian/Pacific Islander	2%	Other/Unknown	9%

Primary Language	
English	93%
Spanish	4%
Other/Unknown /Not Reported	3%

N=15,870 – this number does not include Outreach and Engagement

Primary Diagnosis			
Anxiety disorders	14%	Psychosis	22%
Bipolar disorders	8%	Substance related	4%
Depressive disorders	25%	Neurodevelopmental/ cognitive disorders	4%
Disruptive disorders	3%	None/Deferred	3%
Other	18%		

Region	
Central Valley	20%
Desert/Mountain	38%
East Valley	25%
West Valley	12%
Out of County	6%

Note: not all numbers add to 100 due to rounding.

CSS Data Explanation

CSS programs provide data on both consumer demographics and the number of consumers served in each program. The number of consumers served and the number for demographics may differ depending on the level of services received. The number served is inclusive of all providers and includes data for all FSPs within the program. The demographics represent the data for unduplicated consumers seen by the providers within the program, which may result in lower numbers compared to the data for number of consumers served.

CSS Capacity Assessment

The Community Services and Supports component consists of eighteen (18) programs designed to support a continuum of services that support the mental health needs of diverse Children, TAY, Adults, and Older Adults based on their specific need. In compliance with 9 CCR § 3650, each program was developed through the Community Program Planning Process and includes: a description of services, the number of people served by each program, demographics of consumers, program outcomes, and includes a summary of challenges and solutions related to program implementation.

The Department of Behavioral Health (DBH) conducted an analysis of available San Bernardino County data to understand the scope of mental health needs among the four age-specific target populations. The data was reviewed and analyzed to determine estimates of the unserved, underserved, and inappropriately served individuals in the county. For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 212-218.

As part of the program implementation, DBH is committed to the ongoing review of community behavioral health needs, the staff capacity, the public behavioral health system, and the implementation of continuous improvement efforts based on qualitative and quantitative data and informatics.

DBH collects, prepares, and presents data and information to its stakeholders. Stakeholders review the information and provide feedback on identifying additional populations, program improvement and design, priorities, and unmet needs.

Populations for Full Service Partnerships

The CSS section of this Update provides detailed overviews of all Full Service Partnership (FSP) programs, including demographics, goals, and key outcomes. These programs are designed to meet the needs of the specific populations. Below is a list of the prioritized populations to be served in FSP programs by age.

Children and Youth

• Those children and youth who:
  • Are identified as living with serious emotional disturbances
  • Have problems at school or are at risk of dropping out
  • Are at risk of, or are involved in, the juvenile justice system
  • Need crisis intervention and/or are at serious risk of psychiatric hospitalization
  • Are at risk of residential treatment or are stepping down from residential treatment
  • Are homeless or at risk of homelessness
  • Are high users of service; multiple hospitalizations/institutions
  • Are at risk due to lack of services because of cultural, linguistic, or economic barriers
  • Are at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse
  • Have co-occurring disorders
  • Are at-risk of or experiencing sexual exploitation

Transitional Aged Youth

• Those transitional age youth who:
  • Have serious mental illness or serious emotional disturbances
  • Have repeatedly used emergency mental health services
  • Have co-occurring disorders
  • Are homeless or at risk of homelessness
  • Are at risk of involuntary hospitalization or institutionalization
  • Are involved in the juvenile justice system
  • Are in out-of-home placement
  • Are aging out of or part of the child welfare system
  • Are high utilizers of hospital services

Populations for Full Service Partnerships, cont.

Adults

• Those adults who:
  • Are living with serious mental illness (SMI)
  • Are homeless or at risk of homelessness
  • Have co-occurring substance use disorders
  • Are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system
  • Have been recently discharged from psychiatric hospitals/higher levels of care
  • Are frequently hospitalized or are frequent users of emergency room services for psychiatric problems

Older Adults

• Those older adults who:
  • Have serious mental illness (SMI)
  • Are homeless or at risk of homelessness
  • Are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
  • Have reduced personal and/or community functioning due to physical and/or health problems
  • Have a co-occurring substance use disorder
  • Are isolated and at risk for suicide due to stigma surrounding their mental health problems

CSS: Crisis System of Care

Introduction

The primary goals of the Crisis System of Care (CSOC) programs are to reduce hospital emergency room visits and unnecessary acute psychiatric hospitalizations, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short timeframe.

CSOC programs serve MHSA populations by utilizing system development strategies that help enhance the capacity to provide value-driven, evidence-based services. Through system development, counties improve program services and supports for all consumers and families, enhance their service delivery systems, and build transformational programs and services. CSOC consists of a continuum of programs that provide education and support for community partners to divert from unnecessary psychiatric hospitalization when a more appropriate level of care is available.

Programs under the CSOC are:

- A-5 Triage Transitional Services
  - Triage Transitional Services (TTS)
  - Placement After Stabilization (PAS)
- A-6 Community Crisis Services
  - Community Crisis Response Team (CCRT)
- A-16 Crisis Intervention Collaborative Programs
  - Crisis Intervention Training (CIT) Program
  - Community Education Program (CEP)
  - Triage, Engagement, and Support Teams (TEST)

Target Populations

The table below represents the target population of consumers served by programs within the Crisis System of Care.

Crisis Stabilization System of Care Programs	Target Population			
Program Name	Children	TAY	Adults	Older Adult
Triage Transitional Services (TTS)		X	X	X
Community Crisis Response Team (CCRT)	X	X	X	X
Crisis Intervention Training (CIT)		X	X	X
Community Education Program (CEP)		X	X	X
Triage, Engagement, and Support Teams (TEST)	X	X	X	X

Program Updates

In FY 2025/26, the Applied Suicide Intervention Skills Training (ASIST) and SafeTALK curriculum will be moved out of the A-16 Community Education Program (CEP) and will be coordinated and facilitated by the Office of Suicide Prevention (OSP) under Public Relations and Outreach Services (PROS).

Triage Transitional Services (TTS)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Triage Transitional Services (TTS)	2,298	Ages 18+	SMI*	Clinic-based 	Experiencing a behavioral health crisis

*SMI = serious mental illness.

Program Description and Target Population

Triage Transitional Services (TTS) were designed to assess consumers who voluntarily present to the Arrowhead Regional Medical Center – Behavioral Health Unit (ARMC-BHU). As part of a team, TTS collaborates with ARMC-BHU staff to determine if the consumer meets the medical necessity criteria for psychiatric inpatient treatment or if their needs can be met in other, less restrictive settings outside of an emergency department or psychiatric inpatient treatment unit.

The Placement After Stabilization (PAS) program, an expansion of TTS, provides discharge planning and serves as a liaison to facilitate appropriate placement upon discharge for each of the five contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County in the following areas: San Bernardino (2 sites), Joshua Tree, Victorville, and Fontana. The staff work collaboratively with CRT staff to provide services intended to divert and reduce psychiatric inpatient hospitalizations, assist consumers in maintaining self-sufficiency, increase housing stability, and support successful community reintegration.

Demographics

Age

0% Children
21% TAY
75% Adult
4% Older Adult

Gender Identity

63% Male
37% Female
<1% Other

Race/Ethnicity

20% African American/Black
28% Caucasian/White
<1% American Indian/ Alaska Native
2% Asian/Pacific Islander
47% Latinx/Hispanic
2% Other/Unknown

Primary Language

96% English
3% Spanish
<1% Other/ Unknown

N=1,107

Note: not all numbers add to 100 due to rounding.

CSS: Triage Transitional Services (TTS) A-5

Services Offered

TTS staff are co-located with ARMC-BHU to provide the following services:

- Crisis assessment and intervention
- Case management
- Collateral contacts
- Transportation assistance
- Linkage to housing assistance
- Linkage to outpatient resources and providers
- Referrals to medical and social services agencies
- Family and caretaker education
- Consumer advocacy

PAS Clinical Therapists support each Crisis Residential Treatment facility (CRT) and are assigned to provide the following services:

- Screening for discharge services
- Clinical assessments
- Coordinating discharge planning
- Assisting with placement options
- Facilitating transportation arrangements

Positive Results

During FY 2024/25, TTS staff served a total of 1,912 consumers from the ARMC-BHU Triage Unit. Of these, a total of 879 (46%) consumers were diverted from unnecessary hospitalization.

As part of the expanded TTS services, PAS discharge services provided at the CRTs supported a total of 386 consumers during FY 2024/25. Of these, 295 consumers (76%) remained in the CRT program long enough to receive linkage to aftercare services, and 285 consumers were successfully placed into safe and sustainable community placements.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 222-225.

Demographics

Primary Diagnosis

3.0% Anxiety disorders	**<1%** Disruptive disorders	**15.8%** Other
7.8% Bipolar disorders	**<1%** Neurodevelopmental/Cognitive	**39.9%** Psychosis disorders
25.6% Depressive disorders	**1.1%** None/deferred	**6.3%** Substance use disorders

N=1,107

Note: not all numbers add to 100 due to rounding.

Challenges/Solutions

High staff turnover in PAS Clinical Therapist I positions, primarily due to the non-therapeutic nature of the role, impacted program continuity. The program will work with DBH leadership to explore role modifications that incorporate more clinical engagement and therapeutic functions where appropriate. Additionally, targeted recruitment efforts and enhanced onboarding processes will be implemented to improve retention and support long-term staffing stability.

Issues with canceled or no-show transportation through the Managed Care Plan (MCP) resulted in missed appointments, which impacted timely linkage to ongoing services and led to consumers remaining in PAS case management longer than anticipated. To reduce transportation-related barriers, PAS utilized a combination of options, including the MCP's "Call the Car" service for medical appointments and bus passes for non-medical transportation needs. PAS and TTS also utilized transportation teams to support placement transitions and moves to higher levels of care. In FY 2024/25, PAS acquired an additional county vehicle, enabling case managers to transport consumers directly.

Delays in the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) application process led to extended placement stays and increased overall PAS caseloads. To minimize these delays, case managers will collaborate with DBH benefits specialists and community partners to support earlier and more efficient application submission. PAS will also explore interim funding or housing options.

The program experienced delays in outpatient appointments for continued treatment due to a lack of staff/psychiatrists. In response to these delays, DBH implemented a new policy in May 2024 that standardized the scheduling of new, non-urgent service requests across all directly operated outpatient clinics. As a result, follow-up appointments are now scheduled within a more reasonable timeframe, thereby improving continuity of care after discharge.

Limited resources (homeless shelters/housing services) and unsuccessful placements caused challenges for consumers, including transitional-aged youth (TAY). To address the housing challenges, the DHB's Centralized Hospital Aftercare Services (CHAS) program expanded contracts with both new and existing providers, significantly increasing the number of available beds, and broadened access to higher levels of care, resulting in more appropriate and stable placements for consumers. Weekly coordination meetings were also established with TAY programs to improve communication, case planning, and discharge coordination.

Outreach and Engagement

For FY 2024/25, 97 participants attended a presentation where TTS program staff were available to discuss their program and offer resources.

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Community Crisis Response Team (CCRT)	6,085	All ages	N/A	Field-based	Experiencing a behavioral health crisis

Program Description and Target Population

Community Crisis Services (CCS) provides comprehensive, 24/7/365 behavioral health crisis response throughout San Bernardino County through three core components:

Crisis Contact Center (CCC): A centralized hub that offers immediate access to specially trained crisis staff via phone or text. CCC staff assess the situation and, when needed, dispatch mobile crisis teams.

Community Crisis Response Team (CCRT):

A field-based team providing urgent mobile behavioral health services to individuals in crisis. CCRT responds across the East/Central Valley, West Valley, and High Desert regions. Telehealth is available in all cities in the county for individuals who cannot be served in person.

Crisis Mobile Response Team (CMRT): A contracted provider that supports mobile crisis response efforts overnight, ensuring 24/7/365 service availability across the county.

Demographics

Age

21% Children
21% TAY
40% Adult
8% Older Adult
11% Unknown

Gender Identity

49% Male
46% Female
5% Other/ Unknown

Race/Ethnicity

13% African American/ Black
17% Caucasian/White
<1% American Indian/ Alaska Native
2% Asian/Pacific Islander
30% Latinx/Hispanic
37% Other/Unknown

Primary Language

92% English
6% Spanish
2% Other

N=6,085

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

Mobile crisis services are available 24 hours a day, 7 days a week, 365 days a year in community locations around San Bernardino County. Response teams collaborate with a wide range of community partners, including:

- Law enforcement
- Hospitals
- Schools
- Department of Behavioral Health (DBH) clinics
- Contracted behavioral health providers
- Specialty programs
- Group homes
- Board and Care (B&C) facilities
- Families and self-referrals

CCS is committed to delivering behavioral health services in the least restrictive setting possible, prioritizing care for individuals experiencing mental health crises, and ensuring compassionate and effective support for residents of San Bernardino County.

Services Offered

Crisis Assessment & Intervention – Delivered in the field, via text messaging, or through virtual conferencing to meet individuals where they are.

Follow-Up Services – Ongoing support to ensure stabilization and connection to appropriate care after the initial crisis.

Linkage to Community Resources – Assistance connecting individuals to behavioral health providers, resources, and other local services.

Consultation for Interruption of Involuntary Psychiatric Holds (WIC 5150/5585) – Clinical consultations to determine if an involuntary psychiatric hold can be safely interrupted or avoided.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 226-229.

Demographics

Primary Diagnosis

9.7% Anxiety disorders	**3.5%** Disruptive disorders	**13.8%** Psychosis disorders
3.5% Bipolar disorders	**2.7%** Neurodevelopmental/cognitive disorders	**1.7%** Substance use disorders
28.4% Depressive disorders	**1.2%** None/Deferred	**35.4%** Other

N=2,152 – does not include Outreach & Engagement data

Note: not all numbers add to 100 due to rounding.

Positive Results

During FY 2024/25, 1,433 consumers were diverted from hospitalization, representing an approximate 13.28% increase in consumers diverted compared to the previous fiscal year. Of those consumers:

- 90 were diverted to crisis residential treatment facilities,
- 756 were diverted to crisis stabilization unit facilities,
- 215 were diverted to crisis walk-in clinics, and
- 372 were diverted to other qualified crisis intervention alternatives.

Challenges/Solutions

Community Crisis Services (CCS) has been experiencing difficulties in staff retention due to the demanding nature of the program, competition from other county healthcare providers, the requirement for 24/7/365 availability, and the size of the county. Current staff frequently provide additional coverage when needed.

To address this challenge, CCS has actively participated in multiple hiring fairs targeting hard-to-fill positions critical to delivering community services. Additionally, current staff have been strategically allocated across regions based on program needs to maximize coverage, and CCS continues to offer virtual sessions and accessible resources for consumers in their local areas.

These staffing challenges have led to increased response times for consumers, resulting in delays in consumer care and presenting a significant challenge to the program.

To help address these challenges, CCS acquired Beacon Dispatch Software, which aims to enhance dispatch and staff distribution efficiency across regions. Beacon optimizes routing, provides vital crisis call information to field teams, and offers real-time visibility of team locations and status. Field teams can update their status via a mobile app, improving communication and workflow. This technology is expected to facilitate timely access to appropriate care for all community members in the county, helping staff to perform their duties more effectively.

Outreach and Engagement

During FY 2024/25, the CCRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Law Enforcement Collaboration	35	412
School Collaboration	9	1,533
Other San Bernardino County Department Collaboration	11	308
Mental Health Provider/Clinics	6	6
Mental Health Summits/Resource fairs	41	1,675
Total	**102**	**3,934**

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Crisis Intervention Training (CIT)	2,162	Ages 18+	N/A	Field-based	First responders and community partners

Program Description and Target Population

The Crisis Intervention Training (CIT) program provides behavioral health educational training to first responders and community partners**.** The goal of each training is to enhance participants' knowledge of behavioral health, ability to recognize signs of a behavioral health crisis, utilization of communication and de-escalation skills, stigma reduction, and familiarity with behavioral health programs and other support services and how to access them.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2024/2025 through Fiscal Year 2025/2026, pages 230-233.

Demographics

Age

0% Children
8% TAY
70% Adult
1% Older Adult
20% Unknown

Gender Identity

46% Male

32% Female

22% Other/ Unknown

Race/Ethnicity

8% African American/Black
18% Caucasian/White
1% American Indian/ Alaska Native
3% Asian/Pacific Islander
38% Latinx/Hispanic
32% Multiple Races/ Other/Decline to state

N=2,162

Note: not all numbers add to 100 due to rounding.

CSS: Crisis Intervention Collaborative Programs

Services Offered

- In collaboration with San Bernardino County Sheriff's Department:
  - 40-hour CIT course
  - 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT course
- In collaboration with Probation:
  - 8-hour Probation CIT course
- Multiple monthly training sessions for collaborative partners and first responders

Positive Results

In total, 2,162 law enforcement, other first responders, and community partners received training from the CIT program in FY 2024/2025:

- 312 law enforcement personnel completed the 40 Hour CIT Course
- 93 Field Training Officers (FTO) completed the 8 Hour FTO CIT Course
- 1,220 Probation Officers and Probation Correctional Officers completed assigned courses
- 99 Fire personnel received training from the CIT program
- 438 community partners, public employees, and emergency departments received specialized training from the CIT program

Additionally, program staff attended 14 outreach and engagement events and completed 38 formal trainings.

Demographics

Primary Language

76% English

2% Spanish

22% Unknown/Other

N=2,162

Challenges/Solutions

One of the major challenges during FY 2024/25 has been getting new team members trained on the required train-the-trainer certified curriculum as some of the courses are not easily accessible due to being out of the state/country or not offered.

To address the train-the-trainer certification challenges, the CIT program is working on bringing certified trainings to the department for staff development.

Outreach and Engagement

Through community education and outreach, DBH fosters an environment in which the public is more knowledgeable of crisis mitigation and de-escalation skills, self-care, and suicide prevention. San Bernardino County residents who may be experiencing mental health and/or substance use disorder concerns are made aware of diverse resources.

For FY 2024/25, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Outreach/Networking Event	3	1,212
Community Collaborative Meeting	11	272
40 Hour CIT Course	6	312
8 Hour Field Training Officer (FTO) Course	4	93
Probation Department CIT Courses	17	1,220
Fire Trainings	2	99
Community Partner Trainings	13	438
Total	**56**	**3,646**

Community Education Program (CEP)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Community Education Program (CEP)	1,649	Ages 16+	N/A	Field-based	General public, including but not limited to community-based organizations, faith institutions, education institutions, and government agencies

Program Description and Target Population

The **Community Education Program (CEP)** provides education and training opportunities to community members and community partners to promote a greater understanding of behavioral health. This includes the coordination and facilitation of certified curriculum, such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), SafeTALK (Suicide Alertness Training), and Listen, Empathize, Agree, and Partner (LEAP) trainings.

Demographics

Age

<1% Children
16% TAY
54% Adult
6% Older Adult
24% Unknown

Gender Identity

18% Male
57% Female
25% Other/ Unknown

Race/Ethnicity

10% African American/Black
19% Caucasian/White
1% American Indian/ Alaska Native
4% Asian/Pacific Islander
33% Latinx/Hispanic
35% Multiple Races/Other

N=1,648

Note: not all numbers add to 100 due to rounding.

Services Offered

- Community Trainings:
  - Mental Health First Aid
  - Applied Suicide Intervention Skills Training (ASIST)
  - SafeTALK
  - Listen, Empathize, Agree, and Partner (LEAP)
- Community Behavioral Health Presentations

Demographics

N=1,648

Primary Language

70% English

2% Spanish

29% Other/Unknown

Note: not all numbers add to 100 due to rounding.

Positive Results

During FY 2024/25, the Community Education Program (CEP) facilitated a total of 71 trainings for 1,649 community members as follows:

- Mental Health First Aid
  - 305 Adult
  - 90 Youth
- 94 Applied Suicide Intervention Skills Training (ASIST)
- 254 SafeTALK
- 285 Listen, Empathize, Agree, and Partner (LEAP)
- 606 non-certified CEP training or presentation
- 15 How Being Trauma Informed Improves Criminal Justice System (CJS) Responses

Challenges/Solutions

CEP was launched at the beginning of 2024 and continued to face the challenges of a fledgling program in FY 2024/25, including recruiting attendees for trainings.

The program worked on various strategies to increase training attendance. They developed an online interest form, scheduled meetings with various organizations, and attended numerous outreach events to promote CEP trainings. These efforts led to the establishment of strong community connections, which proved instrumental in recruiting attendees.

Outreach and Engagement

For FY 2024/25, the Community Education Program (CEP) program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Community Outreach Events	4	102
Community Collaborative Meetings	9	122
Listen, Empathize, Agree and Partner trainings	8	285
Mental Health First Aid – Adult trainings	18	305
Mental Health First Aid – Youth trainings	3	90
SafeTALK trainings	14	254
ASIST trainings	5	94
Non-Certified CEP trainings	22	606
Trauma-Informed CJS Responses	1	15
Total	**84**	**1,873**

Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Triage, Engagement, and Support Teams (TEST)	6,241	All ages	SED or SMI*	Field-based	Experiencing a behavioral health crisis

*SED = serious emotional disturbance and SMI = serious mental illness.

Program Description and Target Population

The primary objective for the TEST program is the mitigation of unnecessary expenditures for law enforcement by reducing the amount of time law enforcement spends with individuals needing a behavioral health crisis intervention, thus reducing the number of encounters between law enforcement and individuals in behavioral health crisis.

TEST staff are co-located within 32 internal and external County partner agencies, including, but not limited to, law enforcement agencies, hospital emergency departments, and college campuses.

The TEST program offers dedicated support to its partner departments and agencies. TEST staff respond alongside law enforcement personnel in the field and assist other partner agency staff in managing consumer behavioral health crises. In addition to immediate crisis response, the TEST program

Demographics

Age

10% Children
15% TAY
50% Adult
16% Older Adult
9% Unknown

Gender Identity

59% Male
39% Female
2% Other

Race/Ethnicity

14% African American/Black
3% Asian/Pacific Islander
35% Caucasian/White
33% Latinx/Hispanic
<1% American Indian/ Alaskan Native
15% Other/Unknown

N=6,241

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

provides follow-up case management services for up to 59 days, after initial contact, to link consumers with resources for ongoing behavioral health stability.

Four of the co-located sites participate in a collaborative initiative called the Community Outreach and Support Team (COAST). Each COAST unit is a co-response team comprised of a TEST social worker; a firefighter Emergency Medical Technician (EMT) with a therapy canine; and a plain-clothed, specially trained police officer. TEST's role within the COAST teams aligns with its function in other co-located partnerships. The purpose of this model is to provide consumers with rapid access to crisis triage in a non-threatening manner.

Services Offered

- Crisis assessment and intervention in the field
- Case management
- Support for collateral contacts
- Referrals and linkages to community resources and providers
- Family and caretaker education
- Education and support to law enforcement community partners regarding behavioral health concerns and resources

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 234-238.

Demographics

Primary Language

98% English

1% Spanish

1% Other/Not Reported

N=6,241

Primary Diagnosis

4.2% Anxiety disorders

3.1% Bipolar disorders

30.7% Depressive disorders

3.0% Disruptive disorders

11.9% None/deferred

1.8% Neurodevelopmental/ cognitive disorders

16.4% Other

25.2% Psychosis disorders

3.8% Substance use disorders

N=734

Note: not all numbers add to 100 due to rounding.

Positive Results

TEST program data is recorded based on an "encounter," defined as an instance in which TEST staff engage an individual for services. In FY 2024/25, the TEST program:

- Recorded 13,577 encounters.
- Provided 16,997 referrals to behavioral health and community resources. Individuals and families frequently require multiple types of support, and referrals often span several services for a range of needs.
- Increased access to and use of existing community resources.
- Continued use of alternative crisis interventions (e.g., CWIC, CCRT, CSU) that resulted in 68% of TEST Crisis Interventions being diverted from hospitalization.

