VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Mental Health Services Act

Annual Update

Fiscal Year 2025–2026

Loretta L. Denering, DrPH, MS
Director

Christine Doss, MSW, LCSW
Assistant Director

Jason Cooper, M.D.
Medical Director

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Acknowledgements

The Ventura County Behavioral Health (VCBH) Department would like to acknowledge all individuals and organizations who contributed their time and effort to support the development of this Mental Health Services Act (MHSA) Annual Update.

Thanks to all VCBH staff and outsourced MHSA providers for the excellent services they provide, their continued support with respect to data collection, ensuring clients' voices are heard, and their efforts in bringing this report to fruition.

We especially want to thank our diverse stakeholders, individuals, and groups for participating in various focus groups, evaluations, and planning efforts, all of which help to ensure that we serve and assist our Ventura County Community in an equitable manner; always striving to better address disparities.

In addition, we would like to thank the VCBH Contracts, Quality Improvement, and Fiscal teams for their contributions, support, and cooperation in gathering the necessary data and information for this report. We would like to acknowledge and thank the VCBH Data Collection and Reporting team for their professionalism and expertise in extracting and preparing the necessary reports. We also acknowledge and thank EVALCORP Research & Consulting for the preparation of the Prevention and Early Intervention (PEI) Evaluation Report.

Finally, we would like to recognize the MHSA Team for its leadership and support in aligning the State reporting and evaluation requirements while valuing stakeholder input and maintaining transparency.

Director's Message

The purpose of this Mental Health Services Act (MHSA) report is two-fold: (1) provide an update to Ventura County's stakeholders, partners, clients, and community members on the progress of the current three-year plan for mental health services funding in Ventura County for 2023–2026; and (2) report on the activities, services, and programs planned through the MHSA for Fiscal Year 2025–2026. We are also implementing important legislative changes that will shape the way we deliver care. With the passages of Proposition 1 and Proposition 36, and the implementation of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative, the Community Assistance, Recovery & Empowerment (CARE) Act, California Advancing and Innovating Medi-Cal (CalAIM) payment reform—and more—we are seeing major changes to the county behavioral health landscape and the new requirements for care delivery. Through it all, Ventura County Behavioral Health (VCBH) remains committed to our mission to promote wellness through a whole-person care approach that endeavors to be both empowering and culturally sensitive. As the payor of last resort, MHSA funding is a critical resource that aims to ensure essential treatment, services and prevention efforts happen for the betterment of our community. None of this work could be done without the commitment and dedication of our community partners, stakeholders, and contracted providers. It is with all this in mind that I ask readers to consider VCBH's MHSA report.

MHSA County Fiscal Accountability Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Ventura

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Loretta L .Denering	Name: Jeffery Burgh
Telephone Number: 805-981-2214	Telephone Number: 805-654-3151
E-mail: Loretta.Denering@venturacounty.gov	E-mail: Jeff.Burgh@venturacounty.gov
Local Mental Health Mailing Address: 1911 Williams Drive, Suite 200, Oxnard, CA93036	

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.

Loretta L Denering
Local Mental Health Director (PRINT)

Signature 6/3/26
Date

I hereby certify that for the fiscal year ended June 30, 2025, 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 12/30/25 for the fiscal year ended June 30, 2025. I further certify that for the fiscal year ended June 30, 2025, 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.

Jeffery S Burgh
County Auditor Controller / City Financial Officer (PRINT)

Signature 6/3/26
Date

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

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Table of Contents

Acknowledgements **2**

Director's Message **3**

MHSA County Fiscal Accountability Certification **4**

Executive Summary, County Description and MHSA Program **8**

Background **10**
Community Program Planning (CPP) Summary 11
Programs Summary 11
Ventura County Behavioral Health (VCBH) Mental Health Block Grant Descriptions 16
Community Mental Health Services Block Grant (MHBG) 16

Ventura County **17**

Ventura County Planning Process **19**
Overview 20
Stakeholder Involvement 22
Behavioral Health Advisory Board (BHAB) 23
Workgroups 24

Update on the Community Mental Health Needs Assessment (CMHNA) **26**

Community Program Planning Process (CPPP) for the Annual Update **26**
Written Survey Feedback 27
Qualitative Feedback 27
General Feedback 29

Fiscal Year 2024–25 Annual Update **33**

Introduction **34**
Data Notes and Definitions – Mental Health Treatment (FSP and Non-FSP) 36

Full-Service Partnerships (FSP) **37**
FSP Programs Target Goals for Fiscal Year 2025–2026 37
Full-Service Partnership Program Demographics 38

Outreach and Engagement (O & E) **56**

General System Development (GSD) **59**
GSD Programs Target Goals for Fiscal Year 2025–2026 60
General System Development (GSD): Program Demographics 61

Housing (HOU) **116**
Housing 117

Prevention and Early Intervention (PEI) **118**
Data Collection Instruments 119
Prevention 123
Early Intervention 126
Other PEI Programs 128
Highlights for Fiscal Year 2024–2025 Services 131

Workforce Education and Training (WET) **136**

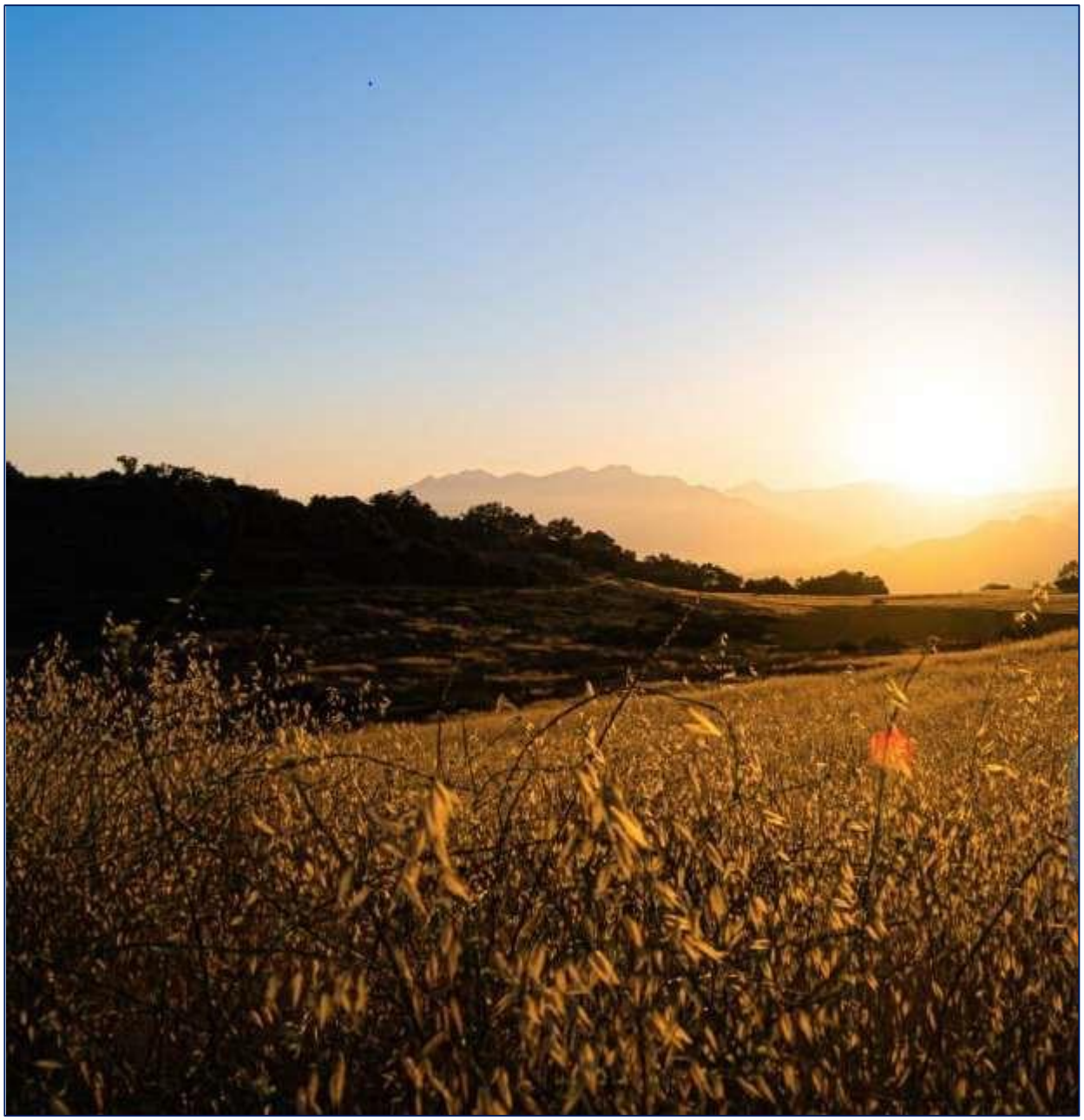
Capital Facilities & Technological Needs (CFTN) **149**

Fiscal Year 2024–25 Mental Health Services Act Annual Update Funding Summary **150**

MHSA Funding **151**
Full-Service Partnership (FSP) Programs 152
Non-Full-Service Partnership Programs 154
Prevention and Early Intervention (PEI) 156
Innovation (INN) 158
Workforce Education and Training (WET) 159
Capital Facilities / Technological Needs (CFTN) 160

Public Comments **161**

Appendices **162**
Appendix A – MHSA Summary Report of the Activities of the LHCN 163
Appendix B – MASH Y3 Annual Report FY24-25 239
Appendix C – MHSSA Wellness Centers Annual Evaluation Report FY24-25 273
Appendix D – Full-Service Partnerships Outcomes Report 306
Appendix E – Annual Innovative Project Report 316
Appendix F – Prevention and Early Intervention FY24-25 327
Appendix G – Community Planning Process (CPP) 647



Ojai

How to read this report

Where does the Mental Health Services Act (MHSA) fit in within the Ventura County Behavioral Health (VCBH) system of care?

VCBH has several funding sources, of which the MHSA is one. The MHSA Plan does not represent all public behavioral health services in Ventura County, and it is not meant to function as a guide to all service options. Not all services can be funded under the MHSA. Reported funding can be from the County's local allocation amount or from state MHSA funding pot which is often in the form of grants. Funding can also be braided or leveraged with other monies such as Realignment or Medi-Cal dollars; those anticipated amounts are reported separately in the program expenditures plan section of this report and actual spend amounts are posted publicly in the Annual Revenue and Expenditures Report (ARER) found at www.vcbh.org[1].

What is the MHSA Three-year Program and Expenditure Plan?

Every three years, Ventura County is required to develop a new Program and Expenditure Plan for MHSA funding. This plan describes goals, objectives and interventions based on needs assessment, stakeholder feedback, and the possibilities and limits defined in State regulations. The Three-year plan outlines and updates the programs and services to be funded by MHSA and allows for a new Three-year budget plan to be created. It also allows the county an opportunity to re-evaluate programs and analyze performance outcomes to ensure the services being funded by MHSA are effective. The current Three-year plan expires in June 2026. A single fiscal year begins July 1st and ends the following calendar year on June 30th.

What is an Annual Update?

MHSA regulations require counties to provide community stakeholders with an update to the MHSA Three-year plan on an annual basis. The community planning process allows stakeholders the opportunity to provide feedback from their unique perspectives about the programs and services being funded through the MHSA. An Annual Update is a standalone report that conveys any changes to the current Three-year Plan. This year's Annual Update report focuses on year three of the MHSA Three-year Plan.

Understanding the numbers:

- Most of the data and the cost per client listed in the document refer to data and amounts from Fiscal Year 2024–2025. To write the plan, the most current and complete data and fiscal reporting (for a full 12 months) is from Fiscal Year 2024–2025.
- This document is written and currently adopted in Fiscal Year (FY) 2025–2026 and will be articulated from that point in time and will include any changes taking place.
- This document title is reflective of the MHSA requirements and therefore will be named Ventura County's MHSA Annual Update for Fiscal Year 2025–2026.
- Funding for the MHSA is based on income tax and cannot be forecasted with complete certainty. Therefore, all updates and plans are subject to change and items that are outlined for funding in the current Three-year Program and Expenditure Plan are updated in Annual Update Reports each subsequent year.

Background

Overview

In November of 2004, California voters passed Proposition 63, which created the Mental Health Services Act (MHSA). The Act instituted an additional 1% tax on any California resident with an income of more than $1 million per year, and this tax is added annually to every dollar over $1 million that residents earn. MHSA revenue is distributed to counties across the state to accomplish an enhanced system of care for mental health services, with a portion of the revenue distributed to agencies at the State level.

The passage of Proposition 63 provided the first opportunity in many years to expand county mental health programs for all populations, including children, transitional age youth, adults, older adults, families, and especially the unserved and underserved. It was also designed to provide a wide range of prevention, early intervention, and treatment services, including the necessary infrastructure, technology, and enhancement of the mental health workforce to effectively support the system.

As part of the system design, the Act provided five fundamental guiding principles in the MHSA regulations:

Community Program Planning (CPP) Summary

Pursuant to the Welfare and Institutions Code (WIC) Section 5848(a), the Mental Health Services Act (MHSA) requires an inclusive and ongoing Community Program Planning process to gather input regarding existing and forecasted community mental health needs, as well as an assessment of the current mental health system that gauges the overall impact and effectiveness of such programs. The results of this process inform future programming adjustments and determine whether additional or different services are required. In partnership with stakeholders, this process provides the structure necessary for the County to determine the best way to improve existing programs and utilize funds that may become available for MHSA components.

Programs Summary

The tables below reflect a summary of MHSA-funded programming by component. Any updates or changes are noted in the corresponding column. Projected fiscal allocations per program for Fiscal Year 2025–2026 are listed in the Program and Expenditure section of the report. Programs not yet launched are listed separately in the Three-Year plan update section below.

Full-Service Partnership (FSP)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Youth FSP Program (ATLAS)		✓	✓	✓
Insights Youth FSP	Ended FY 24–25	✓		
Transitional Age Youth (TAY) Expanded Transitions (TAY FSP)		✓	✓	✓
Casa Esperanza TAY Transitions Program (TAY FSP)		✓	✓	✓
Assisted Outpatient Treatment (AOT) Program		✓	✓	✓
Adult Clinic Based FSP		✓	✓	✓
VCBH Adult FSP		✓	✓	✓
Empowering Partners through Integrative Community Services (EPICS)		✓	✓	✓
VISTA		✓	✓	✓
VCBH Older Adults FPS Program		✓	✓	✓
Child Welfare FSP	New in FY 24–25			✓
Youth Intensive Case Management FSP	New in FY 25–26			✓

Outreach and Engagement (O & E)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Rapid Integrated Support and Engagement (RISE)		✓	✓	✓

General System Development (GSD)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Administrative Infrastructure (temp staffing/consulting/facilities/clinic refresh)		✓	✓	✓
County-Wide Crisis Team (CT)		✓	✓	✓
Crisis Residential Treatment (CRT)		✓	✓	✓
Crisis Stabilization Unit (CSU) Children's		✓	✓	✓
Adult Short Term Treatment Team		✓	✓	✓
Youth and Family Intake Team		✓	✓	✓
Access Program (Access Line)		✓	✓	✓
Fillmore Community Project		✓	✓	✓
Transitional Age Youth (TAY) Outpatient Treatment Program		✓	✓	✓
VCBH Adult Outpatient Treatment Program		✓	✓	✓
The Client Network		✓	✓	✓
Family Access Support Team (FAST)		✓	✓	✓
Growing Works		✓	✓	✓
Mobile Response Team (MRT) for youth and families	Grant	✓	✓	✓
Forensics		✓	✓	✓
Mental Health Diversion Grant Program		✓	✓	✓
Adult Wellness and Recovery Center and Mobile Wellness		✓	✓	✓
TAY Wellness Center		✓	✓	✓
Peer Support Services Integrated Expansion		✓	✓	
Wellness Everyday Website	New to CSS FY 23–24	✓	✓	✓
Youth and Family Enhanced Care Management		✓	✓	✓
Semillas Planting Seeds of Wellness	Moving to PEI		✓	✓
Arts and Wellness Creativity though the Arts	New		✓	✓
Nate's Place Wellness Center	Moving to PEI		✓	✓
Candela Peer Support and Workshops			✓	✓
Moorpark EPSDT Services			✓	✓
MESA Independent Living Support Services	Moving to PEI		✓	✓
Child Welfare Subsystem	Moving to FSP		✓	

Housing (HOU)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
RCFE (Residential Care for the Elderly)		✓	✓	✓
Board and Cares		✓	✓	✓
TAY D Street Housing		✓	✓	✓
Permanent Supportive Housing	Expansion	✓	✓	✓
Temporary Housing Vagabond			✓	✓
HHAP Grant	Grant		✓	✓
BH Bridge Housing Program Grant	Grant		✓	✓
Second Chance Housing Grant	Grant		✓	✓

Prevention and Early Intervention (PEI)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Multi-Tiered System of Supports, VCOE*		✓	✓	✓
Multi-Tiered System of Supports, LEA*		✓	✓	✓
One Step a La Vez Conocimiento		✓	✓	✓
One Step Early Intervention			✓	✓

Prevention and Early Intervention (PEI)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Ignite Conocimiento		✓	✓	✓
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) (VCAAA)		✓	✓	✓
Diversity Collective		✓	✓	✓
Project Esperanza	Expanding	✓	✓	✓
Tri-County GLAD	Adding EI Services	✓	✓	✓
Primary Care Integration with EDMR		✓	✓	✓
COMPASS		✓	✓	✓
Ventura County Power Over Prodromal Psychosis (VCPOP)		✓	✓	✓
Crisis Intervention Team		✓	✓	✓
Logrando Bienestar	Includes PYPF programing	✓	✓	✓
Rapid Integrated Support and Engagement		✓	✓	✓
Wellness Centers - Continued Expansion	Supporting MHSSA sites	✓	✓	✓
MHSSA Grant		✓	✓	
Healing the Community		✓	✓	✓
Suicide Prevention Gatekeepers		✓	✓	✓
Mental Health Awareness though the Arts	Late start		✓	✓
Girl Scouts Mental Health Wellness Badge			✓	✓
Wellness Centers at Community Colleges	New Program		✓	✓
Transportation Purchases			✓	✓
VC Family Justice Center Peer Program	New Program		✓	✓
Suicide Prevention Efforts and Events			✓	✓
Amplify Arts Project (Girls Rock SB)	Network Expansion	✓	✓	✓
Autism Society of Ventura County	Network Expansion	✓	✓	✓
Boys and Girls Club of Greater Oxnard & Port Hueneme	Network Expansion	✓	✓	✓
Childhood Matters	Network Expansion	✓	✓	✓
De Colores Multicultural Folk Arts. Inc.	Network Expansion	✓	✓	✓
Namba Performing Arts	Network Expansion	✓	✓	✓
No Limits Theater Group, Inc.	Network Expansion	✓	✓	✓
Nyeland Promise	Network Expansion	✓	✓	✓
Oxnard Performing Arts Center Corporation	Network Expansion	✓	✓	✓
Two Trees Community	Network Expansion	✓	✓	✓
VC Family Justice Center - Equestrian	Network Expansion	✓	✓	✓

Innovation (INN)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Mobile Mental Health	Launching FY 24–25		✓	✓
Semi Statewide EHR Project		✓	✓	✓
Managing Assets for Security and Health (MASH)		✓	✓	✓
Learning Collaborative Healthcare Network Early Psychosis Project (LCHN)	Launched		✓	✓
Veteran Mentorship Program				✓
Collaborative Care Model				✓

Workforce Education and Training (WET)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Workforce Education and Training	Includes EMDR		✓	✓
Mentorship Internship Program (MIP)		✓	✓	✓

Capital Facilities and Technological Needs (CFTN)

Program	Changes	Fiscal Year		
		23–24	24–25	25–26
Mental Health Rehabilitation Center (MHRC)			✓	✓
BCHIP Y&F Services Building (Braided Funding)		✓	✓	✓
East County Crisis Stabilization Unit (CSU)			✓	✓
Permanent Supportive Housing Units	Delayed			✓
Secondary Data System				✓
Psychiatric Health Facility (PHF)	New			✓

The table below reflects a summary of programming by components that were determined by the last community health needs assessment, community planning processes, noted gaps in services according to existing and forecasted needs, and regulatory requirements. This is the final list of projects that are changing during this planning period. The original and full plan can be found on the VCBH website titled MHSA Three Year Plan 2023–2026.

Changes from the three-year plan are noted below.

Changes to the Three-Year Plan 2023–2026					
Updates	23–24	24–25	25–26	Category	Changes
Housing Vouchers/Rental Subsidies				CSS	Changed to BHSA project
COSRs (to maintain and create permanent supportive units)			x	CSS	Changed to FY 25–26
Permanent Supportive Housing Units				CFTN/IT	Changed to BHSA project
ECT treatment			x	CSS	Not feasible in the timeframe

Ventura County Behavioral Health (VCBH) Mental Health Block Grant Descriptions

The following block grant funding, a result of COVID-19 relief funding, has had an impact on several service areas. It has been included here as a standalone section and greater details will be provided in each of the following service areas throughout the report. In Fiscal Year 2024–2025, MHSA money was utilized for these programs in addition to the grant money.

- GSD Crisis Stabilization
- GSD Peer Services

Community Mental Health Services Block Grant (MHBG)

In August 2021, VCBH submitted grant applications to the Department of Health Care Services (DHCS) for the American Rescue Plan Act (ARPA). On February 16, 2022, an ARPA grant was awarded by DHCS in the amount of $930,321, for the term of September 1, 2021, through June 30, 2025.

The supplemental funding for ARPA will be used by VCBH to support crisis stabilization units (CSU) care coordination, develop an evidence-based Peer Support Program, and increase telehealth access to behavioral health treatment throughout the adult outpatient clinic system. Specifically, the CSU funding will be used by VCBH to recruit a bilingual Community Services Coordinator (CSC) to help facilitate Ventura County's crisis stabilization units, provide the appropriate level of care for CSU clients, and coordinate communication between Ventura County crisis stabilization units, other mental health treatment providers, patients, and their families/supports.

The Peer Support Program will utilize Peer Support Specialists to conduct outreach across all the Transitional Age Youth (TAY) and Adult community-based clinics with a specific focus on the Access Team, and Assist (VCBH's Assisted Outpatient Treatment FSP program) Peer Support Specialists will assist SPMI clients in: (1) navigating the treatment system, (2) attaining appropriate services, (3) connecting with community-based resources, and (4) developing the necessary coping skills to aid in alleviating the impacts of social stigma. All six positions were hired in FY 23–24.

Ventura County

Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles Counties and consists of 1,843 square miles of land. It is set against undeveloped hills and flanked by free-flowing rivers. Ventura County is one of 58 counties in the State of California and offers 42 miles of beautiful coastline along its southern border, with the Los Padres National Forest making up the northern area. It has a beautiful, temperate climate, and its landmass rises from sea level to 8,847 feet at Mt. Pinos in the Los Padres National Forest. At certain times of the year, it is often possible to stand on the beach and see snow on the mountains.

Ventura County is made up of two major sections: East County and West County. Communities in the East County include Thousand Oaks, Newbury Park, Lake Sherwood, Hidden Valley, Santa Rosa Valley, Oak Park, Moorpark, and Simi Valley. West County consists of the communities of Camarillo, Somis, Oxnard, Point Mugu, Port Hueneme, Ventura, Ojai, Santa Paula, and Fillmore. The largest beach communities are in West County on the coastline of the Channel Islands Harbor.

Fertile farmland and valleys in the southern half of the county make Ventura County a leading agricultural producer. The Los Padres National Forest occupies half of the county's 1.2 million acres, and of the remaining land, nearly 60% is devoted to agriculture.

Ventura County has a strong economic base that includes major industries such as biotechnology, healthcare, education, agriculture, advanced technologies, oil production, military testing and development, and tourism.

Naval Base Ventura County is the largest employer with more than 16,000 employees, including civilians and military personnel. The Port of Hueneme is California's smallest and only deep-water port between Los Angeles and San Francisco and plays a major role in the local economy.

Ventura County is home to two universities (California State University Channel Islands and California Lutheran University), several small private colleges, and three community colleges (Oxnard, Ventura, and Moorpark). Through these and other programs, Ventura County enjoys a strong structure for workforce development.

As of January 2024, the estimated population of Ventura County was 835,427.[1] Hispanic or Latino individuals comprised 45.3% of the population and non-Hispanic/non-Latino individuals comprised 54.7%. About 30% of the population was under 24 years of age while 25.2% of county residents were 60 or older. Ventura County was also comprised of 11.9% people with a disability and 5.1% veterans. The median household income was $107,327, however, 9.8% of the people in the county were below the poverty level.

Ventura County ACS Population (N=835,427)	
Age Groups	
0–14 yrs.	17.0%
15–24 yrs.	13.0%
25–59 yrs.	44.8%
60 yrs. and older	25.2%
Race/Ethnicity	
Native American or Alaska Native	2.1%
Asian	7.8%
Black or African American	1.8%
Hispanic or Latino	45.3%
Native Hawaiian or Pacific Islander	0%
White (alone)	46.0%
White (not alone)	71.1%
Multi-racial	25.5%
Another Race/Ethnicity	16.6%
Gender	
Female	50.3%
Male	49.7%
Other Gender Identity	0.9%[2]
Veteran Status	
Veteran (among 18+)	5.1%
Have a Disability	
	11.9%
LGBTQ+ [3]	
	5.3%
Language Spoken at Home	
English	62.1%
Spanish	30.1%
Another Language	7.8%
Health Insurance Status[4]	
No insurance	5.6%
Private insurance	67.9%
Public insurance	38.8%
Underserved Populations	

- LGBTQ+
- Risk of Suicide
- African American
- Those with co-occurring disorders (mental disorder and substance use disorder
- Spanish (any)
- Other
- Language thresholds are English and Spanish.

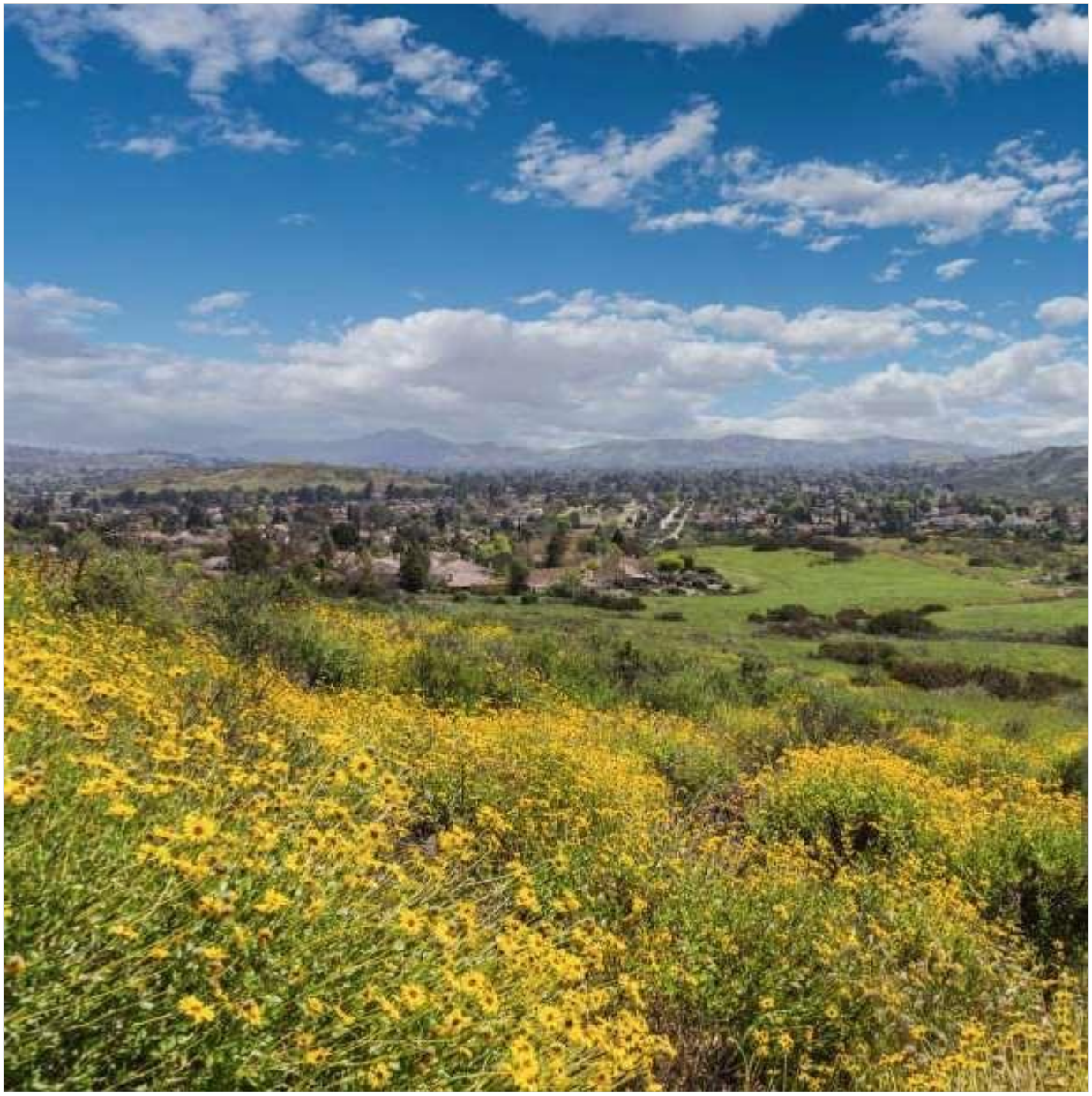
[1]From the American Community Survey for Ventura County, 2024 1-year estimates unless noted otherwise.

[2]Gender: The source below reports 0.86% of individuals aged 18+ in the state of California identify as transgender Source: https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[3]Sexual Orientation: The American Community Survey only reports two genders (male and female) and does not ask about sexual orientation. The Gallup Daily tracking survey reports 5.3% of California's population (from 2012–2017) answer yes to "Do you, personally, identify as lesbian, gay, bisexual, or transgender?" Source: https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density

[4]Health Insurance Status: Percentages add to over 100% due to census estimates reflecting individuals with multiple coverages.

Ventura County Planning Process



Thousand Oaks

Overview

In partnership with county stakeholders, the Community Program Planning (CPP) process provides the structure necessary for Ventura County to determine the best way to improve existing programs and utilize funds that may become available for the MHSA components.

There are numerous groups of stakeholders involved in the CPP process and ongoing feedback is received from the various groups, such as the Behavioral Health Advisory Board (BHAB) members, community providers, focus groups and general community meetings. Additionally, this process is designed to hold annual public education and to provide input on goals set by Ventura County Behavioral Health (VCBH), the Mental Health Oversight and Accountability Commission (MHSOAC), and BHAB, including any community gaps identified by the triannual needs assessment, these same entities, and/or community stakeholders. As of January 1, 2025, the MHSOAC updated its name to the Behavioral Health Oversight and Accountability Commission, also known as the Commission for Behavioral Health.

Community and stakeholder feedback is essential to developing or enhancing behavioral health programs/interventions. This includes the designated MHSA team member's review of annual outcomes and previous-year comparisons, contractual obligations, and cost-effectiveness of all currently funded MHSA programs, which are made available to the community through the MHSA Annual Updates and three-year plans. Based on the community program planning process feedback, recommendations are presented to the VCBH Director followed by presentations to the BHAB as allowed.

Additional CPP processes may take place for specific standalone programs, projects, or initiatives if funding and timelines allow.

Overview of the Community Planning Process for the Annual Update

The following table illustrates the demographics of those who provided feedback in the Ventura County CPP surveys versus the US Census Bureau Data for Ventura County, and their difference.

	CPPP Participants (N=116)	VC Census[1]	Difference
Requested Age Breakouts[2]	(n=99)	(N=835,427)	
0–15 yrs.	9.1%	NA	NA
16–25 yrs.	25.2%	NA	NA
26–59 yrs.	49.5%	NA	NA
60 yrs. and older	16.2%	NA	NA
Census Age Breakouts[2]			
0–14 yrs.	NA	1.07%	NA
15–24 yrs.	NA	13.0%	NA
25–59 yrs.	NA	44.8%	NA
60 yrs. and older	NA	25.2%	NA
Race/Ethnicity	(n=98)		
Native American or Alaska Native	2.0%	2.1%	-0.1%
Asian	5.1%	7.8%	-2.7%
Black or African American	3.1%	1.8%	1.3%
Hispanic or Latino	60.2%	45.3%	14.9%
Native Hawaiian or Pacific Islander	0.0%	0.0%	0.0%
White (alone)	15.3%	46.1%	-30.8%
White (not alone)[3]	7.1%	71.1%	-64.0%
Multi-racial	5.1%	25.5%	-20.4%
Another Race/Ethnicity	2.0%	16.6%	-14.6%
Gender	(n=101)		
Female	67.3%	50.3%	17.0%
Male	31.7%	49.7%	-18.0%
Other Gender Identity	1.0%	0.9%[4]	0.1%
Veteran Status	(n=97)		
Veteran (among 18+)	2.1%	5.1%	-3.0%
Have a Disability	(n=95)		
	12.6%	11.9%	0.7%
LGBTQ+[5]	(n=94)		
	14.9%	5.3%	9.6%
Language Spoken at Home	(n=101)		
English	79.2%	62.1%	17.1%
Spanish	30.7%	30.1%	0.6%
Another Language	9.9%	7.8%	2.1%
Health Insurance Status[6]	(n=80)		
No insurance	7.5%	5.6%	1.9%
Private insurance	43.8%	67.9%	-24.1%
Public insurance	48.8%	38.8%	10.0%

[1]From the American Community Survey for Ventura County, 2023 1-year estimates unless noted otherwise.

[2]Requested CPP age breakouts did not match Census age breakouts.

[3]Respondents who selected White in combination with another race are reported separately to avoid double-counting within the multi-racial category.

[4]Gender: The source below reports 0.86% of individuals aged 18+ in the state of California identify as transgender. Source: https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[5]Sexual Orientation: The American Community Survey only reports two genders (male and female) and does not ask about sexual orientation. The Gallup Daily tracking survey reports 5.3% of California's population (from 2012–2017) answer yes to "Do you, personally, identify as lesbian, gay, bisexual, or transgender?"
Source: https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density

[6]Health Insurance Status: Percentages add to over 100% due to census estimates reflecting individuals with multiple coverages.

Stakeholder Involvement

The Mental Health Services Act (MHSA) requires public involvement in the stakeholder process because it is crucial in achieving an equitable three-year program plan and annual updates. Groups involved in the CPP process include consumers, law enforcement, advocacy groups, and partner agencies. While there are shared requirements for CPP, the process allows Ventura County to tailor its programming to align with its specific needs and adhere to State priorities and regulatory requirements. Ventura County's Stakeholder policy can be found in the Appendix of this report.

The basis for the Ventura County planning process is found in WIC 5898, 5813.5d and 5892c. Standing groups represent different interests across the county and, as the need arises, focus groups are created to address the needs of these populations.

In addition to availing opportunities to participate within these forums, a formal, robust Community Health Needs Assessment (CHNA) was conducted across the county in accordance with the commitment of Ventura County Behavioral Health (VCBH) to address the health needs of a diverse population. An additional targeted component of the CHNA was also conducted, focused solely on unserved and underserved populations. Stakeholder involvement was accomplished by using different forums, which include various stakeholder groups as listed below.

Behavioral Health Advisory Board (BHAB)

The mission of the Behavioral Health Advisory Board (BHAB) is to advocate for members of the community who live with mental illness and/or substance use disorders and their families. This is accomplished through support, review and evaluation of treatment services provided and/or coordinated through the VCBH.

The BHAB is made up of stakeholders appointed by the Board of Supervisors. It serves in an advisory capacity to the VCBH Director and the Board of Supervisors. It plays a significant role in facilitating public discussion of the Mental Health Services Act (MHSA) plans and updates, provides feedback and conducts public hearings. The BHAB, as the local mental health board, has authority to submit plans and updates to the Board of Supervisors for final approval. The BHAB is made up of 20% consumers and 20% family members and includes law enforcement, veterans, and a psychiatrist. All geographic regions are represented. The table below lists the current membership, their geographic representation, and term dates.

Ventura County Behavioral Health Advisory Board
Supervisor, Matt LaVere
Membership Roster for Fiscal Year 2024–2025

District 1	District 2	District 3
Andrei Bobrow 9/24/24 to 9/24/27	Dianne McKay 6/17/25 to 9/16/28	Sylvia Garcia 2/25/25 to 2/25/28
Genevieve Flores-Haro 4/28/24 to 4/27/27	Vacancy	Naomi (Nomi) Marrufo 12/2/23 to 12/1/26
John C. Stenzel 8/12/24 to 8/11/28		Nancy Borchard 1/27/24 to 1/26/27
Cheryl Heitmann 5/11/24 to 5/11/27		Vacancy

District 4	District 5	District 6
Reveka Grigorian 3/12/25 to 3/11/27	Soledad Barragan 9/16/23 to 9/15/26	Educational Agency Rep. Chris Ridge 8/26/25 to 8/25/28
Dalia Robkin 4/25/23 to 4/24/26	Michael Rodriguez 1/25/23 to 1/24/29	Veteran Rep. Daniel Bednar 10/14/24 to 10/13/27
Vacancy	Marlen Torres 1/25/23 to 1/24/29	Law Enforcement Repo. Christopher Dyer 3/28/23 to 3/27/26
	Natalie Torres 3/23/24 to 3/22/27	

Workgroups

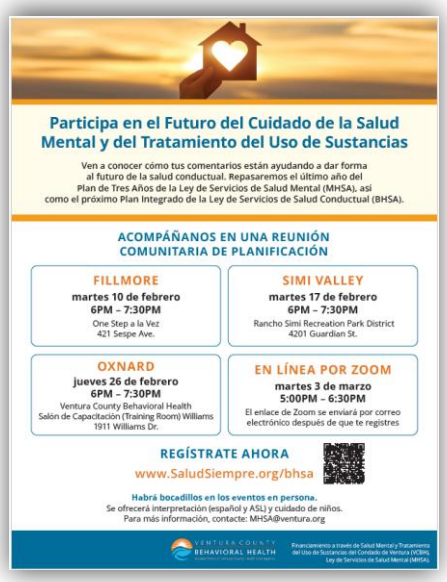
Ventura County Behavioral Health conducts active outreach to ensure that key stakeholders are included in the development of programs and services, so they are reflective of the needs of the population(s) to be served. During the planning period, targeted groups included underserved geographic areas, threshold languages, unhoused individuals, and clients of VCBH services.

Informing the Community about the CPP Process

A media plan is generated for any CPP process and the corresponding events. Announcements are made at BHAB and other County committee meetings as well as through flyer distribution at clinics and community partners and providers. The media plans include a mixed media approach with advertisements on social media and the department's websites (WellnessEveryday.org and vcbh.org) as well as traditional print media such as local newspapers. The promotional efforts resulted in a total of 2,206,345 impressions through April of 2026.

- Print and Digital Media: 1,010,928
- Social Media: 1,195,417

An example of the advertisement to ensure that the community was made aware of the events is provided below.



Print and Digital Media	Social Media	Run Dates
• Amigos 805 • Santa Paula Times • Fillmore Gazette • Vida • Ventura County Star • Acorn • VC Reporter • Ojai Valley News • El Latino • The Breeze	• Facebook • Instagram	01/12/2026– 02/22/2026

Consumer and Family Groups

Feedback is encouraged from other stakeholder groups, such as United Parents, Candela, and The Client Network, through direct consumer/family contact and by supporting their participation in the BHAB as well as subcommittees, workgroups, and task forces. Another avenue for engagement is through VCBH's Patients Rights' Advocate, whose function is to provide information and investigate concerns.

Issue Resolution Process (RP)

Consumers may also voice their views/concerns through the issue grievance process. The Grievance and Appeal Policy, QM-18, has been updated in the last year (most recently in September 2025): QM-18: Person in Care Problem Resolution Processes.

At the time of this report, 65 grievances have been filed regarding services that are funded by the MHSA for Fiscal Year 2024–2025.

Update on the Community Mental Health Needs Assessment (CMHNA)

Community Program Planning Process (CPPP) for the Annual Update

Community Program Planning meetings take place annually under the MHSA. Planning for an Annual Update report focuses on communicating changes to the current three-year plan and receiving feedback on proposed changes.

Feedback Type	Dates	Locations	Total
In person events	February 10th February 17th February 26th	Fillmore, Simi Valley, and Oxnard	107
Virtual Event	March 3rd	Online	90
Response Surveys	Received from Feb 1st through March 6th 2026	All in person events and online attendees	116

Four events were held in total across East and West County communities. Three events took place in person and one was held via Zoom. All events offered Spanish translation (the threshold language in the county). Handouts and PowerPoint slides were provided in English and Spanish. Childcare and a light dinner were also supplied. At these meetings, the VCBH team presented proposed changes to the three-year plan and upcoming legislative changes were discussed. Copies of PowerPoint and subsequent materials can be found in the appendix of this report.

Feedback from the Community Program Planning (CPP) Process can take place during a meeting, through surveys, or via email, up to 30 days after the meetings take place. As feedback is received, the program plan is adjusted when feasible. Below is an overview of the feedback and sentiments received. Participant demographics have been added to the CPP participation table listed on page 18.

The following is a summary of feedback provided during the planning period.

Written Survey Feedback

Attendees were asked to rate their level of agreement with several statements about the quality and content of the MHSA presentations they attended. Overall, satisfaction was high across all measures, with the large majority of respondents indicating agreement or strong agreement.

Satisfaction Measure	Agree/Strongly Agree
Satisfied with the presentation overall	**97.03% (98 of 101)**
Presenter(s) provided useful information	**97.03% (98 of 101)**
Presenter(s) were engaging	**97.03% (98 of 101)**
Satisfied with the amount of information provided	**96.00% (96 of 100)**
Satisfied with the variety of topics presented	**95.96% (95 of 99)**

These results reflect a strong reception of the presentations, with fewer than 3% of respondents disagreeing or strongly disagreeing with any satisfaction measure. The data suggest that the presentations were well-received in terms of content quality, presenter engagement, and breadth of topics covered.

Demographics are reflected in the CPP survey participation table on page 20.

Qualitative Feedback

In addition to the structured survey questions, respondents had the opportunity to provide open-ended comments in two areas: (1) questions or concerns about the final year of the MHSA, and (2) any additional general feedback. A total of 64 respondents shared MHSA-related questions or concerns, and 56 provided other feedback. Specifically, respondents were asked:

- Based on the presentation today about the final year of the Mental Health Services Act (MHSA), do you have any additional questions or concerns?
- Do you have any other feedback?

Responses were reviewed and organized into the following thematic categories.

Theme	# of Responses	% of 64
Funding continuity and transition to BHSA	**11**	17%
No additional questions/Satisfied with presentation	**24**	38%
Housing and residential services	**3**	5%
Services for older adults/seniors	**3**	5%
Support for community-based organizations (CBOs)	**4**	6%
Workforce, clinical, and allied health resources	**3**	5%
Access to beds and outpatient facilities	**2**	3%
Presentation improvement suggestions	**2**	3%
Other/General comments	**12**	19%

Funding Continuity and Transition to BHSA

The most substantive theme in Q3 responses centered on uncertainty about funding under the transition from MHSA to the Behavioral Health Services Act (BHSA). Respondents expressed concern about whether existing programs will continue to receive support, how unspent funds will be allocated, and what the RFP process will look like under the new framework.

> *"How will decisions to use the unspent $30m be made… under BHSA? Will it be split along the pie chart?"*
>
> *"Yes, what are the next steps, what do we need to do to continue receiving funding?"*
>
> *"Worrying about that RFP process and funding that goes to state."*
>
> *"I am still unsure if my program is eligible for continued funding and how our organization fits in with the MHSA/BHSA funding."*

Support for Community-Based Organizations (CBOs)

Several respondents expressed concern about whether community-based organizations—particularly those serving youth and teens—would receive adequate funding under the new structure. Respondents emphasized the critical role these organizations play in serving vulnerable populations.

> *"I'm just worried in regard to the funding going towards community-based organizations... I believe it's essential for teens to receive those types of resources CBOs offer."*
>
> *"How many grants are coming out from the MHSA plan? For nonprofits serving youth, such as the Boys and Girls Club, can apply for?"*
>
> *"Will there be any funds for CBOs who are doing this work?"*

Services for Older Adults and Seniors

A recurring concern from respondents was the perceived lack of funding and services specifically targeting older adults. These responses highlighted both mental health service gaps and related social determinants of health (such as housing conditions) that affect senior well-being.

> *"I don't see any funds allocated for senior behavioral health services — much needed in our community."*
>
> *"As seniors we need more help with housing... While that is not a mental health issue, it can become one because I worry about making sure my home stays secure."*
>
> *"I feel that a lot of programs really miss the boat for senior citizens."*

Housing and Residential Services

Respondents raised concerns about the availability of housing supports and residential options for individuals with serious mental illness (SMI), including the need for more mental health beds and group homes.

> *"More mental/behavioral health beds are needed in Ventura County."*
>
> *"We need more info on mental health help. Rehabilitation and housing after. People should not live alone. What about group homes?"*

Workforce and Allied Health Resources

A small number of respondents raised questions about the integration of allied health professionals—including occupational therapists and community health workers—into MHSA-funded services, as well as interest in contributing lived expertise.

> *"Has Occupational Therapy and its role in mental health services been discussed as an additional resource/support for these populations?"*
>
> *"Continue with outreach-engagement-prevention and early intervention. As a retired RN, having worked in New Start for Moms recovery homes, I can become a trainer for support."*

Satisfaction: No Additional Questions

Approximately 38% of substantive Q3 responses indicated that the presentation had adequately addressed the respondent's questions. Many of these responses were brief affirmations of the session's value.

> *"This session clarified the MHSA to BHSA changes much more clearly than the summer listening session."*
>
> *"No questions, questions were answered greatly."*

General Feedback

Respondents were also invited to share any open-ended general feedback. A total of 56 out of 101 respondents (55%) provided written responses. Most of these responses were positive comments about the presentations, with a smaller number offering constructive suggestions or specific concerns.

Responses were organized into the following thematic categories.

Theme	# of Responses	% of 56
Positive feedback on presentation quality	**19**	34%
No additional feedback	**24**	43%
Housing and continuity of care concerns	**3**	5%
Accessibility and language needs	**1**	2%
Time/format suggestions	**2**	4%
Program-specific continuity concerns	**2**	4%
Other substantive comments	**5**	9%

Positive Feedback on Presentation Quality

The largest category of substantive Q4 responses consisted of positive comments about the presentations. Respondents praised presenters for their knowledge, clarity, and ability to make complex information accessible. Several singled out specific presenters by name.

> *"Presenters were very knowledgeable and spoke very well on the subject matter."*
>
> *"The lead did a great job with synthesizing complicated information so we can understand."*
>
> *"Great presentation and communications and engagement. Thank you all for your time and information provided."*
>
> *"The presenter shared a lot of information but stayed engaging."*

Housing and Continuity of Care

A small number of respondents used the general feedback question to flag additional concerns about housing and the continuity of support for individuals currently receiving services under BHBH and related programs.

> *"Housing is critical!!! How can we assure those being supported under BHBH and are having good outcomes can continue to be supported with the changes?"*
>
> *"Would like to ensure that One Step A La Vez continues to be supported due to its positive impact on community."*

Accessibility and Language Needs

One respondent identified a practical accessibility barrier experienced during the presentation: difficulty hearing when both an interpreter and the presenter were speaking simultaneously, and the absence of a bilingual PowerPoint.

> *"It would be beneficial if the interpreter and community members had headsets. It was difficult to hear both people speaking. It would be better also if the PowerPoint was shown in English and Spanish."*

Presentation Format Suggestions

Two respondents offered constructive suggestions about the format of future presentations, asking for more time for Q&A and a more step-by-step approach to content delivery.

> *"Allow more time for questions."*
>
> *"Break down the information — there were too many chunks being learned. I need it to be broken down."*

Lived Experience and Professional Perspective

One respondent identified themselves as both a medical professional and a parent of a young adult with serious mental illness (SMI), with personal lived experience as well—expressing deep investment in improving this area of healthcare.

> *"I am a medical professional/provider as well as a parent of a young adult with SMI (and have lived experience myself), so have a lot of passion about improving this area of healthcare."*

Public Engagement and Transparency

One respondent expressed appreciation for the county's efforts to reduce adverse outcomes, while calling for more openness to public comment as new BHSA-related changes are implemented.

> *"With more clarity on the new changes I hope that you will be more open to public comments — also appreciate your choices to improve care experience and goals to decrease adverse outcomes in suicides!"*

All the CPPP meeting schedules are shared publicly via the MHSA listserv and at the BHAB monthly meetings. To be added to the MHSA listserv, community members may email MHSA@venturacounty.gov. The websites https://hca.venturacounty.gov/behavioral-health/ and Wellness Everyday.org are also kept up to date with all public meetings.

Results of the extended CPP process and community health needs assessment completed in Fiscal Year 2021–2022 resulted in a set of prioritization areas for the current 3-year plan Fiscal Year 2023–2026. The results are the five categories listed here in alphabetical order and which the department plans to leverage existing operations and utilize local MHSA funding to implement. MHSA funding is not a guaranteed amount. As such, updates on this list will be dependent on allocation amounts and will be communicated through subsequent Annual Updates and Program Review Summary tables (located in section two of this report). Regardless of funding these priorities will be the guide for the full three years of the plan.

Guiding Priorities for the Fiscal Year 2023–2026 Three-Year MHSA Plan

- Access
  a. Improve articulation of continuum of care and drivers of levels of care
  b. Examine timeliness in relation to the level of care
  c. Examine quality improvement opportunities around physical locations and remote access
  d. Develop options for immediate response for enrolled youth

- Alternatives to VCBH
  a. Develop more contracted clinical providers/options for early intervention services
  b. Develop more non-clinical providers/options through mini grants (e.g., drop-in centers, after school programs, indigenous/culturally informed interventions, etc.)
  c. Develop session-based indicated BH prevention interventions for high schools
  d. Develop more providers/options for those with other conditions (e.g., developmental/intellectual, traumatic brain injury, dementia, etc.)

- Clinical Treatment and Services
  a. Addition of staff clinic/program
  b. Expand the number/nature of physical plants to provide clinical treatment and services
  c. Add/expand the types of treatment, cultural and indigenous practices, and other services provided by VCBH (possibly involves the purchase of equipment and supplies). Some examples include expanding the role of peers and increasing 24/7 community crisis response services.

- Housing
  a. Addition of staff for the development of a specialized housing team
  b. Acquisition/development/preservation of housing
  c. Financial support to preserve/expand existing tenancy for VCBH clients

- Outreach and Education
  a. Increase outreach capacity for vulnerable and at-risk populations (i.e., in-house and via contractors)
  b. Expand media campaigns to target vulnerable populations at all care levels
  c. Expand staff and provider training menu
  d. Expand specialized Behavioral Health Outreach Team
  e. Educate around moderate-severe (VCBH domain) versus mild-moderate (others) mental illness, and significant functional impairment (i.e., what VCBH can be expected to do).
  f. Educate around stigma reduction, substance use and impacts, trauma, diversity, equity and inclusion, changes across the lifespan, and other pertinent topics

Provider Information (according to NACT, November 2024)

The Network Adequacy Certification Tool (NACT) assessment is submitted annually to assess the VCBH provider system. As of July 2021, services such as Mental Health Services, Case Management, Crisis Intervention, Medication Support, Intensive Care Coordination, Intensive Home-Based and Field Support were provided by 713 providers.

Through this assessment, VCBH can assess how many existing provider staff are able to provide culturally competent services, in which languages, and whether the Workforce Education Training (WET) plan should be adjusted accordingly. Additional details on this plan can be found in the WET section of this Annual Report.

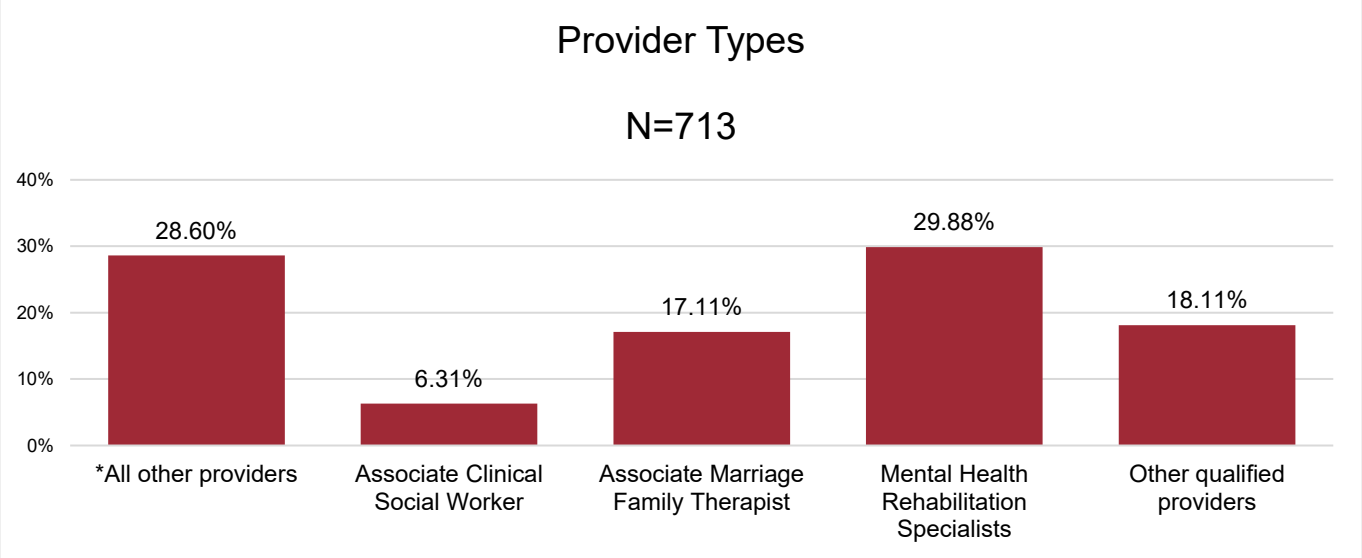
N=714

Languages other than English spoken by Ventura County providers*	% of providers that speak this language*
Arabic	0.28%
Armenian	0.42%
Cantonese	0.14%
Farsi	0.98%
Mandarin	0.28%
Russian	0.70%
Spanish	33.80%
Tagalog	0.98%

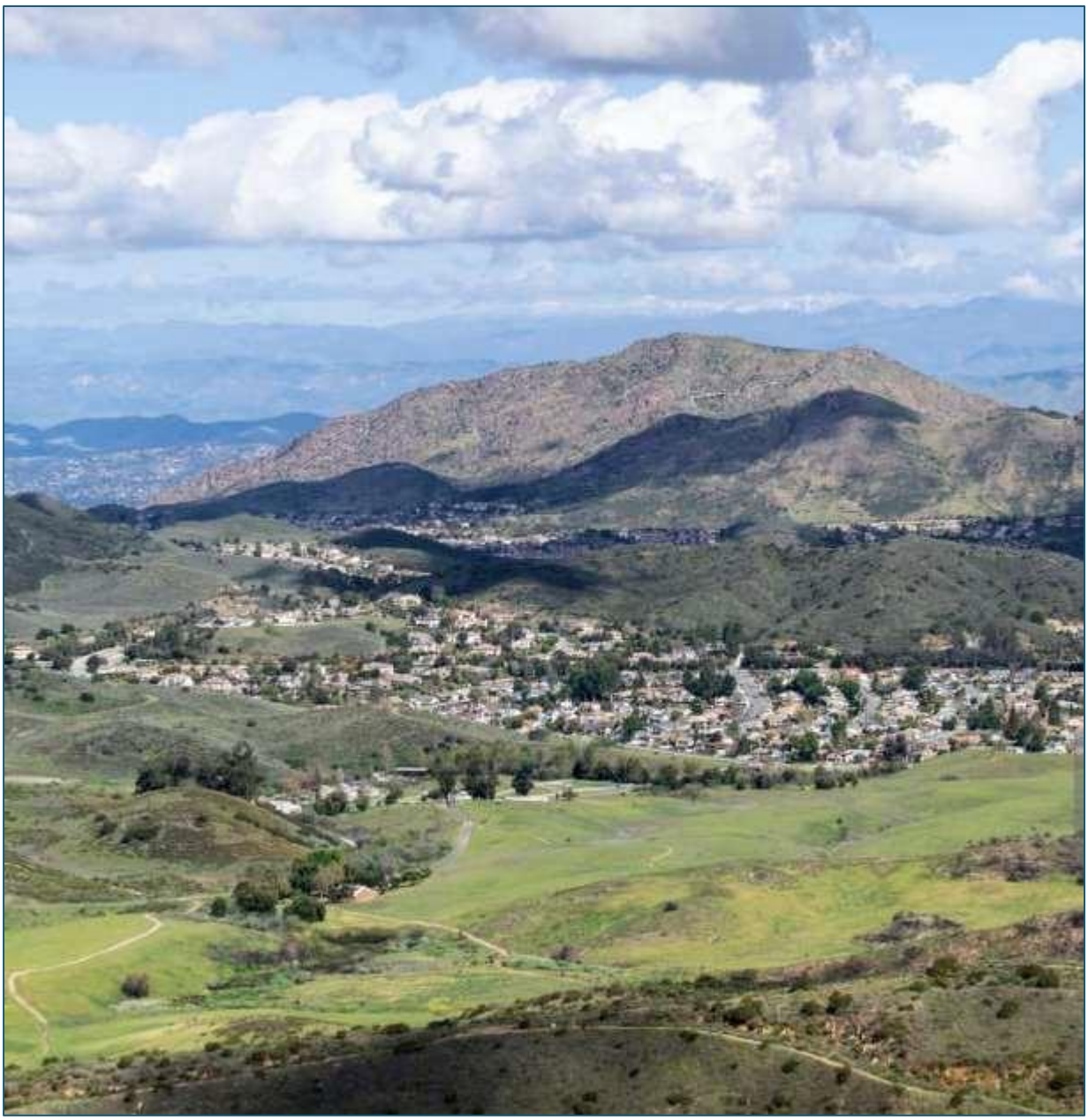
*Some providers speak more than one language other than English.

100%

of providers have received Cultural Competency Training



*Child and Adolescent Psychiatry, Counselor, Licensed Psychiatric Technician, Licensed Vocational Nurse, Nurse Practitioner, Psychiatry, Psychologist, Registered Nurse, Social Worker



Newbury Park

Introduction

Community Services and Supports (CSS) is the largest component of the Mental Health Services Act (MHSA). It focuses on community collaboration, cultural competence, client- and family-driven services and systems, wellness (which includes concepts of recovery and resilience), and integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component and will continue to grow in the coming years. The County system of care under this component consists of programs, services, and strategies identified by the County through the stakeholder process to serve unserved and underserved populations with serious mental illness and serious emotional disturbance, while emphasizing a reduction in service disparities unique to the County.

Programs funded by the CSS component are presented in this report in accordance with the following regulatory categories:

- Full-Service Partnership (FSP)
- Outreach and Engagement (O & E)
- General System Development (GSD)
- Housing (HOU)

Age Group	**n=12,827**	
0–15 yrs.	1,767	11.01%
16–25 yrs.	2,015	15.64%
26–59 yrs.	6,859	56.45%
60 yrs. & older	2,186	16.89%
Primary Language	**n=12,802**	
American Sign Language (ASL)	15	0.11%
Arabic	7	0.05%
Cambodian	1	0.01%
Cantonese	2	0.01%
English	8,979	72.79%
Farsi	3	0.01%
Italian	1	0.01%
Japanese	1	0.01%
Korean	2	0.01%
Mandarin	3	0.01%
Mixteco	8	0.06%
Other Chinese Dialects	1	0.00%
Other non-English	17	0.11%
Portuguese	1	0.00%
Russian	3	0.02%
Spanish	1,141	8.17%
Tagalog	6	0.04%
Thai	2	0.02%
Unknown/Not Reported	2,594	18.43%
Vietnamese	15	0.10%
Gender Identification	**n=14,999**	
Bisexual	12	0.06%
Declined to Answer	15	0.08%
Female	5,639	38.45%
Female-to-Male (FTM)/Transgender Male/Trans Man	21	0.17%

Gay (male)	2	0.01%
Gender Queer	5	0.07%
Heterosexual/Straight	280	1.37%
Lesbian (female)	3	0.01%
Male	5,137	36.87%
Male-to-Female (MTF)/Transgender Female/Trans Woman	15	0.12%
Non-Binary	21	0.17%
Other	10	0.08%
Transgender	16	0.14%
Unknown/Not Reported	3,820	22.34%
Unsure/Questioning	3	0.04%
Sexual Orientation **n=13,129**		
Bisexual	58	0.44%
Declined to Answer	79	0.60%
Declined to State	1	0.00%
Gay (male)	7	0.04%
Heterosexual/Straight	1,377	10.36%
Lesbian (female)	8	0.06%
Other	14	0.07%
Transgender	2	0.01%
Unknown/Not Reported	11,572	88.31%
Unsure/Questioning	11	0.10%
Ethnicity **n=12,912**		
Declined to Answer	56	0.43%
Hispanic/Latino	5,380	42.07%
Multiethnic	5	0.07%
Non-Hispanic/Non-Latino	4,101	34.33%
Unknown/Not Reported	3,370	23.09%
Race **n=14,907**		
Alaska Native or Native American	139	1.10%
Asian	164	1.24%
Black/African American	368	2.80%
Declined to Answer	408	2.93%
Multiracial	16	0.14%
Native Hawaiian or Other Pacific Islander	88	0.66%
Other	3,001	20.79%
Unknown/Not Reported	5,398	33.00%
White/Caucasian	5,325	37.34%
Military Status **n=12,908**		
No	2,970	25.15%
Unknown/Not Reported	9,922	74.72%
Yes	16	0.13%

Data Notes and Definitions – Mental Health Treatment (FSP and Non-FSP)

The following definitions and notes below apply to data collection from the Electronic Health Record (EHR) using the SmartCare system.

Served Client is defined as anyone with a service code billed by an FSP or non-FSP MHSA treatment program in the fiscal year who was not in an FSP treatment track at the time of service.

The words **Client** and **Partner** are used interchangeably. Service codes include no-show service codes.
Service codes must be associated with an FSP or non-FSP episode in a MHSA treatment program that was open in the fiscal year.

Service is attributed to the billing program (not always the same as the program to which the episode is open). Insights is counted as an FSP treatment track for Youth and Family.

Rollover Client is defined as a served client whose episode admission to an FSP or non-FSP MHSA treatment program through which services were rendered during the fiscal year was prior to July 1, 2021.

New Client is defined as a served client whose first episode admission to an FSP or non-FSP MHSA treatment program through which services were rendered during the fiscal year was July 1, 2021 and after.

Age Group Total may not manually add up to the unduplicated client total since clients may have advanced in age and may have moved from one age group to another within the same fiscal year.

Program Total may not manually add up to the unduplicated client total because clients may have been served under more than one program within the same fiscal year and were/are counted under each program in which services were rendered.

The demographic information below is pulled from the first episode occurring in an FSP or non-FSP MHSA program during the fiscal year. If there were multiple entries in an episode, the last entry for the episode was used.

Age is calculated at the date of service for each billed service.

Gender varies by MHSA component.

Preferred Language is the language selected for receiving services.

Ethnicity varies by MHSA component.

Gender Identity varies by MHSA component.

Race Totals may not equal the unduplicated client total as clients may select more than one race (up to five).

Sexual Preference varies by MHSA component.

Disability was not collected for this program at this time. **Veteran** status was not collected for this program at this time.
City of Residence varies by MHSA component.

Service Units Categories are based on VCBH-defined groupings for billing. The “Medication Support MC Billable” category was relabeled as “Evaluation and Management” to be more descriptive of the underlying service codes.

Please note: Percentages may not equal to exactly 100% due to rounding. Also, not all numerators will match unduplicated client counts due to multiple entries by clients.*

*Programs span a wide range of ages, and every effort was made to present data according to the regulations’ requirements.

Full-Service Partnerships (FSP)

Full-Service Partnership (FSP) programs are designed for all age groups and would benefit from an intensive service program. The foundation of Full-Service Partnerships is doing everything possible to help individuals on their path to recovery and wellness. Full-Service Partnerships are designed to be client driven and are based on an individual's needs.

FSP Programs Target Goals for Fiscal Year 2025–2026

Program	Target Served	Projected cost per client
Youth FSP Program (ATLAS)	75	$16,961
Transitional Age Youth (TAY) Expanded Transitions (TAY FSP)	90	$4,501
Casa Esperanza TAY Transitions Program (TAY FSP)	16	$50,778
Assisted Outpatient Treatment (AOT) Program	150	$8,887
Adult Clinic Based FSP	12	$68,963
VCBH Adult FSP	100	$815
Empowering Partners through Integrative Community Services (EPICS)	80	$21,586
VISTA	60	$17,438
VCBH Older Adults FSP Program	100	$12,689
Child Welfare FSP (New in FY 25–26)	125	$28,213

Full-Service Partnership Program Demographics

Unduplicated Clients		
Age Group	**N=625**	
0–15 yrs.	33	3.57%
16–25 yrs.	152	22.19%
26–59 yrs.	280	46.54%
60 yrs. & older	160	27.71%
Gender Identity	**N=625**	
Female	262	41.88%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.22%
Gender Queer	1	0.11%
Male	323	51.95%
Non-Binary	2	0.22%
Unknown/Not Reported	36	5.63%
Race	**N=625**	
Alaska Native or Native American	4	0.54%
Asian	10	1.41%
Black/African American	32	5.30%
Declined to Answer	8	0.97%
Multiracial	1	0.11%
Native Hawaiian or Other Pacific Islander	4	0.76%
Other	214	33.98%
Unknown/Not Reported	88	14.39%
White/Caucasian	264	42.53%
Sexual Orientation	**N=625**	
Bisexual	4	0.65%
Declined to State	1	0.11%
Heterosexual/Straight	92	14.61%
Unknown/Not Reported	525	84.31%
Unsure/Questioning	3	0.32%
Ethnicity	**N=625**	
Declined to Answer	2	0.43%
Hispanic/Latino	262	40.37%
Multiethnic	1	0.11%
Non-Hispanic/Non-Latino	266	44.48%
Unknown/Not Reported	94	14.61%
Language Spoken	**N=625**	
American Sign Language (ASL)	1	0.11%
Arabic	1	0.11%
English	532	86.26%
Other non-English	1	0.22%
Spanish	39	5.63%
Unknown/Not Reported	51	7.68%
Military Service	**N=625**	
No	130	20.67%
Unknown/Not Reported	492	78.90%
Yes	3	0.43%
Disabilities	**Not Collected**	

Youth and Family FSP (ATLAS)

Program Demographics		
FY 24–25 Total Program Cost	$ 1,325,097.15	
Total Individuals Served	76	
Cost Per Individual	$ 17,435.49	
Individuals Served FY 23–24	53	
Age Group	**N=76**	
0–15 yrs.	33	43.4%
16–25 yrs.	43	56.6%
Sex	**N=76**	
Female	45	59.2%
Male	31	40.8%
Sexual Orientation	**N=76**	
Heterosexual/Straight	28	36.8%
Unknown/Not Reported	47	61.8%
Unsure/Questioning	1	1.3%
Gender Identity	**N=76**	
Female	43	56.6%
Male	30	39.5%
Unknown/Not Reported	3	3.9%
Race	**N=76**	
Asian	2	2.6%
Black/African American	3	3.9%
Declined to Answer	3	3.9%
Native Hawaiian or Other Pacific Islander	1	1.3%
Unknown/Not Reported	4	5.3%
Other	28	36.8%
White/Caucasian	35	46.1%
Ethnicity	**N=76**	
Hispanic/Latino	53	69.7%
Non-Hispanic/Non-Latino	20	26.3%
Unknown/Not Reported	3	3.9%
Language Spoken	**N=76**	
American Sign Language (ASL)	1	1.3%
English	64	84.2%
Spanish	9	11.8%
Unknown/Not Reported	2	2.6%
Military Status	**N=76**	
Yes	49	64.5%
No	26	34.2%
Unknown/Not Reported	1	1.3%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

ATLAS program has continued to expand provision of Full-Service Partnership-level services to diverse, underserved communities across Ventura County. The field-based, countywide team (comprised of clinicians, case managers, and peer support specialists) continues to reach marginalized populations. During FY 24–25, the program experienced staffing shortages that impacted service delivery and continuity of care. These challenges led to increased caseloads for existing staff and occasional delays in client engagement. Recruitment efforts were intensified and the program supplemented staffing shortages through temporary staffing agencies. Despite these challenges, the team maintained strong client engagement by meeting youth and families in accessible community settings including schools, homes, and field locations. Funding for basic needs played a critical role in supporting the clients. The ability to provide direct assistance with essentials such as food, clothing, transportation, and housing stability helped reduce barriers to engagement and improved overall client outcomes. This resource strengthened trust and rapport between staff and clients, reinforcing the program's commitment to culturally responsive and trauma-informed practices and recognizing the diverse backgrounds and lived experiences of the youth and families served.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

ATLAS continues to make strides in addressing key community needs and specific areas highlighted in the CPP process from the point of client referral. To improve targeted support, each referral has been categorized by key risk factors such as homelessness, child welfare, justice involvement and youth struggling in school. ATLAS has also continued to develop and strengthen collaborations with law enforcement, public health, probation, juvenile facilities, etc. to support reentry programs that reduce recidivism and foster long-term progress. This close collaboration with partnering agencies has enhanced care coordination and support to youth with complex needs.

The presence of bilingual and bicultural staff on the team significantly enhanced engagement with families from diverse backgrounds. These staff members provided culturally and linguistically appropriate services, helping to build trust, reduce communication barriers, and ensure that families felt seen, heard, and supported throughout their care journey.

Include examples of notable community impact.

ATLAS has made significant progress in helping youth and families secure stable housing, reduce justice system involvement, and increase access to mental health services. The program's mental health associates play an integral part in identifying and addressing homelessness through tracking in the HMIS system. By integrating field-based clinical, case management, and peer support roles, the team was able to deliver comprehensive care directly in the community, meeting youth and families where they are. This approach has reduced barriers to access, increased service responsiveness, and strengthened outcomes across housing, justice involvement, and mental health engagement.

Success story.

A 13-year-old male youth was referred to ATLAS FSP in February 2024 following the sudden loss of his father. He presented significant emotional and behavioral challenges, including depression, irregular school attendance, poor academic performance, and frequent aggressive outbursts. Using a multidisciplinary approach, the ATLAS team supported the youth and his family by providing basic needs assistance to reduce household stress, and therapeutic interventions to help him improve emotional regulation and overall functioning. Throughout the course of treatment, the youth (now 15-years-old) has stabilized emotionally and behaviorally, regularly attend school with a 4.0 GPA, and uses learned coping strategies to regulate mood and emotions. The youth (also struggling with substance use), has been participating in SUS groups and has been sober for 11 months. He began participating in running as an extracurricular activity, which he describes is a way for him to feel connected to his father. The family reports marked improvement in family relationships and a significant reduction in stress.

Transitional Age Youth (TAY) Expanded Transitions Program – FSP (TAY FSP)

Program Demographics		
FY 24–25 Total Program Cost	$	456,727.29
Total Individuals Served		91
Cost Per Individual	$	5,018.98
Individuals Served FY 23–24		21
Age Group	**N=91**	
16–25 yrs.	85	93.4%
26–59 yrs.	6	6.6%
Sex	**N=91**	
Female	53	58.2%
Male	38	41.8%
Sexual Orientation	**N=91**	
Bisexual	1	1.1%
Heterosexual/Straight	11	12.1%
Unknown/Not Reported	78	85.7%
Unsure/Questioning	1	1.1%
Gender Identity	**N=91**	
Female	47	51.6%
Male	37	40.7%
Non-Binary	1	1.1%
Unknown/Not Reported	6	6.6%
Race	**N=91**	
Asian	2	2.2%
Black/African American	4	4.4%
Declined to Answer	2	2.2%
Native Hawaiian or Other Pacific Islander	1	1.1%
Multiracial	1	1.1%
Unknown/Not Reported	15	16.5%
Other	41	45.1%
White/Caucasian	25	27.5%
Ethnicity	**N=91**	
Declined to Answer	1	2.1%
Hispanic/Latino	44	48.4%
Non-Hispanic/Non-Latino	28	30.8%
Unknown/Not Reported	18	19.8%
Language Spoken	**N=91**	
English	78	85.7%
Spanish	6	6.6%
Unknown/Not Reported	7	7.7%
Military Status	**N=91**	
Yes	18	19.8%
No	72	79.1%
Unknown/Not Reported	1	1.1%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The program continues to serve the transitional age youth (TAY) population, ages 18–25, by providing initial services and ongoing mental health support for clients who require a higher level of care. TAY services have expanded countywide, resulting in an increase in client engagement and contact. Staff deliver services using a multicultural approach tailored to each client's individualized needs, with support from certified interpreters for languages beyond English and Spanish. TAY program staff regularly discuss cultural implications—including strengths, challenges, and barriers—when making recommendations for next steps. Additionally, staff support clients in developing self-advocacy skills and building a sense of community within the culture(s) they identify with, as an integral part of the healing and treatment process.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Expanded Transitions program has two HMIS-designated staff who support TAY clients and their families with housing stability and related needs. Since transitioning to a full FSP program and expanding services countywide, the clinic has assisted clients with basic needs requests, including—but not limited to—food, clothing, rent assistance, and additional supports aimed at reducing barriers that impact overall stability. TAY program staff also work regularly to build relationships with community partners to increase access to services for clients who are homeless, experience frequent crises, have repeated psychiatric hospitalizations, or have recent and/or frequent involvement with the justice system. The initial focus of treatment is on addressing clients' basic needs to promote safety, stabilization, and engagement in services.

Include examples of notable community impact.

Since transitioning to a full FSP program, one noticeable impact is that services are no longer limited to specific areas of the county. Instead, program services have expanded to support TAY clients who need FSP-level care throughout Ventura County.

Success story.

There is a TAY FSP client who was facing homelessness, in extended foster care, and struggling to fulfill probationary terms (thus facing jail time). Client presented severe PTSD symptoms and these additional risk factors/stressors were severely impacting her functioning across multiple domains Since being opened to the TAY FSP clinic, client was able to meet her probation terms with support from a community provider that aligned with her cultural and language needs. Additionally, client was able to secure stable housing all while building a strong relationship with her assigned FSP team members.

Casa Esperanza TAY Transitions Program (TAY FSP)

Program Demographics		
FY 2024-25 Total Program Cost	$1,575,306.30	
Total Individuals Served	16	
Cost per individual:	$98,456.64	
Individuals served FY 2023-24	21	
Age Group	**N = 16**	
16 - 25 yrs.	14	87.5%
26 - 59 yrs.	2	12.5%
Sex	**N = 16**	
Female	9	56.3%
Male	7	43.8%
Sexual Orientation	**N = 16**	
Heterosexual / Straight	2	12.5%
Unknown / Not Reported	14	87.5%
Gender Identity	**N = 16**	
Female	9	56.3%
Male	6	37.5%
Unknown / Not Reported	1	6.3%
Race	**N = 16**	
Unknown / Not Reported	1	6.3%
Other	8	50.0%
White/Caucasian	7	43.8%
Ethnicity	**N = 16**	
Hispanic	9	56.3%
Non-Hispanic	7	43.8%
Language Spoken	**N = 16**	
English	13	81.3%
Spanish	1	6.3%
Unknown / Not Reported	2	12.5%
Military Status	**N = 16**	
Yes	5	31.3%
No	11	68.8%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

After spending 12–18 months in the Casa Esperanza (Casa) program, clients are better equipped to navigate emerging adulthood. They develop life and social skills that support their success in entering or completing school, securing long-term housing, and obtaining and maintaining employment.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Casa has served transitional age youth (TAY) FSP clients by providing stable housing and access to basic needs, both of which are critical components of mental health stability and healing.

Include examples of notable community impact.

Following a stay at Casa's social rehabilitation facility, and with support from the TAY FSP clinical team, clients gain increased awareness and skills that help reduce mental-health impairments as they navigate their transition into adulthood. These skills further support reintegration into the community.

Success story.

During their stay at Casa this fiscal year, a client was unstable, was struggling with severe mental health symptoms, had multiple psychiatric hospitalizations, was facing homelessness, and had multiple contacts with law enforcement following a step-down from a locked facility. Since being admitted to Casa, and with support from his VCBH treatment team, clients have become stable and made significant strides by enrolling in college, maintaining their current placement, and obtaining and maintaining employment. Client has had no hospitalizations or contact with law enforcement since being placed at Casa. The program staff are proud of client's accomplishments and their progress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Assisted Outpatient Treatment (AOT) Program

Program Demographics		
FY 2024-25 Total Program Cost		$1,786,658.60
Total Individuals Served		159
Cost per individual:		$11,236.85
Individuals served FY 2023-24		122
Age Group	**N = 159**	
16 - 25 yrs.	23	14.5%
26 - 59 yrs.	124	78.0%
60 yrs & Older	12	7.5%
Sex	**N = 159**	
Female	47	29.6%
Male	112	70.4%
Sexual Orientation	**N = 159**	
Heterosexual / Straight	19	11.9%
Unknown / Not Reported	139	87.4%
Unsure / Questioning	1	0.6%
Gender Identity	**N = 159**	
Female	41	25.8%
Male	100	62.9%
Non-Binary	1	0.6%
Unknown / Not Reported	17	10.7%
Race	**N = 159**	
Asian	1	0.6%
Black/African American	10	6.3%
Declined to answer	1	0.6%
Native Hawaiian or Other Pacific Islander	1	0.6%
Unknown / Not Reported	30	18.9%
Other	55	34.6%
White/Caucasian	61	38.4%
Ethnicity	**N = 159**	
Decline to Answer	1	0.6%
Hispanic	67	42.1%
Multiethnic	1	0.6%
Non-Hispanic	54	34.0%
Unknown / Not Reported	36	22.6%
Language Spoken	**N = 159**	
English	131	82.4%
Spanish	5	3.1%
Unknown / Not Reported	23	14.5%
Military Status	**N = 159**	
Yes	31	19.5%
No	127	79.9%
Unknown / Not Reported	1	0.6%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Assisted Outpatient Treatment (AOT) program had several successful graduations this year. Clients were able to step down to lowers level of care (outpatient clinics) and were able to maintain consistent treatment. The program had clients who were able to find and maintain jobs in the community. AOT's multidisciplinary team meets with clients two–three times per week and conducts needs assessments on an ongoing basis. The intensity of services based on needs leads to better rapport and engagement with the clients. During this fiscal year (2024–2025), the AOT program petitioned 15 clients to county court.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The AOT program team conducts outreach and engagement and completes comprehensive needs assessment to identify client needs and help clients prioritize them. This fiscal year, the AOT team was able to find housing for 100% of their clients and were able to connect all clients to medical benefits. The AOT team continues to work very closely with the Incompetent to Stand Trial (IST) and Felony Incompetent to Stand Trial (FIST) courts to assure clients are being housed and connected to services to decrease incarcerations and/or hospitalizations. The IST and FIST courts send direct referrals to the AOT team to assure clients are already connected to services upon release from jail. In addition, the AOT team has increased collaborations with jails and inpatient hospitals, and the team visits clients weekly until they are released. In this way the rapport is built with clients. They are then released to trusted caseworkers who can take them to a placement.

Include examples of notable community impact.

The AOT team collaborates with several community stakeholders. The AOT team works closely with the inpatient unit, visits clients on weekly basis, work on discharge planning, and clients being released to the AOT caseworker. The same is true with the collaboration with the jail. An AOT case worker will visit clients on weekly basis, clients will be released to the AOT team, this way staff can take them to the placements. The team is dedicated to assuring all clients' needs are met, to decrease incarceration and hospitalization.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VCBH Adult Clinic-Based FSP Treatment Program

Program Demographics		
FY 2024-25 Total Program Cost		$81,691.04
Total Individuals Served		112
Cost per individual:		$729.38
Individuals served FY 2023-24		32
Age Group	**N = 112**	
16 - 25 yrs.	15	13.4%
26 - 59 yrs.	69	61.6%
60 yrs & Older	28	25.0%
Sex	**N = 112**	
Female	45	40.2%
Male	67	59.8%
Sexual Orientation	**N = 112**	
Bisexual	1	0.9%
Heterosexual / Straight	21	18.8%
Unknown / Not Reported	90	80.4%
Gender Identity	**N = 112**	
Female	40	35.7%
Male	64	57.1%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.9%
Unknown / Not Reported	6	5.4%
Gender Queer	1	0.9%
Race	**N = 112**	
Alaska Native or Native American	1	0.9%
Black/African American	3	2.7%
Declined to answer	2	1.8%
Native Hawaiian or Other Pacific Islander	2	1.8%
Unknown / Not Reported	9	8.0%
Other	42	37.5%
White/Caucasian	53	47.3%
Ethnicity	**N = 112**	
Decline to Answer	1	0.9%
Hispanic	49	43.8%
Non-Hispanic	50	44.6%
Unknown / Not Reported	12	10.7%
Language Spoken	**N = 112**	
English	102	91.1%
Spanish	6	5.4%
Unknown / Not Reported	4	3.6%
Military Status	**N = 112**	
No	25	22.3%
Unknown / Not Reported	87	77.7%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Throughout the fiscal year, VCBH has continued to strengthen identification and tracking of individuals eligible for Adult Clinic-Based FSP services to ensure that clients with the highest level of need, including those who are historically unserved or underserved, are connected to the intensive services they need.

The implementation of the SmartCare EHR system required operational adjustments and staff training, and the program also experienced ongoing challenges related to workforce recruitment and retention, as well as increased demand for intensive services. Despite these challenges, the program maintained a strong focus on outreach and engagement of underserved populations, including individuals experiencing homelessness and those with complex behavioral health conditions, helping ensure continued access to comprehensive, person-centered care.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

During Fiscal Year 2024–2025, the Full-Service Partnership (FSP) programs continued to address key community priorities identified through Ventura County's Community Program Planning process, including homelessness, incarceration, psychiatric hospitalization, and barriers to care for unserved and underserved populations. Using a "whatever it takes" approach, FSP programs prioritize engagement with individuals who are/at risk for experiencing homelessness, frequent psychiatric hospitalizations, or involvement with the criminal justice system. Services include housing support, employment and resource linkage, and integrated treatment for individuals with co-occurring mental health and substance use disorders. Through coordinated care, outreach, and team-based services, the Adult Clinic-Based Treatment program supports improved treatment engagement, housing stability, and reduced reliance on crisis and system services for individuals who have the most complex behavioral health needs.

Include examples of notable community impact.

FSP programs provided intensive, team-based services to individuals with the most complex behavioral health needs, including those experiencing homelessness, frequent psychiatric hospitalizations, and justice system involvement—this fiscal year. Through coordinated, person-centered care, the programs supported improved treatment engagement, increased housing stability, and strengthened connections to community resources for individuals who have historically faced barriers to care. By addressing both mental health and co-occurring substance use conditions, and connecting clients to housing, treatment, and supportive services, FSP programs helped to stabilize individuals in the community, reduce reliance on crisis services, and promote long-term recovery and community integration.

Success story.

One transitional age youth (TAY) client, experiencing significant instability, including homelessness, multiple psychiatric hospitalizations, ongoing self-harm behaviors, and very limited natural support, entered services last year.

Through the support of the TAY Full-Service Partnership (FSP) program, the client was connected to rental assistance and stable housing. With the stability of housing and continued engagement in therapy and psychiatric services, the client's mental health significantly improved. Since obtaining housing, the client has experienced no psychiatric hospitalization or incidents of self-harm. In addition to these improvements, the client recently secured employment and has been offered additional shifts due to strong performance in the workplace. This progress reflects the positive impact of stable housing, consistent treatment, and intensive FSP support in helping individuals achieve stability and move toward recovery and independence.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VCBH Adult FSP Treatment Program

Program Demographics		
FY 24–25 Total Program Cost	$	81,691.04
Total Individuals Served		114
Cost Per Individual	$	716.59
Individuals Served FY 23–24		32
Age Group	**N=114**	
16–25 yrs.	15	13.2%
26–59 yrs.	70	61.4%
60 yrs. & older	29	25.4%
Sex	**N=114**	
Female	47	41.2%
Male	67	58.8%
Sexual Orientation	**N=114**	
Bisexual	1	0.9%
Heterosexual/Straight	21	18.4%
Unknown/Not Reported	92	80.7%
Gender Identity	**N=114**	
Female	42	36.8%
Male	64	56.1%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.9%
Unknown/Not Reported	6	5.3%
Gender Queer	1	0.9%
Race	**N=114**	
Alaska Native or Native American	1	0.9%
Black/African American	3	2.6%
Declined to Answer	2	1.8%
Native Hawaiian or Other Pacific Islander	2	1.8%
Unknown/Not Reported	9	7.9%
Other	43	37.7%
White/Caucasian	54	47.4%
Ethnicity	**N=114**	
Declined to Answer	1	0.9%
Hispanic/Latino	50	43.9%
Non-Hispanic/Non-Latino	51	44.7%
Unknown/Not Reported	12	10.5%
Language Spoken	**N=114**	
English	104	91.2%
Spanish	6	5.3%
Unknown/Not Reported	4	3.5%
Military Status	**N=114**	
Yes	25	21.9%
No	89	78.1%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH continued to serve FSP clients using "whatever it takes" funds within the Adult Outpatient Clinics (Conejo Valley, Santa Paula, Simi Valley, Oxnard, South Oxnard and Ventura). The goal was to develop a fully functioning Adult ICM Clinic-Based FSP program to transition these clients to in order for them to receive services from a centralized FSP team. Although that team was created, it was not yet fully integrated, and therefore clients continued to receive services in the FSP treatment tracks at the clinics. Clients continued to obtain clinical support to address their individual needs, including field-based services where needed.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Clinic-based FSP works with Ventura County's clients who have a severe mental illness or who may have co-occurring mental health and substance use disorder. These clients require an intensive service program beyond standard outpatient treatment. This includes clients who are experiencing homelessness, incarceration, and/or psychiatric hospitalizations and often need more frequent interventions to address their needs and support stabilization within the community to reduce recidivism. The clinic-based FSP assists clients with a "whatever it takes" approach. The program provides an integrated treatment experience for individuals in a manner that reduces barriers to improve access for unserved and underserved individuals.

