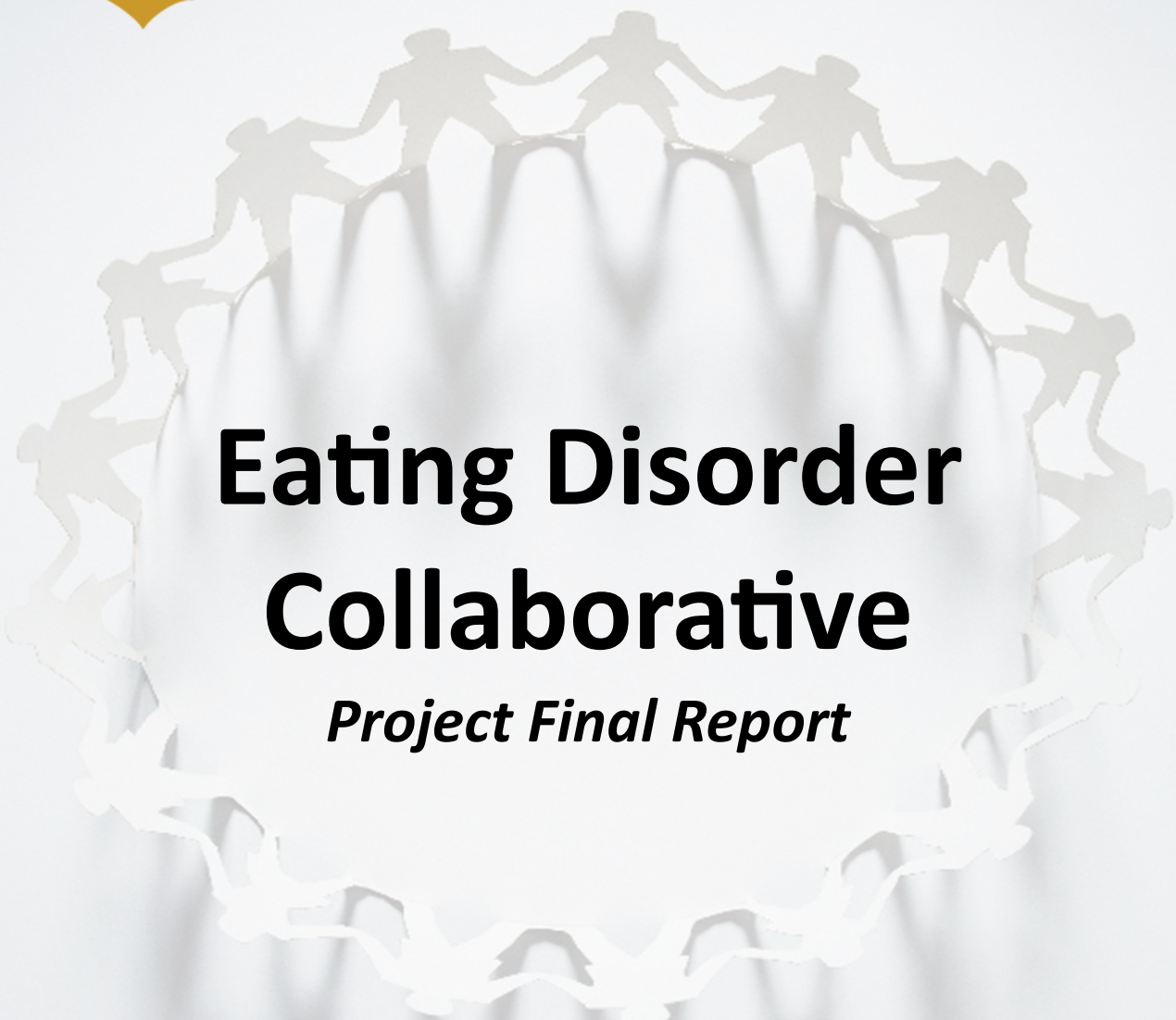
SAN BERNARDINO COUNTY

Behavioral Health



Eating Disorder Collaborative

Project Final Report

Table of Contents

Introduction

Eating disorders commonly emerge between ages 18 and 25, making the transition to college a high-risk period as young adults begin managing their own food choices, health decisions, and exposure to cultural pressures around weight. Without education or early intervention, ordinary dieting can escalate into dangerous behaviors: over one-third of typical dieters' progress to pathological dieting, and a significant portion develop full eating disorders. Yet, screening opportunities on college campuses—both nationally and within San Bernardino County—remain limited, leaving many students undiagnosed. Most local campuses lack routine screening tools, consistent assessment practices, or awareness of county behavioral health resources, despite the high mortality associated with eating disorders and their frequent co-occurrence with substance use disorders.

At the system level, inconsistent assessment practices, limited training for student health centers, and a lack of coordinated, data-driven education hinder early detection and effective treatment. Multidisciplinary care is standard but often disconnected, and treatment access varies greatly depending on insurance coverage, with Medi-Cal and Medicare beneficiaries facing the greatest barriers. Previous county-led focus groups have identified the need for a unified assessment approach, provider education informed by real-world treatment teams, and region-wide collaboration to strengthen early identification, coordination, and equitable access to care.

Project Description

The focus of the Eating Disorder Collaborative (EDC) was to improve upon San Bernardino County Department of Behavioral Health's (SBC-DBH) approach to comprehensively meet the physical and mental health needs of people suffering from eating disorders (EDOs) by:

1. Creating training and informational materials to reach out to Primary Care Physicians, Allied Health Professionals (e.g., nurse practitioners, physician assistants), Mental Health and Substance Use Disorder Staff, and local Colleges and Universities,

2. Creating a more comprehensive and validated initial needs assessment (i.e., an Engagement Assessment) to assist in level of care determination, and

3. Creating multidisciplinary teams to provide more comprehensive treatment services and ensure policies and practices of mental health and physical health are consistent across agencies.

Modifications

The EDC project gradually evolved from its original plan, adapting to emerging needs, operational challenges, and lessons learned, while staying focused on screening, assessment, training, and multidisciplinary coordination. Although staffing changes initially affected outreach capacity and service availability, stability later in the project supported broader and more effective engagement. As outreach expanded beyond colleges and universities to include clinics, crisis services, schools, health fairs, and Managed Care Plans (MCPs), the project strengthened its visibility and deepened its connection within the community.

Final Evaluation

For the EDC final project evaluation, mixed methods were employed to determine whether the original learning goals set at the onset of the projects were met.

These included:

1.) **Project Documentation**: During the project life span, EDC staff entered data on Excel spreadsheets tied to the locations where they had presented, conducted outreach, or provided informational brochures surrounding eating disorders. In addition to these documents, staff worked with the Department of Behavioral Health's (DBH) Workforce, Education, and Training (WET) unit to recover attendance records for a series of trainings and lectures funded by the EDC that would supplement knowledge pertaining to eating disorders. Participants completed evaluations to share their satisfaction and the relevance of the training to their work. Staff then identified the evaluation questions most closely aligned with the learning goals below.

2.) **Staff Interviews**: Open-ended, qualitative questions with project staff were also conducted to understand the nuance of certain business processes and clarify any data-related information.

3.) **Electronic Health Record (EHR), myAvatar – Client Data**: Analysts also reviewed data from the San Bernardino County Department of Behavioral Health's (SBC-DBH) electronic health record (EHR), myAvatar. From this system, staff pulled, analyzed, and aggregated DBH and EDC client project assignments, services, and demographics to provide descriptive statistics as well as pre- and post-analyses with regard to their involvement in the project. This process also included looking at patterns of outpatient services, crisis services, and hospitalizations also

utilized by the client between project inception, January 1st, 2021, and the end of the Innovation component, December 31st, 2025.

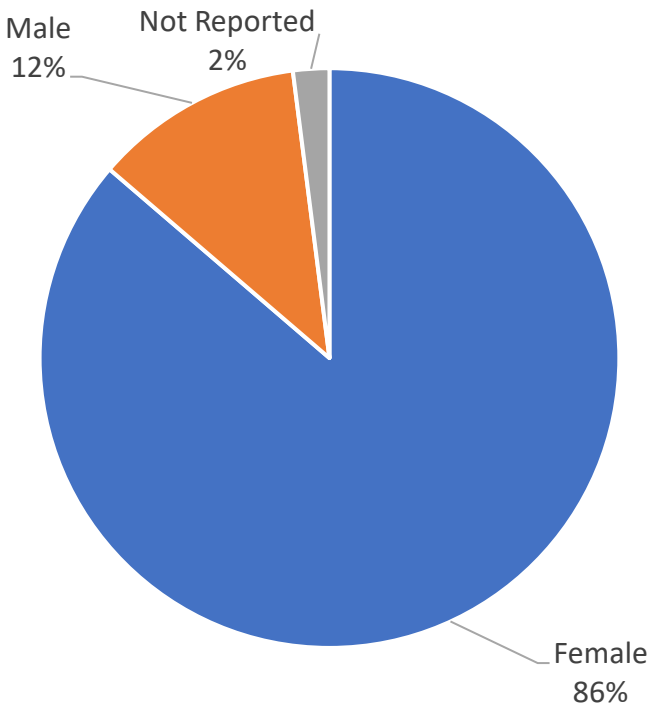
Demographics

Throughout the lifespan of the project, the EDC provided services to 248 unique clients. This information was documented under two different reporting units (RUs), one of which was a pre-admit and the other, the main project. Clients who were in a higher level of care were assigned to the project's pre-admit reporting unit. Once pre-admit clients were released for a higher level of care, they were then assigned to the project's main reporting unit.

Gender

Most clients identified as female, with smaller proportions identifying as male or not reporting gender.

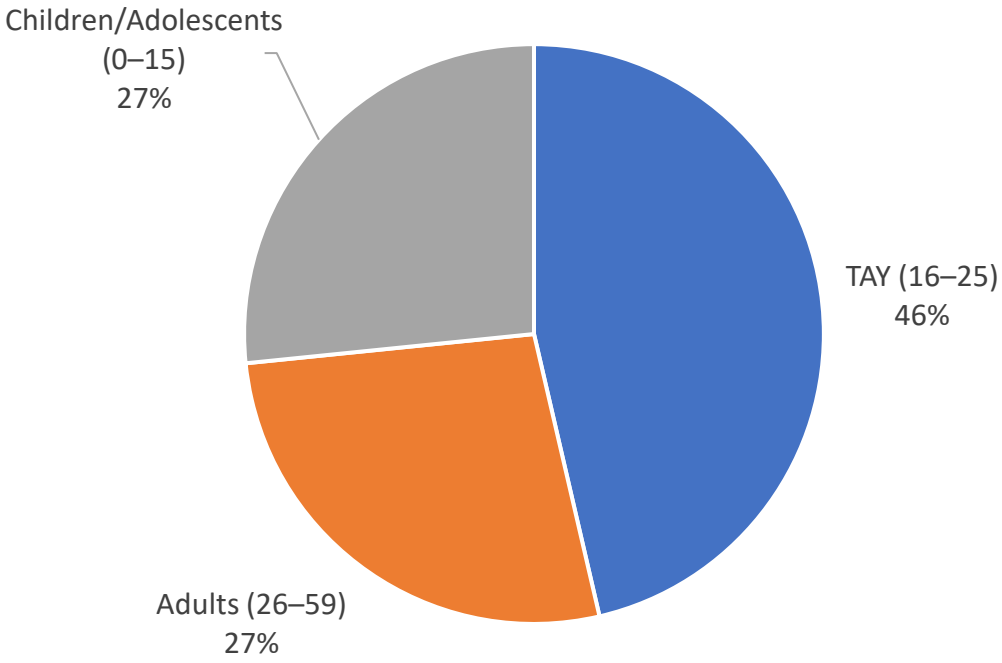
Gender	Number of Clients	Percent
Female	214	86%
Male	29	12%
Not Reported	5	2%



Age

Clients were grouped into four age categories: Children/Adolescents, Transitional Age Youth (TAY), Adults, and Older Adults. TAY represented the largest proportion of clients.

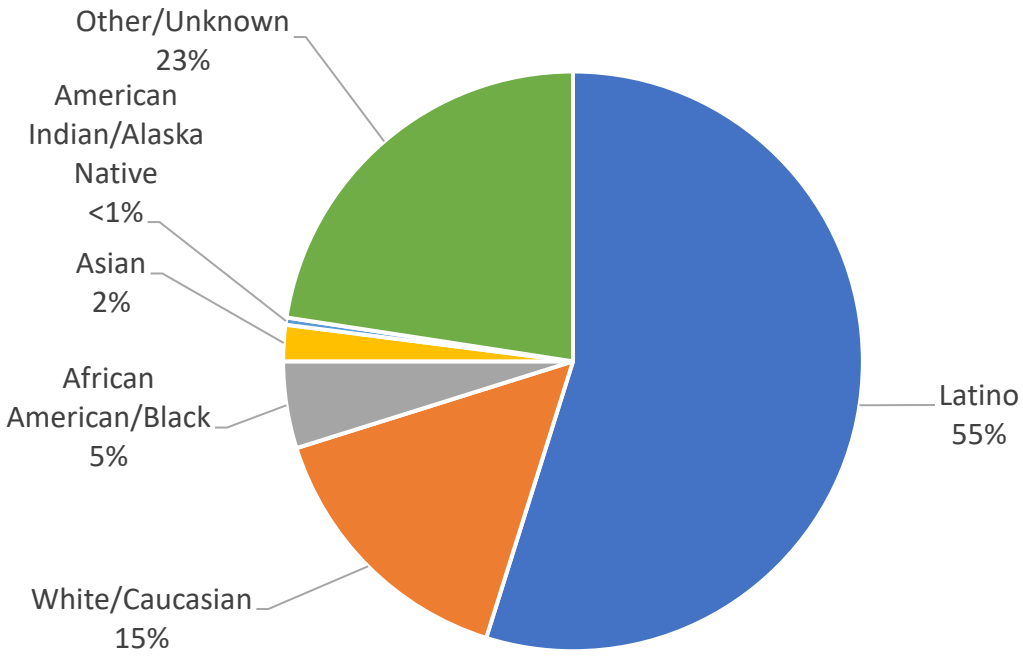
Age Group	Number of Clients	Percent
TAY (16–25)	115	46%
Adults (26–59)	67	27%
Children/Adolescents (0–15):	66	27%
Older Adults (60+)	0	0%



Race and Ethnicity

Clients demonstrated a diverse range of racial and ethnic identities, with Latino individuals representing just over half of those served.