Challenges/Solutions

The TEST program faced persistent recruitment barriers in filling the remaining vacancy at the remote Needles Sheriff's Office, where geographic isolation limits the pool of qualified applicants.

Several solutions were put in place to address staffing challenges at the Needles Sheriff's Office. These included collaborating with the County Human Resource Department to open a special recruitment specifically targeting qualified individuals residing in or near the Needles area. Additionally, the TEST program Deputy Director continued to work closely with the Needles Sheriff's Department, San Bernardino County Board of Supervisors (BoS), and the City of Needles to promote the current vacancy.

Outreach and Engagement

For FY 2024/25, the TEST program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Homeless Outreach	55	1,774
Multi Enforcement Team (MET)	6	143
Community Engagement Outreach	82	4,528
CIT Presentations	2	26
Health and Wellness Outreach	24	766
Mental Health Awareness	18	459
School Outreach (K-12)	11	1,551
School Outreach (Higher Education)	7	335
Gang and Drug Task Force Summit	1	200
Food Drive	5	123
Law Enforcement Outreach	22	437
Law Enforcement Briefings	1,852	21,735
Totals	**2,085**	**32,077**

CSS: Crisis Stabilization System of Care

Introduction

The Crisis Stabilization System of Care operates as part of the 24-Hour and Emergency Services Division of DBH. The services offered through these programs are centered on providing immediate intervention along with stabilization services to consumers who are experiencing a mental health crisis. These care options are accessible in various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman-Petris-Short (LPS) hospitals, Crisis Stabilization Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

Program Updates

Effective October 1, 2025, the A-4 Crisis Walk-In Center (CWIC) program will become aligned with A-4 Crisis Stabilization Unit (CSU) program in both terminology and reporting, as they are identical programs by regulation. This will not result in any operational or service changes for the programs formerly referred to as “CWIC”; it will only standardize the language used by the department and the community when discussing available crisis mental health services.

Target Population

The table below displays the target population of consumers to be served by programs within the Crisis Stabilization System of Care for Fiscal Year 2025/26. The target population is categorized based on MHSA age categories. MHSA age categories are Children, TAY, Adult, and Older Adult.

Crisis Stabilization System of Care Programs

Program Name	Target Population			
	Children	TAY	Adults	Older Adult
Crisis Walk-In Center (CWIC)	X	X	X	X
Crisis Stabilization Unit (CSU)	X	X	X	X
Crisis Residential Treatment (CRT)		X	X	

Crisis Stabilization Unit (CSU)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Crisis Stabilization Unit (CSU)	4,417*	All Ages	All Levels	Clinic-based 	Experiencing a behavioral health crisis

*This number does not include Outreach and Engagement (O&E).

Program Description and Target Population

Crisis Stabilization Units (CSUs) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization due to a mental health crisis. These programs operate 24/7, and services last for less than 24 hours. Each CSU facility has 20 spaces for crisis stabilization services, which include 16 for adults (aged 18 and older) and 4 for children and adolescents (aged 17 and under). CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

Demographics

Age

7% Children
22% TAY
65% Adult
6% Older Adult

Gender Identity

55% Male

45% Female

<1% Other

Race/Ethnicity

20% African American/ Black
2% Asian/Pacific Islander
23% Caucasian/White
51% Latinx/Hispanic
<1% American Indian/ Alaska Native
3% Other/Unknown

Primary Language

95% English
4% Spanish
1% Other

N=4,417

Note: not all numbers add to 100 due to rounding.

Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

Positive Results

The two CSU programs served 4,417 unique consumers and provided a combined 7,281 crisis stabilization services ("admissions") during FY 2024/25. Of the 7,281 admissions, 95.7% were successfully diverted from psychiatric hospitalization at the time of receiving CSU services.

Voluntary consumer satisfaction surveys are provided to consumers who have received crisis stabilization services. Out of 4,053 surveys issued, the program received a combined 92.7% consumer satisfaction rate with the services received.

In FY 2024/25, the two CSUs received referrals from a total of 72 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, schools, faith-based organizations, shelters, and other community agencies. Of these:

- 697 referrals originated from law enforcement, who utilize the CSUs as an alternate destination to psychiatric hospitals or detention facilities when encountering a mental health crisis in the community.
- 259 referrals originated from local hospitals, representing a population whose crisis was appropriately manageable at the CSU rather than at the inpatient level of care.

Demographics

Primary Diagnosis

N=4,417

12.3% Anxiety disorders	**<1%** Neurodevelopmental/Cognitive
7.1% Bipolar disorders	**28.0%** Psychosis disorders
22.1% Depressive disorders	**5.5%** Substance Related
5.2% None/deferred	**<1%** Disruptive disorders
18.2% Other	

Note: not all numbers add to 100 due to rounding.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 241-245.

Challenges/Solutions

The Crisis Stabilization Units (CSUs) struggled with recruitment and retention of qualified staff as remote work opportunities became more commonplace in the healthcare environment. CSU regulations require on-site staff to be present 24/7, so remote work is not an option for direct care staff.

To support staffing, programs are focusing on retention efforts to maintain a high staffing rotation capacity. Additionally, CSUs have a robust intern program that allows them to maintain a solid recruitment pipeline from internship to graduation for clinical roles.

CSUs continue to struggle with safety and security at the sites due to issues with security guard training and inconsistent shifts. CSUs will continue to work with the Department of Behavioral Health (DBH) Facilities regarding these issues to ensure that there is suitable security supporting the program.

The program also faced delays in addressing building-related issues due to requirements in standard DBH Facilities Management procedures, which can affect the number of consumers the facility can accept while waiting for repairs.

Efforts to improve communication between the CSUs and DBH Facilities/Project Management and County Facilities Management have promoted smoother completion of work orders. DBH added Program Administration staff as dedicated support for all CSU concerns, which resulted in a stronger follow-up and support system. The continued growth of this relationship and the introduction of new workflows have been valuable in expediting critical fixes as needed.

Outreach and Engagement

CSU staff and DBH regularly conduct outreach presentations to the community and partnering agencies to increase awareness of available services, educate on program criteria, and demonstrate how to refer individuals appropriately. Additionally, they explain how CSU programs coordinate with DBH's continuums of care.

During FY 2024/25, the CSU program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentations	104	6,331
Telephonic/Electronic Outreach	93	5,372
Totals	**197**	**11,703**

Crisis Walk-In Center (CWIC)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Crisis Walk-In Center (CWIC)	2,008*	All ages	All Levels	Clinic-based 	Experiencing a mental health crisis

*This number does not include Outreach and Engagement (O&E).

Program Description and Target Population

Crisis Walk-In Centers (CWIC) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization as a result of a mental health crisis. These programs operate 24/7, and services last for less than 24 hours. Each facility has 12 spaces for crisis stabilization services. CWIC facilities are intended to serve as a community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 246-250.

Demographics

Age

11% Children
22% TAY
60% Adult
8% Older Adult

Gender Identity

51% Male
48% Female
<1% Other

Race/Ethnicity

15% African American/ Black
1% Asian/Pacific Islander
34% Caucasian/White
21% Latinx/Hispanic
<1% American Indian/ Alaska Native
28% Other/Unknown

Primary Language

93% English
3% Spanish
4% Other/ Unknown

N=2,008

Note: not all numbers add to 100 due to rounding.

Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

Positive Results

During FY 2024/25, the two CWIC facilities served 2,008 unduplicated consumers. These programs provided a combined 2,949 crisis stabilization services ("admissions") to these consumers.

Of the 2,949 admissions, 98.8% were successfully diverted from psychiatric hospitalization at the time of receiving CWIC services.

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services at the CWICs. Out of 1,952 surveys issued by the two CWICs, the programs received a combined 95.4% consumer satisfaction rate with the services received.

Challenges/Solutions

One CWIC site reduced recidivism from 20% to 16%, indicating progress in consumer stabilization. However, the remaining 16% largely reflects consumers who return monthly for crisis medication bridges without fully engaging in recommended ongoing treatment.

To monitor this trend, the program instituted monthly tracking to ensure documentation clearly captures consumer refusals to follow through with referrals and treatment plans. The program is also identifying additional psychiatry and therapy providers who accept Medi-Cal and offer telehealth services to expand access to long-term outpatient care.

Demographics

Primary Diagnosis

N=2,008

15.2% Anxiety disorders

12.1% Bipolar disorders

31.1% Depressive disorders

<1% Disruptive disorders

1.4% Neurodevelopmental/cognitive disorders

25.4% Psychosis disorders

4.4% Substance use disorders

9.2% Other

<1% None/Deferred

Note: not all numbers add to 100 due to rounding.

Outreach and Engagement

CWIC staff and DBH contract monitors provide frequent outreach presentations to the community and partnering agencies to increase awareness of the availability of this service, educate on program criteria and appropriate referrals, and explain how CWIC programs coordinate with the DBH continuum of care.

During FY 2024/25, the CWIC programs conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborative Meetings	35	1,007
Other Outreach Activities	3	7
Presentations	109	642
Telephonic/Electronic Outreach	5	390
Totals	**152**	**2,046**

Adult Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Adult Crisis Residential Treatment (CRT)	442*	Ages 18-59	SMI**	Facility-based 	Experiencing a behavioral health crisis

*This number does not include Outreach and Engagement (O&E). **SMI = serious mental illness.

Program Description and Target Population

The Adult Crisis Residential Treatment (CRT) program offers short-term, voluntary crisis residential treatment options for San Bernardino County residents ages 18 to 59. Individuals may stay for up to 90 days to receive services in a home-like environment that supports and promotes the individual's recovery, wellness, and resiliency within the community.

Services are designed for individuals who are experiencing an acute psychiatric episode or mental health crisis and need short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRT programs operate 24 hours a day, 7 days a week, 365 days a year.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 251-255.

Demographics

Age

0% Children
17% TAY
84% Adult
0% Older Adult

Gender Identity

64% Male

36% Female

Race/Ethnicity

21% African American/Black
30% Caucasian/White
<1% American Indian/ Alaska Native
<1% Asian/Pacific Islander
44% Latinx/Hispanic
4% Other/Unknown

N=394

Note: not all numbers add to 100 due to rounding.

CSS: Crisis Residential Treatment (CRT) Programs A-10

Services Offered

- Comprehensive clinical assessments and therapy
- Crisis intervention
- Psychiatric and medication support
- Life skills coaching
- Peer and family support networks
- Coping techniques
- Recovery education
- Substance use education
- Community resource linkages

Positive Results

During FY 2024/25, the four adult CRT programs received referrals from a total of 48 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, and other community agencies.

The program served a total of 442 unique consumers. Of consumers who were discharged from the program during the fiscal year, 94% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

DBH contracts with two agencies to provide CRT services, and each agency delivers a voluntary consumer satisfaction survey after discharge from the facility.

The first contracted agency operates three CRT programs and evaluates consumer agreement with twenty statements, including topics such as group activities, coping skills, and staff attentiveness. Out of 150 surveys completed, these three programs received a combined average consumer satisfaction rating of 94% across all satisfaction questions, indicating that 94% of respondents agreed or strongly agreed with the given statements.

Demographics

Primary Language

98% English
2% Spanish
<1% Other

Primary Diagnosis

2.8% Anxiety disorders
13.2% Bipolar disorders
20.8% Depressive disorders
<1% None/Deferred
49.8% Psychosis disorders
7.1% Substance use disorders
5.8% Other

N=394

Note: not all numbers add to 100 due to rounding.

Positive Results, cont.

The second contract agency operates one CRT program and evaluates consumer agreement to statements including, but not limited to:

- Were staff willing to see you as often as you felt was necessary?
- Do you feel that staff helped you obtain information you needed to take charge of managing your illness?

Out of 13 surveys, this program received an average 89% consumer satisfaction rating across all satisfaction questions, indicating that 89% of respondents agreed or strongly agreed with the given statements.

Challenges/Solutions

Adult CRTs faced elevated discharges against clinical advice (ACAs); some consumers were exiting this voluntary level of care before completing the program and before their care team identified that they had made sufficient progress to thrive in their next environment.

To reduce ACA discharges, CRT staff received targeted training in the “slow down” technique to improve engagement during moments of crisis, enhanced focus on substance use concerns during screening, and expanded outreach and coordination with local hospitals, CWICs, CSUs, and other admitting/discharging partners to streamline admissions and improve program retention.

These strategies yielded measurable improvements: one CRT reduced ACA discharges from 44.1% in FY 2023/24 to 31% in FY 2024/25 (a 13.1 percentage-point decline), and another reduced their ACA rate from 46% in FY 2023/24 to 37% in FY 2024/25 (a 9 percentage-point decline).

An additional key challenge involved balancing the delivery of acute clinical care with the need to strengthen family dynamics during a brief treatment window. This was evidenced by survey data showing minimal improvement in family connections throughout CRT treatment.

To improve family dynamics in treatment, the CRT program incorporated family relationship questions into the screening and admission process, allowing for the earlier identification of needs and the implementation of family-focused interventions. This led to improved consumer outcomes, with reported dissatisfaction decreasing from 24% to 15% in the third quarter and 17% in the fourth quarter, based on program surveys. Leadership continues to assess and refine strategies to further enhance family engagement as a critical element of consumer recovery.

Outreach and Engagement

For FY 2024/25, the Crisis Residential Treatment (CRT) program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborative Meetings	38	158
Planning Collaboration with other DBH programs	57	173
Presentations	10	40
Tours of the facility for potential program partners	5	10
Totals	**110**	**381**

TAY Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
TAY Crisis Residential Treatment (CRT)	98	Ages 18-25	SMI*	Facility-based 	Experiencing a behavioral health crisis

*SMI = serious mental illness.

Program Description and Target Population

TAY CRT, a specialty CRT for Transitional-Age Youth (TAY) colloquially known as "The STAY", is a short-term, voluntary residential treatment center. The STAY accepts consumers ages 18-25 who are experiencing a mental health crisis. Individuals may stay for up to 90 days and receive services in a home-like environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. The STAY increases access to appropriate mental health services for TAY in crisis. Co-located with the DBH One-Stop TAY Center in San Bernardino, this unique program provides comprehensive and collaborative TAY-targeted services to support maximum recovery for young adults.

Demographics

Age

0% Children
96% TAY
4% Adult
0% Older Adult

Gender Identity

59% Male
41% Female

Race/Ethnicity

24% African American/Black
17% Caucasian/White
5% Other/Unknown
2% Asian/Pacific Islander
51% Latinx/Hispanic

Primary Language

97% English
0% Spanish
3% Unknown/ Not Reported

N=98

Note: not all numbers add to 100 due to rounding.

CSS: Crisis Residential Treatment (CRT) Programs

Services Offered

- Comprehensive clinical assessments and therapy
- Therapeutic and psycho-educational groups
- Activities and training that focus on daily living skills
- Behavioral intervention and modification training
- Individual and group counseling
- Crisis intervention
- Psychiatric and medication support
- Substance use disorder counseling and referrals
- Recreational therapy
- Educational assistance
- Pre-release and discharge preparation and planning

Positive Results

During FY 2024/25, 98 unique consumers were served by TAY CRT. Of consumers who were discharged from the program during the fiscal year, 97% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CRT services.

The TAY CRT received referrals from a total of 30 collaborative partners, including psychiatric hospitals and hospital emergency departments, Crisis Stabilization Units (CSUs), Crisis Walk-in Centers (CWICs), outpatient clinics, law enforcement agencies/officers, and community agencies.

Consumers are provided with a voluntary satisfaction survey once they are discharged from the facility, which evaluates their agreement with statements on topics such as independent living group session outcomes, healthy living, staff support, and personal growth. Out of 61 completed surveys, the program received a combined average consumer satisfaction rating of 99% across all satisfaction questions, indicating that 99% of respondents agreed or strongly agreed with the given statements.

Demographics

N=98

Primary Diagnosis

5.1% Anxiety disorders

1.0% Disruptive disorders

42.9% Psychosis disorders

23.5% Bipolar disorders

21.4% Depressive disorders

1.0% Substance use disorder

1.0% Neurodevelopmental/ Cognitive disorders

4.1% Other

Challenges/Solutions

During FY 2024/25, the STAY (TAY CRT) experienced elevated discharges against clinical advice (ACAs). To reduce the ACA discharge rate, staff received training in the “slow down” technique to enhance consumer engagement during critical decision-making points. The STAY also expanded outreach and education efforts with local hospitals, CWICs, CSUs, and multiple admitting and discharging entities to support smoother admissions and reduce premature consumer departures.

These efforts resulted in an improved ACA rate of 38% during FY 2024/25 compared to the FY 2023/24 ACA rate of 43%. Of the 97 total discharges, 60 were successful, 2 involved transfers to higher levels of care, and 37 were classified as ACAs.

Outreach and Engagement

In FY 2024/25, the TAY CRT program conducted 50 outreach and engagement activities in collaboration with other DBH programs, with a total of 99 participants attending.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 256-259.

Introduction

Peer Support Programs coordinate service delivery efforts that offer stigma-free peer support for consumers living with serious mental illness and/or seeking recovery from substance use and their family members. This person-centered, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Peer Support Programs include Clubhouses, Community Connections, and Peer Provider Workforce Support.

Clubhouses are peer-driven support centers that are recovery-oriented for consumers 18 years or older. There are ten clubhouses located throughout the county that are dedicated to assisting consumers living with a serious mental illness and/or seeking recovery from substance use. Clubhouses are primarily consumer-driven and operate with minimal support from department staff. Clubhouse members drive all operational decisions such as support groups, community engagement, staffing, and activity choices.

The **Community Connections Program** focuses on connecting consumers ages 16 and older with opportunities such as improving pre-employment skills, volunteering, paid employment, and engaging in peer support. Participants partner with Employment Specialists to maximize their existing skills, while also considering their individual wellness goals in relation to potential community commitments.

Peer Provider Workforce Support Program, formerly titled Peer Workforce, is the continuation of DBH's commitment to growing, supporting, and enhancing the inclusion of a fully integrated peer workforce. Current efforts include ongoing support of Peer Certification, identification of department-wide training needs, regularly scheduled engagement meetings with peer providers, and targeted training efforts for supervisors of peer providers.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 260-266.

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Clubhouse and Community Connections	39,251*	18+**	BHC***	Facility-based 	Seeking recovery- based support services

*Actual number served includes: 3,084 General System Development (GSD) and 36,167 Outreach & Engagement (O&E).

**Community Connections serves 16+. ***BHC = Behavioral Health Challenges.

Target Populations

The table below identifies the target population of consumers to be served by the Peer Programs in the upcoming fiscal year.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Clubhouse		X	X	X
Community Connections		X	X	X
Peer Provider Workforce Support Program		X	X	X

Program Updates

The Apple Valley Clubhouse location is expected to open in late 2025.

Program Description and Target Population

Clubhouses are peer-driven support centers for adults aged 18 and over in recovery. Clubhouses offer peer-run programs based on a Recovery, Wellness, and Resilience model in a stigma-free environment for adults, referred to as members, managing their behavioral health. Members do not need to be receiving clinical services in order to attend the program.

There are currently ten clubhouses located throughout the county that are dedicated to enhancing and supporting recovery. The Clubhouses are located in the cities of Barstow, Fontana, Lucerne Valley, Yucca Valley, Ontario, Rialto, San Bernardino, Victorville, Yucaipa, and Needles.

The primary objectives of the Clubhouses are to assist members in making their own choices, provide peer support, and connect with the community as contributing members, thereby achieving a fulfilling life that aligns with their personal recovery goals. Clubhouses also serve as an essential access point for building community and rebuilding daily living skills for individuals who are unhoused or recently housed.

The members operate clubhouses through peer-elected governing boards. In an effort to increase overall independence and community connection, members meet regularly and are encouraged to provide input to programming and operations choices.

Demographics

Age

0% Children
1% TAY
7% Adult
<1% Older Adult
91% Unknown

Gender Identity

56% Male
42% Female
3% Other

Race/Ethnicity

16% African American/Black
34% Caucasian/White
3% American Indian/ Alaska Native
1% Asian/Pacific Islander
33% Latinx/Hispanic
12% Other/Unknown

N=3,375 (does not include Outreach & Engagement data)

Note: not all Peer Programs gather race/ethnicity data, missing data is categorized as “Unknown”. Not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

Members plan and facilitate daily activities and determine workshop topics. Clubhouses also sponsor social and recreational activities, both on-site and in the community, which enhance members' ability to interact and develop skills that improve their relationships within the community and with one another. In addition, the program provides transportation to stakeholder meetings, as well as access to virtual options, to ensure the consumer's feedback is being captured in the stakeholder process.

The **Community Connections** program offers participants the opportunity to develop and enhance their pre-employment skills. The program also assists with coordinating opportunities for members to volunteer, gain paid employment experience, and engage in peer support while keeping the goal of contributing to the community in mind.

Participants partner with staff to determine the area of focus that most suits their wellness goals. Participants leverage their existing strengths while collaborating with Employment Specialists, Social Workers, Mental Health Specialists, Peer and Family Advocates, and their peers. Together, they develop the skills and supports necessary to secure a paid or volunteer position. This collaboration is a crucial part of their journey toward self-efficacy and self-sufficiency, contributing to their overall recovery.

The Peer Provider Workforce Support program coordinates, monitors, and develops DBH's internal supports for peer providers. The designated position of Peer and Family Advocate (PFA) is a growing provider type and a dedicated support structure that was established based on internal stakeholder feedback.

Demographics, cont.

Primary Language

91% English
8% Spanish
<1% Other

N=3,375

Region

28% Central Valley
48% Desert/Mountain
14% East Valley
10% West Valley
<1% Decline to provide

Note: not all numbers add to 100 due to rounding. Number does not include Outreach & Engagement data.

Program Description and Target Population, cont.

This unit monitors the certification and ongoing renewal of Medi-Cal Peer Support Certification for all peer providers, identifies and develops system supports, and works with the PFAs and their supervisors to monitor and improve ongoing implementation efforts. PFA engagement meetings, supervisor collaboration meetings, and ongoing training sessions are currently in the design and implementation phase to meet the continuing education requirements for certification. Despite retention challenges, there are currently 23 Peer and Family Advocates with active certifications, representing over 50% of the current workforce.

Additionally, this unit coordinates DBH efforts to reduce the vacancy rate of this position. It has already implemented a continuous recruitment strategy, standardized classification, and is actively engaged in communication with Human Resources to implement other equity measures. The classification has grown from 36 filled positions in FY 2023/24 to 41 filled positions in FY 2024/25. There are a total of 55 positions in this classification, which represents an increase from the originally acquired 19 positions in FY 2006/07 with the implementation of MHSA.

Services Offered

Services offered through the Clubhouse and Community Connections programs include:

- System navigation assistance
- Supportive group meetings
- Social activities
- Life skills classes
- Physical health classes
- Job skills classes
- Nutrition classes
- Cooking demonstrations
- Clothing closet
- Food distribution
- Laundry machine access
- Showers (at select Clubhouses)
- Volunteer opportunities
- Transportation to stakeholder meetings
- Technical support for virtual platforms
- Education
- Career assessment
- Employment counseling
- Job coaching
- Linkage to other community supports
- Limited Shelter Placement and Housing Navigation

Positive Results

During FY 2024/25, Clubhouses averaged over 79 groups per site per month, with an average of 10 members per group. Additionally, Clubhouses served an average of 292 unhoused individuals per month, representing a 9% increase over the previous fiscal year. Sites averaged 1,600 service deliveries per month, representing an 11% increase compared to the previous fiscal year.

The Community Connections program served 291 participants in FY 2024/25, with 76 successful connections to sustained paid employment, and 178 individuals received resume assistance.