Include examples of notable community impact.

The FSP Treatment tracks in the clinics have been instrumental in being able to provide resources to community members who struggle with mental illness or co-occurring disorders. The program operates in partnership with the outpatient clinics in providing resources that have contributed significantly to the stabilization of clients while they remain in the community. Program staff have been able to help clients with medication management, housing, daily living skills and community resources (like accessing local food banks etc.). FSP enables staff to meet the clients where they are, in the community, thus reducing barriers to access services and needed resources.

Empowering Partners through Integrative Community Services (EPICS)

Program Demographics		
FY 24–25 Total Program Cost	$	1,791,114.55
Total Individuals Served		79
Cost Per Individual	$	22,672.34
Individuals Served FY 23–24		93
Age Group		N=79
16–25 yrs.	3	3.8%
26–59 yrs.	47	59.5%
60 yrs. & older	29	36.7%
Sex		N=79
Female	31	39.2%
Male	48	60.8%
Sexual Orientation		N=79
Declined to State	1	1.3%
Heterosexual/Straight	12	15.2%
Unknown/Not Reported	66	83.5%
Gender Identity		N=79
Female	31	39.2%
Male	48	60.8%
Race		N=79
Alaska Native or Native American	1	1.3%
Asian	1	1.3%
Black/African American	4	5.1%
Other	27	34.2%
White/Caucasian	46	58.2%
Ethnicity		N=79
Hispanic/Latino	23	29.1%
Non-Hispanic/Non-Latino	54	68.4%
Unknown/Not Reported	2	2.5%
Language Spoken		N=79
English	76	96.2%
Spanish	3	3.8%
Military Status		N=79
Yes	4	5.1%
No	75	94.9%
Disability	Not Collected	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Empowering Partners through Integrative Community Services (EPICS) provides intensive, comprehensive, and voluntary services to individuals with severe and persistent mental illness. With intentionally small caseloads, EPICS staff can devote significant time to clients in the community and provide direct field-based support. EPICS serves underserved and unserved populations, many of whom are unhoused or living in temporary settings such as hospitals, skilled nursing facilities, correctional facilities, board and care facilities, room and board homes, sober living homes, or with family and friends. The EPICS team conducts treatment team meetings four times per week to address concerns and discuss next steps to support each client's progress.

The EPICS team is culturally responsive and attentive to ethnic and linguistic disparities, frequently supporting English-speaking clients whose family members are Spanish speaking to ensure that families are included in care planning and decision-making. Staff advocate for clients through behavioral and substance-use relapses and provide access to basic needs and housing funds to support safety, shelter, food, hygiene needs, medical care, and transportation. When basic needs are met, clients experience reduced stress, benefiting both clients and their families. Nursing staff provide medication management education and coordinate medical care. Case managers offer transportation to psychiatric appointments to support treatment adherence. Intensive Services Clinicians and Alcohol and Drug Treatment Specialists on the team provide individual one-on-one therapy to clients. EPICS supports clients with complex symptoms through individualized, recovery-oriented rehabilitation services. The program collaborates with community partners to ensure access to housing, basic needs, and community navigation support, empowering clients to build self-sufficiency and achieve their treatment goals.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The EPICS program serves clients throughout Ventura County and collaborates closely with community partners to ensure access to a comprehensive continuum of care. Services include housing support, basic needs, crisis response, referrals to inpatient and residential treatment, and support with community navigation. The EPICS team actively supports and advocates for clients during periods of incarceration or psychiatric hospitalization by coordinating with correctional facilities and hospitals to plan appropriate next steps. EPICS has successfully facilitated transitions from jails and hospitals to inpatient rehabilitation and crisis residential treatment programs to promote safe reintegration into the community. Staff and clients work collaboratively to build self-sufficiency and achieve individualized treatment goals.

Include examples of notable community impact.

Building rapport and trust within the community is fundamental to the success of the EPICS program. The EPICS team approaches each client with empathy and intentionally invests time in developing strong, trusting relationships. The team recognizes that clients often face multiple, complex needs simultaneously, including legal, medical, and crisis-related challenges. EPICS staff strive to balance direct support with empowering clients to independently access available resources. The EPICS team has successfully assisted unhoused individuals in securing housing, connected clients to necessary treatment programs, provided essential basic needs, supported housing-related financial assistance, and delivered high-quality outpatient mental health services to the individuals they serve.

VISTA (Adults FSP Program)

Program Demographics		
FY 24–25 Total Program Cost	$	1,715,626.17
Total Individuals Served		66
Cost Per Individual	$	25,994.34
Individuals Served FY 23–24		63
Age Group	N=66	
16–25 yrs.	1	1.5%
26–59 yrs.	57	86.4%
60 yrs. & older	8	12.1%
Sex	N=66	
Female	14	21.2%
Male	52	78.8%
Sexual Orientation	N=66	
Heterosexual/Straight	7	10.6%
Unknown/Not Reported	59	89.4%
Gender Identity	N=66	
Female	13	19.7%
Male	46	69.7%
Unknown/Not Reported	7	10.6%
Race	N=66	
Alaska Native or Native American	1	1.5%
Asian	2	3.0%
Black/African American	5	7.6%
Unknown/Not Reported	14	21.2%
Other	27	40.9%
White/Caucasian	17	25.8%
Ethnicity	N=66	
Hispanic/Latino	34	51.5%
Non-Hispanic/Non-Latino	18	27.3%
Unknown/Not Reported	14	21.2%
Language Spoken	N=66	
English	50	75.8%
Spanish	3	4.5%
Unknown/Not Reported	13	19.7%
Military Status	N=66	
Yes	15	22.7%
No	51	77.3%
Disability	Not Collected	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The VISTA program has a multicultural team, which enhances the program's ability to effectively meet the needs of a community with diverse cultural and ethnic backgrounds. The program continues to maintain a fully staffed team, including a Certified Peer Recovery Coach who plays an important role in increasing engagement among individuals who have historically been unserved or underserved.

The clinical team is trained and regularly re-certified in the application of involuntary holds, ensuring preparedness to support clients and collaborate with community partners during times of crisis. Over the past year, the treatment team successfully managed crisis situations without the need to initiate involuntary holds, instead supporting clients in choosing voluntary care and services whenever possible.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The program works specifically with the unhoused, incarcerated, and underserved/unserved groups. The team includes case managers, nurses, prescribers, therapists, substance use counselors, and peers who support clients in becoming independent, supporting their medication regimes, accessing social support, participating in educational groups, obtaining benefits or employment, and learning life skills. Supportive housing assistance is also provided. Services are delivered in person, in the community, in the office, or via telehealth. The program reaches out to clients for several weeks to build rapport and meet them where they are most comfortable. Gradually, staff engage them in services to reduce recidivism, increase housing security, and help them become independent citizens of their community.

Include examples of notable community impact.

Over the past year, the program has placed a strong emphasis on strengthening collaboration with key community and justice system partners. Efforts were focused on increasing coordination with jail staff, court-based programs, and residential treatment providers to help create clearer and more supportive pathways to mental health treatment for individuals upon their release from custody. These partnerships have enhanced continuity of care and improved opportunities for clients to engage in services that support long-term stability and recovery.

In response to the growing impact of substance use in the community, the program also expanded harm-reduction efforts by providing fentanyl test strip packets and Xylazine test strips at the center. These resources are intended to increase awareness and promote safer practices, contributing to broader community efforts aimed at reducing

overdose-related deaths.

Additionally, the program strengthened cross-county collaboration with service providers in Los Angeles and Santa Barbara Counties. These partnerships have improved the program's ability to coordinate care and support clients who are transitioning out of county, ensuring that they are connected to appropriate services and resources as they continue their recovery and reintegration into the community.

Success story.

Client has been enrolled in the program for 18 months and has made significant strides in his reduction of mental health symptoms and increased satisfaction with life. When he began with the program, he had been struggling with Alcohol Use Disorder, Methamphetamine Use Disorder, and PTSD. All these issues are in sustained remission. Initially, he had goals of completing his education and gaining stable employment. Within the first few months, he started and completed his GED program. He successfully completed his DUI classes and has maintained his sobriety for the duration of treatment. He has also maintained employment and continues to live in a sober home where he pays his own rent. Client reports feeling great connection to the AA community and conveys his gratitude for graduating from the program soon.

Program Demographics		
FY 2024-25 Total Program Cost		$2,461,426.45
Total Individuals Served		100
Cost per individual:		$24,614.26
Individuals served FY 2023-24		91
Age Group	**N = 100**	
60 yrs & Older	100	100.0%
Sex	**N = 100**	
Female	76	76.0%
Male	24	24.0%
Sexual Orientation	**N = 100**	
Heterosexual / Straight	8	8.0%
Unknown / Not Reported	92	92.0%
Gender Identity	**N = 100**	
Female	76	76.0%
Male	24	24.0%
Race	**N = 100**	
Alaska Native or Native American	1	1.0%
Asian	2	2.0%
Black/African American	4	4.0%
Native Hawaiian or Other Pacific Islander	1	1.0%
Unknown / Not Reported	16	16.0%
Other	22	22.0%
White/Caucasian	54	54.0%
Ethnicity	**N = 100**	
Hispanic	21	21.0%
Non-Hispanic	71	71.0%
Unknown / Not Reported	8	8.0%
Language Spoken	**N = 100**	
Arabic	1	1.0%
English	90	90.0%
Other Non-English	1	1.0%
Spanish	8	8.0%
Military Status	**N = 100**	
No	93	93.0%
Unknown / Not Reported	7	7.0%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The VCBH Older Adults program is dedicated to serving unserved and underserved seniors living with mental illness by providing field-based, home-delivered mental health services to those who face significant barriers to care, including transportation challenges and social isolation. The program continually develops creative, culturally responsive strategies to engage a diverse elderly population and promote social and cultural integration.

Key initiatives include expanding weekly group therapy sessions within local Residential Care Facilities for the Elderly (RCFEs), fostering communication, socialization, and a sense of community among multicultural participants. To improve access to psychiatric care—historically a major barrier for older adults—the program launched a partnership with the Community Memorial Psychiatric Residency Program, enabling fourth-year residents to deliver in-person, home-based psychiatric services to seniors with serious mental illness. Additionally, the program strengthened post-pandemic recovery efforts by enhancing multicultural holiday events and producing a community art calendar, offering clients meaningful opportunities for expression and connection.

The Older Adults program has been undergoing an expansion of services under the Full-Service Partnership model. This will enable the program to serve the needs of the elderly in a more holistic approach, expanding services related to substance use and addressing risks of homelessness. The Older Adults program has both East and West Teams with locations in Oxnard and Thousand Oaks to provide comprehensive services throughout the county.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Older Adults program provided critical Supplemental Housing Funds to severely mentally ill seniors living on fixed incomes who are unable to meet the escalating rental costs in Ventura County, where housing affordability remains a significant regional challenge. Older adults receiving Supplemental Security Income (SSI) are disproportionately impacted and have historically faced housing instability, resulting in compromised safety and overall well-being. Additionally, to mitigate these and other risks, the Older Adults program utilizes Basic Needs Funding to address urgent financial gaps that arise from unforeseen expenses. These supports—covering essential items such as food, clothing, and emergency supplies—are especially vital during winter months, when financial strain increases and the risk of physical and emotional decline is elevated. Without these interventions, many clients would face crisis conditions, heightened food insecurity, and increased vulnerability.

Multiple assessments have identified social isolation as one of the most significant risk factors for older adults, particularly within Ventura County, where limited public transportation options create barriers to community participation and access to services. The Older Adults program implements a range of targeted strategies to reduce isolation and enhance service linkage for this underserved population. These efforts include facilitating transportation to medical and behavioral health appointments, coordinating access to senior centers, and supporting participation in community activities and essential shopping. Through these interventions, the program strengthens housing stability, reduces crises related to basic needs, and improves social connectedness—key factors that contribute to the overall health, safety, and quality of life of older adults in Ventura County.

Include examples of notable community impact.

During the past year, the Older Adults program underwent two relocations of its home-based service sites. Despite these transitions, the program successfully established a new centralized base for both the Older Adult West and East Teams and utilized this location to implement a countywide Holiday Event designed to promote social connection among senior participants. This event brought together older adults from diverse regions of the county, fostering community cohesion and reducing social isolation through structured, culturally inclusive activities. Preliminary outcomes indicate that participation in this event contributed to increased engagement in services. Clients reported enhanced motivation to connect with peers, and program staff observed improved treatment compliance following the event. As a result, the initiative has demonstrated measurable progress toward reducing isolation among elderly clients and strengthening their integration within the broader community.

Success story.

Robert, an older adult enrolled in the Ventura County Behavioral Health (VCBH) Older Adult Program, presented significant mental and physical health challenges, including Major Depressive Disorder, Hoarding Disorder, and obsessive-compulsive disorder. At entry, he experienced severe depressive symptoms, extreme disorganization, and long-standing avoidance of medical care. His physical health was critically compromised due to inconsistent medication adherence, limited mobility, and multiple chronic conditions such as pulmonary arterial hypertension, congestive heart failure, and severe edema. Additionally, Robert's home environment was unsafe, impacted by extensive hoarding, inoperable utilities, and structural deterioration, restricting all service providers to the front porch.

To address these complex needs, the Older Adults program initiated a coordinated response involving Adult Protective Services (APS), Code Enforcement and the Rapid Response Engagement Team (RRET). During a medical crisis, Robert was hospitalized and subsequently transferred to a skilled nursing facility (SNF). When the SNF incorrectly diagnosed him with dementia, the Older Adults Team advocated further assessment, which identified elevated potassium levels as the underlying cause of his confusion. After appropriate medical intervention, Robert experienced marked improvement in cognition and overall stability.

Concurrently, Robert's partner significantly increased his involvement, removing more than 1,600 pounds of accumulated clutter, repairing essential home utilities, and assisting with medication management. With ongoing therapeutic support and continuous interagency coordination, Robert demonstrated substantial progress: his edema resolved, medication adherence improved, and the home environment was restored to a safe and functional condition. He also overcame his long-standing fear of blood draws and began to participate consistently in both behavioral health and medical services.

This success story illustrates the effectiveness of a comprehensive, person-centered, and collaborative approach. Through persistence, advocacy, and strong partnerships across Older Adults Team, APS, and community service teams, Robert moved from a state of severe isolation and medical risk to one of stability, safety, and meaningful engagement in care. His case highlights how coordinated systems of support can produce transformative outcomes for older adults with complex behavioral health and medical needs.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CARE Program

Program Demographics		
FY 24–25 Total Program Cost	$	258,837.05
Total Individuals Served		34
Cost Per Individual	$	7,612.85
Individuals Served FY 23–24		New Program
Age Group	**N=34**	
16–25 yrs.	2	5.9%
26–59 yrs.	27	79.4%
60 yrs. & older	5	14.7%
Sex	**N=34**	
Female	10	29.4%
Male	24	70.6%
Sexual Orientation	**N=34**	
Bisexual	1	2.9%
Heterosexual/Straight	2	5.9%
Unknown/Not Reported	31	91.2%
Gender Identity	**N=34**	
Female	8	23.5%
Male	21	61.8%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	2.9%
Unknown/Not Reported	4	11.8%
Race	**N=34**	
Black/African American	5	14.7%
Declined to Answer	1	2.9%
Unknown/Not Reported	9	26.5%
Other	8	23.5%
White/Caucasian	11	32.4%
Ethnicity	**N=34**	
Hispanic/Latino	8	23.5%
Non-Hispanic/Non-Latino	15	44.1%
Unknown/Not Reported	11	32.4%
Language Spoken	**N=34**	
English	27	79.4%
Unknown/Not Reported	7	20.6%
Military Status	**N=34**	
Yes	5	14.7%
No	29	85.3%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The CARE Act Program began on December 1, 2024. During the fiscal year, the program served more than 60 active clients for whom CARE Act petitions were filed. The CARE Team operates as a multidisciplinary unit, allowing clients to receive comprehensive and coordinated services that support ongoing treatment stability. Staff meet with clients two to three times per week and conduct continuous needs assessments to ensure services remain responsive and individualized. Building rapport is a key component of the program, as strong engagement helps reduce cycles of repeated incarceration and hospitalization.

Throughout the fiscal year, the CARE Team conducted extensive outreach to multiple community stakeholders to increase awareness of the new program, explain program benefits, and provide guidance on submitting direct referrals and filing petitions. These efforts were designed to ensure that community partners, families, and service providers understood how to connect clients or loved ones to the CARE Act Program.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CARE Team conducts outreach, engagement, and comprehensive assessments to identify client needs and support clients in prioritizing and addressing those needs. The team successfully secured housing for 100% of its clients and ensured all clients were connected to appropriate medical benefits. CARE staff also work closely with Incompetent to Stand Trial (IST) and Felony Incompetent to Stand Trial (FIST) courts to support client compliance and ensure that individuals remain connected to services in order to reduce the likelihood of incarceration and/or hospitalization.

The CARE Program accepts direct referrals from a variety of sources, including hospitals from the Ventura County Health Care Agency (HCA) and the Hospital Policy Committee (HPC), outpatient clinics, IST, FIST and self-referrals. After a referral is received, the CARE Team provides outreach and engagement services, visiting clients in jail or hospitals on a weekly basis until their release. This ongoing contact supports stabilization, engagement, and successful transition to community-based services.

Include examples of notable community impact.

The CARE Team collaborates closely with several community stakeholders to ensure coordinated support for individuals served through the CARE ACT process. The team works directly with Ventura County hospitals (HCA and HPC), which frequently submit referrals to the program. After receiving a referral, the CARE Team assesses clients for eligibility and files CARE Act petitions when appropriate. This allows hospitals to continue providing care without requiring staff to attend court hearings. The team also visits hospitalized clients at least once per week to support engagement and discharge planning.

Outreach and Engagement (O & E)

This Community Services and Supports (CSS) component employs strategies and resources to reach, identify, and engage unserved individuals and communities in the county mental health system with the goal of reducing disparities unique to the county. In addition to reaching out to and engaging several entities, such as community-based organizations, schools, primary care providers, and faith-based organizations, the Outreach and Engagement (O & E) category of programs under CSS engages community leaders, the homeless population, those who are incarcerated, and families of individuals served.

The O & E category in Ventura County is fulfilled by the Rapid Integrated Support and Engagement (RISE) program that assigns various staff to do concentrated outreach to eligible individuals who have difficulty engaging with services. In addition to the RISE program, there are general outreach efforts executed countywide to inform and engage the community regarding mental illness and services available.

Rapid Integrated Support and Engagement (RISE)

Program Demographics		
FY 24–25 Total Program Cost	$2,061,378.00	
Total Individuals Served	1,224	
Cost Per Individual	$1,684.13	
Individuals Served FY 23–24	1,107	
Age Group	**N=1,224**	
0–15 yrs.	17	1.39%
16–25 yrs.	180	14.71%
26–59 yrs.	732	59.80%
60 yrs. & older	295	24.10%
Sex	**N=1,224**	
Female	553	45.18%
Male	664	54.25%
Unknown	7	0.57%
Sexual Orientation	**N=1,224**	
Bisexual	1	0.08%
Declined to State	1	0.08%
Heterosexual/Straight	148	12.09%
Unknown/Not Reported	1,074	87.75%
Gender Identity	**N=1,224**	
Female	413	33.74%
Male	455	37.17%
Male-to-Female (MTF)/Transgender Female/Trans Woman	1	0.08%
Transgender	1	0.08%
Non-Binary	1	0.08%
Unknown/Not Reported	353	28.84%
Race	**N=1,224**	
Alaska Native or Native American	11	0.90%
Asian	15	1.23%
Black/African American	29	2.37%
Declined to Answer	21	1.72%
Native Hawaiian or Other Pacific Islander	3	0.25%
Multiracial	1	0.08%
Unknown/Not Reported	515	42.08%
Other	205	16.75%
White/Caucasian	424	34.64%
Ethnicity	**N=1,224**	
Declined to Answer	5	0.41%
Hispanic/Latino	469	38.32%
Multiethnic	1	0.08%
Non-Hispanic/Non-Latino	383	31.29%
Unknown/Not Reported	366	29.90%
Language Spoken	**N=1,224**	
American Sign Language (ASL)	2	0.16%
Cantonese	1	0.08%
English	741	60.54%
Mandarin	1	0.08%
Mixteco	1	0.08%
Spanish	39	3.19%
Unknown/Not Reported	439	35.87%
Military Status	**N=1,224**	
Yes	3	0.25%
No	247	20.18%
Unknown/Not Reported	974	79.58%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Rapid Integrated Support and Engagement (RISE) is an outreach and engagement program designed to connect individuals who have difficulty accessing services, are often overlooked, or have been historically underserved within the behavioral health system. RISE focuses on identifying barriers to care and creating effective pathways that ensure meaningful and sustained connections to services. The program serves individuals throughout Ventura County, linking them to a wide range of resources, including, but not limited to, behavioral health services and substance use services. RISE services include proactive outreach and direct engagement aimed at connecting individuals with appropriate treatment providers and community-based supports. The RISE team is bilingual and bicultural, offering culturally responsive services and communication in each individual's preferred language to better meet their needs and build trust.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Rapid Integrated Support and Engagement (RISE) program addresses priority community issues identified in Ventura County's Community Program Planning process, including homelessness, incarceration, and serving unserved and underserved populations. RISE partners with local law enforcement, hospitals, and community organizations to proactively engage individuals with Serious Mental Illness (SMI) who frequently utilize emergency services. Unlike traditional crisis response models, RISE maintains an active caseload and focuses on early intervention, outreach, and linkage to ongoing behavioral health and community-based services. Referrals from law enforcement and other partners allow the team to connect individuals to care before crises occur, reducing emergency room visits, hospitalizations, and incarceration. To address homelessness, RISE collaborates with the County Health Care Agency through initiatives such as Backpack Medicine, One-Stop events, and partnerships with hospital emergency departments. These efforts improve access to behavioral health care, medical services, and housing

resources for unhoused individuals. Through bilingual, culturally responsive outreach and continued staff training, RISE reduces barriers and improves access to care for those most in need.

Include examples of notable community impact.

RISE's flexible, field-based approach allows the team to engage individuals who are often disconnected from services and unlikely to respond to traditional outreach. A notable impact of the program is its ability to successfully reengage individuals with Serious Mental Illness (SMI) who have disengaged from treatment—helping prevent crisis episodes that often result in hospitalization or law enforcement involvement.

RISE frequently serves as critical support to treatment providers who lack the capacity to locate and reconnect with clients in the community. Through persistent outreach and relationship-building, the team has helped individuals return to care, stabilize, and reduce their reliance on emergency services. In partnership with the County Health Care Agency, RISE participates in Backpack Medicine and One-Stop events, creating direct access points for individuals experiencing homelessness to receive behavioral health services, medical care, and essential resources. The team has also expanded collaboration with local hospital emergency departments, improving coordination of care and supporting smoother transitions from acute settings to community-based services. Through these efforts, RISE has contributed to reduced hospitalizations, decreased law enforcement contacts, and improved continuity of care for some of the county's most vulnerable and underserved residents.

General System Development (GSD)

General System Development (GSD) is a category under CSS that funds programs and services that support and improve the existing health service delivery system designed for all clients and, when appropriate, their families (including those qualifying for Full-Service Partnership programs and especially target populations). Additionally, a constant and concerted effort is always made to improve and transform systems of care focused on clients and families. Funds under GSD may be used to fund the following:

- Mental health treatment, including alternative and culturally specific treatments
- Peer support
- Supportive services to assist clients (and when appropriate, their family members) in obtaining employment, housing, and/or education
- Wellness centers
- Personal service coordination/case management to assist clients (and when appropriate, their families) to access needed medical, educational, social, vocational, rehabilitative, or other community services
- Individual needs assessments
- Individual Services and Supports Plan (ISSP)development
- Crisis intervention/stabilization services
- Family education services

While these funds are focused on being used to improve the county mental health service delivery system for all clients and their families, they can also be applied to collaborate with other non-mental health community programs and/or services and develop and implement strategies for reducing ethnic/racial disparities. These programs are designed to promote interagency and community collaboration, and to develop values-driven, evidence-based, and promising clinical practices to support populations with mental illness.

The Ventura County GSD programming structure is categorized by the following GSD subcategories:

- Crisis Intervention and Stabilization
- Individual Needs Assessment
- Treatment (non-FSP)
- Peer Support
- Peer Services Coordination and Case Management
- Client Transportation Program
- Forensic Pre-Admit/Mental Health Diversion Grant Program
- Linguistics Competence Services

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GSD Programs Target Goals for Fiscal Year 2025–2026

Program	Target Served	Projected cost per client
County-Wide Crisis Team (CT)	900	$4,830
Crisis Residential Treatment (CRT)	190	$24,112
Crisis Stabilization Unit (CSU)	230	$17,535
Access Program (Access Line)	2,100	$1,017
Fillmore Community Project	200	$4,224
Transitional Age Youth (TAY) Outpatient Treatment Program	300	$8,236
VCBH Adult Outpatient Treatment Program	7,700	$3,917
The Client Network	49	$1,602
Family Access Support Team (FAST)	350	$3,347
Growing Works	50	$11,036
Mobile Response Team (MRT) for Youth and Families	100	$8,510
Mobile Crisis Outreach for Transitional Age Youth (MCOT)	100	$4,236
Therapy Dogs	100	$2,369
Forensic Mental Health Court/Mental Health Diversion Grant Program	650	$1,053
IPS (Launching FY 25–26)	50	$ 7,505
Adult Wellness and Recovery Center and Mobile Wellness	560	$2,080
TAY Wellness Center	150	$3,595
Adult Short-Term Treatment	3,300	$866
Semillas Planting Seeds of Wellness	100	$2,359
Arts and Wellness Creativity though the Arts	100	$4,207
Nate’s Place Wellness Center	100	$694
Candela Peer Support and Workshops Mesa Independent Living - Support Services	110	$694
Moorpark EPSDT	100	$12,327

General System Development (GSD): Program Demographics

Age Group	**N = 12,533**	
0 - 15 yrs.	1,782	14.22%
16 - 25 yrs.	2,085	16.64%
26 - 59 yrs.	6,720	53.62%
60 yrs & Older	1,946	15.53%
Sex	**N = 12,893**	
Female	6,667	52.15%
Male	6,117	47.85%
Unknown / Not Reported	109	0.85%
Gender Identity	**N = 15,137**	
Declined to Answer	61	0.40%
Female	5,723	37.81%
Female-to-Male (FTM)/Transgender Male/Trans Man	21	0.14%
Gender Queer	8	0.05%
Male	5,362	35.42%
Male-to-Female (MTF)/Transgender Female/Trans Woman	15	0.10%
More than One	3	0.02%
Non-Binary	18	0.12%
Other	12	0.08%
Transgender	25	0.17%
Unknown / Not Reported	3,884	25.66%
Unsure / Questioning	5	0.03%
Race	**N = 12,964**	
Alaska Native or Native American	67	0.52%
Another Race	3	0.02%
Black/African American	11	0.08%
Declined to Answer	12	0.09%
Hispanic or Latino	63	0.49%
More than One Race	14	0.11%
Non-Hispanic	7	0.05%
Unknown / Not Reported	12,747	98.33%
White/Caucasian	40	0.31%
Orientation	**N = 12,968**	
Bisexual	91	0.70%
Declined to Answer	287	2.21%
Gay (male)	7	0.05%
Heterosexual / Straight	1,936	14.93%
Lesbian (female)	8	0.06%
Lesbian or Gay	20	0.15%
More than One	3	0.02%
Other	19	0.15%
Queer	18	0.14%
Transgender	2	0.02%
Unknown / Not Reported	10,568	81.49%
Unsure / Questioning	9	0.07%
Ethnicity	**N = 14,015**	
Declined to Answer	101	0.72%
Hispanic	3,814	27.21%
Multiethnic	32	0.23%
Non-Hispanic	1,998	14.26%

Unknown / Not Reported	8,070	57.58%
Primary Language Spoken	**N = 12,942**	
American Sign Language (ASL)	14	0.11%
Arabic	6	0.05%
Cambodian	1	0.01%
Cantonese	2	0.02%
Declined to Answer	13	0.10%
English	9,147	70.68%
Farsi	3	0.02%
Indigenous (Mixtec/Trique/Other)	1	0.01%
Italian	1	0.01%
Japanese	1	0.01%
Korean	2	0.02%
Mandarin	2	0.02%
Mixteco	8	0.06%
More than One	90	0.70%
Other Chinese Dialects	1	0.01%
Other Non-English	16	0.12%
Portuguese	1	0.01%
Russian	3	0.02%
Spanish	1,267	9.79%
Tagalog	6	0.05%
Thai	2	0.02%
Unknown / Not Reported	2,340	18.08%
Vietnamese	15	0.12%
Military Serviced	**N = 12,941**	
Declined to Answer	12	0.09%
No	3,739	28.89%
Unknown / Not Reported	9,140	70.63%
Yes	50	0.39%
Disabilities	**Not Collected**	

County-Wide Crisis Team (CT)

Program Demographics		
FY 24–25 Total Program Cost	$ 3,427,983.51	
Total Individuals Served	875	
Cost Per Individual	$ 3,917.70	
Individuals Served FY 23–24	981	
Age Group	**N=875**	
0–15 yrs.	129	14.7%
16–25 yrs.	219	25.0%
26–59 yrs.	414	47.3%
60 yrs. & older	113	12.9%
Sex	**N=875**	
Female	483	55.2%
Male	369	42.2%
Unknown	23	2.6%
Sexual Orientation	**N=875**	
Bisexual	4	0.5%
Declined to State	7	0.8%
Gay (male)	1	0.1%
Heterosexual/Straight	66	7.5%
Transgender	1	0.1%
Unknown/Not Reported	791	90.4%
Unsure/Questioning	5	0.6%
Gender Identity	**N=875**	
Female	326	37.3%
Male	254	29.0%
Female-to-Male (FTM)/Transgender Male/Trans Man	6	0.7%
Transgender	4	0.5%
Unknown/Not Reported	281	32.1%
Gender Queer	2	0.2%
Unsure/Questioning	2	0.2%
Race	**N=875**	
Alaska Native or Native American	12	1.4%
Asian	15	1.7%
Black/African American	19	2.2%
Declined to Answer	25	2.9%
Native Hawaiian or Other Pacific Islander	8	0.9%
Multiracial	1	0.1%
Unknown/Not Reported	397	45.4%
Other	138	15.8%
White/Caucasian	260	29.7%

Ethnicity	N=875	
Declined to Answer	2	0.2%
Hispanic/Latino	241	27.5%
Non-Hispanic/Non-Latino	240	27.4%
Unknown/Not Reported	392	44.8%
Language Spoken	**N=875**	
American Sign Language (ASL)	2	0.2%
English	475	54.3%
Korean	1	0.1%
Mandarin	2	0.2%
Mixteco	1	0.1%
Other non-English	1	0.1%
Spanish	42	4.8%
Unknown/Not Reported	350	40.0%
Vietnamese	1	0.1%
Military Status	**N=875**	
Yes	1	0.1%
No	661	75.5%
Unknown/Not Reported	213	24.3%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The County-Wide Crisis Team (CT) provides support to individuals within the county who are experiencing a behavioral health crisis. During the last fiscal year, the team consistently delivered in-person responses within the required 60-minute timeframe. The crisis team focused on utilizing interventions such as de-escalation and crisis resolution, identifying natural supports such that all other options were explored before a psychiatric hospitalization was necessary. When appropriate, individuals were connected to outpatient services and community resources for ongoing support.

When bilingual staff were available, they responded in person to clients who shared their language. When this was not possible, the team utilized the on-demand Language Line to secure interpretation services. Throughout the fiscal year, the team also continued its collaboration with community organizations, schools, and law enforcement agencies to increase awareness of CT and to promote understanding of the support the program can provide. These outreach meetings were tailored to the specific needs, questions, and scenarios relevant to each partner agency, while respecting their time constraints.

.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The CT staff collaborates closely with programs and clinics within VCBH, including the Wellness on Wheels program (a program supporting underserved and rural communities throughout Ventura County). The team also collaborates with community agencies to ensure they are informed on how to access mobile crisis services and the fully integrated Access and Crisis Line, which serves as the entry point for behavioral health services. Additionally, the crisis team provides services to individuals anywhere in the county during a crisis—whether in a home, on the street, or another preferred location—ensuring support is delivered where it is most needed.

Include examples of notable community impact.

The team expanded during the past fiscal year, enhancing both the program's response capacity and multidisciplinary expertise. This growth has enabled CT Services to deploy staff with diverse, specialized skill sets, including peer support specialists who offer valuable insight rooted in lived experience; case coordinators who leverage targeted resources to effectively address individual needs; and alcohol and drug treatment specialists who bring extensive knowledge in supporting individuals with co-occurring conditions or primary substance use concerns. This multidisciplinary approach strengthens the program's ability to provide comprehensive, person-centered crisis response throughout the county.

Crisis Residential Treatment (CRT)

Program Demographics			
FY 24–25 Total Program Cost		$ 5,401,223.80	
Total Individuals Served		191	
Cost Per Individual		$ 28,278.66	
Individuals Served FY 23–24		386	
Age Group	**N=191**		
16–25 yrs.		25	13.1%
26–59 yrs.		164	85.9%
60 yrs. & older		2	1.0%
Sex	**N=191**		
Female		85	44.5%
Male		106	55.5%
Sexual Orientation	**N=191**		
Declined to State		1	0.5%
Heterosexual/Straight		30	15.7%
Unknown/Not Reported		160	83.8%
Gender Identity	**N=191**		
Female		78	40.8%
Male		95	49.7%
Male-to-Female (MTF)/Transgender Female/Trans Woman		1	0.5%
Unknown/Not Reported		17	8.9%
Race	**N=191**		
Asian		3	1.6%
Black/African American		14	7.3%
Declined to Answer		3	1.6%
Native Hawaiian or Other Pacific Islander		1	0.5%
Multiracial		1	0.5%
Unknown/Not Reported		21	11.0%
Other		55	28.8%
White/Caucasian		93	48.7%
Ethnicity	**N=191**		
Declined to Answer		1	0.5%
Hispanic/Latino		78	40.8%
Multiethnic		1	0.5%
Non-Hispanic/Non-Latino		78	40.8%
Unknown/Not Reported		33	17.3%
Language Spoken	**N=191**		
English		160	83.8%
Spanish		7	3.7%
Unknown/Not Reported		24	12.6%
Military Status	**N=191**		
Yes		1	0.5%
No		132	69.1%
Unknown/Not Reported		58	30.4%
Disability	**Not Collected**		

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Ventura Crisis Residential Treatment (VCRT) continues to work closely with county partners to address both current and evolving needs of the clients and Ventura County Behavioral Health challenges. Over the past year, the program has noted an increase in justice-involved and dually diagnosed clients. Since this may be the first mental health placement for many of these clients, the program has placed emphasis on gaining their trust and opening their minds to remaining in treatment. This approach was based on experience where many clients would leave treatment early. The program has added several activities, including adding a variety of games to the multi-purpose group room. This includes an extra T.V. and sofa, and two games (air hockey table, and indoor basketball game). Programs first implemented last fiscal year of enhanced daily living support and education have been continued. This effort has proved invaluable in preparing clients for their next living environment. Another strength of the VCRT staff has been their flexibility with an ever-changing client population. This entails having a wide range in verbal and cognitive ability within the client population. Staff identify these needs upon admission and gear clinical groups according to clients' needs and abilities. Ongoing challenges continue to be clients who left treatment early and trying to find suitable therapeutic placements for those ready for discharge. In each situation, staff continue to look at internal mechanisms that can improve the quality of care.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

VCRT continues to have open doors for all eligible clients who need short-term, crisis residential care placement. Admissions from county partners can occur at any time including weekends and late-in-the-night admissions. The program's approach with all populations, especially the underserved (i.e., unhoused and justice-involved), is to work with them to "find a reason and mechanism to say yes" (versus a standard denial of admission for any high-risk populations). The program often gives clients multiple interviews prior to

placement. This is done knowing that some incarcerated individuals struggle with their first assessment and upon a follow-up session, the individual is more comfortable and willing to accept placement. Relationships with county partners and VCBH help to solve challenging issues. There are weekly COC meetings that are an invaluable tool for all partners to share ideas and receive feedback regarding treatment and placement. Part of the program's role is to elicit feedback from the county regarding how VCRT processes referrals, provides customer services to the county, and provides treatment. Additionally, the program will follow up with discharge facilities to ensure success.

Include examples of notable community impact.

This has always been a difficult area to properly assess as the program is not a field-based operation. Admissions and referrals come from county partners. The overall goal is for every person who needs placement to receive professional and timely service. Program staff remain open to hearing feedback not only about the program's strengths, but areas in need of improvement.

Success story.

Ventura CRT had several success stories in Fiscal Year 2024–2025. There were three justice-involved clients, two of whom had multiple prior admissions. All three were successfully discharged to Hillmont House where they remain in good standing. One of these clients had a serious felony charge and this was her first residential placement. Reports indicate that she continues to build on the skills introduced at VCRT. The other two clients had significant histories of leaving placement against medical advice and refusing medications. Despite this, both residents not only remained in placement, but accepted treatment (both medication and psycho-social groups) for the first time. The program had two other clients who had significant successes. Both were successfully discharged and remain in the community. One has earned his LVN license and is working in a skilled nursing facility, and the other is a counselor in a sober living home.

Crisis Stabilization Unit (CSU)

Program Demographics		
FY 24–25 Total Program Cost	$ 4,303,877.11	
Total Individuals Served	230	
Cost Per Individual	$ 18,712.51	
Individuals Served FY 23–24	265	
Age Group	**N=230**	
0–15 yrs.	86	37.4%
16–25 yrs.	144	62.6%
Sex	**N=230**	
Female	162	70.4%
Male	68	29.6%
Sexual Orientation	**N=230**	
Bisexual	3	1.3%
Declined to State	1	0.4%
Heterosexual/Straight	44	19.1%
Lesbian (female)	1	0.4%
Unknown/Not Reported	177	77.0%
Unsure/Questioning	4	1.7%
Gender Identity	**N=230**	
Female	141	61.3%
Male	69	30.0%
Female-to-Male (FTM)/Transgender Male/Trans Man	4	1.7%
Male-to-Female (MTF)/Transgender Female/Trans Woman	1	0.4%
Transgender	2	0.9%
Non-Binary	2	0.9%
Unknown/Not Reported	7	3.0%
Gender Queer	1	0.4%
Other	2	0.9%
Unsure/Questioning	1	0.4%
Race	**N=230**	
Alaska Native or Native American	7	3.0%
Asian	4	1.7%
Black/African American	4	1.7%
Declined to Answer	18	7.8%
Native Hawaiian or Other Pacific Islander	1	0.4%
Multiracial	1	0.4%
Unknown/Not Reported	12	5.2%
Other	84	36.5%
White/Caucasian	99	43.0%
Ethnicity	**N=230**	
Declined to Answer	1	0.4%
Hispanic/Latino	137	59.6%
Multiethnic	2	0.9%
Non-Hispanic/Non-Latino	78	33.9%
Unknown/Not Reported	12	5.2%

Language Spoken	N=230	
American Sign Language (ASL)	1	0.4%
English	192	83.5%
Other non-English	1	0.4%
Spanish	21	9.1%
Unknown/Not Reported	15	6.5%
Military Status	**N=230**	
Yes	1	0.4%
No	3	1.3%
Unknown/Not Reported	226	98.3%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Crisis Stabilization Unit (CSU) for youth is operated by Seneca and serves individuals ages 6–17 who are experiencing a mental health crisis. Youth who are placed on a civil commitment hold or who arrive voluntarily are assessed to determine the most appropriate level of care, which may include inpatient hospitalization. If inpatient hospitalization is necessary, CSU staff coordinate and facilitate the transfer process. Youth who do not meet criteria for inpatient hospitalization are stabilized at the CSU and discharged after completing a psychiatrist assessment, safety planning process, and an aftercare meeting involving the youth, their caregiver, and other service providers. The long-term goal of the CSU is to help youth and caregivers develop coping skills within a short period of time to reduce the symptoms that contributed to the crisis and support effective crisis management, with the aim of preventing or reducing future hospitalizations.

The program operates 24 hours a day, seven days a week, and serves youth regardless of their ability to pay or insurance status. Services are accessible through bilingual Spanish-speaking and bicultural staff, as well as a language line to ensure care is provided in the client's and family's preferred language. CSU staff follow trauma-informed practices and complete required cultural competency training. The CSU also maintains ongoing communication with community stakeholders to increase awareness of available services and to identify and address any gaps in referrals.

This year, CSU served 230 (unduplicated) youth with a diversion rate of 29% of clients returning to their families following CSU support. The CSU served 161 Hispanic/Latino youth, and 39 youth identifying as two or more ethnicities. Regarding preferred language needs, the program is equipped to call in any interpreter support that cannot

be met by the staff. A noted challenge is that some youth who may be eligible for CSU services are routed from emergency rooms to inpatient facilities due, in part, to the current referral process at emergency departments. With this identified, next steps have been to collaborate with emergency rooms and focus on education about CSU services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

This fiscal year, the CSU focused on collaborating with internal outpatient clinic providers, the crisis team, and the contract liaison to ensure that youth referred to the CSU are promptly triaged. This process helps reduce barriers to acceptance and supports youth in receiving care within the county whenever it is safe and appropriate, rather than being sent out of county for a higher level of care. This work is ongoing and includes continued collaboration, as well as expanding outreach to ensure that additional referral sources can be part of these conversations moving forward.

Include examples of notable community impact.

The CSU has made a meaningful community impact by stabilizing youth locally, allowing them to remain in their home county and stay connected to family and natural support. The program connects youth and families to essential resources and provides strong care coordination, including linkage to ongoing mental health and substance use services. By ensuring continuity of care and strengthening family involvement, the youth CSU helps reduce higher-level system involvement and supports long-term stability and well-being for youth.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VCBH Access Program (Access Line)

Program Demographics		
FY 24–25 Total Program Cost	$ 2,084,850.49	
Total Individuals Served	2,161	
Cost Per Individual	$ 964.76	
Individuals Served FY 23–24	1,116	
Age Group	**N=2,161**	
0–15 yrs.	372	17.2%
16–25 yrs.	502	23.2%
26–59 yrs.	1,068	49.4%
60 yrs. & older	219	10.1%
Sex	**N=2,161**	
Female	1,176	54.4%
Male	973	45.0%
Unknown	12	0.6%
Sexual Orientation	**N=2,161**	
Bisexual	9	0.4%
Declined to State	20	0.9%
Heterosexual/Straight	182	8.4%
Lesbian (female)	2	0.1%
Unknown/Not Reported	1,946	90.1%
Unsure/Questioning	2	0.1%
Gender Identity	**N=2,161**	
Female	791	36.6%
Male	683	31.6%
Female-to-Male (FTM)/Transgender Male/Trans Man	2	0.1%
Male-to-Female (MTF)/Transgender Female/Trans Woman	1	0.05%
Transgender	3	0.1%
Non-Binary	4	0.2%
Unknown/Not Reported	671	31.1%
Gender Queer	3	0.1%
Other	1	0.0%
Declined to Answer	1	0.0%
Unsure/Questioning	1	0.0%
Race	**N=2,161**	
Alaska Native or Native American	26	1.2%
Asian	26	1.2%
Black/African American	49	2.3%
Declined to Answer	75	3.5%
Native Hawaiian or Other Pacific Islander	13	0.6%
Multiracial	3	0.1%
Unknown/Not Reported	938	43.4%
Other	332	15.4%
White/Caucasian	699	32.3%

Ethnicity	N=2,162	
Declined to Answer	15	0.7%
Hispanic/Latino	724	33.5%
Multiethnic	1	0.0%
Non-Hispanic/Non-Latino	525	24.3%
Unknown/Not Reported	896	41.5%
Language Spoken	**N=2,161**	
American Sign Language (ASL)	1	0.05%
English	1,176	54.4%
Mixteco	2	0.1%
Other non-English	2	0.1%
Russian	1	0.0%
Spanish	140	6.5%
Unknown/Not Reported	837	38.7%
Vietnamese	2	0.1%
Military Status	**N=2,161**	
No	1,632	75.5%
Unknown/Not Reported	529	24.5%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Access program team continues to make steady progress in connecting community members to mental health, substance use, and crisis services in a timely and compassionate manner. Over the reporting period, the team strengthened its coordination across crisis dispatch, request for services, third-party referrals, and post IPU follow-up, resulting in improved continuity of care and quicker service linkage for individuals at all levels of need.

Implementation of this program continues to evolve as the behavioral health landscape changes. Key differences this period include higher service volumes, growing complexity of cases, and reliance on mobile and field-based interventions. The Access team remains committed to improving equity, enhancing services coordination, and ensuring that all community members, especially those historically underserved, receive timely and appropriate behavioral health support.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

As one of the primary points of entry, the Access team reduces barriers to care by providing timely screening, triage, and linkage to mental health, substance use, and crisis services, and works closely with internal VCBH clinics and programs as well as external community resources. Eligible community members who call the Access Crisis line seeking mental and/or substance use services are provided with an appointment or referred to the appropriate delivery system via warm hand off. To reach individuals who traditionally experience challenges accessing services, the team actively collaborates with outreach-based and community-embedded programs. One key partnership is

Wellness on Wheels (WOW), a mobile behavioral health van dedicated to serving unserved and underserved communities. WOW directly addresses service gaps by meeting individuals where they are and connecting them to appropriate levels of care. In addition, the Access team continues strong partnerships with community-based organizations such as RISE and Logrando Bienestar, which provide culturally responsive, intensive case management services. These collaborations support individuals who face complex social determinants of health, including justice involvement, language barriers, and systemic inequities. By leveraging these partnerships, the team helps ensure that services are accessible.

Include examples of notable community impact.

As the program implemented the required CalAIM DHCS Standardized Screening Tool, the Access team has been able to serve the community in a more streamlined and timely fashion.

Client Counts per Clinic (duplicated count)		
Conejo Adult SST	1,182	13.30%
North Oxnard SST	1,321	14.66%
Santa Paula Adult SST	881	9.25%
Simi Valley SST	1,177	14.77%
South Oxnard Adult SST	1,632	20.29%
Telecare Outpatient non-FSP SST	34	0.25%
Ventura Adult SST	1,805	27.49%
Grand Total	**8,032**	**100.00%**

Program Demographics		
FY 24–25 Total Program Cost		$29,560,239.87
Total Individuals Served		7,759
Cost Per Individual		$3,809.80
Individuals Served FY 23–24		7,668
Age Group	N=7,759	
16–25 yrs.	532	6.86%
26–59 yrs.	5,525	71.21%
60 yrs. & older	1,702	21.94%
Sex	N=7,759	
Female	4,064	52.38%
Male	3,681	47.44%
Unknown	14	0.18%
Sexual Orientation	N=8,069	
Bisexual	44	0.55%
Declined to State	62	0.77%
Gay (male)	7	0.09%
Heterosexual/Straight	965	11.96%
Lesbian (female)	6	0.07%
Transgender	1	0.01%
Unknown/Not Reported	6,983	86.54%
Unsure/Questioning	1	0.01%
Gender Identity	N=9,660	
Female	3,715	38.46%
Male	3,381	35.00%
Female-to-Male (FTM)/Transgender Male/Trans Man	10	0.10%
Male-to-Female (MTF)/Transgender Female/Trans Woman	14	0.14%
Transgender	10	0.10%
Non-Binary	12	0.12%
Unknown/Not Reported	2,492	25.80%
Gender Queer	2	0.02%
Other	8	0.08%
Declined to Answer	15	0.16%
Unsure/Questioning	1	0.01%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Adult Outpatient program consists of six outpatient clinics throughout Ventura County. These programs continue to address key community issues identified through the county's Community Program Planning process, including homelessness, justice involvement, and the ongoing need to reach unserved and underserved adults in Ventura County. The clinics remain committed to providing accessible outpatient mental health services to adults with severe and persistent mental illness, regardless of barriers such as language, housing instability, or legal circumstances. The outpatient clinics continue to prioritize access to services for unserved and underserved populations ages 18 and older, with an ongoing commitment to reducing ethnic and cultural disparities in care. Staffing ensures that services can be provided in both English and Spanish with either trained and certified staff or certified interpreter services or language line support. Cultural considerations are a focus of our Treatment team and discussions allow staff to share client-informed insights and address barriers to accessing mental health services. The teams continue to provide groups that are meaningful and accessible to clients from diverse backgrounds. Challenges continue to include addressing problems such as housing instability and lack of transportation. The VCBH clinics remain committed to addressing these obstacles through flexible service delivery and a client-centered approach that honors the whole person within their cultural and familial context. Over the past fiscal year, Outpatient services strengthened its engagement of individuals experiencing homelessness by increasing collaboration with local housing programs, community support services, and outreach partners. Staff worked to streamline referrals, coordinate care plans, and assist clients in navigating available housing and stabilization resources. With the addition of an Alcohol Drug Treatment Specialist at some locations, programs begun to integrate more effective treatment to our clients that have been struggling with co-occurring disorders. Clinics also maintained close partnerships with law enforcement, probation, attorneys, and other justice system representatives to ensure that clients with legal involvement received consistent behavioral health support. These collaborations helped address issues related to incarceration risk and improved coordination for clients needing immediate intervention or linkage to services following law enforcement contact. In addition, staff worked closely with community-based organizations, local primary care providers, and social service agencies across the county to address unmet needs related to medical care, benefits, transportation, and resource navigation. These partnerships supported increased access for unserved and underserved adults, particularly those facing cultural, linguistic, or socioeconomic barriers. Overall, the

Race	N=9,850	
Alaska Native or Native American	100	1.02%
Asian	105	1.07%
Black/African American	248	2.52%
Declined to Answer	165	1.68%
Native Hawaiian or Other Pacific Islander	67	0.68%
Multiracial	11	0.11%
Unknown/Not Reported	3,437	34.89%
Other	2,067	20.98%
White/Caucasian	3,650	37.06%
Ethnicity	N=7,763	
Declined to Answer	31	0.40%
Hispanic/Latino	3,123	40.23%
Multiethnic	2	0.03%
Non-Hispanic/Non-Latino	3,085	39.74%
Unknown/Not Reported	1,522	19.61%
Language Spoken	N=7,759	
American Sign Language (ASL)	10	0.13%
Arabic	6	0.08%
Cambodian	1	0.01%
Cantonese	2	0.03%
English	6,002	77.36%
Farsi	3	0.04%
Italian	1	0.01%
Japanese	1	0.01%
Korean	1	0.01%
Mixteco	3	0.04%
Other non-English	8	0.10%
Russian	2	0.03%
Spanish	686	8.84%
Tagalog	6	0.08%
Thai	2	0.03%
Unknown/Not Reported	1,012	13.04%
Vietnamese	13	0.17%
Military Status	N=7,759	
Yes	13	0.17%
No	6,002	77.36%
Unknown/Not Reported	1,744	22.48%
Disability	Not Collected	

outpatient programs continue to respond to community-identified needs by prioritizing outreach, strengthening collaborative partnerships, and reducing systemic barriers so that vulnerable residents can effectively access and engage in behavioral health services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

As a community mental health program, the goal is to be attentive to the needs of the clients in our community. The program actively assesses its community mental health needs, listens to clients' concerns, and attempt to solve problems, increase access to services, and develop resources that can promote improvement in the mental health of clients. Teams strive to instill hope and create resilience in the clients that they serve. While the program is navigating and integrating recent changes in the way services are provided, efforts to develop and implement programs that reflect clinical, cultural and linguistic needs of the clients continue. New groups are in development, and new strategies to streamline access to services are being implemented. Clinic census numbers and caseloads have continued to grow, reflecting both increased community need and the outpatient clinics' efforts to remain accessible and welcoming to individuals who may have previously faced obstacles to engaging in mental health services. The peer support specialist role, which was fully integrated in the prior year, has continued to demonstrate meaningful impact by fostering trust and connection with clients who are most vulnerable, including those with histories of homelessness or incarceration. Peers bring lived experience that resonates with clients in ways that traditional clinical roles may not, and their presence has strengthened the program's ability to engage and retain individuals who might otherwise disengage from care.

Conejo Valley Mental Health Services

The Conejo Adult Outpatient program continued to address key community needs identified during the county's Community Program Planning process by expanding meaningful access to services for unserved and underserved adults in the Conejo Valley. The treatment team remained focused on reducing disparities, supporting individuals experiencing homelessness, and enhancing engagement for clients who face linguistic, cultural, or social barriers. During this fiscal year, the team evaluated ongoing service gaps and implemented targeted interventions using the resources already available at the clinic. One of the most impactful additions was the continued development of culturally and linguistically responsive treatment groups. Building on the success of the Emotional Wellness Group for Women offered in Spanish, the clinic expanded group-based supports to further respond to the needs of the community. These groups provided clients with a culturally aligned space to strengthen emotion regulation, socialization, and interpersonal support. Many participants demonstrated improved engagement in care and an increased sense of connection within the clinic.

In response to the identified needs of male clients, Conejo Adult Outpatient maintained and expanded the Men's Wellness Group. This group offered a supportive, structured setting for participants to explore coping strategies,

reduce isolation, and address concerns more common among male clients who historically have been less likely to participate in group services. Attendance and engagement remained strong, highlighting the program's success in reaching a previously underserved population.

As the Conejo Adult Outpatient Program continues to assess the needs of the clients we serve, we also noted that with the shifts in county offered programs, that we began to note the influx of clients in the age range of 19 to 25 years old. Noting that this particular age group often struggles to remain engaged in services, a new clinical group was developed to assist these clients to stay engaged in treatment and feel supported. This group, Path to Progress, was started to meet the needs of this age group.

Mental Health Associates continued to play a critical role in outreach and service coordination, particularly for clients experiencing homelessness. Despite a significant reduction in available housing resources across East County and the Conejo Valley, Mental Health Associates successfully identified and connected unhoused individuals to the limited support that remained. Their focused work resulted in improved consistency in client engagement, better linkage to essential services, and increased stability for several high-risk clients. The Mental Health Associates also play an important role in assessing the needs of the clients we serve and group development. These efforts demonstrate Conejo Adult Outpatient's continued commitment to addressing the complex community issues identified during the planning process, particularly homelessness, limited access to culturally aligned services, and the need for targeted engagement strategies for underserved groups. The program's adaptations and collaborative approach resulted in direct, measurable improvements in clients' ability to access care, develop coping skills, and connect to stabilizing supports within the community.

The Conejo Adult clinical team has noted that since we have continued to increase the number of clinical and social rehabilitation groups, clients now have more options available for treatment in a variety of modalities. This allows for more clinical support and structure and allows us to provide more services to more clients. New groups offered over the past year include Path to Progress (19–30-year-old clients), Co-occurring Disorder Groups. We continue to improve our collaboration with our community partners, and connections to more resources for our clients in the community.

Ventura Mental Health Services

Ventura Adult Outpatient clinic noted additional needs of the clients therefore overhauled their group service model to better align with client needs and outcomes. This resulted in the curation and implementation of 15 additional groups with a variety of topics, ensuring more holistic and targeted care. A few examples include, Grief and Loss, Mindful Art and Therapy Tools (Coping skills, psychoeducation, what to expect in individual therapy).

Santa Paula Mental Health Services

As a result of our county's mental health outpatient clinics evaluating services and focusing on client access and efficiencies a decision was made to integrate care and services. The Santa Paula Adult Outpatient Clinic piloted a regional model by beginning the stage of integration with front office, this also allowed for cross training with the youth and family mental health clinic, resulting in improved efficiencies and better access to care for clients.

Oxnard Mental Health Services

The Adult Outpatient clinics continued to build on the foundation established through the implementation of Short-Term Treatment. It has had a lasting and positive effect by stabilizing staff caseloads. As a result, the clinics have focused on providing a diverse array of groups. During the past year, the clinics focused on expanding and developing a more robust treatment of Co-occurring Disorders. As a result, North Oxnard and South Oxnard's COD (Co-occurring Disorder) Group is one of the best attended and largest groups in these clinics.

Simi Valley Mental Health Services

Simi has a multilingual staff (Spanish, Farsi, Russian, Tagalog, Cantonese, Punjabi) and has served quite a few first- and second-generation immigrants. Many of these are coming from war-impacted countries including Russia, Ukraine, Afghanistan and El Salvador. Our staff works with both the client and the family to help them understand their illness and help them navigate community resources. Dealing with stigma, trauma and exclusion are oftentimes central to this work. Simi has a well-attended LGBTQ+ group and has many of these clients in individual therapy as well. We are also assisting Transgender clients in accessing resources. We continue to develop and maintain a strong working relationship with local community partners, such as, Simi Adventist Hospital and ED, The Samaritan Center, Simi Valley PD and Pathpoint. We continue our commitment to work with students and support our local universities; we have added to our staffing through the addition of MHA students from Cal State Chanel Islands and graduate school clinicians from local colleges. Our students have gone on to work in VCBH and at other local agencies.

Include examples of notable community impact.

Conejo Valley Mental Health Services

K.H. is a 63-year-old female who has a long history of extreme emotional dysregulation, conflictual relationships in the community as well as with family. This has been complicated with substance use, depression, disordered eating. She presented often as very verbally aggressive, splitting of providers, and difficulty with following through with treatment with multiple mental health providers within the VCBH system and in the community. Our ability to collaborate with outside providers, as well as developing cohesive treatment plan within our own treatment team was imperative. The client split treatment between community providers and the clinic. Our efforts to assist the client in consolidating her treatment within the clinic, after a non-successful residential treatment program was key. Her treatment plan included intense collaboration amongst the all-team members, the ability to be able to offer the client multiple modalities of treatment such as individual treatment, psychiatric care, and well as multiple groups in one setting. The result has been an improvement in her ability to engage in treatment, and improved stabilization.

Oxnard Mental Health Services

At the North Oxnard Adult Clinic, Joel D. exhibited significant growth last year. The team has witnessed a lot of growth in past year. He participates in multiple groups including creative wellness, social wellness, and relaxation. He attends the Wellness Center and has reengaged in activities out in the community. During the past year, he has come out of his comfort zone and joined a bowling league. His growth has served as a model for other group members as he encourages his peers and is more outspoken during group activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Child Welfare Subsystem (CWS)

Program Demographics		
FY 24–25 Total Program Cost	$ 302,109.15	
Total Individuals Served	526	
Cost Per Individual	$ 574.35	
Individuals Served FY 23–24	122	
Age Group	**N=526**	
0–15 yrs.	526	100.0%
Sex	**N=526**	
Female	283	53.8%
Male	242	46.0%
Unknown/Not Reported	1	0.2%
Sexual Orientation	**N=526**	
Declined to Answer	2	0.4%
Heterosexual/Straight	27	5.1%
Unknown/Not Reported	497	94.5%
Gender Identity	**N=526**	
Female	232	44.1%
Male	202	38.4%
Unknown/Not Reported	92	17.5%
Race	**N=526**	
Alaska Native or Native American	4	0.8%
Asian	5	1.0%
Black/African American	14	2.7%
Declined to Answer	69	13.1%
Native Hawaiian or Other Pacific Islander	2	0.4%
Unknown/Not Reported	117	22.2%
Other	76	14.4%
White/Caucasian	239	45.4%
Ethnicity	**N=526**	
Declined to Answer	7	1.3%
Hispanic/Latino	370	70.3%
Non-Hispanic/Non-Latino	15	2.9%
Unknown/Not Reported	134	25.5%
Language Spoken	**N=526**	
English	364	69.2%
Mixteco	2	0.4%
Portuguese	1	0.2%
Spanish	61	11.6%
Unknown/Not Reported	98	18.6%
Military Status	**N=526**	
Yes	1	0.2%
No	368	70.0%
Unknown/Not Reported	157	29.8%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The VCBH Child Welfare Subsystem (CWS) provides intensive, field-based mental health services to children and youth in the foster care system throughout Ventura County. Clinicians complete comprehensive bio-psycho-social assessments for all youth entering dependency and deliver individualized treatment services tailored to each youth's clinical needs.

Services include psychotherapy, evidence-based practices, parenting interventions, psychoeducation, and behavioral modification. Clinicians address trauma histories and support youth in adjusting to new environments, caregivers, and peers. All services are trauma-informed and include active engagement of the child, foster parents, and biological parents, with close collaboration across all service providers. In the most recent year, CWS served 526 foster youth countywide. Numerous recent initiatives and mandates related to foster youth have strengthened cross-agency partnerships and enhanced outcomes for children and families.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

CWS transitioned to a Full-Service Partnership (FSP) model on July 1, 2025. This transition added four Mental Health Associates (MHAs) who provide ongoing case management services with a strong emphasis on addressing housing instability. Over the past year, MHAs coordinated Basic Needs funding to support families with utilities and essential household expenses and administered one-time Supportive Housing Funds to assist with deposits, partial rent payments, application fees, and other housing-related costs. These interventions were directed toward families who were unhoused or at imminent risk of losing housing.

CWS continues to maintain a strong partnership with the Ventura County Healthcare Foundation (VCHCF), which provides short-term emergency hotel placements to prevent homelessness during critical situations. Through this collaboration, MHAs secured temporary hotel stays for multiple families transitioning into permanent housing, ensuring stability and continuity of care during housing transitions.

CWS also maintains a strong and collaborative partnership with Probation to ensure that youth who are incarcerated or on probation receive consistent support and comprehensive care coordination. This collaboration promotes a well-supported transition from juvenile facilities back into the community and minimizes disruptions in mental health services upon release. Through this coordinated approach, CWS supports continuity of care, timely service linkage, and a smooth reintegration process for justice-involved youth. Collectively, these efforts reflect CWS's continued focus on homelessness prevention, rapid stabilization, and improved outcomes for vulnerable youth and their families.

Include examples of notable community impact.

Ventura County has convened a local leadership team in compliance with AB 2083, bringing together key partners from child welfare, behavioral health, education, probation, and developmental services. This structure strengthens shared decision-making and information-sharing under the established MOU framework. Through this coordinated approach, Ventura County's interagency teams deliver timely, aligned interventions that ensure youth experiencing trauma receive consistent, integrated services across multiple sectors, including mental health, education, child welfare, and probation. This unified structure has contributed to improved outcomes for youth in dependency by reducing service fragmentation and promoting coordinated, trauma-responsive care.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Youth and Family Intake Team

Program Demographics		
FY 24–25 Total Program Cost	$775,031.65	
Total Individuals Served	1,161	
Cost Per Individual	$ 667.56	
Individuals Served FY 23–24	879	
Age Group	**N=1,161**	
0–15 yrs.	716	61.7%
16–25 yrs.	440	37.9%
26–59 yrs.	5	0.4%
Sex	**N=1,161**	
Female	667	57.5%
Male	483	41.6%
Unknown	11	0.9%
Sexual Orientation	**N=1,161**	
Bisexual	6	0.5%
Declined to State	3	0.3%
Heterosexual/Straight	78	6.7%
Lesbian (female)	2	0.2%
Unknown/Not Reported	1,069	92.1%
Unsure/Questioning	3	0.3%
Gender Identity	**N=1,161**	
Female	544	46.9%
Male	411	35.4%
Female-to-Male (FTM)/Transgender Male/Trans Man	3	0.3%
Non-Binary	5	0.4%
Unknown/Not Reported	193	16.6%
Gender Queer	3	0.3%
Unsure/Questioning	2	0.2%
Race	**N=1,161**	
Alaska Native or Native American	10	0.9%
Asian	17	1.5%
Black/African American	39	3.4%
Declined to Answer	113	9.7%
Native Hawaiian or Other Pacific Islander	6	0.5%
Multiracial	1	0.1%
Unknown/Not Reported	324	27.9%
Other	179	15.4%
White/Caucasian	472	40.7%

Ethnicity	N=1,161	
Declined to Answer	6	0.5%
Hispanic/Latino	683	58.8%
Non-Hispanic/Non-Latino	193	16.6%
Unknown/Not Reported	279	24.0%
Language Spoken	**N=1,161**	
American Sign Language (ASL)	1	0.1%
English	704	60.6%
Mandarin	1	0.1%
Mixteco	3	0.3%
Other non-English	4	0.3%
Spanish	203	17.5%
Unknown/Not Reported	245	21.1%
Military Status	**N=1,161**	
No	679	58.5%
Unknown/Not Reported	482	41.5%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Youth and Family Intake Team and Clinic programs are dedicated to serving underserved, moderate to severe youth populations, providing comprehensive services to individuals from birth through age 21. The team's commitment to cultural competency and linguistic accessibility is paramount. Services are offered in English, Spanish, Farsi, Tagalog, and Hindi. For other languages, certified interpreters or language line services are utilized, prioritizing in-person interpretation whenever possible. This multifaceted approach ensures that staff effectively understand and address the unique needs of each client and family. The Youth and Family Intake Team and Clinic programs actively identify and mitigate barriers to care coordination. Through ongoing education and support, they strive to empower clients and their families, fostering a sense of collaboration and trust. A significant portion of the caseload comprises foster and adopted youth and their families, who often require specialized family therapy and intensive care coordination involving internal and external stakeholders. To maintain high standards of care, staff participate in regular trainings and discussions focused on addressing barriers and disparities. Cultural considerations are a key component of team meetings, prompting a shared understanding and learning environment where staff actively seek to understand and respond to the specific needs of diverse clientele. This ensures equitable access to care.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Conejo Valley

As a community mental health clinic, the program strives for all clients to have the ability to have access to and utilize clinic services regardless of barriers such as language, legal status, housing status, and involvement with the justice system. The Conejo Youth and Families intake team is actively responding to pressing community needs by providing accessible, trauma-informed and culturally informed assessments. Through coordinated screening, timely assessment, and collaborative care planning, the team works to reduce barriers to treatment, connect clients with stabilizing resources, and ensure that individuals and families who have historically faced significant obstacles in accessing care receive the support they need. By regularly partnering with community-based organizations, probation, school districts, primary care, and other support agencies, the intake team helps bridge critical service gaps and promotes equitable access to mental health care across the community.

Simi Valley

The Simi community mental health clinic is committed to ensuring equitable access to services for all clients regardless of potential barriers such as language, socioeconomic status, legal involvement, or housing situation by prioritizing outreach to unserved and underserved populations while intentionally identifying and coordinating culturally responsive services. The mental health associate is an expert care coordinator, who expedites assessments and matches adjunctive community services to the specific needs of children and families. Additionally, collaborative family team meetings have significantly improved the program's ability to connect clients with essential support services that were previously difficult to access. Dedicated staff actively collaborate with a wide range of community partners, including the regional center, Children's Hospital, crisis stabilization units, compass program, law enforcement, legal professionals, primary care providers, school representatives, housing support teams and other agencies. The intake team strengthens access to equitable mental health services and supports more effective, inclusive care for diverse populations within the community.

Include examples of notable community impact.

Conejo Valley

The Conejo team has successfully maintained well above state standards for timeliness and provides culturally informed services. The local school districts are comfortable reaching out to intake staff and collaborating to support successful linkage to underserved populations, resulting in consistency and reliability in service delivery, which strengthens community trust. By showing up as a coordinated and responsive system of care, staff reinforce confidence that individuals' needs will be met with respect, cultural humility, and follow-through.

Simi Valley

The Simi Clinic has made a meaningful impact not only on the individuals it serves, but for the broader community. In addition to providing comprehensive, client-centered mental health care, the clinic is Narcan-trained, equipping staff with the knowledge and tools to respond effectively to opioid-related emergencies and provide psychoeducation to support community safety. The program has provided Mental Health First Aid training, extending education and prevention efforts beyond the clinic walls by empowering staff, clients, and community members to recognize and respond to mental health crises. Staff also actively encourage clients' families and support systems to seek mental health resources for themselves and provide resources for such, recognizing that healing and resilience are strengthened when care extends to families and the community. Additionally, the clinic maintains a strong partnership with Crisis Intervention Team (CIT)-trained law enforcement officers to extend education, enhance client safety, and support appropriate crisis response. This partnership promotes trauma-informed, de-escalation-focused interventions and helps limit unnecessary hospitalizations by connecting individuals to the most appropriate level of care whenever possible. Additionally, on-boarding a bilingual intern this year helped increase bilingual intake availability.

Fillmore Community Project

Program Demographics		
FY 24–25 Total Program Cost	$	877,496.28
Total Individuals Served		211
Cost Per Individual	$	4,158.75
Individuals Served FY 23–24		194
Age Group	**N=211**	
0–15 yrs.	98	46.4%
16–25 yrs.	113	53.6%
Sex	**N=211**	
Female	122	57.8%
Male	87	41.2%
Unknown	2	0.9%
Sexual Orientation	**N=211**	
Bisexual	2	0.9%
Declined to State	1	0.5%
Heterosexual/Straight	12	5.7%
Unknown/Not Reported	196	92.9%
Gender Identity	**N=211**	
Female	106	50.2%
Male	73	34.6%
Non-Binary	2	0.9%
Unknown/Not Reported	30	14.2%
Race	**N=211**	
Alaska Native or Native American	2	0.9%
Asian	2	0.9%
Black/African American	2	0.9%
Declined to Answer	12	5.7%
Native Hawaiian or Other Pacific Islander	1	0.5%
Unknown/Not Reported	69	32.7%
Other	29	13.7%
White/Caucasian	94	44.5%
Ethnicity	**N=211**	
Declined to Answer	2	0.9%
Hispanic/Latino	146	69.2%
Non-Hispanic/Non-Latino	16	7.6%
Unknown/Not Reported	47	22.3%
Language Spoken	**N=211**	
English	168	79.6%
Spanish	13	30.2%
Unknown/Not Reported	30	69.8%
Military Status	**N=211**	
No	158	74.9%
Unknown/Not Reported	53	25.1%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Fillmore Youth and Family Clinic (Fillmore Community Project) team continues to provide essential mental health services to youth and families in the city of Fillmore and surrounding rural communities. During Fiscal Year 2024–2025, the clinic served 211 youth, with 126 new admissions. Demographic data shows that 79% of youth identified as Hispanic/Latino during the fiscal year. More recent data, collected from June 1–30, shows a higher proportion, with 90% identifying as Hispanic/Latino, 4% as multicultural, and 1% as Black/African American. These shifts may reflect improved accuracy and updates in the Electronic Health Record system and ongoing refinements in demographic documentation. This program serves the city of Fillmore and neighboring unincorporated communities which are geographically isolated in the county, with high percentage of residents being either Medi-Cal beneficiaries or indigent. High percentage of the population is comprised of farm workers and their families, who are often underserved or unserved. Staff regularly work with the local homeless shelter, as well as community organizations (school district, One Step a La Vez community center, Tri-Counties Regional Center, etc.) to help bridge the gap between services and community members. Service activity this year totaled 6,129 services. Overall, the Fillmore Youth and Family Clinic team maintained consistent service delivery, supporting a predominantly Hispanic/Latino youth population. The clinic remains committed to improving data accuracy and maintaining accessible, culturally responsive mental health services for the community.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Fillmore Youth and Family Clinic continues to address key community issues such as homelessness risk, limited access to behavioral health care, and the need for services for unserved and underserved families. The community is primarily Hispanic/Latino, with many residents relying on Medi-Cal and/or being uninsured/underinsured. All clinicians are fluent Spanish speakers, ensuring culturally responsive, linguistically appropriate services. The clinic is now part of a larger integration effort that brings youth mental health, substance use treatment, and adult behavioral health services together at one site, increasing access for entire families and reducing system-navigation barriers. Consistent with MHSA goals of early intervention and timely access, families

can receive same-day or within-10-day appointments, allowing immediate support for those at risk of homelessness or other negative outcomes.

Include examples of notable community impact.

Collaboration with the local school district and community partners, including One Step a La Vez, strengthens outreach and whole-person care by connecting youth to social support, job training, academic assistance, and culturally appropriate care. The availability of Full-Service Partnership (FSP) in Fillmore further expands intensive, field-based, and family-centered care for those with the highest needs. Through integrated services, rapid access to care, and strong community partnerships, the Fillmore Youth and Family Clinic continues to reduce disparities and support recovery and resiliency for underserved families in the region.

Success story.

Client was admitted seeking mental health services due to depression. The client endorsed symptoms of depression; flat affect, lack of emotion ("feel numb"), lack of concentration, isolating from others ("avoids others"), lack of sleep, anhedonia, lack of interest, and endorsed daily passive suicidal ideation. Client was actively engaged in treatment, and engaged in individual therapy services, family therapy services, and psychiatric services. Client was receptive to interventions. Client reported significant improvements in terms of depression and SI (which used to be daily, included a plan, one incident of walking to bridge with intent to jump, isolation of others). The client's sleep is well, and appetite is stable. There are no current safety concerns, such as no SI, SIB, or HI. Client's mother reported that she has been more talkative, communicates with family about the client's feelings, is more engaged in activities, more patient, and able to manage anger. The client is now diagnosed with (F33.42) Major Depressive Disorder, recurrent, in full remission, as during the last two months there have been no significant signs or symptoms of the disturbance present. Client successfully met treatment goals and no longer met level of care for specialty mental health services.

Transitional Age Youth (TAY) Outpatient Treatment Program – Non-FSP

Program Demographics		
FY 24–25 Total Program Cost	$2,342,786.16	
Total Individuals Served	573	
Cost Per Individual	$4,088.63	
Individuals Served FY 23–24	684	
Age Group	**N=573**	
16–25 yrs.	519	90.6%
26–59 yrs.	54	9.4%
Sex	**N=573**	
Female	345	60.2%
Male	227	39.6%
Unknown	1	0.2%
Sexual Orientation	**N=573**	
Bisexual	2	0.3%
Declined to State	2	0.3%
Gay (male)	1	0.2%
Heterosexual/Straight	52	9.1%
Unknown/Not Reported	515	89.9%
Unsure/Questioning	1	0.2%
Gender Identity	**N=573**	
Female	296	51.7%
Male	198	34.6%
Female-to-Male (FTM)/Transgender Male/Trans Man	4	0.7%
Male-to-Female (MTF)/Transgender Female/Trans Woman	1	0.2%
Transgender	2	0.3%
Non-Binary	2	0.3%
Unknown/Not Reported	70	12.2%
Race	**N=573**	
Alaska Native or Native American	3	0.5%
Asian	8	1.4%
Black/African American	15	2.6%
Declined to Answer	10	1.7%
Native Hawaiian or Other Pacific Islander	4	0.7%
Multiracial	2	0.3%
Unknown/Not Reported	154	26.9%
Other	194	33.9%
White/Caucasian	183	31.9%
Ethnicity	**N=573**	
Declined to Answer	2	0.3%
Hispanic/Latino	272	47.5%
Non-Hispanic/Non-Latino	132	23.0%
Unknown/Not Reported	167	29.1%
Language Spoken	**N=573**	
English	425	74.2%
Mixteco	1	0.2%
Spanish	39	6.8%
Unknown/Not Reported	107	18.7%
Vietnamese	1	0.2%
Military Status	**N=573**	
Yes	1	0.2%
No	478	83.4%
Unknown/Not Reported	94	16.4%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Transitional Age Youth (TAY) outpatient treatment program continues to serve the transitional age youth population, ages 18–25, by providing initial services and ongoing mental health support for clients who require a higher level of care. TAY program services have expanded countywide, resulting in an increase in client engagement and contact. Staff deliver services using a multicultural approach tailored to each client's individualized needs, with support from certified interpreters for languages beyond English and Spanish. TAY staff regularly discuss cultural implications—including strengths, challenges, and barriers—when making recommendations for next steps. Additionally, staff support clients in developing self-advocacy skills and building a sense of community within the culture(s) they identify with, as an integral part of the healing and treatment process.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The TAY program supports clients through a strength-based, client-centered approach by building community connections and linking clients to needed resources. The program focuses on addressing basic needs, which in turn strengthens clients' overall mental health. TAY staff support clients who face challenges such as belonging to underserved communities, experiencing homelessness or housing instability, being justice-involved, and having multiple psychiatric hospitalizations or crisis contacts. Services are delivered through a person-centered lens with the goal of promoting healing, recovery, and fostering independence.

Include examples of notable community impact.

Access to specialized TAY services throughout the county helps reduce disparities within the agency and addresses long-standing inequities in health care systems that disproportionately impact the most vulnerable communities. When TAY clients receive necessary care, compassion, skill building, and evidence-based practices, the number of individuals who require specialty mental health services beyond this age group is reduced.

TAY staff prioritize meeting clients' basic needs so that higher-level needs can be addressed in support of individualized treatment goals. As a result, the TAY program has seen multiple successful discharges, with clients transitioning to lower levels of care after sustained periods of stability, including no suicide attempts, psychiatric hospitalizations, or crisis contacts.

The Client Network

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Client Network is a peer-run advocacy organization that uses a client-centered approach to behavioral health recovery. The Client Network promotes hope, dignity, personal empowerment, and self-determination. It advocates for clients to become full partners in their unique treatment and recovery journeys. Certified Medi-Cal Peer Support Specialists provide one-on-one peer support, resources, and referrals. The Client Network promotes measures that counteract stigma and discrimination by increasing representation and advocacy at all levels of the behavioral health system where client voices have traditionally not been heard. The Client Network collaborates with community partners on client outreach and engagement and hosts numerous holiday events throughout the year. Members have been appointed to the Behavioral Health Advisory Board and its subcommittees. As part of the Mental Health Services Act (MHSA) Community Program Planning (CPP) process, The Client Network actively contributes to shaping mental health policy and programming through the stakeholder process. Members collaborate with Ventura County Behavioral Health (VCBH) during the three-year strategic planning process and ongoing QIC efforts. The Client Network is in its 27th year of operating as a nonprofit.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc. examples of notable community impact.

Services were recently expanded with the addition of another Certified Medi-Cal Peer Support Specialist. The program is now offering on-site peer support at Villa Calleguas for its residents, which includes crisis assistance, groups, events, and socialization opportunities. The Client Network continues its outreach and peer support to the underserved population who are residents at county Board and Cares, Adult Residential Care Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), as well as unhoused individuals.

Examples of the meetings that Peers attended this year (list is not comprehensive)
Behavioral Health Advisory Board – General
Behavioral Health Advisory Board – Executive Committee
Ventura County Board of Supervisors Meeting
Cal Voices Wise U Meeting
Cal Voices Internal Policy Meeting
Cal Voices MHSA Modernization SB 326 Committee Meeting
Mental Health Services Oversight and Accountability Commission (MHSOAC) Meeting
National Alliance on Mental Illness (NAMI) California
National Council for Mental Wellbeing
Peer Voices Advocacy
Peer Certification Training
Proposition 1 Stakeholder Process
Turning Point Villa Calleguas Support Groups
VCBH QI Community Experience Subcommittee Meeting
VCBH Lewis Rd. MHRC RFP Evaluation Committee Meeting

	Date	Event/Resource	Number
Peer Support Events and Resources	December 2024	The Client Network Holiday Event	90 residents
	May 2025	May is Mental Health Awareness Month: The Client Network Fiesta	70 residents
		Advocacy Events	181 events
		Peer Support 1:1 Sessions	97 sessions
		Bus Passes	3,650 bus passes
		Gift Cards	130 gift cards

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	% Agree
	(N=259)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	87%
Services were available in my preferred language.	88%
It was easy to access the services I needed.	87%
Overall, I am satisfied with the services I received.	87%
I would recommend these services to a friend or family member.	90%
As a result of participating in this program:	**% Agree**
	(N=258–259)
I am happier with the friendships I have.	82%
I have people with whom I can do enjoyable things.	87%
I do better in social situations.	83%
My housing situation has improved.	88%
I feel like I belong in my community.	86%
I feel better about myself.	84%

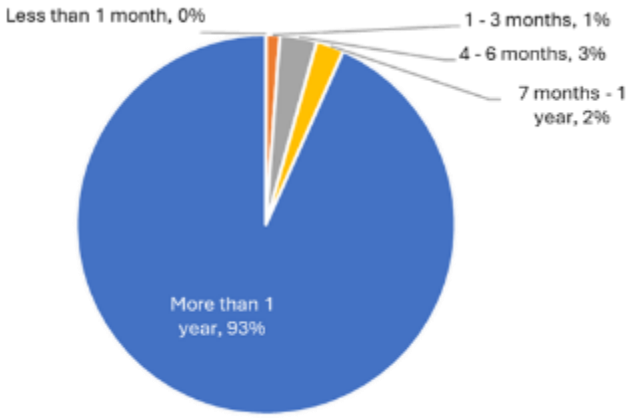
Most useful or helpful about this program: (N = 184)

- Activities/resources
- Supportive staff
- Safe place to express self
- Connection/socialization

Suggestions to make this program better: (N = 173)

- Current program satisfaction
- Acquire vehicle for transportation
- More resources/activities

How long have you been participating in services? (N=255*)



*Percentages may not total 100% due to rounding

Family Access Support Team (FAST)

Program Demographics		
FY 24–25 Total Program Cost		$1,104,939.95
Total Individuals Served		354
Cost Per Individual		$3,121.30
Individuals Served FY 23–24		205
Age Group	**N=354**	
0–15 yrs.	208	58.8%
16–25 yrs.	146	41.2%
Sex	**N=354**	
Female	177	50.0%
Male	177	50.0%
Sexual Orientation	**N=354**	
Bisexual	2	0.6%
Declined to State	2	0.6%
Heterosexual/Straight	45	12.7%
Unknown/Not Reported	304	85.9%
Unsure/Questioning	1	0.3%
Gender Identity	**N=354**	
Female	143	40.4%
Male	149	42.1%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.3%
Transgender	1	0.3%
Non-Binary	1	0.3%
Unknown/Not Reported	57	16.1%
Other	1	0.3%
Unsure/Questioning	1	0.3%
Race	**N=354**	
Alaska Native or Native American	6	1.7%
Asian	4	1.1%
Black/African American	16	4.5%
Declined to Answer	29	8.2%
Native Hawaiian or Other Pacific Islander	1	0.3%
Unknown/Not Reported	75	21.2%
Other	98	27.7%
White/Caucasian	125	35.3%
Ethnicity	**N=354**	
Hispanic/Latino	217	61.3%
Non-Hispanic/Non-Latino	64	18.1%
Unknown/Not Reported	73	20.6%
Language Spoken	**N=354**	
American Sign Language (ASL)	1	0.3%
English	234	66.1%
Other non-English	1	0.3%
Spanish	63	17.8%
Unknown/Not Reported	55	15.5%
Military Status	**N=354**	
No	194	54.8%
Unknown/Not Reported	160	45.2%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Family Access Support Team (FAST) program is designed to provide services to severely emotionally disturbed (SED) children, youth and their families who are also served by Ventura County Behavioral Health, and who are at high risk for hospitalization or out-of-home placement. It is intended to be one component of a larger system of care that will work collaboratively within a community of service provision, providing a family and purpose-driven system of support to children and families. The United Parents Family Access Support Team (FAST) program is staffed solely with Parent Partners (certified peer support specialists) who are parents or caregivers who have raised a child or children with a serious mental/emotional disorder and who receive specialized training to support others in similar situations. Parent Partners collaborate with the treatment team, providing intensive home-based services to families. They offer a menu of services to support the goals of the family and program including education, support, and stabilization, as well as promoting wellness and resiliency, inspiring hope, and encouraging advocacy. They respect the values and cultural, linguistic uniqueness of each community, practice authenticity and acknowledge the importance of cultural responsiveness and humility, and model techniques with both individual and group modalities to support parents in strength-based skill-building and increasing knowledge regarding their child's mental health status. Additionally, the program addresses increasing knowledge regarding services and resources to assist in alleviating crises.

Parent Partners also facilitate monthly support groups in the community as an additional layer of support and resource sharing to those families who are currently or not yet connected to VCBH services. Moreover, they provide services and support for families of other county or community-based programs including Seneca Family of Agencies Children's Crisis Stabilization Unit/COMPASS, Kids and Families Together, Interface, and VCBH Access and Outreach program.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Many families do not have reliable transportation, access to the internet, or a private space to receive services, causing further interruption in care and support. Parent Partners meet the families where they are, i.e., in a safe and convenient location. They bring electronic devices to help families without internet connection fill out necessary

paperwork and forms to assist with their needs. Families who prefer not to meet in person are able to meet Parent Partners via Zoom. Parent Partners continue to be flexible and creative in their outreach to support and engage families in any way possible.