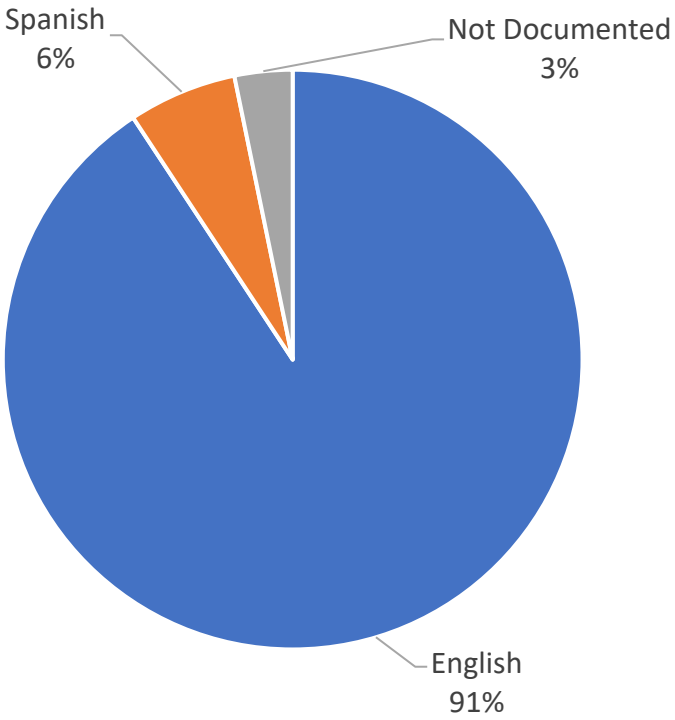
Race and Ethnicity	Number of Clients	Percent
Latino	136	55%
White/Caucasian	32	15%
African American/Black	12	5%
Asian	5	2%
American Indian/Alaska Native	1	<1%
Other/Unknown	56	23%



Primary Language

Most clients reported English as their primary language.

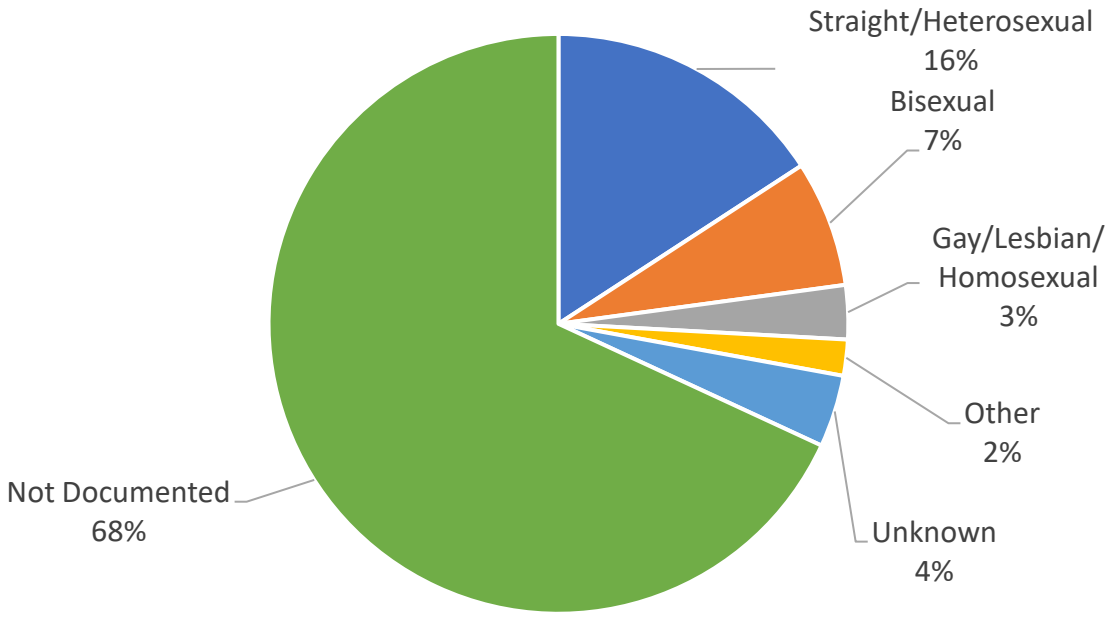
Primary Language	Number of Clients	Percent
English	225	91%
Spanish	15	6 %
Not Documented	8	3%



Sexual Orientation

Sexual orientation information was not reported for most clients; however, available data is summarized below.

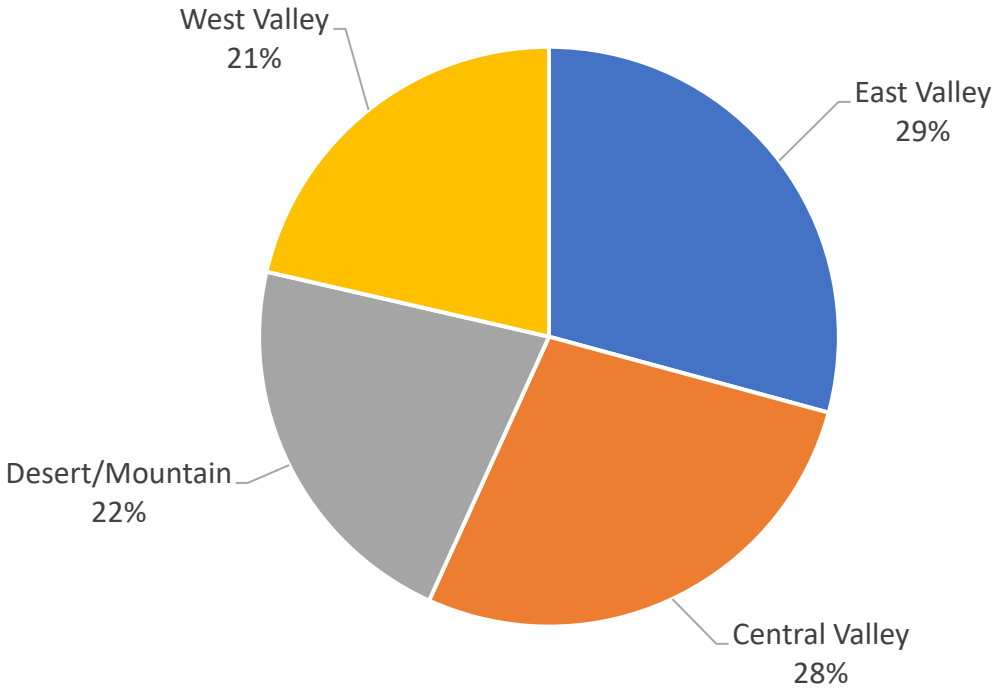
Sexual Orientation	Number of Clients	Percent
Straight/Heterosexual	39	16%
Bisexual	16	7%
Gay/Lesbian/Homosexual	6	3%
Other	3	2%
Do Not Know / Chose Not to Disclose	8	4%
Not Documented	168	68%



Geographic Region

Clients were categorized into four regions within San Bernardino County based on their zip code. Representation was relatively even across regions, with a slight concentration in the East Valley.

Region	Number of Clients	Percent
East Valley	71	29%
Central Valley	67	28%
Desert/Mountain	53	22%
West Valley	52	21%



Overall, the demographic profile of clients served in the Eating Disorder Collaborative reflected a predominantly young (16–25-year-olds), female, and Latino population who may have spoken English. Categories such as sexual orientation showed some gaps in reporting; however, regional information was well documented and showed substantial representation across the County.

Stakeholder Contribution

Across multiple Community Policy Advisory Committee (CPAC) meetings, stakeholders consistently emphasized the significant need for expanded eating disorder services and the importance of sustaining the EDC project. Participants expressed strong interest in additional Workforce Education & Training (WET) opportunities, particularly in areas such as Family-Based Therapy (FBT) and Dialectical Behavior Therapy (DBT) for eating disorders. Many also highlighted the need for training that supports culturally responsive care and strengthens connections with diverse communities.

Stakeholders repeatedly identified early intervention for eating disorders as a critical gap in the county's Prevention and Early Intervention (PEI) system. They stressed the importance of meeting people where they are by offering services in community-based locations, using culturally specific ambassadors such as promotores and community health workers, and strengthening cultural competency committees, including those focused specifically on eating disorders. These comments reflect a desire for prevention strategies that are accessible, culturally grounded, and capable of reducing stigma and barriers to care.

Feedback on the EDC project itself was overwhelmingly supportive. Many stakeholders described eating disorders as a severely underserved area in the county and emphasized that EDC provides specialized services not available elsewhere. They noted that the project plays a vital role in helping clients navigate all levels of care, offering advocacy, and providing education to providers, families, and community members. Several respondents highlighted that the project has recently stabilized staffing, increased outreach, and begun to solidify its structure after several years of development. Several expressed concern that discontinuing the project would disrupt care for a vulnerable population, especially given the life-threatening nature of eating disorders and the lack of local treatment options. Numerous stakeholders urged continued or expanded funding, including extending services to younger youth and older adults and developing in-county inpatient or partial hospitalization programs.

A smaller but notable group raised concerns about the project's effectiveness and clarity of purpose. Some felt that the number of clients served did not justify staffing levels, while others believed the project primarily referred clients to higher levels of care rather than providing direct services. A few stakeholders expressed disappointment that in-county treatment options had not been developed as originally expected. These comments point to a need for clearer communication about project goals, improved outcome tracking, and stronger community engagement.

Additional themes emerged across the feedback, including calls for increased awareness and outreach, more presentations in schools and community settings, and greater overall visibility of the project. Many expressed hope that the EDC project would continue to grow, expand staffing as needed, and embed services across county behavioral health clinics.

Overall, stakeholder sentiment strongly supports the continuation and expansion of the EDC project. While some concerns exist regarding outcomes and service volume, the dominant message is clear: eating disorders remain a critical and underserved area, and the EDC project is viewed as an essential resource that fills a significant gap in the county's behavioral health system.

Project Adaptation

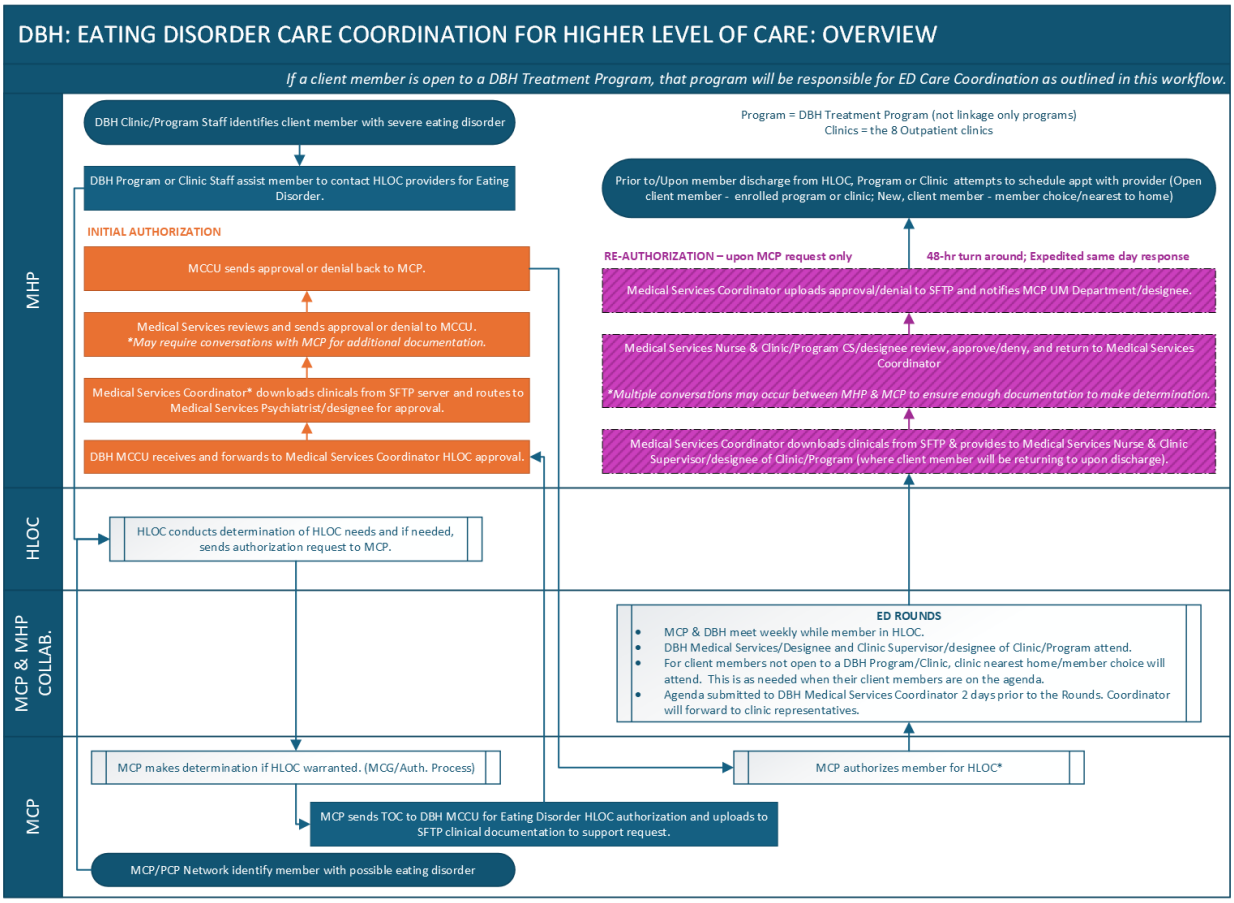
During the EDC implementation, several adaptations were made as the project responded to emerging needs, operational challenges, and lessons learned throughout the project period. While the core goals of improving screening, assessment, training, and multidisciplinary coordination remained consistent, modifications were made to staffing, outreach, and toolkit development.

Throughout the project's lifespan, staffing patterns shifted significantly due to turnover, onboarding, and evolving project needs. These changes affected outreach capacity, service volume, and the availability of certain clinical specialties at different points. As staffing stabilized in later years, the project demonstrated improved outreach consistency and increased service delivery.

Outreach strategies also evolved. Early efforts focused heavily on colleges and universities, consistent with the project's initial goals. However, as collaboration barriers emerged, such as limited campus engagement opportunities and unclear points of contact, EDC expanded its outreach to include community clinics, crisis services, school districts, health fairs, and Managed Care Plans (MCPs). This broadened approach increased visibility and allowed for more consistent community connection.

At the sunset of the EDC project, eating disorder cases were referred to the DBH general mental health clinics or children's specialty programs, depending on the client's age and location. Three eating disorder trainings – Cognitive Behavioral Therapy for Disordered Eating, Eating and Feeding Disorders in Children, and Eating Disorders in Adolescents and Adults – were assigned to the appropriate provider classifications (medical, clinical and paraprofessional) within the DBH general mental health clinics or children's specialty programs.

