SAN BERNARDINO COUNTY

Behavioral Health

Artwork by Luz Gutierrez

Mental Health Services Act

Annual Update for Fiscal Year 2025/2026

Message from the Director

Welcome

On behalf of the Department of Behavioral Health (DBH) staff, community partners, providers, and stakeholders, thank you for your interest in the Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2025/26. The Annual Update provides the opportunity to highlight the achievements of DBH and contracted partner programs during the previous fiscal year (FY 2023/24). This Update demonstrates how community input has shaped DBH programming and implementation and provides updates to existing MHSA programs. Program expansion has created more places for people to connect with mental health and substance use disorder services, enhanced collaboration for the coordination of treatment, continued the growth of the Office of Suicide Prevention, increased the availability of behavioral health crisis services, and implemented successful innovative practices across the continuum of care.

On March 5, 2024, California voters passed Proposition 1, Behavioral Health Services Program and Bond Measure. Proposition 1 amended California's Mental Health Services Act and created a $6.38 billion general obligation bond. For San Bernardino County, Proposition 1 will impact core outpatient, crisis, recovery-oriented and outreach and engagement services, including an impact on workforce initiatives.

Proposition 1 aims to support Californians who are most affected by severe behavioral health conditions and homelessness. The amendment:

- Renames the Mental Health Services Act to the Behavioral Health Services Act (BHSA),
- Changes how revenue from the 1% tax on income above $1 million is spent under the law,
- Increases the community planning process, outcome, and reporting requirements to include the entire county behavioral health system, not only BHSA-funded programs and services.

San Bernardino County has been developing a mitigation plan to address these amendments under the direction and support of the California Behavioral Health Directors Association (CBHDA).

For more information on Proposition 1, please attend the DBH monthly Community Policy Advisory Committee Meetings – See at a glance flyer for dates.

Thank you for your interest, patience and understanding during this transition.

Sincerely,

Georgina Yoshioka, DSW, LCSW, MBA
Director
San Bernardino County, Department of Behavioral Health

Mensaje de la Directora

Bienvenidos

En nombre del personal del Departamento de Salud Mental (DBH por sus siglas en inglés), los socios de la comunidad, los proveedores y las partes interesadas, le agradecemos su interés en la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para el Año Fiscal 2025/26. La Actualización Anual ofrece la oportunidad para destacar los logros de los programas de DBH y de los socios contratados durante el año fiscal anterior 2023/24. Esta actualización demuestra cómo las aportaciones de la comunidad han dado forma a la programación y ejecución de DBH y proporciona actualizaciones de los programas MHSA existentes. La expansión del programa ha creado más espacios para que las personas se conecten con los servicios de salud mental y trastornos por consumo de sustancias, ha mejorado la colaboración para la coordinación del tratamiento, ha continuado el crecimiento de la Oficina de Prevención de Suicidio, ha aumentado la disponibilidad de servicios de crisis de salud mental y ha implementado practicas innovadoras exitosas a lo largo del continuo de atención.

El 5 de marzo de 2024, los votantes de California aprobaron la Proposición 1, Programa de Servicios de Salud Mental y Medida de Bonos. La Proposición 1 modificó la Ley de Servicios de Salud Mental de California y creó un bono de obligación general de 6.38 millones de dólares. Para el condado de San Bernardino, la Proposición 1 tendrá un impacto en los servicios ambulatorios de crisis, servicios orientados a la recuperación y de extensión y participación, incluyendo un impacto en las iniciativas de la fuerza laboral.

La Proposición 1 tiene como objetivo apoyar a los californianos más afectados por problemas graves de salud mental y por falta de vivienda. La modificación:

- Cambia el nombre de la Ley de Servicios de Salud Mental en inglés, Mental Health Services Act por inglés, Behavioral Health Services Act (BHSA por sus siglas en inglés)
- Cambia la forma en que se gastan los ingresos del impuesto de 1% sobre los ingresos superiores a $1 millón según la ley
- Aumenta el proceso de planificación comunitaria, los resultados y los requisitos de información para incluir todo el sistema de salud conductual del condado, no sólo los programas y servicios financiados por la BHSA.

Mensaje de la Directora

El condado de San Bernardino ha estado desarrollando un plan de mitigación para abordar estas modificaciones bajo la dirección y el apoyo de la Asociación de directores de Salud Mental de California (CBHDA por sus siglas en inglés). Para obtener más información sobre la Propuesta 1, asista a las reuniones mensuales del Comité Asesor de Políticas Comunitarias de la DBH – Vea el folleto de Horarios para las fechas.

Gracias por su interés, paciencia y compresión durante esta transición.

Artwork by Rey French

Atentamente,

Georgina Yoshioka, DSW, LCSW, MBA
Directora
Condado de San Bernardino, Departamento de Salud Mental

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Artwork by Sondra Savage

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Bernardino

☐ Three-Year Program and Expenditure Plan

☒ Annual Update

Local Mental Health Director	Program Lead
Name: Georgina Yoshioka, DSW, MBA, LCSW	Name: Dr. Rebecca Scott Young
Telephone Number: (909) 252-5142	Telephone Number: (909) 252-4046
E-mail: Georgina.Yoshioka@dbh.sbcounty.gov	E-mail: MHSA@dbh.sbcounty.gov
Local Mental Health Mailing Address:	Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Dr. Georgina Yoshioka _____ _____

Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Bernardino

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Georgina Yoshioka, DSW, MBA, LCSW	Name: Ensen Mason, CPA, CFA
Telephone Number: (909) 252-5142	Telephone Number: (909) 382-7000
E-mail: Georgina.Yoshioka@dbh.sbcounty.gov	E-mail: Ensen.Mason@sbcountyatc.gov
Local Mental Health Mailing Address: Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Dr. Georgina Yoshioka
_____ _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated January 24, 2025 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Ensen Mason
_____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: 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 2,193,656 (*Source*: US Census -2022). Approximately half of the county's population resides in the West Valley (32%) and East Valley (23%) region, 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, 18% 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 (24%), Asian/Pacific Islander (9%), African American/Black (7%), and Native American (0.2%). 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)	**18%** Older Adults (60+)

Race/Ethnicity	
7% 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=2,193,656

Source: U.S. Census - 2022: 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 report results 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 § 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental health 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, 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): 12 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate cultural specific subcommittees: 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 § 5848.

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 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 Equity and Cultural Competency Officer (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. Within DBH's organizational structure, the Office of Consumer and Family Affairs (OCFA) is elevated, reporting to the Equity and Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the OCFA, the Department's Public Information Office, DBH's seven TAY centers and DBH's nine 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

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

PRO collaborates with many local nonprofit organizations to share information and resources to fulfill shared vision and goals, such as PRO's collaboration with Department of Aging and Adult Services (DAAS) to organize the Evening with the Stars and Summer Wellness Extravaganza event. PRO's activities and events are family driven and incorporate educational opportunities for anyone to attend and learn. When planning events, PRO focuses on DBH's vision of a county that promotes mental health for the community and empowers personal growth. During PRO's events, flyers are shared with the community so they can learn about all the services DBH offers.

During Fiscal Year 2023/24, PRO participated in a total of 257 resource fairs and tabling events. In addition, PRO had 37 trainings on mental health and substance use disorders and 294 outreach events. These events were 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.

PRO collaborated with the Second District of San Bernardino County and County Supervisor Jesse Armendarez for the Office of Suicide Prevention Telephone Townhall "Promote Hope, Let's Talk" on March 12, 2024, to bring a conversation about suicide prevention. There were over 49,000 total calls dialed in with 1,357 accepted calls for the townhall, including 59 Spanish participants. This conversation was broadcasted and uploaded on YouTube to make it available for anyone who was interested in hearing what DBH and the Second District are doing to open the conversation regarding suicide prevention.

Public Relations and Outreach, cont.

The outreach team encountered difficulties during FY 2023/24 in effectively sharing information about services with unhoused communities, as resources often include phone numbers and hotline information that necessitate access to a phone or the ability to travel. To address these difficulties, PRO has enlisted subject matter experts from the Homeless Support and Outreach Services unit to enhance their outreach and engagement strategies with the unhoused community.

Additionally, reaching the high desert region has proven challenging due to the limited number of events in these areas. PRO is exploring an expansion project aimed at forging connections with community-based organizations in the high desert region, thereby increasing their presence at local events and spaces to promote DBH programs and services.

The PRO division also faced obstacles in distributing comprehensive printed materials covering all mental health topics of public interest. To address the need for a more comprehensive catalog of printed materials, the public relations team is revamping their resources. They are developing more targeted, easily accessible informational pamphlets and digital resources that address frequently asked questions and key mental health topics, informed by community feedback.

In addition to the resource fairs and tabling events, PRO conducted the following outreach and engagement activities during FY 2023/24:

Activity Type	Number of Activity Type	Total Number of Participants
Meet the Artist Exhibition	1	200
Evening with the Stars	1	300
Directing Change	1	100
Recovery Happens	1	1,600
Annual Commission Award Ceremony	1	200
Office of Suicide Prevention Telephone Townhall	1	1,357
Sound of Recovery	1	150
Total	**7**	**3,907**

Public Relations and Outreach, cont.

"I have a brother who has major mental illness issues, I am his social security payee, so finding this wonderful art show was an amazing gift last year! I got to meet so many people like me who have family members with mental illness, it was so helpful sharing stories and just knowing that there are others like me and thank you for all you and your coworkers do for the mentally ill community. They need so much support, and I am thankful you and others are available and have programs for them."

-Community Member

"I was a foster child myself, and when I aged out of the system, I received services from the Department of Behavioral Health. Working with you guys in this way was the reason I felt inspired to pursue work in this field, and currently why I have a stable job - so very full circle. Thank you for the work you do".

-Community Member

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. Meetings were available to each region of the county at Family Resource Centers and were also available in Spanish for monolingual Spanish-speaking county residents. A total of **39** 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 (PRO), 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
7% 16-25
80% 26-59
12% 60+
<1% Prefer not to answer

Gender Identity

29% Male
68% Female
3% Other

Race/Ethnicity

20% African American/Black
27% Caucasian/White
4% American Indian/Alaskan Native
5% Asian/Pacific Islander
41% Latinx/Hispanic
19% Other/Unknown

N=360 **Note:** Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

Community Program Planning

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.
- Representatives of law enforcement and the justice system.
- 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 each of their 14 Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers, Clubhouses, and the Department of Aging and Adult Services Senior Affairs Commission. Additionally, the PEI Provider meeting held sessions to include contract providers. 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 arranged for Spanish and American Sign Language interpretation, upon request, at each meeting. As an incentive for participation, Clubhouse upon members were delivered snacks to enjoy during stakeholder sessions.

MHSA Annual Update CPP Demographics

Primary Language

91% English

11% Spanish

3% Other

Region

12% Central Valley

21% East Valley

20% Desert/Mountain

26% West Valley

0% Out of county

21% Prefer not to answer

N=360 **Note:** Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

Community Program Planning

To increase participation opportunities across the county, the department hosted additional online sessions on January 21, 2025, from 10 to 11 a.m. and from 5 to 6 p.m. These sessions provided additional opportunities for individuals unable to attend one of the regularly scheduled meetings to participate via computer, smartphone, and other technological devices.

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, January 16, 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, February 20, 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.

MHSA Annual Update CPP Demographics

Groups Represented

1% Law Enforcement	**1%** Veterans Organizations	**7%** Faith-Based Organization
39% Education/Students	**52%** Family Member or Loved One	**49%** Consumer of Mental Health Services
12% Social or Human Service Program/Agency	**30%** Federal, State, County, or City Government	**7%** Consumer of Substance Use Disorder Services
39% Healthcare – Behavioral/Mental Health and Physical Health	**6%** Alcohol and Drug Service Program Providers	**5%** Youth or Youth Mental Health/ Substance Use Disorder Organization
12% Non-Profit Organization	**4%** Veterans	**21%** Community-Based Organizations
4% Area Agencies on Aging	**4%** Managed Care Plans (MCPs)	**37%** Self Employed/Not Employed/Other

N=360 **Note:** Total does not equal 100% since some respondents represent multiple groups.

Community Program Planning

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 **769** stakeholders attended this year's Community Program Planning stakeholder sessions, and DBH received **360** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions or submitted a form during the 30-Day Public Review and Comment period. Of the those who completed a survey, **90%** were either satisfied or very satisfied with the CPP meeting and its goals.

Really impressed by the system in place to collect stakeholder input in an ongoing basis, how feedback is shared monthly, and really being utilized when making program improvement decisions, as well as amount of what the community needs are. It really keeps it current & relevant. Great Job! Great presentation on the update, plain language, engaging and relatable.

Stakeholder Comments

The Annual Plan was well written and well put together. I thank all involved with putting it together.

Very comprehensive and well put together in terms of discussing roadmaps and improvements over a period of time over the Fiscal years.

I learned that the program has abundant community resources for mental Health. It serves communities with youth, adults, and homeless.

This was a good update - so nice to hear that you take input very seriously.

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 Annual Update FY 2025/2026

Planning Meetings

Please join us at a Mental Health Services Act (MHSA) Annual Update FY 2025/26 stakeholder engagement meeting! Learn about service data from the last fiscal year and get information on program changes and enhancements.

Event will be held in-person

January 2025

08 — 10 a.m. — Mental Health and Substance Use Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 777 142
Join Meeting

08 — Noon — QMAC CEC & Family Member Advisory Subcommittee
Call-In: 1-669-444-9171
Zoom Meeting ID: 959 6126 4010 Passcode: 421362
Join Meeting

09 — 1 p.m. — PEI Quarterly Provider Meeting
Call-In: 1-415-655-0002
WebEx Meeting Number: 2485 096 9219
Join Meeting

09 — 10 a.m. — Disabilities Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 434 2208
Join Meeting

09 — 3:30 p.m. — Second District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2483 823 7369
Password: pxYctfry353
Join Meeting

10 — 10 a.m. — Asian Pacific Islander Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 968 187 539
Join Meeting

13 — 10 a.m. — Suicide Prevention Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 264 6760
Join Meeting

13 — 10 a.m. — Victor Community Support Services
Call-In: 1-669-444-9171
Zoom Meeting ID: 237 481 4005 Passcode: 865178
Join Meeting

13 — 2 p.m. — African American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 893 8322
Join Meeting

14 — 1 p.m. — Spirituality Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 357 009
Join Meeting

14 — 10:30 a.m. — Desert Stars Clubhouse
1841 E. Main St., Barstow

15 — 11 a.m. — Pathways to Recovery Clubhouse
17053 E. Foothill Blvd. Suite B, Fontana

15 — 2 p.m. — Transitional Age Youth (TAY) Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 960 523 715
Join Meeting

15 — Noon — Ontario Montclair School District - Health & Wellness Services Family Resource Center
1556 S. Sultana Ave. Ontario

15 — 6 p.m. — Fourth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 776 5577
Password: fBw5HAvQH23
Join Meeting

15 — 11 a.m. — First District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 662 3366
Join Meeting

16 — 1 p.m. — Cultural Competency Advisory Committee (CCAC)
Call-In: 1-415-655-0002
WebEx Meeting Number: 969 101 891
Join Meeting

21 — 11 a.m. — Amazing Place Clubhouse
2940 Inland Empire Blvd., Ontario

21 — 2 p.m. — Native American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 996 4635
Join Meeting

21 — 10 a.m. — MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2498 681 4350
Join Meeting

21 — 5 p.m. — MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 495 7647
Join Meeting

22 — 11 a.m. — Serenity Clubhouse
12625 Hesperia Rd. Suite B, Victorville

22 — 1 p.m. — Women's Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 967 920 279
Join Meeting

23 — 10 a.m. — Older Adults Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 983 483
Join Meeting

23 — 10 a.m. — Latino Awareness Subcommittee
Call-In: +1-415-655-0002 - Spanish Only
WebEx Meeting Number: 966 009 041
Join Meeting

24 — 12:30 p.m. — Pacific Clinics Family Resource Center
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

27 — 11 a.m. — Consumer and Family Members Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 2495 614 6844
Join Meeting

28 — 11 a.m. — TEAM House Clubhouse
201 W. Mill Street, San Bernardino

28 — 11:30 a.m. — Central Valley Fun Clubhouse
1501 S. Riverside Ave., Rialto

28 — 12:30 p.m. — LGBTQ Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 960 570 704
Join Meeting

28 — 5 p.m. — Fifth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 027 1608
Join Meeting

29 — 11:30 a.m. — Santa Fe Wellness Club Clubhouse
56020 Santa Fe Trail, Suite M, Yucca Valley

30 — 11:30 a.m. — A Place to Go Clubhouse
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

February 2025

3 — 3 p.m. — Veterans Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2482 788 1413
Join Meeting

6 — 9 a.m. — Rim Family Services
Zoom Meeting ID: 825 7790 5597 Passcode: 1800
Join Meeting

12 — 10 a.m. — Victor Community Support Services (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

12 — 11 a.m. — Third District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 962 9460
Join Meeting

19 — 1 p.m. — Senior Affairs Commission
784 E. Hospitality Lane, San Bernardino

20 — 10 a.m. — Community Policy Advisory Committee
720 E. Carnegie Dr. Suite 150, San Bernardino

Event will be held in-person

If you speak another language, language assistance services are available free of charge by dialing (888) 743-1478. TTY users dial 711. DBH complies with applicable federal, civil rights laws and does not discriminate based on race, color, national origin, sex, gender identity, age, disability, or the inability to speak English (LEP).

For more information, please visit sbcounty.gov/dbh/

San Bernardino County Department of Behavioral Health

Community Program Planning

SAN BERNARDINO COUNTY | Behavioral Health

Actualización annual de la MHSA para el año fiscal 2025/2026

Reunión de Planificación

¡Le invitamos a unirse a una reunión de participación de las partes interesadas de la Actualización Anual de la Ley de Servicios de Salud Mental (Mental Health Services Act - MHSA) AF 2025/26! Conozca los datos de servicio del último año fiscal y obtenga información sobre los cambios y mejoras en los programas.

El evento se llevará a cabo en persona

Enero 2025

08 — 10 a.m.
Subcomité de Concientización sobre la Salud Mental y el Uso de Sustancias
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 777 142
Ingresar a la reunión

08 — mediodía
Subcomité Asesor de la CCA y Miembros de la Familia de QMAC
Llamada telefónica: 1-669-444-9171
ID de reunión de Zoom: 959 6126 4010
Código de acceso: 421362
Ingresar a la reunión

09 — 1 p.m.
Reunión Trimestral de Proveedores de PEI
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2485 096 9219
Ingresar a la reunión

09 — 10 a.m.
Subcomité de Concientización de Discapacidades
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 434 2208
Ingresar a la reunión

09 — 3:30 p.m.
Comité Asesor del Segundo Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2483 823 7369
Código de acceso: pxYctfry353
Ingresar a la reunión

10 — 10 a.m.
Subcomité de Concientización de Asiáticos/Isleños del Pacífico
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 968 187 539
Ingresar a la reunión

13 — 10 a.m.
Subcomité de Concientización de Prevención del Suicidio
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 264 6760
Ingresar a la reunión

13 — 10 a.m.
Servicios de Apoyo Comunitario de Victor
Llamada telefónica: 1-669-444-9171
Zoom Meeting ID: 237 481 4005
Código de acceso: 865178
Ingresar a la reunión

13 — 2 p.m.
Subcomité de Concientización de Afroamericanos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 893 8322
Ingresar a la reunión

14 — 1 p.m.
Subcomité de Concientización de Espiritualidad
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 357 009
Ingresar a la reunión

14 — 10:30 a.m.
Casa Club Desert Stars
1841 E. Main St., Barstow

15 — 11 a.m.
Casa Club Pathways to Recovery
17053 E. Foothill Blvd. Suite B, Fontana

15 — 2 p.m.
Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 960 523 715
Ingresar a la reunión

15 — mediodía
Distrito Escolar Ontario Montclair – Centro de Servicios de Salud y Bienestar de Recursos Familiares
1556 S. Sultana Ave. Ontario

15 — 6 p.m.
Comité Asesor del Cuarto Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2495 776 5577
Código de acceso: fBw5HAvQH23
Ingresar a la reunión

15 — 11 a.m.
Comité Asesor del Primer Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 187 662 3366
Ingresar a la reunión

16 — 1 p.m.
Comité Consultivo de Competencia Cultural (CCAC)
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 969 101 891
Ingresar a la reunión

21 — 11 a.m.
Casa Club Amazing Place
2940 Inland Empire Blvd., Ontario

21 — 2 p.m.
Subcomité de Concientización de Nativos Americanos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 996 4635
Ingresar a la reunión

21 — 10 a.m.
Administración de MHSA
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2498 681 4350
Ingresar a la reunión

21 — 5 p.m.
Administración de MHSA
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2495 495 7647
Ingresar a la reunión

22 — 11 a.m.
Casa Club Serenity
12625 Hesperia Rd. Suite B, Victorville

22 — 1 p.m.
Subcomité de Concientización de Mujeres
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 967 920 279
Ingresar a la reunión

23 — 10 a.m.
Comisión de Asuntos para Adultos Mayores
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 983 483
Ingresar a la reunión

23 — 10 a.m.
Subcomité de Concientización de Latinos
Llamada telefónica: +1-415-655-0002 - En español
Número de reunión de WebEx: 966 009 041
Ingresar a la reunión

24 — 12:30 p.m.
Centro de Recursos Familiares de las Clínicas del Pacífico
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

27 — 11 a.m.
Subcomité de Concientización de Consumidores y Miembros de Familias
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 2495 614 6844
Ingresar a la reunión

28 — 11 a.m.
Casa Club TEAM house
201 W. Mill Street, San Bernardino

28 — 11:30 a.m.
Casa Club del Valle Central
1501 S. Riverside Ave., Rialto

28 — 12:30 p.m.
Subcomité de Concientización de LGBTQ
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 960 570 704
Ingresar a la reunión

28 — 5 p.m.
Comité Asesor del Quinto Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 187 027 1608
Ingresar a la reunión

29 — 11:30 a.m.
Casa Club del Bienestar de Santa Fe
56020 Santa Fe Trail, Suite M, Yucca Valley

30 — 11:30 a.m.
Casa Club A Place To Go
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

Febrero 2025

3 — 3 p.m.
Subcomité de Concientización de Veteranos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2482 788 1413
Ingresar a la reunión

6 — 9 a.m.
Servicios Familiares de RIM
Zoom Meeting ID: 825 7790 5597
Código de acceso: 1800
Ingresar a la reunión

12 — 10 a.m.
Servicios de Apoyo Comunitario de Victor (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

12 — 11 a.m.
Comité Asesor del Tercer Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 962 9460
Ingresar a la reunión

19 — 1 p.m.
Comisión de Asuntos para Adultos Mayores
784 E. Hospitality Lane, San Bernardino

20 — 10 a.m.
Comité Comunitario Consultivo de Políticas
720 E. Carnegie Dr. Suite 150, San Bernardino

El evento se llevará a cabo en persona

Si habla otro idioma, hay servicios de asistencia lingüística disponibles de forma gratuita llamando al (888) 743-1478. Los usuarios de TTY marcan 711. DBH cumple con las leyes federales y de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, sexo, identidad de género, edad, discapacidad o incapacidad para hablar inglés (LEP).

Para obtener más información, visite sbcounty.gov/dbh/

San Bernardino County Department of Behavioral Health

Community Program Planning Process Evaluation & Behavioral Health Needs Assessment

In November 2023, DBH partnered with Health Management Associates (HMA), an independent national research and consulting firm in the healthcare industry, to complete an assessment of DBH's Community Program Planning (CPP) process for developing the MHSA Three-Year Integrated Plan and Annual Plan Updates and a behavioral health needs and capacity assessment. The project extended from November 2023 to August 2024.

Administrative Managers, Program Managers, Program Specialists, Peer and Family Advocates, and an Addiction Medicine Physician from the mental health and Substance Use Disorder and Recovery Services divisions made up a project management team, core team, and community advisory group that worked alongside the consultant to provide feedback on data collection, priorities, and recommendations.

Data informed stakeholder engagement, and engagement with populations with disparities and barriers to services was prioritized. The scope of work included but was not limited to utilization data and other available data on access, outcomes, and health measures.

Behavioral health assessment activities included, but were not limited to, reviewing existing Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis data, service data, demographic information, capacity data such as staffing versus need, and behavioral health system and workforce needs.

Health Management Associates (HMA) conducted a population assessment of behavioral health needs to identify the cultural and linguistic needs of served and unserved county residents, in accordance with 9 CCR § 1810.410, and conducted a workforce needs assessment focusing on linguistic capability, provider diversity, and education and training needs in accordance with 9 CCR § 1810.410 and 9 CCR § 3830.

The community program planning process activities included, but were not limited to, leveraging the information gained from conducting key informant interviews and listening sessions, data from surveys, and information from key stakeholder interviews and public forums.

HMA used a combination of data analysis, document review, and community engagement throughout the project to conduct the assessments.

The next few pages provide a summary of the strategies used during the assessment, key findings and areas of opportunities,

and current actions taken. The final report identifies strengths, challenges, and recommendations for areas of opportunity within the Mental Health Services Act (MHSA) programming in San Bernardino County and can be found in the Attachments section on page 426.

Some strategies used for qualitative and quantitative data collection included:

- Collected and analyzed available data on consumer services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others, to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups with 200+ participants, where the groups included individuals with lived experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.
- Observed several DBH-run meetings that are a part of the CPP.

<u>Behavioral Health Needs and Capacity Assessment</u>

Key findings of the behavioral health needs and capacity assessment were broken down by the strengths and opportunities for improvement/unmet needs. The qualitative feedback key findings are organized in the categories below:

Strengths:

- Provider Collaboration
- Service Availability and Accessibility
- County Engagement Efforts
- Effectiveness of Services

Opportunities for Improvement and Unmet Needs:

- Access and Service Availability
- Cultural Responsiveness and Disparity Reduction
- Workforce Recruitment and Retention
- Implementation of New Initiatives
- Internal and External Collaboration
- Operations
- Community Engagement

HMA provided recommendations that could have a significant impact on behavioral healthcare delivery in San Bernardino County. These are categorized into the five areas below:

1. Expand Access to High-Quality Services
2. Improve Service Integration and Coordination
3. Enhance External Communication and Engagement
4. Strengthen Administrative and Operational Processes
5. Address Workforce Challenges

Community Program Planning

DBH is reviewing the recommendations and developing strategies to help improve behavioral healthcare delivery in our county. This is a continuous process, and updates will be shared in future meetings.

Community Program Planning (CPP) Process Assessment

Some key findings related to the observations of the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths:

- Meetings were well attended, there were plenty of opportunities for constituent questions and feedback, and participants were engaged.
- A wide array of special population meetings were held.
- Information shared met Culturally and Linguistically Appropriate Services Standards.

Opportunities for Improvement:

- There was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP.
- The process of submitting comments could be streamlined.
- San Bernardino County could leverage online tools to improve interactions and engagement during meetings.

Some key findings related to the feedback on the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths:

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community and is generally good about receiving feedback.

Opportunities for Improvement:

- Stakeholders have many competing requirements for their time and resources and want clearly defined goals, objectives, and action items for meetings with a stronger focus on operational application rather than statistics.
- There is a need for clearer communication on the objective of the CPP process.
- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another.

HMA found that San Bernardino County has a very successful Community Program Planning Process and a strong foundation on which focused enhancements could

be implemented to improve planning and engagement efforts. Some of the HMA recommendations for enhancing external communication and engagement to help build awareness of the CPP process and support meaningful engagement with consumers and the community include:

- Building awareness of the Community Program Planning (CPP) process
- Improving CPP progress and outcomes tracking
- Leveraging trusted partners to support information sharing
- Improving connections with marginalized communities
- Offering engagement opportunities in community settings
- Leveraging technology to support engagement

DBH is taking the following steps to address the assessment recommendations:

- Providing more context about MHSA and the CPP process during meetings to help educate stakeholders on the planning process and how their engagement and feedback helps to guide DBH programs.
- Expanding stakeholder groups to include more unserved/underserved populations, community members, service partners, faith-based organizations, children and youth groups, etc., to increase community engagement and feedback and to involve more service partners to increase information sharing with the community.
- Coordinating with other departments and organizations to participate in their community/patient needs assessments to identify the needs of the county and expand access and services to meet those needs.
- Holding the monthly Community Policy Advisory Committee (CPAC) meetings in more locations throughout the county to engage with stakeholders in community settings.