In the past fiscal year, the demand for services has greatly increased and the severity of the diagnoses, trauma, and need has also increased. Sixty-five percent of the clients served in Fiscal Year 2023–2024 were Hispanic/Latino and 69% of the Parent Partners are also Hispanic/Latino, allowing them to relate to and deeply connect culturally with the families they are serving. Staff who are stationed at satellite locations (i.e., Insights/Probation, Access and Outreach, Seneca) continue to meet the families where they are, assist with crisis intervention, and provide a smooth connection to the resources they need. Parent Partners at these locations speak English and Spanish.

The agency continues to offer and conduct “refresher presentations” to ensure that all clinics have the most up-to-date information regarding the referral process and waiting list for services. The staff have been utilizing SmartCare and began billing Medi-Cal in January 2023 (two of nine Parent Partners). In July 2024, all Parent Partners will be involved and will be billing Medi-Cal. All Parent Partners are working toward their Peer Certifications. There are now six Certified Peer Support Specialists and three who are scheduled for their exam. One is scheduled to retake the exam, and another will begin training in May 2024. The program has continued to implement multiple in-person support groups in the community. In Fiscal Year 2023–2024, there are five support groups: two Spanish-speaking groups (Oxnard and Santa Paula), one bilingual group (Oxnard), and two English-speaking groups (one in Oxnard for fathers only and one online group). Most of the attendees live in a high-need, unserved/underserved area and are appreciative of this support and are asking for more frequent gatherings.

	Program	Referrals
Community Client Referrals	Seneca	106
	Insights	42

Include examples of notable community impact.

The FAST program continues to establish and provide services in underserved areas including Oxnard, Fillmore, Simi Valley, Ventura, Santa Paula, Ojai, and Piru. The program also opened two parent drop-in centers—one in Oxnard, one in Fillmore—for more outreach and expansion of services/support. These drop-in centers are open to anyone in the community, who can come in and obtain information on community resources, receive support, and get connected to services.

Parent Partners connect families to appropriate and necessary supports that are needed at that moment in time including housing support, rental assistance, food pantries, clothing vouchers, legal aid assistance, cash aid, employment services, etc. The United Parents program has an emergency fund established through fundraising and donations to help clients with temporary assistance while waiting for long-term support. The emergency fund has helped families with rental assistance, utility payments and gift cards for clothing. United Parents additionally has established a success fund to provide one-time assistance to families who have made great progress towards their goals, and families are able to use these funds for celebratory purposes and recognizing their achievements and success.

United Parents has a reputation for helping any family in need. If there is a need, the program will find a way to help or connect. Strong relationships are fostered with other community partners and county representatives to allow for smooth transitions between services for families.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	% Agree
	(N=46–49)
Staff were sensitive to my family's cultural background (e.g., ethnic/religious beliefs).	96%
Services were provided to my family in our preferred language.	96%
My child was connected to services that were right for them.	94%
Overall, I am satisfied with the services we received.	94%
I would recommend these services to a friend or family member.	100%
As a result of participating in this program:	**% Agree**
	(N=28–29)
My child gets along better with family members.	69%
My child gets along better with friends and other people.	71%
My child is doing better in school.	67%
My child is better able to cope when things go wrong.	61%
My child is better able to do things he or she wants to do.	59%
I am aware of when I need to ask for help for my child.	94%
I know where to find help when my child is having a problem.	96%
I believe treatment can help people with mental illness lead normal lives.	94%
The Parent Partners are generally caring and sympathetic to people with mental illness.	92%

Most useful or helpful about this program: (N = 46)

- Emotional support/therapy
- Connecting with staff & similar parents
- Resources for navigating systems
- Parenting skills/child communication

Suggestions to make this program better: (N = 31)

- Satisfied with existing program
- Increase program awareness
- Longer/ more frequent services
- Offer support groups/expand staff access

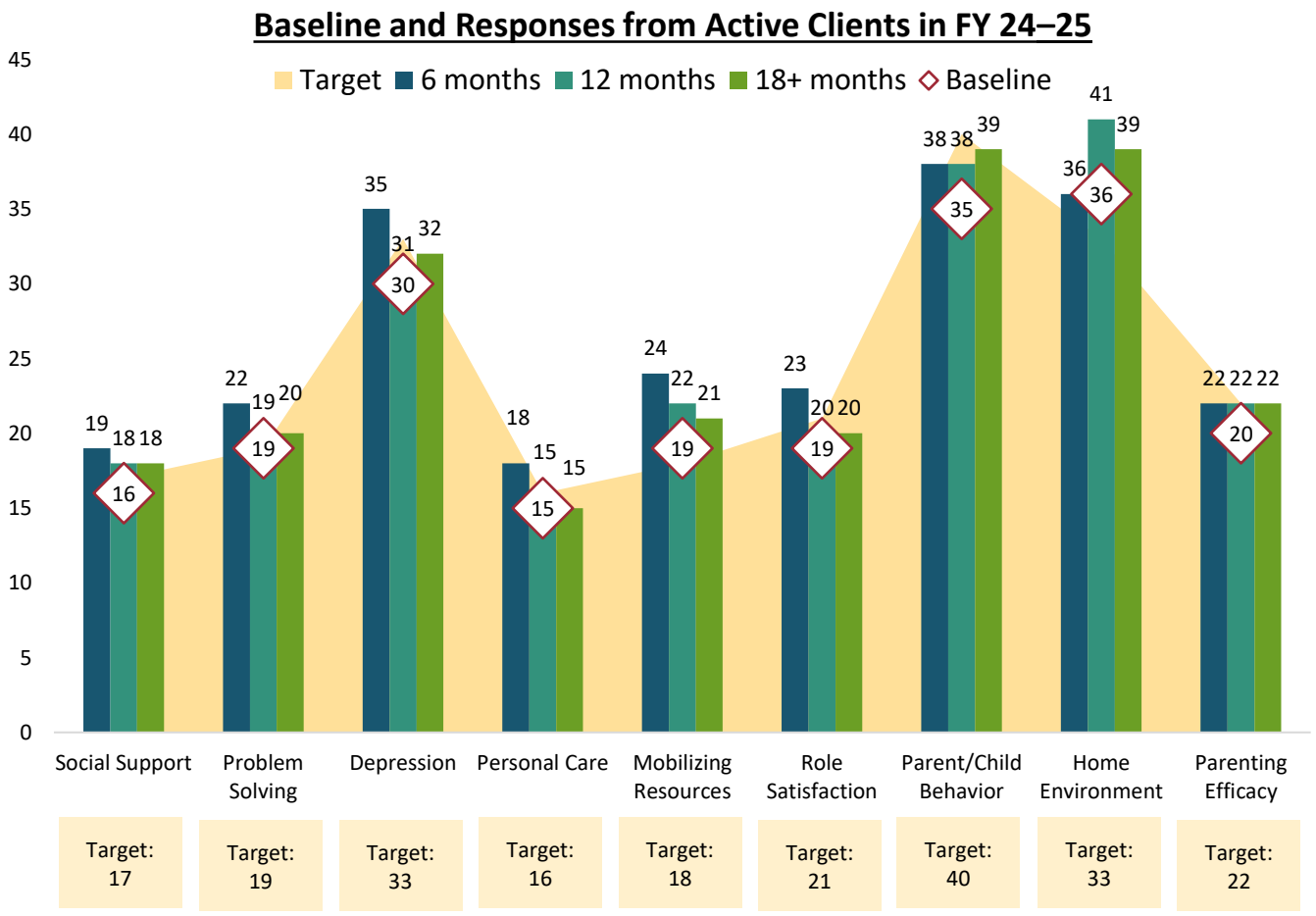
How long have you been participating in services? (N=47) *

*Percentages may not total 100% due to rounding

The FAST program also offers the Healthy Families Inventory (HFPI) to participants. Information on and results from the HFPI are provided here.

Healthy Families Parenting Inventory (HFPI)

- The Healthy Families Parenting Inventory (HFPI) is designed to learn more about you as a parent and how you respond to different aspects of parenthood.
- We are interested in the kinds of changes you may have noticed in yourself since becoming a parent.
- This information is used to help design a plan to better serve you during your involvement with United Parents.
- There are no right or wrong answers.
- Questions are ordered in categories or subscales that help your Parent Partner identify areas of strengths and areas of concern.
- Each category has a baseline number (see below). If the sum number of your responses in that category is above that baseline number, that indicates an area of strength.
- If the sum number falls below the baseline number, that indicates an area of concern that may require a more focused intervention.
- The FAST program is a short-term intervention; however, we realize that changes do take time.
- When looking over your results, it is important to note that you may not see big changes right away.
- This inventory is only a snapshot of your family dynamic, and it is normal to see both upward and downward shifts.
- If you have any questions or concerns with the information you see, please ask your Parent Partner for clarification.



Growing Works

Program Demographics		
FY 24–25 Total Program Cost		$635,451.61
Total Individuals Served		50
Cost Per Individual		$12,709.03
Individuals Served FY 23–24		35
Age Group		**N=50**
16–25 yrs.	4	8%
26–59 yrs.	42	84%
60 yrs. & older	4	8%
Sex		**N=50**
Female	8	16%
Male	42	84%
Sexual Orientation		**N=50**
Heterosexual/Straight	8	16.0%
Unknown/Not Reported	42	84.0%
Gender Identity		**N=50**
Female	8	16.0%
Male	42	84.0%
Race		**N=50**
Black/African American	2	4.0%
Native Hawaiian or Other Pacific Islander	1	2.0%
Unknown/Not Reported	1	2.0%
Other	16	32.0%
White/Caucasian	30	60.0%
Ethnicity		**N=50**
Hispanic/Latino	19	38.0%
Non-Hispanic/Non-Latino	26	52.0%
Unknown/Not Reported	5	10.0%
Language Spoken		**N=50**
English	47	94%
Spanish	3	6%
Military Status		**N=50**
No	41	82%
Unknown/Not Reported	9	18%
Disability		**Not Collected**

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Growing Works served 50 adults with diverse psychiatric diagnoses in Fiscal Year 2024–2025. The most common were schizophrenic or schizoaffective disorders. Other diagnoses included personality disorders, eating disorders, anxiety, obsessive compulsive disorder and substance use disorder. Most clients have severe mental health diagnoses. For many, Growing Works is their primary community outside of their home situation and family, if applicable. Socialization as realized at Growing Works is equally important as the supported employment experience as a component of clients' recovery.

The program population demographics consist primarily of Hispanics/Latinos and males, though Growing Works accepts all gender identities and ethnicities. The staff of six is now 50% Latinx including a male bilingual (Spanish and English) peer. This has increased awareness of cultural issues, set a new standard of inclusivity, and put representatives of underrepresented communities as leaders for membership.

Transportation is particularly difficult with this population. This is exacerbated by program location, which is outside Camarillo city limits and a minimum of a 20-minute drive from Oxnard. It is almost one hour from Santa Paula (30 minutes from Ventura), and far longer from Ojai, Fillmore, Simi Valley and Piru.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Many Growing Works clients have never held jobs, have not held steady employment for years, have experienced homelessness, and/or have experience in the justice system. Volunteers, called Members, must complete 108 hours of volunteer service, the Wellness Recovery Action Plan, and a job skills class to become eligible for one of ten supported employment positions. In the last two fiscal years, whenever the program has had a supported employment position open, there have been a minimum of two candidates; often, there were four. The program could benefit from more supported employment positions to support clients in their mental health and financial recovery.

Members and supported employees work on their recovery by practicing coping skills as they participate in nursery functions including watering, transplanting, order pulling and preparation, taking inventory, and making deliveries. The staff have worked strategically and carefully to create a stigma-free environment which is safe in every way. Clients find a new home where they can try new tasks, develop skills, explore their personalities and gifts, and be seen as valuable and contributing members of the community and business. Growing Works celebrates milestones corporately (beating sales goals, promotions, holidays, etc.). These are Growing Works community events where everyone enjoys the celebration because everyone has contributed. Staff are very aware of the extensive suffering

the population has endured; a significant part of the mission is to celebrate and nurture all the successes that clients experience at Growing Works. This creates a new foundation for self-esteem to help launch clients into new educational and employment opportunities.

The program reached a milestone of 500 participants in the program (since its inception in 2018) in FY 24–25. Three-quarters of the population start volunteering at Growing Works while housed at The Casas de Esperanza or Hillmont House in Camarillo. Many clients leave without updating the program as to their employment status: they often conclude their time in one of the previously mentioned housing/recovery programs, may lack access to transportation to Growing Works, or seemingly do not perceive continuing as an option due to many barriers. If clients have been hired as supported employees, this changes the narrative: employees usually persist beyond South Lewis Road housing.

Include examples of notable community impact.

Former client K came to Growing Works after hospitalization for mental health challenges. Though her VCBH staff wanted her to pursue further treatment, K decided during her tour that she wanted to start immediately and pursue supported employment. K thrived at Growing Works: her intelligence, commitment, friendliness, kindness and flexibility made her popular with her peers, staff and whomever she encountered. When she started at Growing Works (GW), she had two children; during her time there, she took time off to give birth to a son. About nine months later, K returned and jumped back into work. When an opportunity came up for a peer support specialist position at the Wellness Center, the GW Manager recommended K and encouraged her to apply. She did, successfully completed certified peer training, and is now thriving in her work at the Wellness Center.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	% Agree
	(N=35)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	63%
Services were available in my preferred language.	89%
It was easy to access the services I needed.	80%
Overall, I am satisfied with the services I received.	89%
I would recommend these services to a friend or family member.	80%
As a result of participating in this program:	**% Agree**
	(N=34–35)
I am happier with the friendships I have.	86%
I have people with whom I can do enjoyable things.	77%
I do better in social situations.	74%
My housing situation has improved.	49%
I feel like I belong in my community.	76%
I feel better about myself.	71%
I am better able to handle things when they go wrong.	63%

Most useful or helpful about this program: (N = 34)

- Supportive staff / social connection
- Personal growth / mental wellbeing
- Plant skills / knowledge
- Wraparound services / convenient location

Suggestions to make this program better: (N = 20)

- More hiring/employment opportunities
- Increased workplace professionalism
- More support groups/services
- Improve physical work environment

How long have you been participating in services? (N=35) *

*Percentages may not total 100% due to rounding

Program Outcomes

Growing Works tracks outcomes by surveying participants who receive services and staff providing services. A survey is completed by participants and staff at three time points (Intake, Phase 2, and Phase 3) to evaluate initial needs and improved competency as they continue through the program. Results from these surveys are shown in the tables and open-ended program feedback questions that follow.

Participant Self-Assessments

	% Agree/Strongly Agree		
	Intake (N=31)	Phase 2 (N=4)*	Phase 3 (N=3)*
I am comfortable working with people.	87%	100%	100%
I remember and understand instructions.	94%	75%	100%
I am comfortable learning new tasks.	100%	100%	100%
I ask for advice when needed.	94%	100%	100%
I have developed skills that employers want.		75%	100%
I am ready to move into the next phase of employment.		100%	100%

**Phase 2 and Phase 3 reflect very small sample sizes. Percentages are shown alongside raw counts (N) for transparency and should be interpreted with caution.*

Participant Self-Assessments Program Feedback

What interests you most about Growing Works: (N = 31)

- Working with plants
- Connecting with others/peers
- Acquiring new skills

What do you hope to learn or achieve at Growing Works: (N = 31)

- Gain knowledge about plants
- Job skills/experience or employment
- Personal growth

Staff Assessments	% Agree/Strongly Agree		
	Intake (N=30)	Phase 2 (N=2)*	Phase 3 (N=2)*
Works well with other members and staff.	87%	100%	50%
Remembers and understands instructions.	73%	100%	50%
Is comfortable learning new tasks.	77%	50%	50%
Asks for help when needed.	67%	50%	100%
Is engaged in their recovery journey and embraces coping skills.	80%	100%	50%
Has marketable skills.		100%	50%
Is ready to move on to the next phase of employment.		100%	50%

**Phase 2 and Phase 3 reflect very small sample sizes. Percentages are shown alongside raw counts (N) for transparency and should be interpreted with caution.*

Staff Assessments Program Feedback

General observations of this member: (N = 26)

- Positive and challenging social integration
- Cognitive/instructional needs
- Reliable/challenging task performance

Suggestions to make this program better: (N = 25)

- Communication
- Socialization
- Following instructions

Areas of concern (mental health, home life, safety, recovery, etc.): (N = 25)

- Majority of responses expressed no concerns. Other responses varied and included references to no concerns, self-harm, anxiety, sleep, hygiene, home life, health, and communication. No single theme was repeated more than

General Comments: (N = 4)

- Responses varied and included references to positive observations, tardiness, engagement in future employment, and challenges with change. No single theme was repeated more than once.

Mobile Crisis Outreach for Transitional Age Youth (MCOT)

Program Demographics		
FY 24–25 Total Program Cost		$411,420.65
Total Individuals Served		114
Cost Per Individual		$3,608.95
Individuals Served FY 23–24		123
Age Group	**N=114**	
0–15 yrs.	6	5.3%
16–25 yrs.	101	88.6%
26–59 yrs.	7	6.1%
Sex	**N=114**	
Female	61	53.5%
Male	50	43.9%
Unknown	3	2.6%
Sexual Orientation	**N=114**	
Bisexual	2	1.8%
Declined to State	1	0.9%
Heterosexual/Straight	11	9.6%
Transgender	1	0.9%
Unknown/Not Reported	99	86.8%
Gender Identity	**N=114**	
Female	46	40.4%
Male	40	35.1%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.9%
Transgender	2	1.8%
Unknown/Not Reported	24	21.1%
Gender Queer	1	0.9%
Race	**N=114**	
Alaska Native or Native American	2	1.8%
Asian	6	5.3%
Black/African American	2	1.8%
Declined to Answer	7	6.1%
Native Hawaiian or Other Pacific Islander	1	0.9%
Unknown/Not Reported	48	42.1%
Other	16	14.0%
White/Caucasian	32	28.1%
Ethnicity	**N=114**	
Declined to Answer	2	1.8%
Hispanic/Latino	42	36.8%
Non-Hispanic/Non-Latino	27	23.7%
Unknown/Not Reported	43	37.7%
Language Spoken	**N=114**	
English	69	60.5%
Spanish	7	6.1%
Unknown/Not Reported	38	33.3%
Military Status	**N=114**	
No	75	65.8%
Unknown/Not Reported	39	34.2%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Progress over this fiscal year included continued efforts to educate and present program goals to both VCBH community providers and county law enforcement. The team maintained a strong focus on reducing hospitalizations by providing wraparound support services and connecting youth to appropriate mental health providers. MCOT successfully secured urgent appointments at VCBH clinics and with private providers for both Medi-Cal and non–Medi-Cal beneficiaries.

The program team's primary focus remained on safety planning, collaborating with collateral support systems, and ensuring warm handoffs to ongoing mental health services. MCOT also worked closely with the broader crisis response team serving all age groups, which enhanced the team's ability to consult on cases, share transitional age youth (TAY)–specific expertise, and coordinate responses when multiple teams were needed simultaneously. This collaboration also improved access to shared resources, including vehicles.

By employing bicultural team members, MCOT is well-equipped to meet the needs of the Spanish-speaking population. Additionally, the team's peer support specialist moved on but his replacement, who seamlessly entered the role, also understood and had expertise in working with the TAY population.

One ongoing challenge has been inconsistent call volume specific to TAY, with some days experiencing high demand and others receiving few or no calls. Despite this variability, the team has remained proactive by conducting outreach, increasing community education about the TAY population, and strengthening awareness of available resources and linkage to ongoing services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The team demonstrated specialized expertise by focusing on the unique needs of transitional age youth (TAY) and providing ongoing support until everyone was successfully linked to more permanent services. These supports included outpatient mental health care, connections to homeless services, and psychoeducation for the youth and their loved ones.

Include examples of notable community impact.

As a result of focused efforts to educate the community about the MCOT team and its goals, there was a notable increase in engagement from local non-traditional schools and the community college. These partners more frequently utilized MCOT services, reaching out for consultation, problem-solving, and collaborative support to better assist transitional age youth (TAY) experiencing crisis and beyond.

.

Success story.

A client was highly agitated and being aggressive towards family members and law enforcement. With the assistance of the MCOT team and a Certified Peer Specialist, the situation was able to be de-escalated. This resulted in the client being able to be safely transported via ambulance instead of a law enforcement vehicle. The peer specialist's bicultural connection to the family was instrumental to the success of this situation.

Program Demographics		
FY 24–25 Total Program Cost		$656,708.29
Total Individuals Served		105
Cost Per Individual		$6,254.36
Individuals Served FY 23–24		20
Age Group	N=105	
0–15 yrs.	47	45%
16–25 yrs.	58	55%
Sex	N=105	
Female	72	69%
Male	33	31%
Sexual Orientation	N=105	
Bisexual	2	2%
Declined to State	1	1%
Heterosexual/Straight	11	10%
Unknown/Not Reported	89	85%
Unsure/Questioning	2	2%
Gender Identity	N=105	
Female	61	58%
Male	31	30%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	1%
Transgender	2	2%
Non-Binary	1	1%
Unknown/Not Reported	6	6%
Gender Queer	1	1%
Other	1	1%
Unsure/Questioning	1	1%
Race	N=105	
Alaska Native or Native American	4	4%
Asian	2	2%
Black/African American	5	5%
Declined to Answer	7	7%
Native Hawaiian or Other Pacific Islander	2	2%
Unknown/Not Reported	8	8%
Other	45	43%
White/Caucasian	32	30%
Ethnicity	N=105	
Hispanic/Latino	64	61%
Non-Hispanic/Non-Latino	33	31%
Unknown/Not Reported	8	8%
Language Spoken	N=105	
American Sign Language (ASL)	1	1%
English	91	87%
Spanish	7	7%
Unknown/Not Reported	6	6%
Military Status	N=105	
No	27	26%
Unknown/Not Reported	78	74%
Disability	Not Collected	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Mobile Response Team (MRT) provides mobile crisis response services to youth up to age 21 throughout Ventura County. The program was launched in September 2023 and offers immediate phone response, in-person mobile crisis intervention, follow-up support, as well as information and referrals. The team responds in the field anywhere within Ventura County, arriving within 60 minutes when an in-person response is deemed necessary. MRT works with families to help preserve relationships with the youth in crisis by providing developmentally appropriate conflict and crisis management strategies, stabilizing living situations, and reducing distress for both youth and caregivers. Services are delivered in a trauma-informed manner, with careful consideration of each youth and family's strengths, as well as their cultural and linguistic needs.

The team includes bilingual staff and, whenever possible, deploys team members who speak the preferred language of the youth and family. When this is not possible, language services are readily available.

In the last fiscal year, it was identified that limiting services to enrolled clients created a barrier to broader utilization. As a result, MRT services are now available to any youth in the community up to age 21.

A challenge this year has been a staffing shortage, which has at times limited MRT's availability to the community during certain hours.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

MRT reduces unnecessary law enforcement involvement by providing a specialized, clinically trained response to youth experiencing self-identified mental health crises. By diverting these situations away from police intervention, the program helps prevent escalation, minimizes the risk of criminalization, and decreases the likelihood that youth enter the juvenile justice system due to behavioral health needs rather than public safety concerns.

MRT serves both enrolled and unenrolled youth across the county, ensuring access to crisis intervention regardless of prior connection to mental health services. This approach directly addresses gaps for unserved and underserved populations, including youth who may face barriers such as stigma, lack of awareness, language access issues, or

limited availability of culturally responsive care. By meeting youth where they are—both geographically and emotionally—MRT expands equitable access to timely support.

Include examples of notable community impact.

MRT plays a critical role in early intervention and stabilization, which can reduce downstream impacts such as psychiatric hospitalization, family disruption, school disengagement, and potential homelessness. By de-escalating crises in real time and connecting youth and families to appropriate ongoing services through close coordination with Ventura County Behavioral Health, MRT promotes continuity of care and long-term stability.

Program Demographics		
FY 24–25 Total Program Cost	$705,896.99	
Total Individuals Served	674	
Cost Per Individual	$1,047.32	
Individuals Served FY 23–24	228	
Age Group	**N=674**	
0–15 yrs.	1	0.1%
16–25 yrs.	57	8.5%
26–59 yrs.	555	82.3%
60 yrs. & older	61	9.1%
Sex	**N=674**	
Female	172	25.5%
Male	498	73.9%
Unknown	4	0.6%
Sexual Orientation	**N=674**	
Bisexual	3	0.4%
Declined to State	2	0.3%
Heterosexual/Straight	121	18.0%
Unknown/Not Reported	548	81.7%
Gender Identity	**N=674**	
Female	159	23.6%
Male	455	67.5%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.1%
Unknown/Not Reported	59	8.8%
Race	**N=674**	
Alaska Native or Native American	9	1.3%
Asian	4	0.6%
Black/African American	30	4.5%
Declined to Answer	10	1.5%
Native Hawaiian or Other Pacific Islander	2	0.3%
Multiracial	3	0.4%
Unknown/Not Reported	136	20.2%
Other	219	32.5%
White/Caucasian	261	38.7%
Ethnicity	**N=674**	
Declined to Answer	2	0.3%
Hispanic/Latino	290	43.0%
Multiethnic	2	0.3%
Non-Hispanic/Non-Latino	230	34.1%
Unknown/Not Reported	150	22.3%
Language Spoken	**N=674**	
English	545	80.9%
Other non-English	1	0.1%
Spanish	26	3.9%
Unknown/Not Reported	102	15.1%
Military Status	**N=674**	
No	529	78.5%
Unknown/Not Reported	145	21.5%
Disability	**Not Collected**	

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

The Forensic Services Program has made significant progress in expanding access to critical mental health and substance use disorder services for justice-involved individuals. Alongside these advances, the program remains committed to identifying and addressing gaps in care for unserved and underserved populations. Through ongoing collaboration with community partners and stakeholders, specialized programs have been developed to better serve the distinct needs of vulnerable groups.

A core priority has been the reduction of ethnic and cultural disparities. The program has increased the availability of culturally responsive care by recruiting bilingual and diverse staff, strengthening communication, building trust, and improving overall service accessibility for underrepresented communities. These efforts reflect a broader commitment to inclusivity and equitable access values that are foundational to supporting long-term recovery and successful reintegration.

Equity-driven initiatives have also included the expansion of diversion and alternative sentencing programs, such as mental health courts and individualized treatment plans, offering individuals the opportunity to receive appropriate care in place of incarceration. To further reduce common barriers, the program has maintained access to services through telehealth options, streamlined intake processes, and transportation assistance resources that have proven especially impactful for marginalized communities.

The results of these combined efforts have been encouraging. Participants have demonstrated a measurable reduction in recidivism rates, reflecting the positive impact these interventions have in fostering stability and long-term recovery. However, notable challenges persist. Treatment centers operating at full capacity continue to create long waitlists, making timely placement difficult to secure. Compounding this issue, staffing shortages across the behavioral health sector have strained service delivery, reduced the availability of qualified providers and further limited the program's capacity to meet growing demand. High costs and insurance limitations remain significant barriers to access, and strict eligibility criteria further delay entry into care, particularly for individuals with dual diagnoses or specific felony charges, who already have access to a limited range of treatment options.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Forensic Services Program employs a collaborative, community-centered approach to assessing the mental health needs of individuals involved in the criminal justice system. By gathering meaningful input from a broad network of stakeholders including the District Attorney, Public Defender, Sheriff's Department, Probation, and jail medical staff, as well as service providers and individuals with lived experience, the program works to identify and address key issues such as incarceration, barriers to mental health services, and homelessness. To sustain and strengthen these partnerships, the program hosts monthly stakeholder meetings with community partners, providing a dedicated forum for open dialogue, shared problem-solving, and coordinated planning across systems.

These collaborative planning and program improvement efforts have successfully dismantled numerous barriers to existing mental health diversion and court programs, meaningfully enhancing their effectiveness, accessibility, and overall impact. Strengthened coordination among partners has led to improved service delivery and better outcomes for participants, ensuring that justice-involved individuals as well as unserved and underserved populations receive the support necessary for successful rehabilitation and community reintegration.

A significant driver of these outcomes has been the program's diverse and bilingual workforce. By offering culturally and linguistically responsive care, the Forensic Services Program has increased awareness of and access to mental health and substance use services across a wide range of communities. For Spanish-speaking individuals in particular, this approach helps break down language barriers and address cultural stigmas, fostering greater trust, deeper engagement, and stronger rehabilitation outcomes.

To ensure continuity and quality of care, the program maintains structured oversight through weekly team meetings, enabling consistent coordination of support for justice-involved individuals with mental health and co-occurring disorders. By proactively identifying service gaps, refining workflows, and strengthening data collection practices, the program promotes accountability and operational efficiency. Ultimately, by addressing the root causes of justice involvement, the Forensic Services Program contributes to safer communities, reduces strain on public systems, and supports individuals in building stable, productive lives beyond the justice system.

Include examples of notable community impact.

The Forensic Services Program continues to make meaningful impact on community well-being through targeted initiatives designed to address the complex needs of justice-involved individuals and underserved populations.

Reduced Recidivism: By connecting individuals with mental illness and substance use disorders to treatment programs rather than incarceration, the program has driven notable progress through its mental health diversion and court initiatives. Participants have demonstrated consistently lower recidivism rates and achieved sustained, successful reintegration into their communities.

Improved Housing Stability: Through strategic partnerships with transitional and contracted supportive housing programs, the Forensic Services Program has helped justice-involved individuals secure and maintain stable housing, reducing homelessness and laying the foundation for long-term stability.

Successful Diversion Through Mental Health Court Programs: Specialized mental health court programs have offered individuals access to mental health treatment, case management, and life skills training as meaningful alternatives to incarceration. Many participants go on to achieve long-term recovery and full community reintegration, breaking the cycle of repeated criminal justice involvement.

Strengthened Crisis Response and De-Escalation: In partnership with law enforcement and through targeted crisis intervention training, the program has significantly enhanced its capacity to respond to mental health crises among incarcerated individuals, ensuring timely access to appropriate care and services during critical moments.

Improved Treatment Engagement: Tailored, culturally responsive interventions have led to measurable increases in treatment adherence, particularly among individuals with mental illness who are disproportionately represented in the criminal justice system.

Enhanced Community Safety: Through the implementation of validated risk and violence assessments, the program has ensured that individuals with mental health conditions are directed toward appropriate treatment rather than jail, promoting both individual well-being and broader public safety.

Strengthened Collaboration: The program has cultivated strong, sustained partnerships among mental health providers, law enforcement, public defenders, district attorneys, community organizations, and the Court, creating a more coordinated, cohesive, and effective response to mental health needs across the system.

Success story.

A young adult with no prior criminal history experienced a severe first-episode psychotic break that resulted in harm to a family member—a devastating moment for everyone involved. Rather than allowing this crisis to define this young person's future, the Forensic Services Team saw an opportunity to intervene with compassion and purpose.

A System That Chose Treatment Over Punishment

Recognizing that the incident was the direct result of an acute, untreated psychiatric crisis rather than criminal intent, the Forensic Services Team worked closely with the presiding judge, the Public Defender, and the District Services Program Attorney to advocate for community-based treatment in lieu of incarceration or placement in the Department of State Hospitals. Through transparent communication, evidence-based risk assessment, and a shared commitment to doing what was right, all parties agreed on a treatment plan that included outpatient mental health services, psychiatric care and medication management, structured case management, and ongoing court oversight, keeping this young person in the community where healing could truly begin.

Progress That Speaks for Itself

The growth this individual has demonstrated has been remarkable. They have developed a thorough understanding of their diagnosis, maintain consistent medication adherence, and have built strong insight into their personal triggers and early warning signs. They also recognize the significant role substance use plays in worsening their symptoms and have embraced sobriety as a cornerstone of their recovery. Since entering the program, they have had no further criminal justice involvement and continue to exceed all treatment expectations.

A Testament on What Is Possible

This case reflects the very heart of the Forensic Services Program's mission—that with the right support, collaboration, and belief in a person's capacity to heal, recovery is not just possible, it is achievable. This young person's journey is a powerful reminder that when systems choose compassion over punishment, lives are transformed.

Adult Wellness and Recovery Center and Mobile Wellness

Program Demographics		
FY24-25 Program Cost	$ 1,382,728.91	
Total Individuals Served	564	
Cost Per Individual:	$ 2,451.65	
Individuals Served FY 23-24	468	
Age Group	**N = 564**	
0 - 15 yrs.	1	<1%
16 - 25 yrs.	45	8.0%
26 - 59 yrs.	390	69.0%
60 & Older	118	21.0%
Decline to Answer	7	1.0%
Unknown/Not Reported	3	<1%
Gender Identity	**N = 564**	
Female	164	29.0%
Male	369	65.0%
Decline to Answer	10	2.0%
Unknown/Not Reported	21	4.0%
Race	**N = 564**	
White/Caucasian	140	25.0%
Hispanic or Latino	176	31.0%
Black/African American	34	6.0%
Asian	9	2.0%
Native Hawaiian or Other Pacific Islander	4	1.0%
Alaska Native or Native American	24	4.0%
Decline to Answer	50	9.0%
Unknown/Not Reported	47	8.0%
Sexual Orientation	**N = 564**	
Lesbian or Gay	10	2.0%
Heterosexual / Straight	448	79.0%
Bisexual	6	1.0%
Queer/Questioning	1	<1%
Decline to Answer	83	15.0%
Ethnicity	**N = 564**	
Hispanic	279	50.0%
Non-Hispanic	63	11.0%
More than One	14	3.0%
Decline to Answer	83	15.0%
Unknown/Not Reported	125	22.0%
Language Spoken	**N = 564**	
English	379	67.0%
Spanish	114	20.0%
Indigenous	1	<1%
More than One	59	11.0%
Decline to Answer	6	1.0%
Military Status	**N = 564**	
Yes	32	5.7%
No	490	86.9%
Decline to Answer	22	3.9%
Unknown/Not Reported	20	3.5%
Disability	**N = 564**	
Yes	109	19.3%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable

• Administrative staff are continuing to work on developing a fully formed career ladder for peer staff within The Turning Point Foundation that administers the Adult Wellness Center administered (TWC). which would highlight different levels of certification, including being certified as a Medi-Cal Peer Support Specialist, being certified as a WRAP Group Facilitator, and being certified as an Advanced Level WRAP Group Facilitator. This effort would be in addition to potential promotions to leadership positions within the agency.

• The program manager continues to build connections with outside agencies to increase Mobile Wellness service sites provided to the community. At present, Mobile Wellness provides services to a total of nine different residential programs.

• After receiving Advanced Level Facilitator certification, TWC staff have begun providing WRAP Group Facilitation Trainings to outside agencies as a means of increasing collaboration with outside peer support services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process.

• TWC has developed a partnership with the United Parents group and provides a bi-weekly parent support group in the evenings for Spanish-speaking members within the community.

• TWC continues to always establish a consistent ratio of 50% bilingual staff.

• CalMHSA funding has enabled TWC to remain open to the public without requiring any form of insurance, payment or referral. The program increases access to recovery services by offering support without the pressure of enrolling in traditional mental health services. As a result, staff can provide services for individuals regardless of insurance, income, or any other barrier that would prevent an individual from being able to receive services.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	**% Agree**
	(N=118–121)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	83%
Services were available in my preferred language.	93%
It was easy to access the services I needed.	85%
Overall, I am satisfied with the services I received.	88%
I would recommend these services to a friend or family member.	91%
As a result of participating in this program:	**% Agree**
	(N=118–121)
I am happier with the friendships I have.	84%
I have people with whom I can do enjoyable things.	81%
I do better in social situations.	67%
My housing situation has improved.	60%
I feel like I belong in my community.	72%
I feel better about myself.	81%
I am better able to handle things when they go wrong.	71%

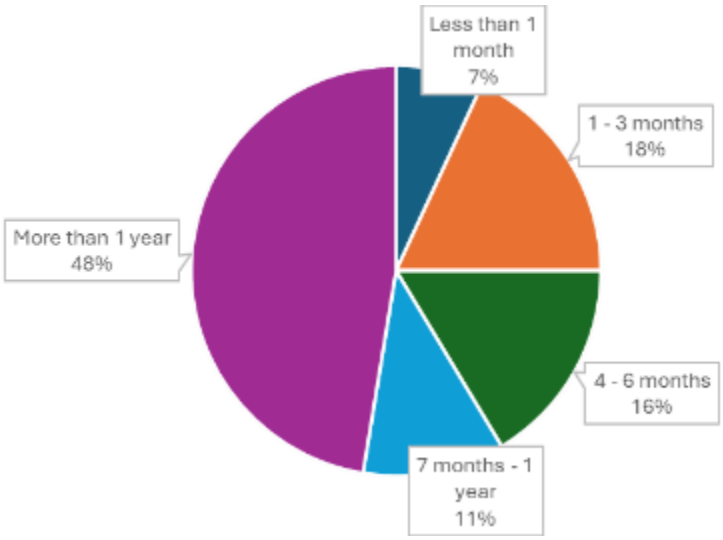
Most useful or helpful about this program: (N = 107)

- A safe place for connection and peer support
- Empowered personal growth
- Provided holistic and essential care

Suggestions to make this program better: (N =82)

- Increase program variety and supports
- Greater community outreach and awareness
- Enhance program resources and amenities

How long have you been participating in services? (N=116)



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TAY Wellness Center

Program Demographics

FY 24–25 Program Cost		$658,958.34
Total Individuals Served		119
Cost Per Individual		$5,537.47
Individuals Served FY 23–24		162
Age Group	**N=119**	
0–15 yrs.	0	0%
16–25 yrs.	113	95%
26–59 yrs.	0	0%
60 yrs. & older	0	0%
Declined to Answer	2	2%
Unknown/Not Reported	4	3%
Gender Identity	**N=116**	
Female	36	31%
Male	37	32%
Transgender	4	3%
Other	1	1%
Declined to Answer	11	9%
Unknown/Not Reported	27	23%
Race	**N=119**	
White/Caucasian	12	10%
Hispanic or Latino	53	45%
Black/African American	6	5%
Other	2	2%
Multiracial	13	11%
Declined to Answer	8	7%
Unknown/Not Reported	25	21%
Sexual Orientation	**N=119**	
Lesbian or Gay	2	2%
Heterosexual/Straight	50	42%
Bisexual	13	11%
Queer/Questioning	6	5%
More Than One	1	1%
Other	5	4%
Declined to Answer	14	12%
Unknown/Not Reported	28	24%
Ethnicity	**N=119**	
Hispanic/Latino	55	46%
Non-Hispanic/Non-Latino	8	7%
More Than One	8	7%
Declined to Answer	9	8%
Unknown/Not Reported	39	33%
Language Spoken	**N=119**	
English	61	51%
Spanish	11	9%
More Than One	18	15%
Declined to Answer	7	6%
Unknown/Not Reported	22	18%
Military Status	**N=119**	
Yes	1	1%
No	78	66%
Declined to Answer	12	10%
Unknown/Not Reported	28	24%
Disability	**N=119**	
Yes	31	26%
No	47	39%
Declined to Answer	12	10%
Unknown/Not Reported	29	24%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The Wellness Center is in a predominantly Hispanic/Latino community, consisting of many Spanish-speaking and bilingual members being served at the center daily. To meet their needs, The Wellness Center maintained 50% bilingual staffing through Fiscal Year 2024–2025 to be able to provide one-on-one counseling services and group counseling services at the center. Additionally, the center offered a minimum of two groups per week that were provided in Spanish, as well as many other groups that offered translation services for any participants attending who did not speak English. The largest barrier towards providing services in FY 24–25 was a lack of available scholarships for newly hired peers to receive Peer Certification. In addition to program staff needing this training to become certified, they also find the certification process to be a valuable training opportunity for newly hired peers to increase their knowledge of their scope of practice and ensure that they can provide quality services.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process.

The Wellness Center remains a free program and does not require insurance or referrals for admittance, reducing the need for waitlists or prolonged intake procedures that create barriers for individuals seeking access to behavioral health services. Many individuals who walk into the center can sign up and receive services on the same day, due to the no-referral-necessary policy in conjunction with No Wrong Door. Additionally, any individual walking into the center who is seeking services not provided by the program is able to sit down with peer support specialists and explore potential community referrals to receive any additional desired services in the area. Staff continue to attend outreach fairs throughout the community, including events targeted for Spanish/Mixteco communities, formerly incarcerated individuals, and homeless individuals throughout the county.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these

Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	% Agree
	(N=38)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	71%
Services were available in my preferred language.	95%
It was easy to access the services I needed.	92%
Overall, I am satisfied with the services I received.	89%
I would recommend these services to a friend or family member.	95%
As a result of participating in this program:	**% Agree**
	(N=38)
I am happier with the friendships I have.	79%
I have people with whom I can do enjoyable things.	79%
I do better in social situations.	55%
My housing situation has improved.	66%
I feel like I belong in my community.	76%
I feel better about myself.	66%
I am better able to handle things when they go wrong.	79%

Most useful or helpful about this program: (N = 37)

- Supportive staff/basic needs services
- Social connection
- Navigating/accessing resources
- Personal development opportunities

Suggestions to make this program better: (N = 22)

- Highly satisfied with program
- More diverse activity options
- Increase support for basic needs
- Expand program reach and content

How long have you been participating in services? (N=38)

Candela

Program Demographics			
FY 24–25 Total Program Cost			$75,522.55
Total Individuals Served			77
Cost Per Individual			$980
Individuals Served FY 23–24			N/A
Age Group	N=77		
26–59 yrs.		61	79.2%
60 yrs. & older		16	20.8%
Sex	N=77		
Female		48	62.3%
Male		29	37.7%
Sexual Orientation	N=77		
Heterosexual/Straight		2	2.6%
Declined to Answer		75	97.4%
Gender Identity	N=77		
Female		48	62.3%
Male		29	37.7%
Race	N=77		
White/Caucasian		41	53.2%
Hispanic or Latino		29	37.7%
Black/African American		1	1.3%
Asian		6	7.8%
Ethnicity	N=77		
Unknown/Not Reported		77	100.0%
Language Spoken	N=77		
English		77	100.0%
Military Status	N=77		
Yes		1	1.3%
No		76	98.7%
Disability	N=77		
No		77	100.0%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Candela's performance for program services exceeded the contract output requirements for all contract deliverables. Candela's flexible service approach reached unserved and underserved populations through all ten cities and unincorporated areas of Ventura County. Throughout the contract period, Candela maintained its commitment to reducing ethnic and cultural disparities by providing services and outreach across the entire county. Candela provides outreach and services throughout the county because staff understand that serious mental illness affects individuals of all ethnic and cultural backgrounds.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Candela's service programs operate for the purposes of serving the following priority populations: 1) experiencing or at risk of homelessness, 2) experiencing or at risk of justice involvement, 3) experiencing or at risk of institutionalization, 4) experiencing or at risk of prolonged suffering, and 5) underserved and historically marginalized communities. Candela served these populations by performing direct community outreach and engagement with the target populations throughout the contract period. Candela hosted workshops at Our Place–Safe Haven, a homeless shelter, and Villa Calleguas, a low-income HUD housing facility.

Additionally, Candela served justice-involved individuals through referrals from partners in the Sheriff's Office, direct community outreach, and referrals from shelters and community-based organizations throughout the county. During the contract period, individuals at risk of institutionalization and prolonged suffering, and with historic marginalization, received one-on-one support with referral linkage to services.

Include examples of notable community impact.

For Fiscal Year 2024–2025, the Candela Group served a total of 173 clients across all program services. Seventy-seven (77) individuals were enrolled and served through Candela's Workshop Series and direct community member engagement; another 96 individuals were served through the community forum event.

Candela's flexible service approach reached unserved and underserved populations throughout the ten cities and unincorporated areas of Ventura County.

Candela hosted a community forum at the Poinsettia Pavilion in Ventura aimed at engagement between clients, consumers, and family members with local providers and stakeholders, focusing on mental health concerns facing the community. Candela provided VCBH outpatient clinic staff information about the event and conducted outreach to inform consumers, clients, and family members of the forum.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	**% Agree**
	(N=53–55)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	89%
Services were available in my preferred language.	95%
It was easy to access the services I needed.	95%
Overall, I am satisfied with the services I received.	80%
I would recommend these services to a friend or family member.	89%
As a result of participating in this program:	**% Agree**
	(N=48–54)
I am happier with the friendships I have.	82%
I have people with whom I can do enjoyable things.	76%
I do better in social situations.	58%
My housing situation has improved.	56%
I feel like I belong in my community.	64%
I feel better about myself.	67%
I am better able to handle things when they go wrong.	82%

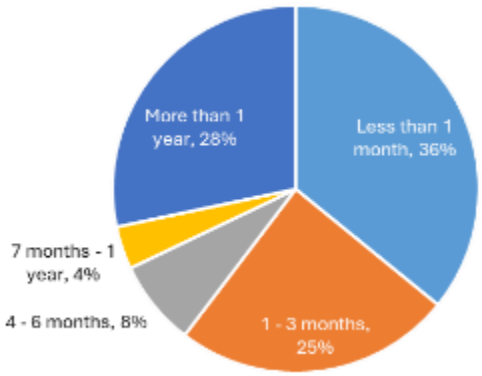
Most useful or helpful about this program: (N = 50)

- Educational content/info sharing
- Supportive/knowledgeable staff
- Community connection/peer support
- Practical resources/tools

Suggestions to make this program better: (N = 35)

- Satisfied with structure/content
- Expand locations/session scheduling
- More resources/topics (employment, transit)

How long have you been participating in services? (N=53) *



** Percentages may not total 100% due to rounding

Mesa Independent Living Program

Program Demographics		
FY 24–25 Total Program Cost		$60,739.08
Total Individuals Served		12
Cost Per Individual		$5,061.59
Individuals Served FY 23–24		N/A
Age Group	**N=12**	
16–25 yrs.	11	91.7%
Declined to answer	1	8.3%
Sex	**N=11**	
Female	6	54.5%
Male	5	45.5%
Sexual Orientation	**N=11**	
Bisexual	1	9.1%
Declined to State	4	36.4%
Heterosexual/Straight	4	36.4%
Lesbian or Gay	1	9.1%
Queer and/or Questioning	1	9.1%
Gender Identity	**N=11**	
Female	6	54.5%
Male	5	45.5%
Race	**N=12**	
Hispanic or Latino	7	58.3%
More Than One Race	2	16.7%
White/Caucasian	3	25.0%
Ethnicity	**N=11**	
Hispanic/Latino	7	63.6%
Non-Hispanic/Non-Latino	2	18.2%
More Than One Ethnicity	2	18.2%
Language Spoken	**N=12**	
English	11	91.7%
More Than One Language	1	8.3%
Military Status	**N=12**	
No	12	100%
Disability	**N=11**	
Yes	2	18.2%
No	8	72.7%
Declined to Answer	1	9.1%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

During the past fiscal year, the Mesa program effectively served transitional age youth (ages 18–25) experiencing mental health challenges and homelessness, a population that is often both unserved and underserved. The program made meaningful progress in reducing disparities by providing accessible, culturally responsive mental health services and stable, temporary housing through its tiny home model. Participants received comprehensive support, including weekly group therapy sessions that promoted emotional well-being, peer connection, and the development of critical life skills. These sessions also contributed to increased social functioning and helped participants build skills necessary for employment, independent living, and long-term housing stability. In addition, the program supported case managers in addressing the unique and diverse needs of each participant, allowing for more individualized and culturally sensitive care.

The program has demonstrated strong outcomes in helping participants transition toward more stable living situations. However, key challenges remain, including limited housing capacity due to the finite number of tiny homes and the complexity of addressing co-occurring mental health and housing instability needs. Despite these challenges, the program continues to play a vital role in reducing barriers and disparities for this vulnerable population.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

This program directly addresses several key community issues identified during Ventura County's Community Program Planning (CPP) process, including homelessness, mental health disparities, and the need to better serve unserved and underserved populations. By focusing on transitional age youth (ages 18–25) who are experiencing both homelessness and mental health challenges, the program targets a population that is at high risk for long-term housing instability, involvement in the criminal justice system, and ongoing behavioral health needs.

The program provides safe, temporary housing through its tiny home model, helping to reduce homelessness while creating a stable environment where participants can engage in mental health services. Weekly group therapy sessions and individualized case management support address behavioral health needs and equip participants with coping strategies, emotional regulation skills, and tools for long-term stability.

Include examples of notable community impact.

For Fiscal Year 2024–2025, the Mesa Independent Living Program provided two key services designed to support residents' mental health and overall program effectiveness: weekly group therapy sessions and clinical support for staff. Weekly group sessions were offered to residents and were facilitated by a licensed psychologist. These sessions addressed a range of topics, including cognitive behavioral therapy (CBT), coping skills development, ethnic identity, LGBTQ+ support, and other relevant mental health and wellness themes.

In addition to group services, the licensed psychologist collaborated closely with Mesa case managers to address the unique and individualized needs of participants. This coordination ensured that residents received tailored support aligned with their personal goals and challenges, while also strengthening staff capacity to respond effectively.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	% Agree
	(N=8)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	88%
Services were available in my preferred language.	100%
It was easy to access the services I needed.	88%
Overall, I am satisfied with the services I received.	100%
I would recommend these services to a friend or family member.	100%
As a result of participating in this program:	**% Agree**
	(N=8) *
I am happier with the friendships I have.	75%
I have people with whom I can do enjoyable things.	100%
I do better in social situations.	100%
My housing situation has improved.	100%
I feel like I belong in my community.	75%
I feel better about myself.	75%
I am better able to handle things when they go wrong.	75%

Most useful or helpful about this program: (N = 8)

- Staff and volunteers
- Housing
- Program services

Suggestions to make this program better: (N = 4)

- Satisfied with current program
- More dedicated one-on-one time
- More weekend program activities
- More frequent check-ins

How long have you been participating in services? (N=7)

Of the seven respondents, five (71%) were enrolled for seven months to one year, one (14%) for four to six months, and one (14%) for more than one year.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Nate's Place Teen Wellness Center

Program Demographics		
FY24-25 Program Cost		$80,192.50
Total Individuals Served		96
Cost Per Individual:		$835.34
Individuals Served FY 23-24		N/A
Age Group	**N = 95**	
0 - 15 yrs.	27	28.4%
16 - 25 yrs.	67	70.5%
26 - 59 yrs.	1	1.1%
Gender Identity	**N = 96**	
Female	42	43.8%
Male	44	45.8%
Transgender	5	5.2%
Questioning or Unsure	2	2.1%
Other	1	1.0%
Decline to answer	2	2.1%
Race	**N = 95**	
White/Caucasian	16	16.8%
Hispanic or Latino	54	56.8%
Black/African American	2	2.1%
Asian	1	1.1%
Native Hawaiian or Pacific Islander	2	2.1%
More than One Race	20	21.1%
Sexual Orientation	**N = 96**	
Lesbian or Gay	7	7.3%
Heterosexual / Straight	63	65.6%
Bisexual	13	13.5%
Queer and/or questioning	9	9.4%
Other	1	1.0%
Decline to answer	3	3.1%
Ethnicity	**N = 87**	
Hispanic	50	57.5%
Non-Hispanic	2	2.3%
More than One Ethnicity	6	6.9%
Unknown / Not Reported	29	33.3%
Language Spoken	**N = 96**	
English	86	89.6%
More than One	10	10.4%
Veteran	**N = 96**	
No	96	100%
Disability	**N = 60**	
Yes	26	27.1%
No	34	35.4%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

NOT APPLICABLE: PROGRAM NEW FOR FY 23–24.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

This new program reaches underserved and unserved individuals up to the age of 25 (significantly from the TAY population), all with mild to moderate substance use disorder or mental health issues, including those who are uninsured, underinsured or have Medi-Cal. Program demographics include 80% Latinx, BIPOC, LGBT+ individuals.

Include examples of notable community impact.

Nate's Place is a pioneering wellness and recovery center that delivers a unique approach to prevention, early intervention, and aftercare services, and includes peer support recovery coaching and healthy recreational activities for teens and young adults ages 13 to 25 years. The program's goal is to increase accessibility to services for those suffering from substance use disorder and mental health crises in Ventura County, specifically seeking to reach marginalized communities including Latinx, BIPOC, LGBTQ+, and individuals who are uninsured, underinsured, or have Medi-Cal. Bilingual services are available for all its programs.

This pilot program includes 1:1 peer support recovery coaching and outdoor activities such as hiking, rock climbing, boating, fishing, outdoor meditation, yoga, and group excursions led by peer coaches and specialists. Activities will be held around Channel Islands Harbor and in Ojai.

Participants engage in peer support recovery coaching outdoors, with 2–3 hours per week of 1:1 engagement, coaching, role modeling, and mentorship in outdoor settings, such as beach walks, nature walks, and hiking. Coaches will lead groups (SMART Recovery) and assist participants in their personal goal setting (using SMART Goals) and identifying outdoor interests and activities.

Health replacement activities are offered outdoors and led by specialists and peer coaches. Equipment and gear are provided by Nate's Place and/or its partners. Activities include group rock climbing excursions, hiking excursions, fishing excursions, boating excursions, juggling and hacky sack lessons, mindfulness meditation and yoga sessions

on the beach, and group beach clean-up sessions.

Success story.

A participant in the program received 1:1 peer support recovery coaching and participated in outdoor activities such as hiking, beach walks, fishing, and mindfulness sessions. The participant engaged in 2–3 hours per week of coaching and attended group activities, including group excursions and a beach clean-up session, while working with a peer coach on goal setting and identifying outdoor interests and activities.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	**% Agree**
	(N=100–102)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	83%
Services were available in my preferred language.	92%
It was easy to access the services I needed.	86%
Overall, I am satisfied with the services I received.	89%
I would recommend these services to a friend or family member.	89%
As a result of participating in this program:	**% Agree**
	(N=100–102)
I am happier with the friendships I have.	75%
I have people with whom I can do enjoyable things.	75%
I do better in social situations.	39%
My housing situation has improved.	46%
I feel like I belong in my community.	66%
I feel better about myself.	63%
I am better able to handle things when they go wrong.	86%

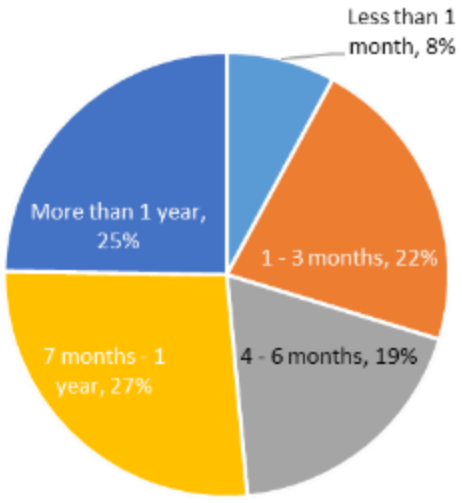
Most useful or helpful about this program: (N = 101)

- Individualized guidance/coaching
- Safe/accepting communal environment
- Supportive program staff
- Diverse activities/skill development

Suggestions to make this program better: (N = 47)

- Satisfied with existing program
- More varied activity content/delivery
- Operational improvements (transportation, food)
- More participant autonomy

How long have you been participating in services? (N=101) *



* Percentages may not total 100% due to rounding

Semillas Sembrando Bienestar (Planting Seeds of Wellness)

Program Demographics		
FY 24–25 Program Cost		$ 206,081.00
Total Individuals Served		94
Cost Per Individual		$ 2,192.35
Individuals Served FY 23–24		N/A
Age Group	**N=94**	
0–15 yrs.	4	4.3%
16–25 yrs.	6	6.4%
26–59 yrs.	70	74.5%
60 yrs. & older	12	12.8%
Declined to Answer	2	2.1%
Gender Identity	**N=93**	
Female	74	79.6%
Male	15	16.1%
Genderqueer	3	3.2%
Declined to Answer	1	1.1%
Race	**N=94**	
White/Caucasian	1	1.1%
Hispanic or Latino	83	88.3%
Black/African American	2	2.1%
Asian	1	1.1%
More Than One Race	4	4.3%
Other	2	2.1%
Declined to Answer	1	1.1%
Sexual Orientation	**N=91**	
Heterosexual/Straight	76	83.5%
Bisexual	3	3.3%
Queer and/or Questioning	2	2.2%
Other	1	1.1%
Declined to Answer	9	9.9%
Ethnicity	**N=91**	
Hispanic/Latino	84	92.3%
Non-Hispanic/Non-Latino	4	4.4%
Declined to Answer	3	3.3%
Language Spoken	**N=94**	
English	53	56.4%
Spanish	39	41.5%
More Than One	2	2.1%
Veteran	**N=92**	
Yes	1	1.1%
No	90	97.8%
Declined to Answer	1	1.1%
Disability	**N=92**	
Yes	6	6.5%
No	86	93.5%

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

During Fiscal Year 2024–2025, Sembrando Bienestar successfully launched programming designed to increase access to culturally rooted, trauma-informed mental health practices for under-resourced communities in Ventura County, with particular emphasis on Mexican, Spanish-speaking, Latine, and Black/African American populations.

Over the course of the year, the program conducted 10 community outreach efforts across Oxnard, Camarillo, Ventura, Moorpark, Santa Barbara, Thousand Oaks, and Port Hueneme, engaging diverse audiences and raising awareness of accessible mental health resources. The program also hosted one community input night to gather feedback and build trust, and delivered nine workshops introducing participants to somatic and nature-based practices designed to promote emotional regulation and well-being.

The program partnered with a wide range of organizations serving youth, LGBTQ+ communities, and men, including M.A.N.D.O., Many Mansions, Oxnard Elementary and High School Districts, Oxnard Performing Arts Center, MICOP, Juneteenth celebrations, and Youth Initiative. These partnerships were critical in reaching underserved populations, increasing community engagement, and reducing ethnic and cultural disparities in access to mental health support.

Despite a brief three-month period of direct program delivery, the program reached 2,878 individuals through outreach and engaged 99 unduplicated participants through workshops. By leveraging trusted community spaces, culturally rooted practitioners, and targeted engagement strategies, the program successfully fostered familiarity with mental health services, built community trust, and laid a strong foundation for sustainable impact and expanded service delivery in future fiscal years.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

Sembrando Bienestar directly addresses several key community issues identified through Ventura County's Community Program Planning process, including disparities in access to mental health services, the needs of unserved and underserved populations, and the long-term impacts of trauma related to homelessness, incarceration, and systemic inequities.

By focusing on culturally rooted, trauma-informed, and nature-based interventions, the program increases access to behavioral health supports for populations that historically face barriers to care—particularly Mexican, Spanish-speaking, Latine, and Black/African American communities. Workshops, community gatherings, and outreach efforts provide practical, low-cost tools for emotional regulation, stress reduction, and resilience-building, helping participants

address challenges associated with social and structural stressors, including exposure to violence and family or community trauma.

The program also fosters engagement with youth, LGBTQ+ communities, and other groups that are frequently underserved in traditional mental health systems, partnering with schools, community organizations, and local initiatives to reach participants who may not otherwise access services. By creating welcoming, familiar, and culturally resonant spaces, and enlisting culturally recognized practitioners, Sembrando Bienestar helps reduce stigma, build trust in mental health resources, and provide early intervention support that helps prevent the escalation of mental health needs.

Through these strategies, the program strengthens protective factors at both individual and community levels, promotes social connection, and contributes to reducing ethnic and cultural disparities in mental health access—directly addressing the priorities identified in the Community Program Planning process.

Include examples of notable community impact.

Sembrando Bienestar has demonstrated meaningful community impact through both reach and participant experience. The program successfully established a trusted, culturally affirming wellness hub that participants described as “familiar” and “like home (como en casa),” emphasizing its role in reducing anxiety and stigma associated with mental health settings.

For many participants, this was their first experience in mental health practice. By creating a warm, accessible, and culturally affirming environment, the program mitigated barriers related to fear, stigma, and unfamiliarity. Several participants reported that gaining familiarity with a welcoming mental health space increased their confidence in accessing behavioral health services in the future.

The program expanded access by offering services in trusted community locations—including gardens, farms, and community-based organizations—allowing participants to engage in familiar, non-clinical environments. These approaches helped normalize emotional regulation and promote healing, particularly among immigrant, Latine, and Black communities who might otherwise avoid traditional mental health settings.

Participants reported improved mood, enhanced ability to manage stress, increased self-efficacy, and a stronger sense of safety and autonomy. These outcomes reflect the program’s success in supporting nervous system regulation and strengthening protective factors for communities impacted by trauma and systemic inequities.

Through collaboration with culturally rooted practitioners, community-based organizations, and schools, the program strengthened community trust, expanded outreach, and increased awareness of available mental health resources. These partnerships also fostered social connection and community cohesion, helping to build a stronger ecosystem of care across Ventura County.

Despite a short implementation period, the program reached 2,878 individuals through outreach efforts and engaged 99 unduplicated participants through workshops, already surpassing early expectations and demonstrating strong community interest in culturally responsive mental health services. After a review of the clients served, this program will be moved from CSS to PEI program next fiscal year.

Success story.

A notable success of the program is the creation of a trusted community wellness space that significantly reduced stigma and increased engagement in mental health services.

For many participants, attending a Sembrando Bienestar workshop was their first experience in a mental health setting. By intentionally designing a warm, culturally resonant environment—including community ofrendas and bilingual facilitation—participants reported feeling safe, welcomed, and at ease.

Several participants shared that the space felt “like home,” which helped reduce anxiety and fear associated with seeking mental health support. This increased comfort led to greater openness to learning and practicing wellness strategies, as well as more confidence in accessing additional behavioral health services in the future.

This program distributes satisfaction surveys twice yearly for a one-month duration each time. Results from these Client Perception and Satisfaction Surveys are summarized below.

Please indicate how much you disagree or agree with the following statements.	**% Agree**
	(N=61–63)
Staff were sensitive to my cultural background (e.g., ethnic/religious beliefs).	100%
Services were available in my preferred language.	100%
It was easy to access the services I needed.	97%
Overall, I am satisfied with the services I received.	98%
I would recommend these services to a friend or family member.	100%
The services I received helped me work toward my personal goals.	100%
As a result of participating in this program:	**% Agree**
	(N=57–63)
I am happier with the friendships I have.	98%
I have people with whom I can do enjoyable things.	98%
I do better in social situations.	61%
My housing situation has improved.	61%
I feel like I belong in my community.	82%
I feel better about myself.	92%
I am better able to handle things when they go wrong.	87%

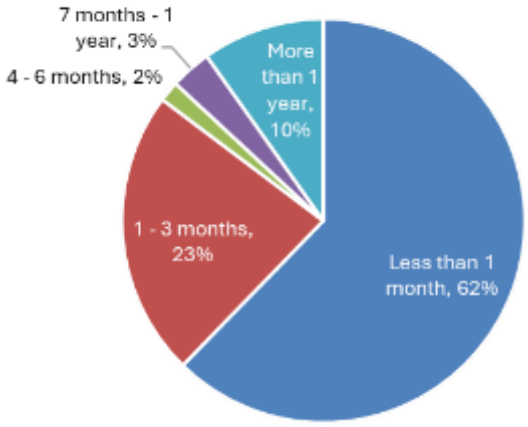
Most useful or helpful about this program: (N = 59)

- Outdoor/nature-based setting
- Peer connection/safe environment
- Bilingual/culturally sensitive approach
- Personal growth/holistic self-reflection

Suggestions to make this program better: (N = 43)

- Highly satisfied with program
- More frequent/expanded reach
- More wellness activity types
- Minor structure/material improvements

How long have you been participating in services? (N=61)



Housing (HOU)

The Housing category under CSS embodies both the individual and system transformational goals of MHSA by facilitating collaboration among County organizations and resources to ensure that consumers have access to an appropriate array of services and supports. VCBH oversees a variety of housing resources for vulnerable clients, people experiencing homelessness, as well as clients who may be provisionally housed and/or underserved.

Housing

Program Information	
Total MHSA FY 24–25	$3,040,703.15
Total Cost	$5,467,242.93
Total Individuals Served	150
Cost Per Individual	N/A

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH has continued the Community Care Expansion (CCE) grant program, providing much-needed facility improvements and operating subsidies to licensed board and care (B & C) facilities.

Through MHSA funds, VCBH has been able to fund interim shelter program, Vagabond. Funding has provided 40 beds for clients who are homeless, allowing for opportunities to find a more permanent housing option.

VCBH continues to work towards increasing affordable housing options for low-income homeless clients and clients at risk of homelessness through its community-based partnerships utilizing voter-approved No Place Like Home (NPLH). Specifically, there are 85 NPLH units.

VCBH continues to support extremely low-income clients at Paseo Santa Clara, an affordable community owned and operated by Cabrillo Economic Development Corp., through rental assistance.

Additionally, VCBH continues to support low-income clients with MHSA Housing Program funding at four affordable housing developments managed by Many Mansions: Peppertree Apartments, D Street Apartments, Hillcrest Villas and La Rahada. Lastly, VCBH continues to serve six families with rental assistance at E Street Apartments in Oxnard.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process.

The licensed care facilities, FSP clients and extremely low-income clients living in subsidized apartments continue to benefit from the MHSA Housing programs.

Include examples of notable community impact.

The expansion of family housing at E Street Apartments is notable. VCBH was able to increase this housing type from four apartments to six apartments.

MHSA Housing Type	Total Beds/Units
Vagabond – Interim Shelter	**40 beds**
B & C – Adult Residential Facility (ARF) Age 18+	**125 beds**
B & C – Residential Care Facilities for the Elderly (RCFE) Age 59+	**86 beds**
Permanent Supportive Housing	**79 units**
Short-term housing funds support	**152 units**

Prevention and Early Intervention (PEI)

Programs under the Prevention and Early Intervention (PEI) component, in collaboration with consumers and family members, serve to promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. Target populations include all ages with a requirement of serving children and TAY (0–25 years) utilizing 51% of PEI funds.

Ventura County categorized all PEI-funded programs to align with regulation requirements and definitions. The required program types are prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment and stigma and discrimination reduction. Suicide prevention and improving timely access to services for underserved populations are optional categories. Additionally, all PEI-funded programs are designed and implemented in accordance with strategies that help with access and services for people with severe mental illness, the reduction of stigma and discrimination with respect to mental illness, and improving timely access to mental health services for individuals and/or families from underserved populations in ways that are non-stigmatizing, non-discriminatory and culturally appropriate.

Data Collection Instruments

In the context of ensuring the efficacy of PEI programs, this section articulates the systematic approach towards assessing the impact of these initiatives. Grounded in the guidelines set forth by the California Code of Regulations for the Mental Health Services Act (MHSA), the framework endeavors to understand the pathways through which PEI programs achieve their objectives.

PEI programs employ a variety of data collection instruments, based on the program category, to measure the impact each program is having on clients. Instruments have been carefully selected and constructed to ensure alignment with the MHSA regulations and appropriateness for program operations. Methods employed include direct, indirect, and quasi-indirect measures of change, adapted to what is best suited for each individual PEI program.

For all Stigma and Discrimination Reduction programs, the California Code of Regulations calls for validated methods to measure changes in attitudes, knowledge, and/or behaviors related to mental illness or seeking mental health services. The Mental Help Seeking Attitudes Scale (MHSAS) is used to measure respondents' overall evaluation of their seeking help from a mental health professional if they find themselves dealing with any type of mental health concern (Hammer, Parent, & Spiker, 2018). Other Prevention or Early Intervention programs utilize the Schwartz Outcome Scale-10 (Schwartz & Michael, 2000) as an indirect measure of a broad domain of psychological health. These tools, among other constructed tools that meet the highest standards of survey item construction, provide insight into the impacts that PEI programs are having within the community.

The full PEI Evaluation Report can be found in the Appendix section of this report.

FY 24–25 PEI Program Categories

Prevention	
Multi-Tiered System of Support	Girls Rock SB (Amplify the Arts)
Ventura County Office of Education	Comadres Unidas (Nyeland Promise)
Everyone Has a Story Book Club (Autism Society)	Girl Scouts
Healing Through the Arts (De Colores Multicultural Folk Arts, Inc.)	Healing the Community (Mixteco Indigena Community Organization Project) (MICOP)
	Playful Bonds (Childhood Matters)
Promoviendo Program (Promotoras y Promotores Foundation) (PYPF)	Tri-County GLAD
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	No Limits Theater Group Inc., DBA No Limits for Deaf Children and Families
	One Step a La Vez (OSALV) Conocimiento
Project Esperanza (Our Lady of Guadalupe Parish)	Wellness Centers Expansion, Ventura County Office of Education
Westside Wellness (Two Trees Community)	
Be Kind Program (Boys & Girls Clubs of Greater Oxnard and Port Hueneme)	NAMBA Rock and Roll High Performing Arts
Wellness Everyday and STAY Media Campaign	Ignite Conocimiento (Catalyst Church)
Idea Engineering, Inc	

Early Intervention	
COMPASS (Seneca Family of Agencies)	Primary Care Program (Clinicas)
Ventura County Power Over Prodromal Psychosis (VCPOP) Ventura County Behavioral Health	Mental Health First Aid (MHFA) (VCBH)
Therapy Horse Program (VC Family Justice)	One Step a La Vez (OSALV) Bienestar
Tri-County Glad Early Intervention and Supporting Services	

Stigma and Discrimination Reduction	
Oxnard Performing Arts Center Corporation (OPAC)	Andale! Wellness and Creativity for Everyone (Oxnard Performance Arts Center Corporation) (OPAC)
Rainbow Umbrella + P.R.I.D.E (Diversity Collective)	

Suicide Prevention	**Access and Linkage to Treatment**
Suicide Prevention (VCBH)	Suicide Prevention (VCBH)

Outreach for Increasing Recognition of Early Signs of Mental Illness
Crisis Intervention Team (CIT)
Ventura County Law Enforcement

Program	Number of Participants	Cost Per Participant	Target to be Served FY 25–26
Prevention Programs	**87,606**		
Girls Rock SB (Amplify the Arts)	130	$540.37	140
Everyone Has a Story Book Club (Autism Society)	35	$810.83	40
Be Kind Program (Boys and Girls Club)	28	$0	35
Playful Bonds (Childhood Matters)	63	$479.53	70
Early Birds Coping Skills (Girl Scouts)	5,600	$24.86	5,650
Healing through the Arts (De Colores)	194	$256.21	200
Ignite Conocimiento (Catalyst Church)	72	$2,969.40	80
Little Listeners (No Limits)	57	$1,198.64	65
Mixteco Indigena Community Organization Project (MICOP)	267	$1,017.33	275
Multi-Tiered System of Support (MTSS) – VCOE	59,029	$34.18	59,050
NAMBA Flamenco Dance, Theater for Wellness	57	$641.54	65
Comadres Unidas (Nyeland Promise)	36	$694.56	40
One Step a La Vez Conocimiento	140	$2,657.26	150
Program to Encourage Active, Rewarding Lives for Seniors	182	$2,875.08	190
Project Esperanza	129	$951.70	135
Promotoras Conexión Program	144	$2,062.05	150
Tri-County GLAD	49	$1,327.51	55
Wellness Centers	21,353	$1.61	21,400
Westside Wellness (Two Trees)	41	$1,895.81	50
Early Intervention Programs	**819**		
COMPASS	18	$112,537.57	25
Mental Health First Aid (MHFA)	180	$141.14	190
One Step a La Vez Bienestar	21	$17,715.04	30
Limits	27	$987.99	35
Primary Care Program (Clinicas)	296	$3,137.71	305
Ventura County Power Over Prodromal Psychosis (VCPOP)	277	$7,535.67	285
Other PEI Programs	**2,546**		
Crisis Intervention Team (CIT)	142	$1,768.76	150
Diversity Collective	113	$490.44	120
Logrando Bienestar	1,693	$1,121.84	1,750
Andale! Wellness and Creativity for Everyone	343	$248.85	350
Suicide Prevention	255	$1,915.06	260
Total:	**90,908**	n/a	**91,270**

FY 24–25 Number of Participants Served by City of Residence[§]

Geographic Area	Number of Participants Served	% of Total
Camarillo	224	7%
Fillmore	195	6%
Moorpark	134	4%
Newbury Park	200	6%
Oak Park	58	2%
Ojai	29	1%
Oxnard	819	24%
Piru	10	<1%
Port Hueneme	92	3%
Santa Paula	419	12%
Simi Valley	254	8%
Thousand Oaks	308	9%
Ventura	520	15%
Other	112	3%
Total with available city of residence data:	**3,374**	

[§]City of residence data is not available for Crisis Intervention Training, Logrando Bienestar, Multi-Tiered System of Support VCOE, Primary Care Program, Suicide Prevention, VCPOP, Wellness Centers, and Wellness Everyday.

Prevention

The goal of the Prevention component of MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. In Ventura County, there are 18 programs primarily categorized under Prevention. These programs serve several historically underrepresented populations including Hispanics/Latinos, Transitional Age Youth (TAY), individuals who are Deaf and Hard of Hearing (DHH), and LGBTQ+. Program services vary but include support groups, workshops, trainings, education, and presentations.

Across programs, participants expressed high levels of satisfaction with the services they received. Additionally, programs serving underrepresented groups reached their intended priority population(s). The following pages outline further details about each program's population(s) served, activities and outreach, and participant outcomes.

Prevention programs offer activities to reduce risk factors for and build protective factors against developing a potentially serious mental illness. They may include relapse prevention for individuals in recovery from a serious mental illness. A total of 661,677 participants were served by Prevention programs in FYs 2021–2022, 2022–2023, and 2023–2024.

Changes: After numerous and ongoing requests and reports of high-need students from the Ventura County Office of Education, VCBH is planning to continue to expand the K-12 Wellness Center program in FY 22–23 and 23–24 with additional PEI money. A full report on activities will be reported in next year's annual update.

Prevention Program Descriptions

Be Kind Program: Promotes compassion, empathy, and inclusiveness to youth aged 6–18 years through workshops and materials.

Comadres Unidas: Assists Latina women farm workers to manage stress, anxiety and depression through creative activities, educational workshops, and community connections.

Everyone Has a Story Book Club: Offers bi-monthly meetings and writing workshops for disabled and neurodivergent individuals to improve mental health, promote community, and expose participants to literature reflective of their experiences.

Girls Rock SB: Promotes creativity, peer connection and self-discovery among girls and gender-expansive youth in grades 6th to 12th through a weekend of artistic workshops.

Girl Scouts: Provides strategies for managing life stress to young girls.

Healing Through the Arts: Engages youth and older adults in a multitude of intergenerational classes to foster confidence, social connections, and community well-being.

Ignite Conocimiento: Promotes mental health and resiliency to Hispanic/Latino communities through educational workshops, counseling, and community engagement.

Mixteco Indígena Community Organization Project (MICOP): Facilitates mental health for the Latinx and Indigenous communities through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Multi-Tiered System of Support (MTSS), VCOE: Provides education and training for school personnel and students, as well as family outreach and engagement to reduce stigma and discrimination about mental illness throughout Ventura County.

NAMBA Flamenco Dance, Theater for Wellness: Promotes creative expression for students aged 12–18 years in underserved areas of Ventura through flamenco dance classes and mental health performance shows.

Little Listeners: Facilitates career exploration for deaf youth and their siblings through curriculum and parent support groups, as well as raises awareness about effective communication strategies with deaf individuals.

One Step a La Vez Conocimiento: Serves Latino/a, LGBTQ+, and TAY at risk of homelessness or in the juvenile justice system populations through outreach, a drop-in center, wraparound wellness services, stress and wellness classes, youth leadership activities, and LGBTQ+ support groups.

Playful Bonds: Provides educational classes to increase positive interactions between parents and caregivers and their children through play.

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS): Offers an in-home counseling program for seniors that teaches participants how to manage depression through counseling sessions supported by a series of follow-up phone calls. Program will close in FY 25–26.

Project Esperanza: Offers mental health service assistance, educational and wellness classes, and activities to Hispanic/Latino families in the Santa Paula community.

Promotoras Conexión Program (Promotoras y Promotores Foundation [PyPF]): Facilitates mental health for immigrant Latinas/Hispanic women at risk of depression through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Tri-County GLAD: Increases knowledge and awareness of mental health concerns in the Deaf and Hard of Hearing community through outreach, referrals, social media videos, presentations, and workshops with middle-school students.

Wellness Centers Expansion: Provides coordinated health/mental health and other support services to maximize student engagement and success through staff and student trainings, family engagement activities, screenings, referrals, and early intervention activities.

Wellness Everyday and STAY Media: Provides prevention, suicide prevention, and coping with trauma messaging via social media campaigns and their website.

Westside Wellness: Provides support groups and group therapy to help Latina/Latino youth aged 9–15 years and parents cope with suicidal ideation and prevent self-harm.

87,606	individuals received core program services†
2,295	individuals referred to mental health care and/or social support services†
80,224	individuals reached through outreach events†

†Number of individuals may be duplicated.

Prevention Programs: Demographics of Participants§

Age*	**(N=2,967)**
0–15	61%
16–25	13%
26–59	16%
60+	10%
Declined to Answer: 7	

Primary Language*	**(N=1,692)**
English	49%
Spanish	43%
Indigenous	4%
Other	4%
Declined to Answer: 13	

Sex Assigned at Birth	**(N=1,264)**
Female	68%
Male	32%
Declined to Answer:13	

Sexual Orientation	**(N=1,067)**
Bisexual	4%
Gay or Lesbian	2%
Heterosexual or Straight	91%
Queer	1%
Questioning or Unsure	1%
Another Sexual Orientation	1%
Declined to Answer: 41	

Current Gender Identity*	**(N=1,342)**
Female	69%
Male	29%
Genderqueer	1%
Questioning or Unsure	1%
Transgender	<1%
Another Gender Identity	1%
Declined to Answer: 18	

Race*	**(N=2,390)**
Native American/Alaska Native	2%
Asian	4%
Black/African American	2%
Hispanic/Latino	46%
Native Hawaiian/Pacific Islander	1%
White/Caucasian	40%
Other	5%
More Than One	<1%
Declined to Answer: 561	

Ethnicity*	**(N=2,137)**
Hispanic/Latino	59%
Non-Hispanic/Non-Latino	41%
More Than One Ethnicity	1%
Declined to Answer: 769	

Hispanic/Latino Ethnicities*^	**(N=924)**
Mexican	93%
Central American	2%
Puerto Rican	1%
South American	1%
Caribbean	1%
Another Hispanic/Latino	4%

Non-Hispanic/Non-Latino Ethnicities*^	**(N=210)**
African	10%
Cambodian	<1%
Eastern European	8%
Filipino	9%
Korean	3%
Vietnamese	<1%
Asian Indian/South Asian	3%
Chinese	7%
European	44%
Japanese	3%
Middle Eastern	5%
Another non-Hispanic/non-Latino	8%

City of Residence	**(N=2,912)**
Camarillo	66%
Newbury Park	7%
Oxnard	20%
Santa Paula	14%
Ventura	15%
Fillmore	6%
Oak Park	2%
Piru	<1%
Simi Valley	9%
Other	4%
Moorpark	4%
Ojai	1%
Port Hueneme	3%
Thousand Oaks	10%

* Percentages may exceed 100% because participants could choose more than one response option.
§ Demographic data was not collected for MTSS VCOE, MTSS LEA, or Wellness Everyday.
^ Percentages and counts reflect the number of individuals who selected each Hispanic/Latino or Non-Hispanic/Non-Latino Ethnicity.

Early Intervention

The purpose of the Early Intervention component of MHSA is to intervene early in the emergence of symptoms of mental illness to reduce negative outcomes and foster positive recovery and functional outcomes. Ventura County funds seven Early Intervention programs that provide crisis stabilization, family support, group and individual therapy, assessment and screening, educational and vocational services, and outreach and education, including the Early Intervention Network Expansion Grants. These Early Intervention services promote wellness, foster health, and prevent suffering that can result from untreated mental illness. Early Intervention programs may include services to family and caregivers of the person with early onset of a mental illness. A total of 1,954 individuals were served by Early Intervention programs in FYs 2021–2022, 2022–2023, and 2023–2024.

Early Intervention Program Descriptions

COMPASS: A short-term residential program for youth ages 12–17 years transferring from the Crisis Stabilization Unit. Services include individual and family therapy, case management, psychiatric care, medication support and assessment to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community.

Mental Health First Aid (MHFA): Provides training to identify, understand and respond to mental health and substance use challenges.

One Step a la Vez Bienestar: Offers assessment, individual therapy, case management, group sessions, and care coordination to youth ages 12–19 years at risk of or experiencing mental health issues.

Primary Care Program: Provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers.

Pathways of Hope: Provides alternative therapeutic practices, community building, and guidance to higher education opportunities to youth exposed to trauma.

Tri-County GLAD – Early Intervention and Supporting Services: Supports the deaf and hard of hearing in accessing early intervention mental health services by reducing language barriers.

Ventura County Power Over Prodromal Psychosis (VCPOP, formerly EDIPP): Conducts community outreach and education to community members about early warning signs of psychosis; provides a two-year intervention program with services and supports.

819	individuals received core program services[1]
2	individuals referred to mental health care and/or social support services[1]
600	individuals reached through outreach events[1]

1 Number of individuals may be duplicated

.

1

Early Intervention Demographics

Age*	(N=407)
0–15	13%
16–25	60%
26–59	27%
60+	1%
Declined to Answer: 14	

Primary Language	(N=653)
English	64%
Spanish	33%
Indigenous	2%
Other	<1%
Declined to Answer: 14	

Sex Assigned at Birth‡	(N=360)
Female	71%
Male	29%
Declined to Answer: 0	

Sexual Orientation‡	(N=303)
Bisexual	5%
Gay or Lesbian	3%
Heterosexual or Straight	90%
Queer	<1%
Questioning or Unsure	0%
Another Sexual Orientation	2%
Declined to Answer: 18	

Current Gender Identity‡	(N=326)
Female	46%
Male	51%
Genderqueer	<1%
Questioning or Unsure	0%
Transgender	2%
Another Gender Identity	1%
Declined to Answer: 1	

Race	(N=473)
Native American/Alaska Native	2%
Asian	1%
Black/African American	2%
Hispanic/Latino	10%
Native Hawaiian/Pacific Islander	<1%
White/Caucasian	59%
Other	24%
More Than One	1%
Declined to Answer: 3	

Ethnicity*§	(N=407)
Hispanic/Latino	80%
Non-Hispanic/Non-Latino	20%
More Than One Ethnicity	1%
Declined to Answer: 188	

Hispanic/Latino Ethnicities*^§	(N=59)
Mexican	89%
Central American	4%
Puerto Rican	0%
South American	4%
Caribbean	2%
Another Hispanic/Latino	2%

Non-Hispanic/Non-Latino Ethnicities*^§	(N=8)
African	0%
Cambodian	0%
Eastern European	0%
Filipino	0%
Korean	0%
Vietnamese	0%
Asian Indian/South Asian	0%
Chinese	0%
European	88%
Japanese	0%
Middle Eastern	0%
Another non-Hispanic/non-Latino	13%

City of Residence	(N=66)
Camarillo	8%
Newbury Park	0%
Oxnard	26%
Santa Paula	5%
Ventura	27%
Fillmore	29%
Oak Park	0%
Piru	0%
Simi Valley	0%
Other	0%
Moorpark	0%
Ojai	3%
Port Hueneme	3%
Thousand Oaks	0%

*Percentages may exceed 100% because participants could choose more than one response option.
§Age and Ethnicity data were not reported for Primary Care Program.
‡Assigned sex, Sexual Orientation and Current Gender Identity data was not reported for COMPASS and VCPOP.
^Percentages and counts reflect the number of individuals who selected each Hispanic/Latino or Non-Hispanic/Non-Latino Ethnicity.

Other PEI Programs

The programs under Other PEI Programs encompass the core program categories of Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction, as well as Suicide Prevention (optional) and Improving Timely Access to Services for Underserved Populations (optional) programs. All programs in this section focus primarily on training potential first responders—including educators, students, law enforcement personnel, first responders, people with lived experience, and other community members—about ways to recognize and respond effectively to early signs of mental illness. Programs also seek to combat negative perceptions about misinformation and/or stigma associated with having a mental illness or seeking help for mental illness.

A total of 15,776 individuals were served by Other PEI Programs in FYs 2021–2022, 2022–2023, and 2023–2024. Other PEI Programs include the following program categories.

Outreach for Increasing Recognition of Early Signs of Mental Illness programs train potential responders to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

Access and Linkage to Treatment programs connect individuals with severe mental illness to medical care and treatment as early in the onset of these conditions as practicable. These programs focus on screening, assessment, referral, telephone helplines, and mobile response.

Stigma and Discrimination Reduction programs reduce negative attitudes, beliefs, stereotypes, and discrimination toward those with mental illness or seeking mental health services and increase dignity, inclusion, and equity for individuals with mental illness and their families.

Suicide Prevention programs provide organized activities to prevent suicide because of mental illness.

Improving Timely Access to Services for Underserved Populations: To increase the extent to which an individual or family member from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

Other PEI Program Descriptions

Andale! Wellness and Creativity for Everyone: Offers culturally relevant mental health information and wellness activities for low-income, underserved Latino youth and families.

Crisis Intervention Team (CIT): Provides training for first responders to assess and compassionately and effectively assist people in mental health crisis through de-escalation, reduced use of force, and collaboration with consumers, families, the community, and other stakeholders.

Diversity Collective: Hosts weekly support groups for LGBTQ+ youth, TAY, and their allies, and promotes cultural competency and other mental health trainings to schools and agencies to raise awareness of LGBTQ+ mental health needs.