In addition, an updated eating disorder care coordination workflow was developed for clients with identified eating disorders. The new workflow was developed to establish a "no wrong door approach" to providing treatment and care coordination. Referral pathways from MCPs to DBH and DBH to MCPs were streamlined to go through the Managed Care Coordination Unit (MCCU).



With the project's Mental Health Services Act (MHSA) Innovation funding ending on December 31, 2025, higher levels of care (residential, partial, and intensive) services will be funded through 1991 or 2011 Realignment or the Behavioral Health Services Act (BHSA) Behavioral Health Services and Supports (BHSS) component. Specialty Mental Health Services Outpatient services will be funded through Medi-Cal and BHSA.

Learning Goals

Learning Goal 1

Examine if a collaborative approach with local colleges can result in the development and utilization of public information campaigns and materials to educate populations most at risk for developing disordered eating practices at the multiple college campuses within one county.

Part 1: Increase collaboration between local college/university partner organizations leading to dynamic, ongoing working relationships.

Although the EDC did not ultimately secure formal collaborations with local colleges or universities, the project established numerous effective partnerships across San Bernardino County. These collaborations included DBH clinics, crisis programs, community organizations, medical residency programs, and school districts. Outreach consisted of live and virtual presentations, informational booths, and training sessions designed to increase awareness of eating disorders and available services.

During Fiscal Year 24/25, the EDC engaged in 8 in-person and 4 virtual outreach events at 12 different locations, engaging with an estimated 357 individuals.

Outreach Location	Estimated Participation
Mariposa Community Counseling	42
Vista Community Counseling	31
Barstow Counseling Center	9
Victor Valley Behavioral Health	23
Phoenix Community Counseling	67 (Virtual)
Apple Valley Community Clinic	11
Mesa Counseling Services	36 (Virtual)
Apple Valley CCRT	11 (Virtual)
West Valley CCRT	12
MCCU & DBH Authorization Unit	18 (Virtual)
Youth Cultural Connect	6
Psychiatry Students (DBH Medical Services)	91

For Fiscal Year 25/26, EDC expanded its reach and conducted 14 outreach events, with 13 in-person and 1 virtual, engaging an estimated 1,030 individuals**.**

Outreach Locations (with Estimated Participation)

Setting Type	Location	Est. Reach
DBH Community Clinics	Mariposa Community Counseling	18
Crisis Services	Wellspring Center	6
Crisis Services	STAY	1
DBH Program	RBEST (Virtual)	7
Contract Provider	Hi-Desert Behavioral Health	1
Community Event	Recovery Happens	350
Schools	Sierra High School	3
School District	Oro Grande Community Resource Fair	200
School Health Symposium	Inland Empire School-Based Health Symposium	225
Medical Provider	Avalon Urgent Care (Yucca Valley)	1
Community Event	Fall Wellness Extravaganza	215
University Medical Program	Psychiatry Fellows (Loma Linda University)	3

Across both fiscal years, EDC staff delivered a consistent presentation covering:

- Program overview
- Early warning signs of eating disorders
- Myths and facts
- Services available
- How to submit referrals

These presentations encouraged discussion, provided opportunities for Q&A, and resulted in productive cross-agency connections.

During these outreach events, staff would provide an overview of the EDC, including services offered, early signs of eating disorders, and how to make a referral. This was done using a PowerPoint presentation that included information on the project, definition of an eating disorder, related facts & myths, signs to look for, goals for individuals suffering from these illnesses, services provided by the project, and how to submit a referral. These also left room for questions and discussion from participants. During fiscal year 25/26, EDC also discussed potential collaboration between the Serving Transitional Aged Youth Residential Treatment (STAY) for discharged consumers who needed ongoing treatment and support, as well as STAY

criteria for admitting clients in crisis who needed residential treatment. They also had similar conversations with the Wellspring Crisis Residential Treatment Center for consumers discharged from the residential treatment center needing ongoing outpatient treatment and support as well as Wellspring Center criteria for admitting clients in crisis needing residential treatment.

In addition, through outreach events and collaborations within DBH's continuum of care, EDC has had positive partnerships with the MCPs, Inland Empire Health Plan (IEHP), and Molina. With these partnerships, EDC and MCP staff would meet regularly to review caseloads, discuss clinical issues, and address referral authorizations. The MCPs would provide medical support to clients and split the payment cost for any clients placed in residential treatment facilities. Residential treatment facilities were locations for clients with an eating disorder that required a higher level of care. EDC and MCP staff would work to obtain authorization by reviewing clinic documentation that would support the client's level of care, which might change throughout their stay at the facility. Authorizations were done on a weekly, bi-weekly, or sometimes a monthly basis. In total, EDC collaborated with 13 different agencies providing higher levels of care across Southern California within San Bernardino, Los Angeles, Orange, Riverside, and San Diego Counties. These encompassed community-based organizations (CBOs), partial hospitalization programs (PHPs), clinic-based intensive outpatient programs (IOP-CBs), home-based intensive outpatient programs (IOP-HBs), clinic-based eating disorder services, and programs with follow-up care without specialty mental health services. These agencies included: Loma Linda University Behavioral Medicine Center – Eating Disorder Program (IOP/PHP), Center for Recovery (IOP/PHP), UCLA Eating Disorders Program (inpatient), UC San Diego Health Eating Disorders Center (IOP/PHP), RADY Children's Hospital-Medical Stabilization Unit (IOP/PHP), Valenta Inc. (IOP/PHP), BHC Alhambra-Reasons (Inpatient, Residential, IOP/PHP), Montecatini (Residential, IOP/PHP), Monte Nido (Residential), Clementine (Residential), Adolescent Growth (Residential), Desert Marriage & Family Counseling (IOP), and Bright Road Recovery (IOP/PHP).

Part 2: Develop a toolkit that includes lessons learned about collaborating with colleges/universities and their health centers.

For this objective of the learning goal, although a toolkit was not developed, lessons learned about collaborating with colleges/universities and their health centers were documented in a "Lessons Learned" document incorporated into this report.

Part 3: Creation of an Eating Disorder public information campaign.

For this aspect of Learning Goal 1, staff created an informational brochure that was distributed at their outreach events. This brochure described the project, eligibility criteria, provided a definition of an eating disorder, highlighted services EDC provided (e.g., assistance with navigating MCPs, coordination of care, linkage to a higher level of care, case management, individual therapy, and group therapy), how to receive an assessment, and what to expect when participating in this project. It also provided additional information on educational and treatment resources as well as phone numbers to contact crisis services, Behavioral Health, and/or Substance Use Disorder Recovery Services (SUDRS) within DBH's continuum of care. This brochure was also translated into three of San Bernardino County's threshold languages, Spanish, Vietnamese, and Mandarin, highlighting their efforts to maintain accessibility and equity.

Part 4: Implementation of public information campaign; dissemination of public information campaign materials.

During Fiscal Year 24/25, EDC distributed 620 brochures to 12 different locations associated with DBH's continuum of care.

Location Type	Site	Brochures Distributed (N)
DBH Community Clinic	Mariposa Community Counseling	50
DBH Community Clinic	Vista Community Counseling	50
DBH Community Clinic	Barstow Counseling Center	50
DBH Community Clinic	Victor Valley Behavioral Health	50
DBH Community Clinic	Phoenix Community Counseling Center	50
DBH Community Clinic	Mesa Counseling Services	50
CCRT	Apple Valley CCRT	50
CCRT	West Valley CCRT	60
CCRT	East Valley CCRT	60
Clubhouse	Amazing Place Clubhouse	50
Clubhouse	Pathways to Recovery Clubhouse	50
Clubhouse	Central Valley FUN Clubhouse	50
Total Distributed		**620**

For FY 25/26, EDC distributed these materials to 19 different locations. Again, these included:

Location Type	Site	Brochures Distributed (N)
DBH Community Clinics	Mariposa Community Clinics	50
DBH Community Clinics	Victor Valley Behavioral Health	20
Crisis Services Provider	Wellspring Center	50
Crisis Services Provider	STAY	30
Crisis Services Provider	Valley Star Crisis Walk-In Center	20
Crisis Services Provider	Community Crisis Services	50
Specialized Program	Recovery Based Support Teams (RBEST) - Virtual	7
Contract Provider	Hi-Desert Behavioral Health	100
Contract Provider	Pacific Clinics	100
Contract Provider	Veterans Alcohol Rehabilitative Program	50
Outreach	Recovery Happens	71
Clubhouse	Pathways Clubhouse	100
Clubhouse	TEAM House Clubhouse	100
Clubhouse	Amazing Place Clubhouse	100
School	Sierra High School	50
School	Pacific High School	20
School	Inland Empire School-Based Health Symposium	25
Outreach	Avalon Urgent Care	100
Outreach	Fall Wellness Extravaganza	10
Total Distributed		**1053**

Funding from the EDC project supported the distribution of educational materials as well as two major training courses and six specialized lectures for DBH and contract staff. The two hybrid trainings, Family-Based Therapy (FBT) and Eating Disorder Management, and Dialectical Behavior Therapy and Application to Eating Disorders training, reached a total of 204 participants. The Family-Based Therapy (FBT) and Eating Disorder Management training held 123 participants, of which 50 were virtual and 73 in-person, with 87% of attendees surveyed reporting that the information was applicable to their work. Similarly, the Dialectical Behavior Therapy and Application to Eating Disorders training engaged 81 participants, of whom 35 were virtual and 46 in-person. The training received strong feedback, with 86% of attendees surveyed noting practical value. The 2025 Eating Disorder Lecture Series also demonstrated highly positive outcomes: Cognitive Behavioral Therapy for Eating Disorders drew 82 participants with 93% affirming relevance to their work; both Motivational Interviewing for Eating Disorders and Exposure and Response Prevention for Eating Disorders had 138 total attendees and received 100% applicability ratings from

surveyed participants. Additional sessions included refreshers on FBT and DBT for eating disorders, along with a course on medical comorbidities and common eating disorder behaviors, further expanding staff knowledge and skills. Attendance included 52 participants for the FBT Refresher with 77% of attendees surveyed finding it applicable. Lastly, 70 participants attended the DBT Refresher, and 15 participated in the Medical Comorbidities & Common Eating Disorder Behaviors session.

Learning Goal 2

Examine if the development and dissemination of a screening tool which may be used in a variety of settings (e.g., college student centers, health centers, substance use disorder providers physician's offices) is effective at increasing the number of individuals assessed for disordered eating issues.

Part 1: Development of a disordered eating screening and referral tool.

For Learning Goal 2 and the development of a screening tool, the EDC implemented the Eating Disorder Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008). The EDE-Q is a 28-question measure asking clients to think about the past four weeks (28 days) and how many of those days the individual exhibited a behavior related to having an eating disorder. Questions 1 through 12 and 19 had a scale that ranged from "No Days", "1-5 Days", "6-12 Days", "13-15 Days", "16-22 Days", "23-27 Days", or "Every Day". Questions 13 through 18 asked clients to fill out the number of days they believed they had exhibited specific behavior. Question 20 asked about guilt associated with eating on a 6-point Likert scale ranging from "None of the Time" to "Every Time", while Question 21 asked about concern with others seeing the individual eat using a 6-point Likert scale ranging from "Not at all" to "Markedly". Finally, Questions 22 through 28 also used a 6-point Likert Scale ranging from "Not at all" to "Markedly" regarding the client's perspective on their eating behaviors. Following those questions, there were three supplementary questions related to health, including weight, height, and menstrual period challenges if female.

To complete the questionnaire, EDC and clinical staff met with clients, assisted them in completing the assessment, and scanned the completed form into the Department of Behavioral Health's EHR, myAvatar. However, this workflow, combined with limitations within myAvatar, made it difficult to aggregate the total number of assessments completed or conduct meaningful analysis of the responses. Moving forward, it is recommended that a dedicated myAvatar form be developed using EDE-Q questions so staff can enter

responses directly into the EHR, enabling analysts to efficiently extract, aggregate, and analyze the data through SQL/SAS tables.

Part 2: The eating disorder screening and referral tool is disseminated to and used by community partners (colleges/universities, health centers, substance use disorder providers, physicians' offices).

The EDC also developed and distributed a referral form which was completed by internal and/or clinical staff with other providers for potential clients eligible for services to address an individual's eating disorder. However, like the EDE-Q, these referrals were completed via fillable form, scanned, and uploaded to DBH's EHR, myAvatar. As such, there was also a limitation with extracting, aggregating, and analyzing data points from this documentation. Again, future recommendation would be development of a form within myAvatar with a referral field which would allow staff to directly enter responses into the EHR and make the raw data more accessible for analysis.

Part 3: Develop a toolkit that includes lessons learned about developing and disseminating a screening and referral tool to community partners.

As with Learning Goal 1, although a toolkit was not developed, the lessons learned from developing and disseminating a screening and referral tool to community partners were integrated into the "Lessons Learned" section of this report.

Part 4: Increase the number of new clients screened, referred, and assessed for eating disorders.

To address this portion of Learning Goal 2, myAvatar data from January 1, 2021 through December 31, 2025 was reviewed. One of the first metrics examined was how many clients entered DBH's continuum of care through the EDC. During this period, 83 unique clients were identified as connecting to DBH via the EDC pre-admit program, where they received referral and case management support before transitioning to a higher level of care. As shown in the table below, the number of new EDC clients increased in FY 21/22 and FY 22/23, followed by a decline in subsequent years. Please note that Fiscal Years 20/21 and 25/26 contain partial data as the project began and ended 6 months into each fiscal year.

Fiscal Year	# of Clients
FY 20/21	13
FY 21/22	23
FY 22/23	23
FY 23/24	10
FY 24/25	8
FY 25/26	6

Part 5: Increase the number of existing DBH clients screened, referred, and assessed for eating disorders.

While the previous part of Learning Goal 2 examined new clients, this portion looked at individuals who had already accessed another area of DBH's continuum of care and were referred to EDC to address their eating disorder. Between January 1, 2021 and December 31st, 2025, the project opened program assignments for an estimated 173 unique clients. Specifically, 168 clients were open with the pre-admit reporting unit, to track coordination of care. Forty-two (42) of these clients were also assigned to the project's main reporting unit. Of these 42 clients, 37 were assessed with needs serious enough to be elevated to receive direct services. An additional 5 clients presented with higher-severity needs or followed an alternative pathway that allowed them to receive direct services without reporting through the pre-admit reporting unit.

Under the pre-admit reporting unit, the number of clients opened each year remained relatively steady, ranging in the low 30s with a peak in Fiscal Year 21/22 of 45 clients. For the main reporting unit, there were peaks in Fiscal Year 21/22 with 24 clients and Fiscal Year 24/25 with 15 clients, while the other four fiscal years opened less than 5 each for their respective time frames.