Both Clubhouse and Community Connections continue to use the “Consumer Empowerment Evaluation” consumer-created outcomes metrics tool, which was created in FY 2021/22. This tool was developed in partnership with the Consumer Evaluation Council (CEC) and Research and Evaluation (R&E). After researching validated evaluation tools, the CEC combined elements of various evaluation measures and adapted the wording to focus on recovery model, peer-led, and strengths-based outcome metrics. All metrics are self-reported to preserve the integrity of measuring subjective suffering. Results are reviewed with the Consumer Evaluation Council every quarter for evaluation and monitoring. In FY 2024/25, 194 surveys were collected and evaluated.

As the number of members identifying as unhoused continues to rise, Clubhouses have expanded their support services. In addition to weekly community meals, all locations offer daily meal support. Clubhouses offer mobile jump starters to members who live in their vehicles and encounter battery issues. Increased hygiene support, including laundry soap, dryer sheets, shampoo, conditioner, oral hygiene items, deodorant, emergency clothing, condoms, etc., is available at all locations. Clubhouses also offer tarps, ponchos, sunscreen, and other weather-related supplies for those exposed to the elements.

Clubhouses partnered with the Office of Homeless Services to designate three locations as cooling centers, which would be activated by the Office of Emergency Management. During activation, Clubhouses provided cooling towels, water, ice, and cooling outdoor areas equipped with misters, as well as emergency food, clothing, and other support services to help maintain safety in extreme heat.

Clubhouses have partnered with the Homeless Outreach and Support Team to access a limited number of Emergency Shelter-Bed Vouchers.

Challenges/Solutions

The lengthy process of expanding facilities to adequately serve the growing population remains a continued challenge, and as a result, the High Desert locations have not received the updated facilities for shower amenities or adequate space for programming.

Progress has been made on the pending relocations of the Victorville, Barstow, and San Bernardino Clubhouses. Facilities and Project Management staff continue to negotiate for pending relocations of these sites.

Outreach and Engagement

During FY 2024/25, Clubhouses and Community Connections conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Integration Excursions	50	525
Crisis Intervention Training	14	825
Cultural Celebrations	60	1,800
Behavioral Health Wellness Triathlon	3	550
NAMI Walk	2	120
Community Food Distribution	60	28,880
Consumer Evaluation Council	24	360
Unhoused Outreach	Daily	5,900
Community Connections – monthly engagement	12	291
Totals	**225**	**39,251**

CSS: Outreach, Access, and Engagement Programs

Introduction

Outreach, Access, and Engagement programs provide linkage to mental health and other necessary services, as well as advocacy, case management services, care navigation, family education, and support. These programs also provide consumers who have been discharged from a psychiatric hospital or a walk-in clinic with referrals to regional outpatient clinics where follow up services can be scheduled.

The Outreach, Access, and Engagement programs include the **Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services** and **Recovery Based Support Teams (RBEST)**. The ACE program provides psychiatric evaluations within seven days of a hospital discharge and within fourteen days of a walk-in clinic request. The RBEST program is a voluntary, consumer-centered program which provides community (field-based) services to individuals with untreated mental illness in an effort to encourage them to participate in appropriate treatment and services.

Program Updates

The A-15 RBEST program discontinued the Connecting Families program in FY 2024/25. Outreach and engagement numbers served were significantly impacted, as Connecting Families had a total of 453 participants during the previous fiscal year.

The decision to discontinue this component was because the original Connecting Families was a “Laura’s Law” alternative program. Since the inception of CARE ACT and Assisted Outpatient Treatment (AOT), DBH no longer utilizes the Laura’s Law alternative program and as such has integrated those teams into the RBEST reorganization to serve CARE and AOT.

Target Populations

The table below identifies the target population of consumers to be served by Outreach, Access, and Engagement programs for Fiscal Year 2025/26.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	X	X	X	X
Recovery Based Engagement Support Teams (RBEST)			X	

Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services	**2,181**	**All ages**	**SMI***	**Clinic based**	**Experiencing a behavioral health crisis**

*SMI = serious mental illness.

Program Description and Target Population

The Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services program seeks to improve the timeliness of access to Department of Behavioral Health (DBH) outpatient services. The ACE program enhances the outpatient care system to ensure that consumers receive the appropriate services to meet their needs.

The ACE program is implemented at the four large regional outpatient clinics (Phoenix in San Bernardino, Mariposa in Ontario, Mesa in Rialto, and Victor Valley in Victorville) and at the two rural outpatient clinics (Barstow and Needles).

Demographics

Age

15% Children
16% TAY
55% Adult
14% Older Adult

Gender Identity

46% Male
54% Female
<1% Other

Race/Ethnicity

18% African American/ Black
1% Asian/Pacific Islander
39% Caucasian/White
38% Latinx/Hispanic
1% American Indian/ Alaska Native
3% Other/Unknown

Primary Language

95% English
4% Spanish
1% Other

N=1,832

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for each consumer. ACE provides evaluations within seven days of a hospital discharge and within 14 days of walk-in clinic requests. The goal is to provide rapid access to mental health services and to provide consumers, who have been discharged from a psychiatric hospital or walk-in clinic, with a referral to an outpatient clinic for a follow-up appointment as soon as possible.

The ACE program includes case managers who assist consumers in connecting to:

- Managed Care Plans (IEHP/Molina/Kaiser) via referrals
- Financial assistance programs [Social Security Disability Income (SSDI), Veteran's Assistance, etc.]
- Transitional assistance programs (Medi-Cal, Cal-Fresh, etc.)
- Prevention and Early Intervention (PEI) services
- Charitable organizations for other needs via referrals

Services Offered

The ACE program offers the following services:

- Mental health assessments
- Psychiatric evaluations
- Referrals and linkage to Housing, Full Service Partnership (FSP), Substance Use Disorder (SUD), Crisis Stabilization Unit (CSU), or Crisis Residential Treatment (CRT) programs

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 267-273.

Demographics

Primary Diagnosis

10.9% Anxiety	**1.8%** Disruptive/Impulse control and conduct	**27.1%** Psychosis
15.0% Bipolar	**7.6%** Neurodevelopmental/neurocognitive	**4.5%** Substance related
23.8% Depression	**1.8%** None/deferred diagnosis	**7.6%** Other

N=1,832

Note: not all numbers add to 100 due to rounding.

Positive Results

During FY 2024/25, ten ACE staff members provided 8,090 services to their consumers, including 395 assessments.

The ACE program successfully linked hospital discharges to appointments during FY 2024/25, as shown below:

1,645 Referrals from Acute Psychiatric Hospitals to ACE	
1,521	Scheduled appointments within 7 days of discharge
64	Scheduled appointments within 14 days of discharge

Challenges/Solutions

ACE faced housing challenges during FY 2024/25. There are limited resources for housing, and some consumers did not qualify for emergency housing. Permanent housing options are limited and often have long waiting lists.

The program is addressing these challenges by identifying additional resources for housing that are more accessible to a wider variety of consumers and developing a streamlined process for applying for these housing programs.

Another challenge encountered has been an increase in referrals to the program that do not meet the criteria for services through DBH due to CalAIMS' "no wrong door" policy. As a result, this leads to delays in services for consumers as they need to go through an additional process to get connected to services.

To address the challenge of connecting consumers to the appropriate level of services, the program is considering a screening protocol that educates consumers about the services provided through the clinics, the population served, and the criteria for services, enabling them to make an informed decision on whether to proceed with an assessment. If the consumer chooses not to proceed with an assessment, they can be provided with resources for the services they are seeking that meet their specific needs.

Outreach and Engagement

The ACE program did not participate in any outreach and engagement activities during FY 2024/25.

Recovery Based Engagement Support Teams (RBEST)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Recovery Based Engagement Support Teams (RBEST)	328	18+	N/A	Field-based	Serious mental illness

Program Description and Target Population

Recovery Based Engagement Support Teams (RBEST) is a voluntary, consumer-centered program that provides community (field-based) outreach and engagement services to adults living with untreated mental illness. The objective of RBEST is to "activate" and link individuals to appropriate treatment, which may include outpatient mental health treatment, substance use treatment, and intensive wraparound support. The primary focus of the program is to meet the initial needs and goals of the individual, eliminate obstacles through engagement, and link the individual to appropriate treatment.

RBEST strives to connect individuals to appropriate behavioral health services and resources by reducing barriers, providing education, and creating a supportive system of care. The goal is to help individuals living with a serious mental illness to better understand their needs,

Demographics

Age

0% Children
16% TAY
72% Adult
13% Older Adult

N=243

Gender Identity

64% Male

36% Female

Race/Ethnicity

17% African American/ Black
24% Caucasian/White
7% Other/Unknown
6% Asian/Pacific Islander
47% Latinx/Hispanic

Primary Language

93% English
5% Spanish
2% Other

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

advocate for themselves, and achieve health and wellness however they define it. Through building trust and linkages to community-based resources, RBEST supports individuals living with a severe mental illness encouraging healthy, independent, and fulfilling lives.

RBEST seeks to assist adults aged 18 and older who are:

- Not active or successful in seeking and receiving necessary psychiatric care.
- The “invisible” consumer who is being cared for by family members and not linked or known to the public mental health system.
- Resistant to traditional engagement strategies due to anosognosia, a neurological condition which disallows insight into their own behavioral health condition.
- Unable to navigate the behavioral health system of care to obtain appropriate treatment.

Services Offered

Services offered by the RBEST program include:

- Outreach and engagement
- Access and linkage
- Advocacy
- Case management services
- Care navigation

Positive Results

During FY 2024/25, 65 RBEST consumers surveyed during the 30 days post-RBEST engagement in comparison to the 30 days pre-RBEST engagement showed:

- 72% decrease in psychiatric hospital bed days;
- 72% decrease in psychiatric hospital admissions; and
- 34% increase in routine outpatient services, including individual therapy, medication services, rehabilitation, activities of daily living, and residential services.

Demographics

N=243

Primary Diagnosis

3.3% Anxiety disorders
8.6% Depressive disorders
2.5% Bipolar disorders
49.0% Psychosis disorders
28.8% Other
3.3% None/deferred
4.5% Substance use disorders

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 274-278.

Challenges/Solutions

The RBEST program serves consumers who are located in different cities throughout San Bernardino County. Because the program is field-based, it can be challenging to reach all consumers given limited resources, such as County vehicles and staff availability. RBEST staff are located in Rialto and Victorville; therefore, providing outreach and engagement services in areas like Barstow and Needles can be time-consuming.

To address serving consumers in such a vast region, RBEST has shifted the way cases are assigned and managed. Consumers are assigned to engagement teams that have the closest proximity to their known location. This allows for engagement teams to conveniently reach consumers in a timely manner.

The RBEST program was expanded in 2024 to meet mandated requirements to provide Assisted Outpatient Treatment (AOT). This implementation led to additional challenges in determining how to incorporate AOT into the existing RBEST program and model of care. Additionally, this created a need to train staff on AOT processes and re-evaluate current RBEST practices.

During the past year, RBEST has made significant changes to its processes and model of care to accommodate the AOT expansion. RBEST has streamlined the screening process so that referrals are addressed and assigned in a timely manner. Additionally, guidelines have been put in place for how frequently consumers should be seen to improve the outcomes of engagement efforts. Policies, procedures, and workflows have been developed and distributed to staff, and they continue to be revisited as processes are adjusted.

Outreach and Engagement

In FY 2024/25, the RBEST program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Presentation to DBH Clinics/Providers	3	67
Presentation to Law Enforcement Agencies	2	40
Presentation to medical facilities/partners	2	28
Presentation to community members	1	30
Total	**8**	**165**

CSS: Full Service Partnerships

Introduction

Full Service Partnership (FSP) programs provide intensive case management and treatment services for consumers living with serious mental illness (SMI) or children with serious emotional disturbance (SED). The FSP framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of consumers, and when appropriate their families, including supports, providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. The primary goal of FSP programs is to improve consumers' quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and reducing high frequency use of psychiatric hospitalizations or emergency and crisis services. FSP programs strive to provide stabilizing services for the consumer at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 279-281.

Services Offered

The full continuum of care is provided for FSP consumers with services including, but not limited to:

- FSP programs in all outpatient clinics in every region of the County
- Substance use treatment services (co-occurring disorders)
- Food, clothing, and transportation
- Outreach and engagement
- Clinical and risk assessments
- Case management and intensive case management
- Coordination of care
- Emergency shelter
- Counseling services (individual and/or family)
- Employment services (job search and coaching)
- Entitlement obtainment (SSI, subsidized housing, etc.)
- Crisis intervention/stabilization services
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Vocational/educational training
- Peer mentoring (Peer Support Specialist)
- Housing assistance/placement supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Respite care

CSS: Full Service Partnerships

Target Populations

The table below identifies the target population of consumers to be served by the Full Service Partnership programs for Fiscal Year 2025/26.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Comprehensive Children and Family Support Services (CCFSS)	X	X		
Integrated New Family Opportunities (INFO)	X	X		
One Stop Transitional Age Youth (TAY) Centers		X		
Forensic Services Continuum of Care*			X	
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services*			X	
Regional Adult Full Service Partnership (RAFSP)*			X	X
Age Wise*				X
Collaborative Adult Full Service Partnership Services			X	X

*Programs may serve other populations as needed.

Program Updates

There are no planned updates for the Full Service Partnership programs.

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Comprehensive Children and Family Support Services (CCFSS)	3,057*	Ages 0-15 16-25	SED and/or SMI**	Clinic and Field	Probation or Children and Family Services Involvement

*This number does not include Outreach and Engagement (O&E). **SED = serious emotional disturbance and SMI = serious mental illness.

Program Description and Target Population

The Comprehensive Children and Family Support Services (CCFSS) program uses the Integrated Core Practice Model (ICPM) and provides services to children and youth living with serious emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their natural environment in order to achieve a positive set of outcomes through unconditional care. The target population for this program is children (ages 0-15) and TAY (ages 16-25) living with serious emotional disturbance and/or serious mental illness who have Probation or Children and Family Services (CFS) involvement.

CCFSS is comprised of three unique Full Service Partnership (FSP) subprograms and a C-1 component of Children and Youth Collaborative Services (CYCS). All utilize the Integrated Core Practice Model (ICPM) to serve children and youth.

Demographics

Age

71% Children
29% TAY
0% Adult
0% Older Adult

Gender Identity

54% Male
46% Female
<1% Other

Race/Ethnicity

<1% American Indian/Alaskan Native
2% Asian/Pacific Islander
20% African American/Black
17% Caucasian/White
48% Latinx/Hispanic
13% Other

N=2,591

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

The three individualized and targeted FSP subprograms are:

- **Children's Residential Intensive Services (ChRIS)**
- **SB163 Wraparound**
- **Success First/Early Wrap**

All CCFSS subprograms utilize the Therapeutic Behavioral Services (TBS) program as a short-term service to provide comprehensive community-based services to children and their families, one-on-one coaching, and develop tailored service plans that focus on individual strengths. Each subprogram is designed to assist children and youth in avoiding out-of-home placements or loss of current placement due to the severity of their emotional disturbance.

Positive Results

The Child Adolescent Needs and Strengths (CANS) is utilized within all C-1 programs. CANS data in FY 2024/25 was used by all C-1 Full Service Partnership (FSP) programs and is analyzed in two ways: (1) Global Measurement and (2) Specific Area/Construct. The Global Measure analysis incorporates specific items in a domain (e.g., Life Functioning) and compares scores from the onset of services to the planned discharge. The Specific Area analysis considers only those children and youth who presented with a significant need for help on that item/construct and reports what percentage of those children and youth no longer needed help at the conclusion of service.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 282-288.

Demographics

Primary Language

90% English
5% Spanish
4% Other

Primary Diagnosis

25.3% Anxiety disorders
<1% Bipolar disorders
22.8% Depressive disorders
12.6% Disruptive disorders
16.6% Neurodevelopmental/ cognitive disorders
2.6% None/deferred
<1% Psychosis disorders
1.1% Substance use disorders
17.5% Other

N=2,591

Note: not all numbers add to 100 due to rounding.

Positive Results, cont.

Global Measurement of Life Functioning (Progression Report):

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one area of impaired life functioning	98.9%	68.7%

Specific Areas of Life Functioning (Impact Report):

Of all the children and youth who started a C-1 FSP program, 69% of them successfully completed the program and had a 'planned discharge'. Of those children and youth, the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Family Difficulties	85%	64%
Social Functioning	73%	64%
Recreational	53%	61%
Sleep	55%	66%
School Behavior	55%	65%
School Achievement	60%	60%
School Attendance	36%	61%
Decision Making	75%	58%

Global Measurement of Behavioral and Emotional Needs (Progression Report):

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one significant behavioral or emotional need	99.0%	67.1%

Specific Areas of Behavioral and Emotional Needs (Impact Report):

Of all the children and youth who started a C-1 FSP program, 67% of them successfully completed the program and had a 'planned discharge'. Of those children and youth, the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Impulsivity/Hyperactivity	66%	56%
Depression	62%	69%
Anxiety	58%	63%
Anger Control	73%	64%
Adjustment to Trauma	67%	56%
Emotional and/or Physical Dysregulation	78%	66%

Positive Results, cont.

The concept of residential stability is quite different for children as it is for adults. Children coming to the CCFSS programs are in a variety of situations regarding their residence. Some are residing with biological families and do not have any Child Welfare involvement; others are with biological families and do have Child Welfare involvement. Some are placed into a family by Child Welfare and others are placed into group homes by Child Welfare. In addition to the basic question of residential stability for the caregiver, the Key Outcomes likely to increase residential stability for a child are (1) being with a caregiver likely to be involved once the child has grown, (2) how well the child is functioning within the family home, and (3) how involved and knowledgeable the caregiver is in regard to the needs of the child. These last items are indicative of a level of engagement from the caregiver, and more engaged caregivers are less likely to work toward having the child removed from their home.

Specific indicators likely to increase residential stability (Caregiver Impact Report):

Of the caregivers of C-1 FSP consumers with a 'planned discharge', the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Caregivers indicated needing help to obtain a more stable residence	4%	38%
Children needing help improving their functioning within their living situation	85%	64%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	10%	69%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	33%	72%

Positive Results, cont.

A significant number of youth (97%) seen in a CCFSS program needed support to reduce difficulties at home that could lead to out-of-home removal. Evaluating the effectiveness of CCFSS in reducing the likelihood of youth being removed from the home focuses on the impact made on these specific issues. This includes addressing a combination of life, behavioral, and emotional difficulties.

Of all the children and youth identified with specific indicators likely to increase the risk of difficulties in the home that could lead to removal, the following presentation and improvement percentages, at the time of a 'planned discharge', were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Family Functioning	85%	61%
Living Situation	73%	63%
School Behavior	58%	59%
Oppositional	55%	57%
Conduct	27%	56%
Emotional/Physical Dysregulation	75%	58%
Substance Abuse	25%	33%
Runaway	29%	54%
Delinquent Behavior	20%	41%
Fire Setting	2%	50%
Family Communication	66%	39%
Family Conflict	62%	46%

Positive Results, cont.

A significant number of children seen in a CCFSS program (65%) needed help with issues that could easily lead to criminal or juvenile justice involvement; however, 10% had specific difficulties related to formal legal charges. Evaluating the effectiveness of CCFSS on reducing the likelihood of juvenile justice involvement focuses on the impact made on these specific issues which could lead to juvenile justice involvement.

Of all the children and youth identified with specific indicators likely to increase juvenile justice involvement, the following presentation and improvement percentages, at the time of a 'planned discharge', were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Delinquency	13%	50%
Danger to Others	27%	64%
Runaway	21%	64%
Conduct Disorder Behaviors	21%	61%
Oppositional Behaviors	52%	63%

Challenges/Solutions

During the past fiscal year, staffing challenges continued to impact our MHSA-funded programs (Wraparound, Success First/Early Wrap, and Children's Residential Intensive Services (ChRIS)) and CYCS Administrative Staff. These challenges continue to deeply affect service delivery and overall program performance by limiting the number of new consumer admissions, disruptions of timely Child and Family Team (CFT) meetings, limiting access to Specialty Mental Health Services (SMHS), and compromising the integrity and continuity of care within the ChRIS program, all of which lead to increased workloads, staff burnout, and potential compliance issues.

To address the staffing shortages, the program maintained consistent dialogue and provided ongoing assistance to contracted providers concerning current staffing capacity and referral volumes. We streamlined the referral process to enable a more efficient distribution of cases, held regular meetings to discuss transitions to lower levels of service, and ensured referrals were appropriate based on age and care needs. Providers were actively assessing and redirecting referrals to programs with available capacity and earlier appointment options. The programs also partnered with providers to reexamine and potentially

Challenges/Solutions, cont.

adjust minimum job qualifications to broaden the pool of eligible candidates, and it's anticipated that this cooperative strategy will contribute to identifying new solutions for staffing shortages. Additional strategies included training administrative and clerical staff to support data entry and tracking for the providers.

The programs also faced challenges with a severe increase in the acuity of mental health needs among the children and families served. Rising clinical complexity required greater deployment of specialized resources, further straining limited staffing and fiscal capacity. Treatment plans had to be updated more frequently, increasing pressure on multidisciplinary teams. These factors contributed to delays in service initiation and waitlist expansion, placing additional stress on an already burdened system.

In response to the growing complexity of consumer needs, CYCS is strengthening both training and oversight efforts. The Supervisory team delivers regular training to internal staff and contracted agencies, while line staff offer ongoing clinical support and serve as liaisons to providers. Trauma-informed care and evidence-based practices are prioritized to equip staff in effectively supporting high-risk youth. Meeting training objectives will be a shared responsibility between CYCS and our providers. To better monitor and address these youths' needs, we have developed dashboards that track key indicators, including Child and Adolescent Needs and Strengths (CANS) scores, facilitating assessment of risk levels and behavioral and emotional needs.

Outreach and Engagement

For FY 2024/25, the CCFSS program conducted 9,394 outreach and engagement events with a total of 19,099 participants. Outreach and engagement activities included consultations/screenings, presentations, outreach efforts, and coordination between programs and regulatory requirements (e.g., AB1299, Administrative Sub-Committee of Wraparound, Healthy Homes Prescreens, Interagency Placement Council, Qualified Individual).

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Integrated New Family Opportunities (INFO)	140*	Ages 13-17	SED**	Clinic and Field	Probation Involvement

*This number includes FSP services only. **SED = serious emotional disturbance.

Program Description and Target Population

Integrated New Family Opportunities (INFO) is a National Association of Counties (NACo) and Counsel on Mentally Ill Offenders (COMIO) award-winning program that uses intensive probation supervision and evidence-based Functional Family Therapy (FFT). The goal is to provide and/or obtain services for children/youth and their families who are unserved or underserved. The program works with the juvenile justice population, ages 13-17, and their families.

Services provided by INFO increase family stabilization, help families identify community supports, and encourage recovery, wellness, and resiliency.

Services Offered

- Intensive probation supervision
- Evidence-based Functional Family Therapy (FFT)

Demographics

Age

35% Children
64% TAY
<1% Adult
0% Older Adult

Gender Identity

80% Male
19% Female
<1% Other

Race/Ethnicity

0% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
15% African American/ Black
6% Caucasian/White
74% Latinx/Hispanic
4% Other/Unknown

N=137

Note: not all numbers add to 100 due to rounding.

CSS: Integrated New Family Opportunities C-2

Positive Results

During FY 2024/25, the program worked to expand the screening and referral process to include more families who could be appropriately served by INFO.

Youth who completed the program during FY 2024/25 served significantly fewer days in detention after the program compared to youth who declined to participate or did not finish the program. The table below shows the improvement for the youth who participated in the INFO program during FY 2024/25:

Item/Issue	Improvement of the Need
Frustration Management	66%
Family Functioning	75%
School Behavior	82%
School Attendance	70%
Anger Control	74%

Challenges/Solutions

Due to an increase of new San Bernardino County Probation Department staff who were unfamiliar with the referral process, the INFO program saw a decrease in referrals during FY 2024/25.