Logrando Bienestar: Helps youth and adults in the Hispanic/Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services to support productive, healthy lifestyles.

VCBH Suicide Prevention: Provides resources to advance awareness and knowledge of suicide and related topics.

2,546	individuals received core program services[†]
2,223	individuals referred to mental health care and/or social support services[†]
49,011	individuals reached through outreach events[†]

Other PEI Programs Demographics

Age§	(N=2,861)
0–15	38%
16–25	22%
26–59	34%
60+	6%
Declined to Answer: 10	

Primary Language*	(N=2,750)
English	63%
Spanish	34%
Indigenous	1%
Other	1%
Declined to Answer: 7	

Sex Assigned at Birth	(N=529)
Female	67%
Male	33%
Declined to Answer: 10	

Sexual Orientation*§	(N=514)
Bisexual	11%
Gay or Lesbian	5%
Heterosexual or Straight	72%
Queer	9%
Questioning or Unsure	1%
Another Sexual Orientation	3%
Declined to Answer: 55	

Current Gender Identity*§	(N=2,376)
Female	64%
Male	34%
Genderqueer	1%
Questioning or Unsure	<1%
Transgender	1%
Another Gender Identity	1%
Declined to Answer: 11	

Race*	(N=2,201)
Native American/Alaska Native	2%
Asian	3%
Black/African American	2%
Hispanic/Latino	32%
Native Hawaiian/Pacific Islander	1%
White/Caucasian	41%
Other	19%
More Than One	1%
Declined to Answer: 26	

Ethnicity*	(N=1,570)
Hispanic/Latino	84%
Non-Hispanic/Non-Latino	15%
More Than One Ethnicity	1%
Declined to Answer: 33	

Hispanic/Latino Ethnicities^	(N=363)
Mexican	89%
Central American	2%
Puerto Rican	2%
South American	2%
Caribbean	1%
Another Hispanic/Latino	4%

Non-Hispanic/Non-Latino Ethnicities^	(N=122)
African	7%
Cambodian	0%
Eastern European	5%
Filipino	12%
Korean	0%
Vietnamese 0% Another non-Hispanic	9%
Asian Indian/South Asian	0%
Chinese	1%
European	48%
Japanese	4%
Middle Eastern	2%
Another non-Hispanic/non-Latino	11%

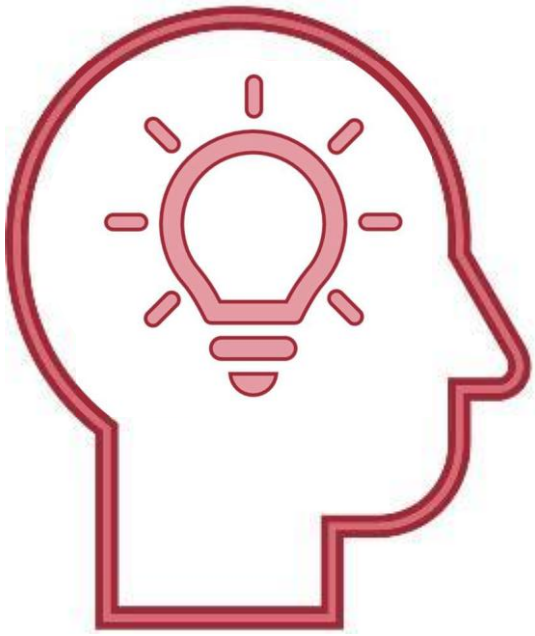
City of Residence‡	(N=396)
Camarillo	10%
Newbury Park	0%
Oxnard	59%
Santa Paula	1%
Ventura	17%
Fillmore	3%
Oak Park	0%
Piru	0%
Simi Valley	1%
Other	2%
Moorpark	2%
Ojai	1%
Port Hueneme	4%
Thousand Oaks	1%

*Percentages may add to or exceed 100% because participants could choose more than one response option.
§Assigned sex data, Age, Sexual Orientation and Current Gender Identity data was not collected from RISE.
^Percentages and counts reflect the number of individuals who selected each Hispanic/Latino or Non-Hispanic/Non-Latino Ethnicity.
‡City of residence data is not available for CIT and Logrando Bienestar.

Innovation (INN)The Mental Health Services Act (MHSA) Innovation component provides California with the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. The primary purpose of Innovation projects is to achieve at least one of the following:

- Increase access to mental health services to underserved groups, including permanent supportive housing.
- Increase the quality of mental health services, including measurable outcomes.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.
- Increase access to mental health services, including permanent supportive housing.

Innovation projects can be built to address issues faced by children, transitional age youth, adults, older adults and families (self-defined), and specific neighborhoods, tribal and other communities, counties, or regions. With the inventive nature of innovative projects, there is the potential to impact individuals across all stages and all age groups using a multitude of approaches, including multi-generational practices/approaches. Projects may also initiate, support, and expand collaboration between systems, with a focus on organizations and other practitioners not traditionally defined as a part of mental health care. The following section highlights projects that have been approved or are in process of achieving approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for Ventura County.



Highlights for Fiscal Year 2024–2025 Services

Innovation (INN) projects that were approved in Fiscal Years 2019–2020 through 2023–2024 are outlined below. Planned projects for Fiscal Year 2025–2026 have been included but are subject to change as VCBH moves through the Community Program Planning Process (CPPP).

Current Innovation Projects	Fiscal Years	Purpose	Status
Semi-Statewide Electronic Health Record (EHR) Innovation	2023–2027	California counties have joined together to envision an enterprise solution where the EHR goes far beyond its original purpose as a claiming system to a tool that helps counties manage the diverse needs of their population(s). The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system.	In process
MASH Senior Support to Reduce Homelessness	2022–2027	To provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions.	In process
Mobile Mental Health Van Project	2025–2028	To provide reliable, flexible physical and mental health care to unserved and underserved individuals in Ventura County, regardless of insurance or legal status.	In process
Learning Collaborative Healthcare Network (LCHN) Early Psychosis Project	2025–2028	Led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary, and several California counties, will bring consumer-level data to clinicians, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis.	In process
Veteran Mentorship Innovation Project	2026–2029	The Veteran Mentorship Innovation Project will focus on assisting veterans and first responders who are transitioning from service to civilian life in Ventura County through a mentorship program.	Launch date FY 25–26
Collaborative Care Model for Youth	2026–2029	The program will pilot the Collaborative Care Model and Behavioral Health Integration models to integrate care by treating both the mental and physical needs of children, adolescents and young adults to improve patient outcomes and satisfaction at a lower cost.	Launch date FY 25–26

Learning Collaborative Healthcare Network (LCHN) Early Psychosis Project

This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, will bring consumer-level data to providers' fingertips for real-time sharing with consumers, and allow programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LCHN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract outputs, and best practices.

Programming Updates

FY 24–25 was the first year of participation for Ventura County. The program has a dedicated report in the appendix that cannot be summarized here due to the complex and lengthy data.

Mobile Mental Health

Program Developments

The Mobile Mental Health program launched in November of 2024 to provide reliable, flexible physical and mental health services to unserved and underserved individuals in Ventura County, regardless of insurance or legal status. The direct and accessible approach to health care can positively affect stigma, emergency room use, and client engagement. The program is designed to deliver quality, quick, and consistent walk-in mobile mental health therapy to residents who have recently been in crisis, live in underserved areas, or identify as being part of underserved communities.

The vehicle order was placed in Fiscal Year 2021–2022 but, due to COVID-19 supply chain issues, it was not delivered until Fiscal Year 2023–2024 and was not scheduled to have the modification completed until 2024–2025. One RFP was completed in Fiscal Year 2023–2024; however, the awarded contractor declined to move forward on the award. VCBH's Critical Care and Navigation team successfully launched the program in Fiscal Year 2024–2025.

The team participated in 36 community engagement events after launch. Each event was staffed by a bilingual, bicultural clinician and an intensive services coordinator, both qualified to provide solution-focused brief interventions and wellness check-ins and/or complete requests for behavioral health service screenings. Staff also delivered education on mental health and substance use services, distributed Narcan kits and fentanyl test strips, and facilitated connections to homeless services and other community resources.

Current field-based services offered via this project include:

- Information about behavioral health services available in the community
- Onsite mental health screenings with initial appointments provided
- Mental health wellness check-ins with solution-focused outcomes
- Information about substance use services
- Completion of Brief Questionnaire for Initial Placement (BQuIP) and initial appointments provided
- Education and provision of Narcan kits and fentanyl test strips

A summary report can be found in the Appendix.

Managing Assets for Security and Health (MASH) Senior Support to Reduce Homelessness

The purpose of the Managing Assets for Security and Health (MASH) program is to provide multiple key supports for seniors at risk of homelessness. The program began on October 1, 2022, and is scheduled to end June 30, 2027. The project's goal is to provide creative case management, therapeutic, and material support to enrolled seniors at risk of losing their housing due to fiscal, cognitive, or physical restrictions. By assigning and monitoring volunteers to work with homebound seniors, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan to include essential services and concrete resources as needed. The participants will be able to explore multiple solutions to their housing situation over time, increasing the chances for success in a new placement. Trained specialty peer volunteers will be matched with homebound seniors to help identify and work with those seniors who are in jeopardy of losing their current housing.

Programming Updates

Since Fiscal Year 2022–2023, the number of adults who have enrolled and completed the initial service in MASH is 335. Most clients were White women, had private insurance (76%), and resided in Ventura (30%). A full description of demographics is included in the appendix report. Two hundred eighteen (218) individuals who completed the initial assessment had scores of five or above, meaning that they generally benefited from higher case management or education. Comparatively, 119 individuals scored less than five on the initial self-determined financial question in the BGS and were prioritized for follow-up with the next MASH assessment survey—the initial Risk and Resiliency (R&R) survey. Of these 119 eligible individuals, 48 clients completed the initial R & R survey. Reasons that eligible individuals did not complete the R&R survey included not being able to be reached by program staff or declining to complete the survey.

A total of 71 clients have been discharged from MASH. Fourteen clients completed exit R & R surveys after discharge. Almost all clients were women who identified as White. All these clients were English-speaking and nearly half indicated that they were experiencing a disability. Three of these clients completed interviews.

In interviews, clients expressed feelings of empowerment because volunteers worked with them to solve problems, rather than taking over, enabling clients to have the final say on their financial decisions. Housing Gap Assistance funds were utilized to improve clients' quality of life, with clients expressing gratitude and appreciation for both small and large purchases, from something as small as hiring a contractor to mount a client's televisions to purchasing a new mattress to replace a twenty-year-old mattress that was contributing to a client's back pain.

Further detail on these responses is outlined in the appendix report.

Semi-Statewide Electronic Health Record INN Project

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project that CalMHSA is concurrently leading (the EHR Project). In Fiscal Year 2024–2025, CalMHSA partnered with 25 counties, collectively responsible for 35% of the state's Medi-Cal members.

This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve.

The key principles of the EHR project include:

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans.
- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.
- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care—toward improving care coordination and client outcomes—are both required and supported by the State.
- **Lean and Human-Centered:** Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- **Interoperable:** Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. VCBH is reimagining the clinical workflow, allowing critical information about the clients to be formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

Programming Updates

VCBH staff have continued to participate in this project as partners. The full allocated amount of funding was expended by FY 23–24. No dollars were spent on this project in FY 24–25, though the county is actively engaging in the effort to continue to refine and build out the EHR as it is adapted to new legislation.

A full update report can be found in the Appendix.

Workforce Education and Training (WET)

The Workforce Education and Training (WET) component includes education and training programs and activities for prospective and current Public Mental Health System employees, contractors and volunteers. Refer to CCR, Title 9, Section 3810 - General Workforce Education and Training Requirements for information regarding how MHSA funds can and cannot be used to support WET programs.

Cultural Core Competencies	self-paced (approx. 2 hrs.)
Southern Counties Regional Partnership (SCRP) Core Competencies Project provides the core competencies and associated Knowledge, and Abilities (KSAs) considered to be essential performance criteria for collaborative behavioral health service providers supporting the continued excellence of the quality of care provided to individuals, family members, and stakeholders served by the SCRP counties.	

VCBH/SCRP Project	Dates	Presenter(s)
Mental Health First Aid (MHFA) for Youth	7/10/2024	Cowie, Stephanie and Arias, Claudia
Mental Health First Aid (MHFA) for Youth	9/19/2024	Arias, Claudia and Cowie, Stephanie
Mental Health First Aid (MHFA) for Adults	10/17/2024	Torres, Monica and Aguilar, Norma A.
Mental Health First Aid (MHFA) for Youth	11/6/2024	Arias, Claudia and Cowie, Stephanie
Mental Health First Aid (MHFA) for Adults	12/10/2024	Ehret, Julie and Aguilar, Norma A.
Mental Health First Aid (MHFA) for Youth	1/16/2025	Dougherty, Jennifer and Cowie, Stephanie
Mental Health First Aid (MHFA) for Adults	1/23/2025	Aguilar, Norma A. and Torres, Monica
Mental Health First Aid (MHFA) for Youth	2/19/2025	Arias, Claudia and Munoz, April M.
Mental Health First Aid (MHFA) for Adults	2/20/2025	Dougherty, Jennifer and Torres, Monica

@

Mental Health First Aid (MHFA) - County	7 hours, offered 6 times annually at minimum
Similar to how CPR training helps one assist someone in cardiac arrest, MHFA teaches how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The training gives one skills to provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	

Presenter(s)	Dates
VCBH - Cowie, Stephanie and Arias, Claudia	07/10/2024 (for youth)
VCBH - Cowie, Stephanie and Arias, Claudia	09/19/2024 (for youth)
VCBH - Torres, Monica and Aguilar, Norma A.	10/17/2024 (for adults)
VCBH - Cowie, Stephanie and Arias, Claudia	11/6/2024 (for youth)
VCBH - Ehret, Julie and Aguilar, Norma A.	12/10/2024 (for adults)
VCBH - Cowie, Stephanie and Dougherty, Jennifer	01/16/2025 (for youth)
VCBH - Torres, Monica and Aguilar, Norma A.	01/23/2025 (for adults)
VCBH - Arias, Claudia and Munoz, April M.	02/19/2025 (for youth)
VCBH - Torres, Monica and Dougherty, Jennifer	02/20/2025 (for adults)
VCBH - Torres, Monica and Munoz, April M.	03/13/2025 (for adults)
VCBH - Aguilar, Norma A. and Munoz, April M.	04/24/2025 (for adults)
VCBH - Dougherty, Jennifer and Julie Ehret	05/08/2025 (for adults)
VCBH - Arias, Claudia	05/22/2025 (for adults)
VCBH - Dougherty, Jennifer and Julie Ehret	06/30/2025 (for adults)

Real Colors	4 Hours, offered to programs annually
Real Colors® is a unique four-color personality assessment and workshop designed to be entertaining and user-friendly. The four-color personality assessment is based on the premise that you can take left-brain (linear) information, and turn it into an exciting, interactive right-brain experience. The right-brain style uses colors, pictures, and interactive activities to hook the participants. It allows participants to learn a great deal of information more quickly. They leave the four-hour workshop with tools they can use and apply to their own lives. Through right- and left-brain activities, small group interaction, and large group discussion, participants take an active role in learning. A portion of the workshop involves the participants teaching each other. This not only establishes new information for the participants but, in fact, adds to the instrument's validity.	

Location and Presenter(s)	Dates
County of Ventura - Hendrickson, Gina Rae	07/16/2024
County of Ventura - Hendrickson, Gina Rae	09/10/2024

Community Resiliency Model (CRM): Introduction	3 hours, offered bi-annually
The Community Resiliency Model® (CRM) of the Trauma Resource Institute trains clinicians and non-clinicians to not only help themselves but to share simple wellness skills with their community. The primary focus of this training is to learn simple biologically based skills, based upon current science, to help individuals and communities regain balance in body, mind, and spirit. CRM skills help individuals understand their nervous system and learn to track sensations connected to their own well-being, which CRM calls the "Resilient Zone." CRM's goal is to help create "trauma-informed" and "resiliency-informed" communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased using this skills-based approach. CRM has been used worldwide. El Modelo de Resiliencia Comunitaria (Community Resiliency Model® (CRM) del Trauma Resource Institute capacita a profesionales y no profesionales no solo para ayudarse a sí mismos sino también para compartir habilidades simples de bienestar con su comunidad. El enfoque principal de esta capacitación es aprender habilidades biológicas simples, basadas en la ciencia actual, para ayudar a las personas y comunidades a recuperar el equilibrio en cuerpo, mente y espíritu. Las habilidades de CRM ayudan a las personas a comprender su sistema nervioso y aprender a rastrear las sensaciones relacionadas con su propio bienestar, lo que CRM llama la "Zona Resiliente". El objetivo de CRM es ayudar a crear comunidades "informadas sobre el trauma" y "informadas sobre la resiliencia" que compartan una comprensión común del impacto del trauma y el estrés crónico en el sistema nervioso y cómo se puede restaurar o aumentar la resiliencia utilizando este enfoque basado en habilidades. CRM se ha utilizado en todo el mundo.	

Presenter	Dates
Joy Chudzynski PsyD	01/09/2025 (with Spanish interpretation)
Joy Chudzynski PsyD	01/09/2025 (with Spanish interpretation)

Eye Movement Desensitization and Reprocessing (EMDR)	Offered annually

Eye Movement Desensitization and Reprocessing (EMDR) Therapy is one of the most researched and utilized methods in the treatment of post-traumatic stress disorder (PTSD). Mindful Journey Center's EMDR Therapy Training Program is offered through a special license from the Institute for Creative Mindfulness with a curriculum designed by Dr. Jamie Marich. In this training, the standard EMDRIA-approved training curriculum is covered in full. The Institute for Creative Mindfulness curriculum equips you to work with real-world clinical presentations from day one, including how to handle complex and developmental trauma, addressing dissociation, and implementing EMDR into your current setting. This EMDR Therapy Training program curriculum and Mindful Journey Center are approved by the EMDR International Association. EMDR requires training.

Presenter Irene M. Rodriguez, LMHC offers the training in English and Spanish, preparing bilingual clinicians to use the model with their bilingual Spanish speaking clients.

Training included training manuals for all participants and the following training schedule:
Lecture and Practicum (Part 1 – in person/Part 2 – virtual))

- 20 hours of lecture
- 20 hours of practicum
- Consultation – 10 hours minimum

Presenter	Dates
VCBH – Mindful Journey Center, LLC	01/29/2025 through 01/31/2024 (in person)
VCBH – Mindful Journey Center, LLC	04/14/2025 through 04/16/2026 (virtual)
VCBH – Mindful Journey Center, LLC	02/11/2025 through 06/17/2025 (consultation)

Introduction to DBT Skills	Offered annually

This workshop will be an overview of the skills in Dialectical Behavior Therapy (DBT). Participants will receive a broad introduction to DBT and instruction on the format of skills teaching. Participants will also learn specific DBT skills from the Emotion Regulation, Distress Tolerance, and Interpersonal Effectiveness modules. The training will include many exercises and opportunities for practice and participation. Participants learn: the difference between comprehensive DBT and skills-only DBT, the three states of mind in DBT, three ways to reduce vulnerability to unwanted emotions, three Distract skills, and at least one way to challenge interpersonal effectiveness myths.

Location and Presenter	Dates
SCRP: Leslie Anderson Ph.D.	06/25/2024 and 06/26/2024
SCRP: Leslie Anderson Ph.D.	11/18/2024 and 11/19/2024

Suicide Prevention	6 hours, twice annually
In this workshop participants learn techniques and obtain tools for assessing suicidal risk among consumers, with cultural awareness, humility, and sensitivity. They learn crisis intervention techniques that allow them to practice to the standard of care. Evidence-based therapies for working with suicidal clients is discussed and self-care for clinicians to protect them from burnout when working with this population is also discussed. At the conclusion of the training, attendees can: identify five myths of suicide, list five theories to explain suicidal behavior, name and give an example of each of the six steps of Brown and Stanley's Safety Plan, and list three evidence-based treatments for suicide.	
Location and Presenter	**Dates**
VCBH: Estefania Elizalde, LCSW	09/30/2024
VCBH: Estefania Elizalde, LCSW	11/06/2024

Crisis Assessment	1.5 hours, offered annually at minimum
This training will review how to initiate, coordinate, and complete a crisis evaluation. This training will cover assessment considerations and review case examples. Participants will learn how to analyze and assess appropriateness of potential outcomes in crisis evaluations, such as safety planning, voluntary hospitalization, and involuntary hospitalization. Participants will be able to explain how to assess staff safety, client safety and community safety when responding to crisis evaluations. This training will cover utilization of referrals and collaboration with community partners.	
Location and Presenter	**Dates**
VCBH: Estefania Elizalde, LCSW	10/29/2024
VCBH: Estefania Elizalde, LCSW	04/16/2025

Clinical Supervision Training	6 hours, offered annually at minimum

The Therapist Development Center (TDC) partnered with the SCRP to provide the legally required biennial six-hour CE course for clinical supervisors. The TDC Clinical Supervision training uses TDC's HEART framework: Humanistic, Emotionally Aware/Ethically Aligned, Responsible, and Transformative. HEART Clinical Supervision prioritizes the ethical responsibilities of the supervisor and supervisee over the course of treatment. The ethical responsibilities of the supervisor are operationalized through a humanistic theoretical lens that emphasizes attending to the here-and-now, emerging relationships between the supervisor/supervisees, supervisees/clients, and, ultimately, their clients/environment.

This training utilizes best practices in adult learning to ensure the content is learned and integrated into participants' clinical work as supervisors.

First, participants independently review course concepts via audio-recorded lectures and handouts. Second, participants take part in a live group integration session to share and learn from each other through interactive exercises that demonstrate and practice the concepts. Finally, as part of the department's commitment to helping clinical supervisors in their challenging work, participants are offered the option to attend biweekly consultations for an additional three months to ensure they receive ongoing support as they integrate new tools into their practice. The six-hour training is divided into four hours of self-learning audio recordings and two hours of a live group integration session.

Location and Presenter(s)	Dates
SCRP: Therapist Development Center: Amanda Rowan, LCSW, Michelle Seely, LMFT and Lisa Conn-Akoni, MA, LMFT	11/01/2024 through 11/14/2024
SCRP: Therapist Development Center: Amanda Rowan, LCSW, Michelle Seely, LMFT and Lisa Conn-Akoni, MA, LMFT	02/17/2025 through 03/27/2025

Wrap Facilitator Training	Offered annually

WRAP Seminar II

This 40-hour training guides participants through the values and ethics of the Wellness Recovery Action Plan (WRAP) material through the scope of being a group facilitator. The WRAP curriculum is comprised of six sections, and is designed to help increase participants' self-awareness, personal responsibility, and knowledge of coping skills and resources to assist them in their wellness journey. WRAP has been recognized by SAMHSA as an Evidence-Based Practice since 2010, and has been found to help reduce symptoms, improve quality of life and increase feelings of hope and empowerment. Participants are provided with the necessary tools and materials to be able to able to facilitate their own WRAP Groups. Participants who complete this training receive a two-year certification as a WRAP facilitator. Participants learn the values and ethics of WRAP Group Facilitation, gain confidence in their strengths and values as a group facilitator, learn the fidelity of the group facilitation model, and receive a manual that guides facilitators through the process of facilitating the material.

Location	Dates
VCBH – Turning Point Foundation	09/16/2024 through 09/20/2024

Southern California Regional Partnership (SCRP) Retention Strategies

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

A second Southern Counties Regional Partnership (SCRP) was funded in 2021. The Partnership represents 10 counties committed to expanding Southern California's public behavioral health workforce. This fund has approximately 11 million dollars and 4 million in "matching" funds from all SCRP counties by 2024, making available 15 million dollars to spend in approximately five years.

In Fiscal Year 2024–2025, Retention Strategies Funding supported eight training opportunities and a Strategic Planning session to identify and plan for an upcoming robust FY 25–26 training schedule to meet workforce training needs as identified in grant planning, informed by ten counties' Community Mental Health Needs Assessments. FY 24–25 training in evidence-based practices (EBPs) focused on DBT skills—addressing trauma-informed treatment and the treatment of co-occurring disorders. In response to the Community Mental Health Needs Assessment, SCRP funding continued to offer Suicide Prevention training. To continue the identified need to grow the profession, in FY 24–25, SCRP also provided required training for continuing clinical supervisors.

In addition to the individual regional training, the retention strategy also includes an annual conference for 150 attendees each year that addresses strategies for the enhancement of the workforce wellness and professional growth needs.

One conference was held this fiscal year (209 total in attendance; 18 VCBH staff were invited, of which 15 attended):

Transforming the Landscape of Behavioral Health Service Delivery: March 18–19, 2025

An Opportunity for Mental Health Professionals from the Southern Counties to:

- ♦ Explore integration of new laws and practices impacting behavioral health systems
- ♦ Enhance understanding of the integration of substance use treatment into mental health care
- ♦ Develop skills in whole-person care
- ♦ Improve engagement skills with clients with complex clinical presentations

Additionally, SCRP-funded trained facilitators were able to continue to provide Mental Health First Aid (MHFA) Training. MHFA is a nationally respected evidence-based practice "skills-based training course that teaches participants to identify, understand and respond to mental health and substance use challenges." The MHSA update on the Community Mental Health Needs Assessment (CMHNA) emphasized a need for prevention and early intervention services, as well as outreach and awareness - not stigmatizing conversations and terminology, building trust to address barriers. EBP focuses on education to reduce stigma and includes education across generations and throughout the community. Training is specialized for Youth and Adults. SCRP funding from 2022–2024 allowed VCBH staff to be trained as facilitators in the model. In 2023–2024, two VCBH trainers were trained in providing the training in Spanish, supporting VCBH to offer this training in Spanish once in FY 24–25. A structure for providing Mental Health First Aid was developed in FY 23–24 and received continued support through FY 24–25.

Furthermore, the Cultural Competence module created through the SCRP-funded Core Competencies project continues to be assigned to all VCBH staff annually, enhancing staff's skills, knowledge and abilities to serve a diverse community.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The SCRP partnership creates a collaborative effort to address the needs of the CMHNA. FY 24–25 continued to provide training to address trauma, risk assessment, suicide prevention, reducing stigma, increasing access to the underserved populations and opportunities to address staff wellness. The FY 24–25 conference topics supported staff

wellness, integration of substance use treatment into behavioral health care, whole-person care and trauma treatment, with the keynote presentation by Jesse Leon, who shared his lived experience to strengthen the safety net cultural response when supporting trafficking survivors. Further, continued support to address growing professionals, an identified need in the CMHNA, through strengthening the skills of VCBH clinical supervisors through quality clinical supervision training.

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

Mental Health Services Act Workforce Education and Training (WET) programs currently include participation in the 1) Mentored Internship Program (MIP) grant for two sites and 2) Southern California Regional Partnership.

VCBH is honored to be an awardee of The Mentored Internship Program (MIP) grant for two VCBH sites over two grant cycles. The MIP grant is a "component of the California Department of Health Care Services (DHCS) Behavioral Health Workforce Development (BHWD)" efforts with a primary goal to enhance professional development that helps meet California's urgent needs for a diverse behavioral health (BH) workforce and to expand California's future BH workforce, developing ongoing partnerships between BH systems and local educational institutions. Round 2 of the MIP grant ended in December 2024.

The 2024–2025 academic year focused on creating structures and protocols to sustain the Internship Program. Educational partnerships and number of students hosted were sustained, the number of bilingual students was increased, students' onboarding protocols were improved and foundational training for students were solidified.

The Southern Counties Regional Partnership (SCRP) was funded a second time in 2021. The Partnership represents 10 counties committed to expanding Southern California's public behavioral health workforce. This fund has approximately 11 million dollars and 4 million in "matching" funds from all SCRP counties by 2024, making available 15 million dollars to spend in approximately five years.

In Fiscal Year 2024–2025, $62,000 was moved from Graduate Stipend funding to Undergraduate funding to meet the growing need to support undergraduate students in FY 24–25 and planning for FY 25–26. The FY 24–25 Pipeline Program funded:

Seven undergraduate stipends ($5,000 each) to bachelor-level undergraduate behavioral science students completing their Mental Health Associate internship.

Funds continue to be available to award 25 peer stipends at $500 each; contract with vendor was recently modified to allow flexibility in the use of this $12,500 in funding to best support VCBH peer needs, expanding the usability of these funds for peer trainings to be spent in FY 25–26.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Community Mental Health Needs Assessment (CMHNA) emphasizes the need to grow and train the behavioral health workforce. Stipends encourage students interested in a career in behavioral health work to consider a career in public service, offering them a paid opportunity to be exposed to the field while receiving quality training at VCBH, including foundational evidence-based practice training. Further, a stipend attracts bilingual Spanish students to choose VCBH as a placement. In FY 23–24, VCBH hosted four undergraduate bilingual Spanish-speaking students, each receiving either an MIP- or SCRP-funded stipend.

As more peers enter the workforce, SCRP funding will be able to be utilized to support peer-specific training needs. In addition, further supporting pipeline development, SCRP funds provided career pathway information material in FY 22–23 which continued to be distributed to local high school districts in FY 24–25. As recommended in the CMHNA, career pathway information was offered in various formats (posters, pamphlets, e-version).

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

The SCRP-funded Loan Repayment Program aims to provide financial assistance to employees in high need and hard-to-fill positions, as designated by each county. Applicants apply for the program through the HCAI centralized application and are scored by CalMHSA on an objective approach following the model of the MHLAP. The information is reviewed by each individual county to confirm eligibility. Eligibility for the program is based on individuals who are regular full-time employees, with an emphasis on selecting applicants who enhance the diversity within the public behavioral health system of care (PBHS). Recipients are required to complete a work obligation of one year and to complete an annual follow-up survey for up to three years regarding employment status and satisfaction within the PBHS. VCBH budgeted for 52 $7,500 awards.

Thirty awards were used by the end of FY 23–24, with 22 potential awardees identified for the 3rd and final cohort of awards and service agreements being sent out to each potential awardee. Awardees from the 1st cycle (FY 21–22) completed their work agreement in August 2023 and received their loan repayment award towards their educational loans. Awardees for the 2nd cycle (FY 22–23) completed their work agreement in August 2024 and funding was issued at that time towards their educational loans.

Key challenges included having many applicants such that not every applicant could receive an award, as well as a certain number of awardees not fulfilling requirements, thus continually changing the number of awards available for each cohort. Some staff left after the one-year work obligation, suggesting that a retention plan may need a longer work obligation. Further, other state funding programs with non-compete clauses had some awardees decline the award to benefit from other programs and CalMHSA, the third-party administrative entity, experienced changes in assigned staff between 2023 and 2026. These changes make reporting on this program not accurately available until all funds have been disbursed in FY 25–26. A full report will be available at that time, with approximately $390,000 spent on this workforce retention effort.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Community Mental Health Needs Assessment (CMHNA) emphasizes the importance of a quality educated and trained workforce as well as a diverse workforce. Loan Repayment is a retention effort that supports keeping staff who VCBH has invested in training for a minimum of two years. They must be past probation to qualify to apply (one year) and then, if chosen, must complete a year of service before they can accept the $7,500 award.

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH continues to be invested in workforce development efforts. In Fiscal Year (FY) 2023–2024, VCBH hosted 10 undergraduate students and 22 graduate-level students for their school-related field experience. Stipends provide financial support to graduate students completing a clinical degree while they are completing their required clinical training within the public behavioral health system. This financial incentive program has provided a valuable motivation for graduate students to encourage gaining knowledge and experience within the public behavioral health system. Ideally, through this exposure, it will inspire new graduates to continue their professional development by pursuing employment in the public behavioral health system after they have had their exposure.

MIP funding was available to support student stipends in the 2022–2023 and 2023–2024 fiscal years, ending December 2024. SCRP stipend funds supplemented stipends in 2023–2024 and 2024–2025. VCBH awarded $35,000 in MIP stipend funding to support two undergraduate students and five graduate students. SCRP stipends awarded $12,000 to four Doctoral Practicum students, $10,000 to two graduate students, and $8,000 to four graduate students (utilizing $100,000 of stipend budget) and $5,000 to seven undergraduate students (utilizing $35,000 of pipeline budget).

Key Challenges: MIP funding ended in December 2024 and SCRP stipend funds must be expended by June 20, 2025; thus, an alternate funding stream must be identified in order to keep this valuable workforce development tool.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The Community Mental Health Needs Assessment (CMHNA) emphasizes the importance of a quality educated and trained workforce as well as a diverse workforce. The Internship stipends encourage students interested in a career in behavioral health work to consider a career in public service, offering them a paid opportunity to be exposed to the field while receiving quality training at VCBH, including foundational evidence-based practice training. Further, a stipend attracts bilingual Spanish students to choose VCBH as a placement. In FY 24–25, VCBH hosted 10 graduate-level and six undergraduate bilingual Spanish-speaking students.

Include examples of notable community impact.

In FY 24–25, the Department has since hired 10 FY 23–24 interns. To date, two of the FY 24–25 interns have been hired.

Briefly report on the performance of the program during the prior fiscal year, including progress in providing services to unserved and underserved populations, with the emphasis on reducing ethnic and cultural disparities. Describe any key differences and major challenges with implementation of this program, if applicable.

VCBH WET funding enhanced the SCRP-funded training opportunities to further address training needs identified in the Community Mental Health Needs Assessment (CMHNA).

Addressing the CMHNA-identified need to expand types of treatment, VCBH offered training in the Community Resiliency Model as an alternate trauma-informed treatment. "The Community Resiliency Model (CRM)® is evidence-based and trains community members to not only help themselves but to help others within their wider social network. The primary focus of this skills-based, stabilization program is to re-set the natural balance of the nervous system. CRM's goal is to help to create "trauma-informed" and "resiliency-focused" communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased using this skills-based approach."

The CMHNA highlighted the need to provide tools to address those who experienced trauma. To supplement SCRP FY 24–25 trainings, VCBH continued to offer trauma-informed training such as the Community Resiliency Model® and invested in growing the first cohort of clinicians in one of the most researched and utilized methods in the treatment of post-traumatic stress disorder (PTSD)—Eye Movement Desensitization and Reprocessing (EMDR). WET funded 20 VCBH clinician's training and in this evidence-based practice through and EMDRIA-Approved EMDR Training for Bilingual Clinicians, making this treatment available to both English-speaking and Spanish-speaking clients.

In addition, WET funds were used to strengthen VCBH's Medi-Cal Peer Support Specialists' skillset with training to facilitate the Wellness Recovery Action Plan (WRAP) curriculum. WRAP has been recognized by SAMHSA as an Evidence-Based Practice since 2010, and has been found to help reduce symptoms, improve quality of life and increase feelings of hope and empowerment.

Crisis Assessment training was also provided to enhance annual Suicide Prevention training and strengthen service providers' skills to manage risk and meet clients' safety needs.

VCBH continues to partner with the Ventura County CEO Training Administration to bring Real Colors as a training opportunity to improve staff's wellbeing and gain a compassionate understanding of a diverse workforce and improve communication with others.

Describe how this program addresses the community issues identified during the County's Community Program Planning Process, e.g., homelessness, incarceration, serving unserved or underserved groups, etc.

The VCBH Training Plan included many training courses which addressed the needs of the CMHNA. There was an emphasis on providing quality training to the workforce focused on a variety of issues, including training which addresses underserved populations, trauma, risk assessment, reducing stigma, and strengthening skills.

Further, MHFA and Community Resiliency Model may be utilized by any facilitator, including all types of licensed certified and unlicensed professionals (including ADTS counselors) as well as peers, paraprofessionals (MHAs, CSCs), and advocates. This expands meeting the identified need to developing more non-clinical provider options and increasing the breadth of who may be helped by these practices—especially important given the survey results indicating almost one of five respondents reporting having suicidal thoughts and suicide attempts, and the prevalence of trauma, depression and anxiety identified by the focus groups.

Include examples of notable community impact.

In FY 24–25, the Department has since hired ten interns from FY 23–24. To date, two of the FY 24–25 interns have been hired.

MHFA training was provided to VCBH staff, Ventura County employees, staff at VCCCD, Oxnard and open to the Ventura County community (see table below for actual numbers)

The trauma-informed Community Resiliency Model was provided with Spanish translation and made available to VCBH staff and contracted partners.

Capital Facilities & Technological Needs (CFTN)

Project Name: Youth and Family Community Resource Center

The ground-up construction of community mental health clinics to serve youth, family and TAY individuals needing substance use or specialty mental health services, that will also offer community wellness events for the community (that include cooperative play, engagement and social skills activities, cultural activities and parent workshops), continue to advance. This facility is being developed in South Oxnard, an area identified as high need for the largely Hispanic/Latinx impoverished population, to have increased access to accessible behavioral health services. Design development is complete and plans are submitted with an estimated date to start construction now being June of 2026. There was no MHSA spending on this project in the current reporting period as it is an awarded BHCIP project, so it was fully supported with grant funds.

Project Name: East County Crisis Stabilization Unit (CSU)

This is an infrastructure project utilizing CFTN dollars to develop a Crisis Stabilization Unit (CSU) in East Ventura County in Simi Valley. Currently, this important component of the behavioral health continuum of care has only been established in West Ventura County, so this new CSU will provide East County residents experiencing behavioral health emergencies access to a facility in their neighborhood. A building which is currently owned by the county will be renovated to accommodate the operational needs of a CSU. The CSU will open with an initial four stabilization chairs, but the plans and renovation work will be done to eventually allow expansion to eight chairs. The building is located next door to the site where Ventura County has a Bond BHCIP award to develop a Psychiatric Health Facility expected to be completed in late 2028, so in the future state, there will be a synergistic relationship between the two facilities. The project has completed design development, has approved plans, and is anticipated to start construction very soon. There will be some challenges and potential delays to the construction timeline and the project could experience some cost increases due to the recently released interim LPS guidelines that are now requiring LPS designated CSU facilities to either be locked or secured with delayed egress, so design plans are now having to be updated to include a sprinkler system and fire panel in the building.

Project Name: Mental Health Rehabilitation Center (MHRC)

This is a Bond BHCIP-awarded project that will rehabilitate an existing building to be a 38-bed Mental Health Rehabilitation Center (MHRC). CFTN dollars will be utilized for the required 10% match from the county for the project. The MHRC will sit on a county-owned 54-acre campus providing a variety of housing and wellness services. It will be a locked facility serving the anticipated client population of adults stepping down from an inpatient hospital environment on conservatorship who meet criteria for specialty mental health services. Due to lack of available beds, Ventura County often has to place clients in out-of-county MHRC placements. This MHRC will bring residents back to the Ventura County and closer to home for their treatment. The project design for the building remodel is complete, the plans have been approved, and we will be moving toward the bid package for the contractor very soon.

Project Name: Fiscal Accounting Software

In order to provide timely and useful reports, Ventura County Behavioral Health (VCBH) will be seeking programming and consultation services for a customizable cloud-based, vendor-hosted product that will perform cost allocation calculations, provide systemwide reporting and produce detailed program-level, customizable reports.

Santa Paula

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MHSA Funding

County: Ventura

Date: 04/06/2026

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	82,638,637	19,971,544	12,614,666	115,723	20,501,396	0
2. Estimated New FY2025/26 Funding	43,686,487	14,312,036	2,800,000	0	0	0
3. Transfer in FY2025/26	(9,255,999)	0	0	555,999	8,700,000	0
4. Access Local Prudent Reserve for FY2024/25	0	0	0	0	0	0
5. Estimated Available Funding for FY2024/25	117,069,125	34,283,580	15,414,666	671,722	29,201,396	0
B. Estimated FY2025/26 MHSA Expenditures	56,472,370	20,002,013	3,122,311	555,999	722,072	0

C. Estimated Local Prudent Reserve Balance						
1. Estimated Local Prudent Reserve Balance on June 30, 2026		8,491,905				
2. Contributions to the Local Prudent Reserve in FY 2025/26		0				
3. Distributions from the Local Prudent Reserve in FY 2025/26		0				

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

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Full-Service Partnership (FSP) Programs

County: Ventura **04/06/2026**

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Adult						
Adult Clinic-Based FSP	533,609	319,741	200,129	0	0	13,739
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	1,118,070	758,502	325,331	0	0	34,237
VCBH FSP Treatment Program	81,536	81,536	0	0	0	0
Care Act Program	334,712	232,916	43,053	0	0	58,743
Empowering Partners through Integrative Community Services (EPICS)	1,212,559	644,877	558,493	0	0	9,188
Full-Service Partnership (FSP) Admin	51,789	51,789	0	0	0	0
VISTA	888,663	32,583	803,931	0	0	52,149
TAY						
Transitional Age Youth (TAY) Outpatient Treatment Program	405,090	232,750	161,335	0	0	11,005
Empowering Partners through Integrative Community Services (EPICS)	50,481	26,848	23,251	0	0	383
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	215,092	145,919	62,587	0	0	6,587
VISTA	13,643	500	12,342	0	0	801
Care Act Program	38,478	26,776	4,949	0	0	6,753
Casa Esperanza TAY Transitions Program (TAY FSP)	812,451	0	771,153	0	0	41,298
Adult Clinic-Based FSP	26,178	15,686	9,818	0	0	674
Full-Service Partnership (FSP) Admin	8,580	8,580	0	0	0	0
Youth and Family (Y&F) FSP	715,801	581,837	119,972	0	0	13,992
Youth						
Child Welfare Subsystem Program	3,526,646	2,852,293	654,960	0	0	19,392
Full-Service Partnership (FSP) Admin	2,064	2,064	0	0	0	0

Youth and Family (Y&F) FSP	1,272,148	1,034,063	213,218	0	0	24,866
Older Adults						
VCBH Older Adults FSP Program	1,268,905	962,710	304,945	0	0	1,250
Empowering Partners through Integrative Community Services (EPICS)	463,917	246,726	213,676	0	0	3,515
VISTA	143,980	5,279	130,252	0	0	8,449
Care Act Program	58,421	40,653	7,514	0	0	10,253
Adult Clinic-Based FSP	267,769	160,448	100,426	0	0	6,894
Full-Service Partnership (FSP) Admin	30,652	30,652	0	0	0	0
Assisted Outpatient Treatment (AOT) Program (Laura's Law)	99,496	67,498	28,951	0	0	3,047

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Non-Full-Service Partnership Programs

County: Ventura

Date: 04/06/2026

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs						
Crisis Stabilization Unit (Children)	4,033,151	3,686,543	338,258	0	0	8,350
Crisis Tracking System	14,913	14,913	0	0	0	0
ARPA - Peer Support Program	115,746	115,746	0	0	0	0
The Client Network (CN)	267,210	267,210	0	0	0	0
County-Wide Crisis Team (CT)	4,347,337	3,563,930	656,205	0	0	127,202
Youth & Family Intake Team	866,659	217,230	564,803	0	0	84,626
Rapid Integrated Support and Engagement (RISE)	2,067,606	1,539,037	153,080	0	0	375,489
Crisis Residential Treatment (CRT)	4,581,329	2,465,616	1,987,723	0	0	127,990
MCOT TAY	423,642	349,981	65,054	0	0	8,608
Fillmore Community Project	844,946	276,991	547,606	0	0	20,349
Family Access Support Team (FAST)	1,171,647	911,316	118,660	0	0	141,670
Mobile Response Team (MRT)	851,071	700,030	114,098	0	0	36,943
VCBH Adult Outpatient Treatment Program	30,161,055	9,740,563	17,253,718	0	0	3,166,774
Adult Short Term Treatment Program	2,856,717	525,235	2,172,335	0	0	159,148
Access Program (Access Line)	2,137,353	1,994,197	130,714	0	0	12,442
Transitional Age Youth (TAY) Outpatient Treatment Program	2,470,940	1,419,711	984,100	0	0	67,129
Upgrades, remodeling, expansion of current service sites	957,563	957,563	0	0	0	0
Housing	9,015,539	3,997,421	550,412	0	0	4,467,705
TAY Wellness Center	539,382	538,479	0	0	0	903
Growing Works	551,814	392,039	157,670	0	0	2,105
Wellness Everyday	193,242	193,242	0	0	0	0
Wellness and Recovery Center and Mobile Wellness	1,164,850	1,164,850	0	0	0	0

Moorpark EPSDT & O&E Services	1,232,728	750,558	482,170	0	0	0
Nate's Place Wellness and Recovery Center	69,368	69,368	0	0	0	0
Candela Group	76,305	76,305	0	0	0	0
Creativity through Music	420,752	420,752	0	0	0	0
Semillas Counseling and Wellness	235,989	235,989	0	0	0	0
Child Welfare Subsystem Program	1,175,549	950,764	218,320	0	0	6,464
Therapy Dogs	236,946	236,946	0	0	0	0
Individualized Placement and Supported Employment (IPS)	375,250	375,250	0	0	0	0
New Vehicles for CSS	825,814	825,814	0	0	0	0
Transcranial magnetic stimulation (TMS)	299,173	299,173	0	0	0	0
Communities Lifting Communities	20,307	20,307	0	0	0	0
CARE Act Program	152,422	106,066	19,606	0	0	26,750
VCBH Older Adults FSP Program	670,092	508,395	161,037	0	0	660
DSH Diversion Grant	550,000	170,753	124,662	0	0	254,586
CSS Administration	14,101,485	7,830,857	3,161,842	0	0	3,108,786
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	103,716,621	56,472,370	34,712,358	0	0	12,531,893
FSP Programs as Percent of Total	24.2%					

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Prevention and Early Intervention (PEI)

County: Ventura Date: 04/06/2026

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outreach, Referral & Engagement						
One Step a la Vez PEI	426,833	426,833	0	0	0	0
Project Esperanza	136,598	136,598	0	0	0	0
Tri County Glad	82,195	82,195	0	0	0	0
Catalyst Church	219,692	219,692	0	0	0	0
Logrando Bienestar	1,260,339	625,996	607,494	0	0	26,850
Suicide Prevention Efforts and Events	163,808	163,808	0	0	0	0
Crisis Intervention Team (CIT) Training	273,075	273,075	0	0	0	0
Primary Care Program						
Primary Care Program	388,572	388,572	0	0	0	0
Promotoras Program						
Healing the Community - (MICOP)	307,274	307,274	0	0	0	0
K-12						
K-12 Prevention	2,162,498	2,162,498	0	0	0	0
Wellness Centers Expansion K-12	5,728,959	5,728,959	0	0	0	0
PEI Programs – Early Intervention						
One Step a la Vez EIP	116,985	116,985	0	0	0	0
Ventura County Power Over Primordial Psychosis (VCPOPs)	1,411,188	86,428	994,760	0	0	330,000
Older Adults - VCAAA	34 0,797	340,797	0	0	0	0
COMPASS	1,987,335	1,552,761	325,250	0	0	109,325
VC Family Justice Center	804,009	804,009	0	0	0	0
Eye movement desensitization and reprocessing (EMDR)	230,178	230,178	0	0	0	0
Wellness Centers at Community Colleges	943,210	943,210	0	0	0	0
Prevention						
Amplify Arts Project (Girls Rock SB)	72,669	72,669	0	0	0	0
Autism Society of Ventura County	31,862	31,862	0	0	0	0
Boys and Girls Club of Greater Oxnard & Port Hueneme	29,811	29,811	0	0	0	0

Childhood Matters	44,797	44,797	0	0	0	0
De Colores Multicultural Folk Arts. Inc.	51,616	51,616	0	0	0	0
Namba Performing Arts	38,317	38,317	0	0	0	0
No Limits Theater Group, Inc.	70,716	70,716	0	0	0	0
Nyeland Promise	30,526	30,526	0	0	0	0
Two Trees Community	83,617	83,617	0	0	0	0
Ventura County Family Justice Center Foundation, Inc	62,338	62,338	0	0	0	0
Mesa (Mesa Independent Living)	10,984	10,984	0	0	0	0
Two Trees Community	83,617	83,617	0	0	0	0
MHSSA Grant-Wellness Centers K-12	566,974	122,888	0	0	0	444,086
Parent Drop-In Center	462,707	462,707	0	0	0	0
Mental Health Services for PEI	250,524	250,524	0	0	0	0
Teen Drop-In Center	276,550	276,550	0	0	0	0
Girl Scout Badge Program - Mental Health Awareness	83,117	83,117	0	0	0	0
Better in Community	134,565	134,565	0	0	0	0
MZ Independent	134,774	134,774	0	0	0	0
Idea Engineering - STAY	280,117	280,117	0	0	0	0
Stigma & Discrimination Reduction						
Oxnard Performing Arts Center Corporation	88,313	88,313	0	0	0	0
Diversity Collective	73,846	73,846	0	0	0	0
Mental Health First Aid - In Spanish	49,474	49,474	0	0	0	0
Mental Health Awareness through Arts	651,986	651,986	0	0	0	0
CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY	41,547	41,547	0	0	0	0
EVALCORP	405,817	405,817	0	0	0	0
PEI Administration	3,127,864	1,828,667	573,231	0	0	725,966
Total PEI Program Estimated Expenditures	24,138,974	20,002,013	2,500,735	0	0	1,636,227

Innovation (INN)

County: Ventura Date: 04/06/2026

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention	236,131	236,131	0	0	0	0
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-ADMIN	0	0	0	0	0	0
CAREGIVERS Homeless Prevention-M.A.S.H Senior for Homeless Prevention-EVALUATION	0	0	0	0	0	0
CMH Training Program	431,711	431,711	0	0	0	0
CMH Training Program - ADMIN	49,985	39,988	9,997	0	0	0
CMH Training Program - EVALUATION	0	0	0	0	0	0
Learning Healthcare Network (LCHN)	2,081,140	900,959	1,180,181	0	0	0
Learning Healthcare Network (LCHN) - ADMIN	240,960	192,770	48,190	0	0	0
Learning Healthcare Network (LCHN)- EVALUATION	0	0	0	0	0	0
Therapeutic Crisis Response-Mobile Mental Health Van	623,418	623,418	0	0	0	0
Therapeutic Crisis Response-Mobile Mental Health Van-ADMIN	72,181	57,745	14,436	0	0	0
Therapeutic Crisis Response-Mobile Mental Health Van-EVALUATION	0	0	0	0	0	0
Veteran Mentorship Program	200,000	200,000	0	0	0	0
Veteran Mentorship Program - ADMIN	23,157	18,525	4,631	0	0	0
Veteran Mentorship Program - EVALUATION	0	0	0	0	0	0
INN Administration	720,210	421,062	131,990	0	0	167,158
Total INN Program Estimated Expenditures	4,678,894	3,122,311	1,389,425	0	0	167,158

Workforce Education and Training (WET)

County: Ventura

Date: 04/06/2026

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
Workforce Education & Training Stipends	142,770	142,770	0	0	0	0
Residency/Internship	516,891	229,799	0	0	0	287,092
Continued Staff training	139,175	139,175	0	0	0	0
WET Administration	75,697	44,255	13,873	0	0	17,569
Total WET Program Estimated Expenditures	874,533	555,999	13,873	0	0	304,661

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Capital Facilities / Technological Needs (CFTN)

County: Ventura Date: 04/06/2026

	Fiscal Year 2025–2026					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
Youth & Family Community Resource Center	400,000	0	0	0	0	400,000
Adult Crisis Stabilization Unit - Simi Valley	300,000	300,000	0	0	0	0
Locked MHRC Unit (Lewis Rd)	400,000	100,000	0	0	0	300,000
PHF Psychiatric Health Facility	150,000	50,000	0	0	0	100,000
CFTN Administration	380,083	272,072	0	0	0	108,010
Total CFTN Program Estimated Expenditures	1,630,083	722,072	0	0	0	908,010

Public Comments

30 Day Review

The opening of the 30-day public review began April 20st, 2026, and was announced at the Behavioral Health Advisory Board meeting. The announcement was also posted to the County website and the Department's social media accounts. An email also went out to the MHSA listserv at the start of the public review. A short presentation took place to orient the attendees to the purpose of the report and the Community Program Planning Process.
The public review window closed on May18th, 2026.

Comments received electronically:

There is not enough supervised group housing for mental health consumers in Ventura County. We need more licensed homes

Public Hearing took place May 18th, 2026

Oral Comment: Previous presentation to the VCBH Behavioral Health Advisory Board on the MHSA was very thorough and contained lots of input from community members. -Chris Ridge, Ventura County Office of Education, *Director Comprehensive Health & Prevention Programs and* Ventura County Behavioral Health *Advisory Board Member (1st Vice Chair)*

Social Media

One comment noted that without execution of the draft nothing in the plan will happen.

Appendices

Moorpark

Appendix A – MHSA Summary Report of the Activities of the LHCN

Mental Health Services Act

Collaborative Statewide Early Psychosis Program Evaluation

Annual Innovation Report:

Summary Report of the Activities of the LHCN

Fiscal Year 2024-2025

Draft submitted November 5th, 2025

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Table of Contents

Background **4**

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN. 4

Executive Summary **5**

Current Project Goals **7**

1. Establish a community partner advisory committee that will meet at least every 6 months **7**

December 5th, 2024 Meeting *7*

June 5th, 2025 Meeting *9*

2. Provide results from fidelity assessments of EP programs **10**

Table I: Crosswalk of the FEPS-FS and CHRPS-FS items *13*

Summary of the Fidelity Assessment Results 14
Figure 2: Proportion of programs meeting good to high fidelity on FEPS-FS Items 15
Figure 3: Proportion of programs meeting good to high fidelity on CHRPS-FS Items 16
Figure 4: Change in FEPS-FS Scores Over Time 18
Figure 5: Change in CHRPS-FS Scores Over Time 18
Figure 6: Item-Level FEPS-FS Score Changes Over Time 19
Figure 7: Item-Level CHRPS-FS Score Changes Over Time 20

3. Complete Post-LHCN implementation questionnaires administered to program and county staff **21**

4. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs **22**

5. Submit final data analysis plan for all data **24**

Outcome Measures and Instruments *24*

Table IV. EPI-CAL Outcomes Collected in Beehive 26
Program fidelity 29

Analysis Plan *29*

Qualitative analyses 31

6. Provide report that summarizes outcomes data collected to date via Beehive, including service user-level data on outcomes of interest **31**

Background *31*

Beehive Outcomes Data Collection and Enrollment Progress to Date *32*

Preliminary Feasibility Analysis 32
LHCN Enrollment Progress 32

Preliminary Analysis of Outcomes of Interest *32*

Service user Self-Report Symptoms 32
Service user self-reported education, employment, and social activities 34
Medication Taking Behavior 35
Adverse Childhood Experiences 36

Adverse Childhood Experiences and Family Functioning 37
Adverse Childhood Experiences and Substance Use 38
Childhood Poverty 38

7. Submit report on LHCN enrollment and follow up completion rates for LHCN app in all EP programs 39

LHCN Enrollment Progress 39

Progress of data collection in all EP programs 42

8. Provide findings on cost and utilization data from multi-county integrated evaluation, identification of problems and solutions for county-level data analysis 45

EPI-CAL Revised Utilization and Cost Analysis 45

Four-County Analysis Results 46

Data and Methods 46
Results 47
Discussion 54
Future directions 55

Update for Fiscal Year 24/25: 55

9. Summary of experiences and feedback from all stakeholders, that is responsive to stakeholder feedback on draft report 55

A mixed-methods study exploring the benefits, drawbacks, and utilization of data in care: Findings from the EPI-CAL early psychosis learning health care network 55

Methods 56
Procedures: 56
Results 57
Summary of Quantitative Analysis: 61
Summary of Benefits and Drawbacks of Beehive from the Perspective of Early Psychosis Program Providers and Service Users 63

Barriers and Facilitators to the Implementation of Beehive and Measurement-Based Care in an Early Psychosis Setting 63

Background 63
Methods 64
Summary of Qualitative Findings 64
Summary 72

10. Submit a final report detailing all program- level, county-level outcomes data collected summarizing experiences and feedback from all stakeholders. 73

Discussion and Next Steps 74

Discussion 74

Next Steps 74

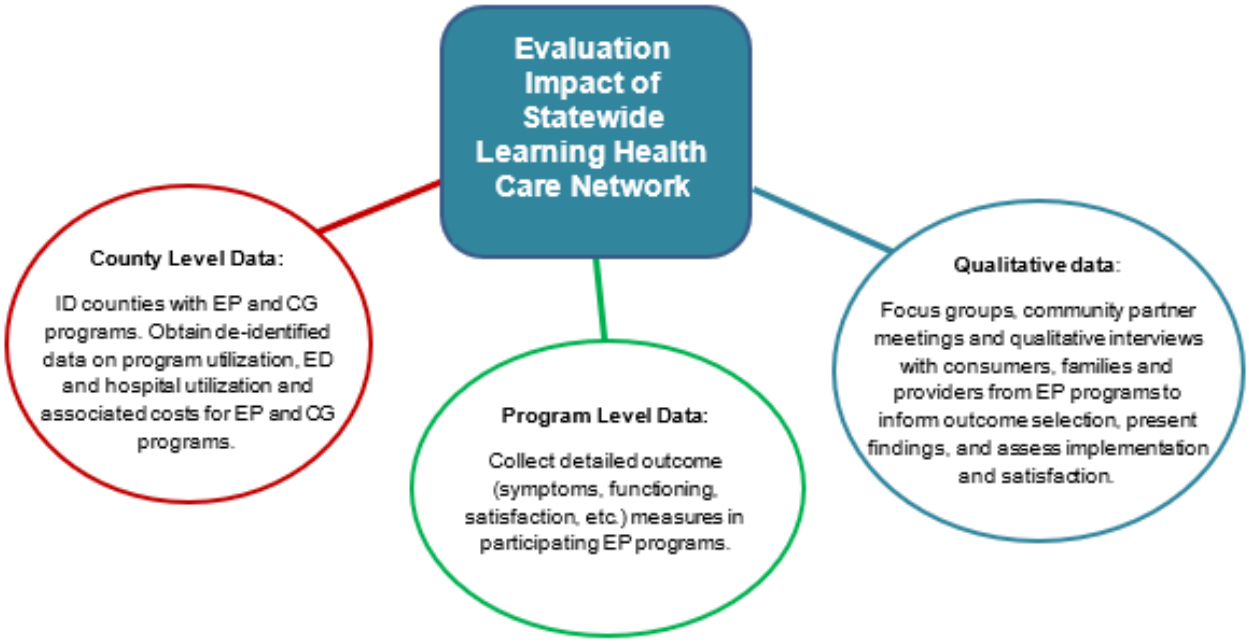
References 76

Background

Multiple California counties in collaboration with the UC Davis Behavioral Health Center of Excellence received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis: San Diego, Solano, Sonoma, Los Angeles, Orange, Stanislaus, Napa, Lake, and the Multi-County Collaborative (MCC) which includes Nevada, Mono, and Colusa Counties. One Mind has also contributed $1.5 million in funding to support the project. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, will bring consumer-level data to the providers' fingertips for real-time sharing with consumers, and allow programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design have been and continue to be shaped by the input of community partners, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018 and

included Los Angeles, Solano, Orange, and San Diego counties. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the University of California, multiple California counties, and One Mind to build a network of California early psychosis (EP) programs. We were able to leverage this initial investment to obtain additional funding from the National Institutes of Health (NIH) in 2019, which enabled six university and two county early psychosis programs to join and also linked the California network to a national network of EP programs, including UCSF PATH, UCSD CARE, UCLA Aftercare & CAPPS, Stanford Inspire, San Mateo Felton BEAM UP/(re) MIND, UC Davis EDAPT and SacEDAPT programs. Since then, we have also had additional counties join EPI-CAL, including Napa, Stanislaus, Sonoma, Lake, Nevada, Mono, and Colusa. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this report, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

The EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 24/25 fiscal year, which are summarized in the current report.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2024/2025. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned.

- We have held two LHCN Advisory Committee meetings in the last fiscal year, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and if available, service users and family members who have been or are being served by the participating programs. We will continue to hold Advisory committee meetings on a bi-annual basis and summarize meetings activities in our deliverables and annual reports.
- Since the EPI-CAL project began, we have completed assessments in 38 programs – 47 FEP and 32 CHR. Twenty eight programs provide services and were assessed for both FEP and CHR service users, 20 were assessed for FEP only, and 4 were assessed for clinical high risk service users only. Amongst programs where a full assessment could be conducted, the mean FEPS-FS score (SD) was 3.82 (0.40) out of 5. With the CHRPS, mean scores were slightly higher at 3.95 (0.52) out of 5. The proportion of assessment items meeting good to high fidelity was 68.46% (10.83) for the FEPS-FS and 70.80% (13.77) for the CHRPS.
- In the LHCN proposal, we proposed to ask service users and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive implementation in each EP program, providers completed "pre-implementation" surveys. We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. At this time, we have 80 provider-completed post-implementation survey packets completed across 14 participating EP programs that meet the criteria for post-implementation.
- As a first step to assessing the successful implementation of the LHCN in EP programs across California, we assess preliminary data on feasibility and acceptability of LHCN app in all EP programs.

To do this, we used a previously defined benchmark of enrollment of at least 70% of eligible participants and 50% of their available family members across the network as enrolled to meet our criteria as feasible and acceptable. Similar to last years' report, we compare actual enrollment against this benchmark and summarize the results in this report.

- In the current report, we describe a detailed statistical analysis plan for outcomes data collected via Beehive. This analysis has not been revised since the last annual report as our analysis plan remains largely the same.
- In the current annual report, we provide a brief summary that focuses primarily on the data collected via Beehive, including service user self-report data, data from the primary support person (PSP) for the service user, and clinician-rated data. Our team has also begun to examine descriptive summaries of specific outcomes data from all EP programs, as well as preliminary analyses examining relationships between specific outcomes. Data is only reported for those users who opted into data sharing for research purposes with UC Davis. Many of the preliminary data summarized in the section was prepared in last years' annual report and was submitted as individual deliverables to additional counties in the past fiscal year. Additionally, the data included here have also been prepared for conference abstracts for wider dissemination.
- We conducted an interim analysis of Beehive enrollment, consumer demographics, data sharing preferences, and survey completion. The observed rate of enrollment across the LHCN is 802 service users across all diagnoses, including 544 service users with a diagnosis that indicates FEP. There are an additional 455 service users who are registered by the clinic in Beehive, but who have not engaged with Beehive by completing the EULA or starting their surveys. We found that a large majority of service users (86%) opted in to sharing data for research purposes with UC Davis, and high completion rates of enrollment surveys (99% of service users have completed at least one service). We will shift our focus in the future to higher survey completion rates, especially at later time points, as we know that while most consumers have completed some self-report surveys, not many have completed the full EPI-CAL bundle of surveys for each time point.
- In the 23/24 fiscal year, we provided an updated analysis on the county-level data analysis. The results in this report present an updated analysis based on data that provided by Los Angeles, Orange, San Diego, Solano counties. This analysis was updated to integrate Solano County's data. We used administrative data to identify youth aged 12 to 25 years who (1) were enrolled in a specialized early psychosis (EP) program from January 2017 to July 2021, and (2) received a first diagnosis of psychosis within one year prior to enrollment. We identified a comparison group (CG) of youth with a first diagnosis of psychosis who received at least one outpatient service during the study period, also within one year of receiving their first diagnosis of psychosis. We summarize service use and cost for Medi-Cal covered outpatient and inpatient services over the first and second years following the first diagnosis of psychosis. We calculated the number of outpatient mental health visits and the number of inpatient psychiatric days. We also summarized the costs of outpatient and inpatient mental health services.
- As part of the EPI-CAL LHCN project, we conducted a series of qualitative interviews to explore provider and service user experiences of utilizing the Beehive platform and adopting measurement-based care in an early psychosis setting. Understanding the potential benefits and challenges to using the Beehive as part of care from the perspective of those that either deliver or receive it is critical to 1) evaluating the impact of utilizing Beehive in care, 2) understanding how Beehive may improve early psychosis care, with the goal of supporting the dissemination of positive practices across the network, and 3) Supporting efforts to refine the Beehive platform to further support positive practices from the perspective of those that delivery or receive care. Findings from these interviews have been

summarized in past reports and have been updated in the current report.

- This 23/24 and 24/25 fiscal years were the last project year for many of the counties and programs that were part of the original multi-county collaborative innovation plan and therefore our team prepared a report that summarizes the overall progress of the LHCN to date. This report included a summary of qualitative data that has been collected over the course of the project, outcomes data collected via Beehive, and a multi-county integrated analysis of cost and utilization data. The summary report was prepared in a separate document from the deliverable and was submitted to our EP program and county partners on May 12, 2024 for feedback and then again on July 1,2025 to additional programs and counties.

Current Project Goals

The current document summarizes project activities for the LHCN for fiscal year 2024/2025. This includes the following project activities:

1. Establish a stakeholder (community partner) advisory committee that will meet at least every 6 months

2. Provide results from fidelity assessments of EP programs

3. Complete post-LHCN implementation questionnaires administered to program and county staff

4. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs

5. Submit final data analysis plan for all data

6. Provide report that summarizes outcomes data collected to date via Beehive, including service user-level data on outcomes of interest

7. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

8. Provide findings on cost and utilization data from multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

9. Provide outline of experiences and feedback from all community partners

10. Submit all program level outcomes data collected and summarize experiences and feedback from all community partners

1. Establish a community partner advisory committee that will meet at least every 6 months

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is co-led by Bonnie Hotz, family advocate from Sacramento County. Recruitment for the Advisory Committee is ongoing, and we have confirmed membership with multiple community partners. These include past consumers, family members, clinic staff and providers. Even though we have already held several Advisory Committee meetings, we continue to distribute flyers to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics.

December 5th, 2024 Meeting

We held the first Advisory Committee meeting of the fiscal year on December 5th, 2024. The meeting was held remotely to allow for statewide participation. See Appendix II for a detailed agenda and Appendix III for a full list of attendees. During the meeting, we discussed recruitment and enrollment progress. Kathleen Nye gave a general overview of enrollment across the LHCN and Beehive development updates, including comparing enrollment today to the last progress report at the last Advisory Committee Meeting in June, 2024. We've seen good progress for most participating EP programs, including establishment of new programs in the LHCN. We also covered survey completion by service users in participating clinics.

The next section of the meeting was presented by Katie Sanford, who updated the group on the Lived Experience Integration (LEI) Team of EPI-CAL. The LEI team is comprised of individuals with research or clinical training or interests in addition to direct experience as mental health service users with a mission to elevate the voices of people with lived and living experience of psychosis and facilitate their substantive presence in all areas of early psychosis work in ways that transform historically disempowering narratives about mental health and treatment. The LEI team envisions a world where people with lived experience are valued, treated as equals, and where our voices directly and meaningfully guide psychosis care, research, and public perception. Katie shared details of the Lived Experience Advisory council progress to date, materials being review for EPI-CAL, activities of the advisory council, and a new team member joining as staff. Katie also described the LEI team's discord that is a peer-moderated online support and resource sharing community open to all individuals with lived and living experience with psychosis, their loved ones, and peer support specialists working with individuals with lived and living experience of psychosis.

Dr. Rachel Loewy then gave an update on the Duration of Untreated Psychosis (DUP) project, including a refresher on the goal of creating and using a DUP form in clinical practice. To date, there are 34 participants enrolled across 10 participating clinics and our goal is to reach 80 total participants by Fall 2025. Dr. Loewy then covered some recent changes to incentives and procedures when using the DUP form, and concluded by asking interested parties to reach out if they are interested in using the DUP form in their clinic.

Sabrina Ereshefsky and Gina Gemignani then presented results from recently submitted manuscript that summarized benefits, drawbacks, and utilization of data in EPI-CAL. This presentation first summarized barriers and facilitator interviews that examined the benefits and drawbacks of adopting an measurement-based care approach, i.e. Beehive, from the perspective of those who deliver and receive early psychosis care. Dr. Gemignani first reviewed the benefits to using Beehive in care that that program providers and service users described, including mitigate risks via an alert system, supporting the clinical assessment process, supporting ongoing care, supporting service user reflection of experiences, and finally supporting a person-centered approach to care. Barriers or drawbacks to using Beehive in care were also described, including reduction of time for care to administer surveys, can negatively impact rapport, and finally that survey content can be triggering or distressing. Then Dr. Ereshefsky reviewed quantitative data regarding the use of the Beehive safety alerts system, including how long on average it took for providers to resolve alerts in the system. Providers responded promptly (n = 338, 97% of alerts resolved: median ~ 2 days). She then review how often Beehive is used in care, and presented that of 596 eligible enrolled service users, 441 (74%) completed at least one key survey in Beehive. Of these, 142 (32%) had their data reviewed by their assigned provider, with most providers prioritizing symptom data. These results provide multiple avenues for improvement on the use of data in care.

Lastly, we ended the meeting with a discussion led by Dr. Tara Niendam about plans to apply for the EPINET P01, a new grant opportunity due in February of 2025. This will be a new type of grant – P01 – that requires an Administrative Core and two research projects. The administrative core and overall project will support engagement with LEI, DEIA, and an Executive Committee of participating clinical sites and will continue

supporting data submission to a National Data Coordinating Center. The first research project plan was presented by Dr. Mark Savill and will focus on using data from Beehive and input from service users and providers we will iteratively co-design a feedback report that service users will receive once they enter their Beehive data, with a plan to train providers and team leadership to integrate the reports into care. The second project, presented by Dr. Rachel Loewy, will focus on developing services intervention to improve use of data in care during shared decision-making through implementation of report developed in Project 1. We concluded the meeting with time for questions about the new research proposal.

A recording of the meeting and a copy of the slides was distributed to all meeting attendees for their reference.

June 5th, 2025 Meeting

We held the second recent Advisory Committee meeting of the fiscal year on June 5th, 2025. The meeting was held remotely to allow for statewide participation. During the meeting, we discussed recruitment and enrollment progress. Kathleen Burch gave a general overview of enrollment across the LHCN and Beehive development updates, including comparing enrollment today to the last progress report at the last Advisory Committee Meeting in December 2024. We've seen good progress for most participating EP programs, including the establishment of new programs in the LHCN. We also covered survey completion by service users in participating clinics.

The next section of the meeting was presented by Katie Sanford, who updated the group on the Lived Experience Integration (LEI) Team of EPI-CAL. The LEI team is comprised of individuals with research or clinical training or interests in addition to direct experience as mental health service users with a mission to elevate the voices of people with lived and living experience of psychosis and facilitate their substantive presence in all areas of early psychosis work in ways that transform historically disempowering narratives about mental health and treatment. The LEI team envisions a world where people with lived experience are valued, treated as equals, and where our voices directly and meaningfully guide psychosis care, research, and public perception. Katie shared details of the Lived Experience Advisory council progress to date, materials being reviewed for EPI-CAL, activities of the advisory council, and a new team member joining as staff. Katie also shared that five members with lived experience are halfway through their two-year term and two more members will join this summer to advise EPI-CAL projects. The LEI team is still seeking new council members.

Dr. Karina Muro and Sophie McMullen then presented on "Exploring Mental Health Data Sharing Practices and Perspectives among Latine Spanish speaking Community Partners." Currently, little is known about Latine preferences for data sharing, and exploring this topic will help increase participation rates and enable providers to support these populations in an equitable way. This work included three exploratory qualitative focus groups with providers, service users, and support persons to explore beliefs and preferences among Latine communities. Clinical implications are that provider approach is crucial for facilitating trust, a finding that is consistent with cultural values among Latine populations. Research implications suggest that mental health stigma and perceived trust in technology need to be addressed. Going forward, Dr. Muro and Sophie hope to adjust forms to match a 6th grade or elementary school reading level and allot more quality time to check for understanding among limited English proficiency populations.

Dr. Rachel Loewy then shared about "Utilization and Cost for Mental Health Services for Early Psychosis in CA," which included data collected from Los Angeles, San Diego, Orange, and Solano counties regarding FEP service users only (not CHR users). The results are that youth enrolled in EP programs had higher outpatient service use and costs than a comparable of youth who were receiving services in standard outpatient service programs. Also, youth enrolled in EP programs had less psychiatric inpatient use than a comparable group of youth receiving services in standard outpatient programs. An additional finding is that total costs, including

costs relating to crisis services, were not significantly different between the two groups. Further steps would involve incorporating more counties and examining more subsets of groups.

The next part of the meeting, led by Dr. Stephania Hayes, focused on "Understanding EP Care Needs Across California: Insights from Statewide Data." Emergency department records, Medi-Cal eligibility, and utilization data were implemented to assess needs and services at a state level. The aforementioned items were used because about 70,000 individuals go to the ER for psychosis-related issues as their primary diagnosis. Dr. Hayes is working on descriptive analyses about annual reports of emergency room use for psychosis, trends, and updated incidence estimates using public insurance. Clinics can then use this information for staffing decisions, fidelity evaluation support, and planning outreach and engagement. Dr. Hayes will discuss with clinics to address more gaps in the data, such as first visits to the emergency room compared to psychiatric hospitals. Dr. Hayes is also interested in exploring the data in more depth, such as examining by zip code rather than by county.

Lastly, we ended the meeting with Dr. Tara Niendam discussing the new Center of Excellence (COE) for Coordinated Specialty Care (CSC) updates. EPI-CAL is the COE for CSC starting July 1, 2025. Training, fidelity, and outcome data collection will be provided. EPI-CAL plans to engage with counties and programs once the introductory webinars are complete. Dr. Niendam will reach out to commercial insurance market providers soon.

A recording of the meeting and a copy of the slides was distributed to all meeting attendees for their reference.

2. Provide results from fidelity assessments of EP programs

This section includes preliminary findings from the fidelity assessments conducted across the LHCN. These include programs that are not currently in the LHCN but have received a fidelity assessment from our team through their participation in EPI-CAL.

Fidelity assessments serve many purposes both for the LHCN and EPI-CAL. Fidelity assessments can support quality improvement activities, highlighting individual areas of strength and areas for improvement. Second, it can enable individual clinics to review how their program compares to validated international standards and other programs across the state. Third, the information collected can be vital for county leadership and other key community partners to understand exactly what is being delivered by programs in a concrete, standardized format. Fourth, when combined with systematic data collection of service user outcomes across multiple programs, fidelity assessments can be used to assess how variation in service delivery may impact service user outcomes. Available data on which service components lead to specific outcomes could be used to advance the field of early psychosis care and to advocate for potential changes in program funding and structure. For newer and developing clinics, fidelity assessments can be used as a metric to track clinics' progress as they work to build their program.

In the fidelity assessments, the First-Episode Psychosis Services – Fidelity Scale (FEPS-FS)(Addington, 2021) is used to assess adherence to current best practice guidelines for early psychosis care. However, many programs within EPI-CAL also serve individuals experiencing clinical high risk for psychosis (CHR), in addition to people with a first episode psychosis (FEP), with significant overlap in the range of services offered to both groups. To allow for an evaluation of these differing practices, in addition to using the FEPS-FS to measure FEP care, in collaboration with the author of the FEPS-FS we have developed a new tool to evaluate CHR care, called the Clinical High Risk for Psychosis Services –Fidelity Scale (CHRPS-FS) (Savill et al., *in press*). A summary of each tool is provided below.

The First Episode Psychosis Services – Fidelity Scale (FEPS-FS)

The FEPS-FS(Addington, 2021) is a widely used fidelity measure of team-based early psychosis care(Durbin et al., 2019; Meneghelli et al., 2023),(Durbin et al. 2019; Meneghelli et al. 2023; Tomaskova et al. 2023) and is reliable for use in remote assessments(Addington, Noel, Landers, & Bond, 2020). The most recent iteration (version 1.1) assesses 36 different components. Each item assesses a different domain of early psychosis care, including team model and function, population-level interventions and service access, pharmacotherapy, psychosocial therapies, and service user and program assessment and monitoring. All items are rated on a behaviorally anchored 5-point scale, with a score of 4 or 5 considered good-to-high fidelity.

FEPS-FS fidelity scores are typically determined based on three data sources: staff interviews, program-level administrative data, and de-identified data abstracted from chart records. The chart record review is completed using three distinct samples: Chart Review Sample 1) a randomized sample of 10 existing FEP service users enrolled in the program for at least one year; Chart Review Sample 2) the last 10 service users discharged from the program; and Chart Review Sample 3) the last five service users admitted to a psychiatric hospital.

The Clinical High Risk for Psychosis Services – Fidelity Scale (CHRPS-FS)

The CHRPS-FS was developed using a three-step development, measurement, and validation process (see Savill et al., 2024). The final version of the scale includes 33 items, including 28 items identical to the FEPS-FS, two items the same but with modified rating criteria, and three items that are unique to the CHRPS-FS. A crosswalk of the FEPS-FS and CHRPS-FS are presented in Table I.

Fidelity Assessments for Small and New Programs

In addition to developing new tools to capture the full range of care provided by EPI-CAL EP programs, during the implementation of the fidelity assessments, it became evident that many new and small programs did not have a sufficient program census to complete the assessments in the standard format. For example, in a standard fidelity assessment, the health record review typically requires data from a minimum of five service users (and ideally, 10), who have been in the program for at least one year. However, of the first 23 FEPS-FS assessments completed across EPI-CAL, seven (30.4%) could not meet this requirement. To address this challenge, in collaboration with Dr. Addington, the Fidelity Team has developed additional assessment approaches to accommodate small and new programs.

I. Standard Fidelity Assessments

In standard assessments, the chart record review typically includes a randomized sample of 10 existing FEP service users enrolled in the program for at least one year; the last 10 service users discharged from the program; and the last 5 service users admitted to a psychiatric hospital.

In cases where the program did not have at least 10 current FEP service users enrolled for one year, standard FEPS-FS assessments are still conducted so long as at least 5 service users meet criteria. In items assessed on the proportion of individuals that receive a particular service using chart data, the denominator used is the total number of cases included in the review.

II. Formative Assessments for New Programs

Formative fidelity for new programs is for services that have a sufficient census of service users in treatment (i.e., ≥5), but have not been open long enough for a sufficient proportion to have received care for ≥1 years. To meet eligibility, the program must have been open and serving service users for <2 years and have 5+ active service users who have received services for 6+ months.

In formative assessments, the criterion for service users to be eligible for the chart review is reduced to six months. Items that measure care typically delivered during the intake stage are scored following

standard FEPS-FS assessment rules. For Items scored based on the volume of care provided over 12 months, the number of sessions required to meet the threshold are reduced by 50%. The item focusing on the volume of targeted outreach delivered is pro-rated for the duration the program has been open if this is less than 12 months. Finally, the annual comprehensive assessment item is not typically scored.

III. Formative Assessments for Small Programs

Formative assessments for small programs are for services that have an insufficient service user census of service users to conduct a review of care delivery. In formative assessments for small programs, administrative data collection and interviews are conducted and items scored primarily on these data are scored normally. Items scored from the chart review concerning care provided over time are not typically scored. If the program has 5+ active service users enrolled, then a chart review concerning the initial stages of care is completed following standard assessment rules. If the program does not have five active service users at the point of assessment these items are not scored. Items concerning care planning and contact after inpatient discharge are scored normally, assuming 5+ service users meet the criteria for chart review.

Table I: Crosswalk of the FEPS-FS and CHRPS-FS items

Component	Where Item is Used	Basis of Rating
1. Practicing Team Leader	FEPS-FS and CHRPS-FS	Team leader provision of clinical care, and administrative and clinical supervision.
2. Patient-to-Provider Ratio	FEPS-FS and CHRPS-FS	Target ratio of active service users to provider team.
3. Services Delivered by Team	FEPS-FS and CHRPS-FS	Presence of key components of the team-based approach to psychosis care.
4. Assigned Case Manager	FEPS-FS and CHRPS-FS	The proportion of service users that have an assigned case manager.
5. Prescriber Caseload	FEPS-FS and CHRPS-FS	Target ratio of active service users to prescriber team.
6. Prescriber Role on Team	FEPS-FS and CHRPS-FS	Degree of integration of the prescriber with the team.
7. Team Meetings	FEPS-FS and CHRPS-FS	Frequency and content of multi-disciplinary team meetings.
8. Diagnostic Admission Criteria	FEPS-FS and CHRPS-FS, with different rating criteria	Programs are mandated to serve service users with psychosis spectrum disorders, and proportions that meet these criteria.
9. Population Served	FEPS-FS only	% of the population served within a specified catchment area.
10. Age Range	FEPS-FS only	The degree to which the program serves the entire age spectrum from 14-65.
11. Duration of Program	FEPS-FS and CHRPS-FS	Duration the service is formally available to service users.
12. Targeted Outreach	FEPS-FS and CHRPS-FS	The frequency and range of outreach to community services the program conducts.
13. Early Intervention	FEPS-FS only	% of service users that receive inpatient care before program admission.
14. Identification of Outcome Targets	CHRPS-FS only*	% of service users that have secondary diagnostic targets for treatment following assessment.
15. Timely Contact Following Referral	FEPS-FS and CHRPS-FS	% of service users seen within 2 weeks of referral.
16. Family Involvement in Assessments	FEPS-FS and CHRPS-FS	% of families seen during initial patient assessment.
17. Stepped Care Approach	CHRPS-FS only†	The degree to which the program implements a stepped-care approach to service delivery.
18. Clinical Assessment	FEPS-FS and CHRPS-FS	% of clinical assessments that include multiple key assessment components.
19. Psychosocial Needs Assessment	FEPS-FS and CHRPS-FS	% of psychosocial needs assessments that include multiple key assessment components.
20. Clinical Care Planning	FEPS-FS and CHRPS-FS	% of service users that have documented treatment plan that the service user has signed off on.
21. Antipsychotic Medication	FEPS-FS and CHRPS-FS, with different rating criteria	% of service users receiving antipsychotic medication.
22. Antipsychotic Dosing	FEPS-FS only	% of cases where antipsychotic dosing is within government-approved guidelines.
23. Antidepressant Medication	CHRPS-FS only*	% of service users who are prescribed antidepressant medication.
24. Clozapine Administration	FEPS-FS only	% of the program cohort that are prescribed clozapine.
25. Patient Psychoeducation	FEPS-FS and CHRPS-FS	% of service users who receive ≥6 sessions of psychoeducation within 12 months.

26. Family Education and Support	FEPS-FS and CHRPS-FS	% of families receiving ≥8 sessions of family services within 12 months.
27. Cognitive Behavioral Therapy (CBT)	FEPS-FS and CHRPS-FS	% of service users that receive ≥10 sessions of CBT within 12 months.
28. Supporting Health	FEPS-FS and CHRPS-FS	The degree to which the program supports the service user's physical health.
29. Annual Assessment	FEPS-FS and CHRPS-FS	% of service users that receive a comprehensive annual assessment
30. Substance Use Disorder Services	FEPS-FS and CHRPS-FS	Range of substance use disorder services provided to service users in need.
31. Support Employment (SE)	FEPS-FS and CHRPS-FS	Presence of key SE service components.
32. Supported Education (SEd)	FEPS-FS and CHRPS-FS	Presence of key SEd service components.
33. Service user Engagement in Community	FEPS-FS and CHRPS-FS	% of time spent engaging with service users out in the community.
34. Patient Retention	FEPS-FS and CHRPS-FS	Ratio of service users who discontinue services within the first year, to the current census.
35. Crisis Intervention Services	FEPS-FS and CHRPS-FS	Presence of key crisis care components
36. Contact After Inpatient Discharge	FEPS-FS only	% of service users seen within 2 weeks of discharge from an inpatient unit.
37. Assuring Fidelity	FEPS-FS and CHRPS-FS	The program monitors quality using a published fidelity scale or quality indicators.
38. Peer Specialist	FEPS-FS and CHRPS-FS	Presence of key peer support specialist components.
39. Care Transitions	FEPS-FS and CHRPS-FS	% of discharged service users that have a documented discharge plan.

The Caveats and Limitations to Consider When Reviewing Fidelity Assessments

While the fidelity assessments can provide multiple benefits to service improvement efforts, it is important to note that they come with multiple caveats:

1. The field of early psychosis is a rapidly developing one, with evidence-based practices and recommendations evolving over time.
2. While there is good evidence for coordinated specialty care leading to improved outcomes in early psychosis (i.e., Guo et al., 2010; Kane et al., 2016; Secher et al., 2015), understanding what the necessary specific components of coordinated specialty care are that leads to these improved outcomes, and how they should be optimally delivered, is in many cases still a matter of debate.
3. The measure selected for use across the EPI-CAL network (the FEPS-FS v1.1), is one of multiple that exist. The FEPS-FS was selected due to the fact the tool is currently one of the most extensively used and validated in the field (Addington et al., 2020; Durbin et al., 2019)
4. The FEPS-FS has been developed as an international standard, and so the tool has been designed to work across different systems of care. This may make high scores on some items much harder to achieve in the US due to the current structure of behavioral health service provision across the country.
5. The ratings and the feasibility of meeting high-fidelity scores may vary widely depending upon the context in which the program is delivered. The FEPS-FS may include items where a high-fidelity score may be constrained by state, local, or insurance coverage decisions outside of the control of the specific program.