DBH leadership is working on identifying additional opportunities for improvement and continues to encourage stakeholder engagement and feedback to guide its programs and services.

Public Review and Comment Period

The MHSA Annual Update was posted on the department's website for stakeholder review and comment from February 14, 2025, through March 17, 2025, at https://wp.sbcounty.gov/dbh/programs/mhsa/, per Welfare and Institutions Code 5848. Stakeholder comment forms and directions were posted with the draft MHSA Annual Update on the department's website.

Stakeholders were also informed that they could submit comments/recommendations via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Annual Update draft was posted for public comment. Stakeholders were informed that comments can be received anytime throughout the year but will not be included in the final MHSA Annual Update unless provided during the 30-day comment period.

If you would like to provide comments/recommendations after the close of the 30-day posting period, you may request a comment form be sent to you by contacting DBH at MHSA@dbh.sbcounty.gov or calling 1-800-722-9866 for more information.

DBH would like to thank everyone who reviewed the plan and/or submitted a comment. There were no substantive comments received during the 30-day public review and comment period. DBH encourages and supports community collaboration, particularly involvement of stakeholders, in all aspects of the MHSA.

Summary and Analysis of Stakeholder Comments

During the Community Program Planning meetings and the 30-day public review and comment period, DBH received several inquiries on the stakeholder comment forms asking: what services are available in their region, 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.

Summary and Analysis of Stakeholder Comments, cont.

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.

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

Feedback from regularly occurring stakeholder meetings is compiled throughout the year(s) and included with feedback from any special sessions that are held to review the Annual Plan Update.

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

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, 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

Summary and Analysis of Stakeholder Comments, cont.

Annual Update and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/08/COM0947.pdf.

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.

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.

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.

Additional information about past MHSA-approved plans can be accessed at the following link: https://wp.sbcounty.gov/dbh/programs/mhsa/. 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 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.

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 with this population (Developmental Disabilities and

Summary and Analysis of Stakeholder Comments, cont.

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 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 Walk-In Clinics (CWIC)/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 Walk-In Clinic (CWIC) 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 Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) components. There are no planned program changes under the Innovation (INN) component.

The following are proposed changes in programs and components:

Prevention and Early Intervention

Child and Youth Connection – Budget Increase

The Children's Assessment Center (CAC), administered by Loma Linda University Children's Hospital (LLUCH) under the Child and Youth Connection (CYC) program, will increase funding from $62,000 to $165,000 per year. This funding change will increase early access and linkage to medically necessary care and treatment. It connects children and youth with severe mental health conditions to care as early in the onset of these conditions as practicable, to medically necessary care and treatment. It includes, but is not limited to, care provided by county mental health programs.

Goals of the project:

- Pre-forensic examination counseling services to help minimize the children's/youths' trauma from the examination and decrease the psychological distress associated with child abuse allegations.
- Provide pre-forensic examination counseling services to an estimated 900 unduplicated children and adolescents.

This program serves consumers ages 0-18 years old throughout San Bernardino County.

Family Resource Center (FRC) – Expansion Update

Department of Behavioral Health, Prevention and Early Intervention (PEI) Family Resource Center is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as specialty mental health services for children, youth, and adults with mental health concerns. This expansion will increase the annual FRC budget by $1,500,000 from $2,774,774 to $4,274,774, previously budgeted increase in the MHSA Annual Plan Update for FY 2022/23. This expansion will enable DBH to broaden its scope of services by providing a comprehensive approach to family wellness while continuing to offer essential services to promote wellness, recovery, and resiliency for its clients.

FRC programs offer:

- Services tailored to individualized communities' specific needs and cultural requirements.
- Services and activities at non-traditional locations, such as community centers, where other collateral services are also provided.

Summary of Program Changes, cont.

- A reduction in stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

Population served will be children and their families throughout San Bernardino County.

Preschool PEI Program (PPP) and Lift Program
The Prevention and Early Intervention Preschool PEI and Lift programs are being evaluated for transition to early intervention programs for children ages 0-5.

Community Services and Supports

Housing and Homeless Services Continuum of Care Program – Position Transfer
The Homeless Outreach Support Team (HOST) under the Housing and Homeless Services Continuum of Care Program is transferring a Clinical Therapist I Psychologist position to the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program under the Forensic Services Continuum of Care program.

- This change will allow the CHOICE program to provide psychiatric services directly to consumers enrolled in the CHOICE Mental Health Outpatient program at the Probation Department Day Reporting Centers rather than referring them to another clinic.

This position will be funded under the AB109 Realignment.

Innovation

Eating Disorder Collaborative – Project Sunset
Eating Disorder Collaborative (EDC) is scheduled to sunset in December 2025. DBH is in the process of reviewing project data and outcomes to determine continuation of the project. DBH is considering options to continue the project or project services under Community Services and Supports (CSS) Full Service Partnership (FSP) program and/or other opportunities with Managed Care Plans (MCPs) to continue to provide project services where appropriate.

Cracked Eggs – Project Sunset
The contract for Cracked Eggs ends June 2026 and will not continue as a standalone program. Low enrollment rates combined with the substantial operational costs have rendered it unsustainable. However, the project highlighted that art can be a therapeutic tool. DBH will explore ways to incorporate some of the artistic strategies learned during this Innovation project to include in our system of care where appropriate. The final report will be released in FY 2026/27.

Public Hearing

The Public Hearing was conducted at the San Bernardino County Behavioral Health Commission general session on April 3, 2025, at County of San Bernardino Health Services Building Auditorium located at 850 E. Foothill Blvd., Rialto, CA 92376. Satellite locations were also available at the Department of Behavioral Health Apple Valley Community Clinic located at 18818 Highway 18, Apple Valley, CA, 92307, and at the Family Resource Center located at 58945 Business Center Drive, Yucca Valley, CA, 92284. The agenda, meeting regulations of MHSA public hearings, and a copy of the MHSA Public Hearing presentation were verbally and/or electronically accessible for all attendees during the meeting. As with all public meetings, interpretation services and materials in other languages were available upon request.

Commissioners' questions were addressed during the Public Hearing. No substantive recommendations were made during the public hearing.

The Behavioral Health Commission affirmed that the DBH adhered to the MHSA CPP process and supported the submission of the MHSA Annual Update for Fiscal Year 2025/26 to the San Bernardino County Board of Supervisors scheduled for approval in a May 2025 meeting and the subsequent submission to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.

Improvements in Progress

Stakeholder feedback received during the continuous Community Program Planning (CPP) process indicated that stakeholders want to receive more information on the Behavioral Health Services Act (BHSA) and how it might affect programs.

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 throughout the next 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 Integrated Plan is currently being developed, and DBH will continue to engage stakeholders and obtain feedback through the Community Program Planning (CPP) process during development of the Plan over the next fiscal year.

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.
- 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 25/26: PEI Component including Annual Prevention and Early Intervention Report

Prevention and Early Intervention

Introduction

Prevention and Early Intervention (PEI) program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for underserved populations.

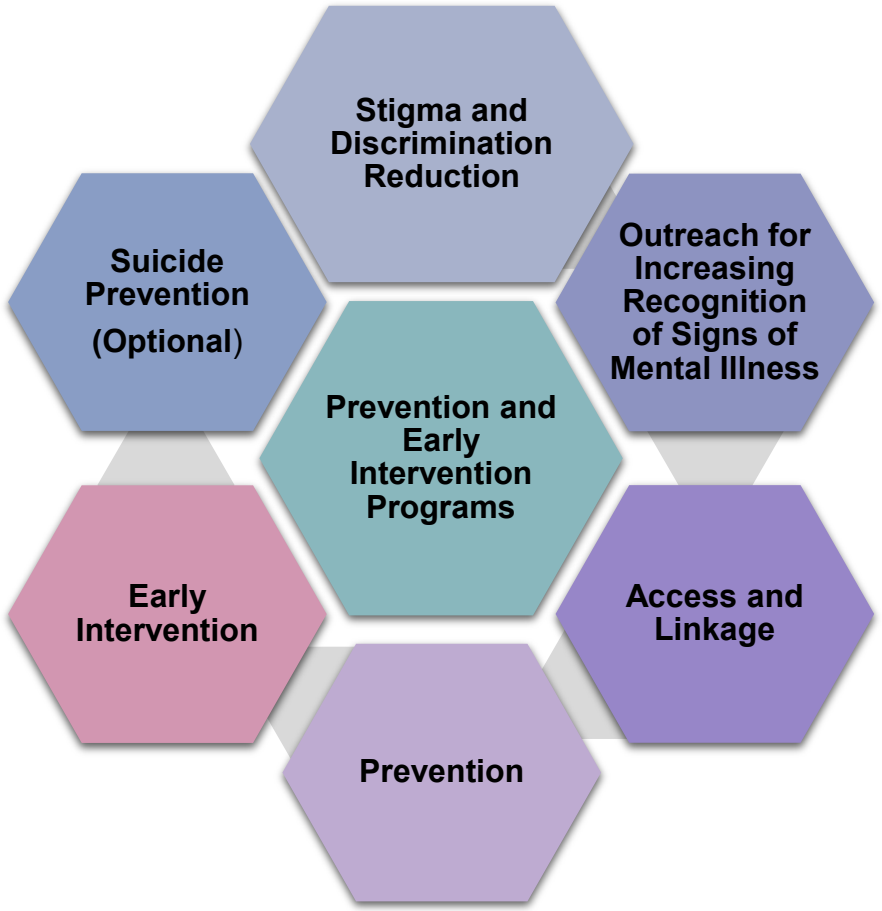
Strategies and activities are applied early on to avert the onset or relapse of mental health conditions among individuals. The component also seeks to change community conditions known to contribute to behavioral health concerns.

PEI programs incorporate the values of cultural competence, consumer and community empowerment, collaboration, and inclusion in providing services that emphasize recovery, wellness, and resilience.

PEI initiatives 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.

Local PEI Construct

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

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 24/25 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
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 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 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 in FY 23/24. 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 was a two-hour presentation via Webex in order to reach a greater audience.

- District 1 – November 15, 2023
- District 2 – January 11, 2024
- District 3 – February 14, 2024
- District 4 – February 21, 2024
- District 5 – January 23, 2024

In addition to the District Advisory Committee meetings, PEI completed a presentation in the Community Policy Advisory Committee (CPAC) on October 18, 2023, where we presented a complete overview of the PEI programs.

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:

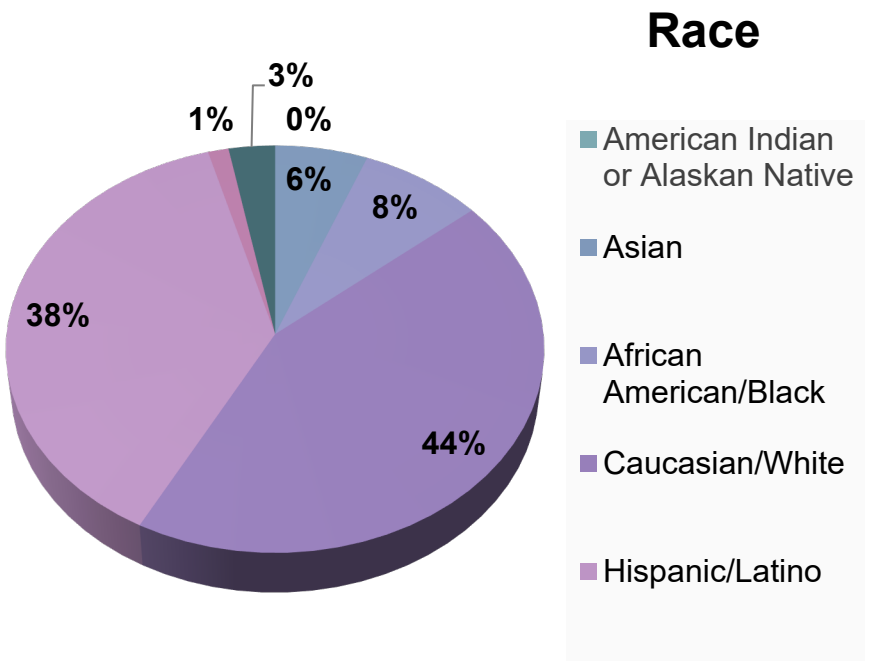
- Culturally competent and linguistically appropriate.
- Strategies targeting mental health needs of older adults.
- Childhood trauma early intervention to deal with early origins of mental health and substance use disorder needs.
- Early psychosis and mood disorder detection and intervention and mood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

Introduction, cont.

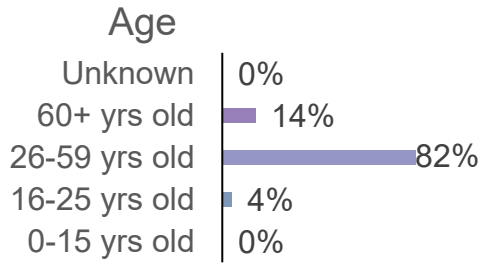
PEI Community Program Planning, cont.

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

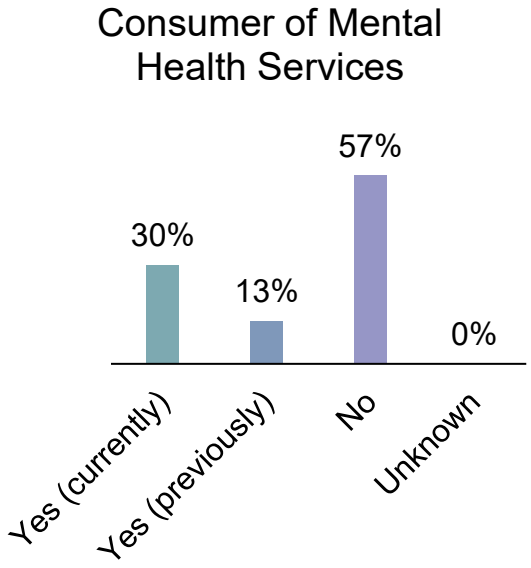
The rich racial diversity of San Bernardino County was reflected in the demographic data of the participants, with 8% identifying as African American/Black, 6% Asian, 44% Caucasian, 38% Latinx/Hispanic, and 1% Native Hawaiian/Pacific Islander. In addition, 3% of participants indicated that they identify with more than one race.

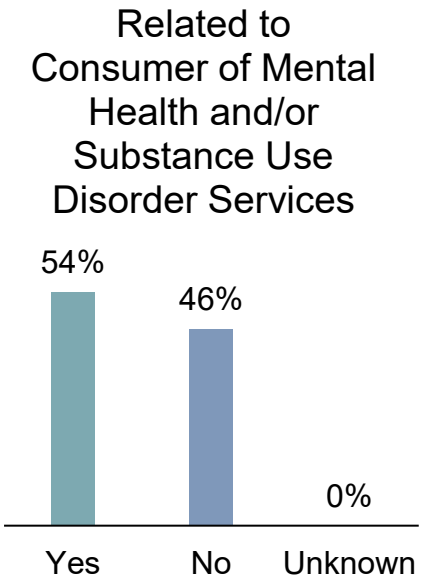


The majority of participants were adults, with 82% reporting that they were between 26-59 years old, 14% were older adults over 60, and 4% TAY aged youth (16-25).



Participants comprised of a mix of individuals with 43% reporting that they are either a current or previous consumer of mental health services and 54% reporting that the are related to a consumer of either mental health or substance use disorder services.





Introduction, cont.

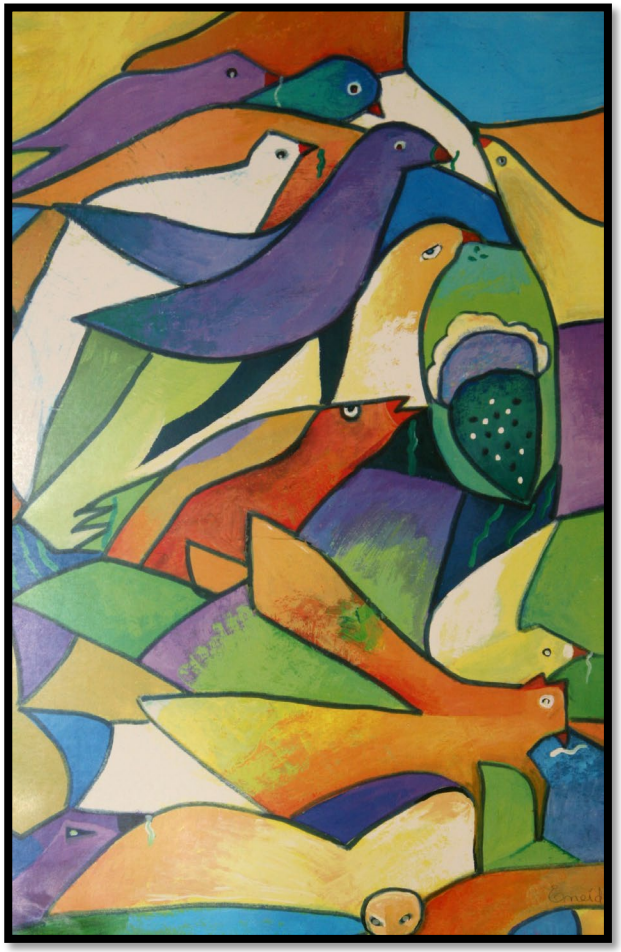
PEI Data Collection

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.



Artwork by Eneida Reboucas

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.

The three (3) statewide projects include:

1. Take Action for Mental Health (formerly Each Mind Matters)
    - **Goal**: Eliminating stigma and discrimination against individuals with mental illness.
2. Directing Change (Student Mental Health Initiative)
    - **Goal**: Strengthening school (K-12) and higher education mental health programs.
3. Know the Signs (Suicide Prevention)
    - **Goal**: Supporting and coordinating with counties on the implementation of the California Strategic Plan for Suicide Prevention.

These projects are administered by CalMHSA and are represented under the Take Action for Mental Health project. Strategies for FY 2023/24 included:

- Distribution of the Take Action for Mental Health campaign's materials and messages,
- Technical assistance and outreach to members contributing to the PEI Program,
- Mental health and suicide prevention training to diverse audiences, and
- Engaging youth through the Directing Change program.

Technical Assistance (TA) is provided to San Bernardino County and local community organizations. The TA Team can provide crisis support, capacity building, guidance, and resource navigation of stigma reduction, suicide prevention, and student mental health.

Introduction, cont.

San Bernardino County Local Impact

Directing Change is a statewide contest that engages students in creating 60-second public service announcements about suicide prevention and mental health stigma.

Two hundred and nine participants submitted a total of 70 films. Entries were submitted by filmmakers from twelve San Bernardino County schools: Apple Valley High School, Silverado High School, Upland High School, Entrepreneur High School, Encore High School, Cajon High School, Jurupa Hills High School, San Andreas High School, University Preparatory, Fontana High School, Rim of the World High School, and Hesperia High School. San Bernardino County filmmakers whose entries competed in the categories of Mental Health Matters, Suicide Prevention, Animated Short, Walk in Our Shoes and Through the Lens of Culture.

San Bernardino County hosted a Directing Change Award Ceremony at the Harkins Movie Theater in Redlands on May 11, 2024, to honor the San Bernardino County filmmakers.

NOTE: The annual budget shown is the amount of the MHSA PEI funding which has been allocated to these programs. It may differ from the amounts in the Fiscal section as those account for anticipated utilization values.

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.

Number of Consumers to be Served

The tables below demonstrate the number of consumers to be served by program name for Fiscal Year 2025/26:

Program Name	Fiscal Year 2025/26 Total
Child and Youth Connection	6,529
Coalition Against Sexual Exploitation	1,500
Community Wholeness and Enrichment	5,914
Early Psychosis Program/Improving Detection and Early Access	26
Family Resource Center	26,945
Lift Progam	120
Military Services and Family Support	3,878

Program Name	Fiscal Year 2025/26 Total
Native American Resource Center	1,751
Older Adult Community Services	3,166
Preschool PEI	1,508
Promotores de Salud/Community Health Worker	30,687
Resilience Promotion in African American Children	4,753
Student Assistance Program	15,126
Substance Use Prevention & Pathways to Outreach and Treatment	3,400

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.

Program Serves	**Children** **TAY (16-25)** **Adults** **Older Adults (60+)**
Location of Services	Counseling Centers
Annual Budget FY 25/26	$500,000
Cost Per Client FY 25/26	$285

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

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.

NARC saw a decrease in the utilization of behavioral health services FY 2022/23 to FY 2023/24.

However, as a result of the culturally-based mental wellness activities offered by NARC, the total number of individuals participating in NARC activities exceeded their projected targets for a third consecutive year. The high participation numbers highlight the continued need for support in addressing behavioral health issues within Native American communities in San Bernardino County.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	1,751	4,138	5,566	3,334
Number of Services	2,544	5,200	5,972	4,153

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. This rise in referrals is linked to a growing demand for mental health services that exceed basic care, stemming from the after-effects of the pandemic.

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 21/22	FY 22/23	FY 23/24
Number of Referrals Provided	5	4	20
Number of referrals to county-funded / administered programs	0	0	0
Number of referrals to other programs	4	4	20
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 21/22	FY 22/23	FY 23/24
Number of Referrals Provided	294	247	313

Native American Resource Center (NARC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	2%	2%	3%	1%	91%
FY 22/23	3%	6%	12%	3%	76%
FY 23/24	9%	8%	34%	9%	40%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 21/22	0%
FY 22/23	<1%
FY 23/24	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	11%	26%	0%	64%
FY 22/23	8%	17%	<1%	75%
FY 23/24	15%	49%	0%	36%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 21/22	0%
FY 22/23	1%
FY 23/24	2%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 21/22	1%
FY 22/23	3%
FY 23/24	6%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	97%	0%	0%	3%
FY 22/23	14%	<1%	<1%	86%
FY 23/24	59%	2%	<1%	39%

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 again offered the opportunity to complete paper surveys instead of only electronic surveys.
- With the increase of surveys completed, NARC was able to more accurately identify communities participating in their activities.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	1%	2%	8%
	American-Indian/Alaska Native	6%	10%	21%
	Asian	1%	1%	2%
	Hispanic/Latinx	0%	7%	8%
	Native Hawaiian or Pacific Islander	0%	<1%	<1%
	Caucasian/White	<1%	3%	4%
	More than One Race	1%	0%	6%
	Other Race	3%	10%	24%
	Declined to Answer	87%	67%	35%

Native American Resource Center (NARC), cont.

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	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%
	Hispanic/Latino	1%	7%	0%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	1%	0%	0%
	More than one ethnicity	0%	0%	0%
	Declined to Answer	98%	93%	100%

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 21/22: 5 FY 22/23: 0* FY 23/24: 0*
Stigma Reduction Questionnaire (SRQ) Survey	Survey to measure changes in attitudes, knowledge and behavior related to mental health services.	Post-activity	FY 21/22: 8 FY 22/23: 147* FY 23/24: 1,757

*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.

While the transition to Screendox resulted in the exclusion of certain questions from the current data set, PEI and NARC are collaborating to create a more effective data collection method that will fully capture the information outlined in the table below.

Percentage of participants who agreed that they would be more likely to engage or support someone living with a mental health challenge			
	FY 21/22 N=8*	**FY 22/23 N=147***	**FY 23/24 N=1,757**
More likely to seek mental health support if needed	100%	87%	100%
More likely to talk to a friend or family member about mental health needs	100%	84%	0*
More likely to take action to prevent mental health discrimination	88%	83%	0*
More likely to actively and compassionately listen to someone in distress	100%	89%	0*

*Shows areas for improvement in survey distribution.

Native American Resource Center (NARC), cont.

Challenges/Solutions

NARC current challenge is to replace an employee who was providing services for the NARC program. NARC has put out recruitment request and should be filled within the first month of the new fiscal year.

NARC coordinator is working with its Human Resource Director regarding the recruitment process to hire a new prevention educator. In the meantime, other staff from other programs are assisting in collaborating events.

Success Story

Navajo Language Class- In April NARC attended and assisted with Navajo Language Classes located at the Barstow RSBCIHI location. This course is designed to teach participants how to introduce themselves in Navajo along with the cultural significance behind it. Learning a Native language creates a space for a person to connect with others, to feel more comfortable to go to new places, and creates feelings of inspiration and community. After the end of one of the classes a participant expressed her gratitude towards the facilitators stating she "was not able to learn the language growing up, even though my family knows how to speak Navajo. My entire family is from Arizona but I was born here in Barstow, I always felt left out but now I feel more confident in myself'.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

*Promotores de Sal*ud/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 program. 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
Annual Budget FY 25/26	$1,264,429
Cost Per Client FY 25/26	$41

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

State Program Positive Results

The *Promotores de Salud*/Community Health Worker (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/*Community Health Workers.

The program relies heavily on recruiting and training community members with lived experience or family members to become PdS/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.

Number of CHW Individuals / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Individuals	15,568	12,820	24,083	37,584
Number of Services	24,764	13,851	24,764	37,755

Number of PdS Individuals / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Individuals	15,119	49,875	40,570	36,949
Number of Services	15,119	58,519	47,925	45,833

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 201,881 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. Community members are requesting more in-person services and presentations from PdS/CHW's. While virtual presentations are still common, potential responders do prefer field-based outreach to participate in activities and trainings.

The PdS/CHW program captures information on the number of potential responders trained each year. This enables tracking the increase in mental health awareness in the community. Between FY 2021/22 and FY 2023/24, the program engaged an average of 60,362 potential responders per year.

Potential Responders			
	Number of Potential Responders		
	PdS	*CHW*	*Total*
FY 2021/22	48,753	12,610	61,363
FY 2022/23	34,426	23,800	58,226
FY 2023/24	24,279	37,218	61,497

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 list below displays the most prevalent types of settings used to engage potential responders during the 2023/24 fiscal year.

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, 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 program made over 9,004 referrals this last fiscal year.

Improving Timely Access Referrals			
	FY 2021/22	FY 2022/23	FY 2023/24
# of Referrals Provided	205	15,006	9,004
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 and 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 21/22	1%	2%	1%	2%	94%
FY 22/23	2%	3%	5%	2%	88%
FY 23/24	2%	3%	7%	2%	85%

Fiscal Year	PdS Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	12%	20%	56%	7%	6%
FY 22/23	8%	16%	63%	10%	3%
FY 23/24	7%	13%	64%	11%	4%

Fiscal Year	CHW Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	PdS Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	CHW Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	4%	7%	<1%	90%
FY 22/23	3%	7%	<1%	90%
FY 23/24	5%	10%	<1%	85%

Fiscal Year	PdS Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	5%	89%	0%	6%
FY 22/23	3%	93%	<1%	4%
FY 23/24	14%	22%	<1%	65%

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

Demographics, cont.

Fiscal Year	CHW Veteran Status
% of consumers who identified as a veteran	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	PdS Veteran Status
% of consumers who identified as a veteran	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	CHW Disability
% of consumers who identified a physical disability	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	1%

Fiscal Year	PdS Disability
% of consumers who identified a physical disability	
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	1%

Fiscal Year	CHW Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	46%	0%	2%	52%
FY 22/23	6%	<1%	1%	92%
FY 23/24	15%	<1%	1%	84%

Fiscal Year	PdS Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	5%	89%	0%	6%
FY 22/23	3%	93%	<1%	4%
FY 23/24	2%	94%	<1%	3%

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 21/22	FY 22/23	FY 23/24
Race	African-American/Black	<1%	27%	2%
	American-Indian/Alaska Native	2%	1%	2%
	Asian	2%	1%	1%
	Latinx/Hispanic	<1%	3%	2%
	Native Hawaiian or Pacific Islander	<1%	<1%	<1%
	Caucasian/White	0%	1%	4%
	More than One Race	0%	1%	1%
	Other Race	<1%	3%	2%
	Declined to Answer	96%	63%	85%

	CHW Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	<1%	<1%	0%
	Asian Indian/South Asian	<1%	<1%	0%
	Cambodian	0%	<1%	0%
	Chinese	2%	4%	6%
	Eastern European	0%	0%	0%
	European	0%	<1%	<1%
	Hispanic/Latino	<1%	1%	21%
	Filipino	<1%	<1%	<1%
	Japanese	0%	<1%	0%
	Korean	<1%	<1%	<1%
	Middle Eastern	0%	<1%	0%
	Vietnamese	0%	2%	3%
	Other	<1%	<1%	<1%
	More than one ethnicity	0%	<1%	<1%
	Declined to Answer	98%	92%	64%

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.
- Most individuals served in FY 23/24 were female, Spanish speaking adults aged 26-59.