Reporting Unit Type	Fiscal Year	# of Clients
Pre-admit	FY 20/21	32
Pre-admit	FY 21/22	45
Pre-admit	FY 22/23	35
Pre-admit	FY 23/24	31
Pre-admit	FY 24/25	31
Pre-admit	FY 25/26	18
Main	FY 20/21	1
Main	FY 21/22	24
Main	FY 22/23	4
Main	FY 23/24	4
Main	FY 24/25	15
Main	FY 25/26	1

Learning Goal 3

Examine if the development and utilization of the engagement assessment facilitates better linkage to effective treatment services.

Part 1: Provider satisfaction with engagement assessment tool.

Part 2. Development and implementation of an eating disorder engagement assessment.

These portions of Learning Goal 3 were not met, as an engagement assessment tool had not been developed. However, engagement was monitored through the volume and length of services provided following the initial assessment.

Part 3: Increase the length of time and/or number of services utilized by clients with an eating disorder diagnosis and episode who receive an engagement assessment.

While an eating disorder engagement assessment had not been developed, to supplement this learning goal, client data was reviewed to determine whether the length of time and/or number of services utilized by EDC clients increased following their initial service with the project. Across the lifespan of the project, under both reporting units, 248 clients received a total of 4,826 services, accounting for 91,748 minutes or about 1,529 hours. On average, clients received 19.5 services with a minimum of 1 and a maximum of

266. With length of time, the average was 370 minutes or 6 hours, with a minimum of 0 and a maximum of 7,550 minutes or about 125 hours.

Variable	Mean	Minimum	Maximum
Total Minutes	370.0	0	7550
Total Services	19.5	1	266

When this same analysis was done across all project fiscal years, it was discovered that the average number of services per client did increase following FY 20/21 to a high of 16.48 average services per client, but subsequently dropped the next fiscal year with a low of 8.88 in FY 23/24, then picked back up the next two fiscal years. There was a similar pattern with length of time where across fiscal years, the average length of time per client increased following the fiscal year to a peak of 5.41 hours per client, then steadily dropped to a low of 2.64 hours per client in FY 24/25, but picked back up during this last fiscal year with an average of 3.96 hours per client.

The combination of shifting staffing levels and growing client demand in the later years of the project made the development of an engagement tool challenging. These trends reflect a pattern in staffing changes that are discussed in greater detail as part of Learning Goal 4.

Fiscal Year	Average # of Services	Average Length of Time (Hours)	# of Clients
FY 20/21	7.32	1.35	37
FY 21/22	16.48	5.41	89
FY 22/23	14.13	4.67	93
FY 23/24	8.88	3.50	50
FY 24/25	11.03	2.64	69
FY 25/26	10.94	3.96	52

Learning Goal 4

Examine if the use of multidisciplinary team, all comprised of MHP staff, can effectively liaise with a variety of organizations (e.g., Colleges, College Health Centers, individual Physician Offices, Independent Physician Associations, Management Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

Part 1: Develop a toolkit that includes lessons learned about creating, implementing, and maintaining an eating disorder multidisciplinary team.

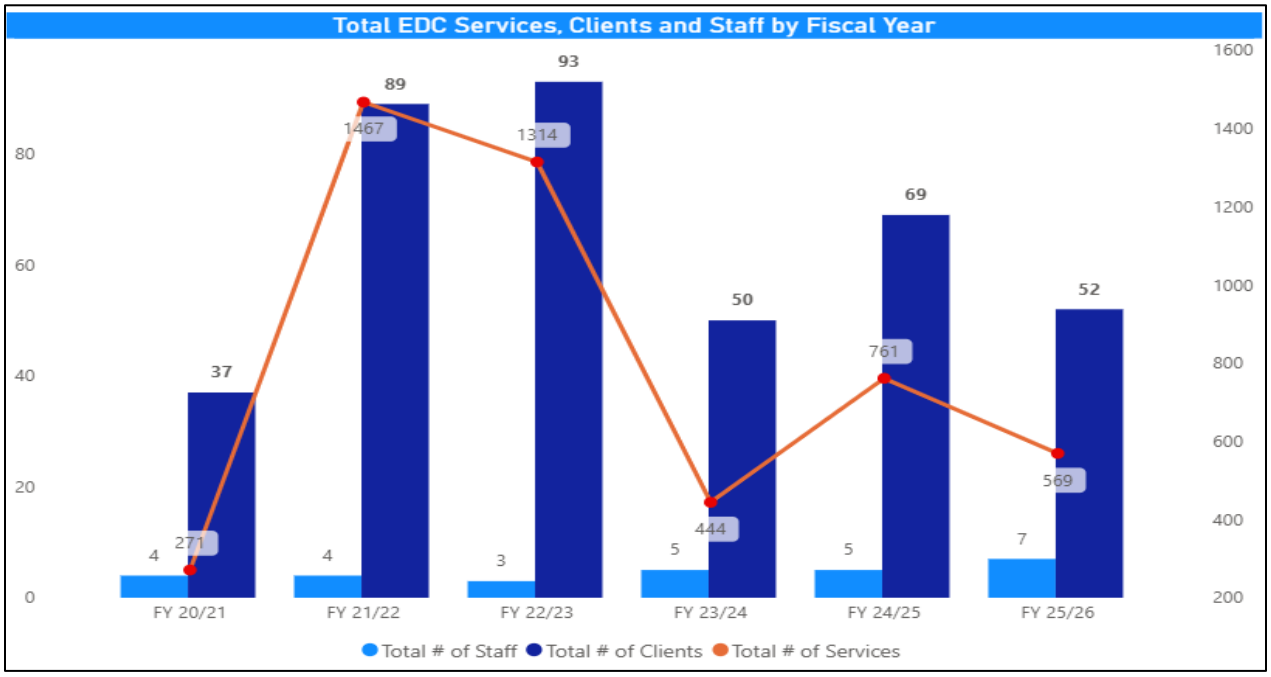
To support this learning goal, a comprehensive "Lessons Learned" document was developed and integrated into this report, summarizing key insights from collaboration efforts with colleges, universities, and their health centers. In addition, an in-depth analysis of staffing patterns and the services provided through the EDC helped highlight the strengths and effectiveness of using a multidisciplinary team. Together, these efforts deepen understanding of what contributes to successful engagement and coordination within the EDC model.

As noted in our demographic profile of EDC clients, there were 248 unique clients who obtained services through the life of the project. Overall, EDC staff rendered 4,826 services from FY 20/21 through FY 25/26. The trend shows an initial surge from 271 services in its inaugural year to 1,467 services in the following fiscal year, an increase of 429%. After an initial surge, we see a trend indicating a gradual decline in services, reaching 444 in FY 23/24. There is a partial recovery in FY 24/25 that shows a rendering of 761 services, which is double the previous year, but in the final year, we see the final FY of services end at 569 services. Again, however, data for FY 25/26 is only partial, suggesting the potential for the number of services rendered to bounce back, double that of the previous year. In essence, the trends suggest that the EDC project had 1) a strong initial launch, 2) a mid-cycle contraction, and 3) a late-stage recovery with signs of project recalibration.

In terms of the total number of clients, the trendline seems to follow a similar path to the EDC services rendered. The project started with 37 clients in FY 20/21, increased to 89 in FY 21/22, and peaked at 93 in FY 22/23. In the following fiscal years, there was a considerable drop to 50 clients (FY 23/24), which slightly rebounded in FY 24/25 to 69 clients while concluding its project cycle, serving 52 clients in the partial FY 25/26.

Many of these patterns can be attributed to staffing trends and external factors stemming from the global COVID-19 pandemic, which changed the trajectory of service delivery. At the inception of the project in FY 20/21, the EDC project began with four staff members who provided services. This staffing level was maintained until FY 22/23, when the project lost a staff member and had only three individuals able to provide services. However, in the following fiscal years, the project increased staffing to 5 staff members (FY 23/24) and reached a maximum of 7 staff members providing services in the final year (FY 25/26).

I. Services Rendered by EDC Staff by FY

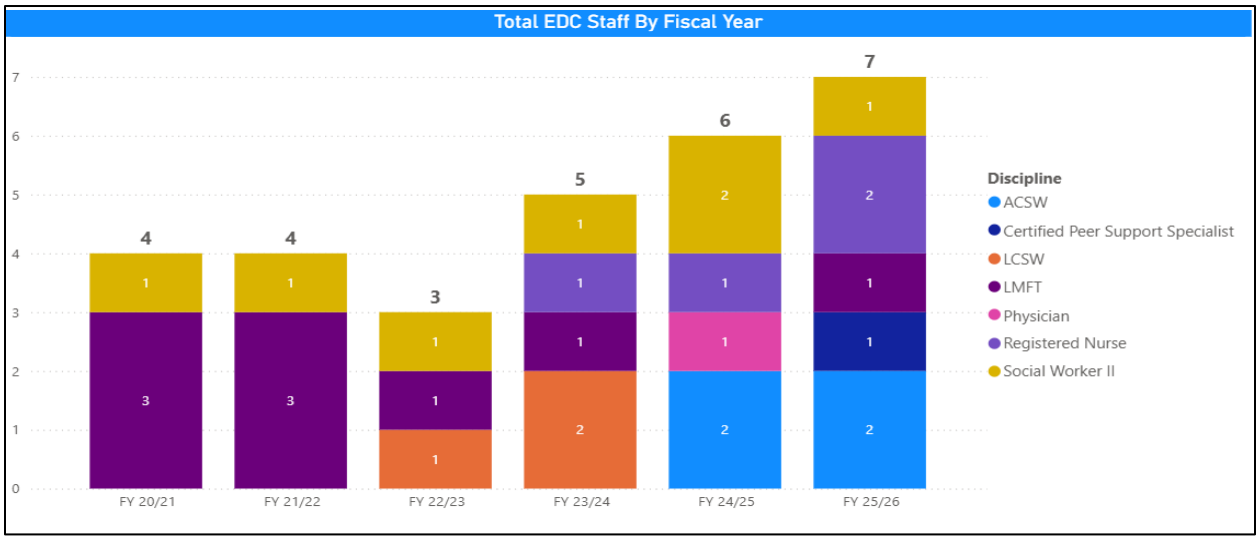


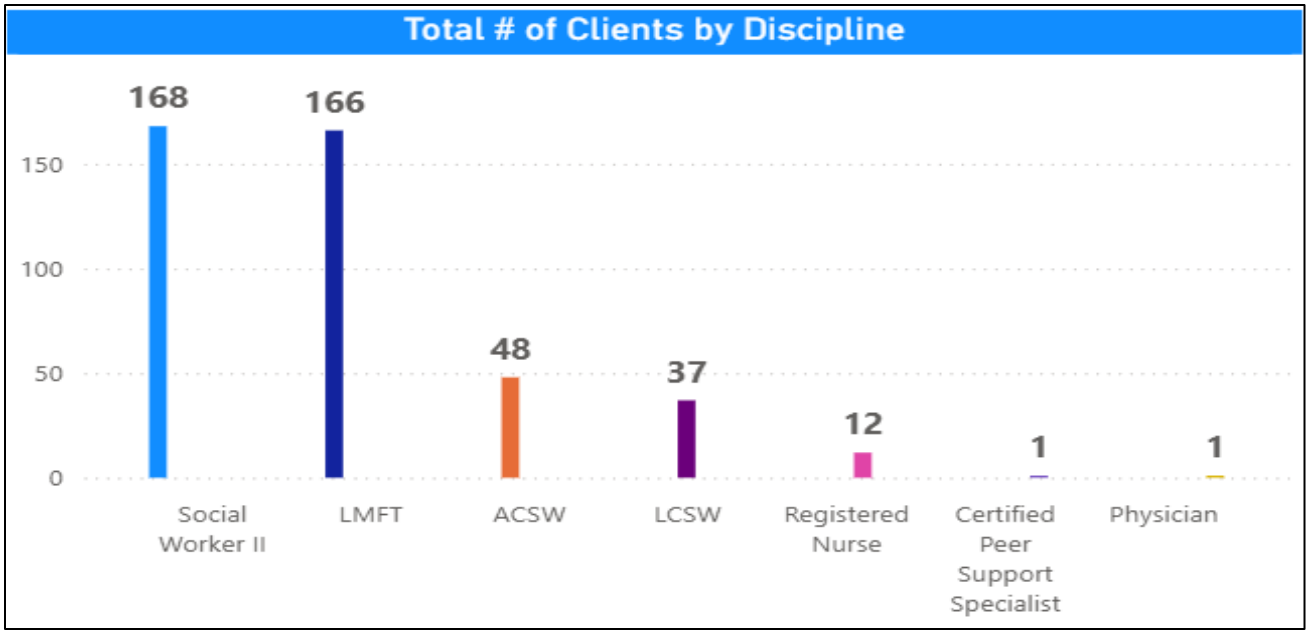
A further breakdown of staffing shows the specific discipline by Fiscal Year. During the inception of the project and the following fiscal year (FY 21/22), the EDC was composed of and serviced by four main staff, three Licensed Marriage and Family Therapists (LMFTs), and one Social Worker II (SW II). In FY 22/23, there were two departures of LMFTs and the addition of a Licensed Clinical Social Worker (LCSW). This was the only year that the project had fewer than four staff members providing services for clients. In the following years, the project added and lost different staff member specialties. During FY 23/24, the project added

another LCSW and a Registered Nurse (RN). In FY 24/25, the two LCSWs departed from the project, but one Physician, one Social Worker I (SW I), and two Associate Clinical Social Workers (ACSWs) were onboarded. During the last year, the EDC project was composed of two ACSWs, two Registered Nurses (RNs), one Certified Peer Support Specialist, one LMFT, and one SW I.