Summary of the Fidelity Assessment Results

To date, we have completed assessments in 38 programs – 47 FEP and 32 CHR. 28 programs provide

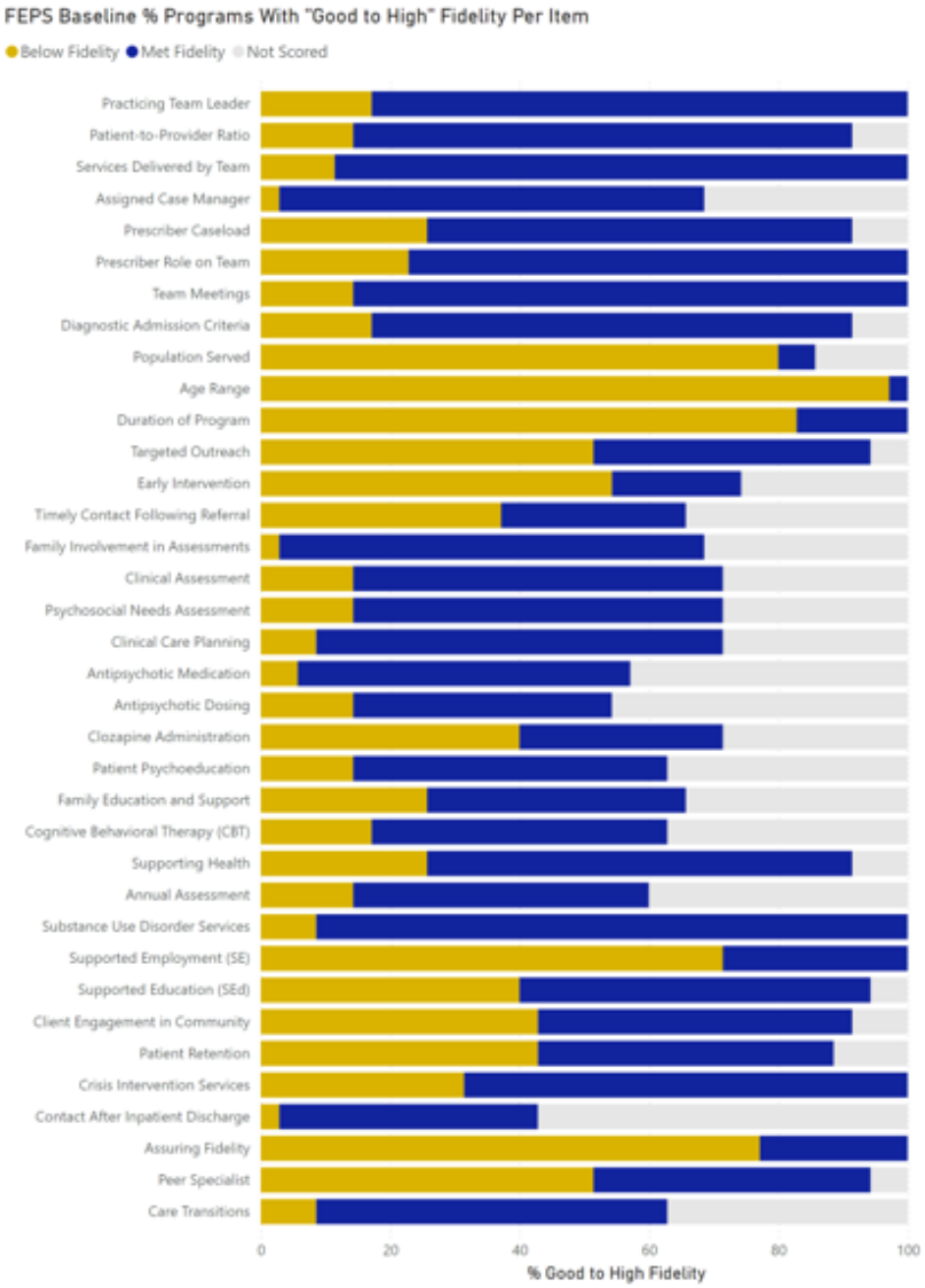
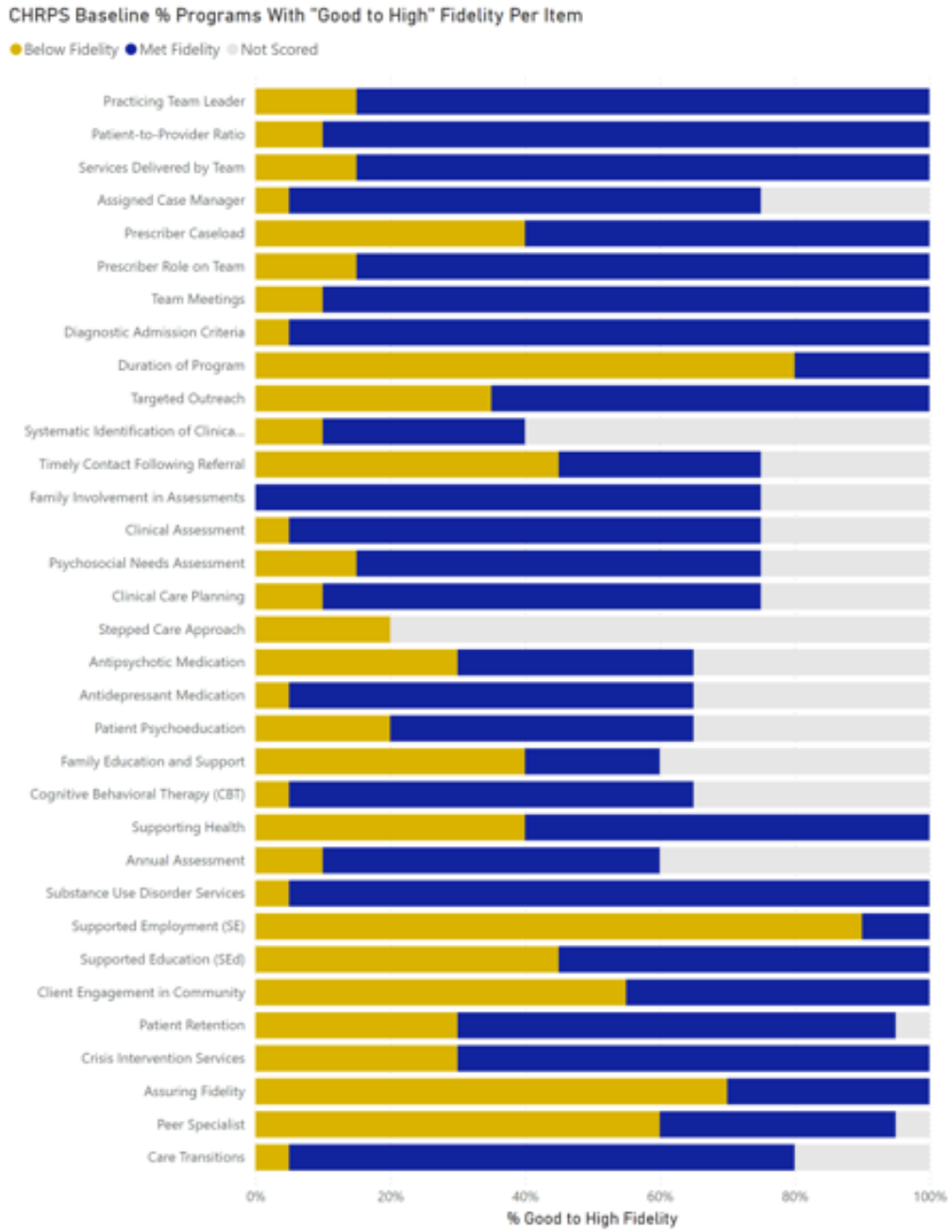


Figure 3: Proportion of programs meeting good to high fidelity on CHRPS-FS Items

services and were assessed for both FEP and CHR service users, 20 were assessed for FEP only, and 4 were assessed for clinical high-risk service users only (see Table II for details). For both FEPS-FS and CHRPS-FS, the full assessment was possible in the majority of programs (48.94% and 56.25% respectively). Amongst those where a full assessment could be conducted, the mean FEPS-FS score (SD) was 3.82 (0.40) out of 5. With the CHRPS, mean scores were slightly higher at 3.95 (0.52) out of 5. Figure 2 and Figure 3 show a



Follow Up Fidelity Assessment Findings

Across EPI-CAL, programs complete fidelity assessments every 24 months. As of 10/27/2025, 13 programs have completed a follow-up FEPS-FS assessment, and 10 completed a CHRPS-FS. The findings are presented in Figures 4 and 5.

At the baseline assessment, programs achieved a mean FEPS-FS score of 3.69 and a mean CHRPS-FS score of 3.85. After 24 months, the FEPS-FS mean score significantly increased to 3.96, and the CHRPS-FS to 4.20. At the baseline assessment, 3 programs achieved a mean score of ≥4 (25%) with the FEPS-FS. At the follow-up assessment, this increased to 7 programs that met this threshold (53.8%) for the FEPS-FS. This is

noteworthy, given that a mean FEPS-FS score of ≥4 is typically used as the threshold to identify programs delivering care at good-to-high fidelity to the EP best practices(Addington et al. 2016).

The reason for the improvement detected is currently unclear, but may be attributable to at least three distinct mechanisms, including 1) the programs individual efforts to improve care delivery over time, 2) the receipt of regular training and technical assistance provided to California EP programs by EPI-CAL, and/or 3) the positive impact of the fidelity assessments themselves, that have been found to increase adherence to best practice care(Williams et al. 2021).

A summary of what items programs were found to have improved over time is presented in Figure 5. Across the 36 items of the FEPS-FS, the largest increase in fidelity was related to improved fidelity assessment of their programs. However, improvements in scores over time were identified in almost all FEPS-FS items assessed (29 of 36 items, 85.6%).

Figure 4: Change in FEPS-FS Scores Over Time

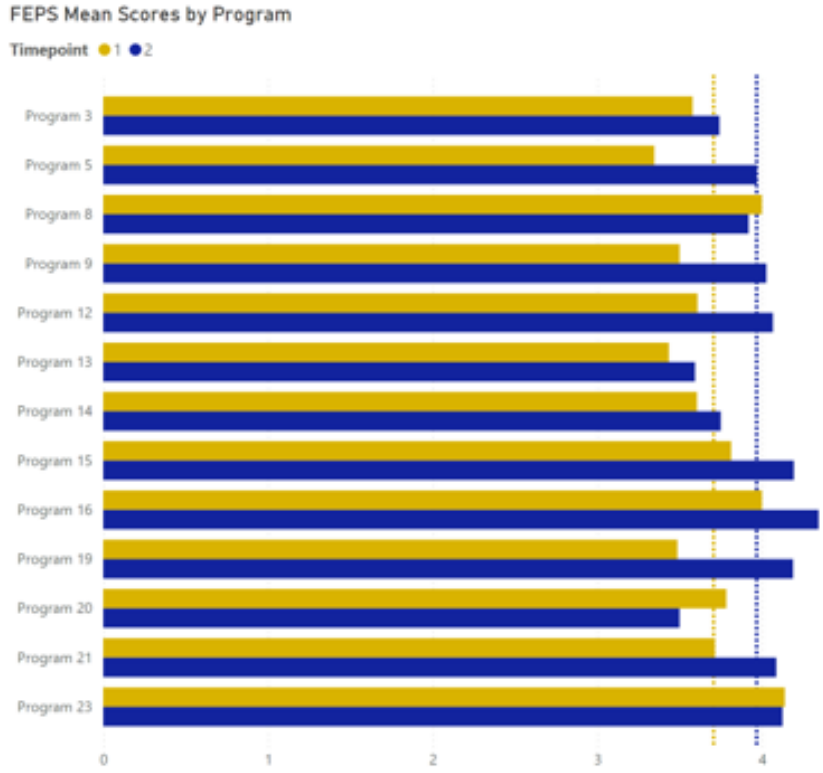


Figure 5: Change in CHRPS-FS Scores Over Time

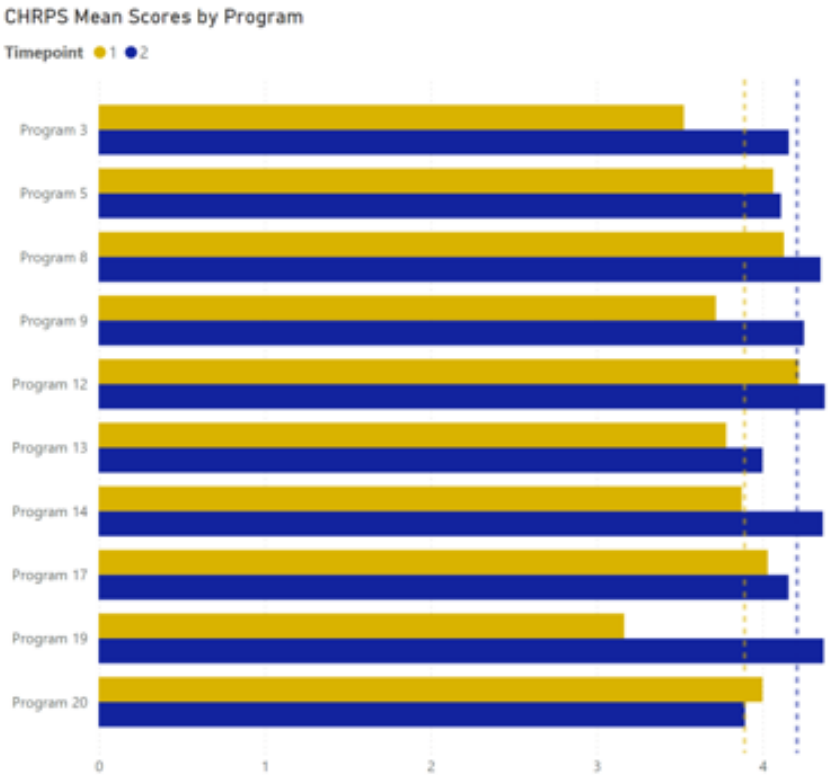


Figure 6: Item-Level FEPS-FS Score Changes Over Time

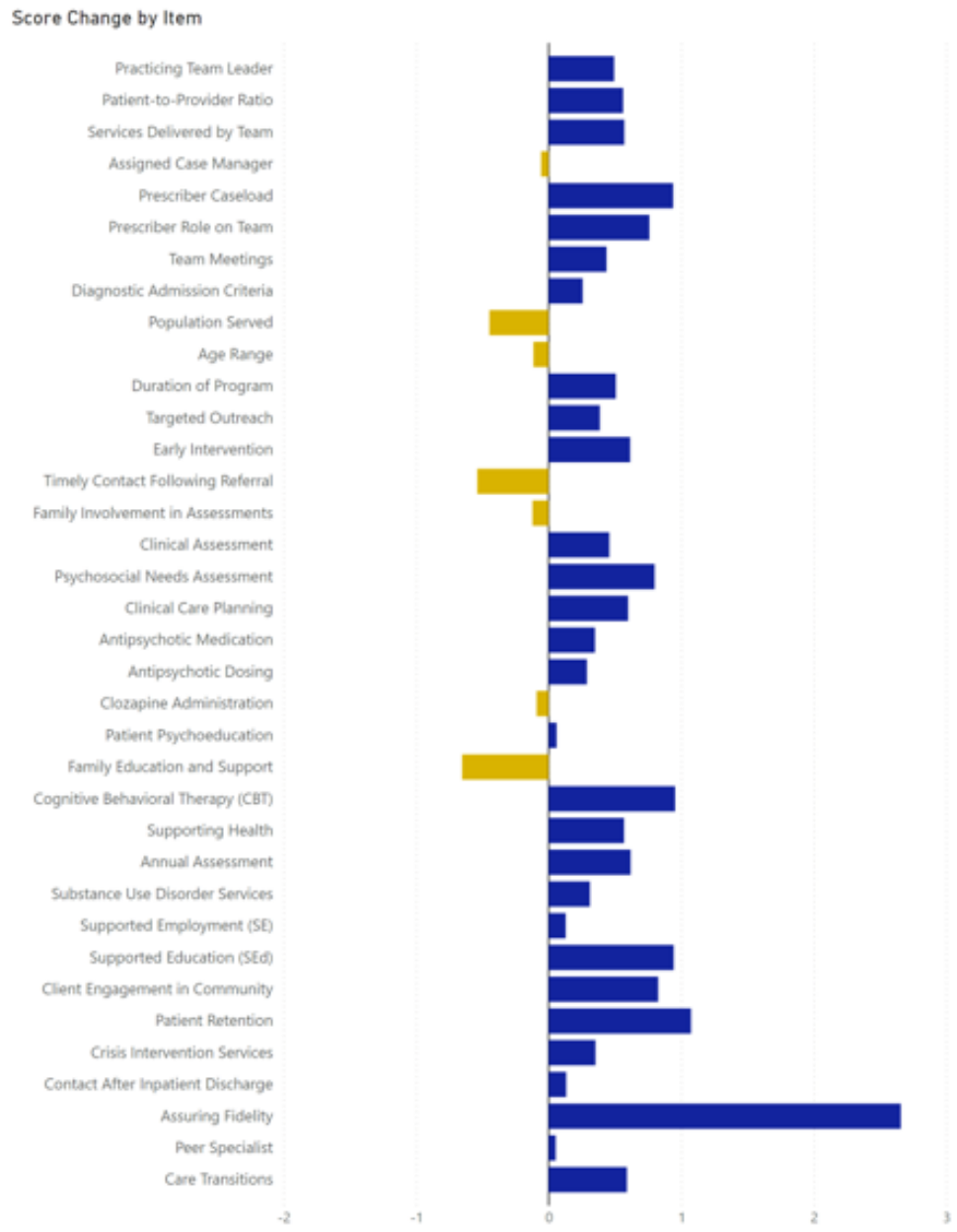
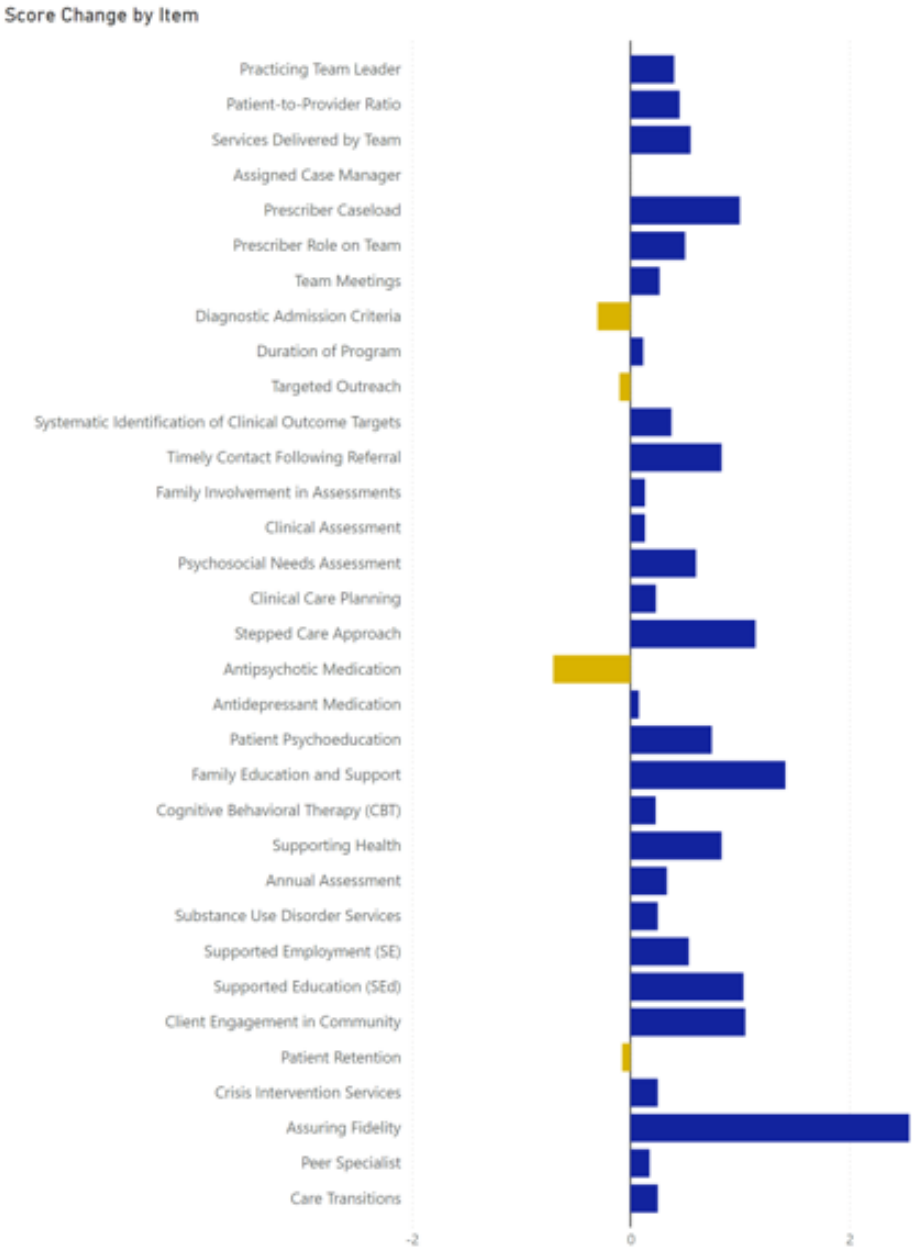


Figure 7: Item-Level CHRPS-FS Score Changes Over Time



3. Complete Post-LHCN implementation questionnaires administered to program and county staff

In the LHCN proposal, we proposed to ask service users and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive

implementation in each EP program, providers completed "pre-implementation" surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and completed questionnaires on their Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. Service users are also asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. Beehive training materials were implemented consistently across participating EP program, highlighting the utility of data to identify treatment goals and metrics of improvement during treatment planning, and provided guidance on service user-centered ways to review data to monitor progress during treatment.

We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. At this time, we have 80 provider-completed post-implementation survey packets completed across 14 participating EP programs (Kickstart, IMCES, The Help Group, San Fernando Valley Community Mental Health Clinic, The Whole Child, Aldea Solano SOAR, Aldea Sonoma SOAR, Aldea Napa SOAR, EDAPT, SacEDAPT, UCD MCC, UCSD CARE, Felton reMIND San Mateo, and Stanislaus LIFE Path). These programs were amongst the earlier programs to be trained to use Beehive in their program in the LHCN. We are continuing to recruit providers and service users from EP programs to complete these surveys once sufficient time has passed from initial Beehive implementation. These data will be used in analyses to assess changes in these variables prior to implementation of Beehive compared to after use of Beehive with service users in EP programs.

Additionally, our post-implementation analysis will include provider-rated "use of data in care" questions, which are intermittently presented to providers while they are reviewing a service user's data page in Beehive so that they may indicate 1) if the data was reviewed during a session with the service user or family and, if yes, 2) how the data was used as part of care, such as "followed up by phone" or "scheduled follow up appointment," or "no action taken." These data use metrics allow analysis on rates of adoption and level of implementation of Beehive. Exploratory analysis will examine clinician expertise and training needed to effectively implement clinician review of service user outcome data using Beehive at 80% of available time points.

4. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs

One of our primary metrics to evaluate the feasibility and acceptability of the Beehive application in EP programs it to examine isprograms is to examine whether we achieved adequate enrollment in Beehive. We examined this using a previously defined benchmark of enrollment of at least 70% of eligible participants, who are representative of the target population based on current program demographics, and 50% of their available family members, across the network were enrolled. To approximate the number of total service users eligible for enrollment, we have asked the programs to provide us with their current total census number. This was compared to service users currently enrolled in Beehive, and not including service users who have been discharged from Beehive. Service users must have completed their EULA to be considered enrolled. For the purposes of the preliminary analysis, we are only considering individuals who have agreed to share data with UCD as "enrolled", but service users can decline this option and still use their data within their program for clinical purposes. Data on of the number of available family members is available in Beehive and we are able to assess whether a primary support person (PSP) has completed enrollment. Just like service users, primary support persons are not considered enrolled unless they have agreed to share data with UCD. Service users and support persons can make different choices regarding their data sharing permissions, i.e., a service user

can decline to share their data for research purposes while a support person can opt in. For the purpose of the preliminary feasibility analysis, we are only examining what proportion of enrolled service users also have an enrolled PSP, acknowledging that there may be more enrolled PSPs whose corresponding service user opted out of data sharing. Programs who had not begun enrollment are not included in this analysis.

Table III: Preliminary service user and PSP Beehive enrollment

Program Name	Current Census	% FEP	Currently Enrolled	% Enrolled	Enrolled FEP	Service users with an enrolled PSP	% with a Primary Support Person
UCD SacEDAPT	51	90%	53	104%	45	31	58%
UCD EDAPT	63	60%	48	76%	42	35	73%
Solano SOAR	14	64%	7	50%	5	3	60%
Napa SOAR	11	63%	8	73%	3	3	38%
Sonoma SOAR	21	71%	21	100%	16	8	38%
LAC-IMCES 3	11	40%	11	100%	8	5	45%
LAC - IMCES 4	23	30%	21	91%	12	3	14%
LAC - SFVCMHC	19	40%	3	16%	0	0	0%
LAC- The Whole Child	29	3%	16	55%	4	2	13%
LAC- The Help Group	21	29%	13	62%	2	9	69%
OC CREW	55	100 %	17	31%	17	2	12%
San Mateo Felton	54	75%	49	91%	45	12	24%
UCLA - Aftercare	23	100 %	8	35%	8	2	25%
UCLA - CAPPS	48	0%	13	27%	0	7	54%
UCSD CARE	144	66%	26	18%	22	3	12%
Stanislaus LIFE Path	10	80%	6	60%	5	4	67%
Lake County EIS	8	25%	3	38%	3	0	0%
Yolo County	8	25%	2	25%	1	1	50%
MCC	Mono: 0 Nevada: 3 Colusa: 2		Mono: 0 Nevada: 5 Colusa: 1	Mono: N/A Nevada: 166% Colusa: 50%		Mono: 0 Nevada: 0 Colusa: 0	Mono: 0% Nevada: 0% Colusa: 0%

As described in Table III, there is quite a bit of variability across programs in the proportion of the program's census that are enrolled in Beehive (mean = 58%, range = 16-104%). One program has more service users enrolled in Beehive than currently in their program, indicating they have service users who have been discharged from the program but not Beehive. EPI-CAL point persons continue to work with the sites to make sure they discharge service users from Beehive in a timely manner moving forward. Seven of the participating programs meet or exceed the previously defined benchmark of 70% of eligible service users are enrolled. There was also extensive variability in the number of PSPs enrolled in Beehive across the programs as well (mean = 36%, range = 0-73%). Seven of the participating programs meet or exceed the previously defined benchmark of 50% of PSPs enrolled in Beehive.

The heterogeneity of enrollment across sites supports the need for qualitative barriers and facilitators interviews to understand the issues that sites are facing. Future analyses will examine survey data from service users in more detail, and survey data analysis procedures for clustered data (treating early psychosis programs as clusters) will summarize characteristics of enrolled service users who complete enrollment and at least one longitudinal assessment.

5. Submit final data analysis plan for all data

As a reminder, this project contains data collected via three components: program-level data, county-level data, and qualitative data (Figure 1). The county data analysis plan was described in other sections. While we describe some qualitative analysis here, much of the qualitative data analysis was described in prior deliverables.

Outcome Measures and Instruments

The first aim of the project is to determine the feasibility of implementing an LHCN across a diverse, decentralized group of EP programs. To determine if the LHCN has been effectively implemented (Aim 1), we record the total number of eligible service users who enroll in the EP program during the study period, the number that successfully complete the End User Licensing Agreement (EULA)(Tully et al., 2023), the number that agree for their data to be used to support research activities, and the number of service users and support persons that complete at least one survey. We expect that 70% of eligible EP program participants and 50% of their available support persons across the network will enroll and complete baseline surveys based on prior studies within an EP population (T. A. Niendam et al., 2023). To determine this, EP programs will be asked to provide our team with the total program census number annually, which is compared to service users enrolled in Beehive. Service users must have completed their EULA to be considered enrolled. Data on the number of available support persons is available in Beehive, and we can assess whether a primary support person (PSP) has completed enrollment.

We will measure survey completion of any of the surveys available in Beehive's Core Assessment Battery (CAB) in order to further assess implementation success. The CAB includes validated measures for both service users and their primary support person to complete. The initial proposed CAB was developed by selecting relevant measures from the PhenX toolkit (Hamilton et al., 2011), the Mental Health Block Grant (MHBG) minimum dataset, Mental Health Services Act (MHSA) demographic reporting requirements, and existing program evaluation measures. From there, the final measures and domains were reviewed and refined in focus groups with service users, family members, and providers conducted by our team (Savill et al., 2024), and the EPINET workgroup. The EPI-CAL CAB overlaps significantly with the EPINET CAB("EPINET CAB," 2022) (https://nationalepinet.org/core-assessment-battery-cab/) but differs in some domains and administration

methods. See Table IV for a comprehensive list of outcomes assessed by the CAB. In addition to the EPI-CAL CAB, service users will also be able to complete cognitive testing through Beehive annually.

We also conduct semi-structured qualitative interviews with service users and providers to assess barriers and facilitators to implementing the LHCN examining service user-, provider- and program-level barriers to enrollment and completion. Purposive sampling will be used to recruit participants across clinics where Beehive adoption and implementation has been either high or low, and with service users who have and have not received measurement-based care. Service user participants will be recruited either through clinician referral or by the research team directly by contacting individuals who had previously given permission to be contacted for future research opportunities.

To determine if implementation of the LHCN leads to an increase in the delivery of measurement-based care (Aim 2), providers will complete self-report questionnaires in the pre- and post-implementation period of the project. To examine adoption of a new technology in the EP program, we will compare providers with respect to their self-reported use of data to determine treatment choices at two timepoints: prior to Beehive implementation, and then after training in and use of Beehive. Pre- Beehive implementation surveys include Treatment Alliance and Use of Data in Care Planning in reference to specific service users. Providers will also complete the Comfort with Technology survey. The sampling frame for each site will consist of surveys about service users of currently enrolled EP providers, restricted to service users with at least six months under treatment and who had been seen in the preceding month. Beehive training materials will then be implemented consistently across participating EP programs; implementation efforts will highlight the utility of data to identify treatment goals and metrics of improvement during treatment planning and provide guidance on service user-centered ways to collaboratively review data and monitor progress during care. Then, in post-implementation, the same set of surveys are administered to EP programs who have implemented Beehive in their program for at least a year. The survey sampling strategy used in the pre-implementation period to select clinician-service user pairs will be repeated after Beehive has been implemented in the clinic for a full year, to ensure a valid pre/post comparison on this outcome. Due to expected turnover from the clinician side and discharge/exit from the program on the service user side, we will not be able to sample the same group from the pre-implementation period. However, there will most likely be some representation in the post-implementation period from respondents who participated in the first phase of surveys. Therefore, these are not completely independent samples, nor are they completely repeated samples.

To determine the extent to which providers utilize the Beehive platform to deliver measurement-based care (Aim 2), we adopt two different approaches. First, we will examine whether a service user's treatment team lead reviews completed surveys in Beehive, which is recorded by the application. During service user registration in Beehive, EP providers designate the service user's treatment team lead, typically their primary clinician. Once a survey respondent completes a survey in Beehive, the data are immediately available to view in the Beehive dashboard. The Beehive survey reports will include a variable that shows whether or not each survey has been viewed by the service user's treatment team lead (binary yes/no). Research staff will use this data to determine the degree to which providers are actively viewing data collected in Beehive.

To explore how Beehive data are used by those who frequently utilize the application, two types of in-app queries were developed: urgent clinical issues and data-use questions. Urgent clinical issues are a type of notification (in-app and email) in Beehive that encourages EP staff to review service user data. These notifications trigger if, during registration or survey completion, a service user endorses risk-to-self or risk-to-others on the Modified Colorado Symptom Index (MCSI) (Boothroyd & Chen, 2008), the intent to stop taking their medication (Shulman, Buck, Gahm, Reger, & Norr, 2019), or lack of a permanent address. Beehive displays urgent clinical issues on a dashboard widget and to resolve them, users must indicate how they used

the data in care. Additionally, an in-app query is presented to the service user's treatment team lead every ten visits to the service user's data page. Data-use questions assess 1) if the data was reviewed during a session with the service user or support persons and, if yes, 2) how the data was used as part of care.

We will then examine whether providers' implementation of measurement-based care is associated with significant improvements in key outcomes (Aim 3). To do this, we will compare adjusted between-groups mean differences in baseline to 12-month change in surveys available in the Beehive CAB, including the MCSI. Groups will be defined by clinician metrics from Beehive described above and assessed during this 12-month period. The MCSI is a 14-item, self-report scale designed to assess the frequency of psychiatric symptoms related to psychosis, mood, desire to hurt oneself and others, cognition and forgetfulness. Each item is scored on a 0-4 Likert-style scale and added together to give a score between 0 and 56, with higher scores indicating greater emotional distress. Reduction in score over time indicates clinical improvement.

Table IV. EPI-CAL Outcomes Collected in Beehive

Domain	Respondent	Measure and/or Source*	Timepoint
Demographics & Background	Service user	- EPI-CAL team	Enrollment
Demographics and Background	Service user	- EPI-CAL researchers - California State Required Demographics Reporting - Modification from EPINET version of this question "Are you a veteran?" required question for PEI/INN Reporting - A question measures a risk factor for persistent poverty(Ratcliffe & Kalish, 2017). - An item was created by the EPI-CAL team and assesses factors which put a person at increased risk for homelessness (Grattan et al., 2022) - Part of EPINET CAB("EPINET CAB," 2022) (https://nationalepinet.org/core-assessment-battery-cab/)	Enrollment
Primary Caregiver background	Service user	- EPI-CAL researchers and EPINET CAB("EPINET CAB," 2022)	Enrollment
Traumatic Events and Experiences	Service user	- Pediatric Adverse Childhood Experiences (ACEs) and related life events screener (PEARLS) (Koita et al., 2018)	Enrollment
Demographics and Background	Service user	- A question measures a risk factor for persistent poverty(Ratcliffe & Kalish, 2017). - An item was created by the EPI-CAL team and assesses factors which put a person at increased risk for homelessness, as described in literature (Grattan et al., 2022) - Part of EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)
Education	Service user	- Homelessness Risk item created by EPI-CAL team derived from literature review (Grattan et al., 2022)	Every 6 months (including Baseline)
Employment and Related Activities	Service user	- EPI-CAL researchers and EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)

Domain	Respondent	Measure and/or Source*	Timepoint
Social Relationships	Service user	- Attachment Item from Social Provisions Scale (Cutrona & Russell, 1987) - EPI-CAL researchers - Distress Disclosure Index (Kahn & Hessling, 2001)	Every 6 months (including Baseline)
Family Functioning	Service user and PSP	- SCORE-15 Index of Family Functioning and Change (Stratton, Bland, Janes, & Lask, 2010)	Every 6 months (including Baseline)
Legal Involvement and Related	Service user	- EPI-CAL researchers and EPINET CAB("EPINET CAB," 2022). Response options were informed from literature (Livingston et al., 2014) and community partner feedback during focus groups(Savill et al., 2024).	Every 6 months (including Baseline)
Substance Use	Service user	- EPINET CAB	Every 6 months (including Baseline)
Medication, Side Effects, and Treatment Adherence	Service user	- Adherence Estimator - Glasgow Antipsychotic Side-effect Scale (GASS) (Waddell & Taylor, 2008) - Brief Adherence Rating Scale (BARS) (Byerly, Nakonezny, & Rush, 2008) - Additional items derived from focus group feedback and written by EPI-CAL team	Every 6 months (including Baseline)
Intent to Attend and Complete Treatment Scale	Service user	- Intent to Attend and Complete Treatment Scale (Shulman et al., 2019)	Every 6 months (including Baseline)
Symptoms	Service user	- Modified Colorado Symptom Index (MCSI) (Boothroyd & Chen, 2008)	Every 6 months (including Baseline)
Recovery	Service user	- Questionnaire about the Process of Recovery (QPR) (Neil et al., 2009)	Every 6 months (including Baseline)
Life Outlook	Service user	- A question was derived from suggested questions from Nev Jones (personal communication, August 2020) to capture role satisfaction - Question 1 from Personal Wellbeing Index(Group, 2013) - Construct prioritized in outcomes focus groups	Every 6 months (including Baseline)
Hospitalizations	Service user	- EPINET CAB	Every 6 months (including Baseline)
Traumatic Events and Experiences	Service user	-Life Events Checklist (LEC-5) (F. Weathers et al., 2013) and PTSD Checklist for DSM-5 (PCL-5) (F. W. Weathers et al., 2013)	Every 6 months (including Baseline)
Traumatic Events and Experiences	Service user	- Child and Adolescent Trauma Screen (CATS) – Youth Report (Age 7-17) (Sachser et al., 2017)	Every 6 months (including Baseline)

Domain	Respondent	Measure and/or Source*	Timepoint
Shared Decision Making and Treatment Satisfaction	Service user	-Shared Decision Making Questionnaire (SDM-Q-9) (Kriston et al., 2010) - Kickstart Satisfaction: domain required for primary aims	Every 6 months (including Baseline)
Pathways to Care	Clinician	- EPINET CAB("EPINET CAB," 2022)	Enrollment
Diagnoses and Duration of Untreated Psychosis (DUP)	Clinician	- EPI-CAL modified this survey from EPINET CAB("EPINET CAB," 2022) to include more specific and exhaustive list of DSM-5 diagnoses	Every 6 months (including Baseline)
Family and/or Support Person Involvement	Clinician	- EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)
Risk to Self/Others	Clinician	- EPI-CAL researchers modified from EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)
Health	Clinician	- EPI-CAL researchers modified from EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)
Medications	Clinician	- EPINET CAB("EPINET CAB," 2022)	Every 6 months (including Baseline)
Service Use	Clinician	- EPI-CAL researchers	Every 6 months (including Baseline)
Functioning	Clinician	- Either Global Functioning: Role(T. Niendam, Bearden, Johnson, & Cannon, 2006) and Global Functioning: Social (Auther, Smith, & Cornblatt, 2006) or MIRECC GAF(Niv, Cohen, Sullivan, & Young, 2007)	Every 6 months (including Baseline)
Symptoms	Clinician	One of: - Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962) - Positive and Negative Symptoms of Schizophrenia Scale (PANSS-6) (Østergaard, Lemming, Mors, Correll, & Bech, 2016) - COMPASS-10 (Robinson, Miller, Schooler, John, & Kane, 2021)	Every 6 months (including Baseline)
Demographics and Background of Primary Support Person (PSP)	PSP	- A question included to measure exposure to poverty at a young age, which was indicated as a risk factor for persistent poverty(Ratcliffe & Kalish, 2017). - A question derived from ABCD Study("ABCD Study," 2024) (https://abcdstudy.org) and Deanna Barch (Personal Communication, September 2020) - Collateral report for the service user-self report question. Response options were informed from literature(Livingston et al., 2014) and stakeholder feedback during focus groups.	Enrollment
Demographics and Background of Primary Support Person	PSP	- EPI-CAL Researchers	Every 6 months (including Baseline)

Domain	Respondent	Measure and/or Source*	Timepoint
Legal Interactions and Related	PSP	- Collateral report for the service user-self report question. Response options were informed from literature(Livingston et al., 2014) and stakeholder feedback during focus groups.	Every 6 months (including Baseline)
Family Impact	PSP	- Burden Assessment Scale (Reinhard, Gubman, Horwitz, & Minsky, 1994)	Every 6 months (including Baseline)
Symptoms	PSP	- Modified by EPI-CAL team for collateral report from original MCSI (Boothroyd & Chen, 2008)	Every 6 months (including Baseline)
Medications	PSP	- Modified by EPI-CAL team for collateral report from original GASS (Waddell & Taylor, 2008)	Every 6 months (including Baseline)

*For measures without a single validated source, our team and other collaborators created the questions based on multiple sources.

Program fidelity

In addition to the program-level data described here, we also collect project data via fidelity assessments, program surveys, and the program level core assessment battery (PL-CAB). Each program has completed a fidelity assessment to determine the components of coordinated specialty care (CSC) provided using the First Episode Psychosis Services Fidelity Scale (FEPS-FS) (Addington, 2021), a standardized measure of fidelity to EP program best practices. Similar to the fidelity assessments, program surveys and the PL-CAB assess various components offered through the CSC program, program census, and staffing. The data from these other sources may also be used to inform the analysis of the program-level data.

Analysis Plan

Prior to analysis, we will complete descriptive summaries for all data collected in Beehive, including service user and clinician demographics, survey completion for each survey at each timepoint, and survey scores for quantitative measures. The distribution and completeness of each analysis variable will be examined to determine appropriateness of different statistical methods. The availability of within-person longitudinal data will be reviewed to determine whether longitudinal or cross-sectional approaches are most appropriate. Descriptive summaries will be generated for each clinic individually, as well as network wide.

To address Aim 1, we will examine whether we achieved adequate enrollment in Beehive by using descriptive statistics to see if at least 70% of eligible participants and 50% of their available support persons across the network were enrolled and completed at least one survey timepoint. To approximate the number of total service users eligible for enrollment, we will pull the total census number from each program annually. Eligible service user participants are defined as those who are determined eligible to receive care at each program. Available support persons are defined and identified by the service user. Service users must have completed their EULA to be considered enrolled. For the analysis, we only consider individuals who have agreed to share data with the University of California, Davis (UCD) as "enrolled", but service users can decline this option and still use their data within their program for clinical purposes. Just like service users, primary support persons are not considered enrolled unless they have agreed to share data with UCD. Service users and support persons can make different choices regarding their data sharing permissions, i.e., a service user can decline to share their data for research purposes while a support person can opt-in. For the feasibility analysis, we will only examine what proportion of enrolled service users also have an enrolled PSP, acknowledging that there may be more enrolled PSPs whose corresponding service user opted out of data sharing. Survey data analysis procedures for clustered data (treating EP programs as clusters) will summarize characteristics of enrolled service users who complete enrollment and at least one survey. Enrollment rates (with 95% confidence interval) will be computed for 1) all eligible service users and 2) potentially available support persons. For the

latter, we will report, for the denominator of eligible service users with available support persons, what proportion of those service users had at least one support person complete a baseline or 6-month survey assessment.

To assess Aim 2, the adoption of Measurement-Based Care (MBC), we will first examine the degree of use of data in care between the pre- and post-implementation periods of the project. Before Beehive implementation in each EP program, providers complete pre-implementation surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and complete questionnaires on their 1) beliefs about the utility of data in care planning and 2) skills in discussing data with service users. Compared to the pre-implementation period, we hypothesize that providers will report a change in the use of data to determine treatment choices after training and using the app for at least one year. Separate models will be fit for each of the primary and alternative operationalization of Beehive clinician-usage metrics as the exposure variable of interest. Adoption of data in care will also be measured by examination of whether a service user's treatment team lead examined completed surveys from service users. To determine the degree to which providers are actively viewing data collected in Beehive, research staff will review the Beehive survey reports variable that shows whether or not each survey has been viewed by the service user's treatment team lead (binary yes/no). We hypothesize that EPI-CAL treatment team leads will have viewed service user data collected through Beehive in at least 50% of cases. Lastly, we will examine whether the clinician reported that Beehive data impacted the treatment plan as assessed by the in-app queries periodically presented to EP provider users.

Through the qualitative work that was completed in the first phase of this project (Savill et al., 2024), a variety of key outcomes were identified by our program, service users, and support person workgroups. Psychiatric symptoms, quality of life, and functioning were prioritized as key outcomes by all types of respondents and our analysis will center on these domains. When examining group-level differences, it is important to note that there is not a "Beehive" and "not Beehive" group of service users; all service users are assigned to the Beehive group and thus no analysis can examine the effect of Beehive use in treatment compared to a typical control group. Instead, to assess the impact of utilizing MBC in an EP LHCN (Aim 3), we will analyze a dataset consisting of one record per service user per follow-up assessment timepoint and outcomes expressed as within-person change scores from baseline (for continuous measures) or as count or binary outcomes. For count or binary outcome data, the corresponding baseline value of the outcome will be included as a person-level covariate, when appropriate. Outcomes will be measured by the MCSI, personal wellbeing index (PWI), and functioning measures (Global Functioning Social and Role Scales (GF:S and GF:R) or Mental Illness Research, Education, and Clinical Center (MIRECC) version of the Global Assessment of Functioning (GAF) scale) for each of the six-monthly assessment timepoints during the first 24 months. Continuous outcomes will be transformed into within-person change scores from the baseline assessment for each follow-up assessment. Data are structured hierarchically; there is nesting of measurements from service users, who are nested within clinicians within EP programs. Therefore, for continuous, binary, and count outcomes, generalized linear mixed models will be used to estimate the adjusted effects of exposures on the key outcomes of interest, adjusting for a parsimonious set of other clinician- and service user-level covariates. Random effects will be specified for sites, with additional effects specified for clinician and service users' contribution to the model fit, according to the Schwarz Information Criterion.

A key operationalization of the exposure indicator will be based on a composite indicator for any review of the service users' completed surveys. In particular, this variable will be scored a 1 for a given service user in a given follow-up assessment if the treatment team lead reviewed the service users' completed survey data. The comparison groups are defined by clinician metrics from Beehive aggregated over the 6-, 12- and 18-month assessment period, and the primary analysis is based on a composite indicator for any review of the service

users' survey data by the treatment team lead. We will also assess timepoint-specific changes in psychotic symptom severity for each of the half-yearly assessment timepoints during the first 24 months, with the primary analysis based on a time-varying indicator for any endorsement of "impact on treatment plan" on the in-app queries as a time-varying independent variable.

Qualitative analyses

Though qualitative data is not be directly linked to Beehive user IDs, we also use interview data to examine service user-, provider- and program-level barriers and facilitators to enrollment and completion via semi-structured qualitative interviews with service users and providers. Service user-, provider- and program-level implementation barriers will be identified utilizing an inductive approach to thematic analysis. Purposive sampling will be used to recruit participants of service users and providers across clinics where Beehive adoption and implementation has been both high and low, and with service users who have and have not received measurement-based care. Multiple coding will be adopted, and where possible, service users and providers will be involved in developing the topic guide and reviewing the data analysis and interpretation.

6. Provide report that summarizes outcomes data collected to date via Beehive, including service user-level data on outcomes of interest

Background

The LHCN focuses on a longitudinal, prospective evaluation of core data elements for early psychosis across the state. The Learning Health Care Network program works with participating EP programs for the purposes of harmonized, statewide outcomes data collection. The EPI-CAL program links these early psychosis clinical service programs into the Learning Health Care Network using a core assessment battery of valid, low burden measures and mHealth technology platform (Beehive) to collect service user-level information as part of standard care, visualize such information via clinician dashboard for treatment planning, and integrate across clinics to provide statewide summaries of outcomes data and mental health metrics from participating programs.

Beehive is a co-designed platform that was created to collect and summarize program level outcomes data across the state of California. The outcomes data collected is our EPI-CAL Core Assessment Battery (CAB) and includes various validated measures for service users, their primary support persons, and their clinical team to complete. The initial proposed CAB was reviewed and refined in focus groups conducted by our team ((Savill et al., 2024); see qualitative section below). The surveys in the CAB are administered through Beehive. Beehive was primarily designed to: 1) collect outcomes data from service users receiving care at an EP program and their support persons (i.e., family or other close individuals who service user choose to involve in their treatment), 2) provide the data for providers on a secure web-based dashboard, a subset of which is visualized and 3) allow data to be used for program or research analysis. The use of Beehive by service users, families, and EP program staff does not require written informed consent, but rather a signed end user license agreement (EULA).Trained EP program staff introduce Beehive to participants who are either shown a video explaining the purpose of the study and how their data are used or be presented with the EULA that they are required to read to make their data sharing choices prior to participation. The EULA was designed with input from service users, family members, and providers to ensure transparent data use ((Tully et al., 2023); see qualitative section below).

The program level summary of this report focuses primarily on the data collected via Beehive, including service user self-report data, data from the primary support person (PSP) for the service user, and clinician-rated data. The EPI-CAL team provides ongoing technical assistance to each participating program by supporting ongoing Beehive implementation efforts within the program, including weekly check-in meetings (if the program is

available), on-demand problem-solving to resolve any technical barriers, training refreshers, and summaries of enrollment progress. Program staff have access to the Beehive resource guide, a searchable wiki, and asynchronous training videos in a learning management system for additional training and information on Beehive workflows. To date, 18 EP programs have completed the full Beehive training series, with a total of 25 completing at least some of the Beehive training series. Once Part 1 Beehive training is completed, programs can initiate enrollment of their service users in Beehive and begin data collection on the outcomes surveys. As of May 29, 2025, those 18 EPI-CAL clinics have registered 1257 service users in Beehive. Of those who have completed their EULA(N=984), 82% (n=802) have agreed to share their de-identified data with NIH and 86% percent (n=847) have agreed to share their de-identified data with UCD

Beehive Outcomes Data Collection and Enrollment Progress to Date
Preliminary Feasibility Analysis

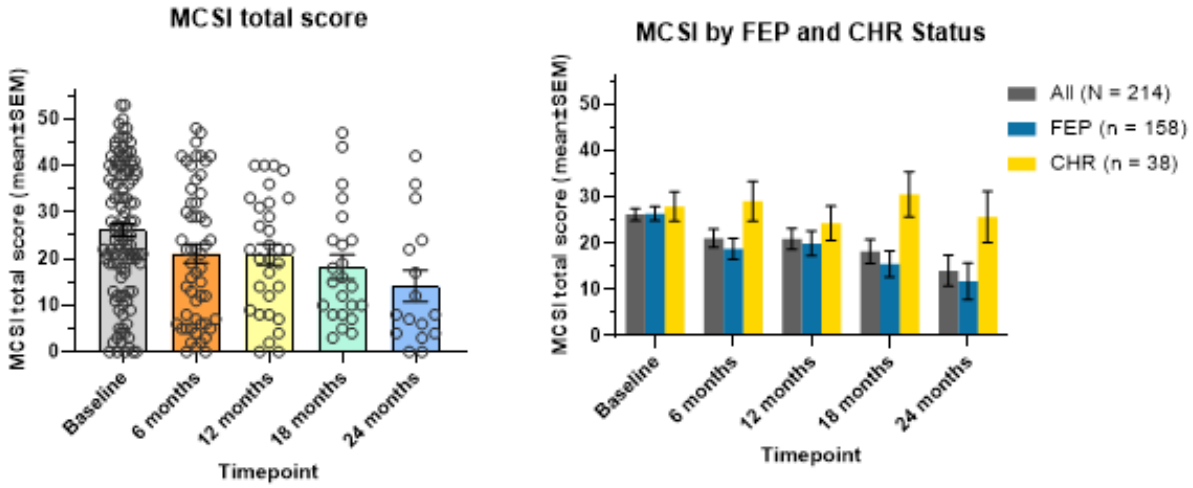
One of our primary metrics to evaluate the feasibility and acceptability of the Beehive application in EP programs it to examine isprograms is to examine whether we achieved adequate enrollment in Beehive. Please review results summarized in another section of the current report to examine feasibility data.

LHCN Enrollment Progress
Enrollment progress is summarized in another section of this report.

Preliminary Analysis of Outcomes of Interest
Our team has also begun to examine descriptive summaries of specific outcomes data from all EP programs, as well as preliminary analyses examining relationships between specific outcomes. Preliminary analyses are grouped by outcome below. Data is only reported for those users who opted into data sharing for research purposes with UC Davis. Many of the preliminary data summarized in the next section below have been prepared for conference abstracts for wider dissemination.

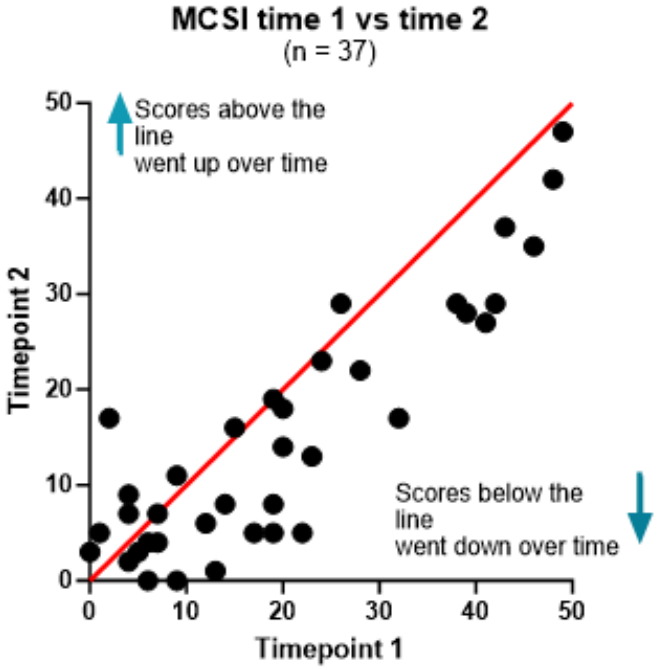
Service user Self-Report Symptoms
The Modified Colorado Symptom Index (MCSI) is 14 items and asks service users to rate the frequency of their symptoms over the past month. Scores range from 0-56 and scores of 16 and above meet "clinical threshold." This survey is administered to service users in Beehive at baselined and at every 6 months thereafter. In the current sample, participants completed 326 MCSI surveys across all timepoints. When computing total scores for the MCSI, we excluded surveys that included the response "prefer not to say" (n = 58). In our initial examination, there were 319 complete MCSI surveys from 267 unique individuals across 18 clinics. In that sample, there were 261 surveys with a score for all 14 items from 214 unique individuals.

Figure 8: MCSI total Score Across Time in Program



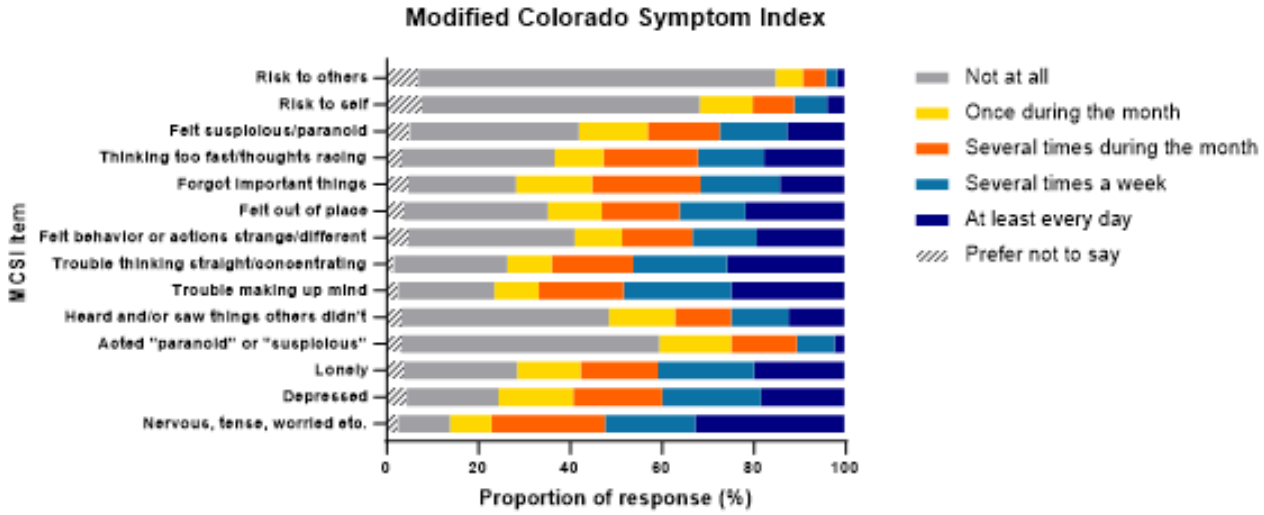
While we did not yet do any formal statistical analysis on MCSI score, we found that there is a pattern of lower scores over time. It is important to note that this is for all participants, even if they have only completed one MCSI survey. We also examined MCSI scores for those who have completed their survey at more than one timepoint. We found that service users who entered data over multiple timepoints tend to have lower scores over time.

Figure 9: MCSI Total Score Across Repeated Timepoints



We also examined responses to each individual MCSI survey question to understand which symptoms service users were endorsing most frequently. We found that service users most frequently endorsed feeling nervous, tense, worried, depressed, trouble making up their mind, and trouble thinking straight and/or concentrating (Figure 10).

Figure 10: Frequency of Symptoms Varies Item to Item



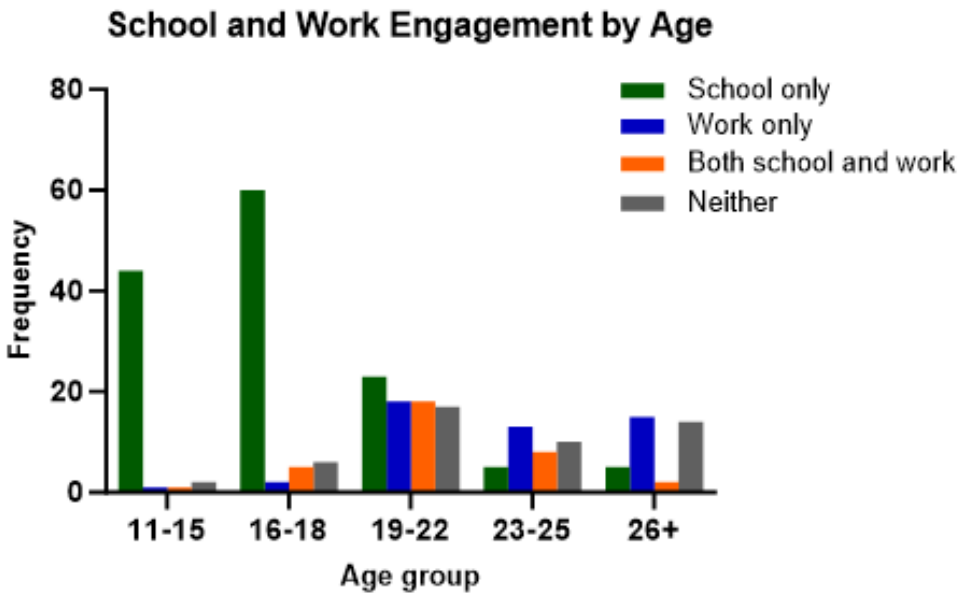
Longitudinal examination of key outcomes is important to understanding how individuals are reporting changes across outcomes of interest over the course of their EP program treatment. This data can offer clinical teams key metrics to track service user progress. As data collection continues across EPI-CAL sites, results from an increased sample will be reported.

Service user self-reported education, employment, and social activities

We examined outcomes data collected related to service users' self-reported functioning, including survey responses regarding life outlook, social relationships, employment, and education. At the time of the analysis, 287 service users across 20 EPI-CAL clinics have completed surveys on life outlook, education, employment and related activities, and social relationships. In that subset of participants, services users received diagnoses associated with a first episode psychosis (FEP; n = 208, 72%), clinical high risk (CHR; n = 65, 23%), or FEP/CHR status not confirmed (n = 14, 5%). Ages ranged from 11 to 36 (M = 20.01 years, SD = 4.7).

School and work attendance was examined across age groups with 137 individuals (48%) reporting school attendance only (part-time or full-time), 49 individuals (17%) in work only, 34 individuals (12%) in both school and work, and 49 individuals (17%) engaged in neither school nor work. Chi-square analysis was used to examine age group differences between education and employment activities. As expected, there was a significant effect of age on the type of activities that individuals were engaged in ($\chi 2(9)=127.75$, $p < 0.001$), with younger people proportionally participating in only school to a higher degree than other roles and older adults (26+ years) were engaged in only work or neither work nor school to a higher degree than other age groups (Figure 11).

Figure 11: School and Work Engagement by Age



When asked whether they were engaged in as much work, volunteering, or school as they wanted, 115 (40%) service users either agreed or strongly agreed and 101 (35%) disagreed or strongly disagreed. A linear regression was run to examine the effect of role satisfaction and social relationships on overall life satisfaction as measured by the Personal Wellbeing Index (PWI). Social relationships (belonging to a group of people that share attitudes and beliefs), role satisfaction (feels that current role will help them reach their long-term goals), and participation in education and/or employment activities significantly predicted overall satisfaction with life as a whole (R^2 for overall model 23.1%; $F(5, 238) = 14.27$, $p < .001$).

We found that work and school engagement vary widely across service users in EP programs as the individuals in these programs represent a diverse group that are at different developmental stages in their life. Self-reported social relationship satisfaction, role satisfaction, and work and/or school engagement were significantly related to overall life satisfaction. Therefore, EP service providers must focus on occupational, educational, and social relationship satisfaction as recovery goals for individuals receiving early intervention services.

Medication Taking Behavior

Medication side effects can impact individuals' perceptions of medication efficacy and subsequent medication taking behaviors. In early psychosis intervention (EPI), taking medications as prescribed and having a support person (e.g., family) involved in care are key factors associated with better outcomes. Facilitating communication regarding medication side effects between care providers, support persons, and individuals receiving care may assist in side effect management, shared decision making, and support healthy medication-taking behaviors. As such, it is important to identify whether individuals in care and their primary support person (PSP) report similar patterns of side effects, and whether there are areas for improved communication. The present analysis aimed to investigate whether there are differences in PSP and individual report of medication side effects, characterize any patterns in discordance, and identify areas for potential clinical intervention.

Within the first 6 months of EPI engagement, individuals and their PSPs were asked whether the individual is prescribed any medication. Those who endorsed having at least one prescription medication were administered a modified version of the Glasgow Antipsychotic Side-effect Scale (GASS). We used paired samples T-test examined GASS sum scores to determine whether individuals were systematically reporting more side effects than PSPs. Individual and PSP GASS item level endorsement concordance was evaluated utilizing Cohen's Kappa. Finally, bivariate correlations were conducted between GASS scores and measures assessing intent to remain in EPI care and taking medication as prescribed. Concordance between PSP, individual, and clinician agreement on medication status was also examined.

In a total sample of 114, agreement of medication prescription status between individuals and PSPs was high ($k = .84$, $p>.001$ at baseline, $k=1.00$, $p>.001$ at 6 months). Individuals who endorsed prescription medication and completed the GASS were examined (n=54 at baseline, n=22 at 6 months of EPI engagement). At baseline, 80% of individuals (n=41) reported taking any medication as prescribed 0-25% of the time; at 6 months, 93% of individuals (n=14) reported taking medication as prescribed 0-25% of the time. Paired sample T-test results indicated that individuals and PSPs report similar rates of side effects. However, of the 27 side effect items assessed at baseline, individuals and PSPs showed slight to moderate agreement on 16 items (ranging from $k=.19$ to $k=.47$). At 6 months, only 7 items performed above chance (ranging from $k= .22$ to $k=.48$). GASS scores did not significantly correlate with intent to continue or complete EPI services, medication-taking behaviors, or medication related beliefs. However, individuals' distress regarding side effects was significantly correlated with concerns that taking medication will do more harm than good ($r=.32$, $p<.05$).

In the present sample, most individuals reported they take medication as prescribed 25% of the time or less. These medication taking behaviors may impact the number of medication side effects individuals experience and reduce overall medication efficacy. Individual and PSP agreement on side effects was moderate to low at baseline and decreased over the course of EPI. Lack of PSP and clinician awareness and communication around individuals' medication taking behavior may contribute to poor outcomes. Therefore, increased communication between individuals, their support systems, and their care teams is crucial to address individuals' concerns regarding medication and increase shared decision making.

Adverse Childhood Experiences

Research shows individuals with psychosis often have a history of trauma that contributes to poor outcomes across multiple domains. Trauma is common (Neria et al., 2002; Varese et al., 2012): 6.8% with PTSD in general population vs 23% in first episode psychosis. Up to 80% of youth a clinical high risk for psychosis endorse a lifetime history of traumatic events and victimization during childhood. Trauma is poorly diagnosed in individuals with serious mental illness (Grubaugh et al., 2011). History of trauma exposure in psychosis can lead to more severe symptoms, poorer social relationships, increased substance use, as well as increased risk for hospitalization, homelessness, and suicide (e.g., Grattan et al., 2019).

We examined group differences between individuals who had ACEs Scores of 4+ ("High ACEs Group") as that number of experiences is associated with poorer clinical outcomes. In this preliminary analysis, 302 service users completed the ACEs survey in Beehive at enrollment. In our sample, 17% of individuals reported no history of ACEs, 47% of Individuals reported ACEs in the clinical range, and 26% of individuals reported ACEs levels expected by a 20-year life expectancy decrease (6+).

We found that experiences of several adverse childhood experiences (ACEs) in individuals with early psychosis is associated with poorer life outlook, and higher risk of suicidal and homicidal ideation in our preliminary data collected in Beehive. Additionally, individuals with higher ACEs are more likely to have experienced lifetime housing instability and individuals who identify as LGBT are more likely to report higher

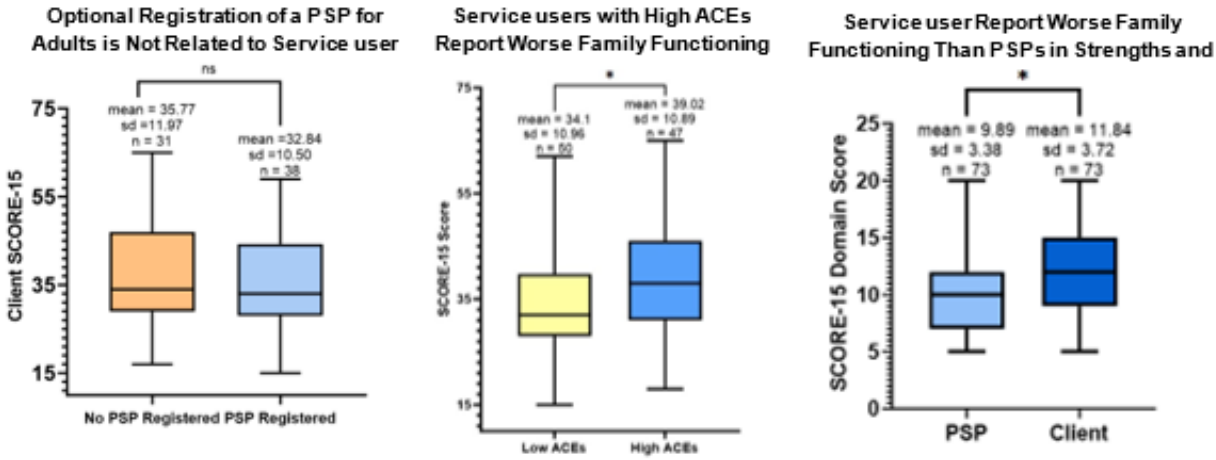
ACEs. ACEs and other social determinants are likely drivers of poor outcome in early psychosis and should be addressed in treatment.

Adverse Childhood Experiences and Family Functioning

Our qualitative data highlighted how adverse childhood experiences (ACEs) impact the lives of individuals experiencing psychosis. Intensity of traumatic experiences throughout childhood could represent a modulating factor of psychotic symptoms and overall functioning, including family functioning. Beyond psychosis, family functioning can have a moderating effect on the negative impact of ACEs on emotional well-being. This suggests a strong association between ACEs, mental health difficulties, and family functioning, though these relationships have been minimally examined in the context of early psychosis. The current analysis examines the relationships between service user ACEs and family functioning as reported by both service users and primary support persons (PSP) in EPI-CAL.

Participants completed the Pediatric ACEs Screening and Related Life-events Screener (PEARLS) and the SCORE-15 in Beehive. In this particular analysis, 217 service users (Ages 12-32, M=19.04, SD=4.28; 71% FEP, 21% CHR, 8% Diagnosis unconfirmed), completed the PEARLS version of the ACEs-10 (M = 3.52, SD = 2.74) at enrollment. They identified as 50.5% female sex at birth; 42% female gender; 73% non-White; 41% Hispanic/Latinx; and 7% were not born in the US. All analyses utilized a subset of items reflective of the original ACEs-10. Adults were asked to rate experiences prior to age 18. ACEs scores of 4+ are considered high risk for poor outcomes. In this sample, 47% respondents had an ACEs score of 4 or higher and are considered high risk for poor outcomes. Service users' self-reported SCORE-15 total scores (n=103, M=33.68) was positively correlated to their ACEs scores (r = 0.295, p=0.002). Conversely, PSP SCORE-15 total (n=71, M=30.13) and subdomain scores were not significantly related to their associated service user's ACEs score (r = 0.19, p=0.11). The same pattern was found in each of the three SCORE-15 subdomains (strengths and adaptability, overwhelmed by difficulties, and disrupted communication). Higher SCORE-15 scores indicate worse family functioning. Exploration of matched pairs between service user and PSP will be examined as more data is collected.

Figure 12: ACEs and Service user/PSP Reported Family Functioning (SCORE-15)



ACEs are common for individuals receiving care in EP programs. These experiences are associated with worse family functioning per service user report. Given the importance of family treatments as an evidence-based approach for FEP, and the negative impacts of ACEs on service user outcomes, these data suggest that

EP programs should identify and treat individuals who experience traumatic events and to target areas of family functioning, with the goal of improving outcomes.

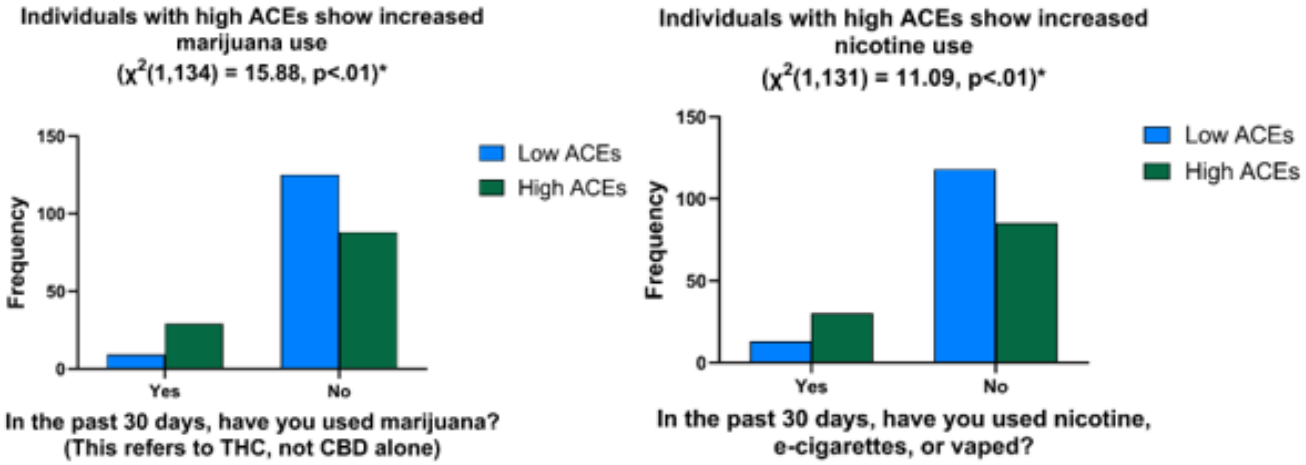
Adverse Childhood Experiences and Substance Use

Higher prevalence of adverse childhood experiences (ACEs) is related to increased rates of psychosis symptoms and substance use (SU) disorders separately. Few studies have jointly examined these factors in the early psychosis (EP) population. We investigated whether individuals in EP programs above clinical threshold for ACEs endorsed SU at higher rates.

Individuals with first episode psychosis (FEP) or at clinical high risk for psychosis (CHR) completed Pediatric ACEs Screening and Related Life-events Screener (PEARLS; adolescent version) and SU surveys. The current analysis used the ACES-10 items and the clinical threshold of ≥4 ACEs. In the SU survey, individuals reported usage of alcohol, marijuana, nicotine, opioids, and stimulants over the past 30 days. 179 service users (ages 12-32) completed the ACEs-10 and SU survey. 86 respondents (48%) had an ACEs score of 4 or higher. 30 service users (16.8%) reported nicotine use, 38 service users (21.2%) reported alcohol use, 27 service users (15.1%) reported marijuana use. Use of opioids and stimulants were minimal in this sample.

Chi-square tests were used to evaluate group differences. Individuals with high ACEs showed increased nicotine and marijuana usage (Figure 13) while there were no significant differences for alcohol usage.

Figure 13: Differences in Substance Use Between High and Low ACEs



We hypothesized individuals with a high number of ACEs would show increased substance use of nicotine, marijuana, alcohol, stimulants, and opioids compared to individuals with a low number of ACEs. There was not enough use of stimulants and opioids to perform analyses (<5). Additionally, we found that individuals who experienced a high number of ACEs showed increased use of nicotine and marijuana only when compared to individuals with low ACEs. Individuals with a high number of ACEs did not show significant differences in alcohol usage when compared to individuals with low ACEs. Highly endorsed questions can help identify specific adverse childhood experiences (ACEs) that are more prevalent among the EP population. Understanding which specific experiences result in increased substance usage can inform targeted interventions and reduce poor outcomes in this population.

Childhood Poverty

Recent studies suggest that CSC is not as effective for individuals with less economic advantage. This is critical, as approximately 37 million, or 12%, Americans, lived in poverty each year between 2020 and 2022. In 2022, 15% of American children lived in poverty, noteworthy because childhood economic disadvantage is predictive of both development of psychosis-spectrum disorders as well as other health problems. To better understand early experiences of poverty of service users in community CSC programs, this current analysis examined experiences of early childhood poverty of EPI-CAL service users and explored how these experiences are related to high-priority clinical outcomes.

CSC service users and their primary support persons (PSP) completed Beehive surveys at EPI-CAL enrollment and every 6 months throughout treatment. PSPs who lived with the service user before they turned five reported subjective poverty indicators experienced in the household during that time. Participants also reported their demographics and clinical outcomes, including symptoms (Modified Colorado Symptom Index (MCSI)), recovery (Questionnaire about the Process of Recovery (QPR)), and quality of life (Personal Wellbeing Index (PWI)). Descriptive analyses summarized demographics and poverty indicators. Independent-samples t-tests were run to determine if there were differences in specific outcomes (MCSI, QPR, and PWI) between service users with and without a history of early poverty, and family-wise error rate was adjusted to correct for multiple comparisons. Chi-square tests were used to examine group differences between specific demographic factors and those with and without childhood poverty experiences.

At enrollment, 165 PSPs (Ages 16-66, M=45.76, SD=9.17) reported on subjective experiences of poverty had by the service user (ages 12-32, M=17.78, SD=3.72; 66% FEP, 27% CHR, 11% Diagnosis Unconfirmed) prior to age five. We found 29 (18%) PSPs who endorsed that the service user had at least one subjective experience of poverty prior to age 5. When examining demographic factors, there was a significant association between race and experience of childhood poverty ($\chi^2(4) = 14.91$, $p < .01$) with African American/Black individuals reporting more childhood poverty experiences than expected. Individuals who had subjective experiences of poverty during childhood reported worse clinical outcomes on the recovery measure at baseline, with individuals without poverty experiences having higher scores on the QPR (M = 34.63, SD = 8.90) than those with poverty experiences (M = 27.94, SD = 11.00; $t(49) = 2.31$, $p = .01$, corrected $p = .038$).

To date, the proportion of individuals with experiences of childhood poverty is higher than the general American population. These experiences of poverty disproportionately affect Black and African American service users. Individuals with these experiences were less likely to agree with statements indicating recovery at their first recorded assessment in CSC. This continues to support that socioeconomic experiences should be considered as a factor contributing to clinical outcomes. Future analyses will examine current socioeconomic status (SES) as a moderator of clinical outcomes at baseline and explore how childhood poverty and current SES may moderate change in clinical outcomes throughout CSC treatment.

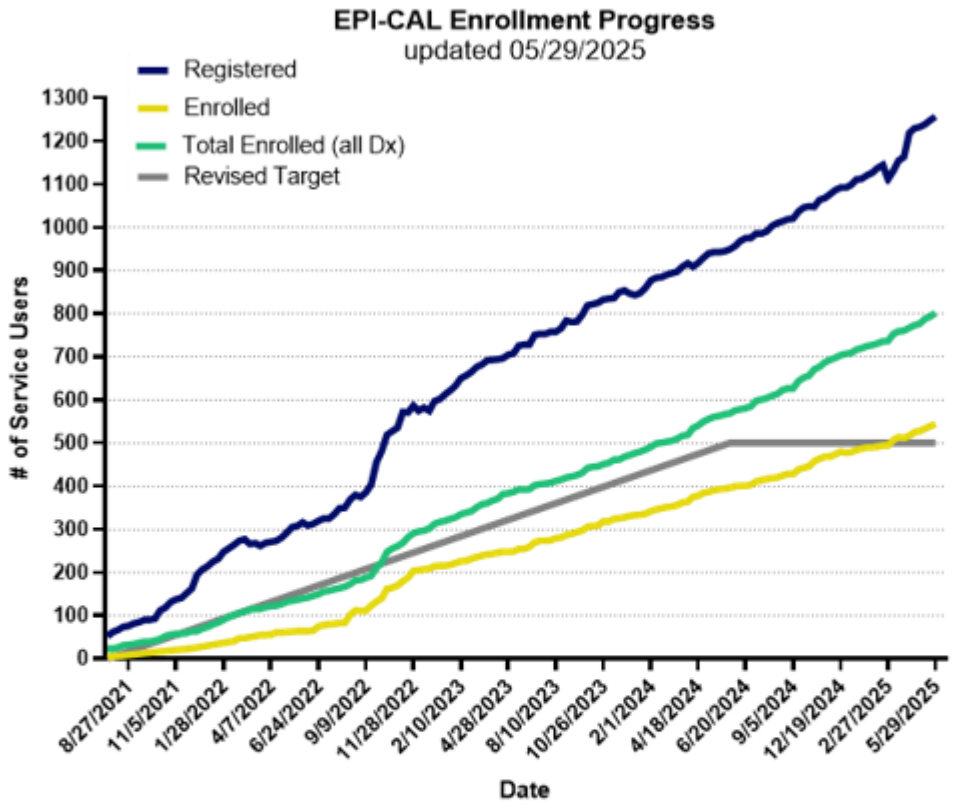
7. Submit report on LHCN enrollment and follow up completion rates for LHCN app in all EP programs

LHCN Enrollment Progress

Figure 14 shows the LHCN Progress towards EPI-CAL Enrollment targets as of May 29, 2025. Service users are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If service users do not allow their data for use in research but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. In summer of 2022 we worked with sites to create a revised enrollment target (light gray line) based on observed rates of enrollment up to that point. At this point in the project, the revised goal is to have 500 individuals enrolled. The observed rate of enrollment across the LHCN is 802 service users across all diagnoses (green

line in figure below), including 544 service users with a diagnosis that indicates FEP, (the yellow line in figure below). There are an additional 455 service users who are registered by the clinic in Beehive (dark blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys.

Figure 14: LHCN Progress Towards EPI-CAL Enrollment Targets



Figures 15-16 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of May 29, 2025. Figure 15 shows all registered service users, regardless of EULA completion status. Hence this figure shows the room for growth if sites support service users to complete their EULA in Beehive if those service users agree to data sharing.

Figure 15: Proportion of Service Users Sharing Data with UCD for Research by Site

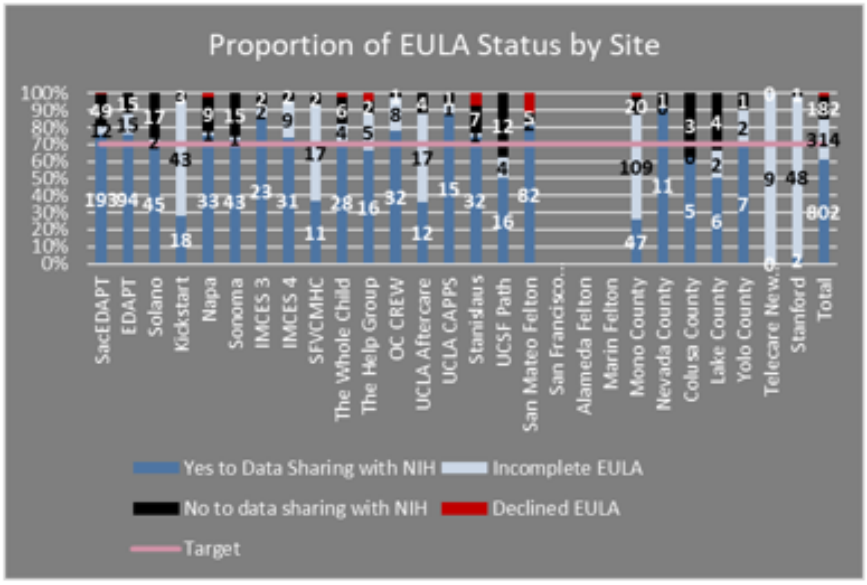
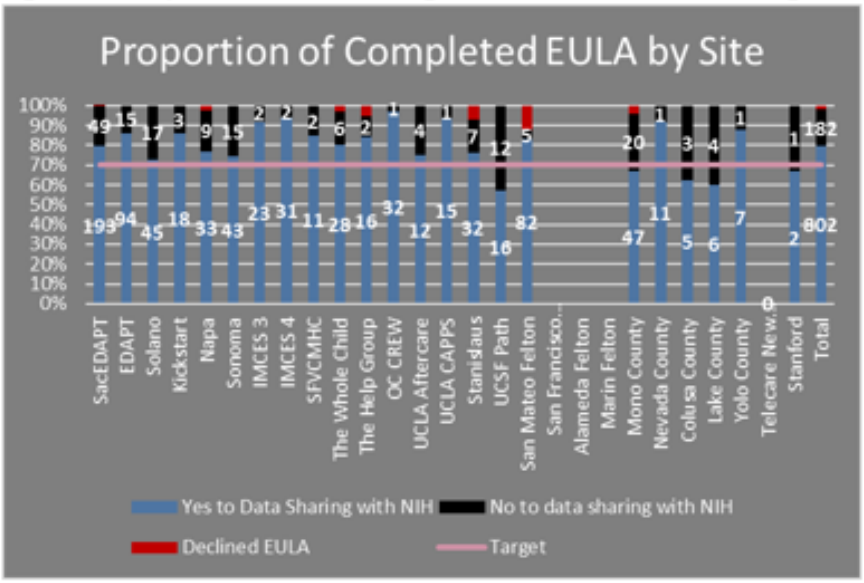


Figure 15 shows the proportion of data sharing choices made by those service users who have completed their EULA in Beehive. We can see that some sites on this graph do not have a bar at all because they do not have any service users who have been registered in Beehive.

Our goal is that 70% of active service users at each site agree to use Beehive and share their data for research purposes. When considering all service users known to EPI-CAL (i.e., all those registered in Beehive), we can see that several sites are meeting this metric. Further, among those individuals who have actually engaged with Beehive and completed the EULA, we are exceeding our target across the network, and at most sites individually as well. When considering all enrolled service users across the LHCN, 847 out of 984 (86%) service users have agreed to share their data with UC Davis and 802 out of 984 (82%) service users agreed to share their data with NIH for research purposes.

Figure 16: Proportion of Data Sharing with UCD for Research among Completed EULAs

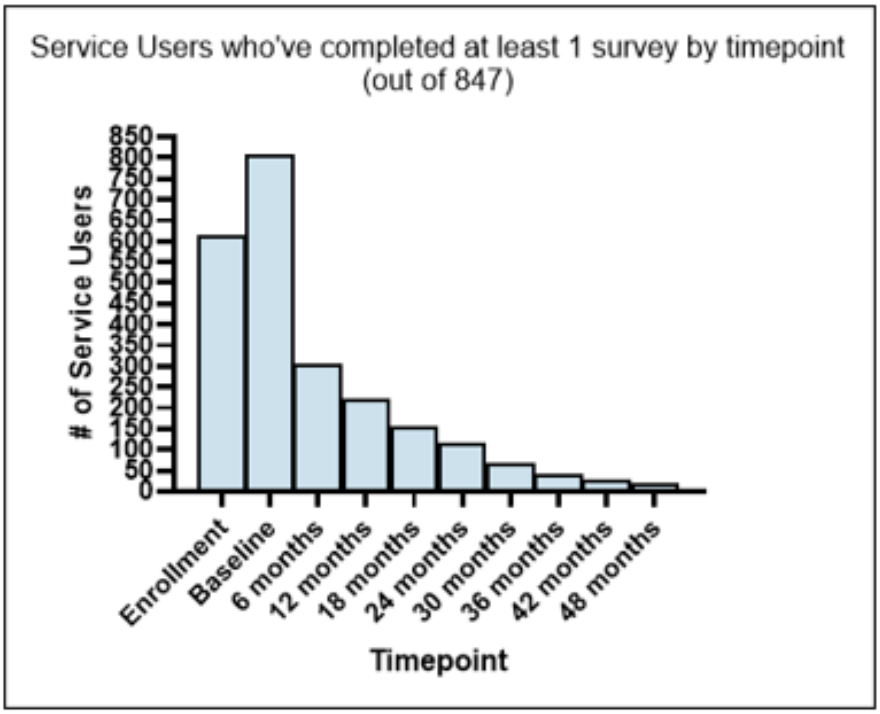


Progress of data collection in all EP programs

As of May 29, 2025, 28 EPI-CAL clinics have registered 1801 service users in Beehive. This includes service users who have been registered and have closed episodes without ever engaging in Beehive. Of those service users who have been registered, 55% (n=984) have completed their Beehive EULA and are considered to be enrolled in Beehive. Of those who have completed their EULA, 82% (n=802) have agreed to share their de-identified data with NIH and 86% percent (n=847) have agreed to share their de-identified data with UCD.

Figure 17 shows network-level survey completion rates by time point as of May 29, 2025. Note that all service users can complete enrollment surveys regardless of when in their treatment they are enrolled. Service users are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some service users have completed surveys at more than one time point. Of the 847 service users who have been enrolled in Beehive and agreed to share their data with UCD, 99% (n = 840) have completed at least one survey in Beehive. Figure 17 shows survey completion by timepoint for individuals who have agreed to share their data with UCD.