	PdS Race	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	<1%	<1%	<1%
	American-Indian/Alaska Native	<1%	<1%	0%
	Asian	<1%	<1%	0%
	Latinx/Hispanic	92%	39%	62%
	Native Hawaiian or Pacific Islander	<1%	<1%	0%
	Caucasian/White	47%	36%	1%
	More than One Race	6%	1%	<1%
	Other Race	6%	8%	7%
	Declined to Answer	40%	16%	29%

	PdS Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	<1%	0%	<1%
	Asian Indian/South Asian	<1%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	<1%	0%	0%
	Hispanic/Latino	92%	39%	68%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	<1%
	Middle Eastern	<1%	0%	0%
	Vietnamese	<1%	0%	0%
	Other	21%	68%	12%
	More than one ethnicity	<1%	0%	0%
	Declined to Answer	78%	32%	20%

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

Program Goals

The goals of the PdS/CHW program are to:

- 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 use 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 21/22: 4,277 FY 22/23: 828 FY 23/24: 102
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 21/22: 430 FY 22/23: 1,571 FY 23/24: 6,759

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.

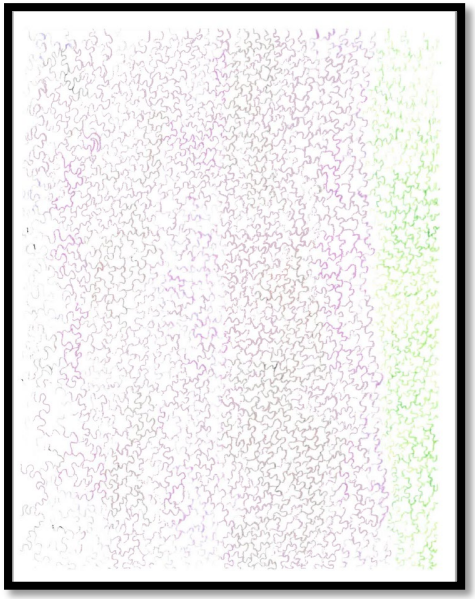
Outcome Discussion, cont.

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.



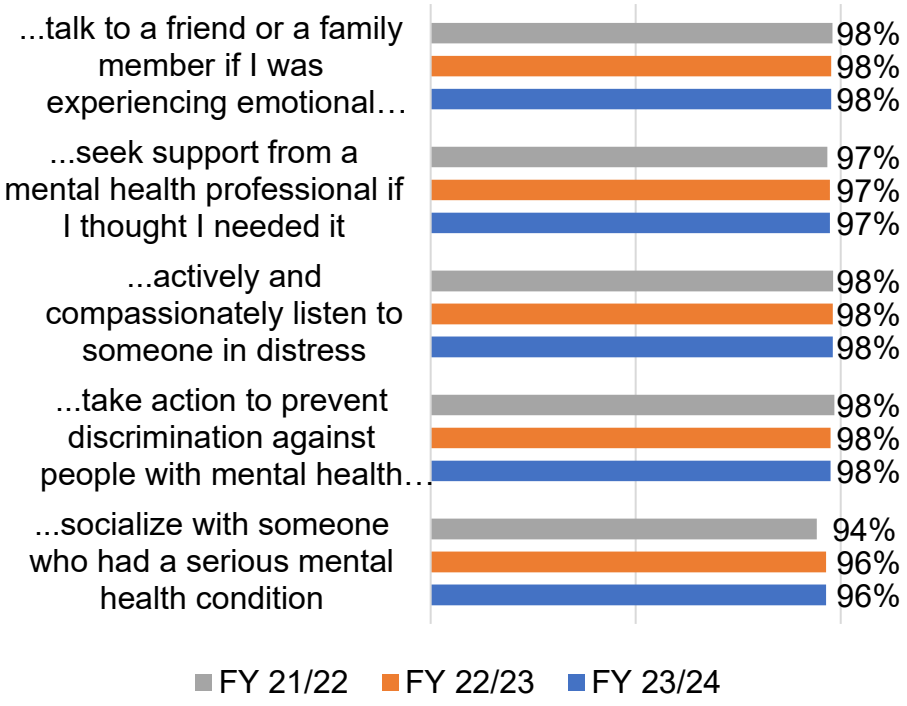
Artwork by Michael Moreno

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

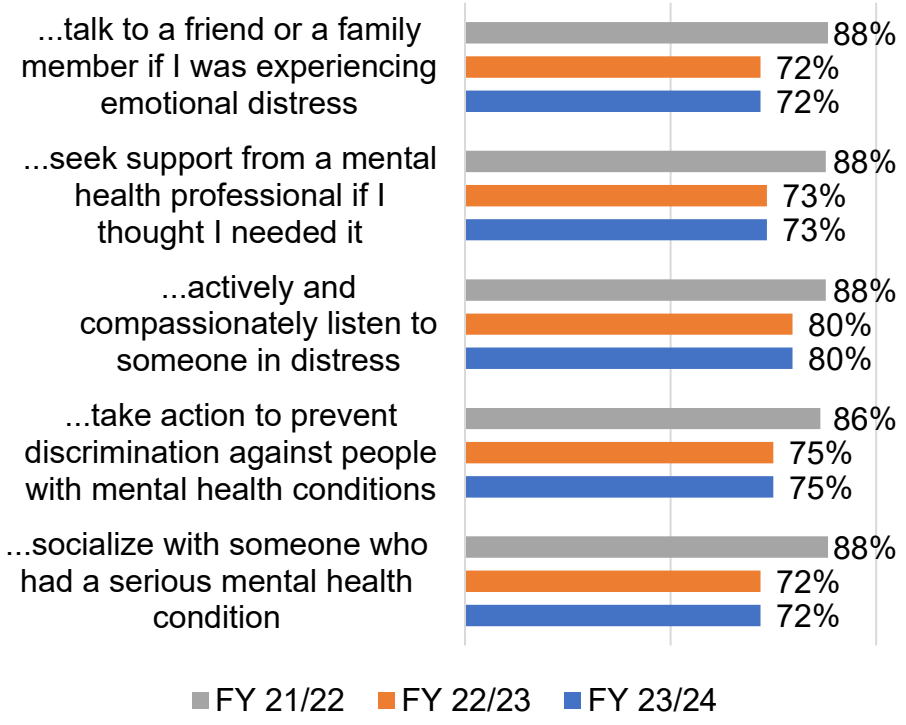
Outcome Discussion, cont.

In FY 23/24, survey data shows that 84% of individuals agree or strongly agree with the stigma survey questions after attending an event or activity, which is represented in the charts below. The findings gathered this fiscal year show that PdS/CHWs' initiatives continue to assist reduce stigma in their target populations.

(PdS)
As a direct result of this training I am MORE likely to...



(CHW)
As a direct result of this training I am MORE likely to...

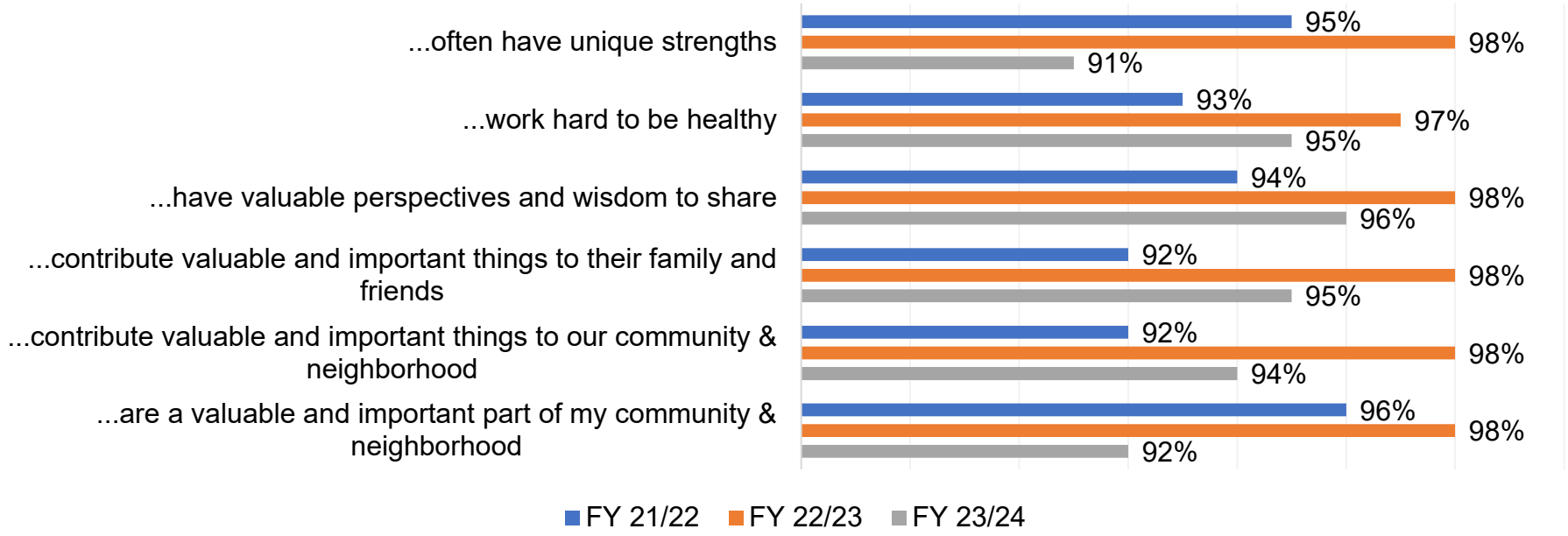


Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

Additional stigma survey results below demonstrate a change in attitude of the individuals who received a stigma-reduction activity. FY 23/24 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. PdS's 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.

Promotores de Salud: As a direct result of this training I agree I am MORE likely to feel that people experiencing mental health challenges...



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

Challenges/Solutions

While the PdS/CHW program repeatedly exceeds in serving the number of projected individuals, it still encounters its own challenges.

For instance, program providers experience difficulty making the most out of their engagement efforts with potential responders at outreach events. While at busy outreach events, it is a challenge to build rapport and trust with individuals in a limited amount of time. This in turn creates an unwillingness for some individuals to complete surveys or provide feedback.

The stigma attached to mental health and illness in the Asian and Pacific Islander (API) community remains one of the primary challenges faced. CHWs in the API community are building creative engagement efforts within the community so that they can reduce the stigma associated with mental health while also recruiting community partners to assist in CHW efforts.

While not as severe as the historic 2023 winter storms, the San Bernardino County mountain communities faced heavy winter storms in 2024 that again provided barriers to service. At times, PdS/CHW's relied on providing services virtually due to challenges in road transportation.

For PdS/CHWs in remote geographical regions within the county, there are challenges in attending and curating culturally specific events. Additionally, it is also a challenge to sufficiently recruit and retain staff to carry out the goals of the program.

As a result, PdS/CHWs continue to provide incentives as motivation for participation. These incentives consist of resources to help with unmet needs such as school and office supplies, food, rental, and utility assistance.

The program strives to foster open communication and strengthen ties with community partners as it is crucial for overcoming future obstacles and ensuring that CHW's effectively identify new upcoming opportunities to engage in future community events.

Lastly, PdS/CHWs continue to engage with individuals, agencies, and schools regarding the importance of collecting demographic data. Also, finding improved methods of gathering demographic data, which include creating the most ideal survey presentation that will collect the most information and prevent survey fatigue.

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

Lessons Learned

PdS/CHW providers continue to cultivate a proactive approach to build trust with organizational partners by ensuring clear communication and collaborative problem solving to encourage stronger results. The process of recruiting and retaining PdS/CHWs and peer providers in a competitive job market requires creative strategies. Building ideal, culturally appropriate surveys, improve the quality of data received from the program's individuals served. This coupled with survey education, allows for PdS/CHWs to improve and provide access to individual demographic data.

Success Story

"*Promotora* referred a client for services due to having relationship problems with her daughter and experiencing low self-esteem. The client shared with *Promotora* that after she received individual and family therapy, she gained effective communication and coping skills that helped her strengthen her relationship with her daughter. In addition, she shared that she was feeling better about herself and decided to enroll in school."

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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 (PRO) 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
Annual Budget FY 25/26	$417,500
Cost Per Client FY 25/26	$122

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 in the use of Naloxone/Narcan.

In FY 23/24, 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 3,662 unduplicated participants at 110 community health fairs.

The SUPPOrT program outreach efforts reached out to 1,609 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.

SUPPOrT program has successfully distributed the following: 1,232 Naloxone Medication, 1,524 Deterra Medication disposal pouch, and 1,677 Fentanyl Test strips. Out of the naloxone distribution, one report was submitted of an overdose reversal due to participant receiving training on how to administer Naloxone and save someone's life.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	3,400	N/A	212	3,662
Number of Services	3,400	N/A	216	4,333

Number of Potential Responders		
FY 21/22	FY 22/23	FY 23/24
N/A	212	3,338

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 21/22	N/A	N/A	N/A	N/A	N/A
FY 22/23	0%	19%	10%	1%	70%
FY 23/24	1%	8%	24%	3%	64%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	N/A
FY 22/23	<1%
FY 23/24	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	N/A
FY 22/23	7%
FY 23/24	3%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	N/A
FY 22/23	8%
FY 23/24	6%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	N/A	N/A	N/A	N/A
FY 22/23	7%	22%	1%	70%
FY 23/24	12%	24%	0%	64%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	N/A	N/A	N/A	N/A
FY 22/23	30%	<1%	0%	70%
FY 23/24	33%	3%	<1%	64%

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

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African American/Black	N/A	2%	6%
	American-Indian/Alaska Native	N/A	0%	1%
	Asian	N/A	1%	6%
	Latinx/Hispanic	N/A	24%	18%
	Native Hawaiian or Pacific Islander	N/A	<1%	1%
	Caucasian/White	N/A	3%	10%
	More than One Race	N/A	1%	1%
	Other Race	N/A	1%	1%
	Declined to Answer	N/A	69%	56%

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	N/A	2%	6%
	Asian Indian/South Asian	N/A	1%	1%
	Cambodian	N/A	1%	<1%
	Chinese	N/A	0%	<1%
	Eastern European	N/A	1%	<1%
	European	N/A	2%	7%
	Latinx/Hispanic	N/A	22%	19%
	Filipino	N/A	1%	1%
	Japanese	N/A	0%	0%
	Korean	N/A	0%	1%
	Middle Eastern	N/A	1%	<1%
	Vietnamese	N/A	0%	<1%
	Other	N/A	2%	5%
	More than one ethnicity	N/A	2%	2%
	Declined to Answer	N/A	65%	54%

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 21/22: N/A FY 22/23: 68 FY 23/24: 1580

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:

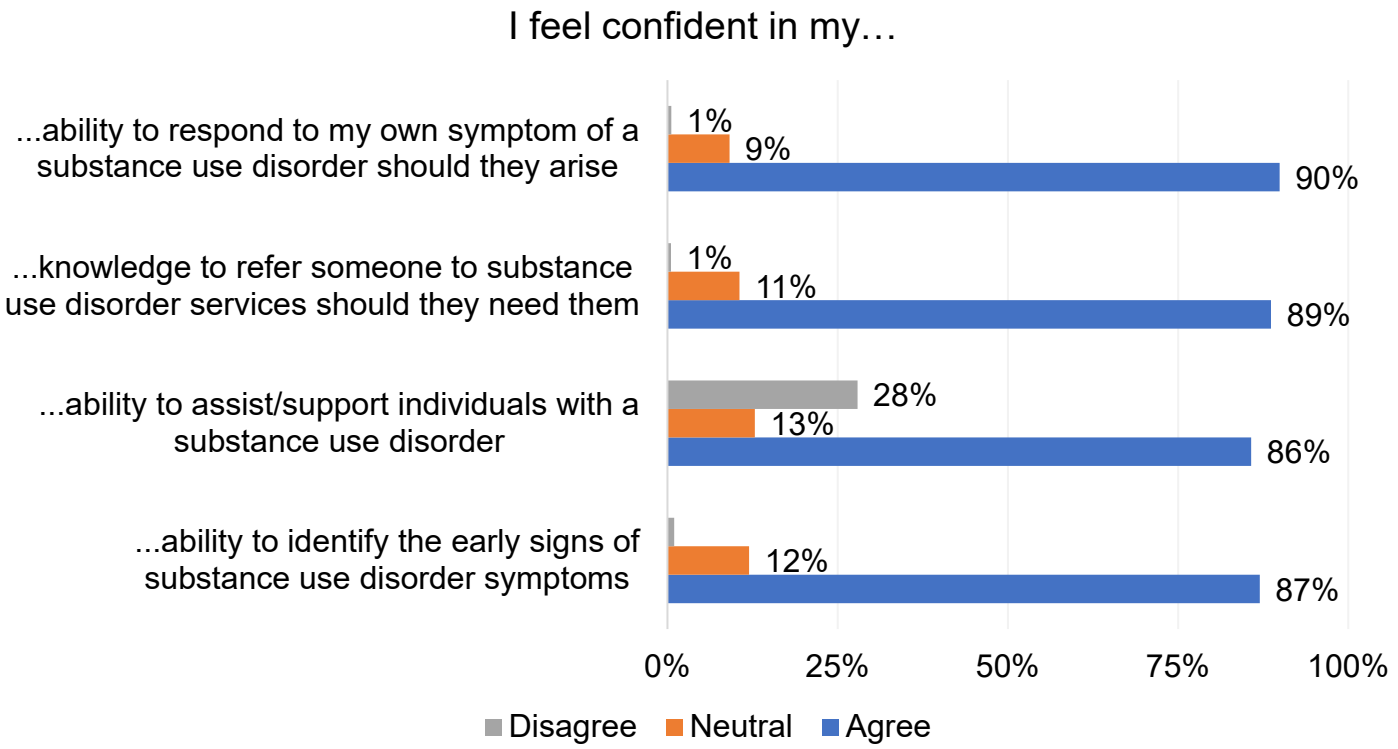
I feel confident in my…

- 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, 87% 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.



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

Challenges/Solutions

Staffing was one of the most significant issues for the SUPPOrT program in Fiscal Year 2023/24. The program has received increased requests to provide outreach and educational activities, requiring more staff to assist with outreach events to provide information on substance use disorder to raise awareness.

As a result, the program will engage in efforts to recruit additional staff in the near future. In addition to this, SUPPOrT will collaborate with DBH's Public Relations and Outreach team for substance use disorder outreach efforts.

Lessons Learned

Program feedback has revealed a need to expand outreach to the mountain communities around Rim Forest, Arrowhead, and Big Bear. The focus will be on creating more places for people to connect with mental health and substance use disorder services. The SUPPOrT program has recently been expanded to include Services to the mountain communities around Rim Forest, Lake Arrowhead, and Big Bear.

Success Story

SUPPOrT is centrally located in San Bernardino County, and staff have the capacity to mobilize to any region in the county. With the implementation of the new San Bernardino County Overdose Dashboard (ODASH), the SUPPOrT team can identify hot spots and target those areas in greater need of harm reduction, prevention, and education.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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 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
Annual Budget FY 25/26	$29,339,303
Cost Per Consumer FY 25/26	$4,493

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 DBH 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 San Bernardino 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 overall success of the program can be measured in the number of participants listed below. The number of unduplicated participants per year exceeded projections.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	6,529	9,633	7,111	8,325
Number of Services	70,969	87,867	86,701	103,926

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.

An important indicator in prevention is the number of services provided to individual participants. When participants return more than once to a prevention activity, it shows that they are comfortable accessing services and willing to continue in a group or educational session. The table below illustrates the unduplicated number of participants who participated in a prevention service, and the number of total services provided.

Prevention	FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	3,231	2,349	5,079
Total Services	2,965	3,262	4,028

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 21/22	2,286	2,141	39%
FY 22/23	2,538	2,042	23%
FY 23/24	2,408	2,044	39%

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 a variety of settings, as detailed below.

Potential Responders Reached			
	FY 21/22	FY 22/23	FY 23/24
Potential Responders	917	1,037	1,231

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 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.

Program Highlights, cont.

Linkages to appropriate resources are part of each program's scope. In the last three fiscal years, SART and EIIS providers in the CYC program did not make any referrals to entities outside of the County. Services were provided internally by DBH programs, demonstrating maximum utilization of MHSA funding.

Access and Linkage to Services Referrals			
	FY 21/22	FY 22/23	FY 23/24
Number of Referrals	2,053	1,919	2,408
County-funded	2,053	1,919	2,408
Non-County Funded	0	0	0
Participants Engaged	1,686	1,919	2,044

Improve Timely Access to Treatment:

The Improve Timely Access to Treatment strategy focuses on delivering appropriate services based on the community's assessed needs to promote access to mental health treatments for underserved populations. The CYC program identified the following as unserved or underserved populations in its referral processes.

Underserved Populations
• African American/Black
• Children at risk of school failure, in stressed families, and risk of removal from home
• Co-occurring
• Foster children/former foster children
• Homeless
• Individuals experiencing the onset of serious psychiatric illness
• Latinx/Hispanic
• Trauma-exposed
• Victims of human trafficking

The table below shows the number of referrals to prevention, early intervention, or treatment beyond early onset service over the last three fiscal years. There was a significant increase in Fiscal Year 2023/24. Most issues with the data have been identified, and we are actively working on solution to address them.

Improving Timely Access Referrals			
	FY 21/22	FY 22/23	FY 23/24
Number of Referrals Provided	3,010	1,919	2,408

Child and Youth Connection (CYC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 21/22	27%	<1%	4%	<1%	68%
FY 22/23	36%	3%	26%	1%	34%
FY 23/24	83%	11%	5%	<1%	1%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	0%
FY 22/23	0%
FY 23/24	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	0%
FY 22/23	0%
FY 23/24	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	0%
FY 22/23	0%
FY 23/24	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	<1%	1%	0%	97%
FY 22/23	1%	8%	0%	90%
FY 23/24	46%	54%	0%	0%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	<1%	1%	0%	97%
FY 22/23	1%	8%	0%	90%
FY 23/24	46%	54%	0%	0%

Child and Youth Connection (CYC), cont.

Demographics, cont.

Demographic Observations

The CYC program successfully reached the largest proportion of children, effectively targeting the intended age group. However, in certain categories a significant number of participants chose not to answer. This is often due to the questions being considered inappropriate for that particular age group.

	Race	FY 21/22	FY 22/23	FY 23/24
Race	African American/Black	14%	16%	34%
	American-Indian/Alaska Native	1%	<1%	<1%
	Asian	1%	<1%	2%
	Latinx/Hispanic	20%	39%	31%
	Native Hawaiian/Pacific Islander	<1%	0%	<1%
	Caucasian/White	15%	12%	27%
	More Than One Race	2%	1%	6%
	Other Race	1%	3%	1%
	Declined to Answer	66%	28%	1%

	Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	1%	1%	6%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	4%	9%	69%
	Filipino	0%	0%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	<1%
	Vietnamese	0%	0%	<1%
	Other	1%	4%	25%
	More Than One Ethnicity	1%	0%	0%
	Declined to Answer	59%	9%	0%

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 use 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 21/22: 1,020 FY 22/23: 1,045 FY 23/24: 1,339

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 include:

- 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.

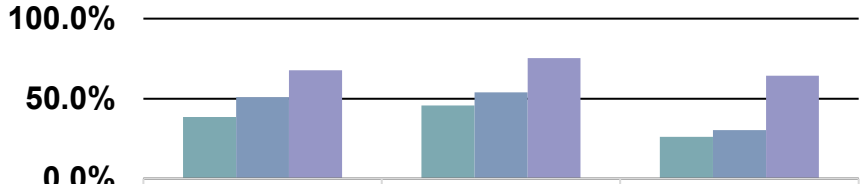
The Ages 0-5 Early Childhood module rates the same sub-domains as the Life Functioning Domain; however, these sub-domains are rated through a lens more focused on the stages of development from ages 0-5 rather than the participant's overall life functioning.

Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

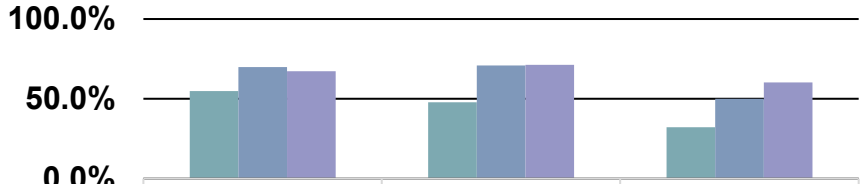
These graphs demonstrate global improvement in life functioning, behavioral/emotional needs, and ages 0-5 early childhood for both EIIS and SART participants of the CYC program. Both programs have maintained an average of 46% improvement in the life functioning domain, 50% improvement in the behavioral/emotional 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 20/21	38.6%	45.7%	26.1%
FY 21/22	51.0%	53.9%	30.4%
FY 23/24	67.8%	75.3%	64.3%

CYC EIIS % Improved by Fiscal Year

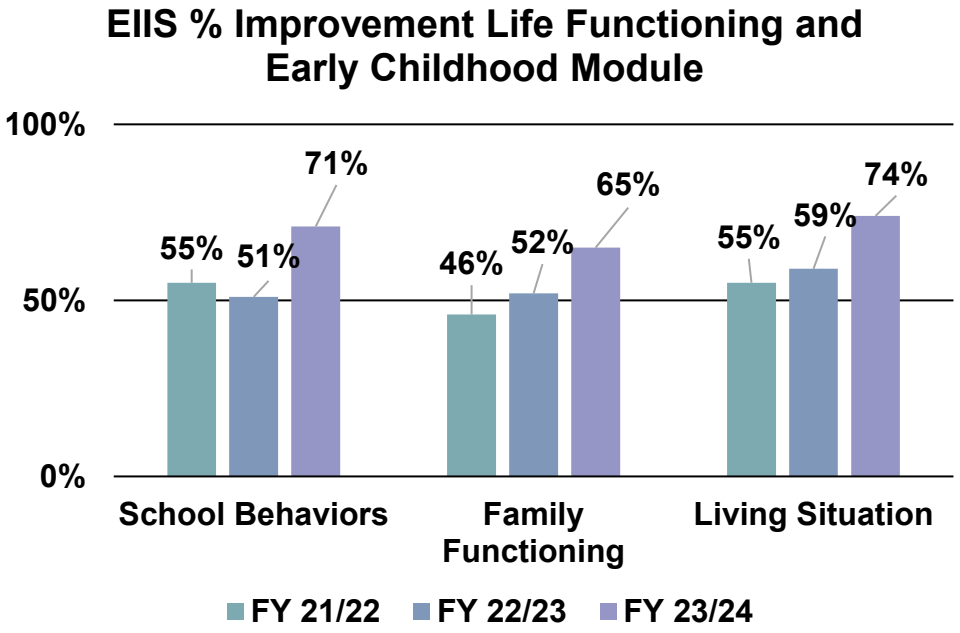


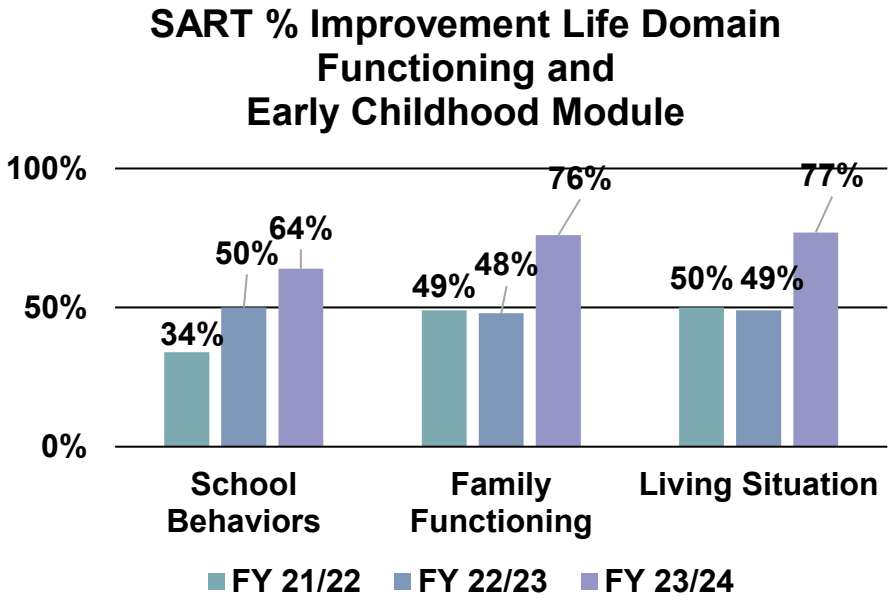
	Life Functioning	Behavioral/ Emotional Needs	Ages 0-5 Early Childhood
FY 21/22	54.9%	47.9%	32.2%
FY 22/23	70.0%	71.0%	50.0%
FY 23/24	67.3%	71.3%	60.2%

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 program steadily improved school behaviors, family functioning, and living situations. School functioning has continued to increase since COVID-19's long-term effects, indicating that children are steadily adjusting to life back in school. These increases also indicate that the children are improving relationships with their families because they engage with the program. Improving the family bonds serves to strengthen protective factors.