To improve the referral process, the Juvenile Justice Program (JJP) updated the referral process to screen all incoming referrals for INFO services, rather than only those sent directly to INFO, to ensure that youth and their families receive the most appropriate services.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 289-291.

Demographics

Primary Language

82% English
18% Spanish
0% Other

Primary Diagnosis

7.3% Anxiety disorders
0% Bipolar disorders
12.4% Depressive disorders
24.1% Disruptive disorders
3.7% None/deferred
3.7% Neurodevelopmental/ cognitive disorders
1.5% Psychosis disorders
3.7% Substance use disorders
43.8% Other

N=137

Note: not all numbers add to 100 due to rounding.

One Stop Transitional Age Youth (TAY) Centers

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
One Stop Transitional Age Youth (TAY) Centers	433*	Ages 16-25	SED and/or SMI**	One Stop Centers	Youth below 200% Federal poverty Level living with Mental illness

*This number includes FSP services only. **SED = serious emotional disturbance and SMI = serious mental illness.

Program Description and Target Population

One Stop Transitional Age Youth (TAY) Centers provide integrated services to the unserved, underserved, and inappropriately served TAY population in San Bernardino County. These youth may be emotionally disturbed, with significant functional impairments, severely and persistently mentally ill or at-risk of mental health issues, high users of acute facilities, homeless or at risk of being homeless (due to an existing out of home placement), have co-occurring disorders, and have a history of incarceration, institutionalization, and recidivism.

One Stop TAY Centers are mental health clinics modeled as drop-in centers to improve TAY participation and allow TAY to utilize the services needed. They maximize their individual potential through the Recovery, Wellness, and Resiliency Model, while already in the community, and prepare for re-entry into the community. One Stop TAY Centers, in

Demographics

Age

<1% Children
97% TAY
3% Adult
0% Older Adult

N=427

Gender Identity

43% Male | **56%** Female | **2%** Other

Race/Ethnicity

16% African American/Black
3% Asian/Pacific Islander
22% Caucasian/White
49% Latinx/Hispanic
9% Other/Unknown

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

partnership with the Department of Probation, Children and Family Services, and numerous community partners, assist TAY in achieving their goals of becoming independent, staying out of the hospital or higher levels of care, reducing involvement in the criminal justice system, and reducing homelessness.

The target population for the program is youth (ages 16-25) who are under 200% of the federal poverty level and with or at-risk of mental health issues. Two of the targeted sub-populations are Latinx/Hispanic and African American/Black youth who are disproportionately over-represented in the justice system and out-of-home placements (Foster Care, group homes, and institutions).

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 292-297.

Services Offered

Services include, but are not limited to:

- Assessment
- Evaluation
- Treatment plan development (Individual Services and Supports Plan)
- Therapy (individual and group)
- Crisis intervention
- Medication support services
- Targeted case management
- Collateral services
- Rehabilitative activities of daily living
- Counseling
- Substance use disorder and co-occurring services
- Groups/Activities
- Housing assistance
- Employment assistance
- Education assistance
- Legal assistance
- Transportation assistance
- Shower and laundry facilities
- Resource room with computer and internet access

Demographics

Primary Language

95% English

2% Spanish

3% Other/ Unknown

N=427

Primary Diagnosis

25.5% Anxiety disorders

15.0% Bipolar disorders

1.9% Neurodevelopmental/ cognitive disorders

<1% None/deferred

35.8% Depressive disorders

<1% Disruptive disorders

11.2% Psychosis disorders

1.4% Substance use disorders

8.4% Other

Note: not all numbers add to 100 due to rounding.

Positive Results

Results from the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) for the period of July 1, 2022, through June 30, 2025*, show the number of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and the percentage who had that issue improve by the completion of the TAY program:

Item/Issue	Presented with a Need	Improvement of the Need
Family Relationships	182	59%
Social Functioning	216	67%
Recreational	170	66%
Legal	12	48%
Physical/Medical	12	32%
Sleep	141	65%
Living Skills	140	61%
Residential Stability	94	64%
Self-Care	159	67%
Medication Compliance	22	63%
Decision-Making/Judgement	132	54%
Involvement in Recovery/ Motivation for treatment	39	66%
Transportation	52	47%

Item/Issue	Presented with a Need	Improvement of the Need
Parenting Roles	14	58%
Intimate Relationships	110	60%
Educational Attainment	112	66%
Family/Family Strengths/ Support	135	53%
Interpersonal/Social Connectedness	184	60%
Optimism	135	66%
Educational Setting	78	59%
Vocational	102	50%
Community Connection	155	55%
Natural Supports	130	55%
Resilience	107	64%
Resourcefulness	94	59%
Sexual Relations	19	61%

*Due to the length of time most TAY consumers spend in the program, data was pulled for July 1, 2022, through June 30, 2025, (the completed fiscal years of the current contract) to showcase the level of progression that TAY members experience over time.

Positive Results, cont.

The One Stop TAY programs added 13 new collaborative partners in FY 2024/25.

Challenges/Solutions

During FY 2024/25, TAY Centers continued to struggle with staffing, making it difficult to provide services to existing consumers or to increase the number of consumers served.

To address the staffing challenge, clinical staff from other programs within the agency are providing clinical services such as facilitating groups, providing individual therapy, etc., while the program works to fill vacant positions.

TAY Centers also experienced an increase in cancellations and no-shows for psychiatry appointments. Additionally, the TAY Centers experienced challenges with reporting service information in their new electronic health record (EHR).

The program offered telehealth psychiatry appointments and transportation to in-person appointments for consumers to help reduce the number of missed appointments. To ensure that service information was reported, the TAY program's administrative management worked closely with their vendor to correct all issues with the EHR system.

The TAY Center's consumers also reported in FY 2024/25 that they felt that leadership opportunities in the area were lacking or insufficient to include in their resumes.

To provide TAY consumers more leadership opportunities, TAY Center staff organized a TAY Council election for various offices such as President, Vice President, and Treasurer to represent TAY youth during peer forums.

Outreach and Engagement

For FY 2024/25, the One Stop TAY Centers program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Agency/Org/Program Tour	4	30
Collaborative Meetings	17	229
Community Outreach	135	622
Conference Resource Booth	4	308
Health/Resource Fair	65	3,242
Mental Health Events Attended	10	200
Online Media	77	80
Orientation	6	6
Other (e.g., Community Consumer Contact)	4	12
Preparation for Service Delivery	23	4
Presentations	6	128
Total	**351**	**4,861**

Adult Forensic Services (AFS)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Adult Forensic Services (AFS)	1,031	Ages 18+	SMI*	Clinic and Field	Justice Involvement

*SMI = serious mental illness.

Program Description and Target Population

The Forensic Services Continuum of Care (Coc) program is designed to serve adults living with serious mental illness (SMI) who are involved in the justice system. The program comprises eight sub-programs, each designed to target a specific population. The targeted subprograms are:

- Supervised Treatment After Release (STAR)
- Community Supervised Treatment After Release (CSTAR)
- Joshua Tree Mental Health Court (JTMHC)
- Forensic Assertive Community Treatment (FACT)
- Community Forensic Assertive Community Treatment (CFACT)
- Corrections Outpatient Recovery Enhancement (CORE)
- Re-Integrative Supportive Engagement Services (RISES)
- Choosing Healthy Options to Instill Change and Empowerment (CHOICE)

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 298-304.

Demographics

Age

0% Children
6% TAY
89% Adult
5% Older Adult

N=763

Gender Identity

75% Male
25% Female

Race/Ethnicity

1% American Indian/ Alaskan Native
2% Asian/Pacific Islander
28% African American/Black
29% Caucasian/White
36% Latinx/Hispanic
4% Other/Unknown

Primary Language

98% English
1% Spanish
1% Other

Program Description and Target Population, cont.

The Supervised Treatment After Release (STAR) and **Forensic Assertive Community Treatment (FACT)** Full Service Partnership (FSP) programs serve consumers living with SMI who are under formal supervision of the Mental Health Courts (MHC) and agree to voluntarily participate in the programs as a condition of their probation. Currently, there are four participating MHC jurisdictions located in the cities of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree. STAR provides both intensive day treatment and outpatient mental health services to individuals with a history of recidivism (reincarcerations) who are living with severe and persistent mental illness. MHC participants usually participate in the STAR/FACT program for 18 months. The FACT program, operated by Telecare, differs from STAR in that it assists consumers who have difficulty participating in traditional outpatient mental health services. FACT services are both community-based and provided in an office for group rehabilitation, prescriber appointments, and individual rehabilitation.

Intensive program services, supportive case management, and psychiatric services are also provided in the home for those individuals who need a higher level of care.

Joshua Tree Mental Health Court (JTMHC) is operated by Valley Star Behavioral Health, Inc. and offers program activities and services similar to those of the STAR program for consumers referred through the Joshua Tree Mental Health Court.

The Community STAR (CSTAR) and Community FACT (CFACT) Full Service Partnership programs operate in the same capacity as STAR and FACT; however, consumers are no longer under formal supervision, but they still benefit from voluntarily participating in mental health and substance use services for a short period. CSTAR is a community-based referral program that also provides mental health treatment services to consumers transitioning from the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program, STAR, and CSTAR Mental Health Diversion (MHD) Court. CFACT consumers transition from Mental Health Court, other Forensic Services programs, or the general community, but must be referred through the Department of Behavioral Health (DBH) Adult Forensic Services (AFS).

Demographics

N=763

Primary Diagnosis

38.5% Psychosis	**4.9%** Anxiety disorders	**14.2%** Depressive disorder	**4.7%** None/Deferred diagnosis
11.4% Bipolar disorder	**17.4%** Substance related	**8.5%** Other	**<1%** Neurodevelopmental/Cognitive disorders

Program Description and Target Population, cont.

The CSTAR program also serves Mental Health Diversion (MHD) individuals determined to be appropriate by Diversion Courts under PC 1001.36 who live with SMI. During FY 2023/24, CFACT began to provide services to consumers in Mental Health Diversion (MHD). MHD participants usually participate in the CSTAR/CFACT program for up to 24 months.

The Corrections Outpatient Recovery Enhancement (CORE) program is an FSP program that provides intensive behavioral health treatment services to adult parolees diagnosed with a SMI and who were designated by the California Department of Corrections and Rehabilitation (CDCR) as receiving Enhanced Outpatient Program (EOP) or Correctional Case Management System (CCMS) services prior to release from state prison. The CORE program provides this population with intensive case management services for 12-14 months in addition to other wraparound support. The program serves individuals who are often not admitted to other community-based services as they have complex and unique treatment needs, which are further compounded by criminogenic factors.

The Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program provides both mental health and substance use disorder services to qualifying adult probationers. These services include screenings, clinical assessments, case management, weekly rehabilitation groups, medication management, emergency housing, and substance use disorder (SUD) outpatient treatment. The CHOICE program also provides linkages and referrals to other MHSA funded programs and services provided by DBH Adult Forensic Services (AFS). CHOICE has several MHSA funded staff at each of the Adult Day Reporting Centers (DRC) and Reentry Services Centers locations. CHOICE is co-located at DRCs in Barstow, Fontana, San Bernardino, and Victorville. CHOICE was designed to provide a “one stop shop” for a vulnerable population, helping consumers reacclimate to their community and reduce recidivism.

The Re-Integrative Supportive Engagement Services (RISES) program serves as a key entry point/linkage to all Forensic Services programs. While the whole program is not MHSA funded, RISES currently has three MHSA funded positions providing services. RISES serves individuals living with a severe and persistent mental illness scheduled for release from county jails to integrate back into the community successfully. The goal is to reduce the likelihood of additional criminal behavior, starting from pre-release from custody, by assessing the consumer’s needs and providing extended after-release services. RISES coordinates and/or provides transportation immediately after consumer release from custody directly to services that best suit their needs, decreasing the likelihood of reincarceration.

Services Offered

STAR and FACT core services include intensive therapeutic programming, supportive case management, in-clinic psychiatric care, transportation assistance, and housing placement. The teams meet weekly with the Mental Health Court (MHC) treatment team to monitor consumer progress and submit bi-weekly reports to the Court. Additionally, they convene in Court chambers every two weeks to discuss consumer outcomes and determine advancement through treatment levels.

Staff are trained in the Listen-Empathize-Accept-Partner (LEAP) model and Motivational Interviewing (MI), which are used to identify individual needs and goals that inform personalized treatment plans. The teams also provide ongoing education about mental health symptoms and offer medication support as part of their comprehensive care approach.

CSTAR provides mental health treatment services to consumers transitioning from the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program as well as the Mental Health Diversion (MHD) Court. Additionally, CSTAR provides psychiatric supportive services, assessments, psychotherapy, medication support, group and individual therapy, case management, crisis intervention, mental health treatment services to those participating in MHD court, housing support services, and transportation services. CSTAR meets weekly with the MHD treatment team, including psychiatry, Probation, Enhanced Care Management (ECM), and Substance Use Disorder (SUD) counselors to review consumer progress. Special multi-disciplinary teams (MDTs) are scheduled with consumers to review their progress and review the completion of treatment levels.

STAR/FACT/CSTAR provide the following treatment levels:

Intensive:
This level is for consumers who are recently admitted to community treatment or have a history of psychiatric decompensation, relapses, or rule noncompliance. They require a high level of care and have the highest risk for various issues. New consumers must have at least 60 days of sobriety and stability before moving to a lower level.

Intermediate:
This level is for consumers who are adjusting to community living and have 60 or more days of sobriety. They are at a relatively high risk for relapse and other issues. They need to be cooperative and have plans for community involvement.

Supportive:
Consumers at this level have at least four months of sobriety and treatment compliance. They are making plans for community involvement and may have successful overnight visits. They require ongoing monitoring and support but have a moderate risk for relapse.

Transitional:
This level is for consumers who have been successful at the Supportive Level for 90 days. They are actively involved in the community and may have decreased treatment sessions.

Services Offered, cont.

Consumers at this level are considered for program completion.

The program emphasizes the importance of sobriety, stability, and community involvement at each level.

FACT services include, but are not limited to:
- Outreach and engagement;
- Comprehensive assessment and treatment;
- Crisis intervention and immediate support 24 hours a day, 7 days a week;
- Community integration through meaningful social activities and outings;
- Case management with linkage to community services and resources;
- Counseling/therapy and psychosocial rehabilitation services that include symptom management, building independent living skills, and enhancing coping and social skills;
- Medication support services;
- Physical health screening, care coordination, and referral;
- Self-help and member-facilitated support groups; and
- Pre-vocational, vocational, and educational assessments and referrals.

Services offered at **CFACT** include mental health treatment for individuals that are transitioning from FACT, FACT/MDD, or CORE who need a softer transition into the community while their Supplemental Security Income (SSI) application is reviewed and benefits are established, having high anxiety related to program changes, or needing assistance adjusting to program culture and/or other barriers that may have become apparent during treatment. Additionally, CFACT offers services to consumers in the MHD Court.

JTMHC services include, but are not limited to:
- Weekly enrichment/psychotherapy groups;
- Assistance with expungements;
- Housing assistance;
- Transportation;
- 24/7 crisis intervention support;
- Peer support services;
- Employment readiness;
- Individual therapy and medication management; and
- Case management and linkage to community services and resources.

CHOICE offers temporary housing services, individual therapy, weekly rehabilitation groups, individual group, medication management, day treatment, case management, collateral, and transportation services.

CHOICE consumers can participate in the program for the duration of their probation and/or as long as they maintain program and medication compliance. Housing services that are offered consists of two components:

Services Offered, cont.

six months of emergency shelter housing and Bridge housing beyond the initial 6-month eligibility. Consumers in emergency housing are assisted by a case manager to connect them to employment, enabling a transition to self-pay housing after six months. A case manager also assists consumers in Bridge housing with applying for Social Security benefits. Bridge housing offers an indefinite time frame for consumers to remain as long as they are actively pursuing Social Security benefits.

Consumers enrolled in the CHOICE program receive weekly case management services, participate in rehabilitative groups, individual therapy, medication management, and substance use disorder services. They are closely monitored by a multi-disciplinary team that will also refer consumers to various levels of care depending on their current needs, such as Enhanced Care Programs, Board & Care, and Inpatient Residential Treatment.

Positive Results

During FY 2024/25, AFS emergency shelter programs collectively provided 33,234 bed days to consumers. This significant level of support reflects the program's commitment to ensuring safe, stable, and structured living environments for individuals transitioning out of the justice system. By utilizing housing funds, leveraging SSI benefits, and connecting consumers with employment or family housing, the programs have effectively reduced homelessness among participants.

These efforts not only provide immediate shelter but also promote long-term residence stability, allowing consumers to focus on recovery, employment readiness, and community reintegration. The bed days recorded demonstrate the success of housing-focused interventions and the importance of coordinated care in reducing the need for higher levels of residential treatment or emergency housing.

AFS programs continue to demonstrate meaningful progress in reducing justice system involvement among participants with serious mental illness. A comparison of combined program data across two consecutive fiscal years reveals notable improvements in public safety outcomes. Between FY 2023/24 and FY 2024/25, there was a reduction in both the rate and duration of incarceration, as shown in the table below:

Public Safety Outcomes	FY 2024/25 Rate (compared to FY 2023/24)
Rate of incarceration	12.4% decline
Duration of incarceration	32.5% decline

The decline suggests that the programs are increasingly effective at diverting individuals from jail and supporting their stability in the community.

Positive Results, cont.

These reductions in both the rate and duration of incarceration reinforce the value of forensic mental health programs in lowering recidivism and promoting rehabilitation. As program enrollment grows, these outcomes support continued investment in community-based alternatives to incarceration that prioritize behavioral health treatment and recovery.

During FY 2024/25, the AFS programs experienced a significant decrease in both psychiatric hospitalizations (55.6%) and hospital bed day usage (46.2%) compared to the prior year, as shown in the tables below.

Item	FY 2023/24	FY 2024/25
Psychiatric Hospitalizations	455	202
Hospital Bed Days	2,270	1,221

Program	Number of Hospitalizations
CHOICE	124
CSTAR	27
CORE	28
STAR	11
FACT	11
Valley Star	1
Total	**202**

This notable improvement reflects the impact of early intervention, crisis stabilization, and increased outpatient engagement across AFS programs. Consumers are receiving more consistent care and wraparound support services in the community, helping them to manage symptoms more effectively and avoid inpatient settings.

The data suggest that enhanced care coordination, effective use of treatment plans, and increased access to alternative crisis interventions, such as Crisis Walk-In Centers (CWIC), Community Crisis Response Teams (CCRT), and Crisis Stabilization Units (CSU), have directly contributed to reducing reliance on emergency and acute psychiatric services.

Consumers also experienced less distress and reported increased satisfaction with their lives, as evidenced by self-reports and changes in assessment scores, leading to better outcomes in other areas, such as housing, employment, and family.

Positive Results, cont.

Success Points

- 16 participants in CSTAR gained employment
- 13 STAR consumers enrolled in GED or high school diploma programs
- DBH and contracted programs participated in several targeted outreach events, gaining 1,300+ participants throughout the fiscal year
- Multiple consumers reconnected with family or transitioned into stable housing (e.g., emergency shelters or family homes)
- Program consumers volunteered and engaged in community integration efforts, such as participating in churches and food pantries

Challenges/Solutions

Across all programs, several common challenges are evident, including staffing issues, dependency on public transportation, and limited housing options. These challenges highlight the complexities involved in providing effective support and services to a diverse consumer base with unique needs. Addressing these challenges is crucial to ensuring the success and effectiveness of the programs.

Programs struggled to maintain stable and consistent staff, as frequent vacancies and high staff turnover impacted the continuity and quality of services. The program remains committed to addressing the growing demands of our consumers and actively exploring avenues to expand staff capacity, including specialized recruitment for justice-involved individuals.

Many consumers lack their own personal transportation and rely on public assistance or public modes of transportation, which can be a barrier to accessing services. Some consumers do not have access to Transitional Assistance Department (TAD) benefits such as Medi-Cal upon release and/or are not enrolled with a Medical Managed Care Plan such as Inland Empire Health Plan (IEHP) or Molina, making it difficult to access rideshare services. Despite these resource constraints, Forensics Services continues to provide essential transportation and public assistance.

Challenges/Solutions, cont.

Additionally, the program faced difficulties in securing appropriate housing for justice-involved consumers, including challenges in finding housing solutions for individuals with P.C. 290 (Registered Sex Offender) status, arson charges (even if the charge may have been due to their mental illness), and the female population. In anticipation of these increasing needs, AFS secured contracts with multiple vendors to offer emergency shelter services, while also fostering collaboration with Homeless and Supportive Services, to tackle housing-related challenges. The program is dedicated to upholding Department of Behavioral Health standards within our shelters, conducting regular inspections, and working closely with service providers to promptly address any concerns that may arise.

AFS remains committed to addressing the growing demands of consumers, actively exploring avenues to expand staff capacity, including specialized forensic recruitments. Despite resource constraints, AFS continues to provide essential transportation and housing assistance to consumers in need, as well as linkages and case management to additional resources and services that consumers require. As of July 1, 2023, AFS programs refer consumers to Enhanced Board and Care facilities and Augmented Residential Facilities for safe, stable, and structured treatment programs in a community setting. These additional resources assist in closing the housing gap for justice-involved consumers and consumers of AFS programs.

Outreach and Engagement

In FY 2024/25, the AFS programs conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Telecare Annual Member Picnic	1	28
Telecare Member Halloween Event	1	34
Telecare Member Holiday Party	1	37
Valley Star Student Attendance Review Board (SARB)	5	200+
Valley Star Community Member Outreach	20	30
Valley Star Resource Fair	6	636
Valley Star Community Coalitions	4	89
Valley Star School Presentations	5	11
Valley Star Youth Coordinated Entry System (YCES)	4	34
Valley Star Community Partner Collaborations	113	260
Total	**160**	**1,359+**

Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Assertive Community Treatment (ACT) Model FSP Services	145	Ages 18+	SMI*	Clinic and Field	High Users of Hospitalization Services

*SMI = serious mental illness.

Program Description and Target Population

The Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services program serves adults 18 years and older residing in San Bernardino County who are living with a behavioral health condition. This program exists to assist consumers in living successfully within the community and support positive progress toward achieving individual personal recovery goals while avoiding unnecessary psychiatric hospitalization. The program consists of two sub-programs: the Assertive Community Treatment (ACT) program and the Members Assertive Positive Solutions (MAPS) program.

The Assertive Community Treatment (ACT) program serves consumers transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs), or locked psychiatric facilities.

The Members Assertive Positive Solutions (MAPS) program serves consumers who are historically high users of acute psychiatric inpatient and crisis services. These consumers may also have a history of a co-occurring substance use disorder (SUD) or a history of identifying as homeless.

Demographics

Age

0% Children
4% TAY
82% Adult
14% Older Adult
N=142

Gender Identity

63% Male
37% Female

Race/Ethnicity

18% African American/Black
4% Asian/Pacific Islander
32% Caucasian/White
43% Latinx/Hispanic
3% Other

CSS: Assertive Community Treatment Model FSP Services A-3

Program Description and Target Population, cont.

The Recovery Model used for both programs builds on traditional Assertive Community Treatment standards. The program's approach is based on the belief that "recovery can happen," creating an environment that promotes personal resiliency. Key components of the ACT model include individualized and guided treatment and support services that are tailored to the consumer's hopes, dreams, and goals for behavioral health and overall wellness.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 305-308.