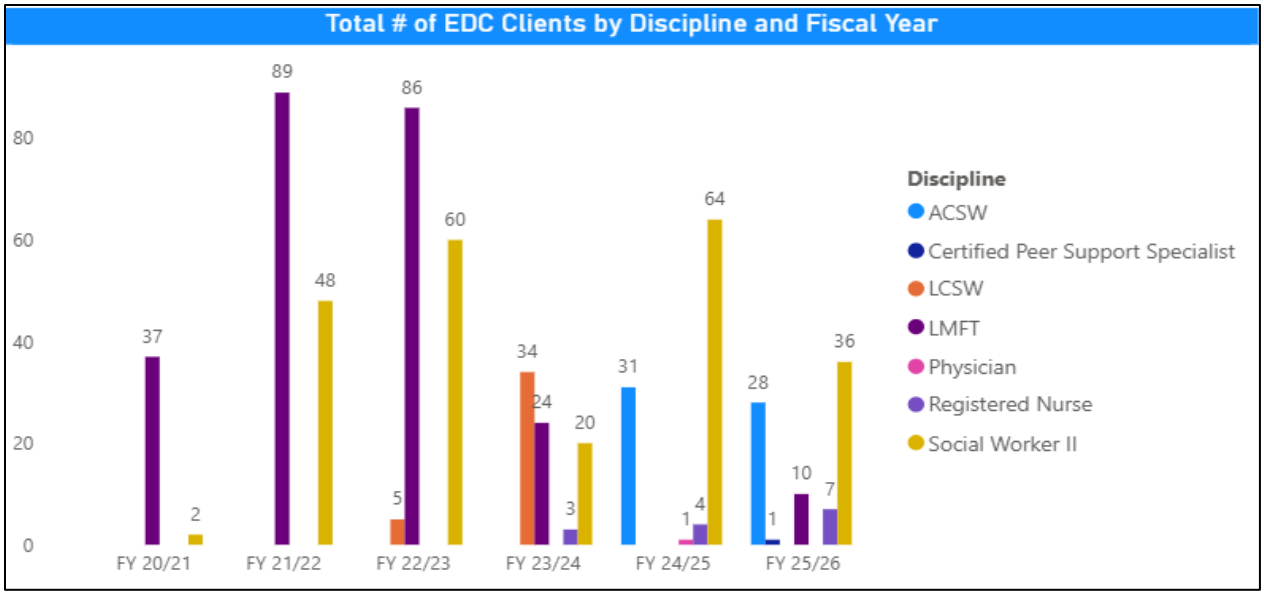
A couple of noticeable trends regarding staffing levels and disciplines were presented. The project ranged from three to seven staff members. The initial trend shows a slight decline from 4 to 3 in FY 23-24, followed by a slight increase from 3 to 7 by the end of the project cycle. The project demonstrated some inconsistencies with staffing similar to the initial years, where LMFTs departed the project, or later on when the project lacked any LCSW expertise. In essence, one can conclude that the project, for the number of staff on its roster, had a moderate level of turnover. This could have affected the number and manner in which services were rendered, and the rapport with clients, in short, affecting the effectiveness and efficiency of a project. Some staff members reported several obstacles to the continuous flow of the EDC project. For instance, some staff members reported that the COVID-19 pandemic hindered their recruitment efforts and the project's effectiveness. Some lessons learned, for one, indicated a more concentrated hiring effort and a deeper dive into retention strategies, as we saw a good number of staff departures. Lastly, the project would benefit from clearly defining what each staff discipline would be responsible for.

II. Breakdown of EDC Staffing

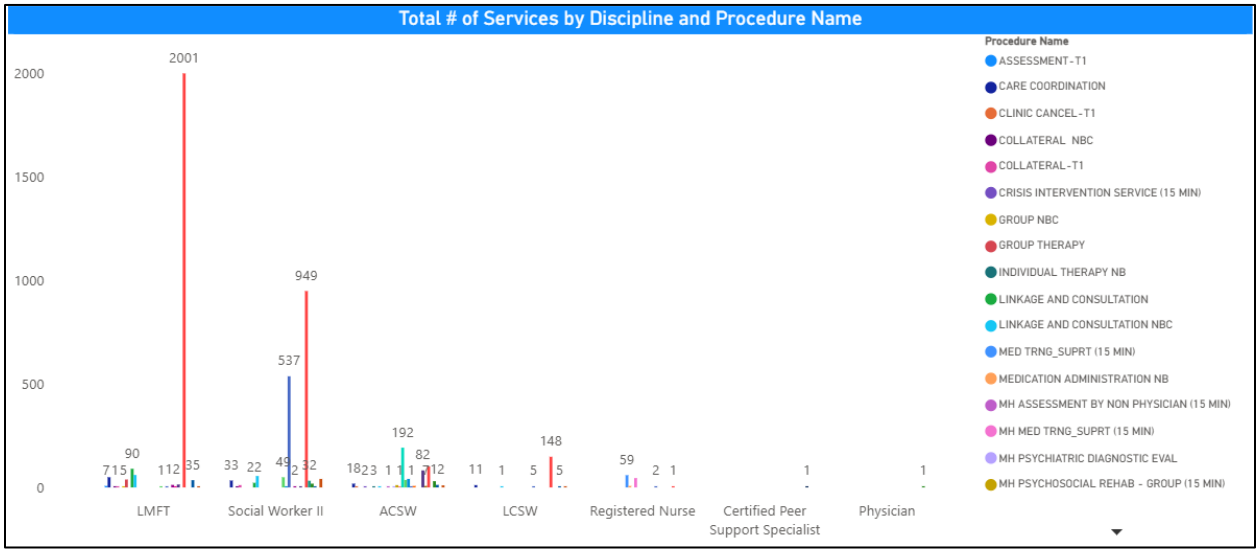




The table above, showing the total number of unique clients by discipline, provides a clearer picture of the workload distribution by staff discipline. The disciplines that served the most clients were Social Worker IIs and LMFTs with a combined total of 334 clients (duplicated), while the remaining disciplines saw a combined 99 clients (duplicated). Clients can be duplicated across disciplines, meaning they are seen by more than one staff member. Some of these positions were not staffed for the entire duration of the EDC, and with the change in staffing, they may not have had the opportunity to be as integrated into the project, and thus were unable to work with as many clients as other disciplines. Reiterating a similar conclusion from previous graphs, this graph shows a peak in the number of clients seen during FY 21/22 and FY 22/23 by LMFTs and Social Worker IIs.



Overall, the data indicated that Social Workers and LMFTs carried the largest share of client encounters within the EDC, a result attributed to challenges in hiring and retaining staff. This distribution aligns with the project's structure, where these roles primarily serve as navigators, case coordinators, and client support. Their consistent presence and workflow alignment naturally led to higher service counts, particularly within the Pre-Admit reporting unit. The later decline in service likely reflects staffing shifts.



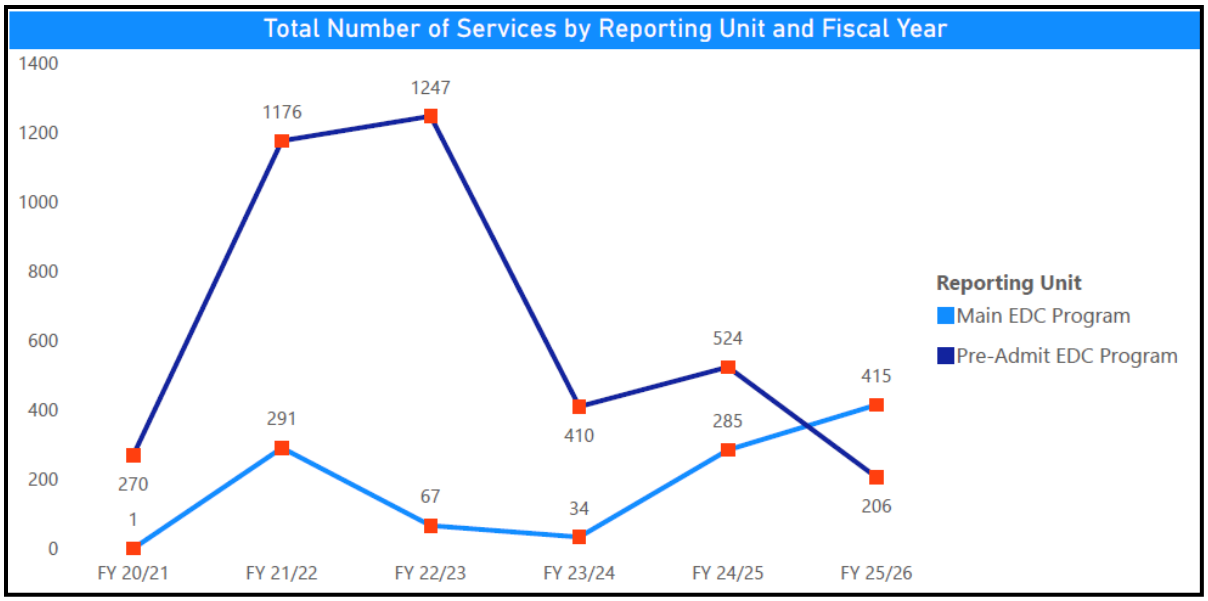
Most of the EDC's activities centered on coordination, which accounted for 3,858 services out of the 4,926 total (78%). The large volume of coordination services reflects the project's emphasis on outreach, navigation follow-up and connecting clients to appropriate levels of care. The remaining service types were

smaller in volume but still meaningful. These included Linkage and Consultation, Plan Development, and Medication Administration. Together, these non-coordination services represent the more specialized or clinically oriented components of the initiative that occurred less frequently but did contribute to the overall support provided to clients. Most services were documented in the pre-admit reporting unit, reflecting the initiative's focus on coordinating, navigation, and early-stage support. The main reporting unit shows fewer entries, which align with the project's limited clinical and medical service components. The graph simply summarizes this distribution by leaning toward pre-admission services.

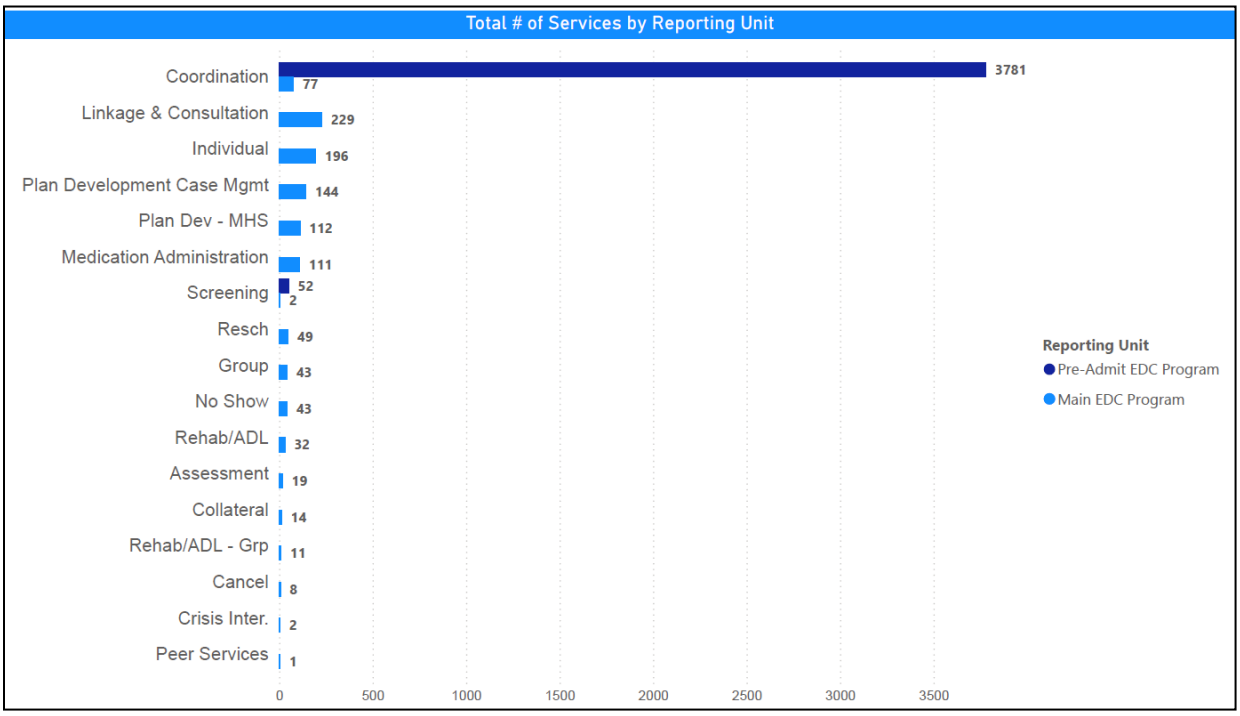
Total Number of Services provided by EDC

Procedure Group Name	Number of Services	% of Services
Coordination	3858	78.32%
Linkage & Consultation	229	4.65%
Individual	196	3.98%
Plan Development Case Mgmt	144	2.92%
Plan Dev - MHS	112	2.27%
Medication Administration	111	2.25%
Screening	54	1.10%
Resch	49	0.99%
Group	43	0.87%
No Show	43	0.87%
Rehab/ADL	32	0.65%
Assessment	19	0.39%
Collateral	14	0.28%
Rehab/ADL - Grp	11	0.22%
Cancel	8	0.16%
Crisis Inter.	2	0.04%
Peer Services	1	0.02%
Total	**4926**	**100.00%**

The main reporting unit generally showed lower volumes; however, in FY 25/26, it surpassed the pre-admit reporting unit, reflecting a shift toward more clinically orientated or ongoing service activity in the final year. This pattern aligns with the broader service trend while highlighting a notable change in where work was being documented.



Overall, the data shows a project shaped primarily by coordination and pre-admission activities with staffing patterns and reporting structures driving where most services were documented. Variability in staffing, leadership transitions, and limited procedural documentation contributed to shifts in service volume and the balance between the number of services between the pre-admit reporting unit and the standard reporting unit. In all, these trends highlight the need for clear workflow and continuity practices to support consistent service delivery.



Part 2: Sixty percent of clients will receive engagement services before and after assessment to ensure effective connection to treatment.

As with Learning Goal 3, this component of Learning Goal 4 could not be fully addressed. As outlined in the previous section, adjustments to staffing and the project's overall direction over the course of EDC resulted in a natural shift from the original vision. It was identified that there is a critical need for sufficient and stable staffing levels, as enhanced workforce capacity would have substantially improved community outreach and engagement services for this highly specialized population. Consequently, a clear definition of engagement services was not established.

Part 3: Referrals by the eating disorder team will lead to client engagement in treatment, both within the DBH system of care and outside of the DBH system of care.

In this last section of Learning Goal 4, as in previous sections, service trends for clients connected to the EDC were explored. Using data from DBH's EHR, myAvatar, a three-tier analysis was conducted. This analysis examines the number of services a client receives across DBH's continuum of care over three timeframes. These are broken down into 90 days before a client's initial service with EDC (Pre), 90 days after their first service with EDC (Mid), and finally, between 90 and 180 days following their first service (Post). Furthermore, this pattern was explored between different program types like outpatient programs, including the DBH Community Clinics, Community Clinic Full-Service Partnerships (FSPs), TAY Programs, as well as Crisis Programs, which included Community Crisis Response Teams (CCRT), Crisis Residential Treatment Centers (CRT), Crisis Stabilization Units (CSU), TAY Crisis Residential Treatment Centers, and hospitalizations. For this analysis, the ideal trend would be for the number of services to increase under Community Clinics, FSPs, TAY Programs, and services to drop under Crisis Programs and hospitalizations.