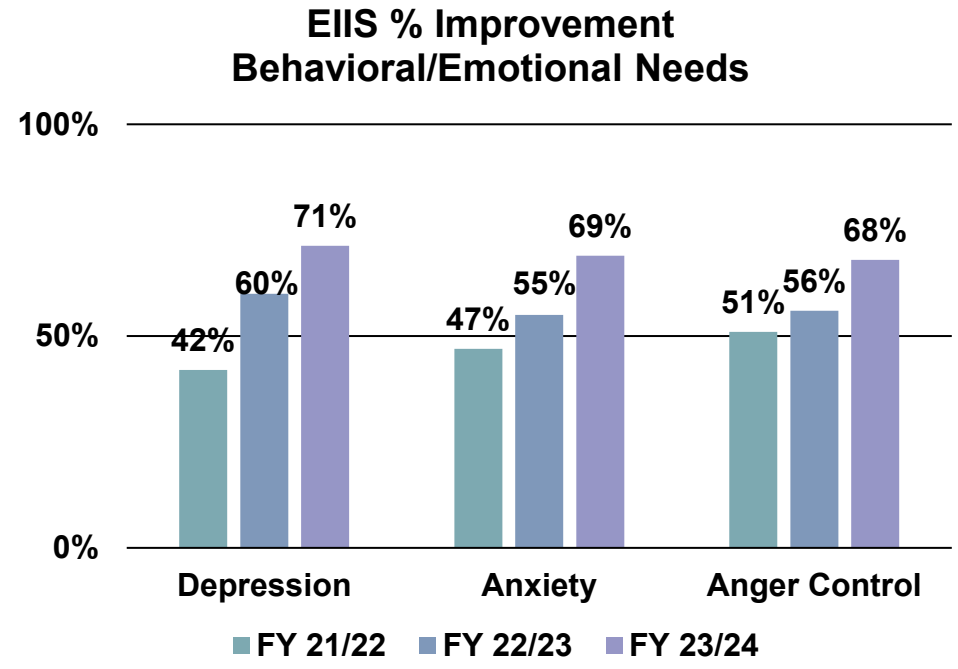


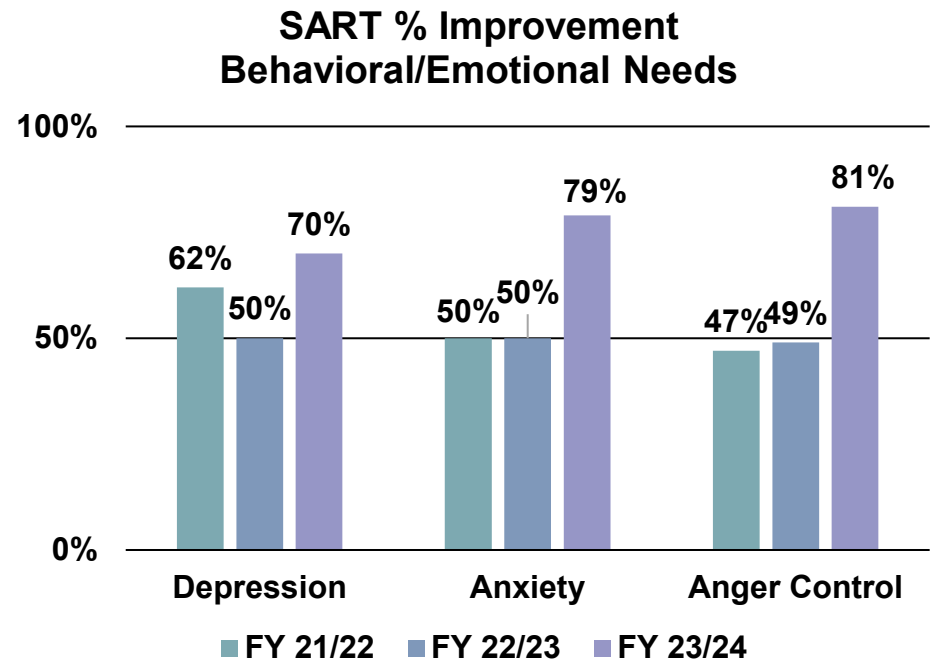


Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

Depression can be a significant barrier to child development. Both programs have been successful in maintaining an average of 53% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 69%. Reducing anxiety leads to improved behavioral and emotional functioning. The program maintains an average improvement of over 50% over the three-year review period.





Child and Youth Connection (CYC), cont.

Challenges/Solutions

The ongoing challenge for CYC providers is caregiver acknowledgment of the benefits of mental health services, especially for younger children and infants. It can be difficult for caregivers to understand the benefits of mental health treatment in infants and young children. Additionally, it can be difficult for caregivers to obtain transportation to and from appointments, as well as integrate treatment into already busy schedules.

The CYC programs work collaboratively with the caregivers to build rapport and provide education so that the caregiver has a full understanding of the benefits and value of mental health treatment. Providers are trained to educate caregivers on the benefits of infant mental health and the significant impact of addressing behavioral and emotional needs within the first few years of life.

Caregivers are provided referrals for resources and offered treatment via telehealth or other platforms to allow greater options for scheduling treatments for the children. Overall, this has helped to decrease missed appointments and increase the cooperation of caregivers.

Lessons Learned

With the implementation of the data collection system, the CYC SART and EIIS providers were directed to discontinue entering some of their data as it would be collected utilizing the DBH Behavioral Health Management Information System (myAvatar). However, due to unforeseen challenges with myAvatar, a more efficient process has been identified for collecting SART and EIIS data from providers. This data collection method will be utilized moving forward.

Child and Youth Connection (CYC), cont.

Success Story

A 7-year-old male was referred to West End Family Counseling Services due to symptoms of depression, anger, anxiety, and problematic peer interactions, which affected his ability to maintain social connections and daily routines. Living with his mother, aunt, cousins, and grandmother, his behavior was disruptive at home and put his school placement at risk.

He went through a comprehensive evaluation by a transdisciplinary SART team and received intensive play therapy to improve coping skills, process family dynamics, boost confidence, and reduce anxiety and anger. His mother collaborated with the team, following recommendations, including implementing a 504 plan to address school behaviors.

The clinical staff worked closely with the child and mother, improving their bond, communication, and interaction. The child showed significant progress over a year of treatment in his daily routine, social interactions, and overall mood. His relationship with his family improved, and he demonstrated increased persistence in challenging tasks. Due to his positive behavior, the 504 plan was not needed this school year.

The child's mother actively supported the treatment process, helping the child use coping strategies and improve confidence. Their connection has strengthened, and the child now responds positively to praise, smiling and hugging his mother when acknowledged for his efforts.

Program Updates

The Children's Assessment Center (CAC) by Loma Linda University Children's Hospital (LLUCH), under this program will have an increase in funding from $62,000 to $165,000 per year. The funding will increase early access and linkage to medically necessary care and treatment by connecting children and youth with severe mental health conditions.

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 San Bernardino 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.

Program Serves	**Children, TAY (16-25), Adults, Older Adults (60+)**
Location of Services	Preschool, In Home, and Counseling Centers
Annual Budget FY 25/26	$425,000
Cost Per Client FY 25/26	$281

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

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 Projected vs Actual				
	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	1,508	697	409	354
Number of Services	3,545	3,183	1,358	1,075

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Building social-emotional skills in preschool-aged children helps them learn to recognize, understand, 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 receive training in using classroom management strategies to meet children's developmental milestones and teach emotional literacy, friendship skills, self-regulation, and problem-solving skills.

The teacher education component of the PPP develops skills for teachers to promote children's social, emotional, and academic competence and to work with parents to support their school involvement promoting consistency between home and school.

Ongoing evaluations ensure that teachers are using classroom management strategies correctly. The effectiveness of these strategies is evidenced by the improvement in key areas within the Desired Results Development Profile (DRDP).

In Fiscal Year 2022/23, an emerging trend indicated a decrease in self-regulation among preschoolers. In response, PSD Class Teacher Coaches were utilized to address intervention strategies and provide Second Step curriculum training to teachers and Behavioral Health Specialists received training on the Teaching Pyramid curriculum.

Fiscal Year 2023/24 saw the continued support for Second Step and the Teaching Pyramid curriculums by adding additional guidance through training and integrated coaching.

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 Fiscal Year 2023/24, PPP transitioned to a new program to address loss. The Living in Grief Healing Together (LIGHT) Program is an eight-week workshop for enrolled PSD children, facilitated by MFT Interns and supervised by a Clinical Supervisor. The LIGHT team focuses on discussing loss, fostering hope, and understanding emotions. The program works with children who have experienced trauma, especially grief and loss.

Number of Children Participating in the TLC Group		
FY 2021/22	FY 2022/23	FY 2023/24
18	76	0

Number of Children Participating in the L.I.G.H.T. Program		
FY 2021/22	FY 2022/23	FY 2023/24
0	0	43

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 21/22	53%	45%	30%	1%	4%
FY 22/23	51%	4%	26%	1%	18%
FY 23/24	54%	5%	33%	1%	7%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 21/22	0%
FY 22/23	0%
FY 23/24	0%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 21/22	0%
FY 22/23	0%
FY 23/24	<1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 21/22	3%
FY 22/23	5%
FY 23/24	4%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	28%	44%	0%	26%
FY 22/23	32%	38%	0%	30%
FY 23/24	19%	34%	<1%	46%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	84%	7%	2%	0%
FY 22/23	79%	7%	1%	0%
FY 23/24	84%	6%	1%	9%

Preschool PEI Program (PPP), cont.

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	20%	21%	24%
	American-Indian/Alaska Native	2%	<1%	1%
	Asian	0%	2%	0%
	Hispanic/Latinx	0%	1%	<1%
	Native Hawaiian or Pacific Islander	0%	1%	1%
	Caucasian/White	33%	31%	27%
	More than One Race	5%	0%	6%
	Other Race	1%	7%	40%
	Declined to Answer	35%	37%	34%

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	0%	2%	<1%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	3%	0%
	Eastern European	0%	0%	0%
	European	0%	2%	0%
	Hispanic/Latinx	42%	88%	18%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	1%	1%
	Vietnamese	0%	0%	0%
	Other	0%	3%	9%
	More than one ethnicity	1%	3%	0%
	Declined to Answer	58%	3%	52%

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 Development 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 21/22: 2,451 FY 22/23: 1,290 FY 23/24: 1,219

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 2021/22			FY 2022/23			FY 2023/24		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Identity of Self in Relation to Others	49%	65%	16%	48%	70%	76%	52%	79%	66%
Social and Emotional Understanding	46%	62%	16%	48%	67%	75%	48%	75%	67%
Relationships and Social Interactions with Familiar Adults	48%	68%	20%	52%	70%	80%	54%	81%	67%
Relationships and Social Interactions with Peers	53%	72%	19%	58%	76%	82%	59%	84%	70%
Symbolic and Sociodramatic Play	29%	44%	15%	33%	44%	59%	*	*	*

*Not included in FY 2023/24 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.

Challenges/Solutions

Children enrolling in preschool after COVID-19 have demonstrated serious self-regulation concerns. An increasing number of preschool-age children are entering the classroom and consistently posing a safety threat to themselves and other children. Additionally, the PPP encountered barriers of low participation in Theraplay, a form of structured therapy to address building adult-child relationships. Interactive, physical, and fun activities are used to create healthy caregiver-child attachment.

To support increased usage of Theraplay, PSD has incorporated nine trainings in the program year, with five days exclusively set for Teaching Pyramid modules. An additional support of coaching is integrated to assist staff with implementation of Theraplay interventions. Theraplay groups are now being offered with increased fidelity and support.

Lessons Learned

Parents or caregivers and preschool teaching staff can lack the training necessary to understand and provide effective intervention strategies for preschool children. PSD continues to engage various mental health professionals to evaluate DRDP and background data to identify areas of need.

Program Updates

This program is being evaluated for transition to early intervention program for children ages 0-5.

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

Success Stories

"[The student] has now made his transition over to TK. In our time together, we focused on engagement and better communication with mom. [The student] is now more confident with expressing his feelings and sharing why something made him upset or why he reacted the way he did when he was asked about it. He has improved in using his words instead of just screaming or crying loudly at mom. He is also more redirectable compared to when we first started. Overall, his mom feels that improvements have been made and that she's appreciative of the services that were given to [The student]."

-MFT Intern #1

"In our time together with [The student] and their family, we focused on structure and nurture between them and mom. With each home session, [The student] was easily able to redirect their attention and efforts back to the activity. Their listening skills improved with both mom and therapist interns. Lastly, [The student] improved on their communication. For example, they would ask rather than demand for something… and they are more able to acknowledge their emotions when asked about it. We also saw mom and [The student's] bond become closer throughout each session. Once again, mom feels that [The student has] made major improvements and is also appreciative of the services that were provided."

-MFT Intern #2

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
Annual Budget FY 25/26	$1,700,688
Cost Per Client FY 25/26	$358

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 21/22	FY 22/23	FY 23/24
Unduplicated Individuals	4,753	1,078	1,076	1,464
Number of Services	8,339	5,962	7,474	9,136

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 grade 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 session, 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 adjacent chart shows the number of early intervention services as reported by the RPiAAC program.

Early Intervention Individuals / Services			
	FY 2021/22	FY 2022/23	FY 2023/24
Unduplicated Individuals	41	42	75
Number of Services	239	908	1,950

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

State Program Positive Results, cont.

Early Intervention, cont.

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. Partially successful means that the individual did not meet all their goals but met most. It can also mean that the individual discontinued services early due to relocation. The information 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 2021/22	335	122	38%
FY 2022/23	335	51	38%
FY 2023/24	467	5	73%

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.

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.

State Program Positive Results, cont.

Outreach, cont.

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 below illustrates the number of potential responders reached during each of the three previous fiscal years.

Potential Responders Reached			
	FY 2021/22	FY 2022/23	FY 2023/24
Potential Responders	977	992	932

Artwork by Lana Manzo

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

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	13%	4%	0%	0%	83%
FY 22/23	12%	6%	0%	0%	83%
FY 23/24	40%	15%	17%	6%	22%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	0%
FY 22/23	0%
FY 23/24	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	0%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	0%
FY 22/23	0%
FY 23/24	6%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	34%	51%	0%	15%
FY 22/23	30%	46%	0%	22%
FY 23/24	34%	52%	<1%	14%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	88%	0%	12%	0%
FY 22/23	89%	1%	<1%	10%
FY 23/24	76%	5%	<1%	19%

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

Demographics, cont.

Demographic Observations

- The RPiAAC program has consistently served the target population over the last three fiscal years, with 55% of the individuals served being children and TAY aged 0-25 years old. This aligns with the program's target population.
- Although the program focuses on African American/Black students, RPiAAC continues to successfully reach individuals who identify as Latinx/Hispanic.
- There is an increase in adults aged 26-59, showing that more parents are engaged by the program.

	Race	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	77%	70%	59%
	American-Indian/Alaska Native	0%	0%	0%
	Asian	0%	<1%	<1%
	Latinx/Hispanic	18%	25%	12%
	Native Hawaiian or Pacific Islander	0%	<1%	<1%
	Caucasian/White	4%	6%	17%
	More than One Race	4%	2%	2%
	Other Race	1%	6%	5%
	Declined to Answer	3%	6%	5%

	Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	82%	74%	41%
	Asian Indian/South Asian	0%	<1	<1%
	Cambodian	0%	0%	<1%
	Chinese	0%	0%	0%
	Eastern European	1%	7%	1%
	European	3%	0%	6%
	Hispanic/Latino	18%	25%	39%
	Filipino	0%	1%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	<1%	0%
	Vietnamese	0%	0%	<1%
	Other	6%	4%	9%
	More than one ethnicity	4%	7%	3%
	Declined to Answer	2%	6%	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 use 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 21/22: 31 FY 22/23: 32 FY 23/24: 80
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 21/22: 305 FY 22/23: 377 FY 23/24: 689

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,
- Reduction in 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.

The knowledge gained in the Alcohol and Substance Use and Anger Management courses intends to provide identity skills and resources that help develop a healthy, positive lifestyle that can reduce involvement with law enforcement and courts.

On average, youth exhibited an improvement of 11% in their cognitive life skills and skills managing substance and alcohol use and anger management.

NCTI Youth Crossroads			
Curriculum	**Average Pre-Test**	**Average Post-Test**	**Percent Improvement**
Cognitive Life Skills	4.65	5.71	11%
Alcohol and Substance Use	3.70	3.80	2%
Anger Management	3.57	3.83	5%

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

Challenges/Solutions

In today's competitive job market, the RPiAAC program faces challenges with recruitment and retention for some of the programs staff positions. Some of the program's positions are filled by intern staff through a collaboration with local colleges and universities.

The program continues to explore the best paths to access of information management systems and data collection methods to report outcomes. DBH continues it's collaboration efforts with RPiAAC providers to create streamlined access to all reporting databases.

Lessons Learned

In FY 2023/24, the RPiAAC has been successful in building relationships with schools in the high desert region, which has helped the program improve access and linkage to services for at-risk youth.

Success Stories

"This program has taught us how to confront our emotions in everyday life as teens in real life situations and as a result, make ourselves better."

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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
Annual Budget FY 25/26	$963,818
Cost Per Consumer FY 25/26	$227

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 provided below offers an overview of the planned service objectives and the 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 surpasses the projected participation targets, aligning with the prevailing trends in mental health services

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	4,240	11,438	8,957	8,534
Number of Services	6,126	4,181	5,755	4,443

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 over 20,000 participants, also known as potential responders, across FYs 2021/22, 2022/23, and 2023/24.

Potential Responders Reached			
	FY 21/22	FY 22/23	FY 23/24
Potential Responders	9,911	8,988	8,534

Potential participants in this program are 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 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 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 information below illustrates the Early Intervention data for the last three fiscal years.

Number of Open Episodes by Fiscal Year			
	FY 21/22	FY 22/23	FY 23/24
Open Episodes at any time during the fiscal year	21	33*	22

*FY 22/23 reported numbers were incorrect, actual numbers have been updated

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 become more comfortable with technology.

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Early Intervention Services

Treatment Success by Fiscal Year			
	FY 21/22	FY 22/23	FY 23/24
Treatment Successful	33%	15%	32%
Treatment Partially Successful	22%	33%	29%
Treatment Not Successful	38%	44%	36%
Missing or Other	14%	7%	7%

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 21/22	0%	0%	<1%	27%	72%
FY 22/23	0%	0%	<1%	29%	71%
FY 23/24	1%	0%	<1%	20%	73%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	<1%
FY 22/23	<2%
FY 23/24	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	5%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	3%
FY 22/23	3%
FY 23/24	26%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	18%	51%	0%	31%
FY 22/23	13%	35%	0%	52%
FY 23/24	18%	50%	0%	32%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	10%	2%	0%	88%
FY 22/23	12%	3%	<1%	85%
FY 23/24	27%	3%	<1%	70%

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 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.

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Race	African American/Black	1%	<1%	<1%
	Native American or Alaskan Native	<1%	<1%	<1%
	Asian	<1%	<1%	<1%
	Latinx/Hispanic	3%	4%	<1%
	Native Hawaiian/Pacific Islander	0%	0%	<1%
	Caucasian/White	6%	8%	12%
	More than One Race	<1%	<1%	<1%
	Other	<1%	1%	1%
	Declined to Answer	67%	84%	82%

Older Adult Community Services (OACS), cont.

Demographics, cont.

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	2%	<1%	<1%
	Asian Indian/South Asian	1%	0%	<1%
	Cambodian	0%	0%	0%
	Chinese	1%	<1%	<1%
	Eastern European	0%	0%	0%
	European	30%	20%	18%
	Hispanic/Latino	3%	4%	1%
	Filipino	1%	<1%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	<1%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	5%	2%	1%
	More than One Ethnicity	2%	1%	3%
	Declined to Answer	57%	75%	75%

Older Adult Community Services (OACS), cont.

Program Goals

The 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.
- Promoting healthy aging through prevention programing.

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.

Artwork by Peter Millar

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 21/22: 65 FY 22/23: 35 FY 23/24: 21
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 21/22: 255 FY 22/23: 42 FY 23/24: 828
Outreach Questionnaires	A seven-item questionnaire that assesses a participant's improved knowledge of signs and symptoms that can lead to a potentially serious mental illness.	• Pre/Post Mental Health Education Presentation and/or Activity	FY 21/22: 52 FY 22/23: 73 FY 23/24: 347
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 21/22: 25 FY 22/23: 30 FY 23/24: 37

Older Adult Community Services (OACS), cont.

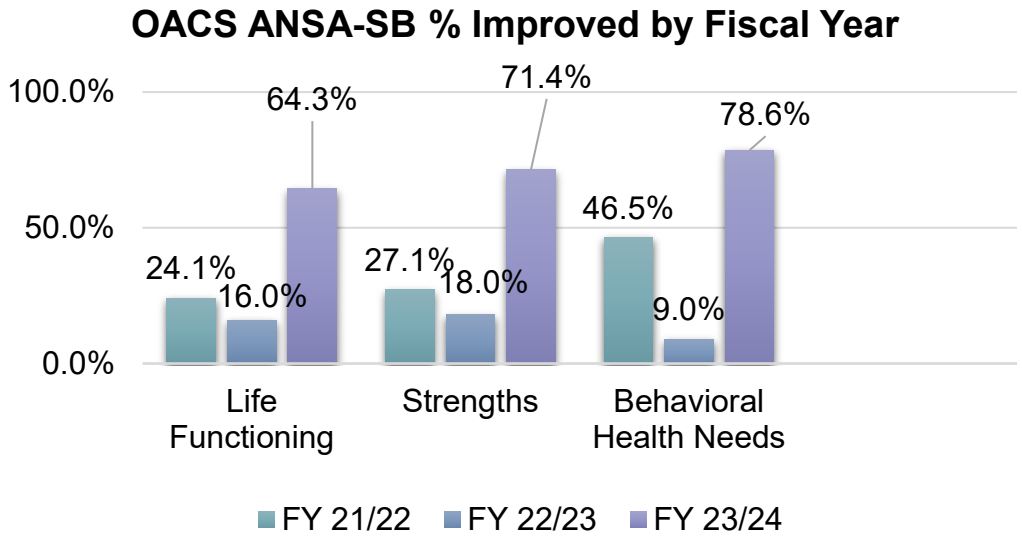
Outcome Discussion

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 dimensions 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 23/24, all three areas saw a significant improvement, since COVID-19. Providers are working on innovative strategies to engage older adults and continue to 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.

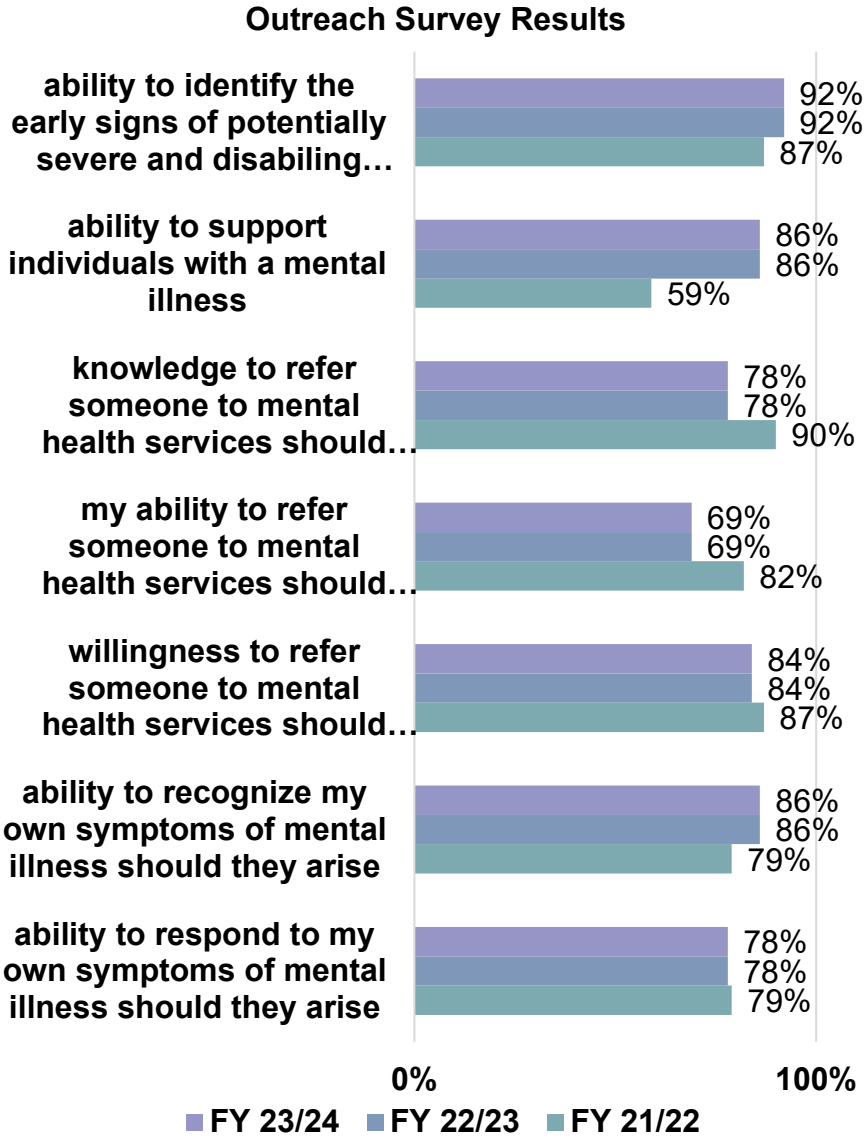
Outreach Survey Results

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 23/24, 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.



Older Adult Community Services (OACS), cont.

Outcome Discussion, cont.

Consumer Satisfaction Surveys

OACS participant satisfaction is critical to the success of the OACS program. The participants are frequently surveyed on activities they want to engage in and educational topics they want to learn. The programming concerns the responses received to reduce stigma and increase engagement. Most, if not all, are satisfied with the program's services. The following represents the average results over the three-year review period.

Fitness Activity Results – Activities designed to improve physical/mental health, mobility, strength and decrease isolation.

74% stated that the program helped improve their mental health.
83% stated that they would continue walking due to the effects on their physical health.
65% stated improvements in quality time spent with friends and family.

OACS Wellness Services – Activities designed to increase knowledge on all aspects of wellness, increase socialization, and decrease isolation.

100% of OACS participants agreed or totally agreed that participants improved their knowledge of mental health and stigma reduction.
100% of OACS Wellness presentation participants agreed that the presentations were useful and the speaker delivered information.

OACS Mobile Outreach and Health Screenings – Designed to decrease transportation barriers and increase access to services by providing on-site assessments and screenings for OACS participants.

98% of participants said they learned something new at the Mobile Outreach or Health screening event.
100% of participants found value in having services delivered in mobile settings.

Older Adult Community Services (OACS), cont.

OACS Program: Addressing Service Access Challenges

The OACS providers continue to face challenges in connecting participants to timely Early Intervention and Psychiatric services, particularly for those with private insurance or requiring a higher level of care. These challenges are especially pronounced in the mountain communities, where there is a shortage of mental health service providers. This shortage creates significant transportation difficulties for older adults, who often must travel long distances to access necessary services.

Another ongoing challenge for the OACS program is identifying and providing services to homebound or isolated seniors, especially during the winter months in remote areas of the county. The mountain regions, in particular, are impacted by harsh weather conditions, making it difficult for seniors to receive in-person support. To combat isolation issues, OACS providers increase the frequency of safety calls to participants, especially during severe weather. Additionally, they offer a range of seminars and workshops focused on topics such as:

- The benefits of socialization.
- Stress reduction strategies.
- Locating and accessing local resources.