Figure 17: Survey Completion Rates Across EPI-CAL Network



Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table V). Complete demographic information, including all required PEI fields, are administered via a required service-user-entered Beehive survey. For any cell that has an N less than 5 individuals, this data was masked and both the N and proportion cells were updated with "<5" and "<.6%", respectively.

Table V: Demographic Data from all Participating EPI-CAL Clinics

EPI-CAL Combined Demographics, n = 848 (through 05/29/2025)		
Display Language	**N**	**%**
English	823	97%
Spanish	21	2%
Missing	<5	<.6%
Age	**N**	**%**
<12	-	-
12-17	248	29%
18-23	424	50%
≥24	176	21%
Sex at Birth	**N**	**%**
Female	418	49%
Male	423	50%
Intersex	<5	<1%
None of these describe me	<5	<.6%

EPI-CAL Combined Demographics, n = 848 (through 05/29/2025)		
Prefer not to respond	<5	<.6%
Gender	**N**	**%**
Female	357	42%
Male	408	48%
Non-binary	26	3%
Transgender	19	2%
Genderqueer	<5	<1%
Questioning or unsure of gender identity	6	.7%
Other	8	.9%
Prefer not to say	18	2%
Missing	<5	<.6%
Race	**N**	**%**
African/African American/Black	98	12%
Asian	84	10%
American Indian/Alaskan Native	5	.6%
Hispanic/Latinx Only	265	31%
Native Hawaiian/Pacific Islander	<5	<.6%
White/Caucasian	273	32%
More than one race	73	8%
Prefer not to say	-	-
Unsure/Don't Know	17	2%
Missing	<5	<.6%
Other	<5	<.6%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	458	54%
Yes - I identify as Hispanic/Latinx	316	37%
Prefer not to say	27	4%
Unsure/Don't know	70	8%
Missing	5	<1%

Additionally, providers are asked to enter a service user's diagnosis when they register individuals in Beehive, which is reported in Table VI. In the same manner as the table above, cells with less than 5 individuals were masked and both the N and proportion cells were updated with "<5" and "<1%", respectively. Diagnoses are grouped according to two classes of early psychosis: 1) individuals who are deemed to be at clinical high risk for psychosis (CHR), and 2) individuals who have experienced psychotic level symptoms (First Episode

Psychosis, FEP). There is also a section for those individuals for which their FEP or CHR status is not yet confirmed. This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table VI: Service User Diagnoses from all Participating EPI-CAL Clinics

EPI-CAL Combined Diagnoses, n = 848 (through 05/29/2025)	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	49	8%
Genetic Risk and Deterioration Syndrome (GRDS)	<5	<1%
Other	91	15%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset	9	2%
during intoxication		
Mood disorders with psychotic features	110	19%
Schizoaffective Disorder	54	9%
(Bipolar or Depressive Type Combined)		
Schizophrenia	125	21%
Schizophreniform Disorder	17	3%
Delusional Disorder	<5	<1%
Brief Psychotic Disorder	<5	<1%
Other Specified Schizophrenia Spectrum Disorder	26	4%
Unspecified Psychosis	112	19%
Other FEP	113	18%
CHR or FEP Status Not Confirmed	90	14%
Not enough Information	<5	<1%
Missing	42	7%

8. Provide findings on cost and utilization data from multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

EPI-CAL Revised Utilization and Cost Analysis

The goal of this study is to compare service utilization and cost between people with early psychosis seen in coordinated specialty care (CSC) clinics versus a similar group seen in usual care. Based on Dr. Niendam's pilot analysis in Sacramento County, we proposed to harmonize and integrate data across multiple CA

counties to increase our total sample size and statistical power, given the relatively small census size in most CSC clinics.

When we first developed this MHSA Innovations project in 2018, we proposed requesting two separate periods of data. First, we would request three years of "retrospective" service use and cost data (7/1/2015-6/30/2018) to develop our methods. Then, we'd request a separate 3.5-year "prospective" period that would match the time period collecting EP program-level data in other parts of the Learning Healthcare Network (LHCN). The retrospective analysis would help us account for historical trends over time and we could apply what we had learned from the first analysis to the second.

However, our analyses were delayed due to multiple factors, including challenges harmonizing data across counties that were pulled from multiple sources within each county. For example, each type of outpatient service needed to be identified and recoded into subcategories. In some cases, obtaining the detailed information necessary to make these decisions regarding required multiple exchanges with the county and up to a year, simply based on the way these data points are stored and what information is available. We also faced challenges such as extended time required for contract execution, limited county capacity to pull and share the data, the COVID-19 pandemic, and the lead researcher's medical leave. As a result, we requested two slightly different time periods: the retrospective period was 1/1/2017- 12/31/2019 and the prospective period was 1/1/20- 6/30/2022.

Cleaning and harmonization activities with the prospective data then overlapped with work on the retrospective data, rather than being conducted sequentially. We used what we had learned in requesting, cleaning and harmonizing the retrospective data to do so more efficiently with the prospective data. We also realized that the prospective 3-year period provided limited numbers of individuals receiving CSC services for a full 12 months, which would not allow us to examine change over a full year of treatment. Therefore, we in the process of discussing these changes with the OAC and involved counties to obtain their formal approval to conduct one set of analyses using both time periods combined into a single integrated dataset. This means all individuals served over the period 1/1/2017 - 6/30/2022 will be analyzed together, providing increased statistical power for more complex analyses.

We are not requesting any additional data from counties. However, some individuals who entered treatment just prior to the end of the retrospective period may not necessarily have data available in the prospective dataset. Therefore, we will only include full calendar quarters for analysis and may not have a full 12 months available for those individuals.

We also originally proposed designating an index service date for the comparator group that is the first outpatient service associated with a psychosis diagnosis. However, we realized that this would begin the comparison period earlier than the CSC group, who often entered CSC several months after their first diagnosis and services in usual care in the county mental health system. Therefore, we are proposing to compare the year before and after first psychotic disorder diagnosis in both groups. We will compare service utilization and cost by quarter, indicating when CSC services began. We included a sample analysis illustrating the new approach for San Diego County in the December 2024 deliverable. Here we present the analysis using data integrated across four CA counties – Los Angeles, San Diego, Solano and Orange.

Four-County Analysis Results

Data and Methods

This analysis is based on administrative demographic, claims, and encounter data provided by Los Angeles, Orange, San Diego and Solano Counties for 2013-2022. We used administrative data to identify youth aged 12-26 who (1) were enrolled in a specialized early psychosis (EP) program from January 2017 to July 2021

and (2) received a first diagnosis of psychosis (ICD-10 codes F20, F22, F23, F25, F28, F29, F31.2, F31.5, F31.64, F32.3 F33.3) within 90 days of receiving an outpatient service. We shared lists of EP youth with program staff who confirmed that these were past or current service users who received their first diagnosis of psychosis. We identified a comparison group (CG) of youth with a first diagnosis of psychosis who received an outpatient service during the study period, also within 90 days of receiving their first diagnosis of psychosis. We excluded youth and youth who received a diagnosis of intellectual disability (ICD-10 codes F70-F79, ICD-9 codes 317-319).

We summarized service use and cost over four quarters of the year prior and four quarters of the year post first diagnosis of psychosis. We calculated costs for inpatient, outpatient, and crisis services. Inpatient services included admissions to psychiatric hospitals, admissions to psychiatric units of acute care hospitals, and crisis residential services. Outpatient services included case management, medication management, and mental health services including rehabilitation and therapy. Crisis costs included crisis intervention, crisis stabilization, psychiatric emergency and mobile response teams. We also calculated total costs.

We estimated the probabilities of using services with logistic regression models. We estimated costs using a generalized linear model with a gamma distribution and a log link function. In each model, we included covariates for age, gender, race/ethnicity, language preference, and initial psychiatric diagnosis along with an indicator for participating in an EP program. We calculated standardized estimates for each outcome and quarter using the estimated coefficients to generate predicted values for each youth in the sample as if they were alternately assigned to EP and CG. The standardized mean is the mean of the predicted values across the sample. We calculated standard errors using the non-parametric bootstrap, and significance values using non- parametric permutation.

Results

We identified 336 youth in EP programs (Tables VII and VIII). Mean age was 18 (SD=3); 130 (39%) were female; 59 (18%) were non-Latino White, 37 (11%) were Black, 12 (4%) were Asian, 200 (60%) were Latino, and 28 (8%) had another or unknown race/ethnicity; and 36 (11% listed Spanish as their preferred language. The initial diagnosis for 30 youth (9%) was schizophrenia; 17 (5%) received an initial diagnosis of schizoaffective disorder, 229 (68%) unspecified psychosis, and 60 (18%) mood disorder with psychosis. Youth in the CG were older, more likely to be Black or have other or unknown race/ethnicity and were more likely to receive a diagnosis of schizoaffective disorder or mood disorder with psychosis (P<.001 each).

Table VII. Demographics of Youth Experiencing a First Episode of Psychosis

	Early Psychosis Program (N=336)		Usual Care (N=19,930)		p
Age	18	3	19	4	<.001
Age 12-16	57	17	2907	15	
Age 17-18	147	44	3679	18	
Age 19-20	77	23	4291	22	

	Early Psychosis Program (N=336)		Usual Care (N=19,930)		p
Age 21-25	55	16	9053	45	
Male	204	61	11,117	56	
Female	130	39	8705	44	
Other/unknown	2	1	107	1	
Non-Latino White	59	18	2448	12	
Non-Latino Black	37	11	3309	17	
Non-Latino Asian	12	4	621	3	
Latino	200	60	9754	49	
Other/unknown	28	8	3781	19	
No	300	89	18233	91	
Yes	36	11	1697	9	
Schizophrenia	30	9	1130	6	
Schizoaffective	17	5	2486	12	
Unspecified Psychosis	229	68	9477	48	
Mood Disorder with Psychosis	60	18	6837	34	

Table VIII. Demographics of Youth Enrolled in Early Psychosis Programs

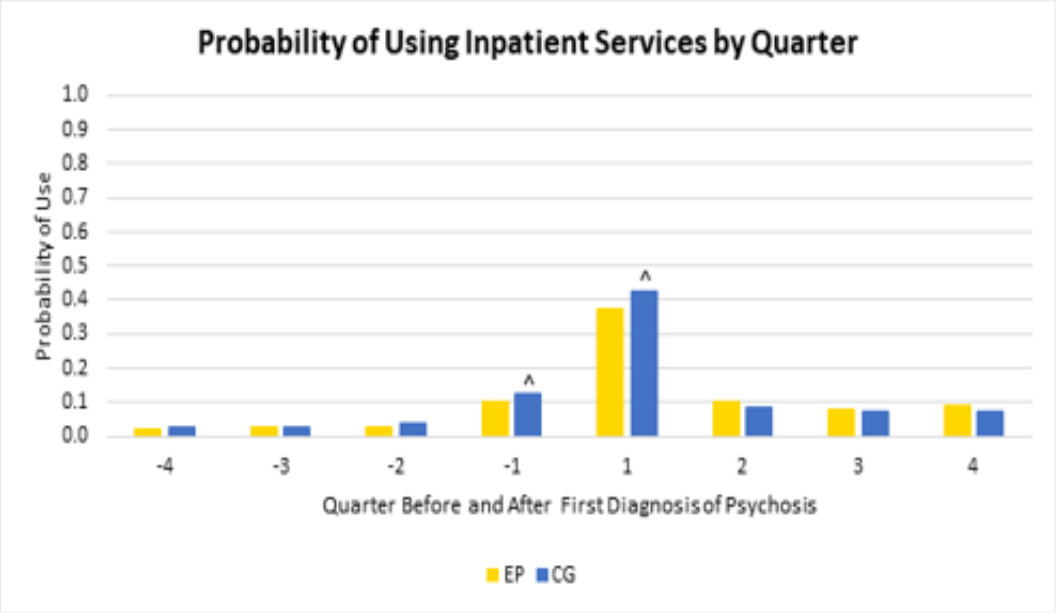
	Los Angeles County (N=81)		San Diego County (N=148)		Orange County (N=60)		Solano County (N=47)		p
Characteristic	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Age	18	3	18	3	17	3	17	4	

	Los Angeles County (N=81)		San Diego County (N=148)		Orange County (N=60)		Solano County (N=47)		p
Age groups	N	%	N	%	N	%	N	%	0.074
Age 12-16	13	16	17	11	13	22	14	30	
Age 17-18	32	40	70	47	31	52	14	30	
Age 19-20	20	25	38	26	9	15	10	21	
Age 21-25	16	20	23	16	7	12	9	19	
Gender	N	%	N	%	N	%	N	%	0.593
Male	46	57	97	66	34	57	27	57	
Female	35	43	50	34	25	42	20	43	
Other/unknown	0	0	1	1	1	1	0	0	
Race and Ethnicity	N	%	N	%	N	%	N	%	0.005
Non-Latino White	12	15	29	20	6	10	12	26	
Non-Latino Black	4	5	24	16	2	3	7	15	
Non-Latino Asian	1	1	4	3	6	10	1	2	
Latino	54	67	82	55	40	67	24	51	
Other/unknown	10	12	9	6	6	10	3	6	
Spanish Language Preferred	N	%	N	%	N	%	N	%	0.029
No	77	95	135	91	49	82	39	83	
Yes	4	5	13	9	11	18	8	17	
Initial Diagnosis of Psychosis	N	%	N	%	N	%	N	%	<.001
Schizophrenia	15	19	4	3	0	0	11	23	
Schizoaffective	5	6	10	7	0	0	2	4	
Unspecified Psychosis	39	48	106	72	60	100	24	51	

	Los Angeles County (N=81)		San Diego County (N=148)		Orange County (N=60)		Solano County (N=47)		p
Mood Disorder with Psychosis	22	27	28	19	0	0	10	21	

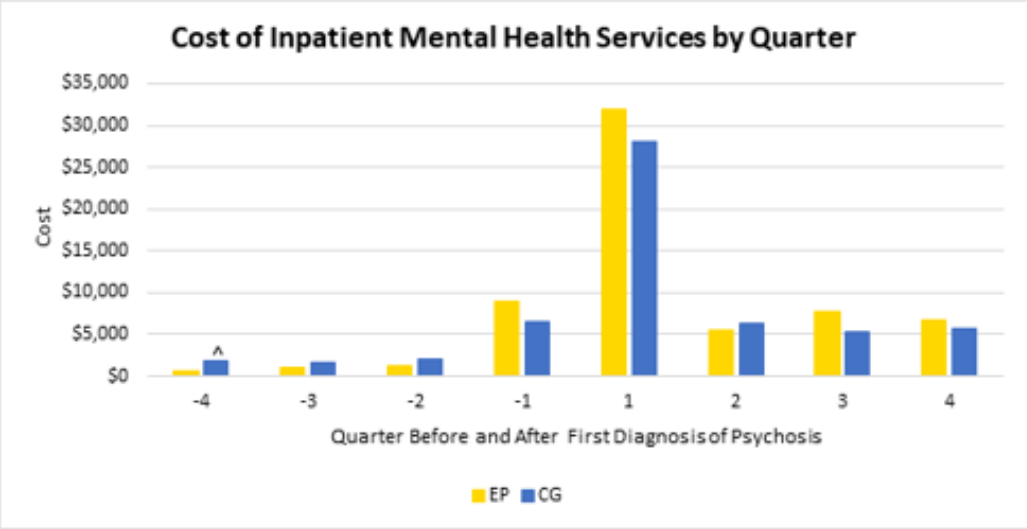
Figures 18 and 19 show the standardized estimates of inpatient service use and costs in the four quarters before and after receiving an initial diagnosis of psychosis. EP youth were less likely to have an inpatient admission in the quarter prior (10.0% vs 12.6%, P=.045) and the quarter post (37.2% vs 42.6%, P=.037) initial diagnosis. There were no significant differences in inpatient admissions in the other quarters. Inpatient costs were lower among EP youth four quarters prior to initial diagnosis. There were no significance differences in inpatient costs in other quarters (Figure 19). Overall, EP youth were less likely to have an inpatient admission over the two-year period: 48.7% vs 55.5%, P=.010, see Figure 20.

Figure 18: Probability of Using Mental Health Inpatient Services Before and After First Diagnosis of Psychosis



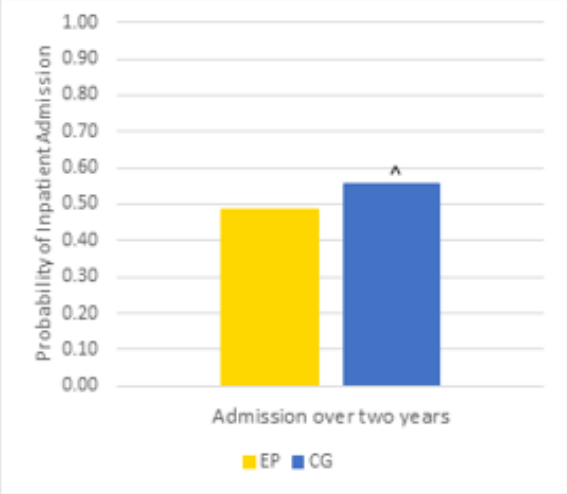
^$p < .05$; *$p < .001$

Figure 19: Costs of Mental Health Inpatient Services Before and After First Diagnosis of Psychosis



^$p < .05$; *$p < .001$

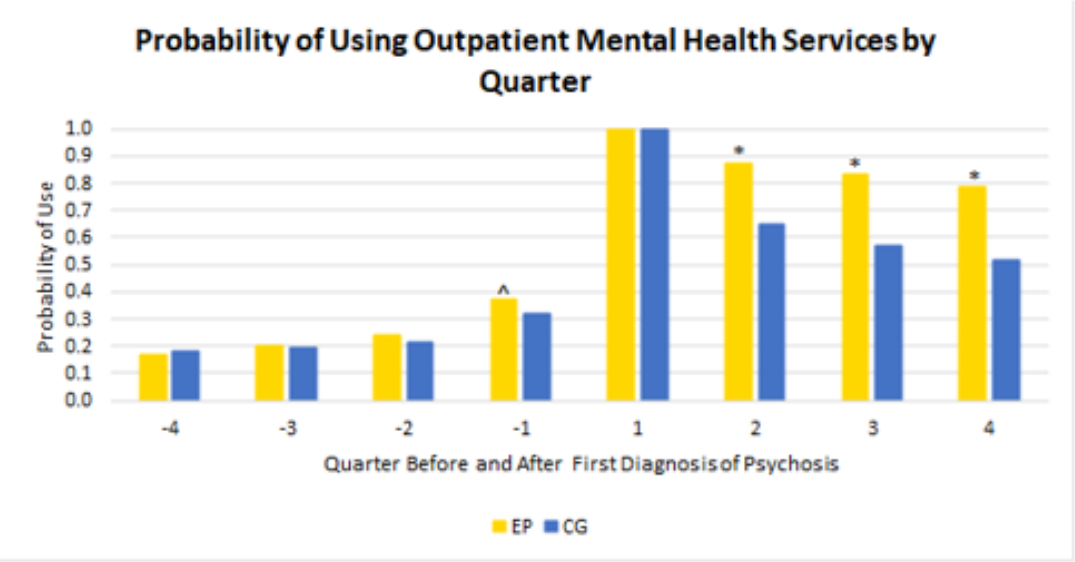
Figure 20: Probability of Inpatient Admission Over Two Years



^$p < .05$; *$p < .001$

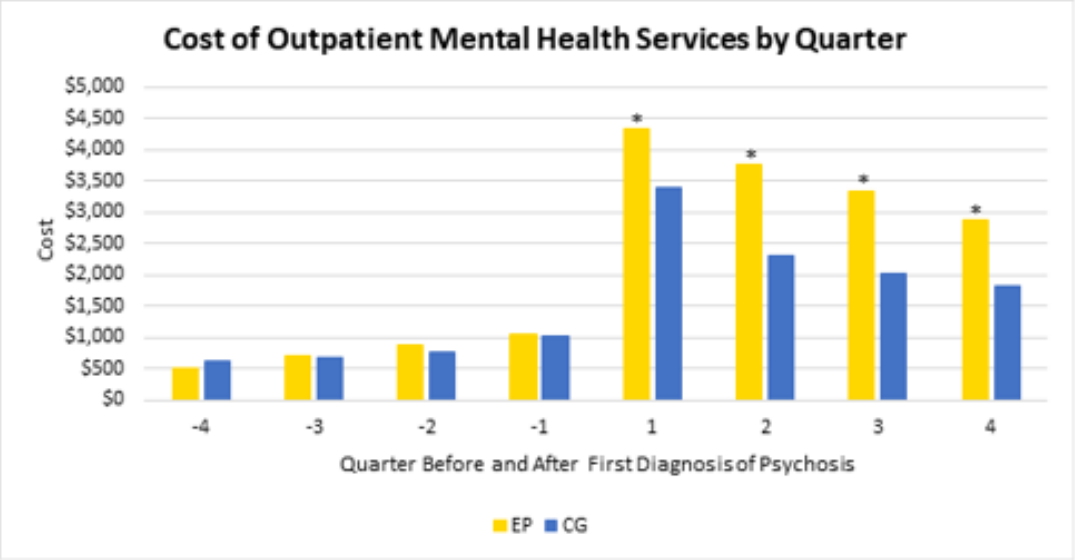
Figures 21 and 22 show the standardized estimates of outpatient service use and costs in the four quarters before and after receiving an initial diagnosis of psychosis. Youth in the EP group were more likely to use outpatient services during the quarter prior to initial diagnosis (P=.026) and in each of the quarters following diagnosis (P<.001 each; all youth used services in the first quarter following diagnosis by data set definition). Costs of outpatient services were higher for EP youth in each quarter following diagnosis (P<.001 each). Overall costs for EP youth were $6,413 higher over the two-year period (P<.001), which was driven by higher outpatient costs, see Figure 23.

Figure 21. Probability of Using Mental Health Outpatient Services Before and After First Diagnosis of Psychosis



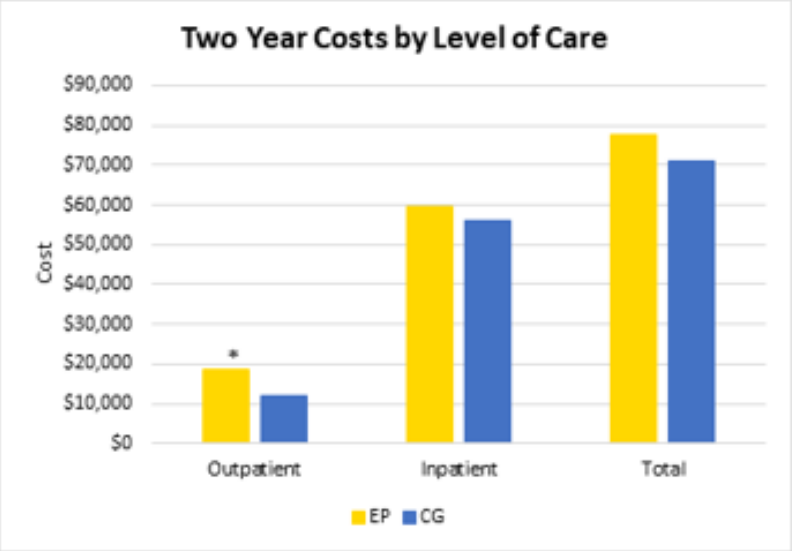
^$p < .05$; *$p < .001$

Figure 22. Costs of Mental Health Outpatient Services Before and After First Diagnosis of Psychosis



^$p < .05$; *$p < .001$

Figure 23. Two Year Cost of Mental Health Services by Level of Care

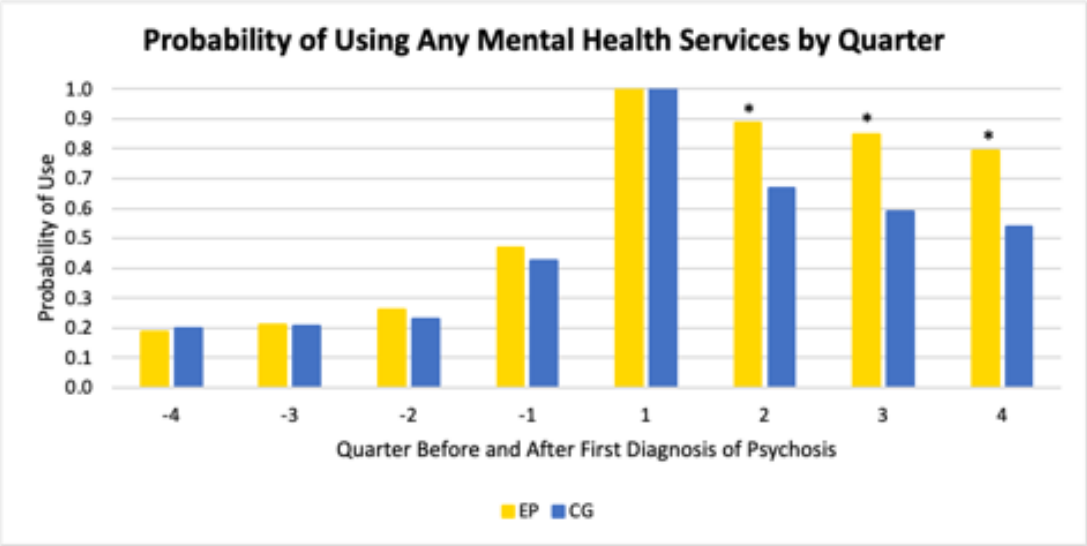


^$p < .05$; *$p < .001$

Figures 24 and 25 show the total service use and costs among youth. The probability of using any services was higher among youth in the EP group in the quarters following first diagnosis (P<.001 each). Total costs were significantly different between the groups in the fourth quarter prior to diagnosis ($1,048 lower among EP youth, P=.029) and the third quarter following diagnosis ($3,321 higher among EP youth, P=.008).

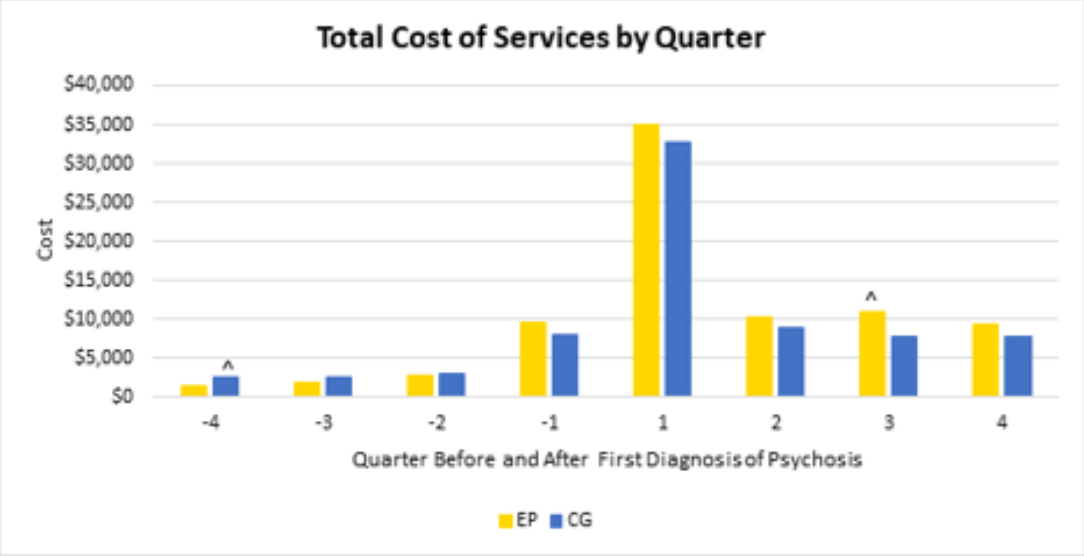
Total costs were not significantly different between groups over the two-year period. There were also no differences in use or costs of crisis services between EP and CG youth (data not shown).

Figure 24. Probability of Using Any Mental Health Services Before and After First Diagnosis of Psychosis



^$p < .05$; *$p < .001$

Figure 25. Costs of All Mental Health Services Before and After First Diagnosis of Psychosis



^$p < .05$; *$p < .001$

Discussion

Youth enrolled in EP programs had higher outpatient service use and costs than a comparable group of youth who were receiving services in standard outpatient programs in the quarters following initial diagnosis of psychosis. This finding is consistent with the intensive approach to early intervention. EP programs provide intensive case management, medication management, and mental health services to improve the long-term trajectory of youths' mental health and quality of life.

Youth in EP programs had a lower probability of psychiatric inpatient use than CG youth in the quarter prior and quarter post initial diagnosis. It is possible that families and providers of youth who eventually enroll in EP programs are more focused on finding non-inpatient treatment solutions, and that entry into EP program successfully keeps youth from needing higher levels of care. There was no significant difference in the inpatient costs during these quarters. There was no difference between groups in probability of use or cost of crisis services. Total costs were also not significantly different between the two groups.

First, the combination of higher outpatient service use and lower inpatient use for youth in EP services is consistent with the goals of CSC to reduce reliance on higher levels of care. Assuming outcomes are better for those in EP care, as was seen in the multi-site randomized controlled RAISE trial (Kane et al., 2016), the lack of difference in cost can be seen as a positive outcome. Better outcomes for the same cost would be seen as cost-effective.

Limitations of our analysis include challenges with identifying youth with early psychosis seen in usual care using diagnostic county records, while the EP group was usually diagnosed using semi-structured interviews. It is likely that some of the CG group have been experiencing psychosis for longer than 2 years, but either the diagnoses or their use of that county's services did not occur until later in the course of their psychosis. There

is also bias in who is admitted to CSC programs that leaves the CG group with more complexity, higher rates of substance use, more comorbidities (e.g. autism spectrum) and need for higher levels of care at baseline. These differences could also explain the difference between groups on service use and cost seen here.

Future directions
We intend to conduct secondary analyses to explore these data further. First, we will compare the EP and CG groups on number of each type of service (e.g., inpatient days), in order to determine whether the lack of cost differences is due to even numbers of inpatient days averaging between the groups or due to variation in inpatient costs. We will also compare the CG and EP groups on specific subcategories of outpatient services (psychotherapy, case management, groups, family services). Finally, we will conduct subgroup analyses to see if outcomes differ based on demographic variables or other baseline characteristics.

We shared these results with all participating counties, sponsors and our Advisory Board on June 5, 2025. We expect to follow up on additional questions raised.

Update for Fiscal Year 24/25:
At this time, we are still working with two counties (Napa and Stanislaus) to obtain, clean and merge their data with the other counties. For Napa county, we have begun merging and integrating their data and are only waiting for diagnostic data for a subset of service users. We expect to complete remaining tasks shortly and will analyze the data once all available data is also merged and integrated. For Stanislaus county, we have decided to request a new data pull for all servicer users and costs. Due to delays between initial submission and analysis, both parties have agreed this is the best course of action at this time. Given the work already conducted on previous versions of the datasets, we anticipate receiving all data by the end of August 2025, and being able to clean, harmonize and merge the data with the multi-county dataset by October 2025, for completion of primary analyses with the 6-county dataset by December 2025. We will be able to obtain stakeholder feedback, then summarize and respond to all feedback by June 2026.

9. Summary of experiences and feedback from all stakeholders, that is responsive to stakeholder feedback on draft report

An earlier version of this section of the report was submitted in prior annual reports and has been updated with additional data.

A mixed-methods study exploring the benefits, drawbacks, and utilization of data in care: Findings from the EPI-CAL early psychosis learning health care network
Using data collected in routine care delivery to inform treatment is a key feature of a learning health system (LHS). In this study, we explored the experiences of service users and providers adopting measurement-based care (MBC) in early psychosis (EP) specialty care settings. Qualitative interviews were conducted with 32 providers and 12 service users across 18 programs in the Early Psychosis Intervention Network of California (EPI-CAL). These findings were compared and contrasted with quantitative utilization data from Beehive, EPI-CAL's data collection and review application. In the qualitative data, three broad themes were identified regarding the clinical benefits of MBC in EP; supporting safety monitoring and response, the assessment process, and delivery of psychotherapy. Outside of direct clinical care, provider participants reported that Beehive can support clinical supervision and external reporting, while service user participants described how data collection can facilitate self-reflection. In the quantitative Beehive application data - collected from 23 EP programs - high utilization of the safety alert system was evident (349 alerts in total, of which 338 [96.85 %] were resolved at a median of 2.03 days). However, service users' key survey data was only reviewed by

assigned providers in 32.22 % (142 of 441) of cases. While providers and service users saw many benefits to Beehive, utilization was highly inconsistent outside of the alert system. Going forward, further consideration of how best to support EP providers to consistently use data in care is necessary to maximize the utility of the LHS approach and positively impact outcomes.

Methods

Qualitative interview participants

For provider participants to be eligible, they were required to have enrolled service users into Beehive, assisted service users or support persons with the enrollment or data collection process, integrated Beehive data into care delivery, or supervised those charged with conducting these activities. Purposive sampling was utilized to ensure provider participants were recruited across as many of the 23 active programs as possible. Similarly, efforts to recruit clinic coordinators, supported education and employment specialists, case managers, clinicians, and senior management were made to explore how staff in different roles experienced the application.

For service-user participants to be eligible, they were required to 1) be at least 15 years old, 2) be able to complete the interview in English, and 3) have engaged with the Beehive application while receiving care from a participating EP program. The latter could include enrolling in Beehive, entering data into Beehive, or knowingly receiving care informed by Beehive data.

Quantitative data: Beehive-application-use participants

Participants included all providers and service users who agreed to their Beehive data being used for research purposes. This was confirmed as part of the Beehive End User License Agreement (EULA) process (Tully et al., 2023), which includes a video explaining how data is stored and used and an opt-in/opt-out agreement to use data for research purposes. Since data sharing permissions are required for each type of Beehive user (service user and provider), each dyad had to agree to data sharing for research purposes for their data to be included in the analyses.

Procedures:

Qualitative interview procedures

All EPI-CAL team members, including point persons, program coordinators, and senior leadership serving in clinical and non-clinical roles participated in interview guide development. Interview guides focused on Beehive users' impressions of the application and their experiences of training, enrollment, registration, entering data, and using data in care.

Approximately one year after the initial implementation of Beehive, providers at EPI-CAL programs were contacted to participate in qualitative interviews. Upon completion of the provider interviews, service-user recruitment began. All participants were compensated $30 - $50 (compensation was increased during the study to reflect inflation and boost participation). Up to two investigators were involved in each interview (LB, MS, and/or RG). Throughout data collection, the research team met frequently to discuss preliminary themes and refine the interview guides, where necessary. Interviews were audio recorded and transcribed, with identifying information removed.

Quantitative Beehive data procedures

How providers used Beehive in care was explored by examining the frequency with which providers reviewed service-user data, responded to pop-up prompts asking providers how they used this data in care, and how providers addressed urgent clinical issues.

To measure how often providers reviewed service-user data, research staff manually inspected each service user's Beehive data summary page to determine if service users' data had been reviewed by their assigned provider. The reviewed measures (symptom, recovery, and life outlook) were selected based on identification by community partners as key outcomes in EP care (Savill et al., 2024).

To explore how providers used data in care, researchers reviewed the "data-use-in-care pop-ups" Beehive feature, which is a screen that appears every 7-10 times the assigned provider visits a service user's Beehive data page. The pop-up asks: "How was this data used as part of care?", and providers are given options to select all that apply from a checklist.

To examine providers' use of the alert system, researchers reviewed data from the urgent clinical notifications widget. While resolving alerts, a provider or administrator reports how they responded with an "all-that-applies" checklist on how the data was used in care, the same as for the data-use-in-care pop-ups. All data related to data-use-in-care pop-ups and urgent clinical alerts were obtained via a report generated from Beehive.

Results

Summary of Qualitative Analysis

In total, 32 providers and 17 service users were interviewed. Participant details are summarized in Table IX. Providers represented 16 different EP programs. A total of 12 interviews were completed with providers who work in university programs, and 20 in community programs. A broad range of provider roles are represented, including clinicians (n=12), program managers and senior leadership (n=9), intake and program coordinators (n=5), supported education and employment specialists (n=2), and peers, research assistants, case managers, and administrative leads (n=4). Service user participants represented 9 different EP psychosis programs, with 5 from university programs and 12 from community programs. In total, 78% of the providers and 29% of service users identified as female.

Table IX: Provider Participant Demographics

	Providers (n=32)		Service Users (n=17)	
Provider Participant Demographics	**n**	**%**	**n**	**%**
Programs				
Total EP Programs Represented	18	-	9	-
UCD SacEDAPT	2	6	1	6
UCD EDAPT	1	3	3	18
UCD SacEDAPT & EDAPT	4	13	-	-
UCD EDAPT & MCC	1	3	-	-
Aldea SOAR Solano	3	10	-	-
Aldea SOAR Sonoma	1	3	-	-
Aldea SOAR Napa & Sonoma	3	10	1	6

	Providers (n=32)		Service Users (n=17)	
Kickstart Pathways	1	3	-	-
IMCES 3 & 4	3	10	2	12
SFVCMHC	1	3	1	6
The Whole Child	1	3	3	18
The Help Group	1	3	-	-
OC CREW	2	6	-	-
San Mateo Felton re(MIND)	1	3	3	18
UCLA – Aftercare	1	3	2	12
UCSF PATH	1	3	-	-
UCSD CARE	2	6	-	-
Stanislaus LIFE PATH	3	10	1	6
Program Type				
University	4	13	5	29
Community	20	63	12	71
Both	8	25	-	-
Gender				
Male	7	22	12	71
Female	25	78	5	29
Other	0	0	0	0
Ethnicity				
Asian	2	6	1	6
Black / African American	1	3	3	18
Hispanic / Latinx	12	38	7	41
Jewish	1	3	0	0
Middle Eastern	1	3	1	6
White	7	22	0	0
More than one race	1	3	5	29
Missing	7	22	0	0
Role				
Clinician Providers	12	38	-	-

			Providers (n=32)		Service Users (n=17)	
		Managers/ Supervisors	9	28	-	-
		Coordinators	5	16	-	-
		SEE Specialists	2	6	-	-
		Other	4	13	-	-

Key: SEE, Supported Employment and Education, SFVCMHC = San Fernando Valley Community Mental Health Center, IMCES = Institute for Multicultural Counseling & Education Services, MCC = Multi-County collaborative, UCD = University of California, Davis, UCLA = University of California, Los Angeles, UCSD = University of California San Diego.

Providers and service users described numerous benefits of MBC delivered via Beehive, which are grouped under three overarching themes: direct benefits to clinical care, benefits of data collection outside of direct care provision, and how Beehive supports improved care. Perceived drawbacks of Beehive fall under two broad themes: negative impacts of data collection and the limitations of data in informing care. Quotes for each theme are presented in Table X below.

Table X. Select quotations on the acceptability of Beehive, coded by theme

Direct Benefits to Clinical Care
Safety monitoring: *The alerts that I get are really, really helpful and really important. … And some of those, we didn't realize the thoughts of self-harm or harm to others was even happening. (1010, clinical supervisor)*
Assessment: *That Beehive baseline is so essential for me in my work because it really helps me target my questions and it helps me cut back on that intake. Like, 'Okay, they didn't have any trauma. I'm going to ask one question only and if the answer is no, then I'm not even going to touch on it.' (1025, clinician)*
Supports delivery of psychotherapy (*Psychoeducation, goal setting/ treatment planning, and initiating therapeutic conversations)*: • *So Beehive is used as part of a treatment for service users to help them gain information about what their treatment plan is and also different parts of their overall treatment. And this helps to record that, help them track it. (1021, SEES)* • *Asking the service user, 'Where would you like to work on the next one month or two months?; or creating small little goals out of the data. … It's definitely another tool I use if it feels like we don't have a clear direction of where they want to go. (1015, clinician)* • *I think it definitely helped because it would get my case manager and therapist to bring up some issues that I myself wouldn't have brought up otherwise. … The surveys gave me the opportunity to be vulnerable so that I could fix my issues later on during my appointments with my doctors. (2006, service user)*
Benefits Outside of Care Provision
Supervision: *I like that I can easily go in under a provider username or a service user username and see all of their data as someone that's providing training and supervision. It's really helpful for me. (1001, clinician)*

External reporting: *Because we can get more real-life data in Beehive, this'll be the first year that I'm writing a report … where I can use some of the data that actually applies to these service users, versus the data [county name] wants us to use. (1018, clinical supervisor)*

Advances EP field: *I feel like it's a good thing to do … and hopefully prove it's worthwhile having the early psychosis intervention so other places can look at the research and think, 'Maybe we should do this.' (2005, service user)*

How Beehive Data Supports Care

Provides information not disclosed: *[The clinician asks about] some of the survey questions, ask questions about things that I wouldn't be able to say out loud, and he'll be able to see it. He'll be able to know the answer, and I want him to know. (2010, service user)*

Person-centered approach: *I think that it's a really nice way to talk with patients about mental health and about how they can have more empowerment over their own mental health and that talking about these things and filling out questionnaires like this makes them more aware. … Whenever they fill out a survey, we end up talking about it. And I think that's very powerful. (1026, clinical supervisor)*

Supports independent reflection: *Each question as I'm going through it, I'm like, 'Oh wow, I didn't think to ask myself this. I didn't think to kind of do a mental check-in. Am I experiencing a little bit of depression, or anger, or anxiety? Or am I really happy?' … Sometimes I'll forget to ask myself those questions, and when the survey asks me, that's a good time to you know, just check in. (2004, service user)*

Progress monitoring: *If they feel as though they're stuck, then I like to pull that up to assist them in looking at baseline and where they're at now, even if it's just a little shift, a little move. I think that that's empowering, that gives them hope. (1024, clinician)*

Drawbacks

Negative impacts on care *(Takes time away from care, impacts rapport):*

- *We are seeing people for therapy less frequently. So taking a session or two to do assessment is a little more disruptive if you're only seeing people every two or three weeks, versus if you're seeing them every week. (1007, clinical supervisor)*
- *It does impact rapport with the service user. When they have to decide, 'I'm going to lose his service user, because I'm already having trouble engaging him, and now I'm supposed to try to get him to fill these forms out and he just doesn't want to do it?' (1000, clinical supervisor)*

Problems with what was collected and how: *(Surveys triggering, reductionist, redundant):*

- *They've been very triggered and that's when they have decided to stop. … I don't know what that would look like for them if they were by themselves completing it. (1014, clinician)*
- *I don't really think about how they can use it to track how you're doing. … I feel like the surveys aren't that frequent, so it wouldn't be super useful compared to just the check-ins with your therapist and their notes. (2005, service user)*

Note: SEES = Supported Education and Employment Specialist

Direct and Indirect Benefits to Clinical Care

Providers identified multiple benefits of MBC through the Beehive system in early psychosis treatment. A central feature was the urgent clinical issues alert system, which notifies providers of high-risk issues, including "risk to self," "risk to others," "risk of homelessness," and "plan to stop taking medication." These alerts were largely seen as enhancing risk assessment and safety planning, although several providers expressed concern

that the system was occasionally too sensitive. Beehive also supported the intake process by supplying self-report data on symptoms, trauma, and substance-use before assessments, allowing for more individualized and efficient evaluations. Furthermore, the platform facilitated therapeutic work by supporting psychoeducation, goal-setting, and the initiation of meaningful clinical conversations. Both providers and service users noted that Beehive data helped identify behavior patterns and opened dialogue on important but often overlooked topics.

Beyond direct care, providers and service users reported benefits related to supervision, reporting, and research. Supervisors found it useful for monitoring caseloads and guiding newer clinicians on treatment goals and risk management. For reporting, Beehive streamlined data collection aligned with EP care standards, making external reporting more efficient and relevant. Additionally, service users expressed appreciation for contributing to research through their participation, viewing it as a way to advance EP care and support others experiencing similar challenges.

How Beehive supports improved care

Providers and service users reported that Beehive supports improved care through improved communication and more person-centered care. Self-report surveys encouraged service users to share sensitive or difficult topics they might not raise in sessions, creating a more open and reflective therapeutic environment. Both providers and service users reported that surveys enhanced mutual understanding and centered the individual's voice in care planning. Completing surveys between sessions was seen as an opportunity for service users' reflection outside of their clinical appointment regarding personal goals, progress, and broader thoughts and emotions related to the process of recovery. Additionally, participants viewed Beehive's visual data tools and the ability to track changes over time as an important factor in improved care. This not only provided actionable insights but also supported engagement in care by highlighting areas of growth and ongoing need.

Drawbacks of Beehive

The most frequently discussed drawback of Beehive was the time clinicians spent assisting service users with survey completion, which some providers felt encroached on valuable session time and detracted from rapport building. While most service-user participants reported no difficulties completing the surveys independently outside of sessions, one user who required additional support acknowledged that survey completion did take away from session time. A second drawback concerned the limitations of survey data in informing care, with several providers and service users suggesting that survey questions could be reductive, miss important nuances, or fail to add value beyond standard care. Some providers also noted that the questions could be upsetting or triggering, though service-user responses were more mixed—some described the experience as "cathartic" (2002, service user), "therapeutic" (2010, service user), or a way to "release stress" (2003, service user). As a result of these issues and other factors, a number of providers reported that they had not used Beehive data as part of care. Of the 32 providers interviewed, 23 were delivering direct clinical care, and among these, 52% (12 providers) said they were actively using Beehive data in their practice, while 48% (11 providers) were not. Stated reasons for not using the data included the time and effort required to administer surveys, skepticism about the data's usefulness, and a need for additional training.

Summary of Quantitative Analysis:

In total, 121 providers and 599 service users were included in the quantitative analysis of Beehive data collected between 2021 to mid-2024. Service users represented were fully enrolled in Beehive (n = 596; i.e., completed the EULA process) or were only registered but endorsed a housing alert (n = 3).

Of 596 eligible enrolled service users, 441 (73.99%) completed at least one key survey in Beehive (symptoms, recovery, and/or life outlook). Of these, 142 (32.22%) had their data reviewed by their assigned provider. Of the three surveys, providers most frequently reviewed symptom data (129 of 427, 30.21%), followed by recovery data (80 of 420, 19.05%]), and then life outlook data (45 of 427, 10.54%).

Regarding how reviewing data informed care, 27 assigned providers triggered the data-use-in-care pop-up question a total of 58 times, representing 52 unique service users. The most frequent use of data was related to providing psychoeducation (n = 22, 37.93%). From the perspective of the assigned provider, the data available reinforced or illustrated progress towards already defined treatment goals almost a quarter of the time (n = 13, 22.41%). In response to visiting the service user's Beehive data page, providers indicated they changed their session plans in variable ways: in 12 cases (20.69%), scheduling a session with the service user's support person; in 10 cases (17.24%), scheduling an urgent appointment; and in 8 cases (13.79%), increasing the frequency of sessions. Finally, providers reported that they "did not change current treatment or session plans" after reviewing the data approximately half the time (n = 30, 51.72%).

In total, 349 urgent clinical notifications were triggered across four alert types (RTS: risk to self [n = 196], RTO: risk to others [n = 108], plans to stop medications [n = 36], risk for homelessness [n = 9]). Between one and six alerts were available for 211 unique service users, meaning some service users could have endorsed the same alert type (i.e., RTS) or multiple alerts (i.e., RTS and RTO) across multiple time points. Additionally, 71 providers who received these alerts resolved between 1 and 34 alerts each, with many providers overseeing multiple alerts for each service user. Almost all notifications were resolved (n = 338, 96.85%), with a median time to resolution of around two days. Across the two symptom risk categories, conducting a risk assessment (RTS: n = 120, 63.16%; RTO: n = 68, 65.38%) was the most common provider response followed by activities supporting safety planning (RTS: n = 52, 27.37%; RTO: n = 27, 25.96%) and scheduling an urgent follow-up appointment (RTS: n = 43, 22.63%; RTO: n = 26, 25.00%). Providers resolving alerts related to plans to stop medication most commonly (n = 13, 37.14%) provided psychoeducation or did not change their treatment or session plans. Several providers (n = 9, 25.71%) stated plans to discuss the medication alert with other team members, which may have included prescribers. Upon being notified that a service user did not have an on-file address, most providers did not change their session plans (n = 5, 55.56%), but many did schedule a session with the service users' support person (n = 4, 44.4%). A full list of responses to alerts and pop-ups are presented in Table XI.

Table XI. Beehive provider measurement-based care responses

	Data Use	Urgent Clinical Notifications				
	Total (*n* = 58)	Total (*n* = 349)	Risk to Self (*n* = 196)	Risk to Others (*n* = 108)	Plan to Stop Medication (*n* = 36)	Homelessness Risk (*n* = 9)
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Resolution of Alerts						
Unresolved	-	11 (3.15)	6 (3.06)	4 (3.70)	1 (2.78)	-
Resolved	-	338 (96.85)	190 (96.94)	104 (96.30)	35 (97.22)	9 (100)
Response Time (Median [days])	-	2.03	2.03	2.13	1.12	6.13
Response Time (IQR [hours - days])	-	3.77 - 8.05	4.57 - 8.03	3.54 - 7.09	2.63 - 14.08	1.27 - 14.60
	Data Use	**Urgent Clinical Notifications**				
Responses *(select all that apply)*	Total (*n* = 58)	Total (*n* = 338)	Risk to Self (*n* = 190)	Risk to Others (*n* = 104)	Plan to Stop Medication (*n* = 35)	Homelessness Risk (*n* = 9)

Data did not change current treatment or session plan	30 (51.72)	72 (21.30)	38 (20.00)	16 (15.38)	13 (37.14)	5 (55.56)
Conducted risk assessment	6 (10.34)	200 (59.17)	120 (63.16)	68 (65.38)	9 (25.71)	3 (33.33)
Created / updated / reviewed safety plan*	8 (13.73)	79 (23.37)	52 (27.37)	27 (25.96)	-	-
Sent for emergency care	4 (6.90)	2 (0.06)	-	2 (1.92)	-	-
Illustrated progress towards specific treatment plan goals	13 (22.41)	14 (4.41)	6 (3.16)	4 (3.85)	4 (11.43)	-
Taught a new skill	9 (15.52)	29 (8.58)	18 (9.47)	10 (9.62)	-	1 (11.11)
Provided psychoeducation	22 (37.93)	58 (17.16)	27 (14.21)	17 (16.35)	13 (37.14)	1 (11.11)
Scheduled a session with collateral	12 (20.69)	58 (17.16)	30 (15.79)	20 (19.23)	4 (11.43)	4 (44.44)
Scheduled more frequent sessions	8 (13.73)	22 (6.51)	15 (7.89)	4 (3.85)	1 (2.86)	2 (22.22)
Scheduled urgent follow-up appointment	10 (17.24)	71 (21.01)	43 (22.63)	26 (25.00)	2 (5.71)	-
Modified treatment plan	6 (10.34)	8 (2.37)	5 (2.63)	2 (1.92)	1 (2.86)	-
Denied response**	-	9 (2.66)	6 (3.16)	2 (1.92)	-	1 (11.11)
Plan to follow-up at next session**	1 (1.72)	20 (5.92)	8 (4.21)	4 (3.85)	8 (22.86)	-
Other (e.g., entering data, preparing for assessment/reassessment)	5 (8.62)	-	-	-	-	-
Other (e.g., updated another provider, discharged)	-	38 (11.24)	17 (8.95)	11 (10.58)	9 (25.71)	1 (11.11)

*Category merged across checklist and manually coded "other" values

**Category does not appear in the response options checklist (see Supplemental Materials 2 for provider's view of original checklist categories)
IQR (Inter-quartile range.

Summary of Benefits and Drawbacks of Beehive from the Perspective of Early Psychosis Program Providers and Service Users

Overall, providers reported mixed experiences of integrating the Beehive system into their early psychosis program. Some providers reported that Beehive was easy to use and brought a multitude of benefits as a clinical tool, a supervision aid, and a method to quantify clinic-level data. Multiple service users discussed how Beehive data helped prompt clinical conversations and how filling out surveys provided an important opportunity for independent reflection. However, outside of responding to potential risk issues, the utilization of data in care was low. This is notable given that service-user interviewees expressed a desire for their data to be more integrated into care, rather than less. While findings suggest clear benefits of the MBC approach, some providers highlighted drawbacks, suggesting that Beehive surveys were time-consuming and created a barrier to the effective delivery of early psychosis care. Given the variability of perceptions and experiences of using the tool, it is critical to explore barriers and facilitators to effective utilization to attempt to understand some of the root causes of this variability. Such work may provide important insights to support the improvement of implementation and effectiveness network-wide.

Barriers and Facilitators to the Implementation of Beehive and Measurement-Based Care in an Early Psychosis Setting

Background

Implementing measurement-based care can be challenging, both in terms of data collection and utilization (Lewis et al., 2019). Barriers that have been identified can include finding the service-user time to complete data collection (de Beurs et al., 2011; Lewis et al., 2019), the impact of service-user symptoms (Lavallee et al., 2016), practitioner attitudes, administrative burden (Jensen-Doss & Hawley, 2011), high staff turnover, and a lack of incentives (Boswell, Kraus, Miller, & Lambert, 2015).

These challenges may be especially pronounced in early psychosis settings. For example, early psychosis programs often emphasize rapid referral and intake procedures, which can make it difficult to incorporate additional data collection into the already intensive intake process (MacDonald et al., 2018). Furthermore, service users in these programs frequently experience symptoms such as cognitive impairment, intrusive delusions and hallucinations, and amotivation (American Psychiatric Association & Association, 2013), all of which may hinder the completion of self-reported outcomes measures.

As noted above in Section 3.5.1, utilization of Beehive data in clinical care remains relatively low across the EPI-CAL network. To understand the barriers and facilitators to implementation, the EPI-CAL team conducted a series of interviews with providers and service users across the network. Identifying these key factors is essential for two primary goals: (1) improving the implementation and impact of Beehive in individual clinics and across the network of EPI-CAL, and (2) contributing to generalizable knowledge about integrating measurement-based care tools like Beehive into early psychosis care settings.

Methods
(see section 12.1 for a summary of qualitative research methods for this study)

Summary of Qualitative Findings
Provider and service user participants identified barriers and facilitators to Beehive implementation, focusing on three broad areas: general factors that related to implementation as a whole, factors that impact Beehive data collection, and factors related to using Beehive data in care. A summary of key themes in each of these areas is presented below and in Table XII.

I. General Barriers and Facilitators to Utilizing the Beehive Platform
A frequently cited barrier was the presence of bugs and technical difficulties in the Beehive application. Reported issues included problems with logging into the system or viewing the End User Licensing Agreement (EULA) video, progressing through the survey bundles, slow page loading, and limited functionality on mobile devices, which could be problematic given that some service users accessed Beehive via smartphones outside of the clinic. Providers stated that these technical issues were considered a source of frustration to providers, service users, and support persons, and were noted to contribute to disengagement from the platform. In some cases, persistent technical difficulties experienced during sessions with the provider reduced the time available for clinical care.

Importantly, these problems were more commonly reported in early interviews. More recent participants, both providers and service users, indicated that software issues have substantially improved over time. Newer users often did not report significant problems, suggesting that software improvements by the development team have addressed many initial concerns. In some cases, connectivity issues were resolved by providing mobile internet hotspots, which proved especially helpful when working with service users in the field.

In addition to the resolution of technical problems, several technological factors were described as facilitators of Beehive implementation. Many participants found the software easy to use after an initial period of

familiarization. A certain level of technological literacy was considered essential, with providers noting that individuals who were more comfortable with technology adapted to Beehive more quickly. In contrast, those with limited technological experience, particularly family members, were more likely to struggle. Providers also emphasized the responsiveness of the EPI-CAL team in addressing technical issues. In particular, liaison staff who acted as points of contact between clinics and the EPI-CAL team were seen as instrumental in troubleshooting problems and maintaining momentum. Regular check-in meetings between clinic teams and these point people were also described as highly beneficial.

Organizational barriers were a prominent theme in the interviews. Providers frequently cited low staffing levels and high staff turnover as obstacles to Beehive implementation. When programs lacked sufficient clinical or administrative staff, it was difficult to support the added responsibilities associated with Beehive. The lack of administrative staff support was particularly acute in clinics funded by private insurance, as opposed to Medi-Cal billing, which included most university-based programs. Staff turnover was also seen as a barrier, as this required ongoing Beehive retraining.

Providers described key organizational facilitators to implementation, including leadership support, collaboration, and training. One program-level facilitator identified by multiple participants was the presence of strong leadership support. Programs in which clinical leadership actively promoted and prioritized Beehive implementation tended to show more consistent use of the platform and better integration of data into care. In some clinics, individual team members served as onsite champions who took responsibility for driving Beehive adoption, supporting colleagues, and addressing emerging issues. Their efforts were often central to successful implementation.

Collaboration between team members was also viewed as essential to successful implementation. Providers described how responsibilities related to enrollment and data collection were shared across the clinical team, helping to distribute workload and increase overall engagement with Beehive. Several providers reported that open communication, coordinated efforts, and teamwork have been critical to problem-solving and ongoing success.

Training also played an important role in facilitating implementation. Most participants reported that the initial Beehive training sessions were highly useful and addressed their key questions and needs. However, given the frequency of staff turnover, some current staff members had not received training. Additionally, in some cases, there was a significant time gap between the initial training and the point at which staff were able to apply the system in practice. As a result, some providers reported forgetting how to use key features by the time they began working with service users in Beehive.

II. Data Collection Barriers and Facilitators

Barriers to Data Collection Experienced by Providers

The most cited provider-level barrier to Beehive data collection was the time and effort involved. Many providers reported a lack of time, describing feeling burned out and overburdened by the demanding nature of clinical care and the extensive program, county, and state reporting requirements. Due to these obligations, some providers stated that they view Beehive as a lower priority, "extra," or "optional" task. Multiple providers expressed a desire for more integrated data systems, though they acknowledged the challenges of achieving such integration.

The impact of insufficient provider time was considered problematic in terms of finding the time to support data collection and the time to learn the nuances of the system. One solution proposed by some participants was for

service users to complete more surveys at home, rather than during clinical time. However, while this appeared to be an effective solution for some service users, it led to Beehive surveys not being completed for others.

Facilitators to Data Collection Experienced by Providers

Providers identified two key facilitators that support successful data collection. One major facilitator was the involvement of administrative staff. Depending upon the clinic, this support took on different forms, from assisting with enrollment and survey completion to more detailed contributions such as replacing service user anonymized ID codes with secure identifiers in clinic communications or creating data collection calendar reminders to make the process easier for clinics to keep on top of Beehive-related tasks. In clinics that serve privately insured individuals, less administrative support was available due to billing constraints, and this was considered a major barrier to effective Beehive implementation.

Another important facilitator was the strategic integration of Beehive into the clinical workflow. Providers stated that this often required deliberate effort and planning, but ultimately improved data collection processes. Clinics implemented various strategies to support this integration. In some settings, responsibilities for data collection were shifted from licensed clinicians to administrative personnel, while in others, survey completion was postponed until later in the intake process. Although collecting data later precluded the inclusion of survey results in initial assessments, which was considered a drawback, providers noted that having more clinical context and fewer administrative distractions at that point made survey completion more manageable and efficient. Notably, amongst clinics where Beehive integration has been particularly effective, one has incorporated Beehive very early in the process, while the other initiates Beehive approximately 4-6 weeks after the first appointment. This suggests that, rather than a one-size-fits-all solution, flexible, site-specific strategies may be more effective.

Barriers to Data Collection Experienced by Service Users and Support Persons

Service user participants reported few barriers related to Beehive data collection. This contrasts significantly with the service user barriers reported by providers (see below), and it is important to note that this may reflect a selection bias, as those who volunteered for Beehive interviews may feel more positively about the platform. Still, this is an important finding that highlights the positive experience some service users have with Beehive. The time reported for completing all the surveys varied significantly, ranging from 30 to 90 minutes. However, even those who found the process somewhat lengthy described it as manageable and worth the time. Most service users said the survey questions were clear and did not require explanation, although several did have questions about the meaning of some survey items; these were typically addressed by a parent or provider. Service users also described Beehive surveys as easy to complete on both the iPad and their phone. Three service users reported challenges when answering sensitive questions, including feeling anxious about how their data would be used, which they sometimes described as related to their symptoms. One chose to skip a question altogether, after speaking to clinic personnel, who were unable to fully reassure them about responding to that item.

Provider participants described a range of service user experiences with Beehive data collection. Some service users completed surveys successfully with little assistance, while others faced significant obstacles. Providers explained that the time required was a barrier for some service users. This was especially true when service users were managing acute symptoms or other urgent needs, particularly during the initial stages of care. Symptom-related barriers that may impact concentration, understanding, or comfort with the survey questions were also mentioned as important barriers for some. Limited internet connectivity and the challenges of navigating Beehive on a mobile phone were frequently cited issues that disproportionately affected those with

lower resources. Additional obstacles included worries about data privacy and a lack of interest or motivation from service users themselves or family members.

Facilitators to Data Collection Experienced by Service Users and Support Persons

While the majority of service users said that they completed the surveys independently on a phone or tablet, some preferred to complete the surveys during a session with a provider, whether an intake coordinator, supported education and employment specialist, or clinician. This additional support was considered important to explain the benefits of data collection, address questions about survey questions or data privacy, and to strengthen rapport – all recognized as important factors in engagement. Providers also viewed this form of support as a key facilitator for data collection. However, clinics where staffing was already stretched or experiencing burnout sometimes found it challenging to provide this additional help consistently.

Providers described other facilitators to support service users' Beehive engagement related to the timing and frequency of data collection. Some providers chose to delay survey administration until after the initial intake period, allowing service users more time to adjust to care and reducing the burden of completing surveys during a hectic data collection phase. Furthermore, providers sometimes prioritized specific survey batteries and distributed their administration across multiple sessions, making the task more manageable.

In relation to completing surveys at the clinic, both providers and service users stated that providing a private area to complete surveys was especially valued. Additionally, explaining the broader purpose of Beehive data collection, particularly its dual role as a clinical and research tool, helped service users and their families appreciate the value of their participation.

Looking forward, some providers suggested that revising the survey battery to reduce its length may further support sustained engagement and successful implementation of Beehive.

III. Data Use in Care Barriers and Facilitators

Barriers to Data Use in Care Experienced by Providers

A key barrier to data use in care among providers involved difficulty accessing survey data. Some providers reported challenges remembering how to navigate dropdown menus to locate specific survey results and noted that the volume of information available could be overwhelming. Reviewing charts with service users during clinical sessions was also described as cognitively demanding, particularly when attempting to identify and prioritize the most relevant data for care decisions.

In order to address this challenge, many providers expressed a need for more streamlined data presentation. Several suggested the addition of summary reports in PDF format to allow for easier scrolling and quicker reference during sessions. Others proposed the development of service-user-friendly reports that could be uploaded directly into the service user's chart, improving integration into the care process.

Facilitators to Data Use in Care Experienced by Providers

Several factors were identified as facilitating Beehive data use in care. Some providers highlighted the utility of Beehive's data visualizations, which they found helpful when reviewing progress with service users. Providers with prior training in the use of data in clinical care noted that this background supported their confidence and interest in implementing measurement-based care. Additionally, providers emphasized the benefits of receiving critical data alerts automatically, rather than having to search for them within the Beehive system. These alerts, related to high-risk concerns such as suicidal ideation, risk of homelessness, or plans to stop taking

medication, were seen as highly valuable. Several providers suggested expanding this feature to include additional clinical indicators.

Barriers to Data Use in Care Experienced by Service Users and Support Persons

Few service users interviewed reported that their data had been used in clinical care, limiting the insights available from the service user perspective regarding barriers. However, two service users suggested that increasing the frequency of survey completion could make it easier to incorporate data into care, as more data points would be available for review.

Facilitators to Data Use in Care Experienced by Service Users and Support Persons

The primary facilitator of data use in care from the service user perspective was the strength of their relationship with their provider. Service users who experienced responsive engagement from their provider regarding Beehive surveys were more likely to perceive the data as meaningful and relevant. Additionally, several service users noted that Beehive allowed them to express topics that were difficult to raise in conversation, and they appreciated it when providers acknowledged and addressed these issues during sessions.

Table XII. Select quotations on barriers and facilitators in Beehive implementation, coded by theme

I. General Barriers and Facilitators
a. Technology Barriers
Bugs, glitches
• We've had issues [with the application] for sure… It seems like when I first started, there was a lot of, "They can't get the tablet to work, they can't log in on the tablet. We don't know why." It was a lot of trial and error as far as that goes, but now it seems like every time we're using it with them, it's going a little more smoothly. (1025, clinician)
b. Technology Facilitators
User-friendly software
• It's very user-friendly. With anything, of course, it's going to take a couple of minutes to a couple times to understand it, but other than that, there's no difficulty in using Beehive (1005, case manager)
• I'd say it's pretty good platform. I think I'd probably compare it to other analytical devices like I think SurveyMonkey…If anything, it's a little bit more streamlined than SurveyMonkey. I think it's a lot more user-friendly… (2004, service user)
Technology knowledge and skills
• In the beginning, some [providers] found it easier than others because some were just more computer savvy (1018, program lead)
• Some people are able to finish all of the surveys and love using tablets, they're so excited to finish things and bop through all the buttons. (1019, clinical supervisor)
Responsiveness of EPI-CAL support team
• We have a short 10-minute check-in… It's usually 5,10 minutes on a weekly basis, if there's any issues. And when staff have run into issues, they just email her directly and we figure it out. We haven't had a whole lot of problems with it. She's been very receptive. (1018, program lead)

- The support from UCD has been astonishingly helpful…We didn't all come into this field to sit around with data all the time. That's not the people that we have… And so everybody's been massively supportive and then once we get it, we can do it. (1000, clinical supervisor)

c. Organizational Barriers

Understaffed / staff turnover

- We were having the service user and their support person come to their welcome session 30 minutes early… to meet with our program coordinators to go through those surveys with them. Due to some staffing shortages now that hasn't been able to happen as much. (1025, clinician)
- Turnover's happening all the time. I just wish in a perfect world where I could see the future and know, hey, in a couple of months it's going to be stable and I'm going to be fully staffed, and those staff are going to stick around for a while. That would be a great time to come and do a refresher training. (1010, program lead)

d. Organizational Facilitators

Support from clinic leadership

- I think my director does that part on his own reaching out to Beehive to [address Beehive issues] and then brings it to us. So that's where he has been really supportive and, "Okay, what is the issue? Let me figure it out," and then brings it to us or resolves the issue so that we don't have to focus on that. (1014, clinician)

Collaborative approach

- Even if the clinician is not available and the service user is still coming in for a group or of any sort, a medication appointment, we all know that there's a survey that needs to be done. And anyone is willing to help and do help and support that service user, and the clinician doesn't have to be here. Any one of us can help and support and get that survey completed, so that's fortunate too. (1027, clinic coordinator)
- Yeah, there's a lot of open communication. We have weekly team meetings, and just... There's always collaboration on how Beehive is working, and if anyone needs extra help. (1015, clinician)

Beehive trainings

- I personally learned a lot from the training… just how to navigate the system and how to read it and know what means what, or what surveys need to be done, or how it's completed…That was really helpful for me with the training. And it helps me support and train the clinicians as well. (1027, clinic coordinator)

II. Data Collection Barriers and Facilitators

(a) Provider Data Collection Barriers

Time and effort required

- I think that [Beehive] adds to the staff feeling a little bit burned out. "Now I've got to do the phone call or schedule the in-person or do all of this, just so I can get that data. And then I've got to put that data in four different places, and now three hours are gone" kind of a thing.(1001, clinician)
- It's a lot, [Interviewer]. I think I come from a place where I like surveys and I like that extra data and I like research, but I've heard other clinicians say, "It's a lot of work." There's a lot of clicking. There's a lot of looking around. It gets busy for the eyes sometimes. (1028, clinician)

(b) Provider Data Collection Facilitators

Administrative staff role

- The program coordinators have kind of been involved with the service user setup from the beginning.

They're setting up the interviews, they're getting the consent forms, they've really followed this service user all the way until the clinician meets them at treatment. So they're really following the data in Beehive, and making sure that we have everything ready, so that the data can be collected correctly (1015, clinician)

Integrating into clinic workflow

- So we've just started actually trying to implement it more widely as part of our standard care. When we register our patients, we have someone who registers our patients on Beehive and goes through the process of the EULA and everything, signing that part. And then our clinicians are supposed to do their part of the clinical ratings. Then we go ahead and schedule a follow-up where there will be a feedback session with the participant, where we can then talk about the assessments. And then we have this one individual who calls our patients and tries to remind them to complete their part of the form. And then we'll try to do that after six months again. (1030, program lead)

(c) Service User and Family Data Collection Barriers

Survey length

- It felt manageable. [The time required] was mainly just because I was thinking and recollecting memories and everything like that. (2001, service user)
- I feel like if you're motivated to do it, I feel like it is, it probably is a little bit long, but it doesn't feel that long because for me, I like talking about my psychosis. I like talking about my situation and how I feel and stuff in my personal life. So it didn't feel that long for me and I liked it. (2003, service user)
- Every service user has different capacities and their cognition is different too… They would ask me questions, "What does this mean?" And so stopping to explain that or being able to reframe the question that they've been asked, it takes more time. Even though it says three minutes, I remember some of them didn't take that long, so that's why we weren't able to finish. (1014, clinician)

Effort required to complete surveys

- They're just going through other situational family life things, and it's overwhelming to do the Beehive surveys for them right now. And they're managing crisis for their loved ones in the clinic. And so they want to focus on that, versus the repeated emails from Beehive. That's direct feedback from them. (1006, clinic coordinator)

Access to technology

- Not all families have access to devices that can be used with Beehive. Not all of them have multiple devices. So if they're on Zoom with us doing the appointment, they are having trouble also using the Beehive link. (1006, clinic coordinator)
- We had to connect through our cell phones, and sometimes it didn't work. Sometimes we wouldn't have a connection, because a lot of people live in apartment complexes and stuff. So, I had to be with my tablet and my cell phone, kind of walking around. Sometimes I would meet with them in the park or asking for WiFi to the Starbucks person. So, thankfully they just mailed us two hotspots. (1020, case manager)

Symptom-related barriers

- I felt a little stuck on some of my questions… It was almost like a fixation, I was stuck on the question that they asked me, and I couldn't move forward from it… It was a like a roadblock… It was an insecure feeling like where are they going to take these questions." (2011, service user)
- Mostly just negative symptoms. There's been a few kids, probably like 30%, 35% of my kids who just straight up refused outright, or didn't want to participate at all. So I think the barriers would probably be symptoms. (1012, clinician)

Concerns about data privacy

- I mean they're just not comfortable with their information going to different places and not knowing where it's going to end up. And also I think there's a lot of mistrust among immigrants when they're not documented. (1022, clinician)

Not motivated to complete surveys

- I think it's motivation and will more than anything. There has been maybe some issues as far as them thinking they filled it all out but realizing there's other surveys and they just have to get to it, that type of thing. But I think the biggest thing is just them finding the motivation to do it. (1013, clinician trainee)

(d) Service User and Family Data Collection Facilitators

Prioritizing and breaking up survey bundles

- We don't make them do it all in one shot. And I like how it's set up where I'll say, "This is a 10-minute one, this is a 15-minute one." So we'll say, "Oh, look, these two are just going to be 15 minutes, so we'll have you do those. We'll do the next surveys next time." (1018, program lead)

Provider support and reassurance

- Maybe it would be helpful if they have someone helping you fill it out. I know people like me, they sometimes aren't ... they might think something happened, but it didn't. That's why I was concerned about it. That's what I was thinking when I was filling out. (2008, service user)
- I did talk about it to one of my counselors. I was telling them, "Ooh, I don't know how I felt about that question." And then when I talked to them more about it, they kind of helped me through it. And then once I got back to those questions, I was fine. (2007, service user)
- And with the population that these surveys are meant for and the population that we serve, it can be a struggle… and so it can require as well taking time out of our sessions to support them in the surveys as well as reaching out to their support person or having their support person with them so that they can do those surveys. (1025, clinician)
- The younger ones tend to need more support, so I'll help them if they're having trouble reading it or if there's something going on with the processing… I make sure we take it slow, being patient with them, and they'll read it and I support them. Or if they need me to read it, I'll support it with them. (1021, SEES)

Completing surveys in person

- When they do the surveys in office in person, it's been a breeze. There hasn't been any concerns or questions about clarifying what they're being asked or how to answer questions. It's something that the service users can do very independently, taking the tablet, answering the questions on their own and going through that… I do kind of have a mix of people who can do it in the office and prefer to do it that way and then two people who can do it independently. (1011, SEE specialist)

Appropriate space

- Probably a private room would've been nicer. Yeah… It just felt like I was able to gather my thoughts better and with the intense type of questions I would feel a little bit uncomfortable kind of being around someone. Let's say if someone was watching me answer the questions, I would feel uncomfortable. So I think being in a separate room would be more comfortable. (2001, service user)
- Explaining the purpose of Beehive
- To help service users be invested and engaged, I say two things. I say, "Well, this could be used in your treatment since your responses can be tracked over time."… and I also say, "It'll help others. It'll be used in research." And those are pretty effective things to say, and I am able to get service users to be engaged if they're interested in those things. (1002, peer specialist)

III. Data Use Barriers and Facilitators

(a) Provider Data Use Barriers

Difficulties accessing survey data

- As a supervisor, I think the other snags are a little bit of the moving around within Beehive. So if I'm trying to review the forms that they've completed, it's a little tricky to get from one form to the next. I would love to have a printout. (1007, clinical supervisor)
- Streamlining it, making these a little bit more like one or two clicks to find whatever graph you're looking

for. If I want to look up the BPRS and the changes, right now you have to do all this kind of dropdown menus and do all this stuff. I don't even remember how to do it. (1012, clinician)

Survey data missing from service users

- Oh yeah, 100%. I would use Beehive if I could see all that it brings with it. It's just that unfortunately, when I log into Beehive, it's a whole bunch of data that's missing out of all these service users. (1023, clinician)

(b) Provider Data Use Facilitators

Previous training using data in care

- I am also very data-driven, and so even if it was not required of me, I would still get measurements to see where the service users are at. So that's something that I'm comfortable with. That's something that I've been trained to do, and that's something that I use periodically, regardless. (1024, clinician)

Data visualization

- Definitely, I would like… a graph as to the decrease in symptom or if there has been an increase. That's how I would be able to use it on a six-month basis to work that into our sessions and say either, "These symptoms have increased. What can we do? How can I support you?", or if they have decreased, being able to also show that to the service users. (1014, clinician)

Data pushed to provider

- As a clinician, what I would appreciate is that I could choose things that are pushed to me and then they would just be pushed to me in some way and then I could review them, as opposed to trying to develop some sort of practice where I go to it every time and just scan everything. That's very inefficient. (1009, program lead)
- I think going based off what we have noticed and the amount of information that comes in, maybe prioritizing certain things. Like you mentioned, if there's something that's a really low satisfaction or something that might be more immediate, like the food, having those alerts as well… So having some kind of prioritization system so that the bits that are actually most concerning are the easiest to find. (1011, SEE)

(c) Service User Data Use Barriers

Low frequency of surveys

- The [therapist] could see the answers... but I don't really think about how they can use it to track this, how you're doing and stuff. Because I feel like the surveys aren't that frequent, so it wouldn't be super useful at that, compared to just the check-ins with your therapist and their notes. (2005, service user)

(d) Service User Data Use Facilitators

Provider rapport responsiveness

- I know he looks at what I have the input for, and knowing that helps me like, I guess, be able to say things that I wouldn't be able to say out loud, or they ask sometimes some of the survey questions, ask questions about things that I wouldn't be able to say out loud. (2010, service user)
- If it is something delicate, she is more wary about it, or if it's something that she thinks I need to talk about more, it helps her kind of tailor our session to that specific answer that I gave. (2016, service user)

Note: SEES = Supported Education and Employment Specialist

Summary

Overall, provider experiences with implementing measurement-based care through the Beehive application were mixed. While some providers found the system easy to use, others described it as complicated,

particularly when it came to accessing data. These differing experiences often reflected individual levels of technological comfort and experience using Beehive. Providers who used the platform frequently reported increased ease and familiarity over time, while those with limited exposure, either due to smaller clinic size or a lack of integration into daily tasks, often found their initial training faded with disuse, making the system harder to navigate. Beyond the platform itself, time constraints were a significant barrier. Many providers found it difficult to prioritize Beehive amid extensive administrative responsibilities. However, clinics with sufficient administrative support, engaged leadership, and a collaborative team culture were better able to integrate Beehive into routine practice.

Service user and family experiences with Beehive were similarly variable. From the perspective of the service users and support persons who agreed to participate, individuals were generally positive about Beehive and did not identify many barriers to use. However, the providers interviewed reported that many of their service users did experience challenges in entering data into Beehive. This suggests either that service user participants who did not have a positive experience of utilizing Beehive were less comfortable with being interviewed, or providers had an overly negative perception of the service user experience. To address this, the EPI-CAL team will make further attempts to identify and interview service users who may have experienced more barriers, after which we will review their perspectives with the experiences reported by the providers.

From the perspective of providers, some service users encountered challenges such as survey length, technology access, privacy concerns, and symptom-related difficulties. Providers addressed these barriers by breaking up survey bundles across multiple sessions and offering support with completion. Interestingly, no service users interviewed reported that the surveys were too long or difficult, though several preferred to complete them with provider assistance. Looking ahead, key facilitators for successful Beehive implementation include strong program leadership support, ongoing training (especially for new staff), accessible technical support, streamlining data reporting, availability of clinical and administrative time dedicated to Beehive, and a plan for Beehive data collection tailored specifically to accommodate ongoing clinical and administrative requirements were all considered key facilitators to effective implementation.

Importantly, many service users reported that they did not experience their Beehive data being actively used in care and would have liked to this be a bigger part of their treatment. This finding highlights the importance of understanding and addressing these barriers to support greater utilization of data in care.

10. Submit a final report detailing all program- level, county-level outcomes data collected summarizing experiences and feedback from all stakeholders.

Last fiscal year was the last project year for many of the counties and programs that were part of the original multi-county collaborative innovation plan and therefore our team prepared a report that summarizes the overall progress of the LHCN to date. This report included a summary of qualitative data that has been collected over the course of the project, outcomes data collected via Beehive, and a multi-county integrated analysis of cost and utilization data. The report was prepared for review by our county and program partners, and aimed to have community partners provide feedback on the overall success and challenges of implementing a Learning Health Care Network of EP Programs in California. Our team has prepared a draft report providing an overall summary of progress and accomplishments of the Learning Health Care Network since project activities commenced in Spring of 2019. While each participating county may be on slightly different timelines, the draft summary report summarizes the overall progress of the EPI-CAL team and all participating counties. Since there are three main components to the data collected for the LHCN, County Level, Program Level, and Qualitative data (Figure 1), the summary report has broken down progress into three sections for each component. The summary report was prepared in a separate document from the report

and was initially submitted to our EP program and county partners on May 12, 2024 for feedback. During the 24/25 fiscal year, the report was due to additional counties that had their contracts coming to and end, and an updated version of the report was submitted to EP program and county partners on July 1, 2025 for feedback. We will continue to update the report each fiscal year and submit to all relevant partners for continued feedback and review.

Discussion and Next Steps

Discussion

Over the last fiscal year, the team has continued to meet each of the goals that were set to out for the original the multi-county Innovation project, which has grown to include other funding streams and additional counties over the years. The LHCN represents a collaborative university-county partnership between the University of California, Davis, San Diego and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own. The team feels confident that we have made excellent progress at implementation on an innovative mental health strategy.

We have completed Beehive training with all the original LHCN counties as well as several recent additions. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 27 programs having contributed data thus far. Over the past project period, three programs registered and enrolled their first service users (Telecare New Compass, Stanford INSPIRE, and INSPIRE 360). Based on feedback from users in these programs, we have continued to work with Beehive developers to make modifications to the application, such as localizations for all Medi-Cal threshold languages and additional visualizations for more surveys for both service user and clinic entered data. We continue to modify our training approach based on constructive feedback from programs.

As noted previously, we were able to successfully complete our preliminary multi-county integrated county data analysis and provide preliminary results on service utilization and costs associated with those services across counties. However, we continue to gather data from additional counties and plan to harmonize and merge the new data with the multi-county dataset by October 2025, for completion of primary analyses with the 6-county dataset by December 2025. We will be able to obtain stakeholder feedback, then summarize and respond to all feedback by June 2026.

Next Steps

At the time of this report, the Learning Health Care Network is an actively expanding network that continues to allow new programs to join the existing infrastructure. While at this stage programs will not be able to have input on the battery of outcomes to be collected or the initial design of the application, there are benefits to joining the project at this later stage. For example, counties joining at this later stage are joining at a time where the application for data collection, Beehive, has already been developed and data collection is active and ongoing. Therefore, new LHCN programs are able to hit the ground running with data collection and do not have to wait for the development stage of the project to transpire. In addition, our training approach to implementing Beehive in EP programs is well-established. Our team continues detailed analysis on outcomes and what components of care influence service user outcomes, and new programs joining the LHCN will be able to benefit from that information from the large statewide dataset to inform clinical practice in their own clinics. In summary, counties and their EP programs joining at a later stage of the project are benefitting from an established infrastructure. In addition to the benefits to the program in joining an established Learning Health Care Network, the LHCN itself benefits from additional programs joining. There are more programs

contributing data to the harmonized dataset, and the service users in each of the programs are unique to their region of California.

As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it.

While this is the last annual report for a couple of the participating counties through the innovation funding mechanism, the LHCN work is ongoing and will continue into the next year. Over the next fiscal year, the LHCN team expects to continue analysis for the cost and utilization as additional datasets are being sent to our team, onboard new programs that have joined the EPI-CAL network (e.g., Ventura and Kern), and continue Beehive data collection.

References

Addington, D. (2021). *First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) and Manual*.

Addington, D., Noel, V., Landers, M., & Bond, G. R. (2020). Reliability and feasibility of the first-episode psychosis services fidelity scale–revised for remote assessment. *Psychiatric Services, 71*(12), 1245-1251.

Adolescent Brain Cognitive Development (ABCD) Study. (2024). Retrieved from https://abcdstudy.org

Auther, A., Smith, C., & Cornblatt, B. (2006). Global functioning: social scale (GF: social). *Glen Oaks, NY: Zucker-Hillside Hospital*.

Boothroyd, R. A., & Chen, H. J. (2008). The psychometric properties of the Colorado Symptom Index. *Administration and Policy in Mental Health and Mental Health Services Research, 35*, 370-378.

Byerly, M. J., Nakonezny, P. A., & Rush, A. J. (2008). The Brief Adherence Rating Scale (BARS) validated against electronic monitoring in assessing the antipsychotic medication adherence of outpatients with schizophrenia and schizoaffective disorder. *Schizophrenia research, 100*(1-3), 60-69.

Cutrona, C. E., & Russell, D. W. (1987). The provisions of social relationships and adaptation to stress. *Advances in personal relationships, 1*(1), 37-67.

Durbin, J., Selick, A., Langill, G., Cheng, C., Archie, S., Butt, S., & Addington, D. E. (2019). Using fidelity measurement to assess quality of early psychosis intervention services in Ontario. *Psychiatric Services, 70*(9), 840-844.

Grattan, R. E., Tryon, V. L., Lara, N., Gabrielian, S. E., Melnikow, J., & Niendam, T. A. (2022). Risk and resilience factors for youth homelessness in western countries: A systematic review. *Psychiatric Services, 73*(4), 425-438.

Group, I. W. (2013). Personal wellbeing index. *Australian Centre on Quality of Life, Deakin University*.

Hamilton, C. M., Strader, L. C., Pratt, J. G., Maiese, D., Hendershot, T., Kwok, R. K., . . . Pan, H. (2011). The PhenX Toolkit: get the most from your measures. *American journal of epidemiology, 174*(3), 253-260.

Kahn, J. H., & Hessling, R. M. (2001). Measuring the tendency to conceal versus disclose psychological distress. *Journal of Social and Clinical Psychology, 20*(1), 41-65.

Koita, K., Long, D., Hessler, D., Benson, M., Daley, K., Bucci, M., . . . Burke Harris, N. (2018). Development and implementation of a pediatric adverse childhood experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: A pilot study. *PloS one, 13*(12), e0208088.

Kriston, L., Scholl, I., Hölzel, L., Simon, D., Loh, A., & Härter, M. (2010). The 9-item Shared Decision Making Questionnaire (SDM-Q-9). Development and psychometric properties in a primary care sample. *Patient education and counseling, 80*(1), 94-99.

Lewis, C. C., Boyd, M., Puspitasari, A., Navarro, E., Howard, J., Kassab, H., . . . Douglas, S. (2019). Implementing measurement-based care in behavioral health: a review. *JAMA psychiatry, 76*(3), 324-335.

Livingston, J. D., Desmarais, S. L., Verdun-Jones, S., Parent, R., Michalak, E., & Brink, J. (2014). Perceptions and experiences of people with mental illness regarding their interactions with police. *International journal of law and psychiatry, 37*(4), 334-340.

Meneghelli, A., Ciancaglini, P., Di Domenico, M., Mazzola, A., Ghio, L., & Preti, A. (2023). Implementation of early intervention clinical services within the National Health System in Italy: Third wave survey with focus on structures, resources, and fidelity to the evidence-based model. *Early intervention in psychiatry, 17*(9), 884-892.