Outpatient Programs	Pre	Mid	Post
Community Clinics	383	433	311
Community Clinic FPSs	421	482	366
TAY Programs	156	616	701

Crisis Programs	Pre	Mid	Post
Community Crisis Response Teams (CCRT)	4	7	3
Crisis Residential Treatment (CRT) Centers	24	1	8
Crisis Stabilization Units (CSU)	16	9	6
Hospitalizations	17	8	10
TAY Crisis Residential Treatment Center (STAY)	50	---	---

Looking at the tables above, the trends that appear for the outpatient programs, specifically for the Community Clinics and Community Clinic FSPs, show that following a client's initial service with the EDC, the number of services with these other providers increased during the 90-day mid-point period. Following this 90-day period before the end of the 180-day range, the number of services declined to levels lower than the Pre timeframe before engagement with the EDC. While this may suggest less engagement in services, it can also be theorized that clients have achieved greater stability and are in less need of services during that time. Alternatively, services in TAY programs increased exponentially from 156 to 616, then to 701. This is in line with the demographic breakdown of EDC clients who were primarily TAY-aged youth (16-25 years old), with 115 clients or 46% of the population, and highlights increased engagement with the project.

As for Crisis programs, there is a lot of variety within specific providers. Under CCRT, there was a small increase in services during the midpoint, followed by lower levels in the Post period. Within the CRTs, there was a larger number of services provided during the Pre period, only one during the Mid-point, then a jump back up to eight during the Post timeframe. Similarly, for the TAY-specific CRT or STAY, there were 50 services provided to clients during their Post time frame and then no services during the Mid or Post assessment points. For the CSU, there was a steady decline in services going from 16 to 9 to 6. Lastly, for hospitalizations, there is a sharp decrease at the midpoint with a slight increase in the post-timeframe. Decreases in crisis services and hospitalizations suggest more stability amongst clients and their mental health, as well as less reliance on these programs. While increases during the Mid or Post assessment time frames, specifically for CCRT, CRTs, or CSUs, may be alarming, these can also suggest the ability to more easily navigate DBH's continuum of care and rely on these as a resource rather than go through a hospitalization.

Effectiveness

The EDC Innovation Project has become a cornerstone of specialized eating disorder care in San Bernardino County, addressing critical access gaps for individuals, especially TAY, who often fall between child and adult systems of care. Since launch, the multidisciplinary EDC team has provided assessment, treatment, education, and coordinated access to higher levels of care (HLOC), serving 254 individuals and facilitating HLOC for 55 clients through partnerships with local MCPs, demonstrating tangible impact and system-level value.

The project's evolution reflects a deliberate shift from an initial adult-focused target population (18+) to an emphasis on TAY, acknowledging that these youth do not neatly fit existing pathways and require tailored approaches for engagement, continuity, and outcomes.

During implementation, EDC identified lessons that refine the county's approach to eating disorder services. First, early intervention emerged as essential: prior models commonly waited for severe, "classic" symptoms before treatment, which contributed to entrenched behaviors and poorer recovery. In contrast, timely screening and rapid response in schools, primary care, and digital spaces improve prognosis and reduce the need for intensive interventions. Second, family involvement through Family-Based Treatment proved critical, reinforcing that parents and caregivers are key allies in refeeding support, adherence, and relapse prevention, particularly for younger clients. Third, operational practices such as routine weigh-ins were identified as potential barriers to participation, with clinician feedback suggesting they may deter attendance; the team recommended further study to compare no-show and cancellation rates between appointments with and without planned weigh-ins, aligning clinical vigilance with engagement-sensitive design. Clinical complexity also surfaced as a defining feature. Rates of co-occurring conditions, including anxiety, depression, trauma, OCD, and substance use, were higher than anticipated, underscoring the necessity of integrated, trauma-informed care and the potential for specialized substance use programming tailored to eating disorders.

EDC reaffirmed that there is no single "standard" presentation of eating disorders; reliance on narrow profiles risks misdiagnosis and exclusion, while culturally responsive, inclusive care acknowledges diverse experiences across gender identities, races, ages, body types, and encompasses diagnoses such as atypical anorexia, binge eating disorder, and Avoidant/Restrictive Food Intake Disorder (ARFID).

The project also emphasized the need for robust aftercare, including step-down supports, peer connection, and skill-building in emotion regulation and distress tolerance to sustain gains, recognizing that recovery is non-linear and benefits from ongoing monitoring and community reinforcement.

Modern communication and training strategies have been central to EDC's approach. To reach diverse audiences and reduce stigma, the project prioritized digitally accessible education, peer-to-peer storytelling, and rapid-access crisis supports (e.g., text/chat lines and QR-linked resources) that align with how clients, particularly youth, seek information and help.

On the provider side, technology-enabled professional training (webinars, e-learning, and online certifications) expanded access to evidence-based practices such as Family-Based Treatment (FBT) and Enhanced Cognitive Behavioral Therapy (CBT-E), helping address workforce limitations and improving fidelity of care across the county. Together, these strategies strengthen both the demand and supply sides of the service continuum, making it easier for clients to find credible resources and for clinicians to deliver specialized interventions.

In January 2026, services were expanded from one localized team to the DBH outpatient clinics serving the entire county. To operationalize access to higher levels of care and ensure continuity, EDC established a revised workflow that integrates MCPs, DBH clinical teams, and the DBH Managed Care Coordination Unit (MCCU). MCPs or PCPs identify members who may have eating disorders, and DBH clinicians may also flag severe cases for review. When appropriate, MCPs submit a Transition of Care request to MCCU, which evaluates the case and authorizes higher levels of care when warranted. After authorization, DBH staff assist members in contacting MCP Member Services to begin the referral process for higher levels of care. Upon discharge, MCCU connects clients to a DBH clinic based on preference or proximity, enabling a warm handoff and a smooth return to standard services for ongoing support. This workflow standardizes responsibilities, reduces friction at key handoffs, and ensures seamless movement between intensive and outpatient settings, strengthening the county's continuum of care.

This workflow will help ensure that San Bernardino County does not lose its only dedicated eating disorder treatment program, including its unique capacity to coordinate physical-health integration, mental-health treatment, and access to higher levels of care, which is a loss that would directly impact the severely mentally ill population and reverse gains achieved through the Innovation phase.

The project demonstrates that early, family-inclusive, culturally responsive, and digitally enabled care delivered through an integrated workflow with MCPs and MCCU improves access, engagement, and continuity for individuals experiencing eating disorders. By transitioning to CSS under the TAY Full-Service Partnership, the county safeguards a proven, multidisciplinary model, preserves hard-won capacity, and positions services to adapt to future needs, ensuring that residents continue to receive timely, coordinated, and comprehensive care.

Challenges

Despite these achievements, several challenges limited the project's full realization. Staffing turnover disrupted service continuity and contributed to uneven service volume across years. Key deliverables—including the engagement assessment and a fully developed screening/referral toolkit—were not completed, in part due to limitations in myAvatar, which could not support structured data capture. Formal partnerships with colleges, an original project priority, were difficult to secure. Stakeholders also noted inconsistent communication about project scope, variability in workflows, and limited direct clinical service compared to coordination-focused activities. Below is a table of the top challenges faced during the EDC project:

Challenges	Description
Limited College Collaboration	• College campuses were difficult to engage • Unable to establish formal partnerships or ongoing screening processes • Gaps in campus communication structures and unclear points of contact hindered sustained collaboration
Incomplete Development of Key Tools	• Unable to develop a validated engagement assessment and fully integrated screening/referral toolkit
Data Capture and System Limitations	• The myAvatar EHR lacked forms for structured data entry, which contributed to limited data collection and evaluation opportunities
Staffing Instability and Turnover	• Fluctuations in staffing • Affected outreach, service capacity, client continuity, and fidelity to a multidisciplinary model
Mid-Cycle Decline in Services	• Service volume, client enrollment, and clinic engagement would increase, then drop mid-cycle • Correlated with staffing instability and operational shifts
Limited Clinical Service Delivery	• Majority of services provided were coordination contacts rather than direct therapy or clinical interventions • Stakeholders reported confusion about the level of care EDC actually provided

Challenges	Description
Uneven System Engagement and Follow-Through	• TAY programs showed strong increases in engagement • Community Clinics and FSPs showed post engagement declines • Inconsistent crisis patterns
Lack of Clarity in Scope and Procedures	• Unclear definitions for "engagement services," inconsistent workflows, and varying documentation practices

Areas for Improvement

In reviewing the project's challenges, a future eating disorder specific program could benefit from several improvements. The table below outlines the potential areas of benefit:

Theme	Description
Integrated EHR Forms for Screening & Referral	• Develop forms that can be integrated into myAvatar • Improve data collection and program analysis
Assessment Tool	• Develop a standardized, validated assessment
Higher Education Partnerships	• Designate dedicated higher education liaisons • Establish form MOUs • Simplified workflows to implement campus screening, referral, and education
Workflow Stability	• Introduce retention strategies • Clearer role definitions • Balanced caseload expectations
Direct Clinical Service Capacity	• Increase availability of EBPs for eating disorders • Diversify staff roles • Clarify expectations for clinical service delivery beyond coordination
Communication of Project Purpose	• Clearly define EDC services
Multidisciplinary Workflows	• Establish clear protocols for coordination with MCPs, DBH clinics, crisis services, and hospitals
Outcome Tracking	• More robust tracking of pre-mid-post engagement

Lessons Learned

The table below summarizes key lessons learned from the EDC, highlighting how evolving research, clinical insights, and community feedback have reshaped understanding of effective eating disorder prevention and treatment. It identifies major themes such as the importance of early intervention, inclusive and family-centered care, attention to co-occurring conditions, culturally responsive practices, and modernized outreach and training approaches. Together, these insights point to opportunities for strengthening future programming and improving outcomes for diverse individuals affected by eating disorders.

Topic	Lesson
Change in population served	Initially project target population was 18+ yrs old. Population selected under the assumption that the child's system of care would have an existing means of EDO treatment via the managed care plan (I.e., IEHP). While that assumption is generally true, the opportunity for innovation existed in designing a EDO treatment programs that treats individuals in the TAY age range. Because TAY age youth do not neatly fit in either the children or adult system of care.
Timing of treatment/intervention is important – cost-to-benefit analysis would probably favor an increase in funding toward prevention efforts rather than just focusing on treatment after the fact.	Then: In the past, eating disorders were often treated only after symptoms became severe or life-threatening, sometimes requiring inpatient or residential care as a first step (this is currently the DBH model of EDO treatment). Now: Research shows that early detection and rapid intervention dramatically improve prognosis. Screening in schools, primary care offices, and even via social media outreach has become a priority. Lesson learned: Waiting for "classic" symptoms to become severe leads to more entrenched behaviors and poorer recovery rates.
Project should be modified to be more inclusive of family participation	Approaches such as Family-Based Treatment (FBT/Maudsley Method) show that empowering families as allies in refeeding and support leads to better recovery, especially in adolescents. Lesson learned: Parents and caregivers are critical partners that any model of treatment should include.
Including a weigh-in for clients as part of treatment is a barrier to clients wanting to participate in treatment (per feedback from EDO clinicians)	Clients are resistant to taking weight at appointments. May need to do a short-term study to see whether appointments with a preplanned weigh-in have a higher no-show or cancellation rate than those without a weigh-in. Now: While medical stabilization is still essential, we know that full recovery requires addressing underlying cognitive, emotional, and behavioral patterns at the same time as nutritional rehabilitation. Lesson learned: Treating the body alone doesn't cure the illness; mind, body, and behavior must be addressed in parallel.

Topic	Lesson
Higher rate of co-occurring conditions present than anticipated	Anxiety, depression, trauma, OCD, and substance use were often treated separately or only after ED symptoms subsided. Now: There is recognition that comorbidity is the rule, not the exception, and integrated treatment plans (e.g., trauma-informed care) lead to more sustained recovery. Lesson learned: Ignoring co-occurring issues can increase relapse risk. Any EDO program should have a substance use component – this is a possible new innovation project idea where the substance use treatment program is specialty tailored to EDO needs (quick research did not show any program of this type in California).
There is no "standard" presentation of what an EDO looks like	Many protocols were designed with a narrow profile in mind, young, white, cisgender women with anorexia nervosa, to this point, during the initial stakeholder meetings one reoccurring question expressed concern that we would be spending MHSA monies on a "white rich girl disease" which demonstrates the significant lack of understanding of how EDOs work—leading to missed diagnoses in males, people of color, older adults, LGBTQ+ individuals, and those with higher-weight bodies. Now: Greater cultural competency, recognition of atypical anorexia, binge eating disorder, ARFID, and consideration of gender/sexual identity and cultural food norms are standard. Lesson learned: Eating disorders do not discriminate, and treatment must be culturally responsive and inclusive.
Any EDO treatment program needs an "after care" program	Discharge from treatment often came once weight was restored or acute symptoms resolved, with limited long-term follow-up. Now: There is a stronger focus on relapse prevention, skill-building (emotion regulation, distress tolerance), and community support to sustain recovery. Step-down levels of care and peer support are emphasized. Lesson learned: Recovery is non-linear, and ongoing monitoring/support increases long-term success.

Topic	Lesson
Information concerning EDOs needs to change to make the ways in which information is consumed by the target population	Currently, EDO education relies on printed brochures, occasional public service announcements, school talks, and clinician referrals. This information was slow to disseminate and often limited to medical or academic language. Outreach and communication should be: • 24/7 online access to articles, videos, podcasts, webinars, and support communities. • Credible organizations (e.g., NEDA, Beat, ANAD) maintain searchable, plain-language resource hubs. • ED screening tools (like the SCOFF questionnaire) are available online for self-assessment. Lesson learned: People can learn about early warning signs and treatment options *before* symptoms escalate, even without seeing a clinician first.
Peer-to-peer education and recovery storytelling	Currently, these types of stories are shared only through in-person support groups or, occasionally, in written form with limited distribution beyond treatment centers: • TikTok, Instagram, YouTube, and blogs provide platforms for recovery influencers and survivors to share experiences, coping tools, and treatment journeys in real time. • Storytelling normalizes help-seeking and reduces shame. Lesson learned: Lived-experience voices have become central to ED education, especially for younger audiences.