The OACS program focuses on activities tailored specifically to older adult men, a group that is often less engaged in traditional wellness programs. These activities include male-centric workshops, fitness classes, and peer-led support groups to foster camaraderie and encourage participation in mental and physical health initiatives. Additionally, the program addresses transportation challenges faced by seniors, especially in rural areas, by partnering with health insurance providers to offer free or subsidized transportation to medical appointments. The OACS provides workshops to help seniors navigate public transit, enhancing their mobility and access to essential services and community activities.

Older Adult Community Services (OACS), cont.

Lessons Learned

The use of technology with the older adult population is not ideal. It has been found that many older adults do not have access to a computer or smartphone. Many others have no interest in learning how to use platforms such as Zoom or Facebook to access mental health services. Increased technological use has been more beneficial for those with physical disabilities as they are more accustomed to embracing creative ways to stay connected.

Peer and Family Advocates have been the most successful component of the program. The advocates are trusted members of the program and were able to continue contact with participants during the pandemic. They were critical for information dissemination via telephone, and the participants felt more connected with their involvement.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

Success Story

An 83-year-old Caucasian male self-referred to the early intervention services program, seeking support for symptoms of anxiety and mild depression. He had recently been diagnosed with Parkinson's disease, a life-altering condition that significantly impacted his daily functioning and life skills. Compounding his struggles, he had also experienced the sudden death of his son about a year prior, leaving him grappling with grief.

Through his participation in EIS, the individual was able to address both his grief and the emotional impact of his declining health. With the guidance of the program, he learned to reframe his losses, shifting his focus from what he could no longer do to what he could still achieve, He also worked on strengthening his family relationships and finding renewed meaning and support through his connections with loved ones.

Over time, the individual felt he had made significant progress. He reported that he was now grieving more healthily and had gained a more positive outlook on his abilities, with strong family support. He ultimately decided to conclude his time in the program, feeling confident that he had met his personal goals and was ready to move forward.

Lift Program

Program Description and Target Population

The Lift Program is a prevention program that is a collaborative effort between the Department of Behavioral Health and the San Bernardino County Preschool Services Department. It is designed to improve the health, well-being, and self-sufficiency for pregnant and parenting mothers, their children, and their families. Nurses visit the individual in their own home and provide education to promote the physical and emotional care of the newborn child.

First-time pregnant mothers who meet income guidelines are given priority enrollment. Mothers with other risk factors are also eligible. These risk factors include homelessness, teenaged moms, child welfare involvement, at-risk for juvenile justice involvement, and pregnant mothers exhibiting signs of depression.

Pregnant mothers receive in-home visits from registered nurses who provide education about the connection between physical and mental health, as well as information about the developmental stages of their children. They provide supportive strategies to ensure that children and family thrive in their environment.

Referrals to the Lift program come from various sources, including community hospitals, local high schools, pregnancy resource centers, homeless shelters, faith-based organizations, the Black Infant Health program, and Women, Infant, 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
Annual Budget FY 25/26	$396,000
Cost Per Client FY 25/26	$3,300

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 21/22	FY 22/23	FY 23/24
Unduplicated Participants	120	154	52	65
Number of Services	1,728	759	360	511

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 from the past three years. In the most recent fiscal year, 65 mothers were screened for signs of depression, highlighting an increased need for support to prevent depression from becoming severe or disabling. Lift nurses continue to provide support and monitor all participants in the program, regardless of their engagement with the program or any other mental health services.

Identification of Depression Related Mental Health Needs

	FY 2021/22 (N=46)	FY 2022/23 (N=52)	FY 2023/24 (N=65)
Exhibited signs of depression	1	6	22
Received mental health supportive services	1	6	6
Required clinical intervention	1	4	0

Lift Program, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 21/22	39%	18%	27%	0%	4%
FY 22/23	63%	0%	37%	0%	0%
FY 23/24	0%	8%	32%	0%	60%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	0%
FY 22/23	0%
FY 23/24	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	1%
FY 22/23	2%
FY 23/24	6%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	2%
FY 22/23	6%
FY 23/24	3%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	21%	69%	0%	9%
FY 22/23	20%	69%	0%	11%
FY 23/24	0%	74%	0%	26%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	74%	8%	7%	8%
FY 22/23	78%	9%	10%	4%
FY 23/24	74%	5%	6%	15%

Lift Program, cont.

Demographics, cont.

Demographic Observations

The Lift program primarily targets first-time pregnant women, new mothers, and with their 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. However, members of the Asian and Native Hawaiian and Pacific Islander communities are not currently participating in the Lift program. Efforts will be made in the upcoming program years to engage this community.

Lift Program, cont.

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	22%	27%	21%
	American-Indian/Alaska Native	2%	3%	3%
	Asian	0%	0%	0%
	Hispanic/Latinx	4%	0%	7%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	Caucasian/White	27%	10%	34%
	More than One Race	8%	0%	0%
	Other Race	10%	26%	3%
	Decline to Answer	27%	34%	30%

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	5%	9%	3%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	71%	52%	39%
	Filipino	1%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	6%
	Vietnamese	0%	0%	0%
	Other	0%	3%	9%
	More than one ethnicity	10%	11%	0%
	Decline to Answer	59%	25%	29%

Lift Program, cont.

Program Goals

The goal of the Lift Program is to promote healthy outcomes for at risk mothers and their infants though 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:

- Improve pregnancy outcomes by helping participants obtain prenatal care from their physician and reduce cigarette, alcohol, and illegal drug use.
- Teach participants about healthy nutrition during pregnancy to improve overall mental health outcomes for mother and child.
- Improve child health and development by helping parents provide appropriate care of their children in the first two years of life.
- Guide parents on caring for and nurturing their children and provide safe and consistent child discipline practices.
- Improve maternal development by helping mothers to develop a vision and plan for their future, make reasoned choices about the partners, family, and friends involved with their child, plan future pregnancies, reach their educational goals, and find employment.

Program Outcomes

Method use 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 21/22: 46 FY 22/23: 52 FY 23/24: 65
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 21/22: 40 FY 22/23: 52 FY 23/24: 65

Lift Program, cont.

Outcome Discussion

Maternal Fetal Attachment Scale (MFA)

The MFA Scale is a questionnaire that assesses the bond between expectant mothers and their unborn child, with higher scores indicating stronger prenatal attachment. The MFA is administered to participants in the Lift program, and the results help identify their unique needs.

Addressing early indicators of maternal-fetal attachment enhances protective factors for both mother and baby, fostering bonding, strengthening family support, and promoting a stable, healthy home environment—all of which contribute to positive child outcomes.

Lift nurses provide individualized support based on MFA findings, focusing on areas such as mothers' willingness to forgo harmful activities, body image, future hopefulness, and reading to their unborn child. Support may include education, nurturing activities, and family counseling, which help develop more positive relationships.

Artwork by Tracey Garcia

Lift Program, cont.

Outcome Discussion, cont.

Nurturing & Attachment			
	FY 2021/22	FY 2022/23	FY 2023/24
I desire this baby / I'm not sorry I became pregnant	100%	100%	90%
I am willing to give up certain things to protect my baby	67%	94%	85%
I read to my baby / unborn child	50%	53%	48%

Family Supports			
	FY 2021/22	FY 2022/23	FY 2023/24
My mate wants this pregnancy	0% No	0% No	17% No
My pregnancy interferes with my relationship with my mate	33% Yes	22% Yes	20% Yes
My family supports my pregnancy	72% Yes	63% Yes	77% Yes
My family will help in caring for my baby	65% Yes	82% Yes	77% Yes

Family support is a valuable protective factor. A new mother or expectant mother relies heavily on the support received from close family and friends during pregnancy and in the early years of the newborn's life.

The Family Supports chart indicates that over the past three years, there has been an increase in respondents reporting that their partner did not want the pregnancy, but there was a slight decrease in those who felt that their pregnancy interfered with their relationship. Participants expressing these feelings are offered family counseling to help address and reconcile them.

Feelings of family support for the pregnancy have risen during this three-year review. Involving all family members in the Lift program interventions strengthens the support system for expectant mothers throughout their pregnancy.

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 monitors 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 2023/24, the percentage of participants with less than a high school education significantly increased from the past year which is reflected in the decrease of stable employment.

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 increased 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 2021/22	FY 2022/23	FY 2023/24
Less than high school education	1%	2%	17%
Unemployed / work occasionally	61%	69%	72%
Some college	26%	46%	34%
Stable employment	26%	31%	17%

Lift Program, cont.

Challenges/Solutions

The LIFT team consists of 1 Supervising Nurse case manager (Vacant since August 2022) and 3 Home Visiting Registered Nurses (RN). This year LIFT had the challenges of the ongoing staffing issues where two of the three RN staff were out for extensive periods of time. This had a direct impact on recruitment efforts and put a strain on the remaining staff to manage the existing caseload.

Lessons Learned

Despite the challenges the department learned to prioritize caseloads to continue the delivery of services to existing clients and reduced the effort of recruiting new clients as referrals continued to come in from our partnerships.

Program Updates

This program is being evaluated for transition to early intervention program for children ages 0-5.

Success Story

"My experience with the Lift program is good, because it came into my life when I really needed it. It gave me very valuable information that was essential at that time. Like the stages I was going through in my pregnancy, how I was preparing for the arrival of a new baby, information on good nutrition, caring for the new baby and how I should also take care of myself. Another thing I am grateful for is the financial help with some essential and safe products for the baby. I recommend this program to all pregnant mothers because it will help them gain knowledge about this new stage of their life and it will also help them financially to have the basics for the arrival of their new baby. Coni was not only [my baby's] and my nurse, she also managed to do something more for me and my [other] children because she was always there to support us."

- Participant

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 works to educate the community, intervene with at-risk youth, and provide vital services and support to children and teens who are victims of commercial sexual exploitation. Through education and training, CASE helps raise awareness of the issue, teaches how to recognize the signs of exploitation, and ensures direct access to resources and treatment for affected youth.

The CASE team is a multidisciplinary group that includes CFS, the Public Defender's Office, and Behavioral Health, as well as attorneys from the District Attorney's Office and Public Defender's Office. In addition, probation officers, public health nurses, advocates from Court Appointed Special Advocates (CASA) and Open Door are part of the collaborative effort. Together, these professionals work to provide comprehensive services to youth who have been identified as commercially sexually exploited.

CASE's primary aim is to reduce both the number of youth who are exploited and the risk factors that contribute to exploitation. By focusing on prevention, the coalition strives to decrease these risks while strengthening protective factors for vulnerable children and teens. This multi-agency model supports state-level prevention initiatives designed to protect at-risk 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
Annual Budget FY 25/26	$255,266
Cost Per Client FY 25/26	$170

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results

The CASE program works to reduce prolonged suffering associated with untreated mental illness by recognizing signs of CSEC involvement and providing access to services early, thereby addressing risk factors and promoting protective factors. Their goals are as follows:

- Train agency staff on identifying and recognizing signs of commercial sexual exploitation of children (CSEC).
- Raise public awareness of CSEC issues.
- Raise knowledge of available community resources.
- Identify youth who are potential CSEC victims and provide access to needed resources and treatment.

Risk factors identified for CASE participants are running away, trauma exposure (e.g., history of sexual abuse and child welfare or probation system involvement), school failure/chronic absenteeism, poverty, substance use, and violence.

Protective factors for CASE participants include positive adult interactions, school/community involvement, resourcefulness, resiliency, peer relationships, 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 help reduce the risk factors for homeless/runaway youth.
- Support, consultations, and advocacy from the San Bernardino Superintendent of Schools, Probation, and the District Attorney's office to help reduce risk factors for youth with a history of violations with truancy, curfew, and/or involvement with the juvenile justice system.
- Creation of safety plans, CFS Social Worker assignment, Child Family Team (CFT) meetings, mentor assignment, Public Health, and therapeutic services are available to youth that face sexual abuse, physical abuse, and neglect risk factors.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	1,500	1,398	1,661	1,626
Number of Services	1,500	1,920	2,044	1,971

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

Prevention activities include ongoing, individualized engagement between the CSEC youth and the multidisciplinary team. There were forty-two total CASE participants in FY 2023/24. The total number of participants is higher than the previous year but remains lower than the high of 58 from FY 2021/22 as shown in the table below.

Number of Prevention Participants			
	FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	58	35	42
Number of participants continuing from previous year	40	24	25
Percentage of continuing participants	69%	69%	60%

Girls' Court

A prevention activity for CASE is Girls' Court, a program for at-risk females between the ages of 12 and 17 who are involved in the legal system. Girl's Court focuses on self-esteem-building and empowerment components for young women. If they complete the program successfully, their criminal records are sealed before turning 18 to alleviate further stigmatization of having prior juvenile justice involvement.

Graduation from Girls' Court requires participants to show progress in the program, meet benchmarks, and obtain supervision goals. The youth's changes demonstrate healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuits, and well being. Participation in Girls' Court reduces negative outcomes by encouraging participants to remain enrolled in school, fostering academic achievement, reducing school dropout rates and attempts to reduce recidivism and incarceration rates by the participants' commitment to healthy lifestyle choices and pro-social behavior.

Girls' Court Completion Rate			
	FY 21/22	FY 22/23	FY 23/24
Completion Rate	20%	41%	26%

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

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

CASE uses the state strategy, outreach for increasing recognition of Early Signs and Symptoms of Mental Illness, as a way to involve child-serving agencies and the community in identifying children who may be at risk of sexual exploitation and provide information and resources on how to keep children safe.

Outreach and education efforts focus on training agency staff on identifying and recognizing signs of commercial sexual exploitation (CSE) in youth, raising public awareness of commercial sexual exploitation of children (CSEC) issues, raising knowledge of available community resources, and increasing the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment.

During FY 2023/24, the CASE program provided educational outreach to 1,971 potential responders, including staff from law enforcement agencies, probation department, attorneys, school personnel, health care providers, and local area community service providers.

Artwork by Sonia Stockton

Coalition Against Sexual Exploitation (CASE), cont.

State Program Positive Results, cont.

In terms of being able to identify youth who are potential CSEC victims, 88% reported that they can recognize key terms relating to CSEC victims and the subculture of trafficking, and 93% now have an increased understanding of trauma bonds and identifying signs of CSEC involvement, as shown in the table below:

Program Goals	
Goal: Raise awareness of CSEC issues	
Ability to define / describe human trafficking	95%
Increased knowledge and awareness of recruiting tactics and locations	93%
Goal: Raise knowledge of available community resources	
Knowledgeable about available resources for CSEC youth	75%
Goal: Identify youth who are potential CSEC victims	
Able to recognize key terms relating to CSEC victims and the subculture of trafficking	88%
Understanding trauma bonds / identifying signs of CSEC involvement **N**=275	92%

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.

Coalition Against Sexual Exploitation (CASE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	0%	11%	20%	1%	68%
FY 22/23	4%	24%	56%	4%	12%
FY 23/24	3%	27%	52%	2%	3%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	0%
FY 22/23	3%
FY 23/24	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	1%
FY 22/23	4%
FY 23/24	3%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	0%
FY 22/23	4%
FY 23/24	4%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	10%	23%	0%	60%
FY 22/23	16%	33%	1%	50%
FY 23/24	14%	28%	0%	58%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	100%	0%	0%	0%
FY 22/23	100%	0%	0%	0%
FY 23/24	48%	2%	1%	49%

Coalition Against Sexual Exploitation (CASE), cont.

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	0%	0%	0%
	Asian Indian/South Asian	2%	0%	2%
	Cambodian	0%	0%	0%
	Chinese	0%	6%	1%
	Eastern European	0%	0%	1%
	European	0%	0%	0%
	Hispanic/Latino	43%	88%	41%
	Filipino	2%	0%	<1%
	Japanese	0%	1%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	1%	0%
	Vietnamese	0%	0%	<1%
	Other	0%	3%	58%
	More than one ethnicity	0%	1%	<1%
	Declined to Answer	51%	5%	1%

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.
- Creation of the "CASE Database" enabled CASE to enter client information on a monthly basis from the beginning of Fiscal Year 2023/24.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	3%	13%	12%
	American-Indian/Alaska Native	0%	1%	<1%
	Asian	3%	4%	3%
	Hispanic/Latinx	2%	10%	0%
	Native Hawaiian or Pacific Islander	0%	<1%	<1%
	Caucasian/White	9%	20%	12%
	More than One Race	0%	0%	7%
	Other Race	0%	6%	2%
	Declined to Answer	83%	46%	63%

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 use 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 21/22: 40 FY 22/23: 24 FY 23/24: 25
Girl's 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 21/22: 40% FY 22/23: 21% FY 23/24: 26%
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 21/22: 214 FY 22/23: 335 FY 23/24: 275

Coalition Against Sexual Exploitation (CASE), cont.

Outcome Discussion

Continuing Engagement

One of the challenges associated with CSEC youth is maintaining continuing engagement. A key indicator of success is building trust and rapport with the youth and allowing them to continue to engage in needed services. One measure of success is continued participation in the CASE program. The percentage of continuing participants in FY 21/22 increased to 69% with 40 of the 58 active participants returning. In FY 22/23, although the total number of participants declined, the percentage of those who continued stayed steady, with 24 of 35 participants (69%) continuing their CASE services. In FY 23/24 the percentage of participants continuing decreased to 60%.

Girls' Court

Girls' Court measures successful completion of program by successfully meeting goals, demonstrating healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being. During FY 21/22, 40% of the Girls' Court participants graduated from the program, 21% during FY 22/23 and 26% in FY 23/24.

Outreach Surveys

Outreach surveys designed to measure the effect of meeting the educational goals of the outreach presentations were implemented in FY 23/24. These surveys measure whether participants gained knowledge and awareness about key topics discussed during the presentation, including increased awareness of CSEC issues, identifying and recognizing signs of CSE in youth, raising understanding of available community resources, and improving the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment. In FY 21/22, 214 surveys were completed, and 335 surveys were completed in FY 22/23 presentations with 275 being completed in FY 23/24.

Coalition Against Sexual Exploitation (CASE), cont.

Challenges/Solutions

Historically, CASE faces the challenge of data collection and tracking of the multitude of services each CASE client receives. Over this fiscal year, the creation of the “CASE Database” has been completed and is ready to begin tracking. As of July 1, 2023, CASE will begin to enter client information on a monthly basis.

The referral process has also been a challenge with staff changes and onboarding processes. During the recent CASE Steering Committee, the lack of new client referrals has been down, meaning one of two scenarios: 1) victimization is down and youth aren’t being exploited in San Bernardino County or 2) Appropriate evaluation/screenings of the youth coming in and out of our providers offices are not being evaluated properly resulting in low number of referrals. Ultimately, resulting in victims or potential victims not getting access to appropriate services.

Lessons Learned

When CSEC youth are placed in single-family homes instead of group homes, they tend to stay engaged with services longer, attend school more regularly, and experience greater overall stability. The supportive environment of a single-family home seems to help these youth feel safer and more secure, leading to better outcomes in both their education and personal well-being.

Artwork by Dani Farmer

Coalition Against Sexual Exploitation (CASE), cont.

Success Story

This past June, a client successfully graduated high school. She graduated with A's and as the class vice president. She continues to attend Santiago College focusing on Forensic Nursing. She recently graduated from the Run 2 Rescue program and was gifted with her first car. She also secured her first job with Run 2 Rescue in which her job entails various tasks and duties. Since graduating from the program, she has been given the privilege to have a phone and learning how to set boundaries and runs the Run 2 Rescue social media page. She is looking to apply to Chapman University and is planning to live on campus next year. Run 2 Rescue and the Public Defender's office continues to be of support to this youth.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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; 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
Annual Budget FY 25/26	$5,100,000
Cost Per Client FY 25/26	$189

Family Resource Center (FRC), cont.

State Program Positive Results

FRCs provide a mix of Prevention and Early Intervention activities to promote mental wellness.

Prevention activities focus on reducing risk factors and building protective factors. FRCs offer parenting classes, NCTI Crossroads© workshops, art programs, computer skills training, resume and job search assistance, and help with accessing basic needs. These programs aim to strengthen relationships, foster community engagement, develop coping skills, and promote healthy lifestyles, all contributing to resilience and self-sufficiency.

Outreach services educate community stakeholders—such as service providers, families, law enforcement, healthcare providers, and school staff—on recognizing early signs of mental illness. Initiatives like community film screenings and expert Q&A sessions help raise awareness of mental health issues.

Early Intervention activities focus on recovery through therapeutic services, including individual counseling, family counseling, group therapy, and relapse prevention. The tables to the right outline projected and actual participant numbers and services provided annually.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	26,945	28,355	36,383	43,992
Number of Services	51,011	39,861	47,207	35,971

Potential Responders Reached

	FY 2021/22	FY 2022/23	FY 2023/24
Number of Potential Responders Reached	17,714	16,927	8,795

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.

FY 23/24 saw a significant increase in referrals. This rise is linked to a growing demand for mental health services that exceed basic care, with many providers pointing to the need arising from the after-effects of the pandemic. 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 2021/22	**FY 2022/23**	**FY 2023/24**
Number of Referrals Provided	52	46	162
Number of referrals to County-funded / administered programs	7	8	117
Number of referrals to other programs	45	38	45
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	42	18	66

Family Resource Center (FRC), cont.

State Program Positive Results, cont.

Improving Timely Access

FRCs work to improve timely access to mental health services for members of historically underserved populations by providing referrals to appropriate prevention, early intervention, and/or higher-level care services as needed. Members of historically underserved populations include individuals who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, as well as members of ethnic/racial, cultural, and linguistic populations that to not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services. FRCs actively work to identify and engage individuals in need and provide referrals that meet their mental health care needs in a culturally relevant manner.

In FY 22/23, a FRC service provider identified and implemented an alternate method for collecting information. This adjustment significantly contributed to the surge in number of referrals aimed at improving timely access. Continuing this method of data gathering into FY 23/24 has yielded more accurate results and indicated an increase in the number of referrals provided. PEI is currently collaborating with other providers to explore avenues for integrating comparable modifications, with the objective of optimizing the capture of such referrals.

Improving Timely Access Referrals			
	FY 2021/22	FY 2022/23	FY 2023/24
Number of Referrals Provided	209	1,318	1,635

Family Resource Center (FRC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	9%	4%	19%	1%	67%
FY 22/23	21%	7%	35%	3%	95%
FY 23/24	17%	8%	27%	7%	41%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	2%
FY 22/23	2%
FY 23/24	3%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	12%	30%	<1%	57%
FY 22/23	17%	31%	<1%	52%
FY 23/24	18%	33%	<1%	49%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	71%	16%	11%	2%
FY 22/23	65%	18%	<1%	17%
FY 23/24	68%	11%	<1%	28%

Family Resource Center (FRC), cont.

Demographics, cont.

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	3%	7%	6%
	American-Indian/Alaska Native	3%	2%	1%
	Asian	1%	2%	1%
	Hispanic/Latinx	12%	31%	28%
	Native Hawaiian or Pacific Islander	0%	<1%	<1%
	Caucasian/White	4%	3%	21%
	More than One Race	4%	19%	4%
	Other Race	14%	12%	6%
	Declined to Answer	19%	42%	33%

	Race/Ethnicity	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	1%	3%	2%
	Asian Indian/South Asian	0%	1%	<1%
	Cambodian	0%	0%	<1%
	Chinese	0%	<1%	<1%
	Eastern European	0%	<1%	<1%
	European	9%	10%	9%
	Hispanic/Latinx	38%	31%	10%
	Filipino	0%	<1%	<1%
	Japanese	0%	<1%	<1%
	Korean	0%	<1%	<1%
	Middle Eastern	0%	<1%	<1%
	Vietnamese	0%	<1%	<1%
	Other	18%	30%	14%
	More than one ethnicity	5%	4%	2%
	Declined to Answer	66%	20%	53%

Demographic Observations

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

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 use 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 21/22: 211 FY 22/23: 312 FY 23/24: 348
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 21/22: 130 FY 22/23: 237 FY 23/24: 241
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 21/22: 98 FY 22/23: n/a* FY 23/24: 102
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 21/22: 154 FY 22/23: 193 FY 23/24: 228

* Due to licensing issues, no data is available for FY 2022/23.

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 a face a variety of challenges. The following tables show some of the most prevalent subdomains and the corresponding rates of improvement. In FY 2023/24, the Strengths Domains saw slight decline from the previous years, whereas the Life Functioning and Behavioral Health Domains both saw increases in comparison to results from previous years.

Child and Adolescent Needs and Strengths Improvement in Primary Domains			
	FY 21/22	FY 22/23	FY 23/24
Life Functioning Domain	45.5%	43.1%	44.2%
Strengths Domain	84%	79.1%	78.9%
Behavioral Health Needs Domain	42.3%	37.4%	43.9%

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 21/22	FY 22/23	FY 23/24
Life Functioning Domain			
Family Functioning	76%	61%	74%
Social Functioning	75%	80%	80%
School Achievement	61%	72%	61%
Strengths Domain			
Family Strengths	70%	59%	50%
Interpersonal	70%	69%	63%
Resiliency	70%	76%	68%
Resourcefulness	69%	61%	64%
Behavioral Health Needs			
Depression	83%	74%	70%
Anxiety	71%	68%	77%
Anger Control	71%	63%	71%
Risk Behaviors			
Suicide Risk	85%	71%	86%
Non-Suicidal, Self-Injurious Behavior	72%	72%	75%

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.

Overall, adults participating in the FRCs' early intervention activities whose treatment sessions opened and closed within the same fiscal year made improvements. The chart below shows that there has been a steady increase across all three domains with FY 23/24 showing the highest improved percentages.

Adult Needs and Strengths Improvement in Primary Domains			
	FY 21/22	FY 22/23	FY 23/24
Life Functioning Domain	62.9%	76.8%	83.4%
Strengths Domain	59.3%	74.2%	80%
Behavioral Health Needs Domain	61.1%	73.2%	79.4%

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Adult Needs and Strengths Assessment (ANSA), cont.

In FY 2023/24, struggles with decision-making and judgement were common issues among adults. Out of 83 individuals with these concerns, 90% showed improvement in this skill.

Adult Needs and Strengths Improvement in Subdomains

	FY 21/22	FY 22/23	FY 23/24
Life Functioning Domain			
Family Functioning	59%	71%	81%
Social Functioning	64%	77%	85%
Decision-Making/Judgment	76%	89%	90%
Parenting Roles	63%	83%	88%
Strengths Domain			
Family Strengths/Family Support	55%	66%	60%
Community Connection	42%	76%	85%
Natural Supports	37%	73%	78%
Resiliency	70%	79%	84%
Resourcefulness	64%	77%	89%
Behavioral Health Needs Domain			
Depression	69%	84%	91%
Anxiety	60%	80%	86%
Adjustment to Trauma	58%	82%	88%
Eating Disturbances	68%	89%	91%

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 21/22	5.73	9.46	65%
FY 22/23	n/a*	n/a*	n/a*
FY 23/24	5.11	19.62	41.46%

* Due to licensing issues, no data is available for FY 22/23.

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

LPS surveys gather detailed family information through interviews and observations. They're completed at intake to assess family strengths and needs and again at the end of services to track progress. LSP measures growth in relationships, resources, medical and mental health, and essentials crucial for mental well-being. The outcomes, indicating average percent increases in these areas over the past three years, are detailed in the table below.

Life Skills Progression Percent Improvement			
	FY 21/22	FY 22/23	FY 23/24
Relationships	13.8%	13.5%	23%
Resources	29.0	18.1%	44%
Medical	8.6%	8.5%	15%
Mental Health	37.9%	18.0%	36%
Basic Essentials	10.9%	12.8%	14%

Challenges/Solutions

A common challenge faced by the FRCs is inconsistent staffing and training, which can directly effect service delivery and program effectiveness. Frequent turnover and vacancies, along with the extensive training needed by staff to engage in community work, have resulted in delays and a slow start in providing services. The rising demand for mental health support and the limited availability of providers.

To address the challenge of inconsistent staffing and training, the FRCs have increased efforts to hire and quickly onboard new staff in key roles to assist in a continuation of services supporting their communities.

Lessons Learned

Since the years following the COVID pandemic, there has been an increase in the demand for mental health services. Recognizing this growing need, the FRCs have made concerted efforts to raise awareness of the mental health resources available to the community.