National EPINET Core Assessment Battery. (2022, 9/1/2022). Retrieved from https://nationalepinet.org/core-assessment-battery-cab/

Neil, S. T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W., & Morrison, A. P. (2009). The questionnaire about the process of recovery (QPR): a measurement tool developed in collaboration with service users. *Psychosis, 1*(2), 145-155.

Niendam, T., Bearden, C., Johnson, J., & Cannon, T. (2006). Global functioning: role scale (GF: role). *Los Angeles, CA: University of California, Los Angeles*.

Niendam, T. A., Loewy, R., Savill, M., Delucchi, K. L., Lesh, T. A., Ragland, J. D., . . . Meyer, M. S. (2023). Effect of technology-enhanced screening in addition to standard targeted clinician education on the duration of untreated psychosis: a cluster randomized clinical trial. *JAMA psychiatry, 80*(2), 119-126.

Niv, N., Cohen, A. N., Sullivan, G., & Young, A. S. (2007). The MIRECC version of the Global Assessment of Functioning scale: reliability and validity. *Psychiatric Services, 58*(4), 529-535.

Østergaard, S. D., Lemming, O. M., Mors, O., Correll, C. U., & Bech, P. (2016). PANSS-6: a brief rating scale for the measurement of severity in schizophrenia. *Acta Psychiatrica Scandinavica, 133*(6), 436-444.

Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological reports, 10*(3), 799-812.

Ratcliffe, C., & Kalish, E. (2017). Escaping poverty. *Washington, DC: Urban Institute*.

Reinhard, S. C., Gubman, G. D., Horwitz, A. V., & Minsky, S. (1994). Burden assessment scale for families of the seriously mentally ill. *Evaluation and program planning, 17*(3), 261-269.

Robinson, D., Miller, A., Schooler, N., John, M., & Kane, J. (2021). *COMPASS-10: A Reduced Item Scale for Assessment of Symptoms in Individuals With First Episode Psychosis*. Paper presented at the NEUROPSYCHOPHARMACOLOGY.

Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., . . . Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of affective disorders, 210*, 189-195.

Savill, M., Banks, L. M., Tryon, V. L., Ereshefsky, S., Nye, K. E., Botello, R. M., . . . Niendam, T. A. (2024). Exploring Data Collection Priorities of Community Partners in Early Psychosis Care. *Psychiatric Services*, appi. ps. 20230455.

Shulman, G. P., Buck, B. E., Gahm, G. A., Reger, G. M., & Norr, A. M. (2019). Effectiveness of the intent to complete and intent to attend intervention to predict and prevent posttraumatic stress disorder treatment drop out among soldiers. *Journal of traumatic stress, 32*(5), 784-790.

Stratton, P., Bland, J., Janes, E., & Lask, J. (2010). Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE. *Journal of family therapy, 32*(3), 232-258.

Tully, L. M., Nye, K. E., Ereshefsky, S., Tryon, V. L., Hakusui, C. K., Savill, M., & Niendam, T. A. (2023). Incorporating Community Partner Perspectives on eHealth Technology Data Sharing Practices for the California Early Psychosis Intervention Network: Qualitative Focus Group Study With a User-Centered Design Approach. *JMIR Human Factors, 10*, e44194.

Waddell, L., & Taylor, M. (2008). A new self-rating scale for detecting atypical or second-generation antipsychotic side effects. *Journal of Psychopharmacology, 22*(3), 238-243.

Weathers, F., Blake, D., Schnurr, P., Kaloupek, D., Marx, B., & Keane, T. (2013). The life events checklist for DSM-5 (LEC-5).

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The ptsd checklist for dsm-5 (pcl-5).

MASH
Managing Assets for Security and Health

VENTURA COUNTY
BEHAVIORAL HEALTH

Managing Assets for Security and Health Senior Supports for Housing Stability

Ventura County Behavioral Health Mental Health Service Act Innovation Project

Year Three Annual Report
FY 24-25
October 2025

EVALCORP
Measuring What Matters

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TABLE OF CONTENTS

Introduction 3

Project overview 3

Evaluation Overview 8

Findings 13

Evaluation Question 1 16

Evaluation Question 2 18

Evaluation Question 3 20

Evaluation Question 4 21

Conclusion 22

INTRODUCTION

On March 21, 2022, the Mental Health Services Oversight and Accountability Commission (MHSOAC)—known now as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC), or the Commission for Behavioral Health (CBH), following the passage of Proposition 1 in 2024—approved the use of Mental Health Services Act Innovation Component funding for Ventura County Behavioral Health (VCBH) to implement the Managing Assets for Security and Health (MASH) project. This is the third annual project report and describes activities that took place during FY 2024-2025.

This report has been developed to provide the BHSOAC and Ventura County stakeholders with a status update on this project. In accordance with Title 9 California Code of Regulations (9 CCR § 3580.010), a report is to be submitted to the BHSOAC each year that includes the following:

- Whether and what changes were made to the Innovation Project during the reporting period and the reasons for changes.
- Available evaluation data, including outcomes of the Innovation Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including the number of participants and demographics of participants served.
- Any other data the County considers relevant.

PROJECT OVERVIEW

VCBH contracted with CAREGIVERS: Volunteers Assisting the Elderly in Ventura County to implement the MASH project. CAREGIVERS is a non-profit organization that recruits volunteers to support home-bound older adults. MASH was launched for low-income older adults aging in place with limited income who fear losing their housing due to fiscal, cognitive, or physical restrictions. The program began on October 1, 2022, and is scheduled to end June 30, 2027.

The Problem

Older adults at risk of or currently experiencing homelessness are becoming increasingly prevalent. Older adults with little to no savings or retirement income

are on the brink of financial crisis and can quickly be destabilized by sudden changes like a rent increase, medical issues, essential expenses (e.g., household or appliance repairs), or the death of a partner or caregiver. Since the pandemic, the housing market has worsened with rent and housing prices soaring. Additionally, fraud abuse among older adults is rampant and can negatively impact their financial situation, increasing their risk of homelessness. Anecdotally, older adult service providers have observed an increase in requests for services and the need for financial counseling from those with low incomes who did not anticipate housing expenses rising so quickly.

The Solution

The purpose of the Managing Assets for Security and Health (MASH) program is to provide multiple supports for older adults at risk of homelessness. Volunteers provide creative case management during a 90-day process that includes intake and screening, case planning, referrals and coordination, ongoing support, and case closure. Once an individual's financial situation is understood, volunteers can offer therapeutic and material support to enrolled clients through education, recommendations, referrals, and personalized assistance. Older adults must also be enrolled with the CAREGIVERS organization to be eligible for the MASH program. MASH clients are not required to follow any of the guidance provided to them.

Assumptions of Program Approach. By assigning and monitoring volunteers to work with homebound older adults, the clients will build a trusting relationship with the organization and be more likely to engage in a housing resource plan that includes essential services and concrete resources as needed. MASH clients will be able to explore multiple solutions to their financial and housing situations over time, raising the chances for increased stability.

Learning Goals

The learning goals and questions to be addressed through the MASH program are:

1. Does enrollment in the MASH program have an impact on the client's motivation to change their housing situation?
2. How much does the program improve clients' sense of security and safety?
    - Aim 1: Living situation
    - Aim 2: Fiscal situation

3. Does enrollment in the program reduce feelings of depression, anxiety, and isolation?
4. Does the program have an effect on enrolled clients' housing situation as measured by the following three aims:
    - Aim 1: Prolonged ability to stay in current housing
    - Aim 2: Reduced evictions
    - Aim 3: Stably housed 6-12 months post-discharge

Project Updates in FY 2024-2025

During this fiscal year, the MASH project experienced substantial changes in its program staff, processes, and budgeting (described below) while continuing their efforts to develop a replicable model for addressing financial and housing insecurity among older adults. CAREGIVERS continued to foster interest, collaboration, and engagement among caregiving organizations, including via resource sharing and through an informational presentation at the National Conference of Volunteer Caregiving. Showcasing the MASH project has garnered interest at the state and national levels and resulted in additional engagements, such as an invitation to present to the Fraud Abuse Specialty Team (FAST), and program expansion, with five volunteer caregiving organizations across California in the process of rolling out MASH programming.

Data Collection and Management

Due to the nature of the BetterAge surveys, the MASH team encounters a high volume of Risk and Referral assessments that they are unable to complete, largely due to prospective clients' declining involvement in the program or disinterest in program participation. To overcome this challenge, the MASH team has integrated BetterAge into the CareWorks system, allowing for easy collection of data, swift extraction of key MASH data, and annual tracking of individual assessments. The team has further focused on intentionally determining how many actual cases come to fruition following assessment outcomes and how many volunteers would be needed to address these cases in a timely matter.

Housing Gap Funds

The MASH team successfully pursued a more flexible approach to spending their 'Housing Gap Assistance' funds this fiscal year. These funds were originally designated for the following:

- *Immediate support* resources to ensure the individual does not become homeless (e.g., financial assistance, temporary shelter, rapid rehousing)
- *Age in place supports* (e.g., include family network to move in if practical, handicap accessible or other home modifications, home share, reverse mortgages, utilities, or other bills requiring backpay)
- *Moving supports* (e.g., secure placement in new housing arrangement, first/last month securities, downsizing, light rental subsidy)

Only being able to provide such specialized support for housing changes limited the program's ability to meaningfully address clients' needs. With greater discretion regarding how funds can be used, the MASH program experienced more latitude in assisting clients in problem-solving financial challenges. For example, funds were used to address major expenses, site modifications for safety, functionality of essential utilities (e.g., water heaters, toilets, refrigerators, microwaves, stoves, air conditioners), mobility challenges, and durability of medical equipment to allow for activities of daily living not addressed through volunteer caregiving.

An analysis of the costs of older adults becoming unhoused supported the MASH program's refined use of Housing Gap Assistance funds to increase seniors' quality of life and safety. Although it is difficult to pinpoint a specific cost associated with preventing older adults from becoming homeless, the general consensus is that it is cheaper in the long run to keep someone housed as opposed to allowing them to become homeless and then finding ways to reconnect a person with housing.

- Prior efforts to study this problem have led to a common figure: A rent subsidy of $300-$500/month or a one-time payment of 5k-10k would have made a significant difference between holding onto housing and homelessness.[1]
- It can cost anywhere from $30,000 to $150,000 to rehouse an unhoused older adult in the first year of them becoming homeless.[2]
- There are potentially large upfront costs associated with home renovations or modifications. Yet, when factoring in the costs of keeping

[1] Espinoza, M., Moore, T., Adhiningrat, S., Perry, E., Kushel, M. (2024). Toward Dignity: Understanding Older Adult Homelessness in the California Statewide Study of People Experiencing Homelessness.
[2] Colburn, G., & Aldern, C. P. (2022). *Homelessness is a housing problem: How structural factors explain US patterns*. Univ of California Press.

someone housed vs. losing housing, it is recommended that preventing homelessness is the more cost-effective option.

For the MASH program, the maximum amount spent to support an at-risk client has been approximately $7,600. More commonly, smaller amounts of Housing Gap Funds are used to assist clients, and some clients do not require any financial assistance. For example, the smallest amount of funds used to support a client was $50 and as little as $800 of housing gap support has been used to keep clients housed, thereby reducing the stress associated with such financial burdens. These smaller monetary investments in clients can help to offset the high costs associated with becoming unhoused and extend clients' housing security.

This thoughtful and generous approach to utilizing Housing Gap Funds has been overwhelmingly beneficial to seniors served through MASH. In nearly two dozen cases, MASH has helped seniors secure sustainable housing solutions and preventing homelessness among this population vulnerable senior citizens. Whether a client's life becomes safer with a home modification or a major expense is paid that relieves them from the potential choice of feeding themselves or not that month, Housing Gap Funds continue to prove successful in improving clients' lives and addressing their housing security.

Volunteer Recruitment and Retention

Volunteer participation remained an ongoing challenge this fiscal year. Although additional volunteers were successfully recruited, the level of volunteer involvement remained inconsistent. This variance in volunteer involvement can inhibit trust-building with a client. Similarly, volunteer discomfort in reviewing specific financial information and collecting income, expenses, assets, and liabilities can negatively impact the completeness of internal records. Volunteer involvement is key to the success of the MASH program as clients cannot be adequately served if volunteers are unavailable to take on cases.

To increase recruitment and retention of MASH volunteers, a volunteer guide was developed that offers volunteers a more uniform and efficient onboarding process. The manual provides an overview of MASH, program processes, volunteer responsibilities and expectations, client resources, and case studies showcasing a variety of client scenarios that may be encountered. Volunteers continually meet with the MASH team to share information and learn about new

resources in an effort to continue their training as volunteers and leaders in the community.

EVALUATION OVERVIEW

CAREGIVERS works with the evaluation team, EVALCORP (EVC), by being responsible for collecting and submitting MASH program data. EVC conducts the analysis, completes reporting, and provides technical assistance to CAREGIVERS in their data collection efforts.

The mixed-methods evaluation includes data collected using surveys, focus groups, and interviews. No focus groups were conducted during years two or three. This design provides a comprehensive look at the MASH program's impacts.

Evaluation Questions

The evaluation questions closely align with the project learning goals:

1) Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?
2) Does the program improve a client's sense of security and safety and if yes, to what degree?
3) Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?
4) Does the program affect the enrolled client's housing situation, and if yes, how?

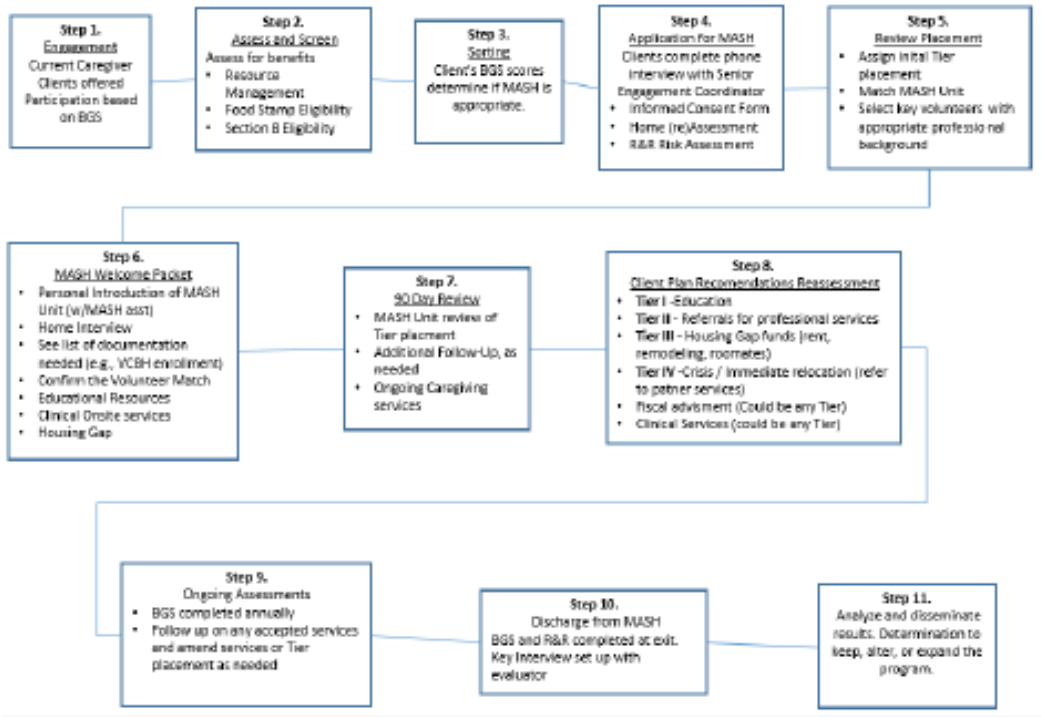
Methods

The evaluation of MASH for FY 2024-2025 is informed by five data sources: (1) BetterAge Guidance System (BGS), (2) Risk & Referral Tool (R&R), (3) program activities log, (4) client interviews and (5) quarterly reports. Demographic data was collected upon completion of the BGS survey and included in the data log. An identification number is used for all assessments. The evaluation team does not have access to the name or other identifying information related to the identification number, which is assigned by CAREGIVERS staff.

Data Collection Tools

Data collection is integrated into CAREGIVERS's process for caring for clients. Figure 1 illustrates this process, including the data collection and decision points.[3]

Figure 1. CAREGIVERS Process for Working with Clients and Data Collection Points



The data collection tools, administration method and timing, and their descriptions are in Table 1. Data collection begins with the initial BGS survey. MASH assessment is based on one self-determined financial question in the BGS: "Please indicate where you are on the ladder right now (0 being the worst possible financial situation and 10 being the best possible financial situation)." A client is eligible to complete the next step in the MASH assessment process, the initial R&R survey, if they score below a five. Tiers are then assigned (see below) following the R&R assessment informing the MASH services they receive.

- Tier 1 (score 0-6): Thriving, self-resolve, education

[3] **It is important to note that the screening tools described do not qualify a person for MASH program eligibility. Rather, the score is indicative of the need for aid or further support or services a person has. While program staff may encourage further support and services, the client always has the right to decline.**

- Tier 2 (score 7-15): Surviving, financial management
- Tier 3 (score 16-20): Struggling, housing gap, clinical services referral
- Tier 4 (score 21-27): Crisis, external intervention services

Finally, the MASH team provides recommendations to enrolled MASH clients after an in-depth examination of their financial situation over the course of approximately 90 days. After that, clients are invited to complete exit BGS and R&R surveys and an interview. The tools are included in Appendices B through F.

Table 1. Data Collection Tools

Tool Name	Administration Method and Timing	Description
Demographics Form	CAREGIVERS client to complete the form at the time of screening for MASH	Includes demographic questions such as gender, sex at birth, and race/ethnicity. The demographics are entered into the data log.
BetterAge Guidance System (BGS)	This tool can be self-administered or administered verbally by a CAREGIVERS staff member or volunteer. Completed at the time of enrollment in MASH, annually, and when the case is closed*	The tool includes 14 close-ended survey questions about mental, physical, and financial health as well as community connectedness. Respondents are asked to rate their responses between zero and 10.
Risk and Referral Tool (R&R)	Administered by CAREGIVERS staff or volunteers upon enrollment in MASH, annually, and when the case is closed*	Includes eight close-ended survey questions about finances and safety.
Data Log	Completed by CAREGIVERS staff and submitted quarterly throughout the MASH project.	This Excel spreadsheet includes information about demographics, referrals, program activities, and success stories.

Client Interview Protocol	Facilitated by EVC researcher in years two, three, four, and five.	Protocol includes questions about program experience and impacts.
Quarterly Report	Completed by CAREGIVERS staff quarterly.	Includes information about program challenges and successes, significant findings, and upcoming activities.

**If the case is closed within one month of the initial BGS assessment, the BGS was not re-administered.*

Interviews

Three phone interviews, lasting between 15 to 30 minutes each, were conducted with MASH clients who were discharged from the program. All interviews were facilitated by an EVC researcher and took place in May 2025. The purpose was to learn about the program's benefits and ways that it can be improved through questions related to client impacts, successes, and challenges. The interview protocol is in Appendix E.

Table 2 is a crosswalk of the evaluation questions and the data sources used to answer that question, as well as the indicators.

Table 2. Evaluation Questions, Tool Used, and Indicators

Evaluation Question	Data Source	Indicators/Metrics
Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?	• Risk Assessment & Referral Survey • Interviews	Questions about money management, ability to cover expenses, and feedback about program impacts.
Does the program improve a client's sense of security and safety and if yes, to what degree?	• Risk Assessment & Referral Survey • Interviews	Survey Question. 1. Considering your current health, to what degree do you worry about your safety e.g., falls, mobility? Feedback about program impacts.

Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?	• BetterAge Guidance System Survey • Interviews	Survey Questions. 1. How would you rate your overall mental health? 2. How often do you feel lonely? 3. How would you describe your sense of belonging to your local community? 4. During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope? 5. During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair? Feedback about program impacts.
Does the program affect the enrolled client's housing situation, and if yes, how?	• Interviews	Feedback about program impacts.

Data Analysis

With fewer than 15 individuals completing initial and exit surveys, conducting pre/post comparisons of clients' scores was not advisable due to the low sample size. However, insights into program impacts were still drawn from this data. Additionally, qualitative data from client interviews and CAREGIVERS quarterly reports were analyzed using thematic analysis to further explore program outcomes.

FINDINGS

MASH Enrollment and Demographics

A total of 335 adults have been enrolled in MASH since FY 2022-2023 and completed the initial BGS survey. Most clients were White women, had private insurance (76%) and resided in Ventura (30%). A full description of demographics is included in the table below.

Demographics of MASH Clients	
Race*	**n = 329**
American Indian/Alaska Native	2%
Asian	3%
Black/African American	3%
Hispanic/Latino	11%
Native Hawaiian, Other Pacific Islander	<2%
White	79%
More Than One Race	-
Another Race	-
Hispanic/Latino Ethnicity	**n < 10**
Mexican/Mexican American/Chicano	-
Central American	-
Puerto Rican	-
South American	-
Another Hispanic/Latino ethnicity	-
Non-Hispanic/Latino Ethnicity	**n < 10**
Asian Indian/South Asian	-
Chinese	-
Another non-Hispanic/Latino ethnicity	-
Primary Language*	**N = 336**
English	99%
Spanish	<1%
Indigenous	-
Both English and Spanish	<1%
Another Language	-

**Individuals could select more than one response*

100% of MASH CLIENTS…

Are 60+ years old *(N = 335)*

No clients identified as being in any other age group (i.e., 0-15, 16-25, 26-45, or 46-59 years)

On average, MASH clients are 65 to 84 years old

Demographics of MASH Clients Continued	
Gender Identity[4]	**N = 335**
Female	80%
Male	20%
Sex Assigned at Birth	**N = 335**
Female	80%
Male	20%
Sexual Orientation[5]	**N = 335**
Heterosexual or Straight	100%
Veteran	**N = 335**
Yes	8%
Disability Status	**n = 328**
Yes	32%
Disability Type*	**n = 130**
Difficulty seeing	15%
Difficulty hearing, or having speech understood	<1%
Another communication disability	-
Learning disability	-
Developmental disability	-
Dementia	<2%
Another mental disability, not related to mental illness	<2%
Physical/mobility disability	49%
Chronic health condition/chronic pain	29%
Another disability	2%

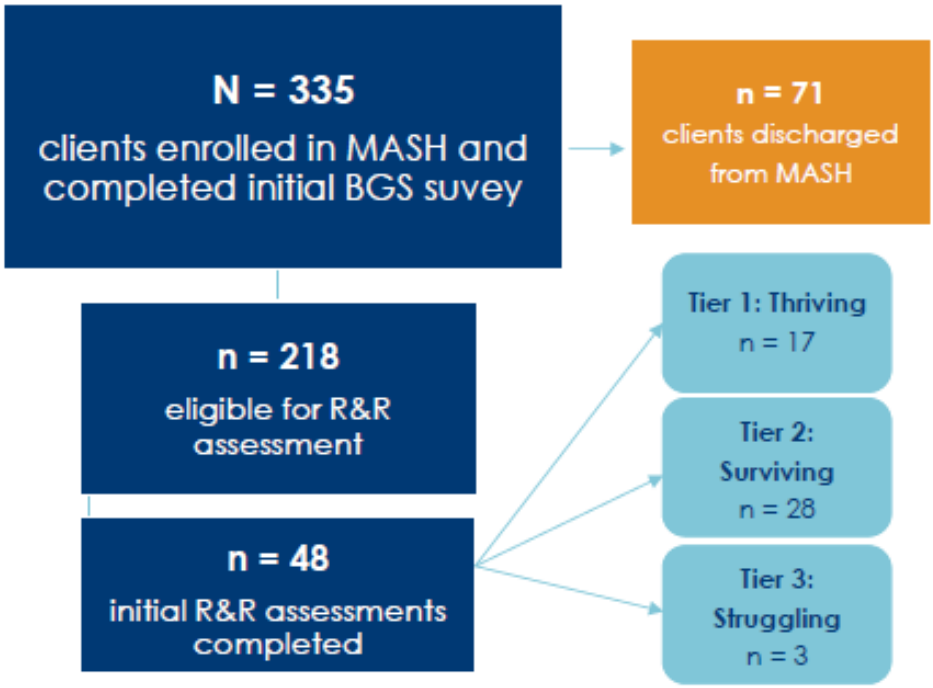
**Individuals could select more than one response*

[4] Although other gender identity options were provided, including transgender, gender queer, questioning or unsure, and another gender identity, clients only self-identified as male or female.
[5] No client identified as any other sexual orientation, including bisexual, gay or lesbian, queer, questioning or unsure of sexual orientation, or another sexual orientation.

Figure 2 describes MASH enrollment. 218 individuals who completed the initial BGS had scores of five or above, meaning they generally benefitted from higher case management or education. Comparatively, 119 individuals scored less than five on the initial self-determined financial question in the BGS and were prioritized for follow-up with the next MASH assessment survey—the initial R&R survey. Of these 119 eligible individuals, 48 clients completed the initial R&R survey. Reasons eligible individuals did not complete the R&R survey included not being able to be reached by program staff or declining to complete the survey.

Of the 48 clients who completed the initial R&R assessment, no clients fell into Tier 4 or crisis. For five clients, cases were stalled and eventually closed before recommendations could be presented due to being nonresponsive (i.e., unable to reach the client) or no longer interested in MASH services.

Figure 2. MASH enrollment



A total of 71 clients have been discharged from MASH. Fourteen clients completed exit R&R surveys after discharge.[6] Almost all of these clients were women who identified as White. All of these clients were English-speaking and nearly half indicated they were experiencing a disability. Three of these clients completed interviews.

EVALUATION QUESTION 1

Does enrollment in the MASH program impact the client's motivation to change their housing situation, and if yes, to what degree?

The shifts in clients' responses to R&R survey questions concerning financial management and expense coverage suggest that MASH services encouraged clients to improve their financial affairs. In interviews, clients expressed feelings of empowerment because volunteers worked with them to problem-solve, rather than taking over, enabling clients to have the final say on their financial decisions.

"Every little bit of change I get goes in a piggy bank. Any extra money goes into savings in the bank. So, I'm pretty good at saving. My financial situation has not changed that much, but I have less money around now because my rent is more."

– 78-year-old male MASH client

[6] Only one client completed an exit BGS survey. This client also completed an exit R&R survey.

Clients also expressed gratefulness for MASH's assistance in improving their housing situations through discretionary purchases, which motivated them to continually ask for assistance as opposed to dealing with subpar living standards.

> *"Whenever I need a referral for something, I go to them…The reason I didn't ask before was because I didn't know they had money to do that, it came as a surprise. And secondly, I don't like to ask for money, I'd rather just take it from my savings and see where it goes from there…For the first time, I actually asked for assistance." – 78-year-old female MASH client*

Housing Gap Assistance funds were utilized to improve clients' quality of life, with clients expressing gratitude and appreciation for both small and large purchases, from something as small as hiring a contractor to mount a client's televisions to purchasing a new mattress to replace a twenty-year-old mattress that was contributing to a client's back pain.

> *"Gap Fund flexibility has worked splendidly. For low-income seniors who have dwindling savings and then a costly major event happens, it is the deal breaker that sends them spiraling. Feel like the biggest takeaway is that if someone were to go homeless in their older years, in can cost anywhere from $30,00 to $150,000 to rehouse them in the first year [of homelessness] and we haven't spent more than $7,500 to keep [a client] in home, elevate their quality of living, and put them in a more sustainable situation. Hopefully [clients can] sustain on for a duration, but now we have an eye on them."*
>
> **– MASH Executive Director**

These examples align with MASH's findings that their ability to use flexible discretionary funds has been a hugely successful resource for clients enrolled in the program. The MASH team has reported similar success stories for clients. Examples of such successes include paying a client's overdue utility bill which alleviated the stress and pressure they experienced after receiving a water shut off notice and replacing a water heater for a client who was boiling water on their stove to bathe comfortably.

EVALUATION QUESTION 2

Does the program improve a client's sense of security and safety and if yes, to what degree?

Client responses to R&R survey items and program reflections captured during interviews were utilized to determine how the MASH program affected clients' desire to alter their living circumstances. Changes in clients' perceptions of their safety, such as mobility issues or risk of falls, varied possibly due to the different medical issues they were managing. As MASH clients are often medically fragile or disabled, their concerns about safety likely fluctuate based on the severity of their health conditions rather than the impact of program services.

Interview data suggests the practical assistance provided through the MASH program increased clients' sense of security by improving their living conditions. For example, one client recognized that they would have lost over a month's worth of living expenses had MASH not offered to pay to replace their water heater and purchased a replacement component for their refrigerator.

> ***"The anxiety that I felt when the water heater went out and I didn't have hot water for over a week. I wrote [MASH] a card the other day, I was thinking about how they brought joy and ease into my life. I always think of them when I turn on the hot water. I think, 'oh my god, I have hot water because of them!' My refrigerator that went out, it's an important part of my life, so it's brought ease and joy, and I get joy from thinking about what goodness they do in the world…You take things for granted until they go out." – 78-year-old female MASH client***

Clients also reported feeling more in control of their situations, often as a result of MASH purchasing mobility assistance devices and aids that enable them to live independently and comfortably. For example, Housing Assistance Gap funds were used to facilitate the installation of grab bars in a shower and the purchase of an electric wheelchair, which relieved clients' feelings of anxiety when it came to their health and safety.

> *"For me to go into the tub, without a shower door and no bars would be pretty scary, with my balance being way off. I bought the bars with my own money and they paid the labor, which helped me out a great deal."*
>
> *– 78-year-old male MASH client*

> *"They have been so great and good to me. I appreciate everything that people do for me. I have a lot of difficulties and a lot of sickness. I had a terrible fall and I hurt myself all over. I get dizzy spells and I fall. I had a few falls already and my nurse said I needed an electric wheelchair but I couldn't afford that. Somehow MASH was able to get me one and that's another thing I am grateful for. To be able to get around, I have a walker, but the walker cannot control me when I get dizzy and I fall. But with the wheelchair, if I get dizzy, I don't fall on the floor and I don't have to hurt myself."*
>
> *– 81-year-old female MASH client*

EVALUATION QUESTION 3

Does enrollment in the program reduce feelings of depression, anxiety, and isolation and if yes, to what degree?

An examination of clients' BGS scores before and after participating in MASH suggests the program had a positive impact on their emotional well-being, especially their feelings of loneliness. Client reflections on their MASH program experiences align as they consistently emphasized the emotional comfort they received from having someone to talk to about their financial issues and personal hardships. Having a confidant facilitated crucial social connections for MASH clients, helping them to manage their emotions and feel less alone.

"There's no words to express my gratitude…I'm all alone, I have no family…They call me to make sure I'm okay, to see if I need anything, that I have enough food. I have my medication, they call me to make sure that I am able to get to my appointments, to my doctors…They have been so kind and good to me and I appreciate everything they have done for me from the bottom of my heart. I am very grateful."

– 81-year-old female MASH client

"[I want to share] how important [MASH] has been in my life, how much ease and joy it's brought by easing my anxiety. I think it's wonderful there is such a thing. I never saw myself getting older, and I still don't feel really old. But it's wonderful there is such a thing…They do personally care about me."

– 78-year-old female MASH client

EVALUATION QUESTION 4

Does the program affect the enrolled client's housing situation, and if yes, how?

Some clients recognized MASH for their efforts in addressing challenging housing situations. For example, one client explained how they reached out for assistance when their housing situation was in the process of changing due to their landlord selling the property. This client noted that MASH helped them search for options and even wrote the property manager a letter explaining their circumstances to increase their chances of moving up on the apartment complex's waitlist, which ultimately resulted in them securing housing.

"I called and four ladies showed up. They began to look up options for me...The group they assembled wrote a letter to this place telling them about my circumstance. It was in my price range. They found me this place."

– 78-year-old male MASH client

Although MASH was not necessarily able to solve specific problems related to housing due to issues outside the scope of services able to be provided (e.g., securing a charitable remainder trust to allow the client to stay in their home), clients appreciated the effort and intention of the MASH team, as well as the resources and support offered.

"Whenever I need a referral for something, I go to them. They listen very well. They have excellent listening skills. They're empathetic, you can hear it in their voices. I feel safe with them. There's no other way to put it than that."

– 78-year-old female MASH client

Interview data suggests MASH primarily offered clients emotional support, financial advice like bill management, and practical aid the form of essential household items that helped clients maintain a stable living environment and likely avoid future complications that might jeopardize their housing security.

CONCLUSION

Data from Year Three suggests that the MASH project is positively impacting clients' emotional well-being, security and safety, financial situations, and housing stability. The project has made strides toward developing a scalable workflow model by refining program processes and budget to tackle challenges in client outreach, engagement, intervention, and volunteer recruitment and retention. Additionally, CAREGIVERS has formed a collaboration of volunteer caregiving organizations, which will soon serve as a foundation for expanding the MASH program into other communities. In Year Four, MASH aims to broaden its reach and expand support for diverse older adults facing financial and housing instability throughout Ventura County.

Looking Forward

Progress on Sustainability

In 2025, CAREGIVERS received $100,000 in grant funding from the May & Stanley Smith Charitable Trust. This one-year foundation grant will support MASH program expansion to five other volunteer caregiving organizations throughout California.

Replicating MASH in Other Communities

In anticipation of bringing this project to other communities, CAREGIVERS Volunteers of Ventura County has been working closely with the National Volunteer Caregiving Network to develop a guide for organizations to use. This guide includes information on the infrastructure that will be needed with suggestions for recruiting and retaining volunteers, a volunteer training guide, and recommendations for troubleshooting issues and creating a gap fund. These materials will be provided for distribution through the National Volunteer Caregiving Network which maintains Standards for Excellence in Volunteer Caregiving.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Appendix A. Demographics Form [Required for Individuals Served (per §3580.010)]

VENTURA COUNTY BEHAVIORAL HEALTH

Demographic Information

Date_____

Your answers to the following questions will help Ventura County Behavioral Health understand who we are serving. The information on this form is private. Please skip any question you do not want to answer. Thank you!

What is your payor source?

- ◻ Medi-Cal/Gold Coast
- ◻ Private Insurance (e.g. Kaiser, Blue Cross)
- ◻ Medicare (Age 65+)
- ◻ No Insurance

What racial categories do you identify with? Please select all that apply.

- ◻ American Indian or Alaska Native
- ◻ Asian
- ◻ Black or African American
- ◻ Hispanic or Latino
- ◻ Native Hawaiian or Pacific Islander
- ◻ White
- ◻ More than one race
- ◻ Another race (please specify): _____

What ethnic categories do you identify with? Please select all that apply.

Hispanic or Latino

- ◻ Caribbean
- ◻ Central American
- ◻ Mexican/Mexican American/Chicano
- ◻ Puerto Rican
- ◻ South American
- ◻ Another Hispanic or Latino ethnicity (please specify): _____

Non-Hispanic or Non-Latino

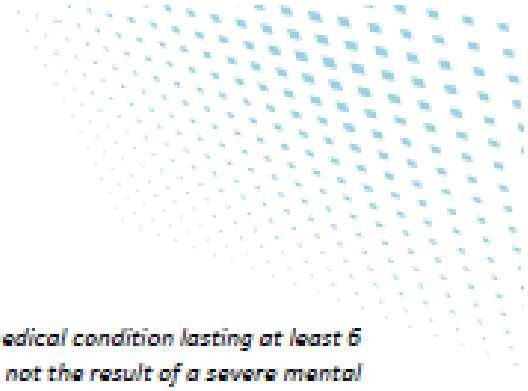
- ◻ African
- ◻ Asian Indian/South Asian
- ◻ Cambodian
- ◻ Chinese
- ◻ Eastern European
- ◻ European
- ◻ Filipino
- ◻ Japanese
- ◻ Korean
- ◻ Middle Eastern
- ◻ Vietnamese
- ◻ Another non-Hispanic or Latino ethnicity (please specify): _____

- ◻ More than one ethnicity

What is the primary language spoken in your home?

- ◻ Spanish
- ◻ English

EVALCORP
Measuring What Matters



□ Both Spanish and English

□ Indigenous (Mixtec or another)

□ Another language (please specify): _____

Do you have a disability?

(Disability is defined as a physical or mental impairment or medical condition lasting at least 6 months that substantially limits a major life activity, which is not the result of a severe mental illness.)

□ Yes □ No

If you have a disability, please select all that apply.

□ Difficulty seeing
□ Difficulty hearing, or having speech understood
□ Another communication disability (please specify): _____
□ Learning disability
□ Developmental disability
□ Dementia
□ Another mental disability, not related to mental illness (please specify): _____
□ Physical/mobility disability
□ Chronic health condition/chronic pain
□ Another disability (please specify): _____

Are you a veteran?

□ Yes □ No

How do you describe your gender?

□ Male
□ Female
□ Transgender
□ Genderqueer
□ Questioning or Unsure of your gender identity
□ Another gender identity (please specify): _____

What sex were you assigned at birth?

□ Male

□ Female

□ Another sex (please specify): _____

Do you consider yourself:

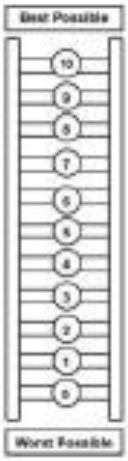
- ▫ Heterosexual or Straight
- ▫ Bisexual
- ▫ Gay or Lesbian
- ▫ Questioning or Unsure of your sexual orientation
- ▫ Queer
- ▫ Another sexual orientation (please specify): _____

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Appendix B. BetterAge Guidance System Questionnaire

Please **circle the answer** that best represents your response to the questions below.

For the first three questions please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the **best possible life for you** and the bottom of the ladder represents the **worst possible life for you.**



1. **On which step of the ladder would you say you personally feel you stand at this time?**
   Worst possible 0 1 2 3 4 5 6 7 8 9 10 Best possible

2. **On which step do you think you will stand about five years from now?**
   Worst possible 0 1 2 3 4 5 6 7 8 9 10 Best possible

3. **Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now.**
   Worst possible 0 1 2 3 4 5 6 7 8 9 10 Best possible

4. **In general, how would you rate your physical health?**
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

5. **How would you rate your overall mental health?**
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

6. **For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?**
   Not limited at all 0 1 2 3 4 5 6 7 8 9 10 Severely limited

7. **I have a sense of direction and purpose in life.**
   Strongly disagree 0 1 2 3 4 5 6 7 8 9 10 Strongly agree

EVALCORP
Measuring What Matters

8. **How often do you feel lonely?**

Never 0 1 2 3 4 5 6 7 8 9 Always 10

9. **How would you describe your sense of belonging to your local community?**

Very weak 0 1 2 3 4 5 6 7 8 9 Very strong 10

10. **If you were in trouble, do you have relatives or friends you can count on to help you whenever you need them, or not?**

Never 0 1 2 3 4 5 6 7 8 9 Always 10

11. **During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope?**

Never 0 1 2 3 4 5 6 7 8 9 Always 10

12. **During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair?**

Never 0 1 2 3 4 5 6 7 8 9 Always 10

Appendix C. Risk Assessment & Referral Form

Managing Assets for Security and Health (MASH)

Risk Assessment and Referral (R&R)

Funding for this Innovation Grant provided by

VENTURA COUNTY BEHAVIORAL HEALTH

Client Name: _____
Date: _____
MASH Unit Lead: _____
Office Team Lead: _____

Managing Assets for Security and Health (MASH)
Risk Assessment and Referral (R&R)

Date: _____
Client ID: _____
AWC Score (QS): _____ **AWC:** *(5-6 Surviving; 3-4 Struggling; 0-2 Crisis)*
R&R Score: _____ **R&R:** *(Higher scores mean a greater concern)*
Tier Placement: _____ **Tier One:** Thriving/Self-resolve/Education (0-6)
Tier Two: Surviving/Financial Management (7-15)
Tier Three: Struggling/Housing Gap/Clinical Services Referral (16-20)
Tier Four: Crisis/External Intervention Services (21-27)

1. Does someone other than you manage your money?
   - ☐ Yes (1) If yes, who is the person (sister, son, etc.) _____
   - ☐ No (0)

2. Please select your ability to pay the following costs per month in the table below.
   Select one response for each row. See Expense and Debt reports for details.

Ability to pay...	Unable to pay this (3)	Able to pay some of this (2)	Can pay this with little or no money left (1)	Can pay this with money left over (0)	Not applicable (0)
your rent or mortgage					
for groceries that you need					
your utility bills					
your debt, such as credit card bills					

3. How often are you behind on rent or mortgage?
   - ☐ Every month (3)
   - ☐ Four or more times a year (2)
   - ☐ One to three times a year (1)
   - ☐ Never (0)
   - ☐ Unsure (0)

4. How confident are you with managing your money e.g. balancing a checkbook, making financial decisions?
   Please circle a number.

Not Confident				Extremely Confident
4	3	2	1	0

EVALCORP

Funding for the Innovation Grant provided by

VENTURA COUNTY
BEHAVIORAL HEALTH

Client Name: _____
Date: _____
MASH Unit Lead: _____
Office Team Lead: _____

5. Do you have a needed major expense that you are putting off due to costs? *(e.g., roof, plumbing, medical, car repair)? See Expense report for details.*

☐ Yes (1)
☐ No (0)

6. Would you like a professional to talk with you about your finances?

☐ Yes (1)
☐ No (0)

7. Does anyone put pressure on you to spend money or give them money?

☐ Yes (1)
☐ No (0)

8. Considering your current health, to what degree do you worry about your safety e.g., falls, mobility.

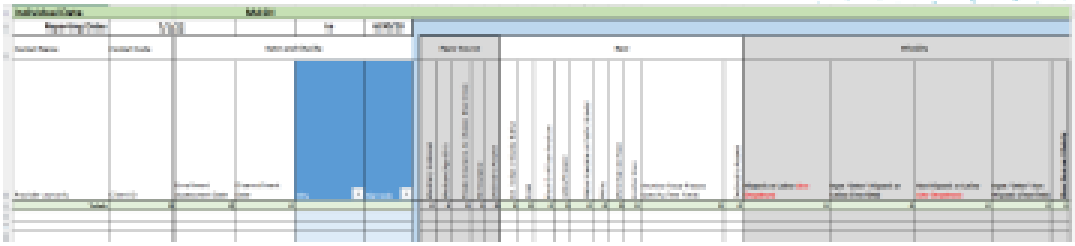
Worry Often				Do Not Worry
4	3	2	1	0

B&R Score: _____

(Higher scores mean a greater concern)

EVALCORP
Measuring What Matters

Appendix D. Data Log Screenshots



Activities Tracking

Provider Name / Outreach and Engagement Provider	MHSH	Directions: Fill out requested information or Place a number 1 in each relevant column to represent yes leave blank for no or n/a			Numbers Reached / Engaged	Event Time	Activity Language			
Activity Name (May be customized activities also)	Type of Activity (Mood/Event)	Additional Title / Topic / Info (if needed)	City	Zip Code	Date of Activity	Total Number of Participants/Flyers (Events)	Length of Time of Activity (Hours)	Activity was in Spanish	Activity was in English	Materials for other Indigenous	Other Languages
TOTAL					0	0	0	0	0	0	0

Monthly Progress Report

Provider Name:	MHSH
Project Name:	MHSH

Directions: This is a fillable Excel form. Type or copy and paste answers below.

Challenges	Status	Date Completed
Successes	**Status**	**Date Completed**

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Appendix E. Interview Protocol

Managing Assets for Security and Health (MASH) Project

Client Interview Protocol

Thank you for taking the time to talk with me today. My name is , and I work for EVALCORP. Ventura County Behavioral Health has contracted with EVALCORP, an established applied research and evaluation consulting firm, to conduct an evaluation of the Managing Assets for Security and Health project, also known as MASH.

The purpose of this interview is to learn about the program benefits and ways that it can be improved. I expect this conversation to last no more than 30 minutes.

Your participation is voluntary. Your identity will be kept confidential, and your input will be shared anonymously. That means nothing you say will be personally linked to you in any reports that result from this key informant interview. All the comments today will be put together as a summary, and your name will not be tied to any information. Do you have any questions before we begin?

The Interview

The CAREGIVERS program provides many types of services. The MASH program is specifically focused on helping seniors improve their financial situation and to help lower their risk of losing their housing. Therefore, the questions that I am going to ask today specifically focus on those areas—financial and housing stability.

1. Please tell me about your engagement with the MASH program in terms of your housing situation.
    a. Did you feel you needed assistance? If so, what assistance did you need?
    b. Did the MASH team address those needs? If so, how?
    c. Did you have any needs that were not addressed? If so, please explain.
2. Has your housing situation changed since beginning the MASH project?
    a. How has it changed? Did the MASH team help you? Please explain.
3. Has your financial stability changed since beginning the MASH project?
    If yes…
    a. How has it changed? Did the MASH team help you? Please explain
    If no…
    a. What would you like to have changed that did not change?
    b. Did you discuss that issue with the MASH team? If yes, what was their response?
4. Now, let's talk about the collaboration between you and the MASH team.
    a. Has the communication been effective?
    b. Have you had opportunities to speak up and share ideas?
    c. Did you feel comfortable with the process?
5. What do you see as the successes of MASH?
6. How can the MASH program be improved?
7. Is there anything else that you would like to share about the MASH program?

EVALCORP
Measuring What Matters

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Appendix F. Quarterly Report Template

Innovation Quarterly Progress Report

Date report completed:

Reporting period (enter the Quarter and the Year of the reporting period):

Name of person completing report:

Email Address:

Organization:

Guidance for Completing the Quarterly Progress Report

The guidance document will help you summarize the activities and accomplishments attained during the reporting period. The purpose of this document is to accurately and comprehensively communicate the program activities to Ventura County Behavioral Health conducted during the reporting period.

This guidance document has seven sections:

1. Major Activities and Accomplishments
2. Problems (Challenges)
3. Successes (Stories)
4. Significant Findings *(Not Applicable for the Year 1 Qtr 1 Report)*
5. Dissemination and Marketing Activities
6. Additional Activities
7. Activities Planned for Next Reporting Period

Responses can be typed directly into this document. **The quarterly reports are due on the following dates:**

- **1/30 (covers October 1 through December 31)**
- **4/30 (covers January 1 through March 31)**
- **7/30 (covers April 1 through June 30)**
- **10/30 (covers July 1 through September 30)**

Quarterly reports should be emailed directly to MHSA staff hilary.carson@ventura.org, and EVALCORP evaluator tkidd@evalcorp.com

EVALCORP
Measuring What Matters

Major Activities and Accomplishments

Use this section to report on activities conducted during the reporting period in preparation and implementation of providing services, such as providing dinners, engaging in field trips, and youth leader engagement. Your responses should correspond to the timeline, core deliverables, and outputs in your proposal and contract documents.

Provider Response [Insert your response here]:

Core Deliverable (From Contract)	Updates	Status
1.		
2.		
3.		

Problems (Challenges)

Describe any changes from the original project design or stated plans from your last quarterly report for the reporting period including any adjustments in task completion dates and special challenges (if any) encountered or expected during this reporting period. Include details about impacts to programming such as closures due to COVID-19 pandemic or staff changes. Please also use this section to advise your program administrator of any program needs that may require technical assistance.

Provider Response [Insert your response here]:

Successes (Stories)

Describe any project successes. For example, share a story about something they did or changed as a result of the program? Did you hold your first workshop?

Provider Response [Insert your response here]:

Significant Findings

Please attach an addendum with any significant findings from your project work that have been compiled, analyzed, or summarized- in this space any actions towards this end goal. If you have questions about what to include or report here please reach out for technical assistance prior to the report due date.

Provider Response [Insert your response here]:

Dissemination and Recruitment Activities

Please detail any dissemination activities, such as presenting the program successes at a school. Also include recruitment and marketing efforts during the reporting period in preparation for starting services, including activities such as community outreach, website development, social media, flyers, or radio advertisements. Please include an update on recruiting new youth. Copies of any new materials should be attached.

Provider Response [Insert your response here]:

Additional Activities

Use this section to address other planning preparations during the reporting period, including how you have shared information about your program with your community, brought partners together, or completed subcontracts or Memorandums of Understanding (MOUs). Please also detail your staffing activities, including the recruitment and hiring of new staff, as well as training new and existing staff.

Provider Response [Insert your response here]:

Activities Planned for the Next Reporting Period

Describe activities planned for the next reporting period, such as your continued planning period activities and the expected date to begin services.

Provider Response [Insert your response here]:

MHSSA WELLNESS CENTERS

ANNUAL EVALUATION REPORT

ACADEMIC YEAR 2024-2025

BOARD OF EDUCATION · VENTURA COUNTY

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Prepared By:

EVALCORP
Measuring What Matters

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Table of Contents

Introduction and Project Overview 2

Evaluation Methodology 4

Overview of Objectives 6

Results by Objective & Outcome 8

Results – Access and Awareness Survey 14

Results - Wellness Peers 28

Results – Successes and Challenges 31

Summary of Findings 32

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Introduction and Project Overview

The Ventura County Mental Health Services in Schools (VCMHSS) Partnership was established in 2012 between the Ventura County Behavioral Health Department (VCBH) and the Ventura County Office of Education (VCOE). In 2019, California's Mental Health Student Services Act (MHSSA) allocated one-time and ongoing funding for school-county mental health partnerships. Ventura County was one of 20 California counties awarded funding to support existing school-county mental health partnerships and was used to implement services through Ventura County Wellness Centers (Wellness Centers) across eight high schools beginning in Fall 2021. An additional three high schools implemented MHSSA funded Wellness Centers beginning in Fall 2022. After the passage of the Behavioral Health Services Act ("Prop 1") in March 2024 in California, MHSSA was renamed to Behavioral Health Student Services Act (BHSSA). More information about the MHSSA/BHSSA can be found here.

The Wellness Centers are designed to implement strategies in schools that increase early identification of mental health needs, reduce access barriers, prevent mental health issues from becoming severe and disabling, and facilitate linkages to ongoing and sustained services by leveraging resources and integrating funding sources. The explicit goals of the Wellness Centers are to:

- prevent mental illness from becoming severe and disabling,
- reduce risk factors that negatively affect mental health and academic success, and
- improve access to school-based mental health services.

Participating Districts and Schools

Eleven high-school campuses spanning five school districts participated in this program during the 2024-2026 school year:

1. **Oxnard Union High School District**: Channel Islands High School, Hueneme High School, Oxnard High School, and Pacifica High School
2. **Ventura Unified School District**: Buena High School, Ventura High School, Foothill High School, and Pacific High School
3. **Fillmore Unified School District**: Fillmore High School
4. **Moorpark Unified School District**: Moorpark High School
6. **Santa Paula Unified School District**: Santa Paula High School.

Implementation

Wellness Peers. A key strategy used to support schools' implementation of the Wellness Center services has been to incorporate student volunteers (i.e. "wellness peers") to help with events and awareness activities. These individuals receive additional training from Wellness Center staff on how to support students who have questions about mental health but may not feel comfortable talking to school staff.

Referrals to VCBH. Another key component of the implementation of the Wellness Centers is the process for referring students to services offered by Ventura County Behavioral Health. If a student does not have private insurance, and the Wellness Center staff needs to refer the student for additional support, the student completes a PSC-36 screening (Pediatric Symptom Checklist). The results of this screening, along with a referral form, are then submitted to Ventura County Behavioral Health to follow up with the student.

Ventura County Behavioral Health provides direct Tier I services (e.g. Mental Health Promotion activities, including Social Emotional Learning) to individuals referred by this method to individuals who score at or below 27 on the PSC-36 (indicating a lack of psychological impairment). Individuals who score higher than 27 are further referred by Ventura County Behavioral Health to additional community mental health resources. Additional information about the Ventura County Wellness Centers can be found here.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Evaluation Methodology

VCBH and VCOE contracted with EVALCORP to conduct evaluation activities, including evaluation planning, data analysis, and reporting. Three distinct surveys, along with an activity tracking log, were developed in collaboration with VCBH and VCOE to evaluate the implementation of the Wellness Centers. Additionally, VCBH submitted service data for students referred to them from the Wellness Centers. A summary of these data collection tools is provided below.

Tracking Log. A tracking log documented implementation of project activities including screenings, referrals, program promotion, and trainings. Additionally, the Tracking Log captured student demographic information for those accessing the Wellness Center. One tracking log is associated with each school and is implemented in a spreadsheet on a shared Google Drive.

Wellness Peers Post-Training Survey. This survey was administered to student volunteers who worked in the Wellness Centers (i.e. "Wellness Peers"). This survey measured topics related to the Wellness Peers' responsibilities, such as confidence in recognizing signs and symptoms of a mental health crisis, confidence in referring students to Wellness Centers, and ability to provide mental health education to student audiences. In addition, the survey provided trained wellness peers an opportunity to describe what additional support they needed. The survey is given to Wellness Peers three times during the year: once after a training session in the Fall, once after a training session in the Spring, and once at the end of the school year.

Mental Health Awareness and Access Survey. This survey was administered to all students at the beginning and end of each school year. This survey evaluated changes in student awareness of the Wellness Centers and other school-based services, as well as student attitudes toward seeking help for oneself and others. This survey also included a slightly modified version of the Mental Health Seeking Attitudes Scale (MHSAS)[1].

Well-being Survey. This survey was administered as a pre/post test to students referred to Ventura County Behavioral Health. The survey was given at the time of referral, and again at the end of the school year. This survey evaluated improvement in measures of well-being including stress, substance use, and social support. This survey included several components of the Panorama Well-Being Survey[2].

[1] For more information about the MHSAS, see:
Hammer, J. H., & Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, reliability, validity, and comparison with the ATSSPH-SF and IASMHS-PO. Journal of Counseling Psychology, 65, 74-85.
[2] For more information about the Panorama Well-Being Survey, see: https://www.panoramaed.com/student-well-being-survey

Ventura County Behavioral Health Service Data. This data set consists of deidentified information about the Tier I services provided to students referred to the VCBH from the Wellness Centers. It is an export from an internal records system used at VCBH, and includes dates of service, types of service, and source of referral (i.e. school).

The following section of the report summarizes the objectives of the MHSSA Wellness Centers program (as specified in the most recent Scope of Work between VCBH and VCOE) followed by the results themselves. The results are organized by objective, with additional results presented after for further context.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Overview of Objectives

The MHSSA grant Scope of Work between VCBH and VCOE specifies 16 measurable outcomes for the program, divided across 6 objectives. The 6 program objectives are specified below, along with a brief description of the type of services described in the objective.

- **Objective 1: Provide linkages to program services to students on campuses.**

  This may include developmental screening and assessment tools, the use of web-based technologies for messaging and screening, and/or providing and tracking mental health referrals and resources.

- **Objective 2: Provide linkages to suicide prevention services.**

  This may include education for staff and wellness peers about signs and symptoms of suicide, and how to intervene or provide de-escalation services. Training programs may include the Applied Suicide Intervention Skills Training (ASIST). Additionally, this may include the use of risk assessment tools and linkages to school and community-based services, including mental health first aid intervention caregivers.

- **Objective 3: Provide linkages to drop-out prevention services.**

  This may include participation on the Student Absentee Review Board (SARB). The goal of SARB is to keep students in school and provide them with a meaningful educational experience by providing help to students and their parents or guardians to solve school attendance and behavior problems through available school and community resources. This process also diverts students with serious attendance and behavior problems from the juvenile justice system.

- **Objective 4: Provide linkages to placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.**

  This may include providing staff, such as a Community Services Coordinator (CSC) and/or clinician, dedicated specifically to meeting the mental health needs of youth identified as needing ongoing services. These staff will ensure that students will be established in a clinical home, have access to a clinician and other service staff to address needs, and be linked with support services as determined by their treatment recommendations.

- **Objective 6: Provide outreach linkages to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school.**

  This may include providing linkages to specialized services, screenings, support groups, and workshops for high-risk youth and their families. An additional goal of this objective is to provide universal screening to special populations with increased risk factors for mental illness, including migrant and homeless youth.

Each of the above objectives are associated with 2-4 measurable outcomes (for a total of 16 measurable outcomes). An overview of these outcomes, along with which data collection tool is used to capture the associated data is provided in Table 1 below.

Table 1. Outcomes Associated with Objectives of the MHSSA Grant

Objective	Outcome	Data Tool
1	Start program services within 90 days by launching the communication program to announce the Wellness Center and its services, communicating where to access services prior to the centers' opening, providing mental health awareness messaging, and recruiting Wellness Peers.	Tracking log
	At least 10% of students at each high school will be served through Wellness Center services during each program year	
	At least 75% of students who have been screened with mental health needs will be linked to an ongoing community health provider or receive services from VCBH CSC and/or VCBH clinician each year	
	At least 60% of students who access Wellness Center services will improve in measures of well-being by the end of the school year	Wellbeing survey
2	At least 75% of students who are referred, or express suicidal ideation, will be assessed by the VCBH Clinician and linked to a mental health provider each year	VCBH service data
	At least 75% of students who screen high-risk on VCBH's Risk Assessment Form will be provided a Brief Intervention and have a Safety Plan developed and implemented each program year	
	At least 75% of students who screen high-risk on VCBH's Risk Assessment Form will be linked with ongoing services each year	
3	At least 5% of students at each high school will be evaluated for drop-out prevention interventions based on risk factors, attendance, or repeated suspensions each program year	Tracking log
	At least 50% of students who are determined to be at risk of dropping out will be linked with ongoing drop-out prevention services each year	
4	At least 50% of students who have been assessed/screened with mental health treatment needs will be evaluated by a mental health provider based on level of care and insurance	VCBH service data
	100% of students who are evaluated or assessed and need mental health treatment will be linked with a clinical home to be placed with an ongoing mental health provider	
	Of the students receiving services by the VCBH CSC or Clinician, at least 75% of students who are evaluated or assessed and need mental health treatment will have a treatment plan developed, implemented, and reviewed at least monthly.	
	At least 75% of students who are linked with ongoing and sustained services will demonstrate an improvement in functioning as measured by improvement on PSC35	
5	At least 50% of targeted special populations will be connected with the Wellness Center and receive mental health screenings	Tracking log
	At least 50% of targeted special populations who access Wellness Center services will be connected with a linkage to ongoing community services, such as support groups, community-based mental health providers, and Student Success Teams	

The results for the 2024-2026 school year, organized by objective and outcome, are presented next, followed by supplemental results from the other data collection tools.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Results by Objective & Outcome

In the following results, the reported values are only for the 2024-2026 school year (not cumulative), and reported counts are units-of-service based (i.e., duplicated), not individual based, unless otherwise specified.

Objective 1. Provide linkages to program services to students on campuses.

Outcome 1. Start program services within 90 days by launching the communication program to announce the Wellness Center and its services, communicating where to access services prior to the centers' opening, providing mental health awareness messaging, and recruiting Wellness Peers.

All Wellness Centers at participating schools were providing services within 90 days of the start of the 2024-2026 school year.

Outcome 2. At least 10% of students at each high school will be served through Wellness Center services during each program year.

Across all schools for which unique student data was available, ***the percent of unique student visits to the Wellness Centers was 9% or higher of the total estimated enrollment.*** Among individual schools, the percent of unique student visits ranged from 9% to 76%.

Table 2. Wellness Center Visits and Student Enrollment

District-School Name	Total Number of Visits	Unique Student Visits	Approximate Enrollment	Percent *(unique student visits)*
SPUSD - Santa Paula	1,998	387	1,708	23%
MUSD - Moorpark	2,619	-	1,849	-
FUSD - Fillmore	16,681	790	1,067	74%
VUSD - Buena	4,178	616	1,710	30%
VUSD – Ventura	624	198	2,096	9%
VUSD – Foothill	9,319	498	999	60%
VUSD – Pacific	1,791	176	234	76%
OUSD – Channel Islands	6,148	767	2,643	29%
OUSD – Hueneme	1,160	-	2,279	-
OUSD – Oxnard	3,077	693	2,786	-
OUSD - Pacifica	1,619	-	3,219	21%
Total	**47,014**	**3,913**	**20,589**	**30%**

Outcome 3. At least 75% of students who have been screened with mental health needs will be linked to an ongoing community health provider or receive services from VCBH CSC and/or VCBH clinician each year.

Across all schools, 3,499 screenings were conducted in the Wellness Centers. ***338 (10%) of the screened individuals were enrolled in a mental health service*** through the Wellness Center. Note that this is of all students screened, regardless of the outcome of the screening (data from these was not available).

Outcome 4. At least 60% of students who access Wellness Center services will improve in measures of well-being by the end of the school year.

Across all schools, 43 Wellbeing intake surveys and 28 Wellbeing follow-up surveys were received. The following results represent paired samples (i.e., matched) comparisons from 11 individuals.

Table 3. Select Wellbeing Survey Results

Indicator	Pre-test Value (average)	Post-test Value (average)	Number (percent) of students improved
Average social support score (range: 1-6, higher score indicates can count on and be yourself around more people)	4.18	6.00	64%
Average number of days in past week experiencing positive feelings	3.96	4.30	66%
Average number of days in past week experiencing challenging feelings	3.28	2.69	64%

Wellbeing survey results are consistent with improved average wellbeing across multiple indicators for students referred to VCBH for Wellness Center services at the end of the school year. Additionally, ***more than 36% of students (with available data) improved on all of the three wellbeing measures.***

Objective 2. Provide linkages to suicide prevention services.

Outcome 1. At least 75% of students who are referred, or express suicidal ideation, will be assessed by the VCBH Clinician and linked to a mental health provider each year.

Of the 146 referrals to VCBH from the wellness centers during the 2024-2026 school year, 128 (88%) were given a mental health assessment by VCBH. Of those assessed, 14 (11% of those assessed) noted suicidal ideation. ***Twelve (86%) of the fourteen students who expressed suicidal ideation were referred to additional mental health services.*** Of the other two, one was referred to CWS services, and the other moved/relocated.

Outcome 2. At least 75% of students who screen high-risk on VCBH's Risk Assessment Form will be provided a Brief Intervention and have a Safety Plan developed and implemented each program year.

Of the 128 referrals to VCBH that resulted in a mental health assessment during the 2024-2026 school year, 14 (11%) resulted in safety plans, ***including for all 14 (100%) of those where suicidal ideation was noted.***

Outcome 3. At least 75% of students who screen high-risk on VCBH's Risk Assessment Form will be linked with ongoing services each year.

Of the 14 referrals to VCBH from the Wellness Centers that received safety plans during the 2024-2026 school year, ***12 (86%) were referred to ongoing services***, including 8 to a higher level of care and 4 to PEI services. Of the other two, one was referred to CWS and the other moved/relocated.

Objective 3. Provide linkages to drop-out prevention services.

Outcome 1. At least 5% of students at each high school will be evaluated for drop-out prevention interventions based on risk factors, attendance, or repeated suspensions each program year.

Across all schools, ***449 instances (1% of visits) of students with previous suspensions were recorded as accessing Wellness Center Services***. Table 4 below provides additional details by school district.

Table 4. Instances of students with prior suspensions accessing Wellness Centers

District-School Name	Times Student with Suspensions Accessed Center	Unique Individuals	Approximate Enrollment
SPUSD - Santa Paula	68	18	1,708
MUSD - Moorpark	21	-	1,849
FUSD - Fillmore	44	40	1,067
VUSD - Buena	-	-	1,710
VUSD – Ventura	-	-	2,096
VUSD – Foothill	-	-	999
VUSD – Pacific	-	-	234
OUSD – Channel Islands	71	16	2,643
OUSD – Hueneme	82	-	2,279
OUSD – Oxnard	2	2	2,786

OUSD - Pacifica	171	-	3,219
Total	449	>76	20,689

Outcome 2. At least 50% of students who are determined to be at risk of dropping out will be linked with ongoing drop-out prevention services each year.

Across all schools, 29 instances of students classified as "at risk of dropping out" (2 of which had prior suspensions) and 447 additional instances of students with previous suspensions were recorded as accessing Wellness Center Services. Of these, ***all 29 (100%) of the visits from students at risk of dropping out were provided with a mental health referral, and 331 (74%) of the visits from students with previous suspensions resulted in a mental health service referral.***

Objective 4. Provide linkages to placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

Outcome 1. At least 50% of students who have been assessed/screened with mental health treatment needs will be evaluated by a mental health provider based on level of care and insurance.

Of the 146 referrals to VCBH from the wellness centers during the 2024-2026 school year, 128 were screened by VCBH. Of these, ***98 (67%) were referred to one or more programs.***

Outcome 2. 100% of students who are evaluated or assessed and need mental health treatment will be linked with a clinical home to be placed with an ongoing mental health provider.

Results from screenings/assessments were not available, however of the 128 individuals screened by VCBH through referrals from the wellness centers during the 2024-2026 school year, 60 were offered therapy and 49 attended. Additionally, 4 were already connected with an outside provider, 98 were referred to additional service, 16 declined service, and 6 did not respond to outreach.

Outcome 3. Of the students receiving services by the VCBH CSC or Clinician, at least 75% of students who are evaluated or assessed and need mental health treatment will have a treatment plan developed, implemented, and reviewed at least monthly.

Treatment plan data was not available, however the following narrative summarizes services received. Based on the VCBH service data, 146 unique individuals received a total 1,034 units of service (between 1 and 21 units per individual) after being referred from the Wellness Centers during the 2024-2026 school year. All 146 individuals received one or more units of case management, 43 individuals received 1 or more units of psychotherapy, and 48 individuals received psychiatric diagnostic evaluation. Additional service types provided included non-billable (66 individuals) and targeted outreach (1 individual).

Outcome 4. At least 75% of students who are linked with ongoing and sustained services will demonstrate an improvement in functioning as measured by improvement on PSC35.

The PSC35 was only completed at intake for students referred to VCBH from the Wellness Centers. However, results from the Wellbeing Survey are consistent with there being an average improvement in symptoms among referred students overall (see Objective 1, Outcome 4).

Objective 5. Provide outreach linkages to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school.

Outcome 1. At least 50% of targeted special populations will be connected with the Wellness Center and receive mental health screenings.

Of the students from these high-risk populations that visited the Wellness Center, roughly 48% of visits resulted in a screening. Additional details are provided in Table 5 below.

Table 5. Screenings conducted by High-Risk Population

High Risk Population	Times Student Accessed Center	Times Screening Conducted	Percent
Foster youth	202	170	84%
Trans and nonbinary youth	367	26	7%
Gay/Lesbian and bisexual youth	8	-	-
Has been suspended	449	293	65%
Has been expelled	3	-	-

Outcome 2. At least 50% of targeted special populations who access Wellness Center services will be connected with a linkage to ongoing community services, such as support groups, community-based mental health providers, and Student Success Teams.

Of the students from these high-risk populations that visited the Wellness Center, roughly 63% of visits resulted in a mental health referral. Additional details are provided in Table 6 below.

Table 6. Referrals conducted by High-Risk Population

High Risk Population	Times Student Accessed Center	Times Referral Provided	Percent

Foster youth	202	176	87%
Trans and nonbinary youth	367	28	8%
Gay/Lesbian and bisexual youth	8	8	100%
Has been suspended	449	331	74%
Has been expelled	3	2	67%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Results – Access and Awareness Survey

This section of the findings presents the results of the Mental Health Access and Awareness survey (Table 7). This survey was administered to all students at each school twice during the school year: once near the beginning of the year ("pre"), and once towards the end of the year ("post"). Pre responses were submitted between August 1, 2024 and December 30, 2024. Post responses were submitted between January 1, 2025 and June 30, 2025. The table below summarizes the number of responses obtained by school.

Table 7. Mental Health Access and Awareness Completion by School, 2024-2025

School Name	Pre - Total Responses	Pre – 9th Grade only	Post - Total Responses	Post – 9th Grade only
Buena High School (BHS)	946	282	321	119
Channel Islands High School (CIHS)	484	237	78	19
Fillmore High School (FHS)	346	121	383	167
Hueneme High School (HHS)	1,632	457	349	96
Moorpark High School (MHS)	664	205	624	166
Oxnard High School (OHS)	405	79	1,761	602
Pacifica High School (PHS)	68	18	166	15
Santa Paula High School (SPHS)	696	202	806	309
Foothill High School (VUSDFHS)	674	198	701	186
Pacific High School (VUSDPHS)	61	1	42	6
Ventura High School (VUSDVHS)	266	92	2	0
Total	6,121	1,892	6,223	1,682

Pre results for Pacifica High School, and Pacific High School and Post results from Channel Islands High School, Pacifica High School, Pacific High School, and Ventura High School will not be included in the school-level results below because of the low number of responses (less than 30 responses). School-specific results (pre/post) are included for 9th graders only to identify results for those who are participating in the program for the first time.

The following three subsections of the report (Willingness to Access Services, Mental Health Stigma – Mental Help Seeking Attitudes, and Awareness of Available Services) summarize the results of the Mental Health Access and Awareness survey by item.

Willingness to Access Services

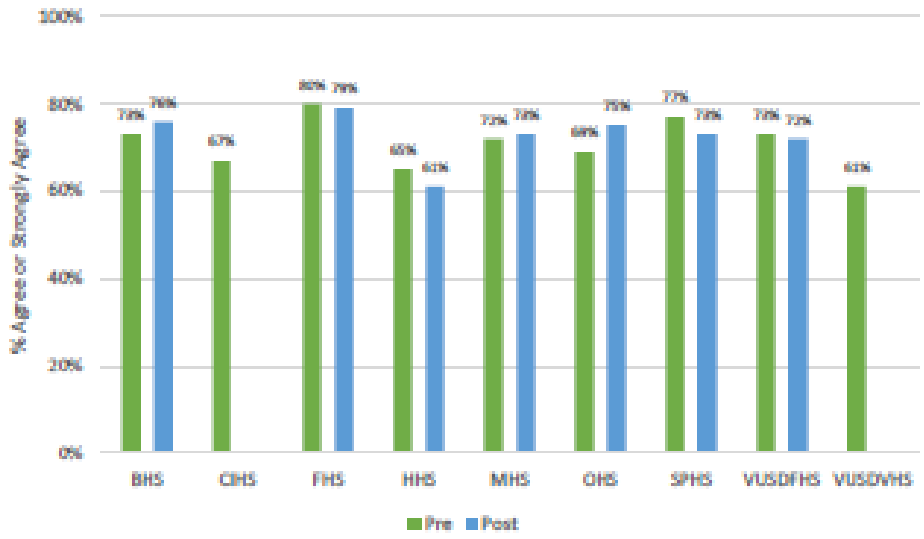
Students were asked to rate their level of agreement or disagreement with statements related to their willingness to seek help for a mental health issue. Figures 1-4 indicate the percentage of students who agreed (or strongly agreed) with each statement at the beginning of the year (pre) and end of the year (post), by school. The tables within the figures display the percentage of students who agreed (or strongly agreed) with each statement for all schools at pre and post this year (2024-2026) compared to the last three years (2021-2022, 2022-2023, and 2023-2024).

Figure 1. "If I Needed Help with a Mental Health Issue, I Would be Willing to Seek Help"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	69%	69%	72%	71%
Post	68%	71%	74%	76%

By School, 2024-2026 9th Grade Only



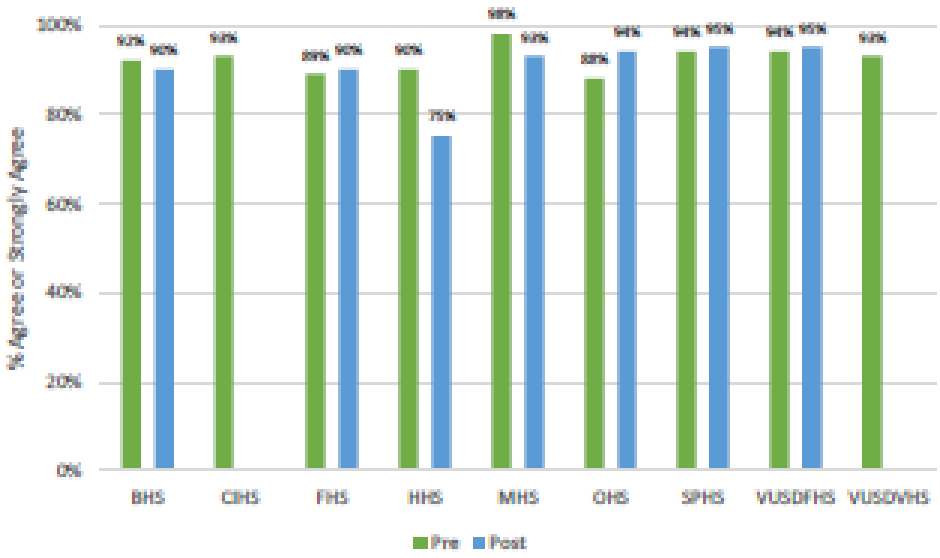
As depicted in Figure 1, in 2024-2026, students were generally willing to seek help for their mental health at the beginning and end of the year (71-76%). This represents a slight increase (2-8%) since the first year of implementation. Pre and Post results within 9th grade participants showed that students maintained general willingness to seek help for their mental health at the end of the year.

Figure 2. "If someone close to me had a mental health issue, I would encourage them to seek help"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-25
Pre	95%	95%	94%	93%
Post	95%	94%	94%	93%

By School, 2024-2025 9th Grade Only



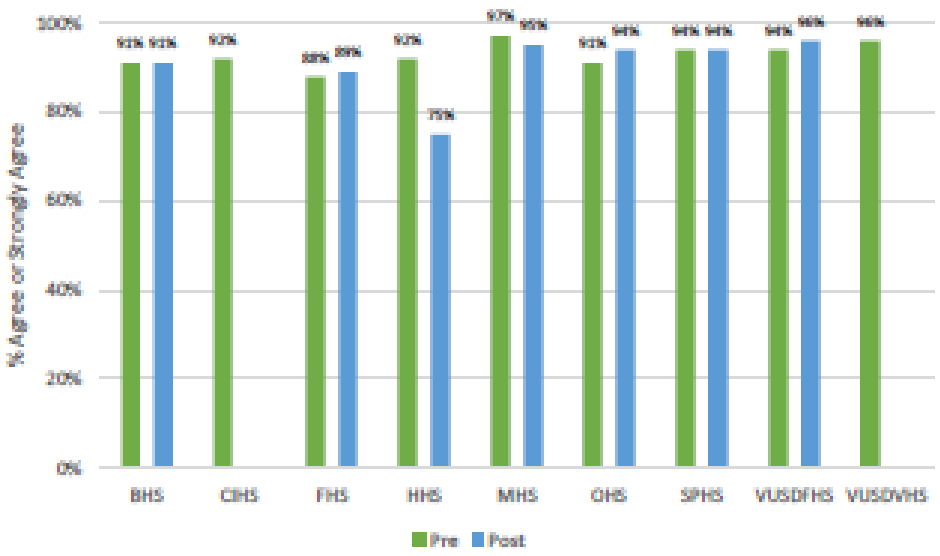
Across all schools, students were very likely (93%) to report that they would encourage someone close to them to seek help with a mental health issue across pre and post tests (Figure 2).

Figure 3. "If someone close to me had a mental health issue, I would listen to them without judging or criticizing"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	96%	95%	94%	94%
Post	96%	96%	96%	93%

By School, 2024-2025 9th Grade Only



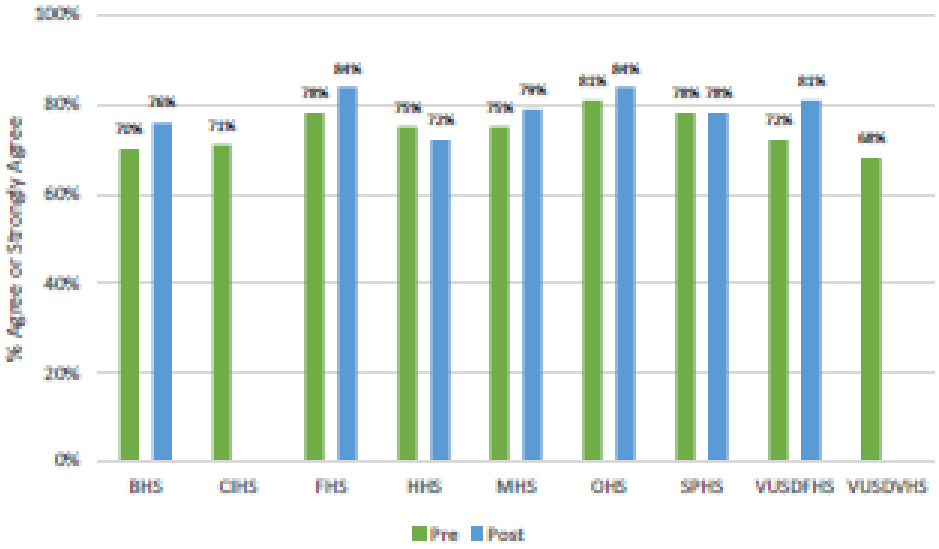
Across all schools and all grades, students were very likely (93-94%) to report that if someone close to them had a mental health issue, they would listen to them without judging or criticizing them at both pre and post tests (Figure 3).

Figure 4. "I know when to ask for help with mental health issues"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	72%	72%	77%	76%
Post	71%	76%	77%	82%

By School, 2024-2026 9th Grade Only



Across all schools and all grades, students who indicated they know when to ask for help with mental health issues increased at the post test (from 76% to 82%) (Figure 4). This represents a slight increase (3-11%) since the first year of implementation.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Help Seeking - Planned Behaviors and Barriers

Additionally, students were asked to indicate what they would do if they were feeling sad, stressed, lonely or depressed as well as what would stop them for talking to a counselor or therapist if they were feeling any of these ways. Post responses to these are provided in Tables 8 and 9, color coded for percent difference from pre to post surveys.

Table 8. "If you were feeling very sad, stressed, lonely, or depressed, would you..."

Post (and change) by School (percent choosing each), 2024-2026 9th Grade Only

	All Schools	BHS	FHS	HHS	MHS	OHS	SPHS	VUSD FHS
talk to your friends?	63%	72%	63%	47%	60%	61%	58%	76%
talk to your parents or someone else in your family?	59%	63%	57%	56%	59%	59%	58%	60%
talk to a teacher or another adult from your school?	28%	33%	41%	50%	19%	22%	33%	22%
get help from counselor or therapist?	16%	18%	26%	31%	11%	12%	15%	13%
be afraid to get help?	14%	9%	17%	16%	19%	11%	12%	17%
not know what to do?	16%	11%	15%	7%	20%	16%	15%	18%
I would do none of these	13%	17%	7%	10%	17%	15%	15%	11%

Legend	Pre test to Post test
no shading	<5% change
light green	5-10% better
dark green	>10% better
light orange	5-10% worse
dark orange	>10% worse

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Table 9. "If you were very sad, stressed, lonely, or depressed, would any of these things stop you from talking to a counselor or therapist?"

Post (and change) by School (percent choosing each), 2023-2024 9th Grade Only

	All Schools	BHS	FHS	HHS	MHS	OHS	SPHS	VUSD FHS
You don't want to talk to a counselor or therapist	31%	32%	20%	6%	41%	32%	29%	42%
They wouldn't understand	23%	23%	26%	21%	27%	19%	21%	29%
Your parents might find out	20%	15%	25%	19%	20%	16%	23%	25%
People would think there's something wrong with you	20%	19%	19%	17%	25%	18%	22%	22%
Other students might find out	19%	13%	20%	13%	23%	16%	24%	24%
You don't know where to go for help	15%	11%	16%	29%	16%	14%	16%	11%
There isn't anyone you can talk to	13%	15%	9%	18%	17%	11%	10%	16%
You don't have a way to pay for it	8%	9%	7%	5%	10%	7%	7%	12%
Other reasons	18%	22%	15%	9%	19%	20%	20%	16%
Does not apply *(none of these things would stop me from talking to school staff)*	27%	29%	22%	14%	28%	28%	28%	34%

Legend	Pre test to Post test
no shading	<5% change
light green	5-10% better
dark green	>10% better
light orange	5-10% worse
dark orange	>10% worse

Help Seeking - Attitudes

The Mental Health Seeking Attitudes Scale (MHSAS) is a semantic differential scale. This type of scale measures attitudes where terms on the left and right are polar opposites. The MHSAS is composed of nine items presented as pairs of individual words with their opposites, and the respondent is asked to answer the prompt on a seven-point rating scale between each pair of words. The pairs of words are listed in Table 10.

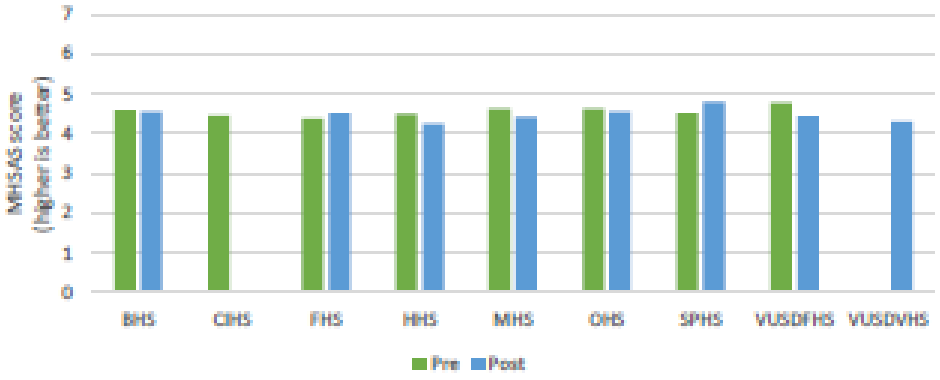
Table 10. Semantic Differential Scale for Mental Health Seeking Attitudes Questions

Useless	Useful
Important	Unimportant
Unhealthy	Healthy
Ineffective	Effective
Good	Bad
Healing	Hurting
Disempowering	Empowering
Satisfying	Unsatisfying
Desirable	Undesirable

Responses were combined into a single composite score for an individual that ranges from 1 (very negative attitude towards seeking help) to 7 (very positive attitude towards seeking help).

Across all schools, the average composite MHSAS score of 9th grade respondents was neutral to slightly positive and did not change from pre to post (4.6). The average composite scores by school at the time of pre and post test are shown in Figure 6.

Figure 6. Mental Health Seeking Attitudes by School, 2024-2026 9th Grade Only



Awareness of Available Mental Health Services

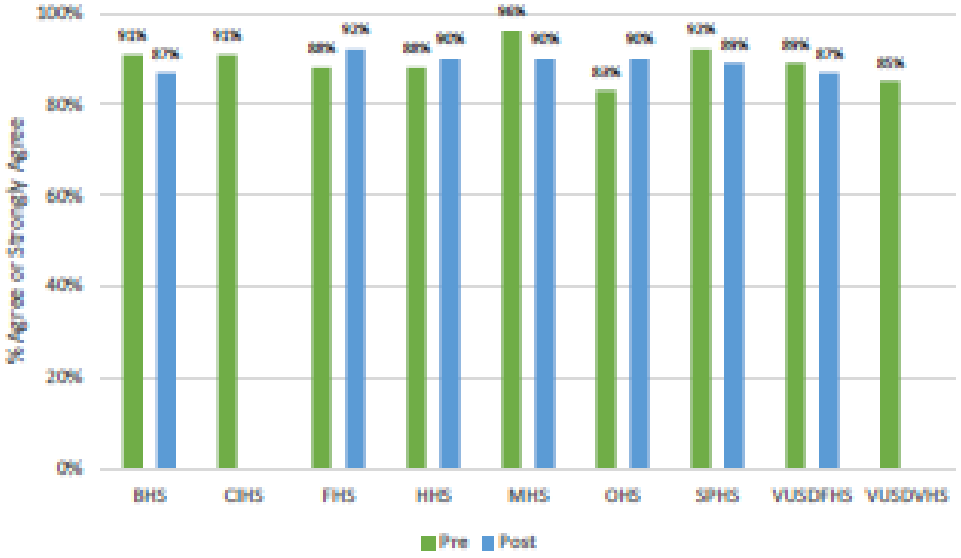
Students were also asked to indicate their level of agreement or disagreement with statements related to the resources and services provided at their school. Figures 6-11 include the percentage of students who agreed (or strongly agreed) with each statement for all schools at pre and post this year (2024-2026) compared to the last three years (2021-2022, 2022-2023, and 2023-2024), followed by school specific results in the chart for the current (2024-2026) year.

Figure 6. "My school has resources/services available for students with mental health issues"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	86%	88%	91%	90%
Post	89%	90%	90%	91%

By School, 2024-2025 9th Grade Only



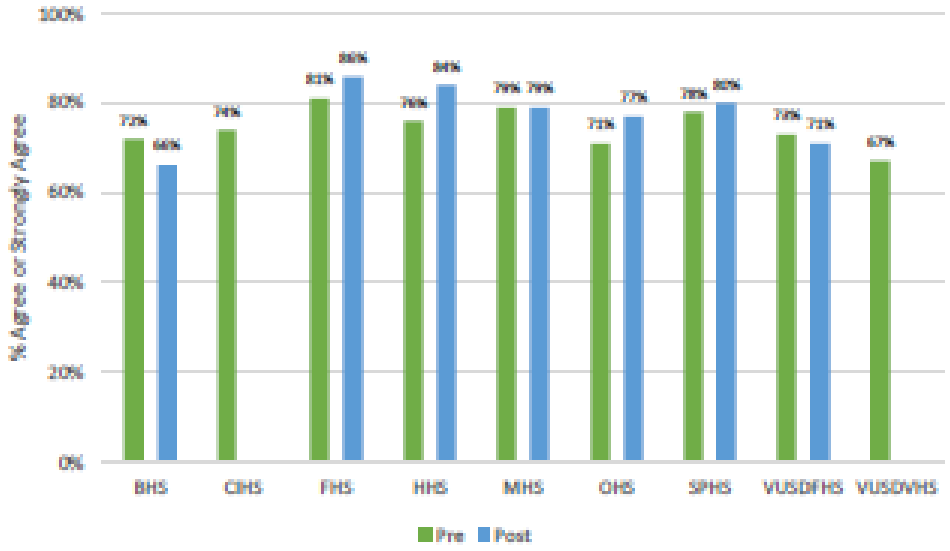
Across all schools and all grades, students were very likely (90-91%) to report that their school has resources and services available for students with mental health issues at both pre and post test (Figure 6). This represents a small increase (2-4%) since the first year of implementation.