Topic	Lesson
Crisis Response and Linkage to Services	Currently, finding help means calling a clinic during business hours and waiting for an appointment, and crisis lines were telephone-only and not widely advertised. • Text lines, chatbots, and telehealth mean help can be accessed within minutes. • Example: NEDA Helpline (phone/text/chat), Crisis Text Line ("NEDA" to 741741), and 988 mental health crisis line. • QR codes on social media posts or flyers link directly to screening tools or appointment booking pages. Lesson learned: Reduced barriers to accessing immediate help, especially for younger people who prefer text-based communication.
Early Warning and Misinformation Challenges	Positive: • AI and algorithms can help identify concerning posts and direct users toward supportive resources. • Some platforms flag ED-related content with resource links (e.g., Instagram's "Get Support" pop-up). Negative: • Pro-ED ("pro-ana," "thinspo") content can spread quickly, potentially triggering vulnerable individuals. • Misinformation about nutrition, weight loss, or recovery strategies can go viral without factchecking. Lesson learned: Education efforts now include digital literacy training—teaching people to critically assess online health content.
Technology Enhanced Professional Training	A reoccurring problem throughout project was providing EDO training to DBH staff and providers. Currently most training is through in-person conferences and print articles. Now: • Webinars, e-learning modules, and online certification courses allow widespread clinician training in best practices like FBT or CBT-E. • Recorded sessions make continuing education more flexible. Lesson learned: More providers can access ED-specific training regardless of location, helping address provider shortages.

Conclusion

The Eating Disorder Collaborative (EDC) demonstrated that a multidisciplinary, county-operated model can meaningfully expand access to specialized eating disorder services within San Bernardino County, particularly for Transitional Age Youth, who constituted the largest share of those served and showed notable increases in engagement across outpatient programs. Through coordinated care pathways, targeted outreach, and cross-system collaboration with MCPs and higher level of care providers, the project strengthened early identification and improved continuity of care for a population historically underserved in the region.

Despite challenges including staffing instability, limited data infrastructure, and incomplete development of planned assessment tools, the EDC generated important insights that refined the county's understanding of effective eating disorder service delivery. These insights underscore the need for early, family-inclusive intervention; culturally responsive and trauma-informed practices; and standardized workflows that integrate medical, behavioral health, and crisis systems. As services transition to sustained support across multiple behavioral health funding sources within the TAY Full-Service Partnership, the county preserves critical capacity and establishes a durable foundation for a comprehensive and equitable system of care for eating disorders.

Attachments

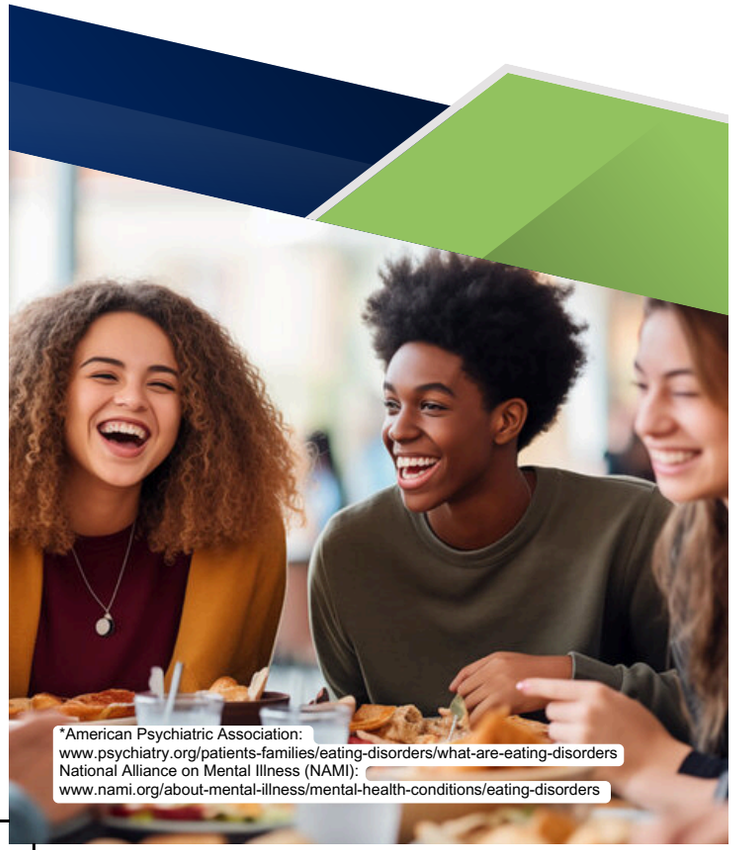
Take an Active Role

You are the most important member of the team. For successful treatment, active involvement is needed. The EDC team can provide education and help you find more information and support. The following are two EDC recommended educational sources:

- National Eating Disorders Association (NEDA), and
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.).

Who Can Join

We are open to clients of all ages who have an eating disorder, however our target population is Transitional Age Youth 16-25 years old.



*American Psychiatric Association: www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders
National Alliance on Mental Illness (NAMI): www.nami.org/about-mental-illness/mental-health-conditions/eating-disorders

Additional Treatment Resources

EDC can assist with linkage to additional treatment resources, including:

- Psychiatrist
- Dietitian/nutritionist
- Dentist
- Primary care provider

For additional information,
call (909) 387-7336 or email
DBH-EatingDisorders@dbh.sbcounty.gov

780 E. Gilbert Street
San Bernardino, CA 92415
www.SBCounty.gov/dbh

DEPARTMENT OF BEHAVIORAL HEALTH

24/7 Community Crisis Response Teams
(800) 398-0018 or
text (909) 420-0560

Access Unit
(Behavioral Health Helpline)
(888) 743-1478

Screening Assessment and Referral Center
(Substance Use Disorder Helpline)
(800) 968-2636

Language assistance services are available free of charge by dialing (888) 743-1478. TTY users dial 711 for all phone numbers listed.

DBH complies with applicable federal, civil rights laws and does not discriminate on the basis of race, color, national origin, sex, gender identity, age, disability or Limited English Proficiency.

SAN BERNARDINO COUNTY | Behavioral Health

EATING DISORDER COLLABORATIVE

Screening
Assessment
Treatment

What is an Eating Disorder?

Eating disorders are behavioral health conditions characterized by severe and persistent disturbances in eating behaviors and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function. Types of eating disorders may include anorexia nervosa, bulimia nervosa, binge eating disorder, and avoidant restrictive food intake disorder.

San Bernardino County Eating Disorder Collaborative (EDC)

The Eating Disorder Collaborative (EDC) provides a structured, nurturing and personalized treatment environment that promotes wellness and recovery from an eating disorder.

This includes affecting physical, psychological, behavioral, emotional, and social growth using direct treatment and referrals. EDC will work with you and your loved ones to uncover the root causes of the disorder and offer alternative ways to cope, communicate, and change patterns.

Services offered

- Assistance navigating Managed Healthcare Plans (MCPs) such as IEHP, Molina and Kaiser
- Coordination of Care
- Linkage to Higher Level of Care (Intensive Outpatient Treatment, Partial Hospitalization, Residential Treatment Care)
- Case Management
- Individual Therapy
- Group Therapy

Where do I start?

Screening and assessment is the first step towards recovery from an eating disorder. Start by calling (909) 387-7336. We will discuss your needs and talk about treatment and recovery options. Together we will develop a roadmap for treating the eating disorder.

Eating disorder treatment includes a combination of support in coordinating your care. The EDC program includes access to higher levels of care, as needed, such as residential treatment, partial hospitalization, and/or intensive outpatient treatment.

What to expect

Treatment can involve a combination of psychological and nutritional counseling and works to address eating disorder symptoms and its harmful effects to your physical health, in addition to the psychological, biological, interpersonal, and cultural forces that contribute to the eating disorder. Treatment may last from a few months to years.

Treatment can help:

- Develop healthy eating patterns
- Improve relationships
- Understand how and why eating disorders develop
- Help manage difficult emotions
- Develop self-compassion
- Address basic and complex needs
- Address eating patterns
- Offer a safe place while addressing eating disorder

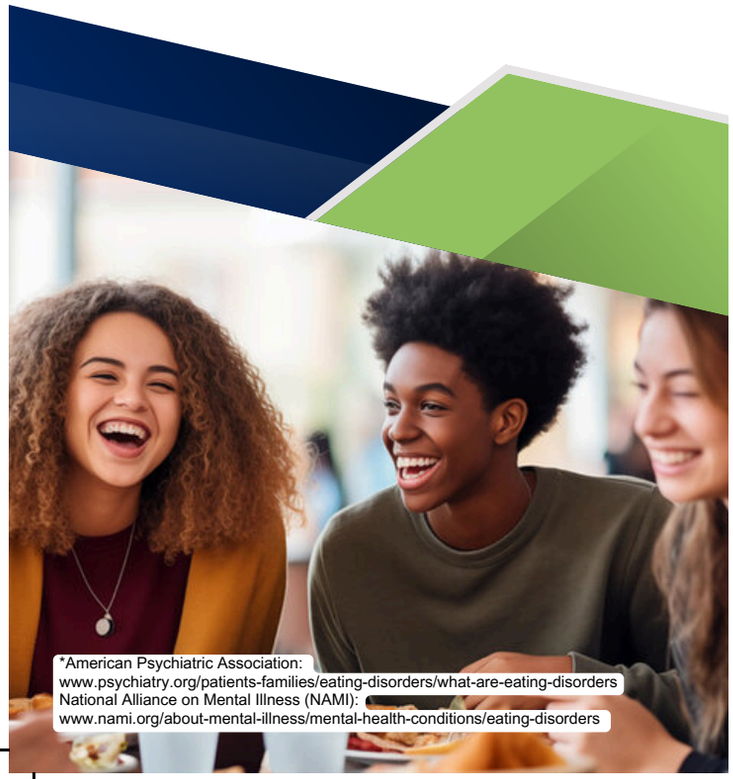
Adopte una Posición Activa

Usted es el miembro más importante del equipo. Para que el tratamiento tenga éxito, su participación activa es necesaria. El equipo de EDC (por sus siglas en inglés) puede brindarle educación y ayudarle a encontrar más información y apoyo. A continuación, se indican dos fuentes educativas recomendadas por EDC:

- National Eating Disorders Association (NEDA)
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.) por sus nombres/siglas en inglés.

¿Quién Puede Unirse?

Aceptamos a clientes de todas las edades que tienen un trastorno alimentario, sin embargo, nuestra población objetivo son los jóvenes en edad de transición de 16-25 años.



*American Psychiatric Association:
www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders
National Alliance on Mental Illness (NAMI):
www.nami.org/about-mental-illness/mental-health-conditions/eating-disorders

Recursos Adicionales de Tratamiento

EDC puede ayudar con la vinculación a recursos de tratamiento adicionales, incluyendo:

- Psiquiatra
- Dietista/nutricionista
- Dentista
- Médico de atención primaria

Para más información, llame al (909) 387-7336 o envíe un correo electrónico a DBH-EatingDisorders@dbh.sbcounty.gov.

780 E. Gilbert Street
San Bernardino, CA 92415
www.SBCounty.gov/dbh

DEPARTAMENTO DE SALUD MENTAL

Equipos comunitarios de respuesta a crisis 24/7:
(800) 398-0018 o SMS (909) 420-0560

Unidad de Acceso (línea de ayuda de salud mental):
(888) 743-1478

Centro de Evaluación y Derivación (Línea de ayuda para trastornos por consumo de sustancias)
(800) 968-2636

Los servicios de asistencia lingüística están disponibles de forma gratuitamente llamando al (888) 743-1478. Los usuarios de TTY deben marcar 711 para acceder a todos los números de teléfono indicados.

DBH cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, sexo, identidad de género, edad, discapacidad o dominio limitado del inglés.

SAN BERNARDINO COUNTY | Behavioral Health

Colaborativo de Trastornos de la Alimentación

Evaluación, Diagnóstico y Tratamiento

¿Qué es un Trastorno Alimentario?

Los trastornos alimentarios son condiciones de salud mental que se caracterizan por alteraciones graves y persistentes de la conducta alimentaria y por pensamientos y emociones angustiantes asociados. Pueden ser trastornos muy graves que afectan el funcionamiento físico, psicológico y social. Entre los trastornos alimentarios se incluyen la anorexia nerviosa, la bulimia nerviosa, el trastorno por atracón y el trastorno por ingesta de alimentos restrictiva y evitativa.

Colaboración para los Trastornos Alimentarios (EDC por sus siglas en inglés) del condado de San Bernardino

La Colaboración para los Trastornos Alimentarios (EDC por sus siglas en inglés) proporciona un ambiente de tratamiento estructurado, enriquecedor y personalizado que promueve el bienestar y la recuperación de un trastorno alimentario.

Esto incluye afectar el crecimiento físico, psicológico, conductual, emocional y social mediante el tratamiento directo y las derivaciones. El EDC trabajará con usted y sus seres queridos para descubrir las causas fundamentales del trastorno y ofrecer formas alternativas de afrontarlo, comunicarse y cambiar hábitos consistentes.

Servicios ofrecidos

- Asistencia navegando Planes de Salud Médicos como IEHP, Molina y Kaiser
- Coordinación de Cuidado
- Vinculación con un nivel superior de atención (tratamiento ambulatorio intensivo, hospitalización parcial, atención de tratamiento residencial)
- Administración de Casos
- Terapia Individual
- Terapia de Grupo

¿Por dónde empiezo?

La detección y la evaluación son el primer paso hacia la recuperación de un trastorno alimentario. Comience llamando al (909) 387-7336. Analizaremos sus necesidades y hablaremos sobre el tratamiento y las opciones de recuperación. Juntos desarrollaremos un plan para tratar el trastorno alimentario.

El tratamiento de los trastornos alimentarios incluye una combinación de apoyo para coordinar su atención. El programa EDC incluye acceso a niveles más altos de atención, según sea necesario, como tratamiento residencial, hospitalización parcial y/o tratamiento ambulatorio intensivo.