These initiatives include outreach programs aimed at educating the community about the range of services offered and extend their reach by partnering with local schools and organizations.

Family Resource Center (FRC), cont.

Success Story

Client sought therapy for grief after the suicide of her grandson whom she was the primary adult caretaker. Client utilized grief group, grief workshops, faith-based women's conferences along with therapy to heal from the pain, find meaning in his suicide, and became trained in a faith-based program for a grief group which she implemented at a local church. Client expanded her world beyond the life and death of her grandson and began to do the things on her bucket list.

Program Updates

PEI FRC is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as Specialty Mental Health Services for children, youth, and adults with mental health concerns.

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
Annual Budget FY 25/26	$1,075,000
Cost Per Consumer FY 25/26	$182

Community Wholeness and Enrichment (CWE), cont.

Program Highlights

CWE is a program that focuses on prevention and early intervention. In addition to these services, the program provides suicide prevention and outreach education. The program uses strategies to increase and improve linkage and timely access to services to ensure participants are connected to appropriate services. These strategies include assessments and case management.

Prevention and Early Intervention

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 services include evidence-based treatments, therapies, and relapse prevention services to promote early recovery and functional outcomes for mental illness. The chart below shows the number of participants that received prevention and early intervention services.

Prevention	Projected	FY 2021/22	FY 2022/23	FY 2023/24
Unduplicated Participants	2,956	3,634	2,091	2,572
Number of Services	7,809	8,306	6,052	5,668

Early Intervention	Projected	FY 2021/22	FY 2022/23	FY 2023/24
Unduplicated Participants	2.958	1,624	2,429	1,372
Number of Services	4,824	1,186	853	3,248

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

The CWE program seeks continuous solutions, such as telehealth services, to boost the percentage of participants achieving their treatment goals. The table below shows the number of episodes opened and closed, and the proportion of participants who met their treatment goals for each fiscal year.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2021/22	399	264	53%
FY 2022/23	430	289	67%
FY 2023/24	352	187	42%

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 is actively adjusting to changing circumstances and while there has been a decrease in engagement, the data for FY 2023/24 presents an opportunity for us to identify areas for improvement and enhance community involvement moving forward.

Potential Responders Reached

	FY 2021/22	FY 2022/23	FY 2023/24
Potential Responders	1,040	1,648	1,033

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 targets those with early-onset behavioral illness. The program is also designed to serve participants with serious mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers need to link individuals to a higher level of care. The CWE program made 10 referrals to treatment beyond early onset over the last three fiscal years. These individuals were engaged in the program.

Improve Timely Access to Treatment

Access & Linkage

The CWE program targets those with early-onset behavioral illness. The program is also designed to serve participants with serious mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers need to link individuals to a higher level of care. The CWE program made 10 referrals to treatment beyond early onset over the last three fiscal years. These individuals were engaged in the program.

Improve Timely Access to Services			
	FY 2021/22	FY 2022/23	FY 2023/24
Number of Referrals	1	0	10
Participants Engaged	0	0	10
Average # of Days Participant Engaged	0	0	0

Within the Improve Timely Access strategy, CWE providers served the following underserved populations:

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

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Suicide Prevention

One primary focus of the CWE program is to provide support for suicide. This includes providing services that are centered around the prevention of suicides. The program distributes information to the community on the signs and symptoms of someone who may be at risk of suicide.

In addition, the program organizes specific educational opportunities to learn more about suicide prevention. They provide access to gatekeeper training such as Applied Suicide Intervention Skills Training (ASIST), SafeTALK, and Question, Persuade, Refer (QPR) to build the communities' capacity to respond to a suicide-related crisis. They also customize suicide prevention training for the specific needs of the community. Community member organizations can reach out to the program and request individualized training for specific communities.

The long-term effects of COVID-19 created challenges in providing suicide prevention training. Providers continue to offer virtual training and utilize curriculums that could be delivered in a virtual platform, such as QPR, to increase participation.

Providers of the CWE program have trained a total of 799 individuals in suicide prevention over the last three fiscal years.

Suicide Prevention Trainings			
	FY 2021/22	FY 2022/23	FY 2023/24
Unduplicated Participants	150	304	345

Community Wholeness and Enrichment (CWE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 21/22	<1%	11%	28%	<1%	60%
FY 22/23	<1%	14%	40%	<1%	45%
FY 23/24	<1%	16%	55%	<1%	27%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	0%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	3%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	7%	18%	0%	75%
FY 22/23	10%	23%	1%	66%
FY 23/24	17%	38%	4%	41%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	80%	17%	0%	3%
FY 22/23	76%	15%	0%	9%
FY 23/24	68%	29%	0%	3%

Community Wholeness and Enrichment (CWE), cont.

Demographics, cont.

Demographic Observations

The CWE program primarily serves Transitional Age Youth (TAY) and adults, aligning with its target population. Mental health concerns are especially prevalent among TAY and young adults, a group facing significant stressors such as new responsibilities, role changes, and financial pressures. Early identification and comprehensive assessments are critical for providing appropriate services and ensuring better outcomes.

In the past three fiscal years, the program has consistently served nearly twice as many females as males, which is in line with research showing that mental illness is more prevalent among females than males. As of 2024, approximately 38% of females experienced mental illness in the previous year, compared to 17% of males. Commonly diagnosed conditions include depression, anxiety, and mood disorders.

Artwork by Carolyn Brown

Community Wholeness and Enrichment (CWE), cont.

Demographics, cont.

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Race	African American/Black	5%	2%	5%
	American-Indian/Alaska Native	<1%	<1%	<1%
	Asian	<1%	<1%	<1%
	Native Hawaiian/Pacific Islander	<1%	<1%	<1%
	Latinx/Hispanic	29%	15%	42%
	Caucasian/White	15%	12%	14%
	More than One Race	4%	2%	7%
	Other	23%	3%	11%
	Declined to Answer	52%	65%	36%

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	0%	<1%	3%
	Asian Indian/South Asian	<1%	0%	<1%
	Cambodian	0%	0%	0%
	Chinese	<1%	0%	<1%
	Eastern European	0%	<1%	<1%
	European	3%	10%	14%
	Hispanic/Latino	29%	15%	42%
	Filipino	<1%	<1%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	<1%	0%	<1%
	Vietnamese	0%	0%	<1%
	Other	5%	3%	11%
	More than One Ethnicity	1%	7%	7%
	Declined to Answer	61%	79%	36%

Community Wholeness and Enrichment (CWE), cont.

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.

Program Outcomes

Method use 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 21/22: 234 FY 22/23: 244 FY 23/24: 171

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.

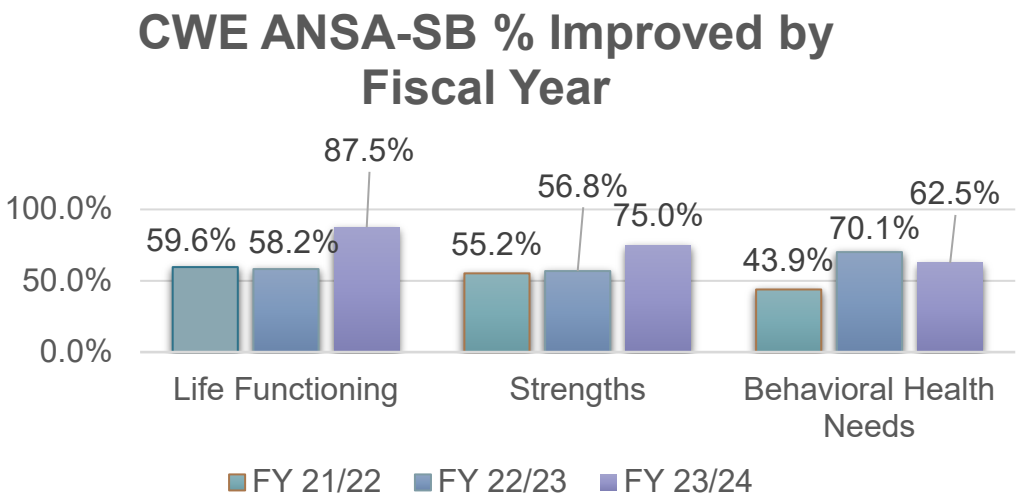
ANSA-SB is an information integration tool for adults with behavioral health challenges. It supports individual case planning and the planning and evaluation of service systems. Each dimension is rated on a four-point scale when the ANSA-SB is administered. It is administered at intake and at three-month 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.
- Strengths domain evaluates factors like family support, optimism, interpersonal, social connectedness, relationship permanence, vocational, and resilience.
- Behavioral Health Needs, which evaluates factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma and substance use.

There was a slight decline in life functioning from FY 21/22 to FY 22/23. However, there was a significant improvement in FY 23/24.
There was a steady improvement in strengths over the three fiscal years, with a notable increase in FY 23/24.
Behavioral health needs increased significantly from FY 21/22 to FY 22/23 and declined in FY 23/24.

The data shows significant advancements in all areas when comparing Fiscal Year 2022/2023 to Fiscal Year 2023/2024. The most notable progress is seen in life functioning and personal strengths, indicating a positive overall well-being and capability trend.



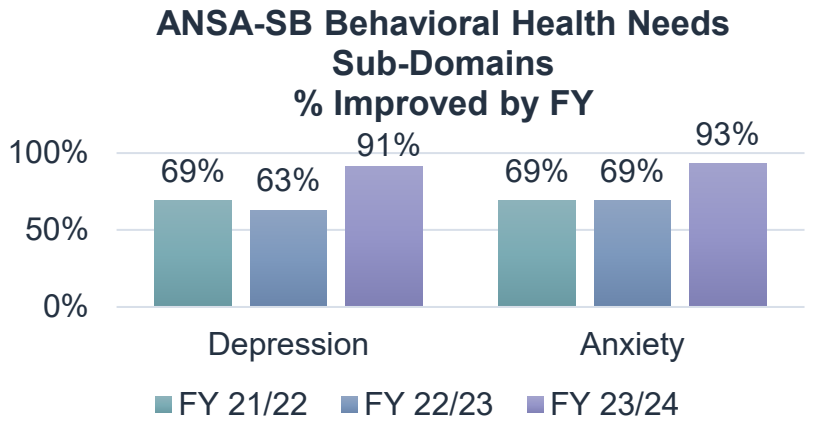
Community Wholeness and Enrichment (CWE), cont.

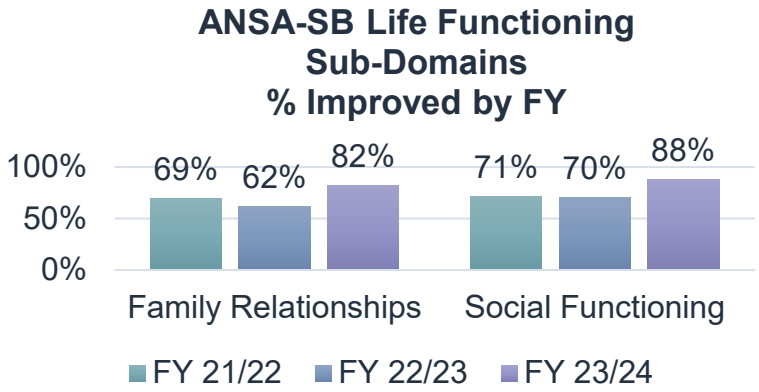
Outcome Discussion, cont.

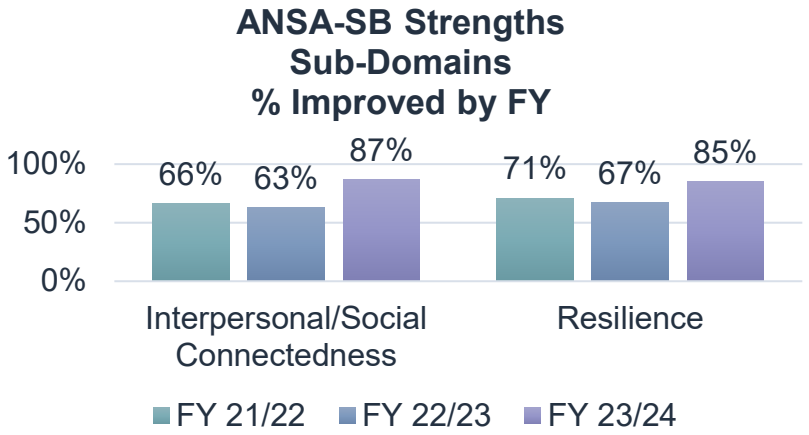
Each domain contains sub-domains that measure:

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

These subdomains were found to align most closely with the goals of the CWE program. The charts on this page illustrate the percentage of improvement in each domain. The upgrades are indicators that the interventions provided by the program helped to avert or lessen the severity of a mental disorder.







Community Wholeness and Enrichment (CWE), cont.

Challenges/Solutions

The primary challenge identified by CWE providers pertains to the stigma associated with seeking mental health services and offering support groups for the loved ones of individuals with a mental health disorder. Engaging family members, particularly in suicide bereavement groups, has proven to be difficult. Stakeholder feedback has indicated that the community perceives group settings as intimidating.

CWE providers are working to strengthen their connections with the community to ensure that people are aware of all the services they offer, including support groups. They are partnering with community organizations and providing education to reduce the stigma surrounding mental health, especially in relation to suicide. The CWE program will continue to advocate for the importance of attending a suicide bereavement group for survivors of those who have lost a loved one to suicide.

Lessons Learned

PEI has identified that managing CWE data within the agencies over the past three fiscal years has presented challenges regarding retrieval and analysis. Providers are committed to enhancing their data management processes in the future to ensure easier accessibility for themselves and DBH.

Success Story

The client, a 19-year-old female, had a history of abuse from her father and was struggling with depression following EMDR therapy for PTSD. She exhibited symptoms such as fatigue, loss of interest in activities, hopelessness, and feelings of worthlessness.

During depressive episodes, she isolated herself and frequently cried, expressing frustration over her emotions. She also reported overthinking and engaging in impulsive behaviors like partying and seeking male attention when feeling low. Her goals included reducing isolation and improving boundaries.

Through therapy, she learned to reframe negative thoughts, develop healthier coping strategies, and set better boundaries with family and friends.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

Military Services and Family Support (MSFS)

Program Description and Target Population

The 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 individual's homes or nearby public places.

MSFS providers utilize stakeholder feedback and community needs assessments to 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
Annual Budget FY 25/26	$725,000
Cost Per Client FY 25/26	$186

Military Services and Family Support (MSFS), cont.

State Program Positive Results

The MSFS program is categorized as a Prevention and Early Intervention program. In addition to prevention and early intervention services, the program offers outreach education and suicide prevention. The MSFS program utilizes the Access and Linkage and Improve Timely Access strategies to ensure individuals are linked to the necessary services to meet their needs. In the past 3 years, the program has consistently exceeded its goals.

Number of Individuals / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Individuals	3,605	6,091	3,480	3,917
Number of Services	6,990	10,168	7,118	7,701

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 table shows prevention individuals and services 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 2021/22	FY 2022/23	FY 2023/24
Unduplicated Individuals	292	414	400
Number of Services	1,100	1,344	1,350

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 changes at military installations restricted access to service areas, resulting in decreased outreach opportunities. 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 2021/22	FY 2022/23	FY 2023/24
Potential Responders	5,786	2,533	2,869

The table below shows the types of responders and in which settings those responders were reached.

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 decreased 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 2021/22	335	122	40%
FY 2022/23	88	51	18%
FY 2023/24	42	40	65%

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 below table 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 2021/22	FY 2022/23	FY 2023/24
Number of Referrals	15	21	30
County-Funded	15	7	14
Non-County Funded	0	8	11
Individuals Engaged	15	15	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 a individual, whether if 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 members of the military, recently retired military/veterans, and their families. The adjacent table provides a sample of the underserved populations served this past fiscal year.

Through the last three fiscal years, individuals were engaged, on average, no more than eight days after 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 been involved in services. This illustrates 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 2021/22	FY 2022/23	FY 2023/24
Number of Referrals	86	96	53
Individuals Engaged	10	19	4
Average # of Days Individual Engaged	9.5	6.89	8.7

Underserved Populations

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

Military Services and Family Support (MSFS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 21/22	3%	3%	16%	3%	75%
FY 22/23	12%	8%	35%	6%	39%
FY 23/24	18%	12%	45%	14%	11%

Fiscal Year	Veteran Status
	% of Individuals who identified as a veteran
FY 21/22	7%
FY 22/23	13%
FY 23/24	14%

Fiscal Year	Sexual Orientation
	% of Individuals who identified as LGBTQ+
FY 21/22	1%
FY 22/23	2%
FY 23/24	1%

Fiscal Year	Disability
	% of Individuals who identified a physical disability
FY 21/22	0%
FY 22/23	0%
FY 23/24	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	13%	23%	0%	64%
FY 22/23	30%	46%	<1%	24%
FY 23/24	36%	54%	<1%	10%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	91%	1%	0%	8%
FY 22/23	98%	<1%	0%	2%
FY 23/24	98%	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 18%, 12%, and 45% respectively. This aligns with the program's goal of serving those with military service and their families.
- The program was consistent in serving the same number of veterans the past two fiscal years.

		FY 21/22	FY 22/23	FY 23/24
Race	African-American/Black	5%	11%	13%
	American-Indian/Alaska Native	0%	1%	<1%
	Asian	1%	1%	2%
	Latinx/Hispanic	10%	10%	15%
	Native Hawaiian or Pacific Islander	1%	2%	1%
	Caucasian/White	18%	31%	43%
	More than One Race	4%	6%	6%
	Other Race	4%	10%	5%
	Declined to Answer	62%	29%	13%

		FY 21/22	FY 22/23	FY 23/24
Ethnicity	African	0%	2%	4%
	Asian Indian/South Asian	0%	4%	1%
	Cambodian	0%	0%	1%
	Chinese	0%	0%	3%
	Eastern European	0%	<1%	<1%
	European	3%	3%	3%
	Hispanic/Latino	10%	10%	3%
	Filipino	0%	<1%	4%
	Japanese	0%	<1%	2%
	Korean	0%	0%	2%
	Middle Eastern	0%	<1%	6%
	Vietnamese	0%	0%	2%
	Other	7%	34%	26%
	More than one ethnicity	9%	17%	8%
	Declined to Answer	80%	36%	34%

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 serious 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 use 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 21/22: 42 FY 22/23: 36 FY 23/24: 27
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 21/22: 6 FY 22/23: 7 FY 23/24: 5

Outcome Discussion

The ANSA-SB is a comprehensive assessment of psychological and social aspects used for treatment planning by MSFS early intervention providers. This assessment assesses 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, they receive 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 a 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 a 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.

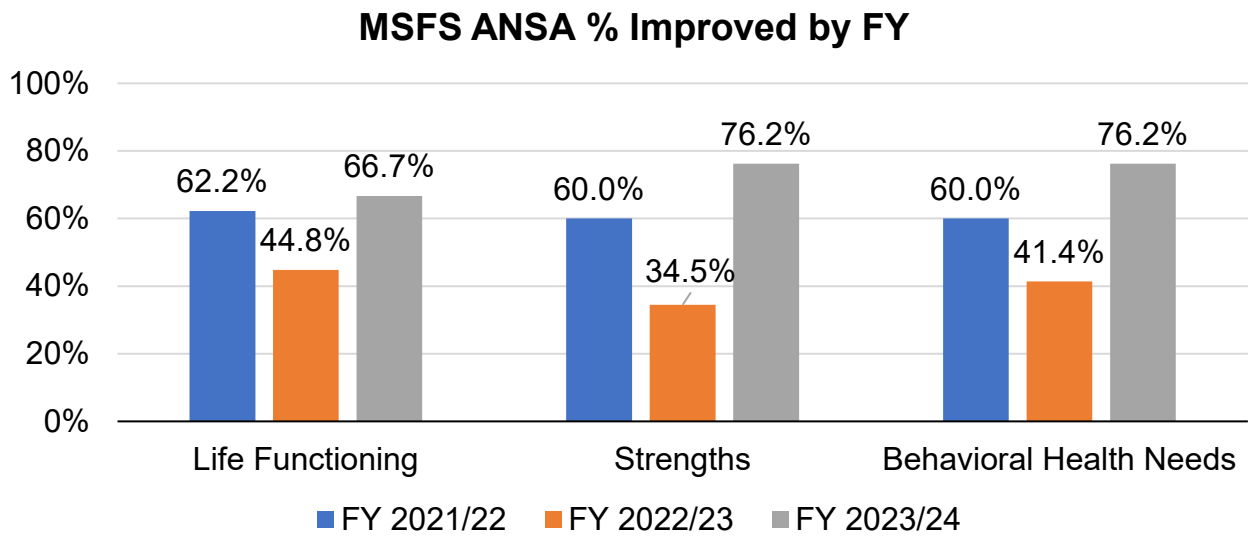
The Behavioral Health Needs Domain identifies the behavioral health needs of a individual.

The table below illustrates the percentage of individual improvement in global areas of Life Functioning, Strengths, and Behavioral Health Needs.

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

These sub-domains are used to measure everyone's specific service needs. During FY 23/24, individuals improved an average of 73% in the Life Functioning, Strengths, and Behavioral Health Needs domains.

The Life Functioning, Strengths, and Behavioral Health Needs Domains saw an average improvement of 58% over the last three fiscal year period.



Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

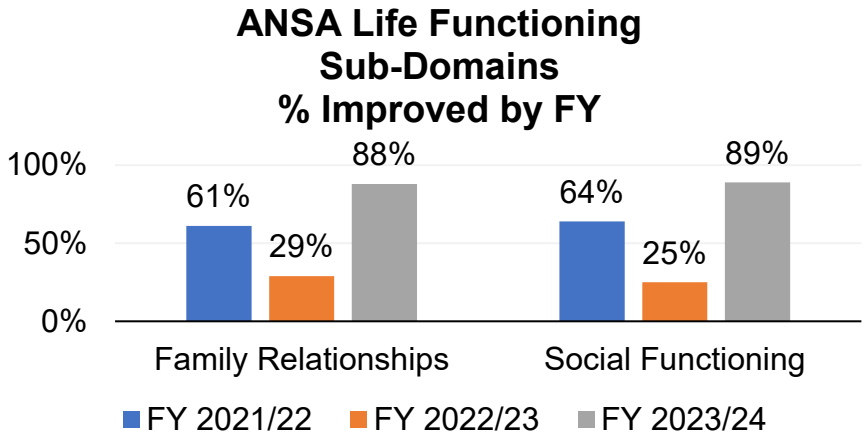
Each domain includes sub-domains that help to evaluate the individual's readiness to participate in early intervention services.

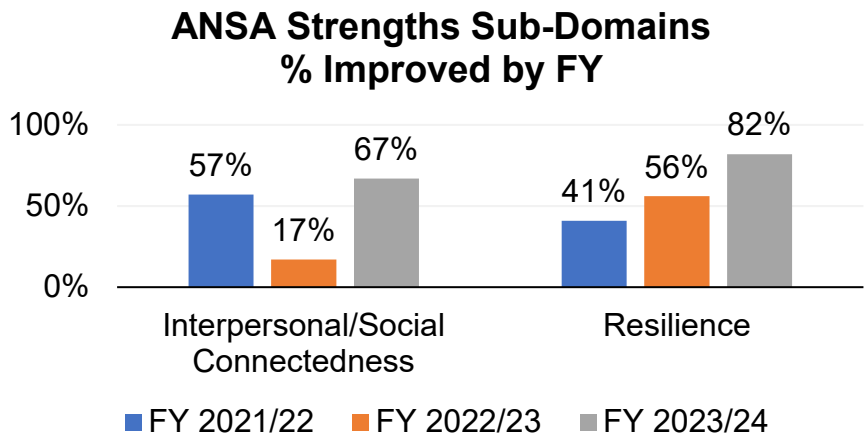
In the domain of Life Functioning, the sub-domain of family relationships evaluates and rates the individual's relationships with their family members: spouse/partner, children, and other family members. The sub-domain of social functioning rates social skills and relationships for a individual.

Individuals saw an average improvement of 88% across the Life Functioning sub-domains of Family Relationships and Social Functioning in FY 23/24.

In the Strengths domain, the interpersonal/social connectedness sub-domain measures a individual's social and relationship. The resilience domain measures a individual's ability to recognize their internal strengths and use them to manage their daily life.

Individuals saw an average improvement of 75% across the Strengths sub-domains of Interpersonal/Social Connectedness and Resilience in FY 23/24. These results demonstrate the effectiveness of early intervention services in improving an individuals' ability to recognize and capitalize on their personal strengths.



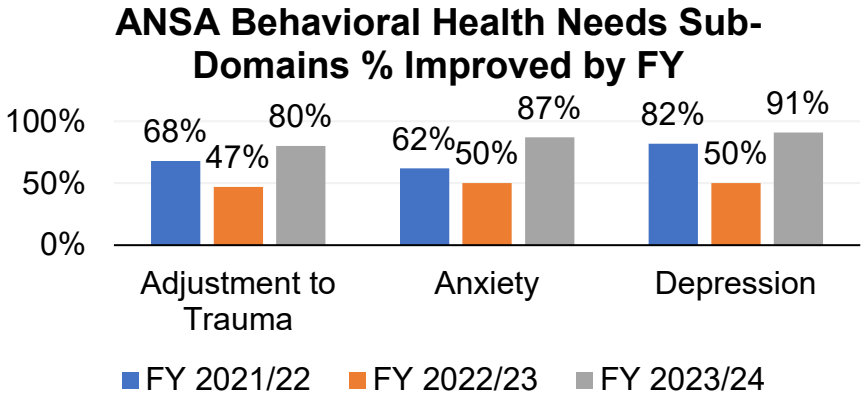


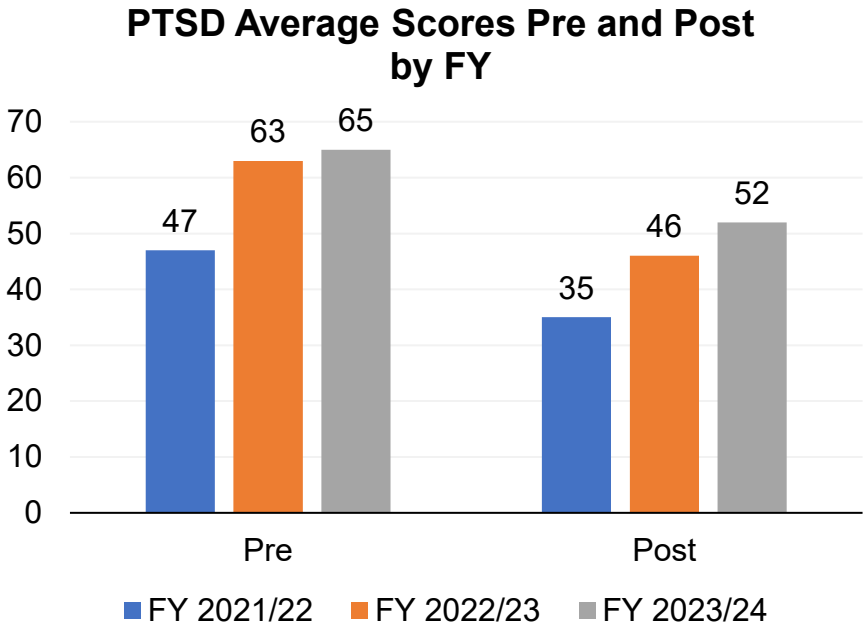
Military Services and Family Support (MSFS), cont.

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. An improvement in an identified need indicates that a individual has improved 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 irritable or depressed mood, social withdrawal, and sleep disturbances.

Individuals saw an average improvement of 86% across the Behavioral Health Needs sub-domains of Adjustment to Trauma, Anxiety, and Depression in FY 23/24.





The table above 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.

Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

Total Symptom Severity Scores can range anywhere from 17 to 85. A cutoff score of 50 or more suggests the presence of a significant level of symptom severity. Results indicate that MSFS early intervention individuals scored 65 points out of a total of 85 on the PCL-M before receiving treatment. After treatment, MSFS individuals scored 52 points on average, reducing their total symptom severity score by an average of 17 points, indicating a reduction in total symptom severity.

Challenges/Solutions

Group participation also continues to be a challenge, as individuals prefer individual meetings via videoconferencing or in person rather than group meetings. Individuals have shared that they prefer virtual individual meetings because they help preserve anonymity within their communities and they face stigmas of being involved in mental health services. In more remote service regions, transportation and reliable internet service continue to challenge individuals.