Services Offered

Services and supports include comprehensive assessment, treatment, crisis intervention, case management, and 24/7 immediate support. Through these programs, consumers have access to:

- Development of individualized service plans
- Psychiatric assessment and treatment
- Medication management and support
- Focused assessment and intervention
- Physical health screening
- Care coordination and referral
- Substance use disorder intervention
- Vocational counseling services
- Social skills building services
- Housing support
- Benefits and entitlements assistance
- Family support
- Education

Demographics

Primary Language

96% English

3% Spanish

<1% Other

Primary Diagnosis

3.5% Anxiety

7.8% Depressive disorder

76.8% Psychosis

<1% Neurodevelopmental/Cognitive disorders

5.6% Bipolar disorder

1.4% Substance related

3.5% Other

<1% None/Deferred

N=142

Note: not all numbers add to 100 due to rounding.

Positive Results

Program staff work with consumers to build their skills and improve their independence. The program implemented a TIER system that gradually steps down into lower intensity services; thereby illustrating decreased impairment and increased resiliency (TIER System: 1 – High intensity, 2 – Moderate intensity, 3 – Low intensity).

During FY 2024/25, the ACT program served 76 consumers, and the MAPS program served 69 consumers. The table below shows the TIER Level Transitions for consumers who stepped down to lower intensity services for each program:

TIER Level Transition	ACT	MAPS
Consumers who remained in TIER 1	9	29
Consumers who transitioned from TIER 1 to TIER 2	44	19
Consumers who transitioned from TIER 2 to TIER 3	23	21

For both the ACT and MAPS programs, 100% of consumers maintained safe housing and avoided homelessness during FY 2024/25. Please see the tables to the right for a breakdown of the housing categories.

ACT Housing Category	Count	Percentage
Board and Care	49	64.5%
Supportive Housing	5	6.6%
Assisted Living	17	22.4%
Live with Family	3	4.0%
Room and Board	2	2.6%

MAPS Housing Category	Count	Percentage
Board and Care	22	31.9%
Live with Family	2	2.9%
Room and Board	45	65.2%

The table below shows psychiatric appointment attendance and the percentage of consumers who had collateral services for each program:

Category	ACT	MAPS
Average monthly attendance for psychiatric appointment	73.8%	74.6%
Consumers who had collateral services	68.4%	50.0%

Positive Results, cont.

The tables below show consumer participation in program services:

ACT Program	Count	Percentage
Attend Day Program	20	26.3%
Attend ACT Groups/Office	24	31.6%
Linked to Rehab/Attend AA Meetings	2	2.6%

MAPS Program	Count	Percentage
Attend Day Program	5	7.3%
Attend MAPS Groups/Office	20	29.0%
Licensed Residential Treatment (Includes Crisis, Short-Term, Long-Term, Substance Abuse, Dual Diagnosis Residential Programs)	7	10.1%

All consumers who identify a substance use concern are referred for substance use treatment. Substance use disorder groups are held at the program's administration office weekly and focus on managing and coping with symptoms. Additionally, consumers are linked to primary care providers for their medical needs.

Of the consumers served by the programs during FY 2024/25:

- 2.6% of ACT consumers were referred and attended AA programs
- 10.1% of MAPS consumers were referred and attended AA programs

Programs utilize the Full Service Partnership services, safety plans, and education on accessing Crisis Stabilization Units to help their consumers avoid unnecessary psychiatric and medical hospital admissions.

During FY 2024/25, the ACT and MAPS consumers avoided unnecessary hospitalizations as follows:

Category	ACT	MAPS
Avoided unnecessary acute psychiatric hospitalization	85.5%	87.0%
Avoided unnecessary medical hospitalization	92.1%	85.5%

Challenges/Solutions

During FY 2024/25, transportation continued to be a challenge, particularly in the high desert area. The Office of the Public Guardian does not permit conserved individuals to use public transportation options, such as Uber, Lyft, IEHP transportation, or buses, to attend community appointments.

DBH, the Office of the Public Guardian, and other partners continue to meet regularly to find solutions to ongoing transportation challenges for all members. They are also exploring alternative transportation options to improve members' independence and quality of life as they prepare to transition to lower levels of care. The program educates members on the use of public transportation, helps them obtain reduced bus passes, and provides transportation to increase access to psychiatric and nursing appointments. They also attend appointments with members to support their recovery.

Housing also remains a barrier, with unsuccessful placements, medical needs, or affordability all presenting significant challenges. The program is actively helping members find new housing by building strong partnerships and collaborating with community vendors to expedite placements. They are also providing housing assistance and connecting them to Supplemental Security Income (SSI) and other financial resources to support their living needs while they await benefits.

The new TIER system has been a challenge for some long-term members to adjust to. While many have reached a stable baseline, some are resistant to the idea of graduation or discharge, which has led to relapse and hospitalization, delaying their transition out of the program.

The program continues to educate members about the TIER system at enrollment and throughout their time in the program, helping them understand the path from intensive to lower levels of care.

Outreach and Engagement Activities

During FY 2024/25, a combined total of 84 participants attended 14 presentations where staff members from the ACT Model FSP Services program were available to discuss the program and offer their services.

Regional Adult Full Service Partnerships (RAFSP)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Regional Adult Full Service Partnerships (RAFSP)	467	Ages 26-59*	SMI**	Clinic and field 	Adults Living With SMI

*The clinics may serve the older adult population as needed. **SMI = serious mental illness.

Program Description and Target Population

The Regional Adult Full Service Partnership (RAFSP) offers Full Service Partnership (FSP) programs in the Department of Behavioral Health's (DBH) Barstow, Phoenix, Mesa, Mariposa, and Victor Valley community clinics. Additionally, DBH contracts with Valley Star Behavioral Health, Inc., and Step-Up to provide FSP services throughout various regions of San Bernardino County. The RAFSP programs provide access and linkage, as well as full wraparound treatment, to consumers.

These services include an intensive level of care provided at clinics and in the field, as well as assistance to help access various levels of care and housing, and/or transition to a lower level of care in the least restrictive setting possible. Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive treatment and intensive case management support.

Demographics

Age

2% Children
10% TAY
74% Adult
14% Older Adult

Gender Identity

52% Male

48% Female

Race/Ethnicity

<1% American Indian/ Alaskan Native
<1% Asian/Pacific Islander
17% African American/Black
36% Caucasian/White
42% Latinx/Hispanic
4% Other

N=463

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

The ratio of staff to consumers is typically 1 to 10, allowing for intense support 24 hours a day, 7 days a week, but can include larger numbers as needed. RAFSP encourages individualized decision making and reinforces self-responsibility. Consumers within the FSP programs are actively involved in ongoing planning, reviewing progress toward goals, and evaluating their treatment. Additional services include activities that support consumers in their efforts to restore, maintain, and develop interpersonal and independent living skills through the Wellness, Recovery, and Resilience Model, utilizing culturally competent, evidence-based practices.

Services Offered

- Food, clothing, and transportation
- Outreach and engagement
- Clinical and risk assessments
- Case management and intensive case management
- Coordination of care
- Linkage to emergency shelter
- Counseling services (individual and/or family)
- Treatment for eating disorders/linkage to more intensive treatment
- Linkage to employment services (job search and coaching)
- Entitlement obtainment (Supplemental Security Income, subsidized housing, etc.)
- Crisis intervention/stabilization services
- Housing assistance/placement
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Linkage to vocational/educational training
- Linkage to Enhanced Care Management (ECM)
- Peer mentoring (Peer Support Specialist)
- Linkage to housing supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Linkage to substance use treatment services (co-occurring disorders)
- Linkage to respite care

Demographics

Primary Language

94% English

5% Spanish

1% Other

N=463

Primary Diagnosis

6.5% Anxiety disorders

13.8% Bipolar disorders

21.4% Depressive disorders

7.8% Other

<1% None/deferred

43.6% Psychosis disorders

5.4% Substance related

1.3% Neurodevelopmental/cognitive disorders

Note: not all numbers add to 100 due to rounding.

Positive Results

Consumers are provided with the full array of FSP treatment services to reduce hospitalizations and hospital bed days. In the table below, the percentage of consumers who avoided hospitalizations in FY 2024/25 is reported by provider.

Provider Name	Unduplicated Consumers Served	% of Consumers who Avoided Hospitalization Completely in FY 2024/25
Barstow Counseling	14	100%
Mesa Counseling Services	33	76%
Victor Valley Counseling Center	109	91%
Phoenix FSP (Clinic Based)	112	88%
Step Up On Second FSP*	636	99%
Valley Star FSP	76	95%
Valley Star Behavioral Health	102	92%
Mariposa Counseling Center	18	61%

*This provider is not included in the actual number served total for RAFSPs and is represented in the Housing and Homeless Services Continuum of Care count.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 309-312.

Challenges/Solutions

In FY 2024/25, the RAFSP program faced continued staffing challenges; limited resources such as housing, clothing, food pantry, and hygiene supplies; a lack of emergency funding for consumer emergencies, such as after-hour food access and gas cards; and a lack of transportation for consumers.

The RAFSP program implemented various strategies to address these issues. The program streamlined the hiring process and implemented pay increases to assist with staff retention. DBH is also encouraging staff to apply for incentives such as a loan forgiveness application for Medi-Cal providers and is reevaluating staffing needs to fill the most-needed positions.

The program is collaborating with other DBH programs to explore additional housing options within our department and identify upcoming new housing projects. They are also building collaborative partnerships with the community to identify additional resources for their consumers, in addition to reviewing budgets and identifying alternative funding sources.

Additionally, the program is providing mobile and in-home services to help address transportation issues and is working with managed care plans to utilize their transportation services to assist consumers.

Introduction

The Collaborative Adult FSP Services (A-20) program is a CSS component under MHSA. It consists of the Community Reintegration Services (CRS) program and the Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program.

The Community Reintegration Services (CRS) program is a Full Service Partnership (FSP) designed to serve adults living with serious mental illness or untreated co-occurring disorders who, in many cases, have recently been discharged from State Hospitals and/or secure psychiatric facilities.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program is designed to provide the FSP-level services to those consumers who have been court-ordered to AOT and provides intensive, consumer-directed treatment and case management services, including obtaining community residential housing, coordination of services (medications, psychiatric and psychological services, substance use treatment), education/understanding and management of symptoms, and advocacy.

Target Population

The table below identifies the target population of consumers to be served by the Collaborative Adult FSP Services programs for FY 2025/26.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Community Reintegration Services (CRS) program			X	
The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program			X	

Community Reintegration Services (CRS)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Community Reintegration Services (CRS)	66	Ages 18-59	SMI*	Field-based	At risk of homelessness, incarceration, or hospitalization/ rehospitalization

*SMI = serious mental illness.

Program Description and Target Population

The Community Reintegration Services (CRS) program is a Full Service Partnership (FSP) designed to serve adults who are living with serious mental illness or untreated co-occurring disorders who, in many cases, have recently been discharged from State Hospitals and/or secure psychiatric facilities. These adults are at risk of homelessness, incarceration, or re-hospitalization.

Services utilize a strengths-based approach by focusing on the consumer's strengths and goals to move towards a new level of functioning in the community. Additionally, CRS embraces a consumer-centered approach that ensures that each consumer's needs are met based on where the consumer is in the process of recovery.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 330-332.

Demographics

Age

0% Children
2% TAY
65% Adult
33% Older Adult

Gender Identity

68% Male
32% Female

Race/Ethnicity

18% African American/Black
39% Caucasian/White
<1% American Indian/ Alaska Native
5% Asian/Pacific Islander
36% Latinx/Hispanic
2% Other/Unknown

Primary Language

97% English
3% Spanish

N=66

Note: not all numbers add to 100 due to rounding.

Community Reintegration Services (CRS), cont.

Services Offered

- Housing, including licensed board and care homes
- Medication support services
- Intensive case management
- Individual psychotherapy where clinically indicated
- Individual rehabilitation skills building

Positive Results

In FY 2024/25, 66 consumers received services from the CRS program.

Of the consumers served:

- 85% did not require psychiatric hospitalizations
- 79% did not require any crisis intervention services

Challenges/Solutions

The Assisted Living Waiver (ALW) program was put on hold briefly in September 2024, so consumers were unable to access these benefits and transition out of Enhanced Assisted Living. Additionally, housing affordability continues to be a challenge for those transitioning out of State Hospitals.

The program is exploring other housing options and continues to use alternative resources for consumers, such as referrals and linkage to housing provided by Managed Health Care and Veteran Affairs.

The program also faced challenges with slow processing of applications for Social Security Administration (SSA) benefits and a change in the appointment process, resulting in even longer wait times before benefits are awarded. These delays prevent consumers from stepping down to lower levels of care as they do not have funding for housing without these benefits.

To help minimize these delays, additional training has been provided to all staff on the process of applying for Social Security benefits, and tracking the status of the applications for benefits has also improved.

Outreach and Engagement

For FY 2024/25, a combined total of 30 participants were engaged through telephone consultations for referrals.

Demographics

Primary Diagnosis

4.6% Bipolar disorders
7.6% Depressive disorders
69.7% Psychosis disorders
7.6% Substance use disorders
1.5% Anxiety
3.0% None/Deferred
6.1% Other

N=66

Note: not all numbers add to 100 due to rounding.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT)

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT)	**28**	**18+**	**SMI***	**Field-based**	**Serious Mental Illness**

*SMI = serious mental illness.

Program Description and Target Population

Assisted Outpatient Treatment (AOT), commonly known as Laura's Law, was signed into law in 2002. Laura's Law authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for those individuals who have a history of untreated mental illness. This program serves seriously mentally ill individuals who are at substantial risk of deterioration and/or detention under WIC5150 as a direct result of poor psychiatric treatment compliance. The program outreaches to these individuals in an effort to engage them in voluntary treatment. If the individual continues to decline treatment, the program may petition the court to order outpatient treatment.

Demographics

Age

0% Children
21% TAY
68% Adult
11% Older Adult

Gender Identity

50% Male
46% Female
4% Other/ Unknown

Race/Ethnicity

21% African American/Black
29% Caucasian/White
<1% American Indian/ Alaska Native
4% Asian/Pacific Islander
39% Latinx/Hispanic
7% Other/Unknown

N=28

Note: not all numbers add to 100 due to rounding.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Program Description and Target Population, cont.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program coordinates with the San Bernardino County Public Defender and collaborates with the Sheriff's Homeless Outreach and Proactive Enforcement (H.O.P.E.) Team.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program is designed to provide the FSP-level services to those consumers who have been court-ordered to AOT and provides intensive, consumer-directed treatment and case management services, including obtaining community residential housing, coordination of services (medications, psychiatric and psychological services, substance use treatment), education/understanding and management of symptoms, and advocacy.

RBEST-AOT's target population is individuals who have a history of untreated mental illness and meet all of the following criteria stipulated in the Code:

1. The person is at least 18 years of age.
2. The person is suffering from a serious mental illness as defined in WIC 5345-5349.5.
3. The person is clinically determined to be unlikely to survive safely in the community without supervision and their condition is substantially deteriorating **or** AOT is needed to prevent relapse/substantial deterioration that would result in grave disability or serious harm to self or others.
4. The person has a history of treatment non-compliance, as evidenced by one of the following:
    - Two occurrences of hospitalization or mental health treatment in prison or jail within the last 36 months - **or-**
    - One occurrence of serious and violent behavior (including threats) within the last 48 months.
5. The person has been offered the opportunity to participate in treatment (including services described in WIC Section 5348-5349.5) and continues to fail to engage in treatment.
6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.
7. The person is likely to benefit from AOT.

For additional information, please refer back to the MHSA Annual Update for Fiscal Year 2025/2026, pages 328-331.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Services Offered

RBEST-AOT provides engagement services, working to identify appropriate resources which may include outpatient treatment, housing placements, and social supports. FSP treatment services will be provided to consumers who meet the AOT legislative criteria.

FSP services may include:

- Initial assessment completed to verify individual meets program requirements
- Clinical evaluation
- Individualized treatment plan development
- Intensive case management:
- Family psychoeducation and support
- Crisis intervention
- Individual therapy
- Individual rehabilitation skills building
- Medication support services
- Transportation services

Demographics

Primary Language

96% English
4% Spanish

Primary Diagnosis

57.1% Psychosis disorders
7.1% None/Deferred
35.7% Other

N=28

Note: not all numbers add to 100 due to rounding.

Positive Results

During FY 2024/25, the RBEST-AOT program provided services to a small group of consumers. As a result, the program was not able to collect enough data to properly evaluate its goal of reducing the frequency of emergency room visits and unnecessary hospitalizations – current data shows 100% decrease in psychiatric hospital bed days and admissions based on only 5 completed surveys.

The program will continue its efforts to expand services to more consumers and expects to present a more accurate representation of program performance in the next year's report.

Challenges/Solutions

RBEST-AOT faced challenges with numerous referrals during FY 2024/25. One of the main sources was the spread of misinformation about the purpose of the program and who is eligible. This misinformation led to a significant number of inappropriate referrals. This led to increased caseloads for the engagement teams and delays in screening referrals due to a shortage of clinicians on staff.

To address inappropriate referrals, RBEST-AOT leadership conducted numerous presentations to educate DBH programs and clinics, partner agencies, and the community

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Challenges/Solutions, cont.

about AOT, what it is and who it is intended to benefit. The program recognizes that training should be ongoing and plans to continue these efforts during the next fiscal year.

New legislation passed in 2024 that also led to an increase in caseload. Senate Bill 1400 allows for courts to refer individuals who are Incompetent to Stand Trial (IST) to AOT if it appears they meet criteria. Once referred, RBEST must investigate and engage, and if appropriate, DBH will file a petition.

To prepare to receive court referrals, the program held meetings with the partners involved to collaborate and develop an efficient process for submitting, investigating, and reporting outcomes of referrals. Forms were developed to ensure clear and consistent communication, and training has been planned for court staff.

Another challenge was hiring, retaining, and training staff. RBEST-AOT conducted interviews to fill vacant positions, but due to delays in the hiring process, struggled to secure candidates and onboard staff in a timely manner. When RBEST was expanded to include an FSP treatment component, staff required additional training to meet the new requirements of the AOT program, while also balancing their RBEST duties and caseloads.

The program focused on training and adequately staffing the RBEST-AOT program. Training topics included FSP requirements such as gathering data for reporting, the Assertive Community Treatment (ACT) service model and providing intensive case management, and documentation guidelines. In addition to the extra training, RBEST-AOT was also able to successfully hire new staff to fill vacant positions.

Outreach and Engagement

For FY 2024/25, the RBEST-AOT program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
AOT Presentations to:		
• DBH Clinics/Providers	9	142
• Law Enforcement Agencies	3	55
• Medical Facilities/Partners	3	38
• Community Members	5	115
All-Agency AOT Training	2	112
Total	**22**	**462**

Age Wise

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Age Wise	2,186*	Ages 59+	SMI**	Clinic and Field	Older Adults Living With SMI

*This number includes FSP (93), GSD (332), and O&E (1,761) services. **SMI = serious mental illness.

Program Description and Target Population

The Age Wise program provides Full Service Partnership (FSP) mental health and case management services throughout San Bernardino County to older adults living with behavioral health and/or co-occurring disorders. Age Wise works to increase access to services for the older adult community and decrease the stigma associated with mental illness. The Age Wise program is managed through the Department of Adult and Aging Services – Public Guardian (DAAS – PG) of San Bernardino County.

Through collaboration, Age Wise focuses on assisting unserved, underserved, and inappropriately served older adults to develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population.

Demographics

Age

0% Children
0% TAY
0% Adult
100% Older Adult

Gender Identity

25% Male
75% Female

Race/Ethnicity

17% African American/Black
33% Latinx/Hispanic
1% American Indian/Alaska Native
1% Asian/Pacific Islander
42% Caucasian/White
6% Other/Unknown

N=84 (This number only includes Full Service Partnership consumers.)

Services Offered

The Age Wise program provides Full Service Partnership (FSP) services which include:

- Clinical assessment
- Crisis intervention
- Case management
- Resource linkage
- Occupational therapy

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 313-318.

Positive Results

The following table reports the measured Age Wise outcome domains and the percentage of consumers served in FY 2024/25 who met the criteria in each category:

Outcome domain	Percentage of consumers who met criteria
Maintained low or reduced risk of subjective suffering	61%
Maintained safe and stable housing	97%
Are stable and able to seek outside assistance to locate their own resources	71%
Consumers linked to a Primary Care Physician	100%
Diverted from hospitalizations related to a behavioral health diagnosis	100%

Demographics

Primary Language

82% English
14% Spanish
4% Other

Primary Diagnosis

14.3% Anxiety disorders
9.5% Bipolar disorder
51.2% Depressive disorder
10.7% Psychosis
1.2% Substance use disorders
11.9% Other
1.2% None/Deferred

N=84 (This number only includes Full Service Partnership consumers.)

Positive Results, cont.

The Age Wise team was notified of the Pacific Village Fire in November 2024 and mobilized immediately to assess the situation and provide resources and behavioral health support. Age Wise was one of the earliest responders at the scene and quickly integrated themselves into the emergency response, helping to coordinate services and offering direct assistance to impacted older adults.

Teams were tasked with ensuring that all displaced residents received appropriate transportation to temporary housing. Through joint efforts with DBH, Valley Star, and Adult Protective Services (APS), transportation was successfully secured for all affected individuals.

Following the initial crisis response, Age Wise continued to provide ongoing care, ensuring the continuity of services and emotional support in the aftermath of the fire.

Throughout the year, Age Wise responded to multiple community fire events that resulted in evacuations to emergency shelters. Age Wise staff conducted twice-daily wellness check-ins at these shelters to ensure that evacuated individuals received timely access to resources, emotional support, and behavioral health services.

Challenges/Solutions

During FY 2024/25, Age Wise experienced significant staffing challenges, with vacancies in leadership and clinical roles that led to clinical staff operating at only 50% capacity, impacting the program's ability to maintain service continuity and meet the increasing demand for behavioral health support among older adults.

To minimize the staffing shortage impact, Age Wise focused on staff wellness, connection, and teamwork to assist the program to function more efficiently. Age Wise will offer trauma-informed self-care training for staff, focusing on practical strategies for fostering workplace resilience. The program is addressing employee retention by providing immediate and comprehensive training on chart documentation, as well as clinical supervision and guidance for those pursuing licensure.

The continued rise in inflation and the growing expenses associated with affordable housing, food security, and reliable transportation created significant hardships for the older adult population served by Age Wise. Additionally, some consumers were directly affected by emergencies, such as evacuations due to fires or power outages, that contributed to increasingly unstable and challenging living conditions.

Challenges/Solutions, cont.

To meet the challenge of rising costs, Age Wise collaborates with other aging-friendly partners to provide complete wraparound care. This includes working with the DBH Mental Health Services Act (MHSA) housing communities, Adult Protective Services (APS), the In-Home Supportive Services (IHSS) program, Innovative Remote Onsite Assistance Delivery (InnROADs), the Recovery Based Engagement Support Team (RBEST), and County Substance Use Disorder and Recovery Services (SUDRS). Age Wise continues to use its resources, gift cards, bus passes, and discretionary funds to help stabilize and support the consumers.

The current political climate also generated heightened fear and uncertainty among consumers, increasing concerns related to economic instability, income insecurity, and personal safety, particularly among individuals from racially and ethnically diverse backgrounds, directly impacting their mental and emotional well-being.

Age Wise has continued to participate in local Health & Wellness Fairs, Senior Community Events, and other community-based events to educate and increase awareness of older adult behavioral health services available to assist these consumers, and provided information, brochures, and flyers advertising the Age Wise 24/7 Senior Hotline and program services.

Outreach and Engagement

During FY 2024/25, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Nutrition Events	16	872
Community Resource Fair	1	143
Emergency Events	3	346
Health Fair	1	150
Senior Resource Fair	3	250
Total	**24**	**1,761**

Introduction

The Housing and Homeless Services Continuum of Care Program (HHSCCP) is a robust continuum of care of services for individuals who are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness and/or substance use disorder. The target population to be served includes transitional-age youth, adults, older adults, and families.