Qué puede esperar

El tratamiento puede involucrar una combinación de terapias psicológicas y nutricionales y trabaja para abordar los síntomas del trastorno alimentario y sus efectos dañinos para la salud física, además de las fuerzas psicológicas, biológicas, interpersonales y culturales que contribuyen al trastorno alimentario. El tratamiento puede durar desde unos meses hasta años. El tratamiento puede ayudar a:

- Desarrollar hábitos de alimentación saludables
- Mejorar las relaciones
- Comprender cómo y por qué se desarrollan los trastornos alimentarios
- Ayudar a controlar las emociones difíciles
- Desarrollar la autocompasión
- Abordar las necesidades básicas y complejas
- Abordar los hábitos de alimentación

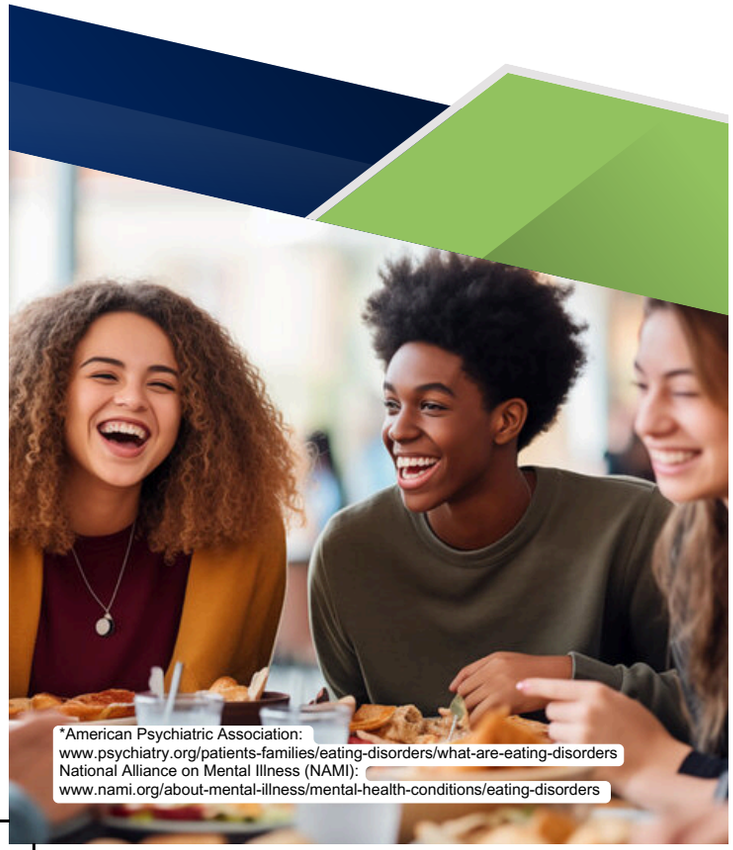
积极参与

您是团队的重要一员。要成功治疗，积极参与必不可少。饮食失调协作中心 (Eating Disorder Collaborative, EDC) 团队可以为您提供相关知识，协助您找到更多的信息和支持。以下是 EDC 推荐的两个教育资源：

- 美国国家饮食失调协会 (National Eating Disorders Association, NEDA)；
- 家庭支持和饮食失调治疗组织（Families Empowered and Supporting Treatment of Eating Disorders, F.E.A.S.T.）

服务人群

我们欢迎所有年龄段的饮食失调患者，主要目标人群是年龄在 16-25 岁、处于过渡时期的青少年 (Transitional Age Youth, TAY)。



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National Alliance on Mental Illness (NAMI): www.nami.org/about-mental-illness/mental-health-conditions/eating-disorders

其他治疗资源

EDC 可以协助患者获取其他治疗资源，包括：

- 精神科医生
- 营养师/营养顾问
- 牙医
- 初级保健提供者

如需更多信息，请致电
(909) 387-7336 或发送电子邮件至
DBH-EatingDisorders@dbh.sbcounty.gov

780 E. Gilbert Street
San Bernardino, CA 92415
www.SBCounty.gov/dbh

行为健康部

全天候社群危机干预小组
(800) 398-0018 或
发送短信至 (909) 420-0560

Access Unit
（行为健康帮助热线）
(888) 743-1478

筛查、评估和转诊中心
（药物使用障碍帮助热线）
(800) 968-2636

您可致电 (888) 743-1478 免费获得语言协助服务。
听障用户请加拨 711。

行为健康部 (Department of Behavioral Health, DBH) 遵守适用的联邦法律、民权法，不因种族、肤色、国籍、性别、性别认同、年龄、残疾或英语水平而歧视他人。

SAN BERNARDINO COUNTY | Behavioral Health

饮食失调协作中心
筛查 评估 治疗

什么是饮食失调?

饮食失调是一种影响健康的行为状态，其特点是饮食行为长期严重紊乱，并伴随痛苦的想法和情绪，严重情况下可能会影响身体、心理功能和社交能力。
饮食失调的类型可能包括厌食、贪食、暴食和回避性/限制性摄食障碍。

圣贝纳迪诺郡饮食失调协作中心 **(EDC)**

饮食失调协作中心 (Eating Disorder Collaborative, EDC) 提供结构化、个性化且充满关怀的治疗环境，促使饮食失调人群的康复，并提升其健康水平。

服务包括直接治疗和转诊，以促进身体、心理、行为、情感和社交能力方面的成长。EDC 将与您和您的亲人共同找出饮食失调的根本原因，并提供应对、沟通和改变行为模式的替代方案。

提供的服务

- 协助患者了解和使用医疗保健管理计划 (Managed Healthcare Plans, MCP)，如 IEHP、Molina、Kaiser
- 护理协调
- 进行转介，使患者接受更高级别的护理（强化门诊治疗、日间住院治疗、住院治疗）
- 个案管理
- 个人治疗
- 团体治疗

我首先该做什么?

筛查和评估是战胜饮食失调的第一步。首先，请拨打 (909) 387-7336。我们将了解患者的需求，介绍治疗和康复方案，并与患者共同制定一份饮食失调治疗计划。

饮食失调治疗包括提供各项支持，协调患者的护理服务。在 EDC 项目中，我们将根据患者的需要提供更高级别的护理，例如住院治疗、日间住院治疗和/或强化门诊治疗。

预期效果

治疗过程可能同时涉及心理咨询和营养咨询，旨在解决饮食失调的症状及其对身体健康的有害影响。此外，我们将关注导致饮食失调的心理、生物、人际和文化因素。治疗可能持续数月或数年。

治疗目标：

- 养成健康的饮食习惯
- 改善人际关系
- 了解饮食失调的成因管理复杂情绪
- 培养自我关怀的能力
- 培养自我关怀的能力
- 满足基本和复杂需求
- 调整饮食习惯
- 在安全的环境下解决饮食失调问题

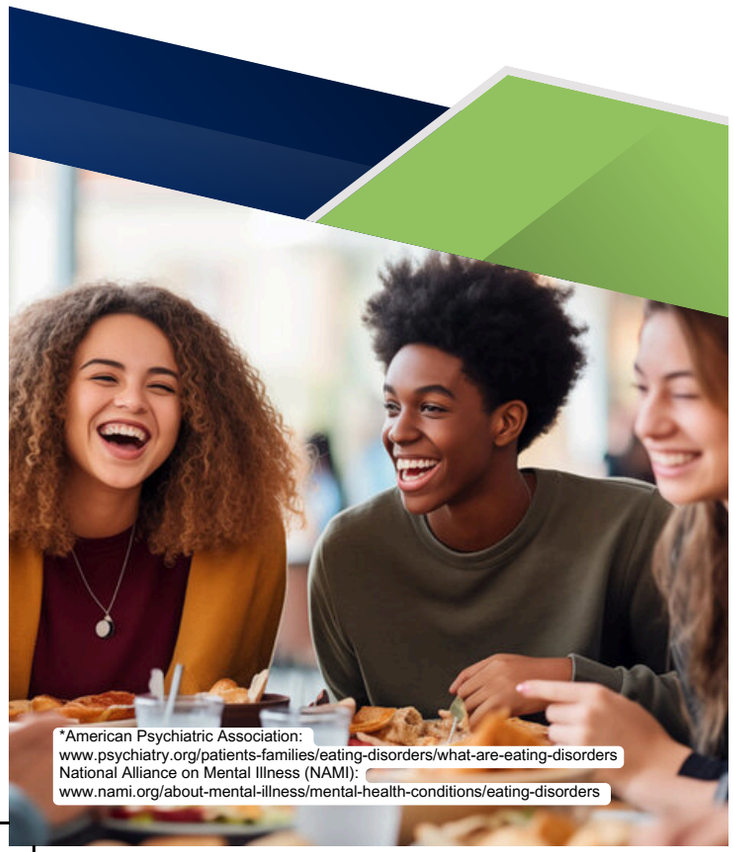
Đảm Nhận một Vai Trò Tích Cực

Quý vị là thành viên quan trọng nhất trong nhóm. Để điều trị thành công, cần có sự tham gia tích cực. Nhóm EDC có thể cung cấp thông tin giáo dục và giúp quý vị tìm thêm thông tin và sự hỗ trợ. Sau đây là hai nguồn thông tin giáo dục theo khuyến nghị của EDC:

- ·Hiệp Hội Điều Trị Rối Loạn Ăn Uống Quốc Gia(National Eating Disorders Association NEDA), và
- ·Các Gia Đình Được Trao Quyền và Hỗ Trợ Điều Trị Rối Loạn Ăn Uống (Families Empowered and Supporting Treatment of Eating Disorders, F.E.A.S.T.)

Ai Có Thể Tham Gia

Chúng tôi sẵn sàng tiếp nhận khách hàng ở mọi độ tuổi mắc rối loạn ăn uống, tuy nhiên nhóm đối tượng mục tiêu của chúng tôi là Thanh Thiếu Niên ở Độ Tuổi Chuyển Tiếp, 16-25 tuổi.



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National Alliance on Mental Illness (NAMI): www.nami.org/about-mental-illness/mental-health-conditions/eating-disorders

Tài Nguyên Điều Trị Bổ Sung

EDC có thể hỗ trợ kết nối với các tài nguyên điều trị bổ sung, bao gồm:

- ·Bác Sĩ Tâm Thần,
- ·Chuyên Gia Dinh Dưỡng,
- ·Nha Sĩ
- ·Nhà cung cấp dịch vụ chăm sóc chính

Để biết thêm thông tin, hãy gọi
(909) 387-7336 hoặc email
DBH-EatingDisorders@dbh.sbcounty.gov

780 E. Gilbert Street
San Bernardino, CA 92415
www.SBCounty.gov/dbh

SỞ CHĂM SÓC SỨC KHỎE HÀNH VI

Dội Ứng Phó Khủng Hoảng Cộng Đồng 24/7
(800) 398-0018 hoặc
nhắn tin (909) 420-0560

Đơn Vị Tiếp Cận (Đường Dây Trợ Giúp về Chăm Sóc Sức Khỏe Hành Vi)
(888) 743-1478

Trung Tâm Sàng Lọc, Đánh Giá và Giới Thiệu (Đường Dây Trợ Giúp về Rối Loạn Do Lạm Dụng Dược Chất)
(800) 968-2636

Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí bằng cách quay số (888) 743-1478. Người dùng TTY quay số 711 đối với tất cả các số điện thoại được liệt kê.

DBH tuân thủ các điều luật dân quyền hiện hành của Liên Bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, giới tính, bản dạng giới, tuổi tác, khuyết tật, hay Trình Độ Tiếng Anh Hạn Chế.

SAN BERNARDINO COUNTY | Behavioral Health

HỢP TÁC XÃ ĐIỀU TRỊ RỐI LOẠN ĂN UỐNG

Điều Trị Đánh Giá Sàng Lọc

Rối Loạn Ăn Uống Là Gì?

Rối loạn ăn uống là các bệnh trạng sức khỏe hành vi đặc trưng bởi sự xáo trộn nghiêm trọng và dai dẳng trong hành vi ăn uống và những suy nghĩ và cảm xúc căng thẳng liên quan. Chúng có thể là những bệnh trạng rất nghiêm trọng ảnh hưởng đến chức năng thể chất, tâm lý và xã hội.
Các dạng rối loạn ăn uống có thể bao gồm chán ăn tâm thần, cuồng ăn, rối loạn ăn uống quá nhiều, và rối loạn hạn chế tránh né thức ăn.

Hợp Tác Xã Điều Trị Rối Loạn Ăn Uống Quận San Bernardino (EDC)

Hợp Tác Xã Điều Trị Rối Loạn Ăn Uống (EDC) cung cấp một môi trường điều trị có cấu trúc, nuôi dưỡng và cá nhân hóa nhằm cải thiện sức khỏe và phục hồi sau rối loạn ăn uống.

Điều này bao gồm tác động đến sự phát triển thể chất, tâm lý, hành vi, cảm xúc và xã hội bằng cách sử dụng phương pháp điều trị trực tiếp và giới thiệu. EDC sẽ hợp tác với quý vị và những người thân yêu của quý vị để tìm hiểu nguyên nhân gốc rễ của rối loạn và đưa ra các cách thay thế để đối phó, giao tiếp, và thay đổi mô thức.

Các dịch vụ được cung cấp

- ·Các chương trình Assistance Navigating Managed Healthcare Plan (MCP) chẳng hạn như IEHP, Molina, Kaiser
- ·Phối hợp chăm sóc
- ·Liên Kết với Cấp Độ Chăm Sóc Cao Hơn (Điều Trị Ngoại Trú Tăng Cường, Nhập Viện Một Phần, Chăm Sóc Điều Trị Nội Trú)
- ·Dịch Vụ Quản Lý Hồ Sơ,
- ·Trị Liệu Cá Nhân,
- ·Trị Liệu Nhóm

Tôi nên bắt đầu từ đâu?

Sàng lọc và đánh giá là bước đầu tiên để hồi phục sau rối loạn ăn uống. Bắt đầu bằng cách gọi số (909) 387-7336. Chúng tôi sẽ thảo luận về nhu cầu của quý vị và bàn về các lựa chọn điều trị và phục hồi. Cùng nhau chúng ta sẽ phát triển một lộ trình điều trị rối loạn ăn uống.

Điều trị rối loạn ăn uống bao gồm một sự kết hợp hỗ trợ trong việc điều phối chăm sóc của quý vị. Chương trình EDC bao gồm tiếp cận với cấp độ chăm sóc cao hơn, nếu cần, chẳng hạn như điều trị nội trú, nhập viện một phần, và/hoặc điều trị ngoại trú chuyên sâu.

Cần mong đợi điều gì

Điều trị có thể gồm có một sự kết hợp của tư vấn tâm lý và dinh dưỡng và cố gắng giải quyết các triệu chứng rối loạn ăn uống và những tác động có hại của nó đối với sức khỏe thể chất của quý vị, ngoài các yếu tố tâm lý, sinh học, liên nhân, và văn hóa góp phần gây ra rối loạn ăn uống. Điều trị có thể kéo dài từ vài tháng đến vài năm.

Điều trị có thể giúp:

- ·Phát triển các mô thức ăn uống lành mạnh
- ·Cải thiện các mối quan hệ
- ·Hiểu được cách thức và lý do tại sao rối loạn ăn uống phát triển
- ·Giúp kiểm soát những cảm xúc khó khăn
- ·Phát triển lòng tự trắc ẩn
- ·Giải quyết các nhu cầu cơ bản và phức tạp
- ·Giải quyết các mô thức ăn uống
- ·Cung cấp một nơi an toàn trong khi giải quyết rối loạn ăn uống