The MSFS program faced difficulties with one of the bases they partner with in Barstow. After a change in command, new limitations were placed on providing group services and access to the base from outside agencies. Even with the challenges presented, the MSFS program has continued to successfully serve the military community by meeting its clients where they are. The program seeks to create groups in a different settings, such as schools, to assist the family of servicemembers.

Lessons Learned

PEI continues to work with MSFS providers to ensure that the appropriate data is collected and to provide technical assistance for database navigation. MSFS providers can reach a larger population through telehealth services, including individuals outside of their service regions. Program staff can train individuals on how to use virtual meeting platforms, especially those poor internet service areas.

Staff recruitment efforts continue in the Central/East Valley regions to ensure that the program's target population is adequately served.

Military Services and Family Support (MSFS), cont.

Success Story

A veteran client with severe PTSD suffering from a lack of familial support initiated at the onset of the pandemic and following loss of business. As treatment progressed, the client created a new support system and began a new job which led to increased anxiety. He used his art, support group, and therapy to cope with thoughts of being useless. After months and near exhaustion of all resources, he was awarded full disability from the Veteran Affairs (VA). Client has renewed hope, financial security, and is now able to focus more time and effort on his art.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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
Annual Budget FY 25/26	$7,832,596
Cost Per Consumer FY 25/26	$518

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 Projected vs Actual

	Projected	Actual		
		FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	15,126	13,337	50,221*	56,608
Number of Services	18,402	20,280	67,095*	58,432

*FY 22/23: reported numbers were incorrect, actual numbers have been updated.

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Early Intervention

The programs 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 in the most effective and practical manner.

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. This would include referrals to a higher level of care.

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

Early Intervention Participants / Services			
	FY 21/22	FY 22/23	FY 23/24
Unduplicated Participants	836	570	905
Total Services	8,188	7,958	12,384

SAP early intervention services rely heavily on school site referrals originating from prevention services. When schools transitioned to distance learning, the prevention services were temporarily suspended but as you can see, there is now an increase in services due to children returning to traditional learning sites.

The chart below provides an overview of client successes. Data shows that their treatment plans dropped slightly over the last three fiscal years. Clients were displaced during the pandemic and moved out of their program service area causing interruptions in services. Some clients did not have adequate technology or space needed for a successful transition to telehealth services.

Treatment Success by Fiscal Year			
	FY 21/22	FY 22/23	FY 23/24
Treatment Successful	38%	38%	37%
Treatment Partially Successful	22%	18%	28%
Treatment Not Successful	32%	36%	23%
Missing or Other	8%	7%	12%

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 are shown to detail 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 Southern Region Student 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 21/22	51%	5%	26%	1%	17%
FY 22/23	55%	17%	14%	<1%	13%
FY 23/24	29%	10%	6%	<1%	55%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	2%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 21/22	<1%
FY 22/23	<1%
FY 23/24	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 21/22	6%	10%	0%	83%
FY 22/23	5%	12%	0%	83%
FY 23/24	15%	22%	0%	63%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 21/22	61%	5%	0%	34%
FY 22/23	71%	5%	<1%	24%
FY 23/24	34%	2%	<1%	63%

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 Southern Region Student 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 demographic of the general population of San Bernardino County.

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Race	African American/Black	8%	9%	5%
	American-Indian/Alaska Native	0%	0%	<1%
	Asian	2%	4%	2%
	Native Hawaiian/Pacific Islander	0%	1%	<1%
	Caucasian/White	18%	19%	7%
	Latinx/Hispanic	16%	27%	16%
	More than One Race	3%	5%	2%
	Other Race	11%	<1%	<1%
	Declined to answer	42%	34%	66%

Student Assistance Program (SAP), cont.

Demographics, cont.

	Ethnicity/Race	FY 21/22	FY 22/23	FY 23/24
Ethnicity	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%
	Hispanic/Latino	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 Goals

The State program's prevention goal is to reduce prolonged suffering associated with untreated mental illness by reducing risk factors and increasing protective factors. The Early Intervention goal is to reduce symptoms and improve recovery, including mental and relational functioning. The SAP program is designed to meet the State's goals by reducing learning hurdles, assisting students in building academic and emotional achievement, and decreasing the period of untreated mental illness. The tools used to measure the effectiveness of the SAP program are listed in the table below.

Method use 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 21/22: 393 FY 22/23: 465 FY 23/24: 595
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 21/22: 485 FY 22/23: 737 FY 23/24: 466
Measurement Outcomes and Quality Assessment (MOQA_SPP/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 21/22: 200 FY 22/23: 229 FY 23/24: 66
Client Satisfaction Survey	Client satisfaction surveys are used to determine whether the participants are gaining useful and valuable information from the program as well as a way to determine whether the participants are engaging in the program in a way that is satisfying and enjoyable.	Completion of Services	FY 21/22: 157 FY 22/23: 162 FY 23/24: 188

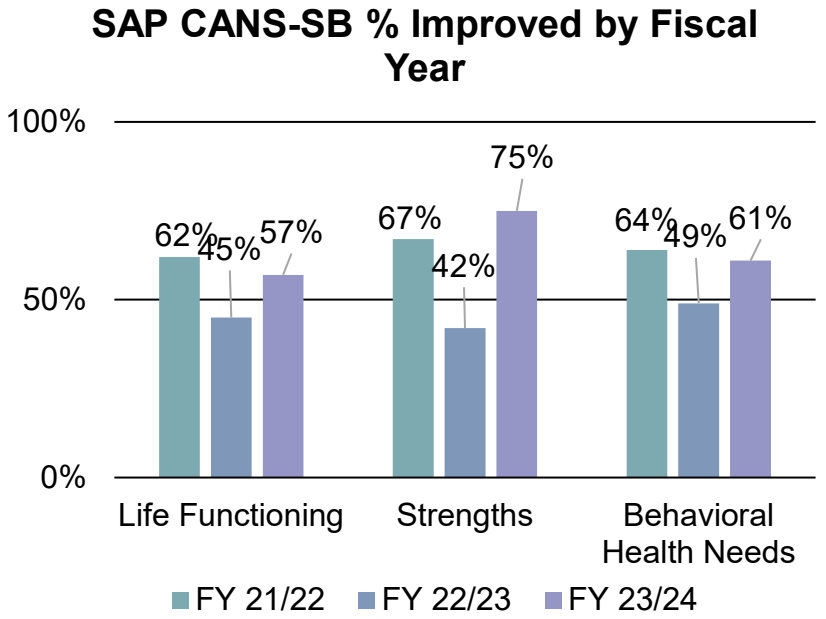
Student Assistance Program (SAP), cont.

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.

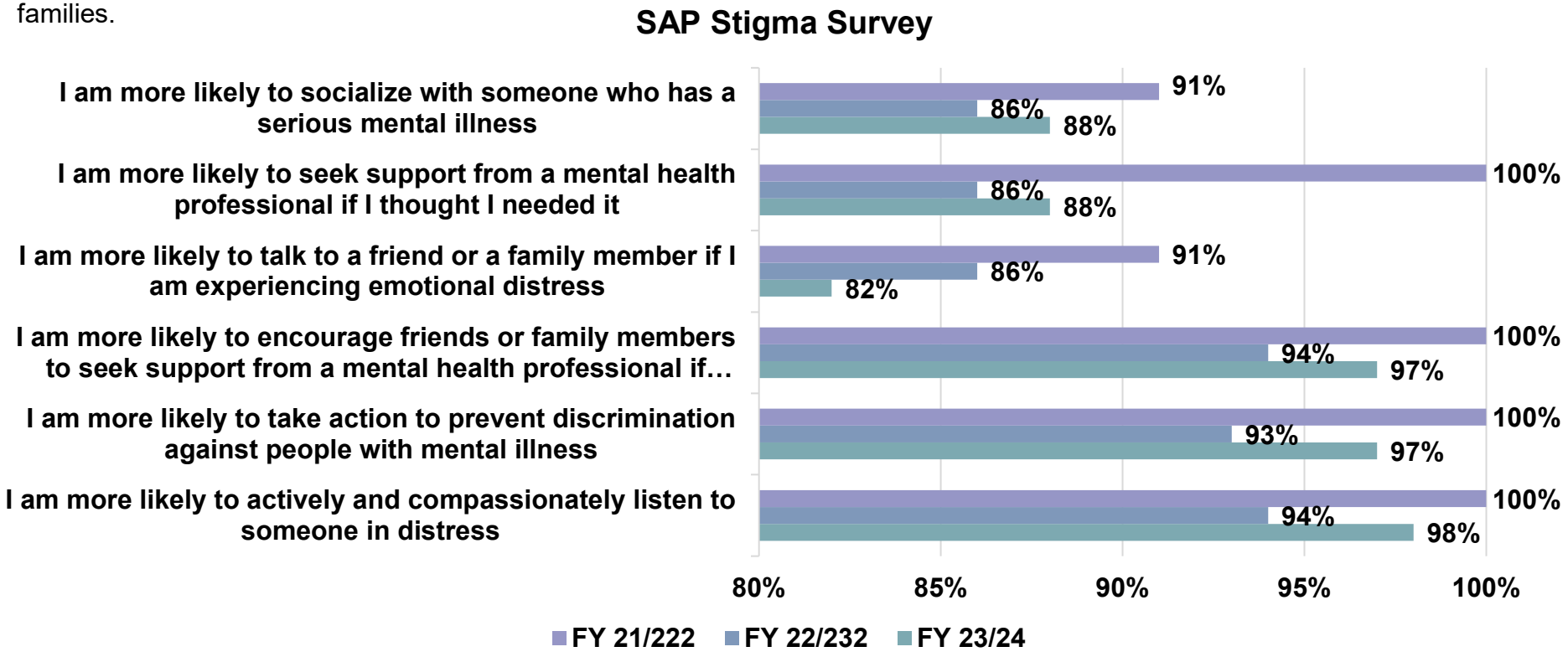
The following graph demonstrates overall improvement in the elements of Life Functioning, Strengths, and Behavioral/Emotional Needs, of participants of the SAP program. The results demonstrate consistent increases in approximately 64% of all three domains. The increase leads to an overall improvement in reducing symptoms and recovery, including mental and relational functioning.



Student Assistance Program (SAP), cont.

SAP Stigma Surveys

The stigma surveys are used to examine whether stigma prevention efforts and/or curriculum aimed at youth effect their knowledge, attitudes, and behavior surrounding behavioral health. Stigma surveys are used after any direct activity whose purpose is to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination relating to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. As a direct result of these trainings the participants answer the questions below. A Stigma and Discrimination Reduction activity also includes direct activities whose purpose is to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.



Student Assistance Program (SAP), cont.

Challenges/Solutions

An ongoing challenge for SAP providers is the high staff turnover at both the provider level and school administration level. The departure of experienced staff have led to disruptions in service delivery. Recruiting and training new staff requires considerable time and resources, which temporarily hampers the program's efficiency and effectiveness. Staff turnover also affects team dynamics and morale, impacting the overall productively and job satisfaction of remaining team members. Replacing experienced staff with new hires requires a period of adjustment, during which the quality and consistency of services may fluctuate.

To address this challenge, strategies have been implemented to stabilize the workforce and improve understanding of staffing ratios. This has included hiring experienced staff with Alcohol and Drug Certification to broaden the range of expertise within the programs. Such qualifications are increasingly relevant given the complex needs of many students and their families, particularly those dealing with substance-related issues. Investing in a robust recruitment and retention initiative is also crucial to attracting and retaining skilled staff members. Additionally, providing ongoing training and professional development opportunities can help new hires quickly acclimate to their roles and improve their effectiveness.

Another challenge is the increase in the severity of symptoms among newly referred students. Many of these students require more intensive programs to address their mental health needs. This shift means that fewer students are being assessed withing the SAP program as they are being redirected to the more intense services. Providers are seeking new referral sources via community-based organizations, churches, and community events that can help expand the SAP reach and ensure that more students in need are identified and supported. Engaging with these local entities not only broadens the referral network but also strengthens community ties and fosters a collaborative approach to mental health care.

Student Assistance Program (SAP), cont.

Lessons Learned

In FY 2023/24, SAP program providers realized that there were multiple agencies that offer similar services on campus. Although this is good for our community and families, it can limit space and be confusing for the school site. As a result, we recognized the need to clearly explain the differences between all the different campus programs and what each one can offer to the students and families.

Success Story

With the lifting of restrictions over community events, there has been an increase in the number of outreach events that SAP providers can attend. These community events help funnel referrals to the providers, allowing them to serve the student population even further. As a result, there has been a sharp increase in the outreach numbers, which in turn has increased the number of referrals received for the Early Intervention process.

Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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 even years—often signal the onset 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 a worsening of mental symptoms, distress, and functional impairment. People at this early stage are at a Clinical High Risk (CHR) of developing a serious illness.

Most individuals who develop psychosis exhibit symptoms between the ages of 16 and 25. According to existing treatment model research, some people can escape a lifetime of impairment and find fulfillment in their everyday lives with proper and timely intervention.

The goal of the IDEA program, formerly known as the Early Psychosis Care (EPC) program, is to identify youth at clinically high risk of psychosis as early as feasible in the warning phase and to begin treatment as soon as possible during the first episode of psychosis.

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
Annual Budget FY 25/26	$1,000,000
Cost Per Consumer FY 25/26	$38,462

Improving Detection and Early Access (IDEA), cont.

Existing Efforts

The Department of Behavioral Health continues to offer a comprehensive continuum of services, including 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. The continuum of care ensures that individuals obtain care in a variety of ways and provides an existing infrastructure for identifying and treating early episodes of psychosis as well as the precursor signs and symptoms (e.g., Clinical High Risk or prodromal phase). The grant-funded Premier program is part of the continuum. Individuals who have been recognized as having their first episodes of psychosis are currently served through the Premier program. Individuals in the Premier program are often identified and referred from inpatient mental hospitals.

IDEA Updates

As stated in the previous Annual Update, the original structure and scope of the IDEA program (formerly the Early Psychosis Program (EPC) introduced in the FY 20/21 Three-Year Integrated Plan) has been modified because of funding reductions resulting from COVID-19 restrictions. Program administrators plan to use the existing infrastructure within the continuum of services offered by the Department of Behavioral Health. The adjusted funding for the program will require a phased approach to program implementation.

A recap of the changes are as follows:

- The program's annual projected number of participants has been reduced from 105 to 26 per year.
- The IDEA program will shift its program planning and implementation from developing multiple Coordinated Specialty Care (CSC) teams to the establishment of a small unit consisting of a Mental Health Clinic Supervisor, Clinical Therapist I, Program Specialist II, Social Worker II, Mental Health Specialist, Office Assistant III, Peer and Family Advocate, and part-time Adult and Child Psychiatrist.
- This unit will be responsible for providing mental health services including screening and assessments, individual and group counseling, case management, family education and support, as well as supported education and employment.

The IDEA program is currently in process of recruiting for the Clinic Supervisor and Clinical Therapist I positions, which are expected to be filled in the first half of the FY 24/25. As the program currently has no clinical staff, they have provided referral services only for nine individuals to date.

Improving Detection and Early Access (IDEA), cont.

The IDEA program will be developed through the following phases:

Phase I: Needs Assessment

- Complete needs assessments to identify training gaps.
- Map existing resources.
- Locate screening tool to be used to identify clinical high risk.

Phase II: Recruitment of Program Support Staff

The program staff will coordinate program referrals and serve as a resource hub and centralized access point for mental health providers to facilitate participants' access to timely and appropriate services.

Phase II will consist of the following:

- Recruiting and hiring a program Clinical Therapist I. This position will be utilized to coordinate and provide the delivery of specialized services for Early Psychosis care in order to enhance the current mental health care system.
- Recruiting and hiring a Program Specialist II to assist with program development and outcome reporting.
- Recruit and hire an Office Assistant III to support clinical staff and facilitate access and linkage services.
- Recruit and hire a Social Worker II. This position will provide outreach and education services to the department clinics, community partners, schools/colleges, and other community members as needed. This position will also conduct screenings for eligibility and fit for the program services offered.

Phase III: Clinical High-Risk Training and Education

The program coordinator will provide training and workshops to program staff within the DBH infrastructure, as well as community partners, school/college counselors, amongst others.

Training will be provided to:

- Prevention and Early Intervention program providers,
- TAY program administrators,
- DBH Outpatient Clinic staff, and
- Community partners.

Office of Suicide Prevention (OSP)

Program Description and Target Population

The Office of Suicide Prevention (OSP) is a new Prevention and Early Intervention (PEI) program, 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 to include staff that can direct their attention to implementing, coordinating, and evaluating suicide prevention efforts in San Bernardino County. This initiative presents an opportunity to be amongst one of the few counties in California to invest in the reduction of suicide by creating a local office dedicated to leading suicide prevention efforts in our county.

The Office of Suicide Prevention consists of full-time staff committed to guiding the continued implementation of a strategic suicide prevention plan for San Bernardino County. As the OSP is still in its infancy of implementation and will have more information to report in future updates.

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
Annual Budget FY 25/26	$380,504
Cost Per Client FY 25/26	$253

Office of Suicide Prevention (OSP), cont.

State Program Positive Results

In September 2023, DBH launched the Office of Suicide Prevention in San Bernardino County, offering a centralized website with up-to-date information on warning signs, upcoming trainings, conversation tips, and available resources. The site is regularly updated to ensure residents have the latest information for residents seeking support.

The OSP will consist of three primary positions to manage the daily operations.

Program Specialist II- Leads a small support team in suicide prevention efforts, oversees tasks, writing strategic plans, and implementing business processes.

Mental Health Specialist- Conducts community trainings and presentations, builds stakeholder networks for suicide prevention, and facilitates meetings within the suicide prevention network.

Office Assistant III- Provides administrative support for the Office of Suicide Prevention (OSP).

Recruitment for these positions began in July 2023 following program approval. We have hired for the Program Specialist II and Office Assistant III position. OSP is still interviewing for Mental Health Specialist.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Community Services and Supports

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).

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.

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.

Artwork by Isis Torres

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 Continuum 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 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 2023/24

Age Group	
Children (0-15)	20%
TAY (16-25)	20%
Adult (26-59)	51%
Older Adult (60+)	10%

Gender	
Female	48%
Male	52%
Other	<1%

Race/Ethnicity			
African American/Black	20%	Latinx/Hispanic	41%
Native American or Alaska Native	<1%	Caucasian/White	29%
Asian/Pacific Islander	2%	Other/Unknown	7%

Primary Language	
English	95%
Spanish	4%
Other/Unknown /Not Reported	2%

N=15,637

Note: not all numbers add to 100 due to rounding.

Primary Diagnosis			
Anxiety disorders	12%	Psychosis	25%
Bipolar disorders	9%	Substance related	4%
Depressive disorders	25%	Neurodevelopmental/ cognitive disorders	3%
Disruptive disorders	3%	None/Deferred	2%
Other	16%		

Region	
Central Valley	22%
Desert/Mountain	35%
East Valley	26%
West Valley	12%
Out of County	6%

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 targeted number of people to be served by age group, 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.

In November 2023, DBH partnered with an independent national research and consulting firm in the healthcare industry to complete an assessment of the stakeholder process for developing the MHSA Three-Year Integrated Plan and Annual Plan Updates and behavioral health needs and capacity assessment (see page 24).

Populations for Full Service Partnerships

The CSS section of this Three-Year Plan provides detailed overviews of all Full Service Partnership (FSP) programs, including demographics, numbers projected to be served, 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 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 to be served by programs within the Crisis System of Care.

Crisis Stabilization Continuum of Care Programs				
Program Name	**Target Population**			
	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

CSS: Crisis System of Care

Number of Consumers to be Served

The table below displays the number of consumers to be served by age group and service category for Fiscal Year 2025/26:

Program	Ages Served	Service Area*
Triage Transitional Services	450 TAY 1,450 Adult 100 Older Adult	2,000 GSD
	TOTAL = 2,000	TOTAL = 2,000
Triage, Engagement, and Support Teams	625 Children 1,625 TAY 3,100 Adult 625 Older Adult	4,650 GSD 1,325 O&E
	TOTAL = 5,975	TOTAL = 5,975
Community Crisis Response Team	1,900 Children 1,620 TAY 2,870 Adult 200 Older Adult	1,770 GSD 4,820 O&E
	TOTAL = 6,590	TOTAL = 6,590
Crisis Intervention Training	250 TAY 1,500 Adult 70 Older Adult	1,820 O&E
	TOTAL = 1,820	TOTAL = 1,820
Community Education Program	25 Children 300 TAY 1,000 Adult 100 Older Adult	1,425 O&E
	TOTAL = 1,425	Total = 1,425

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Triage Transitional Services (TTS)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Triage Transitional Services	2,236	2,000	$2,033,100	$1,017

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 16+	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 works alongside ARMC-BHU staff to assist in determining if the consumer meets medical necessity 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 PAS work collaboratively with CRT staff to provide services that are intended to divert and reduce psychiatric inpatient hospitalization, assist consumers to maintain self-sufficiency, increase housing stability, and assist consumers to successfully reintegrate into the community.

Demographics

Age

0% Children
22% TAY
74% Adult
4% Older Adult

Gender Identity

65% Male
35% Female
<1% Other

Race/Ethnicity

21% African American/Black
29% Caucasian/White
<1% American Indian/ Alaska Native
2% Asian/Pacific Islander
45% Latinx/Hispanic
3% Other/Unknown

Primary Language

97% English
3% Spanish
<1% Other/ Unknown

N=1,138

Note: not all numbers add to 100 due to rounding.

CSS: Triage Transitional Services (TTS)

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 are co-located at each CRT site to provide the following services:

- Screening for discharge services
- Assessments
- Discharge planning
- Placement assistance
- Transportation

Positive Results

In FY 2023/24, TTS staff served a total of 1,781 consumers from the ARMC-BHU Triage Unit. Of these, a total of 926 (52%) consumers were diverted from unnecessary hospitalization.

As part of the expanded TTS services, PAS services assisted a total of 455 consumers. Of these consumers, 285 remained in the CRT program long enough to receive linkage to aftercare services, and 100% were successfully placed in safe and sustainable community placements.

All staff received the Listen-Empathize-Agree-Partner (LEAP) training, a set of evidence-based practices to create therapeutic alliance and trusting relationships with consumers to build rapport and create relationships. This has resulted in providing additional ways to engage with consumers and opportunities to provide services.

Demographics

N=1,138

Primary Diagnosis

3.0% Anxiety disorders	**43.2%** Psychosis disorders
7.7% Bipolar disorders	**5.4%** Substance use disorders
26.9% Depressive disorders	**12.0%** Other
<1% Disruptive disorders	**1.2%** None/deferred
<1% Neurodevelopmental/Cognitive	

Note: not all numbers add to 100 due to rounding.

Challenges/Solutions

TTS staff experienced challenges with limited resources for placement, including homeless shelters and housing services. To address this challenge, staff are collaborating with community and other DBH programs to identify additional placement services as part of their ongoing duties.

Challenges with unsuccessful placements in Board and Care and Room and Board were addressed by working collaboratively with Room and Board homeowners and house managers to improve customer service and more successful placements.

Staffing challenges led to delays in timely outpatient psychiatric appointments and clinic intakes, which could potentially impact access to needed medication. To ensure access to timely medication, TTS staff informed consumers about the option to obtain medication refills at the Crisis Stabilization Units (CSUs) in the interim.

Another challenge for consumers was the lack of transportation options. DBH staff assisted consumers by providing bus passes or contacting Managed Care Plans to secure transportation services for medical appointments.

Program staff faced challenges placing system-involved and pregnant transitional age youth (TAY) consumers in traditional TAY programs. To address this challenge, TTS staff worked to identify other TAY service providers in the community to assist with placements for this specific population.

Outreach and Engagement

For FY 2023/24, 20 participants attended a presentation where TTS program staff were available to discuss their program and offer resources.

Success Story

"Juan" called the program in crisis after a suicide attempt. Due to staff's ability to assess over the phone and adept skills to build a rapport, Juan presented to the hospital and TTS assisted him as a voluntary walk-in. TTS staff provided connection to follow-up outpatient services. Juan thanked staff when it came time for him to be discharged.

Program Updates

There are no planned updates for this program.

Artwork by Willie Cotton

Success Story

"Kenny" was a socially isolated consumer when he entered the PAS program. He was resistant to mental health treatment and services and experienced emotional dysregulation, which resulted in challenges in employment. PAS staff supported Kenny and consistently worked with him to become medication and mental health treatment compliant. He developed great social skills, hosts group meetings in his community residence, and has obtained employment. Kenny is now pursuing career training goals to become a Peer and Family Advocate.

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.

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Community Crisis Response Team	5,474	6,590	$10,501,558	$1,594

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	**N/A**	**Field-based**	**Experiencing a behavioral health crisis**

Program Description and Target Population

Community Crisis Services (CCS) is comprised of the Crisis Contact Center (CCC), the Community Crisis Response Team (CCRT), and the contracted Crisis Mobile Response Team (CMRT). The CCC is a centralized location where anyone can call or text for immediate access to specially trained crisis staff. When necessary, CCC staff dispatch CCRT staff who provide urgent mobile field-based behavioral health services to individuals in cities throughout the County. CCRT and CMRT teams provide mobile crisis response in the East/Central Valley, West Valley, and High Desert regions of the County. Mobile crisis response is available 24 hours per day, 365 days a year at community locations through collaborations that include, but are not limited to: law enforcement, hospitals, schools, Department of Behavioral Health (DBH) clinics, contract providers, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals.

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

Age

26% Children
22% TAY
39% Adult
7% Older Adult
7% Unknown

Gender Identity



47% Male | **45%** Female | **<1%** Transgender | **7%** Other/Unknown

Race/Ethnicity

14% African American/Black
18% Caucasian/White
<1% American Indian/Alaska Native
3% Asian/Pacific Islander
32% Latinx/Hispanic
33% Other/Unknown

N=5,474

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

CCS is committed to assisting San Bernardino County residents in the least restrictive manner by providing behavioral health services where the individual is experiencing their crisis.

Services Offered

- Crisis assessment and intervention in the field, via text messaging, and/or virtual conferencing
- Follow-up services
- Linkage to community resources and providers
- Consultation for interruption of involuntary psychiatric hold (WIC 5150/5585)

Positive Results

In FY 2023/24, 1,265 consumers were diverted from hospitalization, representing an approximate 6.6% increase in consumers diverted over the previous fiscal year. Of those diverted: 61 consumers were diverted to crisis residential treatment facilities, 720 consumers were diverted to crisis stabilization unit facilities, 158 consumers were diverted to crisis walk-in clinics, and 326 consumers were diverted to other qualified crisis intervention alternatives.

Additionally, CCRT provided therapeutic support services at 29 different community events in FY 2023/24. These events included, but were not limited to, the December 2nd Memorial event, Directing Change, Oak Glen/Forest Falls evacuation center, Recovery Happens event, Sound of Recovery Music event, and Into the Light gallery opening.

Demographics

Primary Language

89% English
4% Spanish
7% Other

N=5,474

Primary Diagnosis

9.7% Anxiety disorders
4.2% Bipolar disorders
39.1% Depressive disorders
4.1% Disruptive disorders
1.7% None/Deferred
3.2% Neurodevelopmental/cognitive disorders
18.4% Psychosis disorders
1.7% Substance Use
18.1% Other

N=1,334

Note: not all numbers add to 100 due to rounding.

Positive Results, cont.

Additionally, to streamline access to Crisis Services, a toll-free number was established in January 2023. Community members experiencing a behavioral health crisis can call the CCC at the toll-free number, where specially trained crisis staff will triage the call and determine if a field response is needed.

Challenges/Solutions

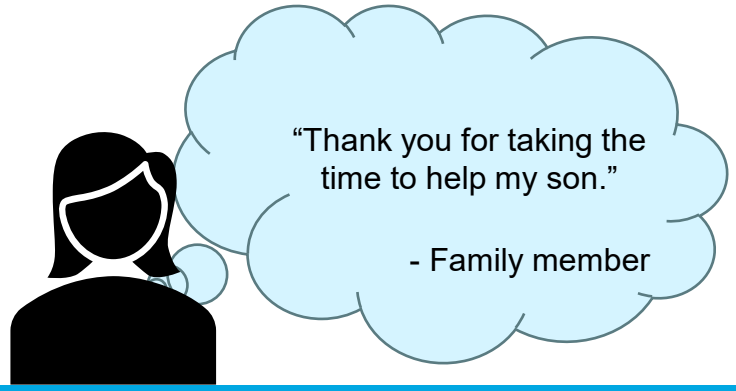
Due to promotional opportunities for current staff and increased competition from other healthcare providers in the county, recruitment and retention of qualified staff remains an ongoing challenge for CCS.