The HHSCCP works collaboratively with the county-wide Coordinated Entry System (CES) and other County and community partners to provide comprehensive services. The Homeless Continuum has adapted and changed to meet the expanding needs of the homeless population and incorporate new and changing funding options.

The HHSCCP is comprised of the Homeless Outreach and Support Team (HOST), Full Service Partnership (FSP) Supportive Services, and Innovative Remote Onsite Assistance Delivery (InnROADs).

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 319-324.

Target Population

The table below identifies the target population of consumers to be served for FY 2025/26:

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Homeless Outreach Support Team (HOST)		X	X	X
Full Service Partnership (FSP) Supportive Services Programs		X	X	X
Innovative Remote Onsite Assistance Delivery (InnROADs)		X	X	X

Program Updates

There are no planned updates for this program.

Component Descriptions

Homeless Outreach Support Team (HOST)

The Homeless Outreach Support Team (HOST) provides community outreach support and response, as well as housing navigation services. HOST staff enter/update unhoused DBH consumers into the Coordinated Entry System (CES). CES is a San Bernardino County system that matches residents to available housing resources.

HOST staff partner with the Housing Authority of the County of San Bernardino (HACSB) to provide housing navigation and housing search services to residents who have been matched to a HACSB voucher through CES. Services include assistance with accessing bridge housing, obtaining necessary documentation, completing rental applications, conducting housing searches, and helping with the move into their new home.

HOST staff are also embedded within the city's homeless outreach teams in Fontana and San Bernardino. Additionally, HOST staff partners with County and community agencies to provide resources and information at community events.

Full Service Partnership (FSP) Supportive Services Program

The FSP Supportive Services program offers tenancy support and case management services to consumers residing in Permanent Supportive Housing (PSH). The goal of the program is to provide ongoing support needed to maintain housing and improve wellness.

Consumers with more intensive needs are referred to contracted Permanent Supportive Housing (PSH) Full Service Partnership (FSP) providers.

Innovative Remote Onsite Assistance Delivery (InnROADs)

Innovative Remote Onsite Assistance Delivery (InnROADs) is a multi-disciplinary, multi-agency, field-based program that offers community outreach and response. InnROADs started as an MHSA Innovation project.

Regionally based teams are currently comprised of a Sheriff's Deputy, a Department of Public Health (DPH) Nurse, a Department of Aging and Adult Services (DAAS) Social Service Practitioner, a DBH Alcohol and Drug Counselor (AOD), and a Clinical Therapist (CTI). Teams provide outreach, engagement, services, and linkages to other resources for our county's homeless and at-risk residents.

In addition, the InnROADs Mobile Medical Team (MMT) consists of a Psychiatric Nurse Practitioner and a Psychiatric Technician (PT) from DBH. They provide psychiatric evaluations and medication support services.

CSS: Housing and Homeless Services Continuum of Care A-7

Program Name	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Housing and Homeless Services Continuum of Care Program (HHSCCP)	**2,894***	**18+**	**SMI****	**Field-based**	**Homeless**

*Includes FSP and InnROADs outreach and engagement. **SMI = serious mental illness.

Services Offered

HOST:
- Housing navigation and housing search
- Bridge housing
- Links consumers to supportive services and treatment
- Community outreach
- Consultation with community partners
- Housing deposits

Full Service Partnership (FSP) Supportive Services Programs:
- FSP and/or mental health services for residents in Permanent Supportive Housing (PSH)
- Tenancy supports
- Eviction prevention
- Financial management
- Support Brokerage
- Housing deposits

InnROADs:
- Outreach and Engagement
- Nursing interventions
- Case management
- Substance Use Disorder (SUD) assessment and linkage
- Mental Health treatment
- Psychiatric evaluation
- Medication management

Demographics

Age

0% Children
4% TAY
71% Adult
24% Older Adult
1% Unknown

Gender Identity

46% Male

43% Female

11% Other/ Unknown

Race/Ethnicity

21% African American/ Black
40% Caucasian/White
<1% American Indian/ Alaska Native
1% Asian/Pacific Islander
23% Latinx/Hispanic
14% Other/Unknown

Primary Language

93% English
2% Spanish
5% Other/ Unknown

N=2,769 (includes InnROADs outreach and engagement data)

Note: not all numbers add to 100 due to rounding.

Positive Results

In FY 2024/25, a total of:

- 136 consumers were assisted into Emergency Shelter Services bridge housing, with an average stay of 141 days
- 70 consumers transitioned to permanent housing through housing vouchers

HOST consumers engaged in services had an average of 10.6 services with the team in FY 2024/25.

InnROADs consumers engaged in services had an average of 10.1 services with the team in FY 2024/25. Increased coordination of care through InnROADs multi-disciplinary teams served 1,735 unique consumers in 5,364 encounters through Outreach and Engagement. Collaborative partners include DBH, Department of Public Health (DPH), Department of Aging and Adult Services (DAAS), and San Bernardino Sheriff's Department.

Challenges/Solutions

Following a decrease in permanent supportive housing vouchers through the Housing Authority in FY 2023/24, large batches of permanent supportive housing voucher referrals were received periodically throughout FY 2024/25, necessitating a rapid shift in priorities and tasks to accommodate the time-sensitive requirements of the vouchers.

Programs offered consumers referred with permanent supportive housing vouchers temporary housing through the Emergency Shelter Services network. They provided ongoing case management while completing the necessary documentation and waiting for the housing application process to be finalized.

Outreach and Engagement

InnROADs provides outreach and engagement services. Activities include educating the community about mental health and substance use services and linking homeless community members to the appropriate resources. All other community events are conducted through DBH Public Relations and Outreach Services (PROS).

Demographics

Primary Diagnosis

16.6% Anxiety disorders	**<1%** None/deferred
10.7% Bipolar disorders	**16.0%** Psychosis disorders
28.3% Depressive disorders	**4.5%** Substance use disorders
<1% Disruptive disorders	**23.3%** Other
<1% Neurodevelopmental/cognitive disorders	

N=1,159 **Note**: not all numbers add to 100 due to rounding.

Introduction

Adult Transitional Care programs provide a continuum of behavioral health services designed to serve consumers with serious behavioral health conditions who are exiting from higher levels of care and require additional services to reintegrate into the community. Services for this target population are intensive and specialized; therefore, the programs described have been grouped together to streamline services and improve overall care. Services under this continuum implement a strengths-based approach, promoting the principles of recovery, wellness, and resilience by maximizing the consumer's functioning to help them maintain a more satisfying quality of life.

The Adult Transitional Care programs are comprised of:

- Adult Residential Facilities Certified in Social Rehabilitation Services
- Enhanced Assisted Living Program
- Enhanced Board and Care Program
- Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)

Services in this continuum include comprehensive medical and psychiatric services designed to promote skill building and activities of daily living to assist consumers to move toward improved levels of functioning in the community. The services provided include specialized rehabilitative psychiatric mental health care in a long-term or transitional residential setting, services to assist consumers' transition and reintegration as contributing members of their community, and enhanced behavioral health services that provide comprehensive medical and psychiatric services for consumers with more severe conditions.

Program Name	Actual Number Served FY 2024/25
Adult Transitional Care Programs	**526**

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 thru Fiscal Year 2025/2026, pages 325-337.

Target Population

The table below identifies the target population of consumers to be served by the Adult Transitional Care programs for FY 2025/26.

Adult Transitional Care Programs				
Program Name	**Target Population**			
	Children	TAY	Adult	Older Adult
Adult Residential Facilities (ARF) Certified in Social Rehabilitation Services			X	
Enhanced Assisted Living Program			X	X
Enhanced Board and Care Program		X	X	
Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)		X	X	X

Demographics

Age

0% Children
8% TAY
83% Adult
10% Older Adult

Gender Identity

67% Male

33% Female

Race/Ethnicity

22% African American/Black
31% Caucasian/White
4% Other/Unknown
5% Asian/Pacific Islander
38% Latinx/Hispanic

N=325

Note: not all numbers add to 100 due to rounding.

Program Updates

The Adult Transitional Care programs have the following updates for FY 2025/26:

- Helping Hearts California, LLC, is transitioning one of their active Social Rehabilitation sites with 10 beds into an Adult Residential Facility (ARF) and adding two additional 10-bed sites, for a total of 30 ARF beds for Enhanced Board and Care. With this addition, DBH will be able to provide for a total of 235 ARF beds with enhanced support and will look to serve a total of 325 consumers annually across all Enhanced Board and Care contracted partners funded within the Adult Transitional Care Programs (A-13).
- Budget increase for Social Rehabilitation - DBH currently contracts for Adult Residential Facilities with Social Rehabilitation Treatment Services (ARF with SRTS) for a total of 66 beds. This change will increase that number of beds by six (6), to 72 total beds, with an increased annual amount of $1,478,250 (from $10,446,300 to $11,924,550). This increase will allow DBH to continue to provide this vital step-down level of care to San Bernardino County consumers. Additionally, the increase to available beds allows additional opportunity for placement at this step-down level of care. These additional beds will reduce costly wait times in higher levels of care.

Demographics

Primary Language

95% English

2% Spanish

3% Other/Not reported

N=325

Primary Diagnosis

<1% Anxiety disorders

4.3% Bipolar disorders

5.2% Depressive disorders

<1% Disruptive disorders

81.2% Psychosis disorders

<1% None/Deferred

2.5% Substance use

4.9% Other

Note: not all numbers add to 100 due to rounding.

Adult Residential Facilities (ARF) Certified in Social Rehabilitation Services

Program Description and Target Population

Adult Residential Facilities (ARF) provide 24/7 nonmedical care and supervision to residents. The particular ARFs funded through MHSA are also licensed and certified through the state to deliver social rehabilitation services, which are provided in a long-term or transitional residential setting for adult consumers.

Adults who enter into this program have been discharged from higher level placements such as acute psychiatric hospitals and Institutions for Mental Disease (IMDs) or are consumers for whom the traditional board and care level of care was unsuccessful, including enhanced board and care.

DBH contracts for these structured services to provide a necessary level of treatment to consumers in an unlocked, home-like, less restrictive environment, providing up to 18 months of residential treatment and rehabilitative services prior to reintegration into the community. These services assist consumers in achieving significant independence and minimize the risk of repeat hospitalizations, overutilization of emergency services, and non-compliance with outpatient treatment services post-hospitalization.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	**SMI***	**Facility-based** 	**Discharged from higher level of care placements or lower level of care placements have been unsuccessful**

*SMI = serious mental illness.

Services Offered

Residential treatment includes but is not limited to:

- Individual therapy/Crisis management
- Group therapy
- Money management
- Medication management
- Recovery groups
- Vocational groups
- Social activities/outings/events

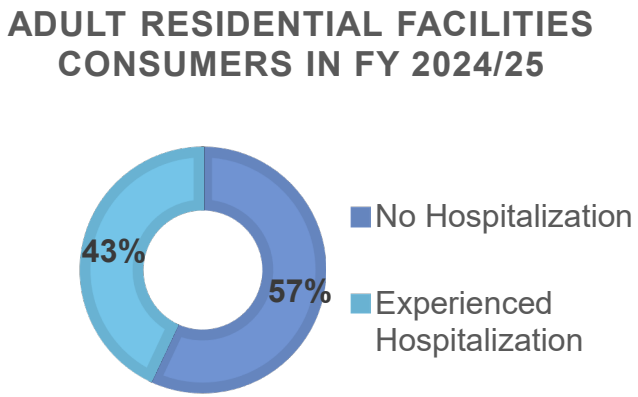
Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

Positive Results

During FY 2024/25, a total of 97 consumers were served through two contracted Social Rehabilitation partners with a total of eight facilities. Both programs admit consumers directly from acute hospitalizations; thereby reducing the administrative hospital days for individuals who would otherwise be waiting for higher levels of care.

Consumers' success rate for the program is approximately 90%. This level of participation and success means consumers are not utilizing emergency psychiatric placement for community needs. The Community Crisis Response Team (CCRT) and other community alternatives are provided with staff support as needed. While in the program, all consumers participate in day programming that includes psychoeducation, vocational rehabilitation, and therapeutic services.

Of the 97 consumers served by the Adult Residential Facilities (ARF) program, 42 consumers were hospitalized for varying psychiatric or medical reasons, which means 57% were able to successfully avoid hospitalization due to the stability and interventions provided by this program, as shown in the graphic below.



Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

Challenges/Solutions

Securing appropriate lower-level care placements, such as room and board or board and care facilities, remains a significant challenge. Additionally, independent living places a considerable financial burden on consumers who have fixed incomes and are unable to work due to mental health conditions.

To address these challenges, the program is continuing to build strong community relationships to identify additional resources for residents, while continuously collaborating with county agencies to secure appropriate lower-level care placements.

Pressure from state and federal mandates, as well as from hospitals, resulted in some consumers being discharged before achieving full stabilization or readiness for Social Rehabilitation level care.

To address this issue, the program expanded contracts to add six (6) additional beds to the continuum of care in FY 2025/26.

Outreach and Engagement

In FY 2024/25, the Adult Residential Facilities Certified in Social Rehabilitation Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Outreach	160	386
Social Community Services	40	338
Total	**200**	**724**

Enhanced Assisted Living Program

Program Description and Target Population

The Enhanced Assisted Living Program serves consumers typically over the age of 50 who have serious behavioral health conditions coupled with critical medical concerns. The program is licensed to provide both behavioral health and medical services to consumers who require a structured setting for their psychiatric and medical care. The program supports consumers' ability to remain in a less restrictive placement in a community setting, allowing them to be closer to loved ones and family support.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 50+	SMI*	Facility Based 	Experiencing both behavioral health and critical medical concerns

*SMI = serious mental illness.

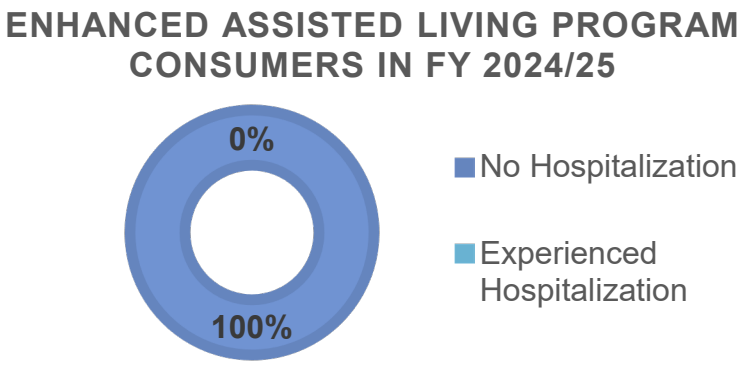
Services Offered

- 24-hour observation
- Comprehensive medical and psychiatric services
- Medication management
- Social/life enrichment activities
- Therapeutic intervention and groups
- Case management services
- Rehabilitation and Activity of Daily Living Skill training
- Collateral services with consumers' caregivers

Enhanced Assisted Living Program, cont.

Positive Results

During FY 2024/25, the program served a total of twelve consumers. Of the consumers served, 100% did not require use of Alternative Crisis Intervention Services. Additionally, 100% were able to avoid psychiatric hospitalization.



Challenges/Solutions

In September 2024, the Assisted Living Waiver (ALW) program was put on hold, resulting in consumers being unable to access these benefits and transition out of Enhanced Assisted Living.

To address this challenge, the program worked to identify and incorporate Assisted Living Waiver alternatives to the ALW program, which has now resumed accepting applications for qualified consumers.

In addition, the program encountered resistance from providers to explore options for adult day programs to help consumers stay engaged during the day.

To address these challenges, the program established connections with local adult day programs and enrolled consumers in them as appropriate.

Outreach and Engagement

For FY 2024/25, the Enhanced Assisted Living Program Provided two referrals to two individuals.

Enhanced Board and Care Program

Program Description and Target Population

The Enhanced Board and Care Program is an expanded MHSA program to enhance the residential support of adult consumers experiencing complex, challenging, and/or chronic mental health conditions and severe co-occurring disorders, including the provision of treatment services specializing in hearing and communication impairments.

As a result of a consumer's long length of stay in a locked psychiatric residential facility, as well as their impulsive and aggressive behavior, additional supportive services and staff are provided on site to maintain stability and positively impact the consumer's reintegration into the community. This level of care provides the consumer with a community step-down opportunity, when clinically appropriate, into an unlocked setting with enhanced staffing to ensure a seamless transition back into the community.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	**SMI***	**Facility Based** 	**Experiencing both mental health and co-occurring concerns**

*SMI = serious mental illness.

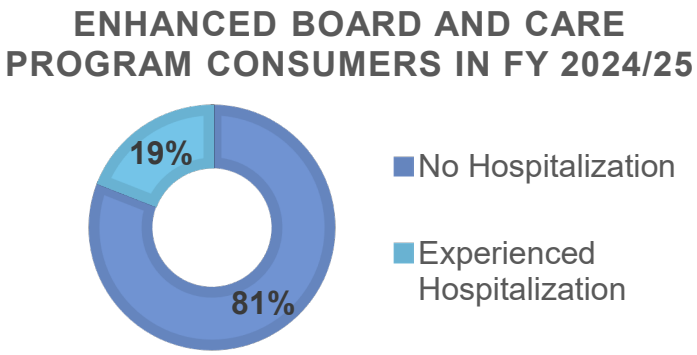
Services Offered

- Residential services
- Special dietary and medical needs
- Transportation
- Facilitate access to needed services
- Recovery-oriented social education classes/groups
- Crisis intervention
- Medication support
- Case management
- Individual therapy as clinically indicated

Enhanced Board and Care Program, cont.

Positive Results

The program served a total of 236 consumers during FY 2024/25. Of the consumers served, 81% (191) were able to avoid psychiatric hospitalization through use of crisis intervention, alternative crisis interventions, and support by program staff.



Challenges/Solutions

The program continues to face challenges with lack of housing for consumers with more acute levels of behavioral health care, especially for consumers on Lanterman-Petris Short (LPS) conservatorship status. There were additional challenges getting consumers on LPS conservatorships into Substance Use Disorder (SUD) treatment programs.

To address these challenges, DBH expanded contracts to allow for increased housing programs in the Adult Transitional Care programs. The department also continues to collaborate with the Office of the Public Guardian (OPG) and local SUD treatment programs to eliminate barriers for the consumers on LPS conservatorships.

Slow processing of applications for Social Security Administration (SSA) benefits and the lengthy process of linkage to these benefits continue to delay consumers in stepping down to a lower level of care.

Additional training has been provided to all staff on the process of applying for Social Security benefits, and tracking of application status for benefits has also improved. All staff complete training from the Substance Abuse and Mental Health Services Administration (SAMHSA) on Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR), which is a national program designed to increase access to the

Enhanced Board and Care Program, cont.

Challenges/Solutions, cont.

disability income benefit programs administered by the Social Security Administration for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

The program also experienced delays in accessing treatment due to difficulties with Medi-Cal transferring to the appropriate providers in San Bernardino County.

To minimize these delays, the Department of Behavioral Health, Long-Term Care (LTC) is working closely with the Office of the Public Guardian (OPG) to identify the need to change Medi-Cal county of residence upon date of move. LTC is also providing written requests for OPG to initiate application for Medi-Cal and SSI benefits for consumers transitioning out of the State Hospital system.

Outreach and Engagement

During FY 2024/25, the Enhanced Board and Care Program educated and/or provided referrals to 188 individuals.

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Program Description and Target Population

The CHAS-PACES team provides on-site services to consumers housed at a contracted 150 bed Enhanced Adult Residential Facility. The facility provides a stable, structured treatment program in a community setting. The CHAS-PACES team provides coordinated ongoing case management and therapeutic services to consumers in the program, including linkage to community resources and providers, enrollment in benefits, psychoeducational groups, and individual therapy.

CHAS-PACES serves adults aged 18 and older who are living with a behavioral health condition and could benefit from enhanced services in a community setting.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	SMI*	Facility Based 	Living with a behavioral health condition

*SMI = serious mental illness.

Services Offered

While the specific services offered to each consumer will depend on their specialized needs, CHAS-PACES will tailor a plan that is both flexible and comprehensive to address all needs as they arise. The services and goals will be developed in partnership with the consumer and will be directed towards utilizing a strength-based approach.

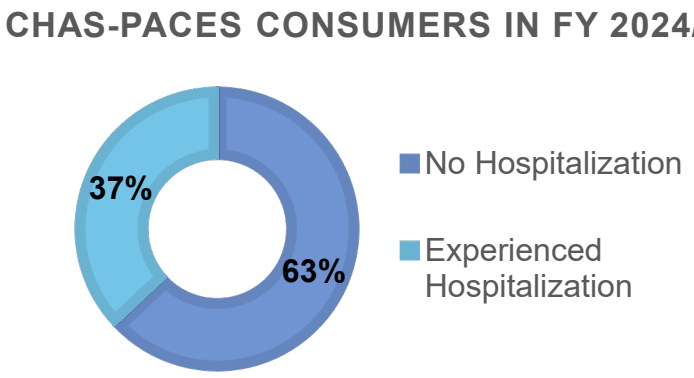
Services include:

- Psychoeducational groups and activities
- Case management services
- Individual therapy
- Referral and linkage
- Assistance to step down and transition to lower levels of care when appropriate

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Positive Results

During FY 2024/25, the CHAS-PACES program served 177 consumers. Of those consumers served, 63% avoided acute psychiatric hospitalization. Additionally, 23 consumers increased their use of alternative crisis interventions (such as CWICs, CCRT, CRTs, and CSUs).



Challenges/Solutions

Throughout FY 2024/25, turnover in key positions with the contracted provider caused instability in the partnership between the provider and program. CHAS-PACES established ongoing meetings and continued working relationships with contracted staff as hired to help strengthen the relationship between the program and provider.

The program also saw increased challenges with consumers' behavior. There was continued community contention regarding consumers engaging in inappropriate behavior while in the larger community; consumption of alcohol and use of illegal drugs among some residents; and inappropriate use of cellphones to call emergency services for non-emergency situations.

The program implemented various steps to address these challenges. The program promptly responds to the community when consumers engage in inappropriate behaviors in the community, and they increased efforts to locate other placements for consumers who persist in these behaviors. CHAS-PACES also modified release of Personal and Incidental funds to consumers using those funds for

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Challenges/Solutions, cont.

purchasing alcohol and drugs, and they coordinated with the provider to transport consumers to 12-Step meetings in the community to address addiction concerns. The program is also providing ongoing education to consumers on the appropriate us of emergency services. In addition to the steps taken above, the program is also developing Behavior Support Services Plans to identify target behaviors and provide incentives for behavioral change.

Outreach and Engagement

During FY 2024/25, the CHAS-PACES program educated and/or provided referrals to 187 individuals.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Innovation

Innovation

Introduction

The goal of the Mental Health Services Act (MHSA) Innovation component is to test methods that adequately address the behavioral health needs of unserved and underserved populations through short-term projects. This is accomplished by expanding or developing services and supports that are considered to be innovative, novel, creative, and/or ingenious behavioral health practices that contribute to learning, rather than primarily focusing on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited up to five years, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are required to support and learn about new approaches to behavioral health care by doing one of the following:

- Introduce a practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral heath, including, but not limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.
- Support the participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

This component is unique because it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Commission for Behavioral Health (CBH).

MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of its design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services, including but not limited to, services provided through permanent supportive housing.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the San Bernardino County Board of Supervisors and the Commission for Behavioral Health (CBH), with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.

Innovation

INNOVATIVE PROJECTS

2012

Interagency Youth Resiliency Teams (IYRT): **January 2012 – June 2015**
Provided mentoring services to underserved and inappropriately served system-involved youth.

TAY Behavioral Health Hostel (The STAY): **July 2012 – March 2017**
Short-term, 14 bed, crisis residential treatment program for the Transitional Age Youth (TAY) population experiencing an acute psychiatric episode or crisis.