To address these staffing challenges, CCS participated in two hiring fairs to fill multiple vacancies: one hiring fair was solely for hiring staff for CCS and the second hiring fair was open departmentwide.

The Department of Health Care Services (DHCS) released Behavioral Health Information Notice (BHIN) 23-025 in June 2023 that mandated 24/7 mobile crisis response. The challenge was expanding services from 15 hours per day to 24 hours per day. Additionally, our Electronic Health Record (EHR) was not programmed to bill for Federal Benefits for mobile crisis response.

To meet this requirement, CCS established its first contract with a community partner to provide overnight mobile crisis response 365 days per year. Between CCS and the contractor, mobile crisis response is provided 24/7/365.The contract with the provider expires on March 31, 2025, therefore, CCS will seek procurement for mobile crisis response effective April 1, 2025. CCS is working with the EHR administrators to develop a system to bill for services provided according to the BHIN 23-025.

Another challenge was the requirement to use mandated tools issued by DHCS. This required training staff on the new tools as well as working with our Behavioral Health Information Management System (BHIMS) partner to integrate the tools into the Department's EHR. To address this, trainings were developed for staff and program management met with the BHIMS vendor to integrate the tools into the Department's EHR.



Outreach and Engagement

During FY 2023/24, the CCRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Law Enforcement Collaboration	18	306
School Collaboration	20	243
Disaster Relief Collaboration	7	18
Community Groups Collaboration	4	89
Other San Bernardino County Department Collaboration	6	189
Mental Health Provider/Clinics	4	6
Total	**59**	**851**

Program Updates

There are no planned updates for this program.

Success Story

The Crisis Contact Center (CCC) received a text requesting a team be sent to an address in Rancho Cucamonga. When CCC staff called the number, it went to voicemail. Within a few minutes, an additional text was received from the same number that stated “I’m suicidal and depressed because I’m getting put out of my daughter’s house today. I’m afraid, please send someone to help me.”

The CCC staff called again, but the call went to voicemail. Due to not being able to confirm that the scene was safe for a crisis mobile team to respond, the Clinic Supervisor requested a welfare check by the Rancho Cucamonga Sheriff. A deputy responded and located a male who sent the texts. Per the deputy, the male did not meet the criteria for an involuntary hold, but stated the male did want to voluntarily admit himself; the deputy asked CCC for guidance on where the male could go. The male’s family agreed to transport, and the male was taken to a crisis stabilization unit.

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Crisis Intervention Training	2,505	1,820	$6,996,318*	$759*

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18+	**N/A**	**Field-based**	**First responders and community partners**

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

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 2023/2024 through Fiscal Year 2025/2026, pages 230-233.

Demographics

Age

<1% Children
10% TAY
59% Adult
3% Older Adult
28% Declined to State

Gender Identity

44% Male
28% Female
28% Other/Decline to State

Race/Ethnicity

9% African American/ Black
19% Caucasian/White
<1% American Indian/ Alaska Native
3% Asian/Pacific Islander
34% Latinx/Hispanic
35% Multiple Races/Other

N=2,505

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

"Great class. Thank you for all the great information. I will definitely apply it to my work environment. Enjoyed the games and class interaction. It made the time fly by, and we were having fun and learning too. Thanks!"

- CIT Student

Demographics

Primary Language

69% English

<1% Spanish

30% Unknown/Other

N=2,505 Note: not all numbers add to 100 due to rounding.

Positive Results

In FY 2023/2024, law enforcement personnel and community partners received training through the CIT program:

- 383 law enforcement personnel completed the 40 Hour CIT Course
- 171 Field Training Officers (FTO) completed the 8 Hour FTO CIT Course
- 652 Probation Officers and Probation Correctional Officers completed the 4 Hour CIT Course
- 212 Fire personnel received training from the CIT program
- 1,087 community partners, public employees, and emergency departments received specialized training from the CIT program
- In total, 2,505 law enforcement, other first responders, and community partners received training from the CIT program in FY 2023/2024.

Challenges/Solutions

The demand for CIT training program training requests has increased every year. However, staffing shortages were a significant challenge during the first half of FY 2023/24. A portion of the training requests were denied or outsourced when possible due to the staffing shortage. CIT continues to recruit and fill positions while leadership continues to work closely with Human Resources to brainstorm and resolve recruiting and hiring challenges.

Additionally, training new staff in certified curriculum has been difficult, as certification trainings are only offered out of the state and country or not offered at all. To address this challenge, CIT leadership is working on bringing LEAP and other 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 2023/24, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Outreach/Networking Event	2	250
Community Collaborative Meeting	11	302
Gang and Drug Taskforce	2	70
40 Hour CIT Course	10	383
8 Hour Field Training Officer (FTO) Course	7	171
4 Hour Probation Dept. CIT Course	22	652
Fire Trainings	6	212
Community Partner Trainings	38	1,087
Total	**98**	**3,127**

Program Updates

There are no planned updates for this program.

Artwork by Roxanne Olsen

"The scenarios were done really well with very good acting and were extremely helpful."

- CIT Student

Artwork by Benjamin Vasquez

"After 15 years in law enforcement, I did not want to come to this training. However, this is possibly the best mental heath class I have attended. Great job by all and look forward to working with you all in the future."

- CIT Student

Community Education Program (CEP)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Community Education Program (CEP)	755	1,425	$6,996,318*	$759*

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
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

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

0% Children
8% TAY
68% Adult
4% Older Adult
19% Unknown

N=755

Gender Identity

16% Male
65% Female
19% Other/Decline to State

Race/Ethnicity

15% African American/Black
18% Caucasian/White
<1% American Indian/ Alaska Native
4% Asian/Pacific Islander
33% Latinx/Hispanic
29% Multiple Races/Other

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

The Community Education Program (CEP) is a distinct program that is part of the Crisis Intervention Training (CIT) Program budget. Existing Workforce Education and Training staff and Public Relations staff and services that were forecasted and allocated in the Three-Year Plan transferred to the CIT budget to meet the needs of this new program.

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

Primary Language

78% English

<1% Spanish

22% Other/Decline to State

N=755 **Note**: not all numbers add to 100 due to rounding.

Positive Results

A total of 41 trainings were facilitated, and 755 community members received training through the Community Education Program (CEP) in FY 2023/24.

- 139 Adult Mental Health First Aid
- 29 Applied Suicide Intervention Skills Training (ASIST)
- 81 SafeTALK
- 161 Listen, Empathize, Agree, and Partner (LEAP)
- 345 community members completed a non-certified CEP training or presentation

Challenges/Solutions

The initial process of establishing the Community Education Program (CEP) was challenging, particularly in recruiting, hiring, and training new staff. This process spanned the first half of the fiscal year, official CEP training were made available to the public beginning in January 2024. CEP leadership worked with Human Resources to hire a new Staff Training Instructor in October of 2023 and is requesting a Mental Health Education Consultant for Fiscal Year 2024/25 as a solution to the staffing challenges.

Training new staff in certified curriculum has also been challenging, as many required trainings are only offered out of state or internationally or are not readily available. To address this challenge, CEP leadership is working on having the vendors for LEAP and potentially SafeTALK provide an in-house train-the-trainer course.

Outreach and Engagement

For FY 2023/24, the Community Education Program (CEP)program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Gang and Drug Task Force	2	70
Community Collaborative Meetings	9	277
Listen, Empathize, Agree and Partner trainings	10	161
Mental Health First Aid – Adult trainings	8	139
SafeTALK trainings	5	81
ASIST trainings	2	29
Non-Certified CEP trainings	16	345
Total	**52**	**1,102**

Program Updates

There are no planned updates for this program.

"Excellent training! Instructors were knowledgeable, thorough, and clearly subject matter experts! Excellent training."

- CEP Student

"Both trainers were great. Both were engaged and helpful, full of info. They made me feel safe and confident that I can apply this in life. This training gave me a boost of confidence to continue my education in mental health."

- CEP Student

"The role-play Rachel conducted was impactful. It was a great way to showcase the material and present LEAP in a way that was tangible."

- CEP Student

Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Triage, Engagement, and Support Teams	4,613	5,975	$6,996,318*	$759*

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
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 main 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.

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

Age

14% Children
19% TAY
50% Adult
16% Older Adult
1% Unknown

N=4,613

Gender Identity

51% Male
47% Female
2% Other

Race/Ethnicity

13% African American/ Black
37% Latinx/Hispanic
3% Asian/Pacific Islander
<1% Native American
35% Caucasian/White
12% Other/Unknown

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

The TEST program provides exclusive support to its partnering departments and agencies. TEST staff respond in the field alongside law enforcement personnel and/or assist other partnering agency staff in managing consumer behavioral health crises. Additionally, TEST 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 are part of a new collaborative initiative known as Community Outreach and Support Team (COAST). COAST units are co-response teams 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 as part of a COAST team is consistent with 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
- Consumer advocacy
- Education and support for law enforcement and community partners regarding behavioral health concerns and resources

Demographics

Primary Language

96% English

2% Spanish

3% Other/Not Reported

Primary Diagnosis

5.2% Anxiety disorders

3.5% Bipolar disorders

36.7% Depressive disorders

2.2% Disruptive disorders

<1% Neurodevelopmental/cognitive disorders

3.0% None/deferred

23.8% Psychosis disorders

3.9% Substance use disorders

21.0% Other

N=772

N=4,613 **Note**: not all numbers add to 100 due to rounding.

Positive Results

TEST program data is captured based on an "encounter," which refers to an instance in which TEST staff engage an individual for services. In FY 2023/24, TEST

- Recorded 12,358 encounters.
- Provided 15,150 referrals to behavioral health and community resources. Often, when TEST staff engage with an individual during an encounter, they identify that these individuals and/or families need more than one referral to multiple types of resources to help meet their needs.
- Increased access to and use of existing community resources.
- Continued use of alternative crisis interventions (e.g., CWIC, CCRT, CSU) resulted in 98% of TEST Crisis Interventions being diverted from hospitalization for FY 2023/24 compared to 92% in FY 2022/23.

Challenges/Solutions

In FY 2023/24, the TEST program experienced challenges with finding qualified candidates for two positions for the San Bernardino County Sheriff's Department (SBCSD) in Needles. This location is in a remote area at the far end of San Bernardino County, making it difficult to fill these positions. Solutions for filling these positions for our Needles Sheriff Station include working with our county Human Resource (HR) Department to open a special recruitment specifically targeting qualified individuals residing in or near the Needles area and collaborating with the SBCSD, the TEST program Deputy Director (DD), San Bernardino County Board of Supervisors (BoS) and the City of Needles to promote the two vacancies.

As the program continues to expand, balancing staffing needs and budgetary constraints remains a challenge. Each co-location site requires infrastructure to accommodate the assigned staff, added costs for space, equipment such as laptops and cell phones, etc. The TEST program continues to look for ways to mitigate these costs into sustainable funding sources.

TEST experiences challenges with the crucial need to maintain a robust collaborative relationship with the various agencies. Continuous, active efforts in building and maintaining relationships with law enforcement and community partners include meetings with all co-location partners to ensure the partners are aware of the purpose of TEST staff. In addition, when requests for new TEST sites are made, data (both internal and provided by collaborative partners) is analyzed to help determine which areas and sites would most benefit from TEST services

Outreach and Engagement

For FY 2023/24, the TEST program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Groups Collaboration	148	2,138
Law Enforcement Briefing	1,738	26,525
Homeless Outreach	27	3,717
CIT Presentations	4	212
Law Enforcement Outreach	2,294	27,820
School Outreach (K-12)	5	618
School Outreach Higher Education)	4	332
Food drive	11	116
Health and Wellness Outreach	11	673
Totals	**4,242**	**62,151**

Success Story

"I wanted to email you to thank you for your concern, and all of the kindness and resources that I have received from the Victor Valley Sheriff Department. I did not expect to encounter so many helpful and genuine individuals. My time in Victorville, although challenging, has opened my eyes to a brand-new perspective on life, but my time here is coming to an end as I move back to Los Angeles, fulltime, in two weeks. I was wondering if it would be possible to meet with Deputy D. Waters in person before I go, to say a proper thank you and goodbye."

Artwork by Garth Pezant Sr.

Program Updates

There are no planned updates for this program.

Success Story

"David" reported feeling extremely overwhelmed and depressed over the past few weeks due to the loss of a sibling and being kicked out of his home. He was experiencing homelessness and temporarily staying in a hotel room. He reported wanting to get out of his situation but did not have anyone to lean on during those times. David shared it had been challenging to work on creating friendships since he usually isolated himself. David had been diagnosed with anxiety and depression and was not taking any medication. Due to this depression and isolation, he began to use methamphetamine to cope with these feelings. David reported previous suicide attempts due to voices telling him that he was worthless.

A TEST social worker assisted David in completing an intake for substance use treatment services and provided regular follow-ups and resources for urgent mental health services. David was informed of bed availability and contacted his social worker to link him to services. David was scheduled to be picked up by the social worker and transported to a substance use treatment center. David was cooperative with maintaining contact with his social worker but stopped communication after the social worker's second attempt at calling him. After 45 minutes of waiting for David, he finally answered the social worker's attempts to contact him. David shared feeling overwhelmed and afraid of what his new future would look like. The social worker provided support and de-escalated him from experiencing a mental health crisis. After some encouragement, David agreed to follow through with receiving treatment. David was cooperative and spoke in a hopeful tone during transport to the center. David was successfully linked to SUD treatment services and thankful for being connected to the services he needed.

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).

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	

CSS: Crisis Stabilization System of Care

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served by age and service categories for Fiscal Year 2025/26:

Program Name		Ages Served	Service Area*
Crisis Walk-In Center		212 Children 496 TAY 1,246 Adult 145 Older Adult	2,099 GSD
		TOTAL = 2,099	TOTAL = 2,099
Crisis Stabilization Unit		366 Children 1,052 TAY 3,631 Adult 368 Older Adult	5,417 GSD
		TOTAL = 5,417	TOTAL = 5,417
Crisis Resident Treatment	Adult CRT	50 TAY 416 Adult	466 GSD
		TOTAL = 466	TOTAL = 466
	TAY CRT	101 TAY	101 GSD
		TOTAL = 101	TOTAL = 101

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

Crisis Stabilization Unit (CSU)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Crisis Stabilization Unit (CSU)	5,258*	5,417	$13,383,661**	$1,781**

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All Ages	All Levels	Clinic-based 	Experiencing a behavioral health crisis

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both CWIC and CSU.

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 as a result of 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 includes 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

8% Children
20% TAY
65% Adult
6% Older Adult

Gender Identity



56% Male **44%** Female **<1%** Other

Race/Ethnicity

21% African American/ Black
3% Asian/Pacific Islander
24% Caucasian/White
50% Latinx/Hispanic
<1% American Indian/ Alaska Native
3% Other/Unknown

Primary Language

96% English
4% Spanish
<1% Other

N=4,856

Note: not all numbers add to 100 due to rounding.

CSS: Crisis Stabilization Unit

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 Crisis Stabilization Unit (CSU) programs served a combined total of 5,258 unique consumers during FY 2023/24. These programs provided 8,206 episodes of crisis stabilization to these consumers.

Of the 8,206 admissions, 97.3% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CSU services.

In FY 2023/24, the two Crisis Stabilization Units (CSUs) received referrals from a total of 87 unique collaborative partners, including psychiatric hospitals, hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, schools, faith-based organizations, shelters, and other community agencies.

- 879 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.
- 342 referrals originated from local hospitals, representing a population whose crisis was appropriately manageable at the CSU rather than at the inpatient level of care.

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services. Of the 5,200 surveys issued by the two CSUs, the programs received a combined 94.2% consumer satisfaction rate with the services received.

Demographics

Primary Diagnosis

10.3% Anxiety disorders	**1%** Neurodevelopmental/Cognitive
9.3% Bipolar disorders	**30.9%** Psychosis disorders
20.9% Depressive disorders	**4.5%** Substance Related
4.1% None/deferred	**<1%** Disruptive disorders
18.3% Other	

N=4,856

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

Maintaining qualified personnel to provide crisis stabilization services continues to be a challenge as remote work opportunities become more commonplace in the healthcare environment. Since CSU regulations require on-site staff 24/7, remote work is not an option for direct care staff, which impacts recruitment and retention.

To ensure ongoing availability of services and to address workforce challenges, CSUs have a robust intern program, that allows them to maintain a solid recruitment pipeline from internship to graduation for clinical roles. The programs are also focusing on retention efforts to maintain staffing rotation at a high capacity.

As CSU programs are housed in county-owned buildings, standard facilities management procedures created delays in addressing building-related issues communicated by CSU staff. These delays can affect the number of consumers the facility can accomodate while awaiting repairs.

Improved communication between the CSUs and DBH/County Facilities Management has facilitated smoother completions of work orders. DBH has also added Program Administration staff as dedicated support for all CSU concerns, which has resulted in a stronger follow-up and support system. The continued relationship growth and new workflow have been valuable in expediting critical fixes as the needs arise.

Success Story

"Jack" came to the CSU feeling sad, hopeless, helpless, and unmotivated. CSU staff worked to stabilize him and provided him an array of services to assist him, including assistance with meals, nursing care, mental health services, and psychiatric evaluation. Staff were also able to connect him to a private faith-based rehabilitation program and advocate for him to be seen for a personal interview on the same day. The administrator of the program agreed to meet Jack for an interview, and he was admitted to the program a few hours later. Jack subsequently contacted the CSU to express his gratitude.

Outreach and Engagement

CSU staff and DBH regularly conduct outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CSU programs coordinate with the DBH continuum of care.

During FY 2023/24, the CSU program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborative Meetings	41	947
Event participation	5	1,457
Other Outreach Activities	2	21
Presentations	39	1,278
Telephonic/Electronic Outreach	21	29
Totals	**108**	**3,732**

Program Updates

There are no planned updates for this program.

Success Story

"Bianca" visited the CSU frequently while she was staying in a room and board facility. She came back multiple times within a week, stating that remaining at the CSU assisted her with refraining from using substances. She reported that she was able to remain clean, felt clear-headed, and was thankful for the staff that let her stay almost every night to keep her safe and off drugs. Bianca is now living independently, remains connected to a program for ongoing treatment, and receives all her benefits.

Crisis Walk-In Center (CWIC)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Crisis Walk-In Center (CWIC)	2,063*	2,099	$13,383,661**	$1,781**

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	All Levels	Clinic-based	Experiencing a mental health crisis

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both CWIC and CSU.

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
23% TAY
59% Adult
8% Older Adult

Gender Identity

49% Male
51% Female
<1% Other

Race/Ethnicity

18% African-American/Black
41% Caucasian/White
<1% American Indian/Alaska Native
2% Asian/Pacific Islander
21% Latinx/Hispanic
17% Other/Unknown

Primary Language

97% English
2% Spanish
1% Other/Unknown

N=2,051

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 Crisis Walk-In Center (CWIC) programs served a total of 2,063 unique consumers during FY 2023/24. These programs provided a combined 3,064 episodes of crisis stabilization to these consumers.

Of the 3,064 admissions, 96.4% were successfully diverted from unnecessary 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 90.9% consumer satisfaction rate with the services received.

Success Story

"Luke" presented at the CWC after recently being displaced from his home, which caused his mental health symptoms to increase. CWIC personnel were able to reconnect Luke with family out of state after he identified them as a support system. His family was open to assisting and housing Luke. CWIC was able to provide a bus ticket for him to travel to his family. CWIC staff researched and provided resources for Luke's continued recovery in the other state in which he would be residing.

Demographics

Primary Diagnosis

14.0% Anxiety disorders
13.1% Bipolar disorders
31.8% Depressive disorders
<1% Disruptive disorders
1.2% Neurodevelopmental/cognitive disorders
27.2% Psychosis disorders
4.2% Substance use disorders
7.1% Other
<1% None/Deferred

N=2,051

Note: not all numbers add to 100 due to rounding.

Challenges/Solutions

The Crisis Walk-In Centers (CWICs) experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CWICs due to the nature of the services provided by the program.

To address workforce challenges, CWICs continue to implement salary market rate adjustments to remain competitive with other providers and maintains sign-on bonuses to boost recruiting and increase candidate pools.

Valley Star Behavioral Health, the contract provider CWICs, communicates any budget adjustment needs with DBH and cooperates in the analysis process to evaluate the need for additional funding.

Success Story

"Matthew" came to the CWIC unmedicated, unhoused, and struggling with co-occurring mental health and substance use diagnoses. He was able to stabilize with the support of a therapist and Peer Support Counselor, who ultimately linked Matthew with housing and outpatient substance use services.

Outreach and Engagement

CWIC staff and DBH provide frequent outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CWIC programs coordinate with the DBH continuum of care.

For FY 2023/24, the CWIC program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborative Meetings	84	361
Other Outreach Activities	3	3
Presentations	17	449
Telephonic/Electronic Outreach	34	82
Totals	**138**	**895**

Program Updates

There are no planned updates for this program.

Adult Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Adult Crisis Residential Treatment	485*	466	$16,610,099**	$29,295**

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both adult and TAY CRTs.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	SMI*	Facility-based 	Experiencing a behavioral health crisis

*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 are in need of 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.

Demographics

Age

0% Children
16% TAY
84% Adult
0% Older Adult

Gender Identity

60% Male
40% Female

Race/Ethnicity

23% African American/Black
32% Caucasian/White
<1% American Indian/ Alaska Native
3% Asian/Pacific Islander
39% Latinx/Hispanic
3% Other/Unknown

Primary Language

99% English
1% Spanish
<1% Other

N=439

Note: not all numbers add to 100 due to rounding.

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 2023/24, a total of 485 unique consumers were served by the four adult CRT programs. Of consumers who were discharged from the program during the fiscal year, 95% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

DBH contracts with two agencies to provide Crisis Residential Treatment (CRT) services. Each agency delivers a unique consumer satisfaction survey after discharge from the facility. All surveys are voluntary.

The first contracted agency operates three CRT programs and evaluates consumer agreement with twenty statements including, but not limited to:

- I felt safe and supported during my crisis.
- I am more resilient and am more likely to overcome challenges after participating in the program.
- Staff understood, respected, and sympathized with my unique abilities.

Out of 158 surveys collected, the 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 Diagnosis

5.9% Anxiety disorders

10.7% Bipolar disorders

21.6% Depressive disorders

<1% None/Deferred

48.3% Psychosis disorders

7.9% Substance use disorders

5.0% Other

N=439

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 251-255.

Positive Results, cont.

The second contracted agency operates one CRT program and evaluates consumer agreement with twelve statements including, but not limited to:

- As a direct result of the services I received, I am better able to deal with crisis.
- Staff here believed that I could grow, change, and recover.
- I was able to get all the services I thought I needed.

Out of 59 surveys collected, 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

Due to the national workforce shortage, and the sudden increase in the cost of living making current wages non-competitive, CRTs experienced challenges with recruitment and hiring. These challenges were further compounded by the growing demand for remote work opportunities, which is not feasible for CRTs due to the in-person nature of the services provided.

Additionally, CRTs are required to have a specific number of specialized staff on site per consumer being treated. Staff shortages have limited the number of consumers a CRT facility can admit on days when staffing numbers are lower than normal.

To address the workforce challenges, CRTs have completed salary market rate adjustments to remain competitive with other providers, implemented sign-on bonuses to boost recruiting and increase candidate pools, and hired a talent acquisition manager/team to engage in more targeted recruitment efforts such as hiring fairs and virtual recruitment projects.

To address the changing needs of the consumer population, CRTs have prioritized Adverse Childhood Experiences (ACE) screening tools, provided recovery-oriented and evidence-based interventions, emphasized the importance of trauma-informed care through hiring choices and workforce development, and worked to promote staff wellness.

Outreach and Engagement

For FY 2023/24, 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 and presentations to increase collaborative partners	5	10
Totals	**110**	**381**

Program Updates

There are no planned updates for this program.

Success Story

After completing the CRT program, “Joseph” was able to fully eliminate his suicidal thoughts, as well as significantly reduce his depression and trauma response symptoms. James was successfully linked to a DBH shelter program with outpatient services to aid in maintaining stability.

Success Story

“Anabel” was referred to the CRT from one of the county’s CSUs. She took full advantage of the diverse groups offered in the program and was also able to meet weekly with a therapist and substance use counselor. When she left the program, Anabel felt much more stable and was able to connect with a room and board the clinician connected her to.

TAY Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
TAY Crisis Residential Treatment	100	101	$16,610,099*	$29,295*

*Annual budget and cost per consumer represent both adult and TAY CRTs.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
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.

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.

Demographics

Age

0% Children
100% TAY
0% Adult
0% Older Adult

N=100

Gender Identity

60% Male
40% Female

Race/Ethnicity

28% African American/Black
20% Caucasian/White
1% American Indian/ Alaska Native
1% Asian/Pacific Islander
48% Latinx/Hispanic
2% Other/Unknown

Primary Language

98% English
1% Spanish
1% Unknown/ Not Reported

CSS: Crisis Residential Treatment

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

In FY 2023/24, 100 unique consumers were served by TAY CRT. Of consumers who were discharged from the program during the fiscal year, 95% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CRT services.

Demographics

Primary Diagnosis

N=100

4% Anxiety disorders	**27%** Depressive disorders
13% Bipolar disorders	**45%** Psychosis disorders
1% None/deferred	**5%** Other
4% Substance Use disorder	**1%** Neurodevelopmental/ Cognitive disorders

The TAY CRT received referrals from a total of 17 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, Crisis Stabilization Units (CSU) and Crisis Walk-in Centers (CWIC), outpatient clinics, law enforcement agencies/officers, and community agencies.

Challenges/Solutions

Due to the national workforce shortage and sudden increase in the cost of living, making current wages non-competitive, TAY CRT experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CRTs due to the nature of the services provided by the program. To address these workforce challenges, TAY CRT continues to complete salary market rate adjustments to remain competitive with other providers and maintains sign-on bonuses to boost recruiting and increase candidate pools.

Additionally, an increasing number of TAY consumers are being routed to adult-oriented CRT programs instead of being referred to TAY CRT first. While all CRT programs deliver quality services that support each individual's stabilization and recovery amid their mental health crisis, TAY CRT programming includes age-appropriate interventions, collaborations, and linkage/referral opportunities that target the TAY age group. To improve the

Challenges/Solutions, cont.

likelihood of referring entities connecting TAY consumers with the TAY initially, TAY CRT continues to provide outreach to community partners, ensuring they understand the benefits of connecting the consumer to the TAY, and working with other CRTs to refer to TAY CRT if consumers in the TAY age group were referred to their program.

Outreach and Engagement

For FY 2023/24, the TAY CRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborations with other DBH programs	52	171
Participation in school event	1	12
Totals	**53**	**183**

Program Updates

There are no planned updates for this program.

Success Story

"Gina" was able to stabilize in 63 days, significantly decreasing psychosis and mood instability symptoms. She was successfully linked to outpatient services and reunited with her family for housing.

Success Story

"Athena" was able to stabilize in 84 days, fully eliminating suicidal ideation and self-harming behaviors, and significantly reducing repression and trauma response symptoms. She was linked to One Stop TAY in San Bernardino to aid in maintaining her stability.

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 support centers that are recovery oriented for consumers 18 years or older. There are nine clubhouses located throughout the county that are dedicated to assisting consumers living with a serious mental illness or seeking recovery from substance use. Clubhouses are primarily consumer-driven and operate with minimal support from department staff. Clubhouse members drive all operations 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, the Peer Provider Workforce Support Initiative continues DBH's commitment to growing, supporting, and improving the inclusion of a fully integrated peer workforce. In FY 2023/24, these efforts were shifted under the Peer Programs division. 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 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Clubhouse and Community Connections	35,560	35,288	$5,897,718	$167

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	BHC*	Facility-based 	Seeking recovery-based support services

*BHC = Behavioral Health Challenges

Number of Consumers to be Served

The table below displays the estimated number of consumers to be served for FY 2025/26.

Program	Service Area*	Total to be Served
Clubhouse and Community Connections	• 2,500 GSD • 32,788 O&E	35,288

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

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