2014

Recovery Based Engagement Support Teams (RBEST): **October 2014 – September 2019**
Provided field-based services in the form of outreach, engagement, case management services, family education, support, and therapy to "activate" individuals into the appropriate treatment.

2019

Innovative Remote Onsite Assistance Delivery (InnROADs): **April 2019 – March 2024**
Provides intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to consumers and their families where they live within homeless communities.

2020

Multi-County Full Service Partnership (FSP) Initiative: **July 2020 – December 2024**
A collaborative partnership between multiple counties and Third Sector to create a data-informed approach to improving FSP consumer outcomes.

2021

Eating Disorder Collaborative: **January 2021 – December 2025**
A comprehensive flexible interagency model of interventions and services for those diagnosed with an eating disorder.

Cracked Eggs: **July 2021 – June 2026**
A workshop that allows participants to discover, learn, and explore their mental states in a structured process of self-discovery through art.

2024

Progressive Integrated Care Collaborative: **April 2024 – April 2029**
A collaborative project that will deliver integrated behavioral and physical health services to Medi-Cal members who have IEHP as their managed care plan at a pilot clinic located in Apple Valley.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services
EDC INN Project	68	All ages	N/A	

Target Population and Project Description

The Eating Disorder Collaborative focuses on increasing the regional understanding of eating disorders (EDOs) to facilitate early identification and access to effective treatments for those consumers needing higher levels of care. The goal of this project is to improve the system of care to better meet the physical and mental health needs of people with EDOs by achieving the following:

- Developing and distributing trainings and informational materials.
- Establishing a more robust initial eating disorder assessment tool.
- Creating and activating specialized, multidisciplinary eating disorder treatment teams.

Consumer Demographics Highlights FY 2024/25

Age

25% Children
44% TAY
31% Adult
0% Older Adult

Sexual Orientation

9% of consumers identified as LGBTQ+

Gender Identity

13% Male

80% Female

OTHER

7%

Language

90% English
4% Spanish
6% Unknown

Race/Ethnicity

4% African American/Black
3% Asian/Pacific Islander
18% Caucasian/ White
57% Latinx/Hispanic
0% American Indian/Alaska Native
18% Multiple Races/ Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

Challenges/Solutions

The table below outlines challenges and solutions the EDC project faced in FY 2024/25.

Category	Challenges	Solutions
Services	Limited outpatient services, outreach, and billing infrastructure prior to FY 2024/25.	Outpatient services expansion to include individual, group, and family therapy and implementation of higher-level care authorizations as needed. Community outreach and engagement recruitment efforts doubled. EDC developed pamphlets and approved two presentations, which were used during outreach activities.
Billing	Staff were limited in their direct billing services that were not included in the Memorandum of Understanding (MOU) with Inland Empire Health Plan (IEHP).	EDC began the process to become a Medi-Cal certified provider, thus, increasing capacity to bill for direct and consultation services.
Care Coordination	Staff experienced challenges with members being opened to the EDC reporting unit and other DBH reporting units.	In FY 2025/26, work with DBH outpatient clinics, health care agencies, Community Based organizations, and DBH Compliance to resolve service delivery and coordination conflicts.
Workforce	EDC Program suffered from staffing shortages and retention issues during early implementation.	In response to staffing shortages, select DBH clinical staff were trained in Dialectical Behavior Therapy (DBT) and Family Based Therapy (FBT) for eating disorder treatment to allow for project services to be fulfilled.

Program Updates

The current initiatives and updates include:

- **Staffing Improvements**: Due to staffing shortages, EDC was unable to outreach to local colleges/universities in FY 2024/25. Beginning FY 2025/26, EDC has begun outreach efforts to colleges and universities. EDC submitted an outreach request to California State University San Bernardino to present on the services offered by EDC and the referral process.
- **Clinic Manual Development**: EDC is in the process of developing a toolkit to evaluate outreach efforts with colleges/universities and track potential referrals resulting from outreach activities.
- **Engagement Assessment:** EDC implemented the use of the Eating Disorder Examination-Questionnaire (EDE-Q) screening to assist mental health and other healthcare providers in screening persons for an eating disorder and initiate a referral to EDC. For FY 2025/26, EDC will continue to use the EDE-Q for screenings and referrals.
- **Referrals**: EDC will continue to increase awareness and referrals from healthcare, mental health, and community providers in FY 2025/26.
- **Project Timeline**: EDC is planned to end as an Innovation project on December 31, 2025.

Project Learning Goals

Learning Goal #1: Examine the factors that make collaboration with local colleges effective for the development and utilization of public information campaigns/materials to educate populations most at risk for developing disordered eating.

Learning Goal #2: Examine the benefits and challenges of developing and disseminating a screening and referral tool which may be used in a variety of settings (e.g., college student centers, health centers, physician's offices); examine the effectiveness of the screening and referral tool at increasing the number of individuals assessed for disordered eating.

Learning Goal #3: Examine the effectiveness of engagement assessments in facilitating participation in treatment services.

Learning Goal #4: Examine the multiple dimensions of the best practices established for a multidisciplinary team, all comprised of MHP staff, effectively liaising with a variety of organizations (e.g. colleges, college health centers, individual physician's offices, Independent Physicians Associations, Managed Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

Cracked Eggs

Innovation Project	Actual Number Served FY 2024/25	Program Serves	Symptom Severity	Location of Services
Cracked Eggs	32	16+	N/A	Various Clubhouses and TAY centers

Project Description

Cracked Eggs is a workshop series designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not view their symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences. The workshops are 100% peer-owned and operated by a production company, Bezerk Productions. Linda Sibio, the creator of Cracked Eggs, is an accomplished artist who lives with mental health challenges herself and has utilized art to help her cope.

Target Population

The target population for this project are individuals living with mental illness over the age of 16.

Consumer Demographics Highlights FY 2024/25

Age

0% Children
100% TAY
0% Adult
0% Older Adult
0% Unknown

Sexual Orientation

31% of consumers identified as LGBTQ+

Gender Identity

38% Male

38% Female

*9% identify as other

Language

97% English

3% Spanish

Race/Ethnicity

19% African American/Black

0% Asian/Pacific Islander

25% Caucasian/ White

41% Latinx/Hispanic

6% American Indian/Alaska Native

0% Multiple Races/ Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

Cracked Eggs

Positive Results

In FY 2024/25, two successful cohorts were held in person. These cohorts had consistent attendance with positive feedback.

- **Cohort 7:** San Bernardino One Stop TAY Center from 07/09/2024 to 09/24/2024
- **Cohort 8:** Ontario One Stop TAY Center from 11/04/2024 to 02/24/2025

Challenges/Solutions

Cohort 6 struggled with participant retention in the hybrid format. In FY 2024/25, cohorts moved to fully in-person at One Stop TAY Centers, adding hands-on instruction. This change significantly improved participation and attendance and received positive feedback.

Participant Quote:

"I get excited about whatever art we do, interacting and talking with our peers."

Artwork from Cohort 7 Perspective Minds

"It helped me visualize my feelings."

- Cohort 8 Ontario TAY Participant

"It helps me translate my symptoms into art and I am able to use the emotional aspect of the art."

- Cohort 7 San Bernardino TAY Participant

Artwork from Cohort 7

Program Updates

- In FY 2024/25, cohorts were conducted in person at the San Bernardino and Ontario One Stop TAY Centers, serving TAY (ages 16–25). Compared with prior adult Clubhouse cohorts, the TAY focus improved quality, effectiveness, and participant experience.
- Cohort 7 incorporated a fashion design element where participants created original wearable textile projects that were modeled by the artists at the final art show, “Perspective Minds.”
- The Train-the-Trainer concept will be launched in FY 2025/26. This track equips participants to facilitate Cracked Eggs courses. A facilitator manual, originated by founder Linda Sibio, will provide participants with structured lesson plans and tools to become future facilitators of the program.
- Cracked Eggs partnered with local businesses to host engaging art shows for participants and the community. Cohort 8 showcased their work at Untitled Art Gallery in Ontario, while Cohort 7's art was displayed at the Garcia Center in San Bernardino. These collaborations have enhanced visibility for Cracked Eggs and contributed to efforts aimed at reducing stigma within the community.
- Cracked Eggs will be ending as an Innovation project on June 30, 2026, when the contract with Bezerk Productions expires.

Cracked Eggs Community Partners:
The Garcia Center for the Arts

Evaluations

Every art workshop cohort includes three evaluation sessions (Initial Evaluation, Mid-Point Evaluation, and Final Evaluation) conducted by San Bernardino County DBH Research & Evaluation Department. These evaluations are an important component of the Cracked Eggs Project, as student's feedback is used to determine how to proceed with the programs. For each cohort, the following mixed methodology was implemented to evaluate the Cracked Eggs program:

- Initial Evaluation
  - Introduction
  - Full scale Survey
  - Initial Goal Cards
- Mid-Point Evaluation
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion
- Final Evaluation
  - Full Scale Survey
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion

For the qualitative analysis component of the evaluation, focus group discussions were recorded and transcribed for both the midpoint and final assessments.

Evaluation Highlights for FY 2024/2025

Participants reported benefits in symptom management, creative expression, and coping skills. Using matched pre and post surveys for Cohorts 7-8, small to moderate gains were observed across key domains with clear movement on several learning-goal items.

↑ 71%

agree Cracked Eggs improved how they view people with mental illness

27%

say Cracked Eggs helped them understand their mental health symptoms

↑ 36%

By Cohort 8, more participants felt their communication with others improved

What have we learned through the evaluations thus far?

Participants have voiced that artistic expression was the most prominent theme, with a desire to explore creativity and build new techniques. Also, participants are fostering stronger peer connections as they actively seek conversation, community, and a creative space. Below are Cracked Egg's learning goals and what we have learned through FY 2024/25.

Learning Goal 1: Examine if participation in Cracked Eggs leads to consumers reaching treatment, social, educational/vocational, and other goals. Examine how participation in Cracked Eggs influences consumers' goals.

- Data shows that 36% more participants by Cohort 8 felt improved communication and stronger peer connection validating progress toward social and educational goals.

Learning Goal 2: Examine if participation in Cracked Eggs leads to improved consumer outcomes.

- Survey data reveals that 27% of participants reported better understanding plus small to moderate gains in symptom management and coping validating improved outcomes.

What have we learned through the evaluations thus far? (cont'd)

Learning Goal 3: Examine if Cracked Eggs, and not least of all Cracked Eggs exhibits and performances, lead to stigma reduction and increased understanding about mental health issues for both consumers and community participants.

- Participants have shown a 71% increase in positive views toward people with mental illness, validating reduced stigma and greater empathy.

Learning Goal 4: Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.

- In-person, hands-on delivery increased participation and attendance, and communication gains indicate readiness for peer leaders, validating scale-up plans for train-the-trainer.

Learning Goal 5: Examine how program evaluation can adapt to best capture emerging themes that consumers find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?

- Themes show strong interest in creativity and technique development, validating use of art-based indicators such as technique growth peer participation and exhibit engagement.

Quotes from students during the Focus Group Discussion portion of the evaluation:

"I feel like being in this group improved myself esteem about my art because, like, I'm very insecure about what I create and getting positive feedback from everyone in the room about my art has made me feel a lot better about what I create."

"It helps me re-connect with it, because I do not get to do that all the time. It helps you re-connect and helps you speak out your opinions. Showing that you can re-connect with your own leadership skills, honing them as you practice them."

"Doing art class helped me do more art outside of here. So, when it's stressful at home, I'll go into my room and put on music and like, do what we do in our class, and draw, and it helps with stress on that part."

"…it helps me translate my symptoms into art and I am able to use the emotional aspect of the art."

"Helped me be able to express myself creatively. Also understanding other people's points of view. Maybe they have some symptoms that are going on and they are able to express themselves, I am able to see that and reflect on that."

"I get excited about whatever art we do, interacting and talking with our peers."

Progressive Integrated Care Collaborative (PICC)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	N/A	Apple Valley Clinic	SMI

Target Population

Individuals 18 years and older experiencing serious mental illness, who are Medi-Cal beneficiaries enrolled with Inland Empire Health Plan (IEHP) as the managed care provider.

Innovative Components

The PICC clinic Innovation project will provide the following physical health services to consumers of mental health and/or substance use services:

- On-site laboratory specimen collection (blood draws)
- On-site electrocardiograms
- On-site chronic disease management, for example, management of diabetes or hypertension
- Direct referral to physical health specialists through Managed Care Plan referral network
- Peer navigation and support
- Comprehensive medication reconciliation by clinical pharmacist
- On-site group nutritional education
- Individual nutrition coaching
- Direct referral for preventive health services

PICC will be located at DBH's Apple Valley Community Clinic

Project Overview

The PICC Project will introduce the innovative concept of *Progressive Integration,* based on a strategy of selecting best practices from a given discipline and applying that uniformly across practice specialties.

- ***Laboratory Studies*:** Physical health, mental health, and substance use treatment rely on the collection of laboratory specimens to evaluate and monitor patients' organ function, sobriety, medication effect, medication levels, and other critical parameters. Onsite collection of urine, blood, and other body fluids with pickup by a contracted laboratory partner will allow all disciplines to have reliable and timely access to this information. The first goal of the PICC project is to facilitate this either through nursing or through the addition of a trained phlebotomist.
- ***Electrocardiograms:*** Electrocardiograms provide critical insight into cardiac function, which is frequently altered by psychotropic medications, potentially leading to medical complications. Electrocardiogram results can offer a preliminary interpretation in the clinic but should be verified by a contracted cardiology service for final results.
- ***Data Sharing:*** Health information related to physician and staff notes, outside laboratory studies, medical imaging studies, specialist procedures, and inpatient psychiatric visits greatly inform high-quality primary care, substance use treatment, and mental health services. Uniform releases of information permitting bidirectional exchange of health information may be developed in the service of this goal. Initially, expansion of mutual read-only electronic health record access for healthcare providers and nursing staff would facilitate this goal. Constructing or implementing a data exchange infrastructure for regulated flow of health information across various electronic health record systems would permit integration into the greater system of care while upholding compliance with applicable regulations of disclosure of protected health information.
- ***Physical Health Specialist Consultation and Referrals:*** Provision of primary care requires a network of medical sub specialists for routine screenings as well as in addressing a variety of medical conditions beyond the scope of primary care. These may include cardiology, gastroenterology, infectious disease, oncology, dermatology, endocrinology, rheumatology, OB/GYN, urology, general surgery, otolaryngology, pain management, neurology, interventional radiology, and orthopedic surgery. Optimally, PICC would establish a mechanism in which integrated care clinic staff can consult specialists for guidance on diagnosis and treatment recommendations.

Project Overview, cont.

- ***Billing:*** Cost data related to laboratory services, electrocardiogram and medical imaging, data-sharing infrastructure, specialist consultation, and referral fees, as well as direct costs related to staffing, facilities, and consumables will be collected on an ongoing basis. This cost data will be aggregated and will inform a cost model for integrated care inclusive of mental health, substance use treatment, primary care, and specialty physical health needs. Progressive gains in efficiency are anticipated as additional layers of integration accumulate.

Project Learning Goals

The PICC project seeks to pursue the following learning goals:

Learning Goal #1: Examine how the integrated model will help improve overall wellbeing for consumers in a rural/developing area of San Bernardino County.

Learning Goal #2: Can an integrated model allow for the development of a value-based payment model?

Learning Goal #3: Examine how integrated model factors help improve overall treatment coordination for consumer.

Learning Goal #4: Examine the benefits of implementing a Universal Consent Form.

Learning Goal #5: Examine the factors that make collaboration with local managed care providers and county hospital agency effective for the development of an integrated psychiatric medical home.

Program Updates

- DBH will integrate mental health and substance use disorder services with Arrowhead Regional Medical Center (ARMC), who has been selected to provide the physical health component of the project.
- The following services are currently in development to support implementation:
    - Formation of internal project workgroups to coordinate planning, address operational needs, and ensure successful implementation.
    - Medication reconciliation to be conducted by a clinical pharmacist for each patient to ensure safe and accurate medication management.
    - Nutritional education to be delivered by a qualified dietician, promoting wellness and supporting integrated care.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Workforce Education and Training

Workforce Education and Training

Introduction

The passage of the Mental Health Services Act (MHSA) in November 2004 provided a unique opportunity to increase staffing and other resources to support public behavioral health programs. MHSA funds increased access to much needed services and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within San Bernardino County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

"Every aspect of my rotation had a lasting impact on my career choice. Between the amazing staff, awesome supervisors, friendly culture, and type of work, I was exposed to many different influences that not only shaped me to be a better psychiatrist for the future but also helped me to understand what to expect of outpatient psychiatric care and the main differences it has to the inpatient care I am so used to providing. It has helped me to discern the factors that can make a clinic good or bad, and I hope to use this knowledge as I continue to progress and determine what I wish to do for my future."

-ARMC Resident

Workforce Education and Training

Positive Results

To meet the goal of addressing workforce shortages, a needs assessment was completed in July of 2008 and 2013. Both assessments identified child psychiatrists and psychiatrists as hard-to-fill and retain positions. Since 2008, the WET program has been successful in increasing the number of applications received for qualified licensed staff. The WET program received an increase in applications for licensed positions in FY 2024/25, including Alcohol and Drug Counselor, Clinic Assistant, Clinical Therapist, Mental Health Specialist, Peer and Family Advocate, Program Manager I, Program Manager II, and Psychiatrist.

"I know for a fact that I am going to pursue a fellowship in child psychiatry after this rotation. I love the county system, and I hope to work for DBH one day to help underserved children to better their mental health."

-California University of Science and Medicine Medical Student

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 355-370.

Workforce Education and Training

Positive Results, cont.

The table below shows the number of qualified applications received for specific job positions in FY 2024/25:

Job Title	Number of Qualified Applications Received in FY 2024/25	Job Title	Number of Qualified Applications Received in FY 2024/25
Alcohol and Drug Counselor	97	Nurse Manager	0
Child Psychiatrist	3	Nurse Supervisor	16
Clinic Assistant	173	Peer and Family Advocate III	483
Clinic Supervisor	51	Pre-Licensed Clinical Therapist, Licensed Clinical Social Worker (LCSW)	276**
Clinical Therapist, LCSW	81*	Pre-Licensed Clinical Therapist, MFT	276**
Clinical Therapist, Marriage and Family Therapist (MFT)	81*	Pre-Licensed Clinical Therapist, Licensed Professional Clinical Counselor (LPCC)	276**
Clinical Therapist, Licensed Professional Clinical Counselor (LPCC)	81*	Pre-Licensed Psychologist	18
Psychologist I	0	Program Manager I	101
Clinical Therapist II	46	Program Manager II	37
Licensed Vocational Nurse	32	Psychiatric Technician I	23
Mental Health Education Consultant	56	Psychiatrist	36
Mental Health Nurse II	86	Research and Planning Psychologist	N/A
Mental Health Specialist	136		

*Clinical Therapists and **Pre-Licensed Clinical Therapists recruited together (LMFT, LCSW, and LPCC)

Workforce Education and Training

Positive Results, cont.

Another program that WET oversees is the License Exam Preparation Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed.

The table below illustrates the progress that LEPP has had in helping staff obtain licensure for their discipline. For LEPP 1-15, there has been, on average, an approximately **78%** licensure rate among the participants.

Program	Fiscal Year	# of Applicants	# Who Became Licensed	% Licensed
LEPP 1	2009/10	60	41	68%
LEPP 2	2011/12	38	24	63%
LEPP 3	2012/13	32	19	59%
LEPP 4	2013/14	18	18	100%
LEPP 5	2014/15	41	38	93%
LEPP 6	2015/16	59	55	93%
LEPP 7	2016/17	65	59	91%
LEPP 8	2017/18	49	40	82%
LEPP 9	2018/19	41	33	80%
LEPP 10	2019/20	35	30	86%
LEPP 11	2020/21	26	25	96%
LEPP 12	2021/22	31	26	84%
LEPP 13	2022/23	15	15	100%
LEPP 14	2023/24	41	22	54%
LEPP 15	2024/25	30	8	27%
Grand Total		**581**	**453**	**78%**

Workforce Education and Training

Positive Results, cont.

DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP as seen below.

Through 14 Cohorts of LEPP, Prior to Implementation of Revised LEPP*			
	Clinical Therapist I	**Clinical Therapist I Psychologist**	**Total**
Licensed	47	2	**49**
Pre-Licensed	145	11	**156**
Total	192	13	**205**
Percentage Licensed	24.5%	15.4%	**23.9%**

*DBH has seen a decrease of 4.8% in the percentage of licensed staff in FY 2024/25.

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs:

- Social Work
- Marriage and Family Therapy (MFT)
- Psychology

Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. In FY 2024/25, there were a total of 53 interns in the Internship Program across the Social Work, MFT, and Psychology disciplines. The MFT program launched a Spring cohort for FY 2024/25 that increased the number of interns that were able to participate in the program from eight to twelve interns.

The Internship Program continues to grow and receive positive feedback from participants who report they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH.

Workforce Education and Training

Positive Results, cont.

DBH is committed to hiring applicants who were previous DBH interns. As seen in the following table, 16% of clinical hires in FY 2024/25 were DBH interns; seventeen DBH interns were hired as pre-licensed Clinicians with the department in FY 2024/25.

Pre-Licensed Clinicians Hired	FY 2024/25
Total Number of Interns Hired	17
Total Number of Non-Interns Hired	89
% of Interns Hired	16%

The DBH Employee Educational Internship Program was created to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degree by allowing them to intern for up to 20 hours per week at DBH as part of their degree requirements. The program was created to support the WET initiative of building a more skilled workforce by "growing our own" qualified staff to fulfill the identified clinical shortages within the department. Since its implementation, the program has increased in popularity, and in April 2015, was expanded by adding the Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) intern career path options.

Additionally, in FY 2016/17, the Medical Education program, which currently offers rotations to medical students and psychiatry residents, had its first Nurse Practitioner (NP) student complete a psychiatry rotation within the DBH clinics. Since then, WET has seen 93 NP students with six of those in FY 2024/25.

To meet the goal of educating the workforce by incorporating the general standards, DBH continues to incorporate the Wellness, Recovery, and Resilience Model in trainings.

The general standards set by the Mental Health Services Act (MHSA) include a Wellness, Recovery, and Resilience model that is culturally competent, supports the philosophy of a consumer/family driven behavioral health system, integrates services, and includes community collaboration.

Among the trainings provided in FY 2024/25, the following are examples of trainings that incorporate MHSA standards:

- Human Trafficking
- Law and Ethics for County Healthcare Providers
- Motivational Interviewing
- Objective Arts
- Transformational Collaborative Outcomes Management
- Trauma Informed Housing During Disasters and Homelessness
- Trauma and Eating Disorders
- Trauma and Post-traumatic Stress Disorder (PTSD)/Complex PTSD

Workforce Education and Training

Positive Results, cont.

The training information table below indicates that the evaluation average of the trainings in FY 2024/25 was 4.53 out of 5. This rating reflects a similar average trainee satisfaction as previous years. There was an 21% increase in attendance of Live/Virtual trainings in FY 2024/25 largely due to the collaboration with the Department of Behavioral Health Public Relations and Outreach Services to develop an exclusive bi-weekly Training Announcement to advertise courses being offered to both department and contract agency employees. The announcement provided a standard method for employees to identify what courses are offered and a direct link from the announcement to register for the courses.

In FY 2024/25, WET launched a new live training named The Cost of Caring: Indirect Trauma, Workplace Burnout & Chronic Stress for Helping Professionals which has become well attended and examines the mental, physical and emotional impact of being a helping professional and explores the dynamics of self-regulation, restorative self-care and psychological resilience for improved health and well-being. Over sixty percent of attendees have reported that it has improved their job performance.

The table below provides additional information regarding trainings provided by WET in FY 2024/25.

Fiscal Year	Attendance	Online Completions	Classes Offered	Continuing Education Credits	Evaluation Average
FY 2013/14	3,095	N/A	136	939.45	4.5
FY 2014/15	3,524	N/A	108	703	4.6
FY 2015/16	3,867	N/A	120	391	4.6
FY 2016/17	4,296	N/A	234	494.5	4.6
FY 2017/18	4,477	N/A	231	281.5	4.64
FY 2018/19	4,371	N/A	283	567.5	4.74
FY 2019/20	4,173	N/A	221	886.5	4.7
FY 2020/21	4,467	N/A	245	92	4.2
FY 2021/22	3,812	N/A	293	177	4.6
FY 2022/23	4,313	9,164	223	327	4.67
FY 2023/24	3,658	11,022	235	540	4.62
FY 2024/25	4,440	12,463	208	449	4.53

Positive Results, cont.

In FY 2024/25, the 4-Month Post-Training Evaluation was developed by the WET Program to assess the long-term effectiveness of training programs. Its primary goals are to measure information retention, evaluate the application of training content, and determine the relevance and benefits of the training to employees' job roles. By gathering feedback from DBH and Contract Agency employees four months after training, WET aims to understand the sustained impact of the training and how well it meets their current job needs. This evaluation provides insights to improve future training sessions, refine materials, and identify if additional resources, follow-up training, or support are needed. Ultimately ensuring our training programs remain effective and aligned with the evolving needs of our workforce.

Peer and Family Advocates (PFAs) are behavioral health consumers, or family members of behavioral health consumers, who provide crisis response services, peer counseling, linkages to services, and support for consumers of DBH services. They also assist with the implementation, facilitation, and ongoing coordination of activities with the Community Services and Supports (CSS) plan in compliance with MHSA requirements. The Peer and Family Advocate position also fulfills the MHSA Workforce Education and Training goal of increasing the number of consumers and family members of consumers employed in the public mental health system.

As seen in the table on the next page, there has been a significant increase in PFAs hired in DBH over the last several years. This is largely due to increasing knowledge and evidence of the benefits when including Peer and Family Advocates in DBH programs and the positive outcomes it has yielded on the consumers served by these programs. DBH strives to continue to increase the number of PFAs being hired and maintained on staff and hosts an annual open recruitment for the PFA position. The recruitment, which includes advertising on social media, flyers, and emails circulated throughout the community, and posting on Jobinsocal.com, is widely popular amongst members of the community and garners between 150 to 200 applications annually. By utilizing different outlets to advertise for the PFA positions, especially social media and word of mouth through current DBH employees, the department increases the public’s knowledge of the Peer and Family Advocate position, as well as increases the number of qualified applicants applying for these vacancies each year.

Workforce Education and Training

Positive Results, cont.

The table below shows the increase in PFAs hired in DBH over the last several years.

Total Peer and Family Advocates with DBH			
Fiscal Year	Positions	**Fiscal Year**	Positions
FY 2005/2006	4	FY 2015/2016	28
FY 2006/2007	19	FY 2016/2017	26
FY 2007/2008	24	FY 2017/2018	36
FY 2008/2009	24	FY 2018/2019	28 (Plus 7 Vacancies)
FY 2009/2010	21	FY 2019/2020	35 (Plus 7 Vacancies)
FY 2010/2011	20	FY 2020/2021	35 (Plus 7 vacancies)
FY 2011/2012	24	FY 2021/2022	29 (Plus 20 vacancies)
FY 2012/2013	25	FY 2022/2023	34 (Plus 21 vacancies)
FY 2013/2014	23	FY 2023/2024	40 (Plus 16 vacancies)
FY 2014/2015	29	FY 2024/2025	41 (Plus 14 vacancies)

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

PFAs Promoted			
Fiscal Year	Promotions	**Fiscal Year**	Promotions
FY 2007/2008	3	FY 2018/2019	6
FY 2011/2012	1	FY 2019/2020	11
FY 2012/2013	1	FY 2020/2021	2
FY 2013/2014	4	FY 2021/2022	5
FY 2014/2015	3	FY 2022/2023	5
FY 2015/2016	4	FY 2023/2024	7
FY 2016/2017	3	FY 2024/2025	4
FY 2017/2018	5		

Two of the three Employee Educational Internship Program (EEIP) interns in FY 2024/25 who successfully completed the EEIP Program were hired on as Clinical Therapist Trainees immediately after the program completion.

Positive Results, cont.

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

In FY 2024/25, DBH continued the Southern Counties Regional Partnership (SCRP) PFA pipeline development program intended to support PFAs who have achieved certification by offering stipends to retain them within the Public Mental Health System. These funds have been set aside specifically to address DBH's need to recruit and retain PFAs. Additionally, the stipends will address a gap in DBH's pipeline development and succession planning by creating a path for this classification to other positions within DBH.

To meet the goal of conducting focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share racial/ethnic, cultural, and/or linguistic characteristics of consumers and family members, the Volunteer Services Coordinator participates in career fairs throughout the County, including remote areas such as Barstow and the Morongo Basin.

As illustrated in the table on the following page, the coordinator maintained a high number of participants during outreach efforts every year through FY 2019/20, subsequent years were impacted due to the COVID-19 pandemic, which caused the Volunteer Services Coordinator to attend fewer outreach events than in previous years. It had increased again every year since 2020 except FY 2023/24 when no new events were scheduled during the search for a new Volunteer Services Coordinator due to promotion. Since the hiring of the new Volunteer Services Coordinator, the numbers have resumed those historically seen of the program.

Positive Results, cont.

The Volunteer Services Coordinator participates in career fairs throughout the County each fiscal year, as illustrated in the table below.

Fiscal Year	Number of Schools Visited	Number of Participants
FY 2011/12	13	2,470
FY 2012/13	16	2,479
FY 2013/14	23	1,706
FY 2014/15	35	2,770
FY 2015/16	35	4,139
FY 2016/17	70	6,958
FY 2017/18	82	9,303
FY 2018/19	63	6,377
FY 2019/20	59	5,818
FY 2020/21	25	2,070
FY 2021/22	32	3,093
FY 2022/23	39	4,222
FY 2023/24	21	1,582
FY 2024/25	31	7,173
Total	**544**	**60,160**

To help reach the Spanish speaking community, the Volunteer Service Coordinator partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helped to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

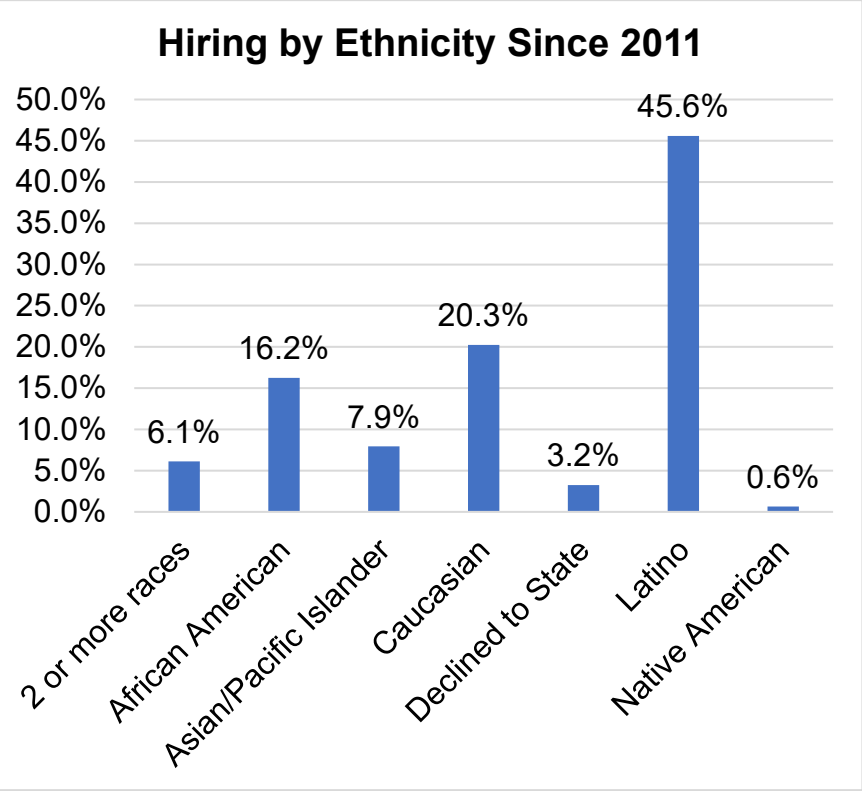
To meet the goal of recruiting, employing, and supporting the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that this measure is met, all staff are required to take either online or in-person cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians) annually.

"The joy that many patients expressed when leaving the office visit makes me consider pursuing this as a possible career. Talking with them for greater lengths of time and making lasting changes that can greatly improve the quality of their lives also makes me consider the field."

-California University of Science and Medicine Medical Student

Positive Results, cont.

To help ensure DBH provides culturally and linguistically competent services, DBH continually recruits new employees that represent the diverse population of San Bernardino County, as can be seen in the chart below.



To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH has increased the number of bilingual staff employed in FY 2024/25. It remains a top priority of the department to continue to recruit and retain bilingual staff.

Fiscal Year	Number of Bilingual Staff
FY 2012/13	150
FY 2013/14	165
FY 2014/15	162
FY 2015/16	171
FY 2016/17	171
FY 2017/18	170
FY 2018/19	172
FY 2019/20	211
FY 2020/21	208
FY 2021/22	214
FY 2022/23	203
FY 2023/24	247
FY 2024/25	259

Most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

Workforce Education and Training

Positive Results, cont.

Although interns are not able to deliver bilingual consumer services, WET has actively recruited bilingual interns. Since FY 2008/09, on average, **36%** of interns have self reported as bilingual. In FY 2024/25, **44%** of interns reported as bilingual. Of the bilingual interns, **87%** reported being Spanish speakers. The table below indicates the bilingual intern information:

Fiscal Year	Total Bilingual	Total Interns	% of Bilingual Interns
2008/09	16	39	41%
2009/10	10	46	22%
2010/11	18	41	44%
2011/12	8	44	18%
2012/13	13	47	28%
2013/14	14	51	27%
2014/15	16	43	37%
2015/16	24	47	51%
2016/17	16	39	41%
2017/18	10	31	32%
2018/19	15	39	38%
2019/20	19	35	54%
2020/21	14	33	42%
2021/22	11	34	32%
2022/23	11	41	27%
2023/24	13	42	31%
2024/25	23	52	44%
Total	**251**	**704**	**36%**

Historically, most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

Positive Results, cont.

The Employee Scholarship Program (ESP) was piloted in 2013 to meet the goal of providing financial incentives to recruit or retain employees within the public mental health system. Within the ESP program, $25,000 in funds are budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel, or other expenses) for employees who are working to earn a clinical or non-clinical certificate, associate or bachelor's degree, or a non-clinical master's or doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable, and diverse workforce within DBH. The table below provides a breakdown of which degrees the awardees were pursuing:

Fiscal Year	Certificate	Associate	Bachelors	Masters	Doctorate	Total Recipients
2012/13	0	2	5	5	0	12
2013/14	0	0	5	6	0	11
2014/15	1	0	4	3	0	8
2015/16	1	0	5	4	0	10
2016/17	1	1	5	2	0	9
2017/18	0	0	6	4	0	10
2018/19	0	0	2	1	0	3
2019/20	0	0	0	0	0	0
2020/21	0	0	1	2	1	4
2021/22	0	0	2	5	1	8
2022/23	0	0	2	1	0	3
2023/24	0	0	2	3	0	5
2024/25	0	0	0	5	0	5
Total	**3**	**3**	**39**	**41**	**2**	**88**

Note: In FY 2019/20, the program was paused due to budget concerns related to COVID-19 but resumed in FY 2020/21.

Workforce Education and Training

Positive Results, cont.

The following table illustrates the number of ESP awardees who have promoted to new positions.

Fiscal Year	Awardees Promoted	Fiscal Year	Awardees Promoted
2012/13	1	2019/20	1
2013/14	2	2020/21	1
2014/15	2	2021/22	3
2015/16	0	2022/23	4
2016/17	1	2023/24	5
2017/18	3	2024/25	3
2018/19	10		

Awardees were given money up to their tuition amount. Sometimes their tuition was less than the award amount.

"[The trainer] is an amazing trainer. She is very engaging, personable, and instantly makes you feel comfortable. She is extremely knowledgeable. She was able to present the information in a way that was easy to retain and follow along. Her authenticity and ability to be vulnerable with the audience set the right tone for the subject matter. I hope I am able to take more trainings with her in the future."

-Training Attendee

WET was able to renew the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2024/25, enabling DBH employees working at those sites to continue to be eligible for NHSC Financial Incentive programs including the Loan Repayment Programs:

- Cottages
- Fontana Day reporting Center

"I greatly valued the opportunity to develop skills in patient communication within a psychiatry setting and to gain experience in documenting comprehensive patient notes. Hearing patients share detailed accounts of some of the most traumatic events in their lives provided a unique perspective compared to other specialties, where time constraints often limit discussions to strictly medical issues. This experience emphasized the importance of seeing patients as whole individuals, fostering a deep sense of empathy and understanding. While my primary interest remains anesthesiology, this rotation has significantly influenced my decision to rank psychiatry as my second choice in the matching process."

-California University of Science and Medicine Medical Student

Positive Results, cont.

DBH uses multiple methods to meet the goal of incorporating the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Equity and Inclusion (OEI) to help maximize the ability of the existing and potential workforce, contract agencies, and fee-for-service providers to provide culturally and linguistically appropriate services to County residents by:

- Providing cultural competence training to all staff
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as guidelines on providing appropriate services for diverse cultural groups
- Providing interpreter training to all bilingual staff
- Recruiting and retaining multilingual and multicultural staff
- Working with the communities served to address the cultural needs of the community
- Participating in Cultural Competency Advisory Committee and fourteen culturally-specific awareness subcommittees

OEI also works closely with the WDD committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the goal of establishing regional partnerships, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities, and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten member counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent since FY 2014/15. San Bernardino County continues to participate in SCRP as a member county.

Workforce Education and Training

Challenges/Solutions

For a period in FY 2024/25, the WET program noticed a reduction in training registrations for live courses provided by the WET program. To improve the registration numbers, WET collaborated with the Department of Behavioral Health Public Relations and Outreach Services to develop an exclusive bi-weekly Training Announcement to advertise courses being offered to both department and contract agency employees. Additionally, WET and PROS began working to develop a WET website so there could be a central location for WET related content and information including a dedicated training schedule and direct links to register for the courses offered by WET.

The DBH Internship Program has experienced challenges in filling its Psychology Mental Health Clinic Supervisor position, which provides supervision to the DBH Psychology Program Interns. The lack of applications from qualified applicants has resulted in DBH expanding its efforts to recruit qualified candidates by keeping the job application open on an ongoing basis and by expanding the recruitment efforts to include popular external recruitment websites. Psychology supervision is currently being handled by the DBH internship Program Manager who is a licensed psychologist. Additionally, the Psychology, MFT, and MSW Internship Program Supervisor positions were reclassified to Mental Health Clinic Supervisor, and a Program Manager I was added to oversee SUD interns.

Outreach and Engagement

In FY 2024/25, WET organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Community Event – Recovery Happens	1	35
College Career Fairs	20	5,020
Classroom Presentations	6	895
Mock Interviews	8	1,188
Total	**35**	**7,138**

Program Updates

During this reporting year, WET received one new position: a Staff Training Instructor. With the addition of this position, WET is able to increase the number of reoccurring trainings. An Administrative Supervisor I position was added to Medical Services, which includes the residency and nursing training programs.

Workforce Education and Training

Collaborative Partners

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University – High Desert Campus
- UMass Global University
- Cajon High School, San Bernardino – Get Psyched
- California Baptist University
- California State University, San Bernardino
- California State University, Fullerton
- Chaffey Joint Union High School District
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY ROP)
- Fontana Unified School District
- Loma Linda University Medical
- Loma Linda University School of Medicine (LLUSM)
- Mountain Desert Career Pathways
- Pomona Valley Hospital Medical Center (PVHMC)
- Reach Out-Inland Health Professional Coalition (IEPC)
- Redlands Unified School District Collaborative
- San Bernardino City Unified School District
- San Bernardino Superintendent of Schools (SBSS)
- San Bernardino Valley College
- Touro University College of Osteopathic Medicine (TUCCOM)
- University of San Diego
- Western University of Health (WUH)

"After this rotation, I am more likely to consider future employment in a county clinic. The structure of the clinic, time with patients, and ability to focus on patient care instead of administrative/clerical work were all enticing aspects."

-Loma Linda Resident

"I enjoyed the training and the safe place that was created during the training. It was good to know that I was not alone in my experiences. Thank you [trainer], for being human in the room and sharing your story. Your truth and realness set the tone for the entire training. I would recommend and do this training again. This training should be a requirement."

-Cost of Caring: Indirect Trauma, Workplace Burnout & Chronic Stress for Helping Professionals Training Attendee

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Capital Facilities and Technological Needs

Capital Facilities and Technological Needs

Introduction

The Capital Facilities and Technological Needs (CFTN) component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of CFTN funds produce long-term impacts with lasting benefits that support the behavioral health system's movement towards recovery, resiliency, culturally competent, and help first models, as well as opportunities for accessible community-based services for consumers and their families. These efforts include the development of a variety of technological advancements, strategies, and/or community-based facilities that support culturally and linguistically appropriate integrated service experiences. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, least restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 371-374.

The San Bernardino County Department of Behavioral Health (DBH) has embraced these transformational concepts, inherent to MHSA, to develop a wellness-focused Capital Facilities and Technological Needs component that supports the public behavioral health system and the infrastructure to improve delivery of services across the county.

Program Description

Capital Facilities

Capital facility expenditures must result in a capital asset which increases the San Bernardino County Department of Behavioral Health's infrastructure on a permanent basis. Simply stated, a building or space where MHSA services can be provided.

Technological Needs

The overarching goal of the technological needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements of the quality and coordination of care, operational efficiency, and cost effectiveness across the Department.

Capital Facilities and Technological Needs

Program Description, cont.

Data Warehouse

Research and Evaluation (R&E) manages the Data Warehouse which houses data from diverse sources that are then combined to provide consistency in advanced analytics and data mining. This provides the necessary framework for meeting the requirements of California Advancing and Innovating Medi-Cal (CalAIM) and the foundation for informed program planning across the continuum of care. By incorporating information about consumers and the services they receive with externally captured outcomes data, the Data Warehouse is uniquely poised to provide the next generation of analytics, dashboard reporting, and clinical decision support needed to meet the County's vision for wellness.

Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)

Innovative Health Information Technology (iHIT) manages all technical solutions associated with the integrated BHMIS - with Billing, Claiming, & EHR functions. The BHMIS supports consumer care by providing secure access and exchange of health information by providers. The purpose of BHMIS is to provide an efficient system to support information collection and enhance coordination of care between internal and external providers. This allows providers to document care in a manner that fosters consumer and family interactions and enables highly functional reporting and data aggregation.

Services Offered

Capital Facilities

- Obtains permanent capital assets to deliver behavioral health services

Technological Needs

- Manage, maintain, and improve the Electronic Health Record (EHR)
- Maintain and utilize the Data Warehouse to
    - Generate Reports
    - Power Business Intelligence Dashboards
    - Conduct Statistical Analysis
    - Develop Outcomes data models
    - Monitor and report on Network Adequacy
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Support the delivery of services for clinicians onsite and remotely
- Provide 24/7 support to the DBH Call Center and Crisis Response Unit
- Support the connectivity, security, and access to resources for staff working remotely
- Support all deployments of staff in response to emergency incidents
- Support DBH's adherence to County directives in compliance with local State of Emergencies

Positive Results

Technological Needs

To address the goal of increasing access to services, DBH's Research and Evaluation (R&E) unit continued utilizing the power of the Data Warehouse to streamline electronic Provider Directory development and reporting. Additionally, new timely access reports and forms were created to assist with capacity planning and informed decision making to ensure access to care. R&E also specifically monitors and reports on access to services for specialized populations such as foster youth, unsheltered individuals, and consumers shared by the Managed Care Plans. Data from the Data Warehouse supports grant requests and contract negotiations, which are instrumental in maintaining and expanding the DBH network of care. R&E focused staff and resources to the development of dashboards that allow complex data to be viewed in easy-to-understand visuals that have allowed DBH leadership to make informed decisions about business operations. R&E will continue to expand the use of dashboards into consumer accessible locations to allow for expanded transparency in the services DBH provides to the community. R&E leads the initiative to develop a data reporting and repository system for SB 929 in collaboration with the San Bernardino County Innovation and Technology Department.

The Data Warehouse continues to support the monitoring and implementation of:

- Data quality improvement initiatives
- Data reporting and analysis for DBH housing programs
- Data reporting for MHSA annual reports, utilization, equity, audits, and reviews
- Expanded reporting to meet Network Adequacy requirements including monthly electronic submissions of the Provider Directory to the Department of Healthcare Services (DHCS)

In order to maintain and utilize the Data Warehouse, DBH incorporates the Department of Health Care Services (DHCS) Plan Data Feed, containing Medi-Cal service and pharmacy data for DBH consumers from external providers along with the measurement of outcomes data over time. This data provides a more comprehensive view of DBH consumers for clinical and medical staff when utilized alongside the DBH EHR data.

The use of the DBH Data Warehouse has proven invaluable in establishing the positive outcomes of programs that originated through MHSA Innovations from RBEST to TEST and InnROADS, providing the information necessary to support continuation of these key programs for high needs populations.

Challenges/Solutions

Technological Needs

Data Warehouse

The Data Warehouse challenges continue to be:

- The integration of the wide range of data, including new clinical data sources;
- The development and use of data mining in clinical support; and
- Integration of text analytics to extract data from text-based systems.

To address these continuing challenges, Research and Evaluation (R&E) has formed a team to foster the development of data mining solutions.

The Plan Data Feed, which is based on services for consumers from other sources than DBH, has been integrated into R&E's processes for calculating a variety of Healthcare Effectiveness Data and Information Set (HEDIS) measures. Additionally, Emergency Department data coming from the Managed Care Plans is being processed and delivered to programs to assist in effective continuity of care efforts.

Innovative Health Information Technology (iHIT)

Several new challenges were faced to provide enhancements to the myAvatar EHR system.

These challenges include:

- **Updating data systems** to meet new Medi-Cal billing rules for Specialty Mental Health and Drug Medi-Cal services. This is critical to ensure DBH receives full payment for the services provided.
- **Implementing the Justice-Involved Reentry Initiative,** a groundbreaking program that offers Medi-Cal services to youth and adults in state prisons, county jails, and youth correctional facilities.
- **Improving data sharing** with Medi-Cal Managed Care Plans to better coordinate care and streamline services.
- I**mplementing multiple avenues of interoperability** that allow for physicians collaborating in consumer care, organizations sharing data for operational improvements, and consumers accessing their personal health care records.

These challenges require continuous system updates to ensure compliance and provide technology solutions that enhance health outcomes for San Bernardino County residents. The Department of Behavioral Health will continue to explore possible solutions to address the identified challenges in the upcoming year including Artificial Intelligence solutions.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Fiscal

Introduction

The department of Behavioral Health (DBH) Mental Health Services Act (MHSA) program expenditure and revenue reports, along with the individual program annual budgeted funds and estimated annual cost per person tables, for FY 2025/26 were reported out in the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/2026 per Welfare and Institutions Code - WIC § 5847(e). Therefore, these are not included in the MHSA Annual Update for FY 2024/25 Outcomes report. The MHSA Annual Update for Fiscal Year 2025/2026 was approved by the Board of Supervisors on May 20, 2025, and was posted to the DBH website in June 2025.

For additional information, please refer back to the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/2026, pages 416-425.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 24/25 Outcomes and FY 25/26 Updates: Attachments

Placeholder for Attachments