Figure 7. "I know what mental health services are provided at my school"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	63%	69%	80%	78%
Post	72%	80%	80%	82%

By School, 2024-2026 9th Grade Only



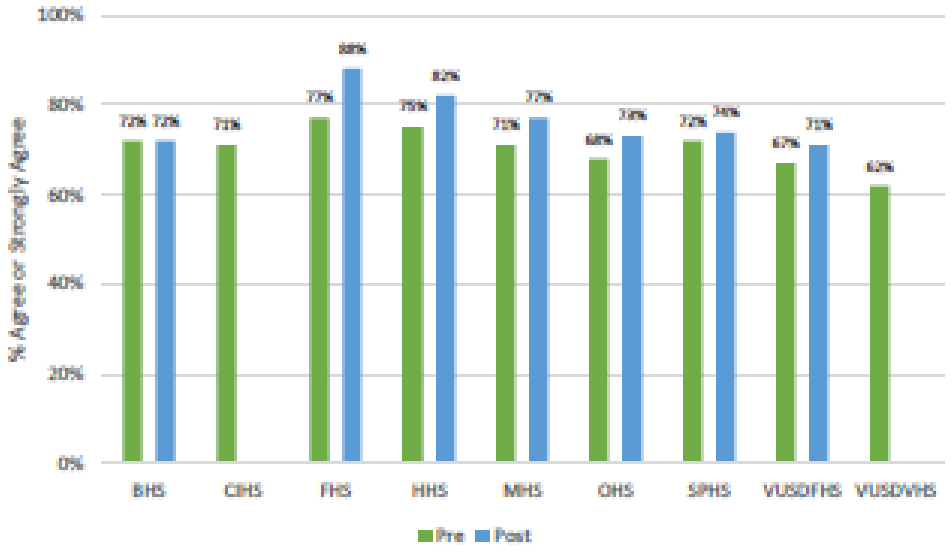
Across all schools and all grades, students were likely (78-82%) to report that they know what mental health services are provided at their school at both pre and post tests (Figure 7). This represents a moderate increase (10-16%) since the first year of implementation.

Figure 8. "I am confident I know where to go and how to access mental health services at my school"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	60%	66%	77%	76%
Post	70%	79%	78%	81%

By School, 2024-2025 9th Grade Only



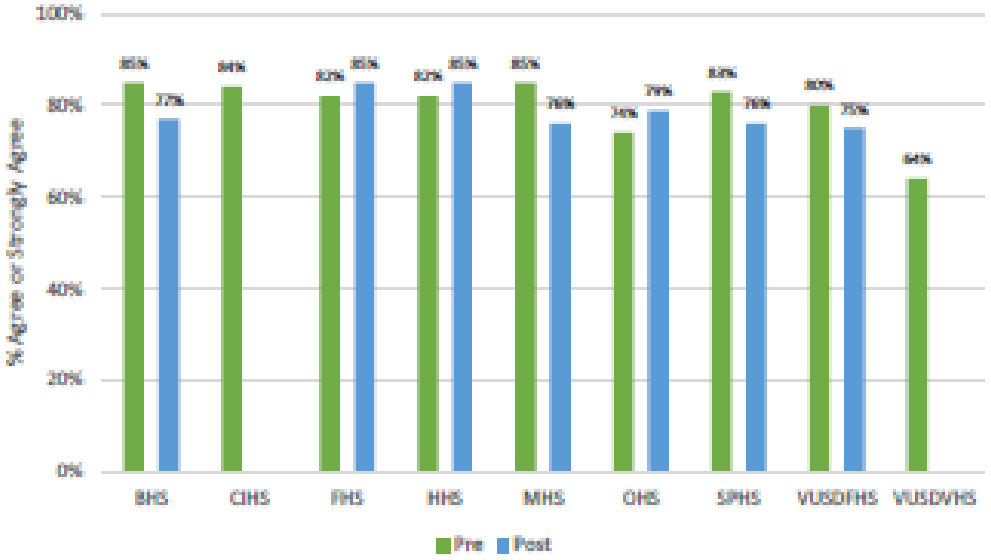
Across all schools and all grades, students were likely (76-81%) to report confidence in knowing where to go and how to access mental health services at their school at both pre and post test (Figure 8). This represents a moderate increase (11-16%) since the first year of implementation.

Figure 9. "A student could find help at my school to stop or reduce using alcohol or other drugs"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	76%	74%	80%	78%
Post	70%	76%	78%	80%

By School, 2024-2026 9th Grade Only



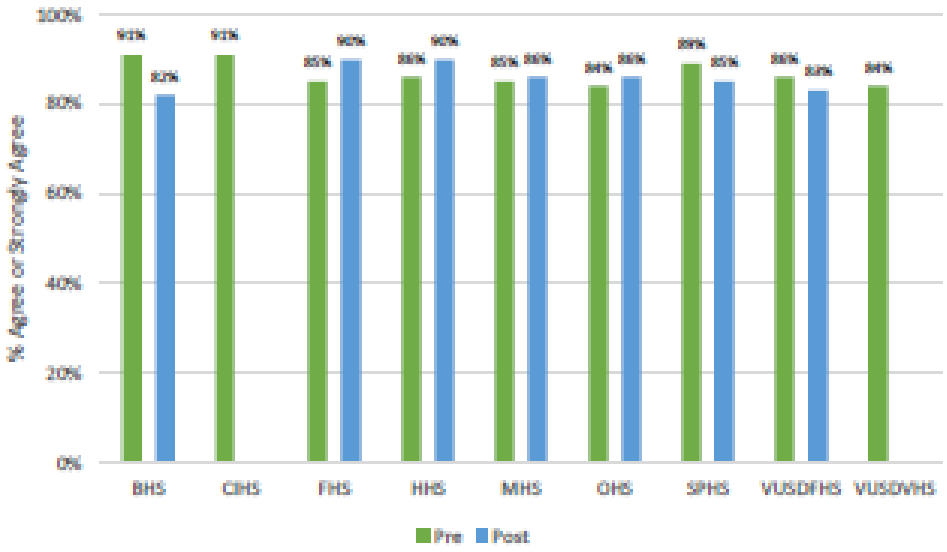
Across all schools and all grades, students were likely (78-80%) to report that a student at their school could find help to stop or reduce using alcohol or other drugs at both pre and post test (Figure 9). This represents a slight increase (3-10%) since the first year of implementation.

Figure 10. "I could help a friend struggling with mental health find the right person to talk to"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	86%	84%	88%	87%
Post	83%	87%	86%	87%

By School, 2024-2025 9th Grade Only



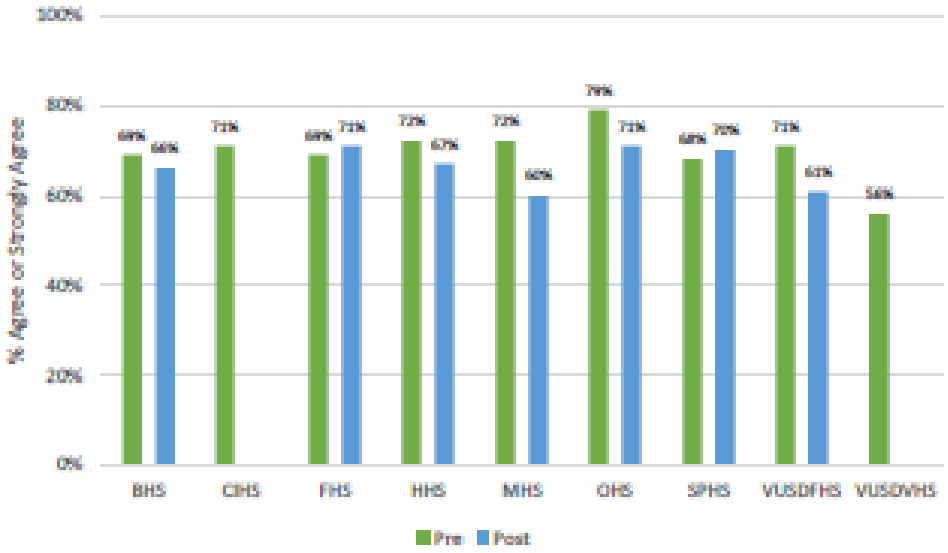
Across all schools and all grades, students were very likely (87%) to report that they could help a friend struggling with mental health find the right person to talk to at both pre and post test (Figure 10). This represents a slight increase (2-4%) since the first year of implementation.

Figure 11. "My school has services to support the mental health issues I struggle with"

All Schools/All Grades by School Year (% Agree or Strongly Agree)

School Year	21-22	22-23	23-24	24-26
Pre	78%	64%	71%	68%
Post	77%	68%	66%	69%

By School, 2024-2025 9th Grade Only



Across all schools and all grades, students were somewhat likely (68-69%) to report that their school has services to support the mental health issues they struggle with at both pre and post test (Figure 11). This represents a decrease (8-10%) since the first year of implementation, although it is similar or slightly higher than the previous year.

Results - Wellness Peers

This section summarizes the activities conducted by the Wellness Peers (student volunteers who help in the Wellness Centers), as recorded in the tracking log. The section also includes the results of the Wellness Peers Training Survey. This survey was administered to all Wellness Peers three times during the year – after a Fall training, after a Spring training, and at the end of the school year (not associated with a specific training).

Activities

The number of (and example) activities that Wellness Peers supported, as recorded in the tracking log by school, are summarized in Table 10.

Table 10. Wellness Peer Activities by School, 2024-2026

School	Activities	Example Activities
Buena High School	40	Making posters, journaling event, Bath Bomb making workshop, Valentine's activity
Channel Islands High School	67	Tabling, Start with Hello Week, Dude be Nice, self-care kits, mental health week
Fillmore High School	63	Create posters/fliers, tabling, Kindness Day, Youth Panel, Wellness Fair
Hueneme High School	126	Lunch activity, tabling/presenting, toy drive, after school events, vision boards
Moorpark High School	46	Tabling, presenting, meetings, bracelet making, suicide prevention, student panel
Oxnard High School	92	Wellness rock painting, affirmations, coping bingo, vision boards, journaling, mindful Monday
Pacifica High School	74	Prepare/present/clean up for workshops, De-Stress Fest poster making, SafeTalk, peer meetings
Santa Paula High School	19	Peer meetings, tabling, lunch activities, aromatherapy, fall leaf decorating
Foothill High School	491	Fun fact bingo, NAMI posters, social media posts, develop posters/signs, event planning
Pacific High School	19	Chalk n Talk, Unity day, aromatherapy necklaces, teacher appreciation week, sound bath
Ventura High School	1	Tabling and presenting (suicide prevention)
Total	987	

Wellness Peer Survey Responses

The results presented below are responses received on the Wellness Peers survey. A total of 262 responses were received across two sessions held on September 1 and February 1, 2026. All of the responses were included in the following analyses, unless otherwise specified.

Knowledge and Confidence

Table 12 depicts the percent of responding wellness peers who agreed or strongly agreed with listed items about several topics related to talking to peers about mental and behavioral health.

Table 12. Aggregated Wellness Peer Survey Results, 2024-2026

	Fall Session	Spring Session
I learned how to talk to my peers about mental and behavioral health	85%	92%
I feel confident I can talk to my peers about mental and behavioral health	90%	93%
I learned the signs of a mental health crisis	90%	79%
I feel confident I can intervene in a mental health crisis	86%	90%
I learned how to regulate my emotions to help others	90%	92%
I feel confident I can refer peers to wellness centers, as needed	89%	90%
I learned how to provide mental health education to my peers	88%	90%
I feel confident that I can provide mental health education to my peers	87%	92%
I learned how to use trauma-informed practices as I support my peers	77%	79%
I learned about different careers in mental health that interest me	72%	65%

Overall, peers were likely (>86%) to report that they learned how to talk to their peers about mental and behavioral health and provide them with mental health education. Similarly, they were likely (>90%) to report that they feel confident in talking to peers about mental and behavioral health and learned to regulate their emotions to help others. Peers were somewhat less likely (66-72%) to report that they learned about different careers in mental health that interest them.

Additional Support Requested

A final item on the Wellness Peers survey asked what other information or support individuals would like as Wellness Peers. The results below are from the 239 non-blank responses received throughout the school year. Of these 239 responses, 97 (41%) responded with "N/A", or did not answer the question. A summary of the remaining 142 substantive responses is provided in Tables 13 and 14.

Table 13. Additional Support Requested, 2024-2026

Additional Support Requested	Fall Session	Spring Session
Awareness of additional resources	4	3
Better meeting time	1	1
Engagement strategies	1	--
Expanded funding for program	--	6
General support for peers	9	6
Hands on activity	6	6
Interaction with other schools/centers	3	1
More diversity	2	--
More group activity	6	10
More information about a specific topic (different topics)	60	39
Speakers	--	2
Training certification	1	--

Table 14. More Information Requested, 2024-2026

More Information Requested	Fall Session	Spring Session
Coping with mental health issues	18	6
Helping in crisis	8	6
Talking to someone about mental health	17	2

Many participants requested more information about a specific topic which included how to cope with mental health issues (i.e., skills around self-care, coping with anxiety, and helping with bullying), talk to someone about mental health issues (i.e., skills around approaching someone about mental health issues and having a trauma-informed approach) and intervene in moments of crisis (i.e., skills around intervening in panic attacks, anxiety attacks, and other serious problems).

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Results – Successes and Challenges

Wellness Center staff shared successes and challenges they experienced throughout the school year as part of the Tracking Log. Illustrative examples of these successes and challenges are provided below.

Successes. Successes reported by Wellness Center staff during the 2024-2026 school year included:

- Value and support provided by wellness peers
- Individual student success stories after engaging with the Wellness Center (e.g. improved grades)
- Meaningful presentations from other county agencies, providers, or CBOs
- Students more familiar with, and comfortable with, the wellness centers
- Coordination and support across stakeholders, including administration, teachers, High School and Middle School Wellness Centers

Challenges. Challenges reported by Wellness Center staff during the 2024-2026 school year included:

- Reduced funding or restrictive requirements on what can be funded (e.g., cannot pay for food associated with events)
- Some teachers are resistant to students leaving class for wellness center activities/events
- Changes in, or limited availability of staff or peers

Summary of Findings

The Wellness Centers continued to receive a large volume of student visitors throughout the school year (over 47,000 visits), representing almost one third of the total students enrolled across all participating schools (although this number varied by school – ranging from 9% to 76% of students having visited the center at some point during the school year). Approximately 12.8% of these 47,000 visits resulted in a referral (6,716 referrals in total) to some kind of mental health service.

Students referred to VCBH clinicians from the Wellness Centers improved in several measures of wellbeing by the end of the school year, and all but one of these referrals for individuals that expressed suicidal ideation were referred to additional services and supports. Additionally, referral rates (to any mental health service) from the Wellness Centers were relatively higher for foster youth and students with previous suspensions (referrals were associated with two thirds or more of all visits from these groups), which highlights the focus on support and connections to care for these higher risk groups.

Averaged across all schools, students reported similar, or slightly higher awareness of, or willingness to access mental health services by the end of the 2024-2026 school year. The same was generally true when reviewing only 9th graders' responses, and generally the case when reviewing school-specific results as well. Finally, several indicators of awareness of services averaged across all schools were slightly higher compared to two or three years ago, when the Wellness Centers were first implemented. This suggests a cumulative impact of the centers' implementation over multiple years, as students remember the services that were introduced in prior years.

Full-Service Partnerships Outcomes Report

VENTURA COUNTY BEHAVIORAL HEALTH

FY 2024-2025

What are FSP Programs?

Under the Mental Health Services Act (Prop 63), Community Services and Supports (CSS) component, Full-Service Partnership (FSP) programs provide intensive wellness and recovery-based services for previously unserved or underserved individuals with serious mental illness (adults and older adults) or severe emotional disturbances (children and youth) that would benefit from an intensive wraparound service program as they seek to achieve their individualized treatment goals. The MHSA has established a standard that 51% of all CSS funding be dedicated to these programs.

Why is this Important?

At Ventura County Behavioral Health (VCBH), the foundation of FSPs lies in a "whatever it takes" approach to help individuals on their path to recovery and wellness. FSPs embrace client-driven integrated services and support that includes treatment, case management, transportation, housing, crisis intervention, education, vocational training and employment services, as well as socialization and recreational activities. Unique to FSP programs are a low client-to-staff ratio, 24/7 Personal Service Coordinator (PSC) availability, and a treatment approach that employs, as the name implies, a "partnership" between consumers, mental health staff, peers and community-based service providers. Embedded in FSP programs is a commitment to deliver services in ways that are culturally and linguistically responsive and appropriate.

Data Collection of FSP Partner Data

FSP providers collect client self-report data, including the Partner Assessment Form (PAF), Quarterly Assessments (3Ms), and the Key Event Tracking (KET) forms. These self-report data are collected in VCBH's Electronic Health Records (EHR) system. Additionally, VCBH's EHR system records and tracks all services rendered to partners. The following pages outline partner information and services rendered stemming from the EHR.

Demographic Information

Table A1 presents demographic information for the *unduplicated* number of partners served in a VCBH FSP program within FY24-25. As illustrated, VCBH served a total of 552 Adult/Older Adult/TAY partners within the fiscal year of FY24-25. In this report, served is defined as having a billed unit for any service rendered to the partner within the fiscal year. *Note*. There were a total of 552 unique Adult, Older Adult and TAY partners served and a total of 76 youth partners served in FY24-25 (demographics for youth displayed separately in Table A2) for a total unduplicated count of 625 FSP partners served.

Adults

As illustrated in Table A1, we have partner demographic information for Age Group, Sex, Sexual Orientation, Employment Status, Ethnicity, Race, and Preferred Language for TAY, Adults, and Older Adults. Table A1 presents demographic information for the unduplicated number of partners served in a VCBH FSP program within FY24-25. As illustrated, VCBH served a total of 552 Adult partners.

Table A1. FY24-25 FSP Partner Demographics for TAY, Adults, and Older Adults (unduplicated client count)

Demographics (N = 552 unduplicated clients)		
Category	**N**	**%**
Age Groups Served (n = 552)		
0-15	--	--
16-25	112	20.3%
26-59	280	50.7%
60+	160	29.0%
Sex/Gender (n =552)		
Female	236	42.8%
Male	316	57.2%
Sexual Orientation (n = 552)		
Bisexual	4	0.7%
Heterosexual	65	11.8%
Unsure/Questioning	2	0.4%
Decline to answer	1	0.2%
Not Reported/Unknown	480	87.0%
Ethnicity (n = 552)		
Hispanic/Latino	211	38.2%
Non-Hispanic	247	44.7%
Unknown/Unreported	91	16.5%
Multiethnic	1	0.2%
Declined to answer	2	0.4%
Primary Language (n = 552)		
English	471	85.3%
Spanish	30	5.4%
Other Non-English	2	0.4%
Not Reported/Unknown	49	8.9%
Military Status (N=552)		
No	83	15.0%
Yes	2	0.4%
Unknown	467	84.6%

Note. Data based on VCBH Electronic Health Records

Please refer to section 4 of the Annual Update for additional information on FSP partners and the various programs that serve them within the county.

Youth

The following section examines data for youth partners who received services in a designated youth FSP program in FY24-25. A total of 76 youth partners were served in FY24-25.

The youth FSP programs were developed to address the needs of a population of clients (including juvenile offenders) who are diagnosed with severe emotional disturbances and, potentially, co-occurring substance use disorders, who do not respond well to existing dispositional alternatives and often linger on probation or revolve in and out of custodial facilities and/or out-of-home placements. The program utilizes a multidisciplinary approach to provide intensive treatment and case management services to these youth. Through a collaborative process, coordinated services are offered to the youth and their caregivers which may include comprehensive mental health services, substance use services, peer and parent supports, and other county and community-based support resources. These youth programs have effectively provided Full-Service Partnership level services to diverse, underserved youth populations in all areas of Ventura County.

Table A2 displays demographic information for VCBH's Youth FSP clients. As illustrated in FY24-25 VCBH served a total of 76 unduplicated clients in youth FSP programs.

Table A2. Youth FSP youth client demographic information (N = 76)

Demographics (N = 76 unduplicated Youth FSP Program Clients)		
Category	**N**	**%**
Age Group (n = 76)		
0-15	33	43.4%
16-25	43	56.6%
Sex/Gender (n = 76)		
Female	45	59.2%
Male	31	40.8%
Sexual Orientation (n = 76)		
Heterosexual	28	36.8%
Unsure/Questioning	1	1.3%
Decline to answer/Not reported	47	61.8%
Ethnicity (n = 76)		
Hispanic/Latino	53	69.7%
Non-Hispanic	20	26.3%
Unknown/Not Reported	3	3.9%
Primary Language (n = 76)		
Spanish	9	11.8%
English	64	84.2%
American Sign Language	1	1.3%
Unknown/Not Reported	2	2.6%
Military Status (N=76)		
No	49	64.5%
Yes	1	1.3%
Unknown/Not Reported	26	34.2%

FSP Client Services & Outcomes (Youth & Adults Combined)

The following section presents outcomes for all partners (youth and adult) who received services in FY24-25. Future reports will aim to provide outcome data (i.e., arrests, etc.) on partners with at least two points of data. Thus, the outcomes presented here are limited to service data that was extracted from the EHR.

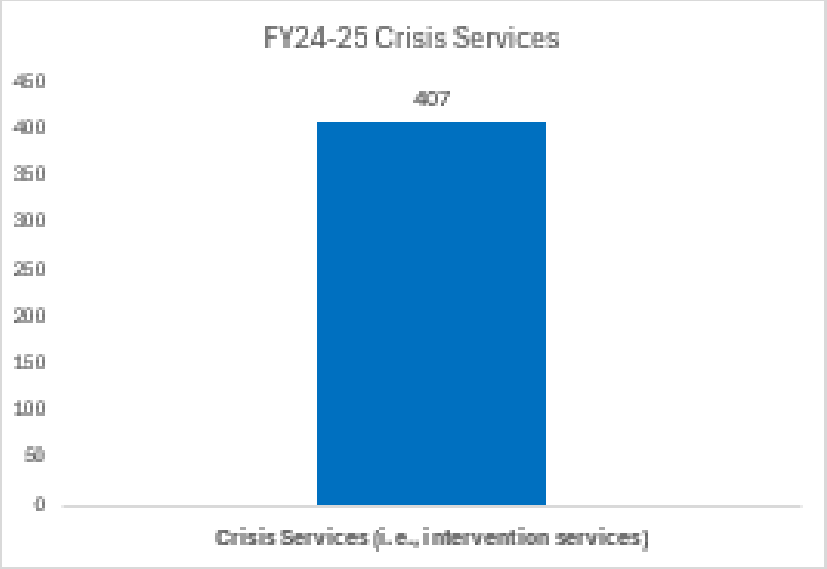
Complete and accurate self-reported data on arrests, employment, or education from the PAF, 3Ms or KETs are currently unavailable and thus will not be presented in this year's report.

FSP clients were rendered various types of services to help meet their needs during FY24-25. The following section presents data on services provided to FSP clients – examples of services presented in this report include number of partners who experienced a crisis event, number of partners who received therapy or therapeutic services, number of partners who received other types of services including case management or psychosocial rehabilitation services, and finally number of partners who were hospitalized for psychiatric reasons, number and types of crisis services, beneficiary satisfaction (for Adult/Older Adult partners).

Partner Number of Crisis Events

Figure A1 displays crisis-related services for FSP partners for events addressed by VCBH's Access and Crisis 24/7 Line. Crisis-related services pertain to events that the crisis team responded to such as various intervention services (including responding to crisis inquiry calls. As illustrated, there were 407 crisis-related services for 130 unique clients for FY24-25.

Figure A1.

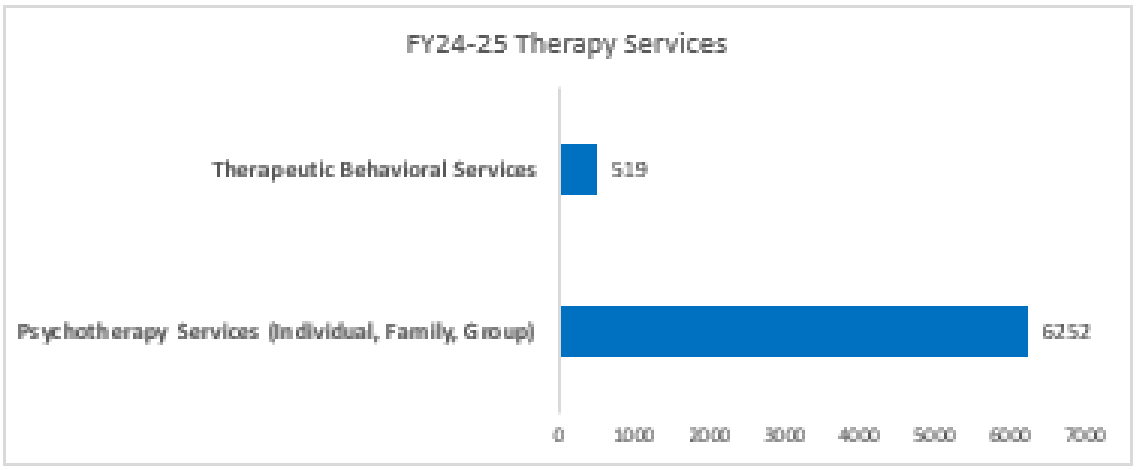


Note. Data based on EHR billed service records for 130 unique FSP clients

Partner Therapy Services

Figure A2 displays billed services for 268 FSP partners who received 'therapy' or 'therapeutic behavioral services' in FY24-25 extracted from VCBH's EHR. As displayed, there were a total of 6,771 therapy or therapeutic services where therapy includes group, family, or individual therapy with the FSP partner.

Figure A2.

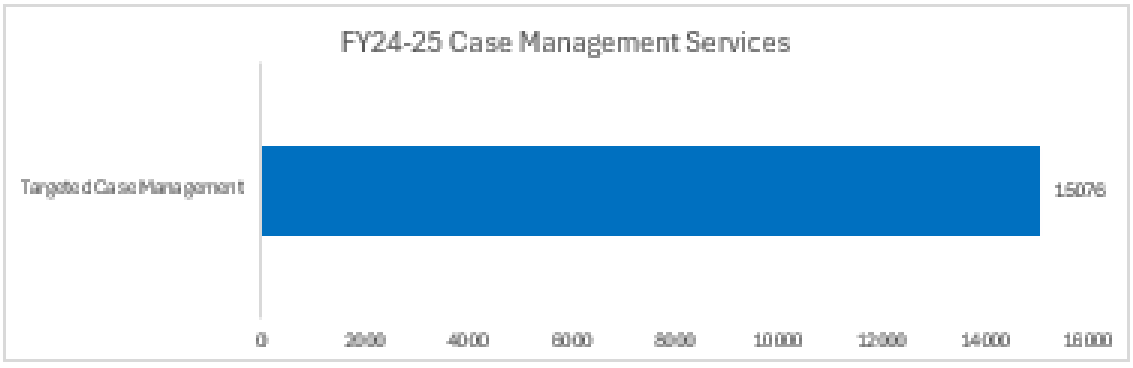


Note. Data based on EHR billed service records for 268 FSP clients.

Partner Case Management Services

Additionally, 582 FSP partners received over 15,000 targeted case management services in FY24-25 (Figure A3). Targeted Case Management includes services such as planning for goals and meeting the client's treatment needs as well as developing transition plans when specific goals are met. Overall, it helps to support the client and ensures their needs are met.

Figure A3.

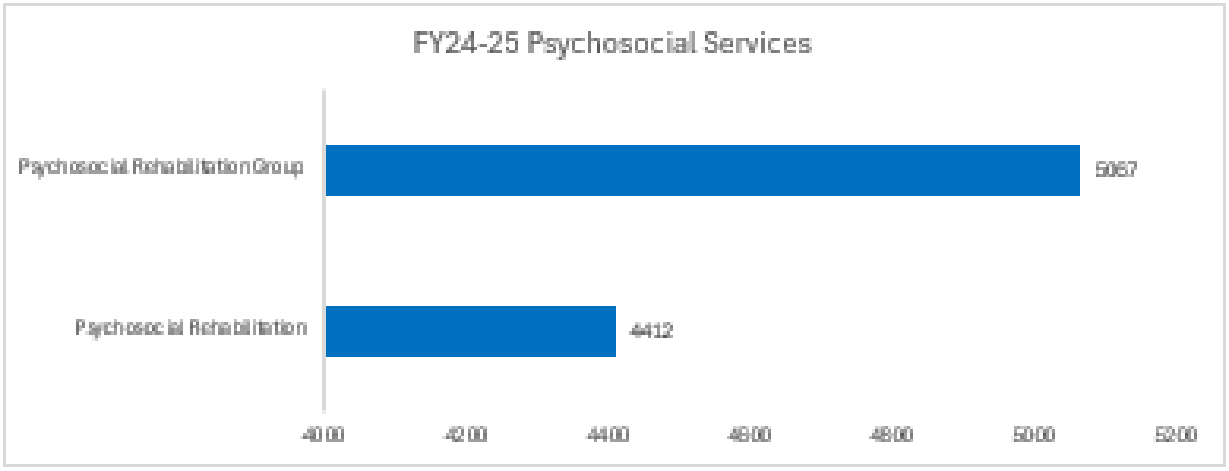


Note. Data based on EHR billed service records for 582 FSP clients.

Partner Psychosocial Rehabilitation Services

Among other services, 268 FSP partners also received services pertaining to psychosocial rehabilitation (individual and/or group). Approximately, 9,500 services combined pertaining to psychosocial rehabilitation were rendered to FSP partners in FY24-25 and these services are designed to improve the lives of people with mental illness by giving them the emotional, cognitive, and social skills needed to live their day-to-day lives (Figure A4). These skills provide opportunities for learning, sharing and skills building.

Figure A4.



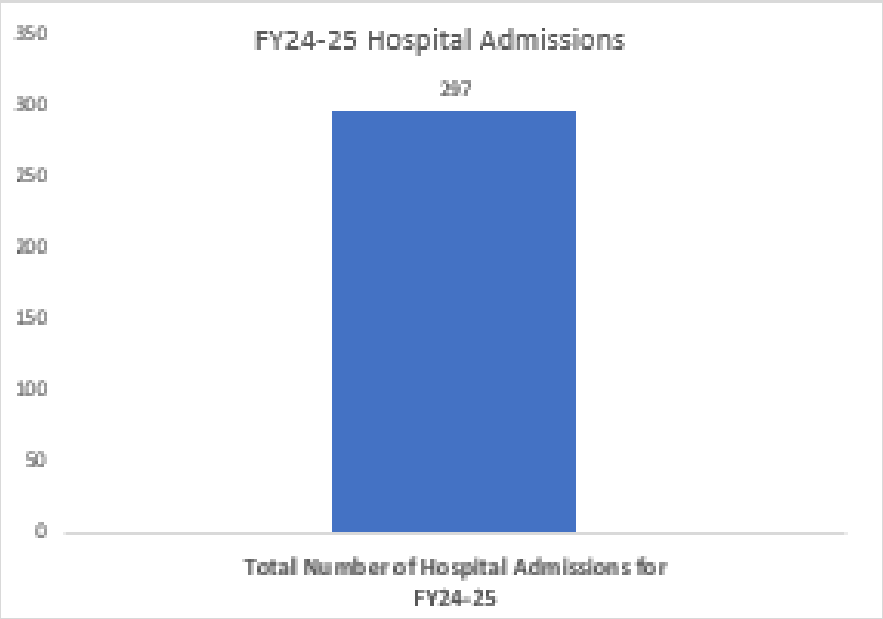
Note. Data based on EHR billed service records for 268 FSP clients.

Partner Psychiatric Hospital Admissions

We examined the number of psychiatric hospitalizations and number of partners hospitalized in FY24-25. Hospitalization data were extracted from VCBH's electronic health record (EHR) system and reflects only the hospitalizations that VCBH has a record of; thus, it may not reflect all hospitalizations if VCBH was not notified of a non-Medi-Cal billed stay. Based on this data for FY24-25 FSP clients, there were 140 partners with 297 hospital admissions.

Figure A5 reports VCBH's data on partner hospitalizations.

Figure A5. Number of Partner Admissions to the Hospital in FY24-25



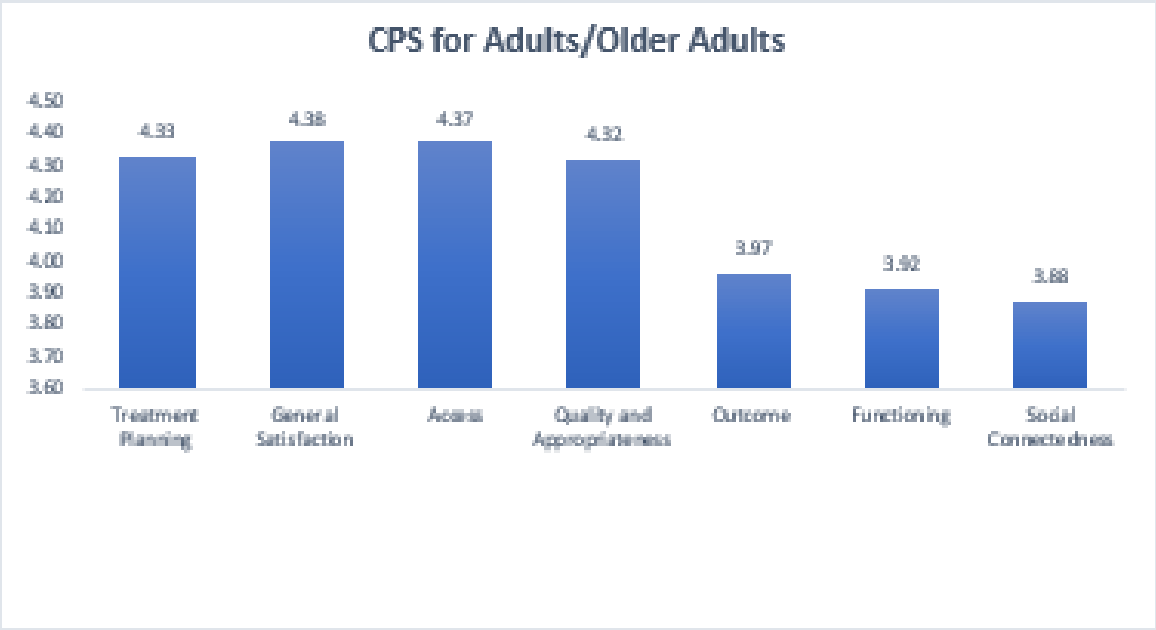
Consumer Perception Survey: Client Satisfaction

Adults

Consumer satisfaction was assessed during FY24-25 using the DHCS Consumer Perceptions Survey (CPS). In May of 2025, VCBH administered the survey for the duration of one week, collecting information from those individuals who attended services during that time. The CPS assesses client perception of treatment using various domains. Items are scored from 1 (Strongly Disagree) to 5 (Strongly Agree) with higher ratings indicative of higher agreement and satisfaction. In this report, we present the domains of General Satisfaction, Access (to services), Quality, Treatment Planning, Outcome, Functionality (Better Functioning), and Social Connectedness for FSP clients served in FY24-25 and completed the CPS in May 2025.

There was a total of 38 FSP clients who participated and submitted a complete CPS during the assessment week. In general, the CPS domains showcase high satisfaction with VCBH services as illustrated in Figure A6. The CPS domain mean averages were the lowest for Social Connectedness (3.88), and Functioning (3.92). The highest rated domains were General Satisfaction (4.38) and Access (to services/care) (4.37; see Figure A6).

Figure A6. Consumer Perception Survey Results Presented for Adults/Older Adults (N = 38) for FY24-25



Note. Data based on DHCS beneficiary satisfaction data from May 2025

Youth

Note. Data for youth are not displayed here due to the very small sample size. However, similar to Adults, the overall satisfaction reported was generally high from those who responded to the CPS survey.

Summary of Results

Are FSP Adult Clients Getting Better?

In addition to the FSP client outcome data presented in the preceding pages, a qualitative description of how an FSP adult client has improved based on a description from their VCBH case manager.

> This success story below was provided by a VCBH staff member for an Older Adult Client in the FSP program:
>
> "Client X, an Older Adult enrolled in Ventura County Behavioral Health (VCBH) Older Adult Program, presented with significant mental and physical health challenges, including Major Depressive Disorder, Hoarding Disorder, and Obsessive-Compulsive Disorder. At entry, he experienced severe depressive symptoms, extreme disorganization, and long-standing avoidance of medical care. His physical health was critically compromised due to inconsistent medication adherence, limited mobility, and multiple chronic conditions such as pulmonary arterial hypertension, congestive heart failure, and severe edema. Additionally, Client X's home environment was unsafe, impacted by extensive hoarding, inoperable utilities, and structural deterioration, restricting all service providers to the front porch. To address these complex needs, Older Adult Program initiated a coordinated

response involving Adult Protective Services (APS), Code Enforcement, and the Rapid Response Engagement Team (RRET).

During a medical crisis, Client X was hospitalized and subsequently transferred to a skilled nursing facility (SNF). When the SNF incorrectly diagnosed him with dementia, Older Adult Team advocated for further assessment, which identified elevated potassium levels as the underlying cause of his confusion. After appropriate medical intervention, Client X experienced marked improvement in cognition and overall stability.

Concurrently, Client X's partner significantly increased his involvement, removing more than 1,600 pounds of accumulated clutter, repairing essential home utilities, and assisting with medication management. With ongoing therapeutic support and continuous interagency coordination, Client X demonstrated substantial progress: his edema resolved, medication adherence improved, and the home environment was restored to a safe and functional condition. He also overcame his long-standing fear of blood draws and began to participate consistently in both behavioral health and medical services.

This success story illustrates the effectiveness of a comprehensive, person-centered, and collaborative approach. Through persistence, advocacy, and strong partnerships across Older Adults Team, APS, and community service teams, Client X moved from a state of severe isolation and medical risk to one of stability, safety, and meaningful engagement in care. His case highlights how coordinated systems of support can produce transformative outcomes for older adults with complex behavioral health and medical needs."

Are Youth Clients Getting Better?

Currently we do not have enough data to make a determination based on outcome measures for youth FSP clients, and the data on CANS is based on a very small sample of youth partners; thus, it should be interpreted with caution. Future reporting will aim to incorporate additional outcome measures to determine improved functionality in youth based on services provided at VCBH. Qualitatively, program staff in Insights and ATLAS aim to improve the overall quality of life for all partner participants through a variety of services and supports including but not limited to, case management, peer support services, basic needs requests, and housing stability. Through such enhancements Youth FSP programs can provide services leading to a healthier and more resilient youth community.

One success story highlighted by staff notes – " A 13 y/o male youth, was referred to ATLAS FSP in February 2024 following the sudden loss of his father. He presented with significant emotional and behavioral challenges, including depression, school attendance, poor academic performance, and frequent aggressive outbursts. Using a multidisciplinary approach, the ATLAS team supported youth and his family by providing basic needs assistance to reduce household stress, and therapeutic interventions to help youth improve emotional regulation and overall functioning. Throughout the course of treatment, youth (now 15 y/o) has stabilized emotionally and behaviorally, regularly attends school with a 4.0 GPA, and uses learned coping strategies to regulate mood and emotions. He was also struggling with substance use, has been participating in SUS groups and is 11-months sober. He began participating in running as an extracurricular activity, which he describes is a way for him to feel connected to his father. The family reports marked improvement in family relationships and a significant reduction in stress."

Limitations of the Data and Future Work

Efforts are in place for continual improvements to VCBH's data collection and reporting for FSP programs and clients. However, due to issues with the new EHR system's incompatibility with the state DCR system, the majority of partner data and outcomes could not be utilized and analyzed for the current report. VCBH's EHR and Data Informatics teams

are currently working through these issues and receiving technical assistance from DHCS's IT staff with the aim of resolving this issue as soon as possible.

Future work will focus on improved data collection and data entry efforts for FSP partners and follow BHSA guidelines. Moreover, future reports will align with Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) guidance. Additionally, VCBH will aim to corroborate partner self-reported information with data collected in the EHR whenever feasible.

Appendix E – Annual Innovative Project Report

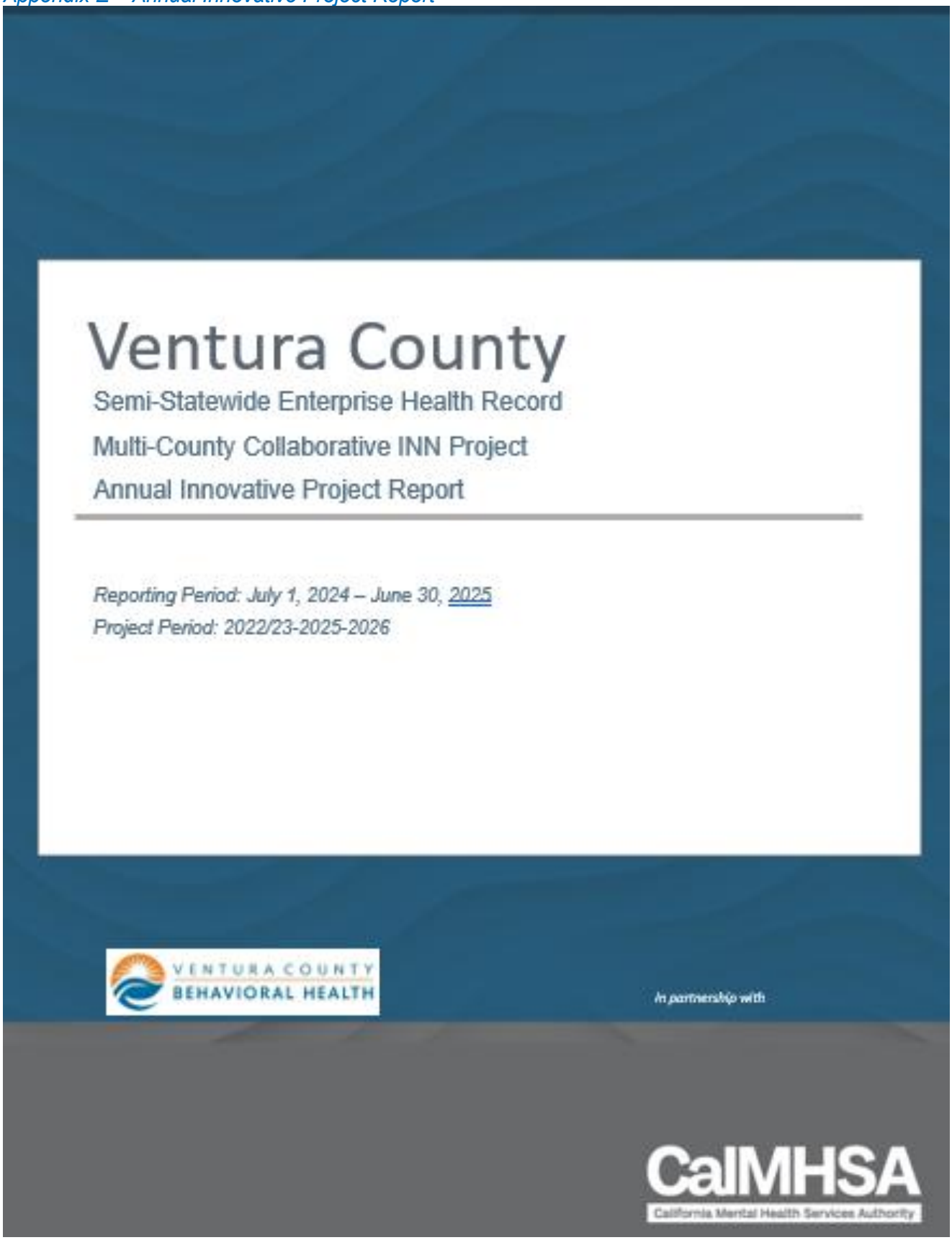


Table of Contents

Project Overview and Local Need 3

Progress Update and Identified Changes 4

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties 4

FY 2024-25 Projects and Initiatives and Learning Goals/Project Aims 5

Evaluation Data 9

Program Information for Individuals Served 9

Budget and Annual Expenditures 9

Project Overview and Local Need

1. Please describe this innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). In FY 2024-25 CalMHSA partnered with 25 counties, collectively responsible for 35% of the state's Medi-Cal members.

This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve.

The key principles of the EHR project include:

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans.
- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.
- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are both required and supported by the State.
- **Lean and Human-Centered**: Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- **Interoperable**: Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow, allowing critical information about the people we serve to be formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

2. Please describe how this project makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.

This project will meet the general requirements by making a change to an existing practice in the field of mental health — specifically, the practice of documenting care in an EHR that meets the needs of the county's workforce and the clients they serve. This innovative project aims to transform the standard use of an electronic health record by standing up a semi-statewide behavioral health electronic health record in collaboration with a cohort of counties. This new EHR is responsive to identified provider needs and supports the spread of best practices among the participating counties. Optimizing the EHR to meet daily workflow needs of treating providers can enhance working conditions, increase efficiencies, and reduce burnout, ultimately improving the conditions under which direct client care is provided. With the input of provider stakeholders and best practice experts in the field of human-centered design, the new EHR is being collaboratively and intentionally designed to improve the method and ease of documenting in the EHR as well as gathering and appropriately sharing pertinent clinical

information from the EHR, which will promote less time spent on "treating the chart" and more time spent on "treating individuals" in need of care.

3. Please describe how this project impacts your County Plan's local need(s).

Ventura County Behavioral Health (VCBH) identified significant operational and clinical challenges with its legacy EHR system that impeded efficient service delivery, compliance with evolving state requirements, and data-driven decision making. The implementation of SmartCare directly addresses these local needs:

Legacy System Challenges Addressed by CalMHSA EHR:

- Documentation and Payment Reform Compliance: The legacy EHR lacked the flexibility to adapt to CalAIM and Behavioral Health Payment Reform requirements, requiring extensive manual workarounds for documentation, service authorizations, and claiming processes.
- Limited Reporting and Analytics Capabilities: VCBH staff relied heavily on manual spreadsheets and custom SQL queries to meet state reporting deadlines (e.g., timeliness, high-cost utilizers, CARE Act reporting). The legacy system's rigid data structure made it difficult to extract timely, accurate data for Quality Improvement, MHSA reporting, and operational oversight.
- Fragmented Clinical Workflows: Providers experienced challenges accessing a holistic view of client information across programs (Adult, Youth, Substance Use Disorder), leading to duplicated data entry and gaps in care coordination.
- Interoperability Gaps: The legacy system had minimal integration with external systems such as Connex (Health Information Exchange) and county partners, limiting coordination with physical health providers and community-based organizations.

How CalMHSA EHR Improves VCBH Processes and Workflows:

- Streamlined Clinical Documentation: SmartCare's configurable note templates, widgets, and structured data fields support more efficient documentation while maintaining compliance with state and federal requirements. Prescribers and nursing staff benefit from medical reconciliation capabilities and tailored workflows. Documentation and Payment Reform features are now part of the new EHR system.
- Enhanced Data Infrastructure: SmartCare's SQL Server database structure enables VCBH's Data Informatics and EHR team to build robust reporting solutions using Power BI, SSRS, and Oracle APEX. The improved data model supports real-time dashboards for program monitoring, timeliness tracking, and outcome measurements.
- Service Authorization Workflow: SmartCare's Service Authorization module creates a transparent request-approval workflow that tracks prior authorizations, units authorized, and units used, reducing administrative burden and improving oversight.
- Interoperability and Care Coordination: Integration with CalMHSA Connex enables VCBH to exchange clinical information with physical health providers and meet

California Data Exchange Framework requirements, improving continuity of care for shared clients.

- VCBH did not establish a formal EHR Steering Committee; however, VCBH has established regular cross-functional meetings with representatives from clinical programs, Quality Improvement, MHSA, Data Informatics, and contracted providers to prioritize SmartCare configuration decisions, gather user feedback, and guide various implementation planning.

Specific Scenarios:

- Example 1 – CARE Act Reporting: SmartCare's CARE Act module enabled VCBH to meet all state reporting requirements for the Community Assistance, Recovery and Empowerment (CARE) Act, including intake tracking, service documentation, and outcome reporting—functionality not available in the legacy system.
- Example 2 – Timeliness and Access Monitoring: The Data Informatics team developed Power BI dashboards using SmartCare data to provide real-time visibility into appointment timeliness and program-level performance, supporting leadership decision-making and Medi-Cal compliance.
- Example 3 – Prescriber Efficiency: VCBH uses CalMHSA Rx, describe the impact, e.g., CalMHSA Rx reduced prescriber documentation time by eliminating redundant data entry and providing automated drug interaction alerts.

Progress Update and Identified Changes

1. Please describe your project progress from July 1, 2024, through June 30, 2025.

- The FY 24-25 period focused on post-go-live stabilization, optimization of clinical workflows, staff training, and deployment of new modules including Service Authorizations, CalMHSA Rx, and CARE Act functionality. A considerable effort was made to establish practical and manageable user access to client records.
- Several new programs were added during FY 24-25.
- A new application, Laserfiche, was acquired, customized, and implemented to provide clinical staff, managers, and Medical Records teams with seamless access to historical client data predating SmartCare implementation. Laserfiche offers dual functionality: retrieval of scanned legacy client documents and on-demand generation of reports in the original Avatar format. VCBH is the only county among the 25 SmartCare-adopted counties to have fully implemented both capabilities within a single integrated solution.

Have any new staff been hired to support the implementation of this project, and if so, please provide position title(s) and role(s)/responsibilities.

- Existing team members were responsible for SmartCare configuration, user support, Report Writing, Data Analysis, Power BI dashboards development, EHR Training etc.
- The EHR team lost 3 resources during FY 24-25.

- VCBH had help from a contractor who was hired to develop a Performance Dashboard for Leadership and Clinic Administrators.

What is the status of onboarding to SmartCare any local CBOs you work with?

- VCBH has successfully onboarded CBOs to SmartCare.

Please describe your experience working with CalMHSA and other participating County Plans in this project. (Has your County Plan used the CalMHSA collective dashboards or any LMS learning opportunities? Has your county used any County Plan-specific dashboards created by CalMHSA, leveraged new reports/list pages or received assistance with State reporting requirements?)

- VCBH opted out of the CalMHSA dashboard solution and instead developed an in-house dashboard tailored to internal reporting needs using Power BI and SQL Server.
- VCBH does utilize CalMHSA-provided reports and list pages within SmartCare for standard operational reporting.
- CalMHSA has provided technical assistance with state reporting requirements; however, gaps remain, and VCBH continues to work with CalMHSA and internal resources to fully meet all state reporting specifications.

2. Has your County Plan experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?

3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

At the outset of the EHR Project, CalMHSA partnered with IDEO, a global, human-centered design and research company with over 40 years of consulting experience working in social and government sectors. As previously reported, IDEO conducted interviews with over 50 county staff, met with EHR and other analogous experts (e.g., digital storytellers, data visualization scientists and behavioral scientists), and completed an in-depth analysis of SmartCare to inform design strategies that align with user needs, promote transparent communication, augment decision-making and best practices and, through increased efficiency, reduce staff burnout and improve workforce retention. IDEO's initial work identified the following key needs that have become the basis for work across multiple project periods:

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses at moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

FY 2024-25 Projects and Initiatives and Learning Goals/Project Aims

During the FY 2024-25 project period, CalMHSA has continued to launch, evolve, or complete initiatives and projects that align with the needs initially identified by IDEO as well as the project aims / learning goals. Additionally, CalMHSA has continued to incorporate County Plan perspectives, feedback, and ideas to build upon the work of previous project periods and identify new areas of focus for innovation work.

Learning Goal / Project Aim: Quality
To include comprehensiveness of client care, efficiency of clinical practice, interactions with the health care team, and clinician access to up-to-date knowledge.

Closed Loop Referrals
Throughout FY 24-25, CalMHSA has worked to develop a closed loop referral process that is designed specifically with behavioral health plan needs and state workflows in mind. When the closed loop referral system goes live in 2026 in alignment with the state's guidance, County Plans will be able to upload and attach clinical information that is part of a client's health record within the referral application. County Plans will also be able to send state forms (such as the Transition of Care Tool or other state screening tools) within referrals. The system developed by CalMHSA will also allow the tracking of referrals to multiple service providers within the same referral process.

Medical Documentation Workflows
CalMHSA has continued to launch additional note templates, widgets, and medical reconciliation capabilities tailored for prescribers and nursing staff. This effort was grounded in extensive user research among County Plans and their users, including formal interviews, focus groups and ongoing input from counties through help desk tickets, training sessions, and direct email correspondence. The goal was to understand pain points in the existing workflow and create a note structure that maintained critical data fields while offering flexibility in documentation style. County Plans have played an active role in an iterative update cycle to continuously refine the templates. The result has been a streamlined, provider-friendly documentation process that meets both clinical and operational needs.

CalMHSA Rx
In response to County Plan feedback about the need for a more efficient outpatient prescribing system, CalMHSA initiated a project to vet, develop, and implement a new e-prescribing tool for outpatient psychiatry. County Plans provided input, and their feedback informed both the overall direction and the design priorities of the tool. CalMHSA Rx was initially piloted in 2 County Plans in September 2024 to ensure real-world functionality and alignment with clinical needs. As of May 2025, 11 County Plans have onboarded with CalMHSA Rx while the remainder of Plans continue to use the legacy SmartCare prescribing module. Throughout the implementation process, CalMHSA has gathered input on workflows and supporting resources during training, onboarding sessions, and via the Help Desk to best support psychiatric prescribing needs.

Service Authorization

CalMHSA developed a method of handling the workflow for Service Request Authorizations when prior authorization is required. This request-approval workflow in the EHR was designed to create an efficient communication channel from requester to reviewer that supports back and forth communication when additional information is needed. Once approved, this workflow also supports the creation of the billing authorization and tracks how many units are authorized and how many have been used.

EHR Training and Support
CalMHSA is gathering perspectives from County Plan EHR users on how to better support users across the SmartCare system. The goal is to use this feedback to strengthen knowledge infrastructure, build change management capacity, and deepen collaboration with counties. Emerging themes for improvement include the creation of tiered learning paths, a central knowledge hub, and additional train-the-trainer activities. Information gathered in FY24024-25 will inform the development of EHR training and support in a future project period.

Learning Goal / Project Aim: Safety and Privacy
To include avoiding errors (i.e., drug interaction), ability to use clinical data for safety, and personal and professional privacy

Inquiry Locking
CalMHSA worked with Streamline to build out functionality that allows County Plans to lock the inquiry form to prevent unwanted edits to the inquiry as well as to the Client Information screen. The Inquiry Locking SmartCare functionality was built and deployed between March and May 2025 and has addressed the issue of data being deleted from the Client Information Screen when changes are made to inquiries.

Inpatient-related EHR Functionality
CalMHSA undertook a comprehensive update of inpatient-related EHR functionalities in response to feedback from County Plans operating Inpatient, Crisis Stabilization Units (CSUs), and Residential Facilities. Through a series of formal and informal meetings, including targeted focus groups, CalMHSA identified key gaps in the EHR related to processes such as seclusion and restraint documentation, legal status tracking (holds, denial of rights), order management, and the Medication Administration Record (MAR). This input guided a redesign of inpatient workflows to better meet documentation standards and improve user experience. To support the utilization of these new functionalities, inpatient training was reinitiated to disseminate the new tools and workflows and to collect further input to ensure alignment with clinical and legal needs.

Learning Goal / Project Aim: Satisfaction
To include ease of use, clinician's stress level, rapport between clinicians and clients, client's satisfaction with the quality of care they receive, and interface quality

EHR User Support
In FY24-25, CalMHSA continued to make improvements to support EHR users and better serve County Plan needs. In summer 2024, a strategic decision based on internal cost analysis and County Plan feedback was made to bring EHR Help Desk Level 1 Support in-house. HubSpot, a state-of-the-art ticketing platform was launched on March 1, 2025, servicing all 25 EHR counties. HubSpot transformed support capabilities in many ways including:

- Advanced workflow automation that intelligently routes tickets based on team member role, expertise, and availability
- Seamless integration with Asana and Slack, creating automated tasks and notifications for high-priority issues
- Enhanced visibility and collaboration across support teams

Clinical Artificial Intelligence (AI) Tools
CalMHSA has launched a request for proposals (RFP) for clinical tools that can work with the EHR to support and enhance clinical workflows to reduce clinician burnout and improve documentation quality. Pending a successful RFP process, tools will be launched in a future reporting year.

Learning Goal / Project Aim: Outcomes
To include communication between clinicians and staff, analyzing outcomes of care, system usefulness, and information quality

Enhancements to meet Business Needs
CalMHSA engaged in a number of efforts to support business needs in a changing regulatory environment. Examples include: a full implementation of CARE Act requirements including functionality that supports all state reporting requirements; an Annual Void Report that was developed to assist County Plans in submitting their annual void reports to the state; an Out of County Medi-Cal Report to provide County Plans with a quick overview of clients whose county of responsibility differs from the submitting count; and the ability to add Start/End Dates to taxonomy codes in SmartCare, giving County Plans the flexibility to adjust codes during different claiming periods, which is especially helpful for clinicians with multiple degrees or when taxonomy and degree associations are revised by DHCS.

Connex
CalMHSA began work toward implementation of the Connex platform in 2023. As of FY24-25, 22 County Plans have achieved full compliance with state and federal interoperability requirements through CalMHSA Connex. The Connex platform was designed specifically for the Interoperability needs of County Behavioral Health and meets California Data Exchange Framework Requirements. Connex facilitates multiple data exchange models such as flat file exchange, standards-based exchange via IHE or FHIR, HL7, as well as the ability to explore custom point to point interfaces, empowering providers to coordinate care, improve outcomes, and meet regulatory requirements with a sustainable, county-driven solution.

Data Analytics & Dashboarding
CalMHSA has continued to work toward building a culture of analytics by promoting the use of real-time dashboards and reports that enhance the ability of the end user to view raw, summarized and analyzed data from the EHR. Dashboards have the capability to support the identification of trends, the investigation of hypotheses, and summary-level insights into county plan activity.

As documented in the 2024 Annual Report, CalMHSA launched PowerBI dashboards "CalMHSA Collective" in February 2024. Collective is designed to provide broad insights into County Plans with the ability to benchmark performance with other Plans. The Collective Dashboards contain aggregated (non-PHI) data and provide insight into

trends in claiming and revenue generation, service provision, provider network performance and treatment population characteristics. In FY 2024-25, Collective had 118 distinct users across 24 County Plans and 9443 total views across SmartCare counties. CalMHSA has engaged in a renewed effort to train county plan staff on Collective dashboards and is monitoring usage trends with an aim to increase utilization over the next reporting year.

In FY 2024-25, CalMHSA launched a new suite of dashboards, "CalMHSA Compass". In contrast with providing high-level, cross-County Plan insights, CalMHSA Compass offers the opportunity for deep insights into the workings of individual County Plans. These dashboards offer the ability to view service trends by program and location, as well as to examine these trends by client characteristics and network provider entity. An initial cohort of three County Plans began using Compass Dashboards in May 2025, with additional Plans preparing to onboard to these dashboards in the next reporting year. The Compass product roadmap for FY 2025-26 includes launching dashboards providing fiscal insights, characterizing the MHP Access process, as well as multiple dashboards to support operational and administrative requirements, such as BHSA reporting.

CalMHSA Cafe
In response to County Plan interest in a platform to support cross-Plan communication, CalMHSA created CalMHSA Cafe, a moderated platform specifically designed to facilitate communication, discussion, and collaboration across SmartCare County Plans. The development and preparation work for the creation of CalMHSA Cafe began in the early months of 2025 with a platform launch planned for September 2025. County Plan input informed the functionality of the site – specifically addressing the request for Plans to have a place to raise issues and collaborate with the ability to upvote or provide feedback/suggestions. The platform also includes the capability to tag posts to specific categories as well as places to post about both positives and challenges. Future functionality will include a mechanism for CalMHSA to solicit County Plan votes as a method to support the shared decision-making model.

County Shared Decision-Making Meetings
CalMHSA continued facilitating shared decision-making meetings in FY 2024-25 to obtain county input on improvements/enhancements/updates to the EHR system. In FY 2024-25, CalMHSA hosted 15 meetings (up from 5 in the previous reporting year) on various topics (including state reporting, clinical documentation, care coordination, CARE Act). On average, 80 individuals representing all SmartCare County Plans attended each of these meetings, which represents a significant increase over the average attendance of 55 individuals in the previous reporting year. Shared decision-making strategies will continue to be used to guide development efforts over time.

Evaluation Data

CalMHSA contracted with the RAND Corporation to conduct a comprehensive evaluation of the project. RAND selected evidence-based EHR metrics grounded in measurement science that are precise, reliable and valid. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches:

1. A pre-post **user survey to measure user experience and satisfaction** of existing EHRs and the new EHR across participating County Plans.
2. Pre-post **task-based usability testing** to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR.

The pre-phase measurements were collected and reported in the 2023 Annual Report. The timeline for completing the post-phase measurements was extended due to multiple DHCS policy changes that impacted county operations during this project period (e.g., documentation reform, payment reform), which contributed to an extended EHR implementation period. RAND initiated the post-EHR migration measurements and evaluation of project aims/learning goals in June 2025.

In this reporting period, RAND began recruitment for task-based post usability testing, with plans to complete the testing and data analysis in FY 2025-26. Additionally, in FY2024-25 an EHR user satisfaction survey was administered electronically to SmartCare users across 24 County Plans. This anonymous survey will be analyzed by RAND in aggregate in FY 2025-26 to assess the effectiveness of SmartCare at meeting county needs across functional areas. RAND's evaluation will allow for an assessment of how the transition to the new EHR resulted in changes in usability and user satisfaction.

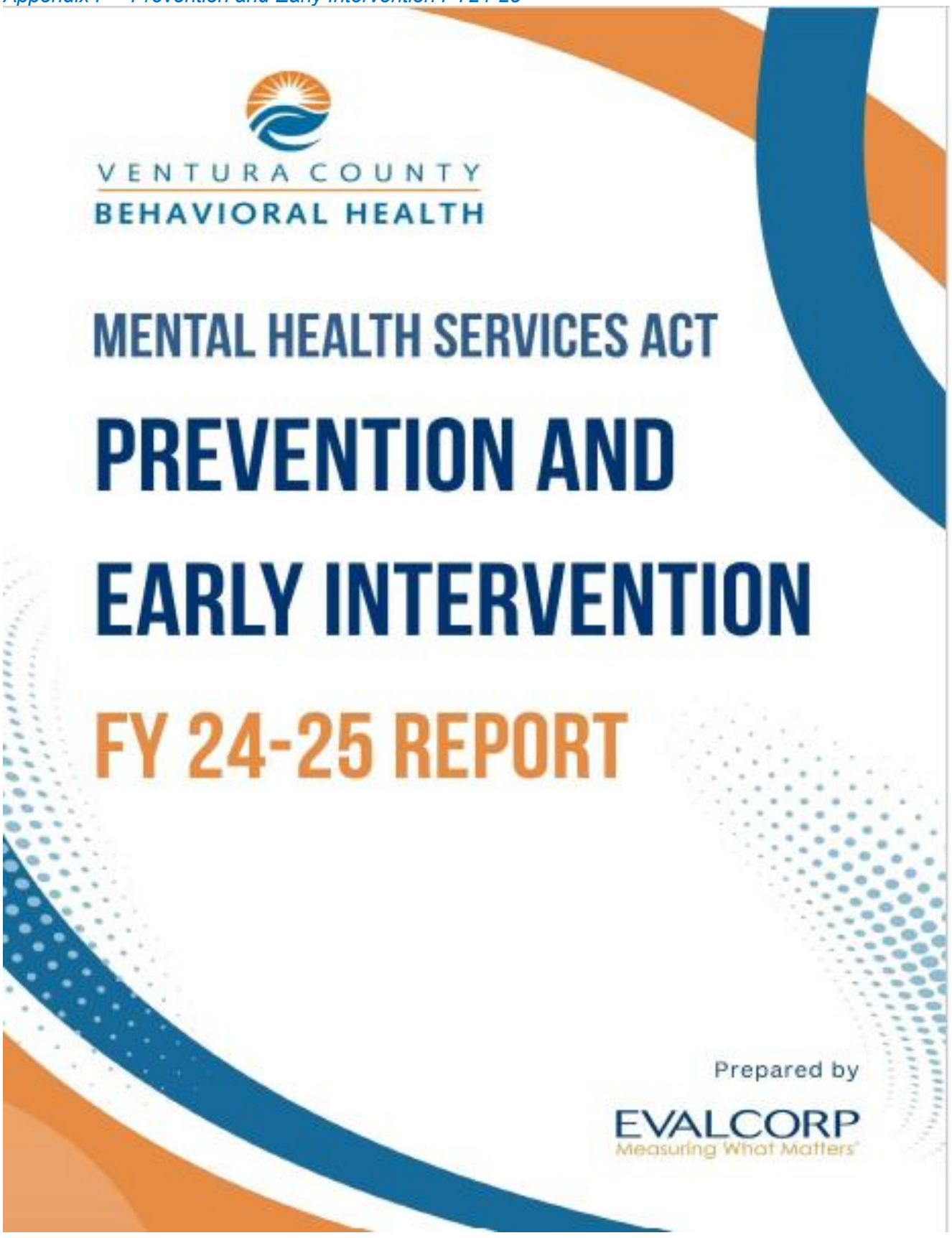
Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. In FY 2024-25, 281,760 individuals were served in the Mental Health delivery system and 74,285 individuals were served in the Substance Use Disorder delivery system. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal members who need specialty mental health and/or substance use disorder treatment services among approximately 35% of California's Medi-Cal members.

Regarding specific project information on individuals served, this project focuses on transforming the current EHR *system and the processes* California County Plans use for the provision of behavioral health services rather than directly testing an innovative approach to *service delivery*.

Budget and Annual Expenditures

Ventura County expended their Innovation dollars for this project in years one and two there are not Innovation dollars to report in fiscal year 24-25.


VENTURA COUNTY
BEHAVIORAL HEALTH
MENTAL HEALTH SERVICES ACT
PREVENTION AND
EARLY INTERVENTION
FY 24-25 REPORT
Prepared by
EVALCORP
Measuring What Matters

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ACKNOWLEDGEMENTS

EVALCORP would like to acknowledge the following individuals for their time and input in supporting the development of this report. First, we thank Ventura County Behavioral Health for their partnership throughout the evaluation process. We would like to thank the Mental Health Services Act (MHSA)/Behavioral Health Services Act (BHSA) Team. We greatly appreciate their collaboration and support. We also want to thank all the funded providers for their hard work in collecting the data presented in this report. Lastly, we want to acknowledge the program participants for completing evaluation surveys and sharing their experiences, stories, and recommendations. This report would not be possible without them.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

INTRODUCTION

Overview

The Mental Health Services Act (MHSA) was approved in 2004 and enacted in 2005 through California's Proposition 63, which imposed a 1% personal income tax on incomes over $1 million to increase mental health funding in the state. The goal of MHSA is to transform "the mental health system while improving the quality of life for Californians living with a mental illness."* MHSA utilizes several components to accomplish this goal, including one devoted to supporting programs that focus on Prevention and Early Intervention (PEI).

Ventura County Behavioral Health (VCBH) funded 32 programs using PEI dollars during fiscal year 2024-2025. The programs were delivered by community-based providers and served children and adults, individuals and families, and trained providers who work with the County's diverse populations.

PEI Regulations

The state legislature and the Mental Health Services Oversight and Accountability Commission (MHSOAC) frequently update MHSA regulations. The most recent update was made in January 2020. The programs funded during fiscal year 2024-2025, and the data presented in this report, are aligned with both the PEI regulations and any amendments to the extent possible.

Since FY 2016–2017, PEI-funded programs have been required to align with at least one of seven categories and employ three required strategies. Program categories and strategies are detailed below.

The program categories include:

- **Prevention:** A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build positive factors. Prevention Program services may include relapse prevention for individuals in recovery from a serious mental illness.
- **Early Intervention:** Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including negative outcomes that may result from untreated mental illness. Early Intervention Program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness:** The process of engaging, encouraging, educating and/or training and learning from potential responders (family, school personnel, peer providers, etc.) about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Outreach for Increasing Recognition of Early Signs of Mental Illness Program services may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.
- **Access and Linkage to Treatment:** A set of related activities to connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment including, but not limited to, care

* https://mhsoac.ca.gov/all/new-tools-focus-on-transparency/. Retrieved February 26, 2026.

provided by county mental health programs (e.g., screening, assessment, referral, telephone help lines, mobile response).

- **Stigma and Discrimination Reduction:** The county's direct activities to 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 to increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.
- **Suicide Prevention (optional):** Organized activities that the county undertakes to prevent suicide because of mental illness.
- **Improving Timely Access to Services for Underserved Populations (optional):** To increase the extent to which an individual or family member from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

The strategies include:

- **Improving Timely Access to Services for Underserved Populations:** See above definition.
- **Access and Linkage to Treatment:** See above definition.
- **Implementing Non-Stigmatizing and Non-Discriminatory Practices:** Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, and making services accessible, welcoming, and positive.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness (optional):** See above definition.

Regulations also require reporting on specific processes and outcome metrics, including the following.

- Unduplicated number of individuals/families served
- Participant demographics (age, race, ethnicity, primary language, sexual orientation, gender, disability status, veteran status)*
- Number and types of referrals to treatment and other services
- Timely follow-through on referrals
- Changes in attitudes, knowledge, and behaviors related to mental illness and help-seeking
- Reduced mental illness risk factors and/or increased protective factors
- Reduced symptoms of mental illness
- Improved mental, emotional, and relational functioning
- Reduced negative outcomes that may result from untreated mental illness including suicide, incarcerations, school failure or dropout, unemployment, homelessness, etc., as defined by the Welfare and Institutions Code (WIC) 5840

*Note that for a minor younger than the age of 12, programs are not required to collect demographic data on sexual orientation, current gender identity, and veteran status. Additionally, programs serving children younger than 18 years of age are only required to collect data to the extent permissible under applicable state and federal privacy laws.

EVALUATION METHODOLOGY

Evaluation Approach

VCBH contracted with EVALCORP Research & Consulting to develop this report, which summarizes data for PEI programs funded during fiscal year 24-25. This report presents state-required metrics as available and other program-specific information collected by the PEI providers. The report also provides a comprehensive review of programs, including the following process and outcome measures.

- Participant demographics
- Program services and activities
- Service participation
- Program impacts and outcomes

Data Collection Instruments

In the context of ensuring the efficacy of PEI programs, this section articulates the systematic approach towards assessing the impact of these initiatives. Grounded in the California Code of Regulations for the Mental Health Services Act (MHSA), this framework seeks to understand the pathways by which PEI programs achieve their objectives.

PEI programs employ a variety of data collection instruments, depending on the program category, to measure the impact each program has on clients. Instruments have been carefully selected and constructed to ensure alignment with the MHSA regulations and appropriateness for program operations. Methods employed include direct, indirect, and quasi-indirect measures of change, adapted to the needs of each individual PEI program.

For all Stigma and Discrimination Reduction programs, the California Code of Regulations calls for validated methods to measure changes in attitudes, knowledge, and/or behaviors related to mental illness or seeking mental health services. The Mental Help-Seeking Attitudes Scale (MHSAS) measures respondents' overall evaluation of seeking help from a mental health professional if they encounter a mental health concern (Hammer, Parent, & Spiker, 2018). Other Prevention or Early Intervention programs utilize the Schwartz Outcome Scale-10 (Schwartz & Michael, 2000) as an indirect measure of a broad domain of psychological health. These tools, along with other constructed tools that meet the highest standards of survey item construction, provide insight into the impacts that PEI programs are having in the community.

Data Collection and Analysis

The evaluation employed a mixed-methods approach, using quantitative and qualitative data provided by PEI-funded programs to the county. Although VCBH strives to standardize data collection across programs to the extent possible, variations existed in each program's specific data collection tools and measures to reflect program uniqueness and target populations; however, all data collection tools were designed to assess progress toward overarching PEI goals.

VCBH PEI-funded programs used five primary types of data collection strategies:

1) **VCBH Template:** In response to October 2015 PEI amendments, VCBH developed a comprehensive data collection spreadsheet to collect program implementation data and process metrics such as number of individuals served, participant demographics, service referrals, outreach and other program activities, and program successes and challenges. Since the template was launched in January 2017, VCBH has continued to tailor it to the needs of each PEI program and to increase the data's adherence to PEI regulations.

2) **Program Surveys:** Multiple PEI programs employ pre- and post-program surveys to collect outcome data required by the PEI regulations and additional information of interest to VCBH. The post-program surveys typically include both closed- and open-ended questions to capture participant attitudes, knowledge, and behaviors; participant risk and protective factors for mental illness; social-emotional well-being and functioning; symptoms of mental illness; participant satisfaction; and recommendations for improvements. Each PEI program uses different surveys to ensure that the data collected are relevant and appropriate to the individual programs. Since FY 2021–2022, VCBH has continued to streamline survey items across programs where appropriate.

3) **Narrative Reports:** When available, narrative reports provided by the PEI programs to VCBH describing key activities, successes, and challenges were reviewed and incorporated into the current report.

4) **Electronic Health Record (EHR) Data:** Some PEI programs use the county's EHR system, SmartCare, to record client data, including demographic information and treatment outcomes. This data source is more common among programs that do not use the VCBH template.

5) **Web Analytics:** A few PEI programs also use web analytics to measure reach and engagement on social media pages and websites.

Extensive data verification, cleaning, and analysis procedures were employed in preparing this report to ensure the accuracy and validity of the data and information presented.

Data Notes

Information about data availability and quality for individual PEI programs is presented within each program's section of the report. Notes on the overall availability and quality of the data presented are listed below, and program results should be considered in the context of these limitations.

Data limitations for some PEI programs in fiscal year 24-25 included:

- **Duplicated data:** For some training programs, participants may attend more than one training, which could lead to duplicated data.
- **Missing data or "declined to answer" selections:** Some questions, particularly for demographic indicators, had low response rates, possibly due to discomfort with or misunderstanding of the question itself.
- **Low participation rates:** Not all participants completed outcome tools/follow-up surveys, and some programs had low numbers of participants.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VCBH continues to enhance data collection tools and procedures across programs to report on demographics and outcomes in accordance with PEI regulations. These efforts also emphasize cultural competence and inclusivity, ensuring that the data reflects the diverse experiences and needs of all participants.

REPORT ORGANIZATION

This report presents the PEI data by program. The programs are organized into three core sections by their primary program categorization (Prevention, Early Intervention, and Other PEI Programs). All program category sections provide an overall summary of the program category and include an overview comprising program descriptions, client demographic profiles, and highlighted successes and challenges experienced by programs within that category.

Each program's results are then presented, beginning with an overview of the program, followed by a detailed analysis of available data for fiscal year 24-25. The type of data presented varies across programs but may include information about participant demographics, program activities and reach, referrals, participant outcomes, participant satisfaction, feedback and recommendations for program improvement, and success stories. Each program section also contains a conclusion and recommendations section. Process and outcome data are reported in alignment with State requirements whenever possible.

Appendix A delineates PEI-funded programs and their alignment with PEI Categories.

Appendix B provides an overview of PEI program participation, detailing the number of individuals served or trained by program and by region.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PREVENTION

The goal of the Prevention component of MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. In Ventura County, there are 20 programs primarily categorized under Prevention. These programs serve several historically underrepresented communities including Hispanics/Latinos, Transitional Age Youth (TAY), individuals who are Deaf and Hard of Hearing (DHH), and LGBTQ+. Program services vary but include support groups, workshops, trainings, education, and presentations.

Across programs, participants expressed high levels of satisfaction with the services they received. Additionally, programs serving underrepresented groups reached their intended priority population(s). The following pages outline further details about each program's population(s) served, activities and outreach, as well as participant outcomes.

Prevention programs offer activities to reduce risk factors for and build protective factors against developing a potentially serious mental illness. This may include relapse prevention for individuals in recovery from a serious mental illness. A total of 87,606 participants were served by Prevention programs in FY 2024–2025.

Prevention Program Descriptions

Be Kind Program: Promotes compassion, empathy, and inclusiveness to youth aged 6 to 18 years through workshops and materials

Comadres Unidas: Assists Latina women farm workers to manage stress, anxiety and depression through creative activities, educational workshops, and community connections.

Everyone Has a Story Book Club: Offers bi-monthly meetings and writing workshops for disabled and neurodivergent individuals to improve mental health, promote community, and expose participants to literature reflective of their experiences.

Girls Rock SB: Promotes creativity, peer connection and self-discovery among girls and gender-expansive youth in grades 6th to 12th through a weekend of artistic workshops

Girl Scouts: Provides strategies for managing life stress to young girls

Healing Through the Arts: Engages youth and older adults in a multitude of intergenerational classes to foster confidence, social connections, and community well-being

Ignite Conocimiento: Promotes mental health and resiliency to Hispanic/Latino communities through educational workshops, counseling, and community engagement

Mixteco Indigena Community Organization Project (MICOP): Facilitates mental health for the Latinx and Indigenous communities through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Multi-Tiered System of Support (MTSS), VCOE: Provides education and training for school personnel and students, as well as family outreach and engagement to reduce stigma and discrimination about mental illness throughout Ventura County.

NAMBA Flamenco Dane, Theater for Wellness: Promotes creative expression for students aged 12-18 years in underserved areas of Ventura through flamenco dance classes and mental health performance shows

Little Listeners: Facilitates career exploration for deaf youth and their siblings through curriculum and parent support groups, as well as raises awareness about effective communication strategies with deaf individuals

One Step A La Vez Conocimiento: Serves Latino/a, LGBTQ+, and TAY at risk of homelessness or in the juvenile justice system through outreach, a drop-in center, wraparound wellness, stress and wellness classes, youth leadership activities, and LGBTQ+ support groups.

Playful Bonds: Provides educational classes to increase positive interactions between parents and caregivers and their children through play

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS): Offers an in-home counseling program for seniors that teaches participants how to manage depression through counseling sessions supported by a series of follow-up phone calls.

Project Esperanza: Offers mental health service assistance, educational and wellness classes, and activities to Hispanic/Latino families in the Santa Paula community.

Promotoras Conexión Program (Promotoras y Promotores Foundation [PyPF]): Facilitates mental health for immigrant Latinas/Hispanic women at risk of depression through support groups and one-on-one support to manage stress and depression, as well as referrals and links to culturally and linguistically competent mental health providers, and outreach to promote awareness of mental health and existing services.

Tri-County GLAD: Increases knowledge and awareness of mental health concerns in the Deaf and Hard of Hearing community through outreach, referrals, social media videos, presentations, and workshops with middle-school students.

Wellness Centers Expansion: Provides coordinated health/mental health and other support services to maximize student engagement and success through staff and student trainings, family engagement activities, screenings, referrals, and early intervention activities.

Wellness Everyday and STAY Media: Provides prevention, suicide prevention, and coping with trauma messaging via social media campaigns and their website.

Westside Wellness: Provides support groups and group therapy to help Latina/Latino youth aged 9-15 years and parents cope with suicidal ideation and prevent self-harm

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

87,606	individuals received core program services[†]
2,295	individuals referred to mental health care and/or social support services[†]
80,224	individuals reached through outreach events[†]

[†]Number of individuals may be duplicated.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Prevention Programs: Demographics of Participants[§]

Ethnicity*	(n = 2,137)
Hispanic	59%
Non-Hispanic	41%
More than one ethnicity	1%
Declined to answer: 769	

Age	(n = 2967)
0–15	62%
16–25	13%
26–59	16%
60+	10%
Declined to answer: 7	

Primary Language*	(n = 1,692)
English	49%
Spanish	43%
Indigenous	4%
Another language	4%
Declined to answer: 13	

Sex Assigned at Birth	(n = 1,264)
Female	68%
Male	32%
Declined to answer: 13	

Sexual Orientation	(n = 1,067)
Bisexual	4%
Gay or Lesbian	2%
Heterosexual or Straight	91%
Queer	1%
Questioning or Unsure	1%
Another sexual orientation	1%
Declined to answer: 168	

Hispanic Ethnicities^			(n = 1,099)
Mexican	93%	South American	1%
Central American	2%	Caribbean	1%
Puerto Rican	1%	Another Hispanic	4%

Non-Hispanic Ethnicities^			(n = 210)
African	10%	Asian Indian/ South Asian	3%
Cambodian	<1%	Chinese	7%
Eastern European	8%	European	44%
Filipino	9%	Japanese	3%
Korean	3%	Middle Eastern	5%
Vietnamese	<1%	Another Non-Hispanic	8%

Race*	(n = 2,390)
American Indian/Alaska Native	2%
Asian	4%
Black/African American	2%
Hispanic/Latino	46%
Native Hawaiian/Pacific Islander	1%
White	40%
Another race	5%
More than one	<1%
Declined to answer: 661	

Current Gender Identity	(n = 1,342)
Female	69%
Male	29%
Genderqueer	1%
Questioning or Unsure	1%
Transgender	<1%
Another gender identity	1%
Declined to answer: 18	

City of Residence					(n= 2,912)
Camarillo	6%	Fillmore	6%	Moorpark	4%
Newbury Park	7%	Oak Park	2%	Ojai	1%
Oxnard	20%	Piru	<1%	Port Hueneme	3%
Santa Paula	14%	Simi Valley	9%	Thousand Oaks	10%
Ventura	15%	Other	4%		

*Percentages may exceed 100% because participants could choose more than one response option.
§Demographic data was not collected for MTSS VCOE, Wellness Centers, or Wellness Everyday.
^Percentages and counts reflect the number of individuals who selected each Hispanic or non-Hispanic Ethnicity.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MULTI-TIERED SYSTEM OF SUPPORT
VENTURA COUNTY OFFICE OF EDUCATION (VCOE)

The Multi-Tiered System of Support (MTSS) is a comprehensive framework designed to align initiatives and resources within an educational organization, such as the Ventura County Office of Education (VCOE), to identify and address student needs. MTSS aligns academic, behavioral, and social-emotional learning in an integrated system of support to benefit all students and positively impact systemic change. VCOE has seven core activities that it must implement countywide. Among these are education and training for school personnel and students, family outreach and engagement, and ongoing technical assistance and contract monitoring for their contracted Local Educational Agencies (LEAs)/School Districts.

Program Strategies

Provides access and linkage to services for those with serious mental illness and serious emotional disturbance.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent, evidence-based trainings to educators to support students from underserved and underrepresented groups.

Program Highlights

59,029 early intervention services were provided†

48,637 individual screenings were conducted†

1,105 referrals to community-based mental health services†

723 confirmed linkages of students/family to referrals†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Program Activities

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by MTSS program staff. Program participants and other community members may participate in these activities and events.

Program Activities by Type[†]	# Activities/ Events
Staff Trainings	3,174
Trainings	51
Family Trainings	659
Youth Mental Health Conference	1
TOTAL # of Activities/Events	3,885

269,017 participants in program activities[†]

Additionally, VCOE established Memorandums of Understanding (MOUs) with the following 12 Local Educational Agencies (LEAs)/School Districts to implement MTSS at all of their school sites.

- Conejo Valley Unified School District
- Fillmore Unified School District
- Hueneme Elementary School District
- Moorpark Unified School District
- Oak Park Unified School District
- Ojai Unified School District
- Oxnard Elementary School District
- Oxnard Union High School District
- Rio School District
- Santa Paula Unified School District
- Simi Valley Unified School District
- Ventura Unified School District

As part of these MOUs, VCOE is responsible for supporting contracted districts in providing multi-generational family engagement, outreach events, and training to enhance public understanding of mental health and reduce mental health stigma and discrimination. Further, VCOE is required to ensure that contracted districts engage and train students on mental health awareness, services, occupations, and peer engagement strategies targeting at-risk populations. For additional information about these activities, please refer to the MTSS Final Evaluation Report for FY 2024–2025, available upon request.

[†]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Program Outreach

Program outreach encompasses activities designed to promote the program within the community, raise awareness of mental health issues, and connect community members with relevant mental health resources.

Program Outreach by Type	# Participants[1]
Parent events	62,569
Student trainings	195,275
Staff trainings	11,205
TOTAL # of Activities/Events	**269,049**

201 students participated in the annual Youth Mental Health Conference

Staff/Student Trainings

One of the primary program activities conducted within MTSS, VCOE are staff/student trainings. These staff/student trainings included the following topics:

- Crisis Intervention
- Cultural and Linguistic Competency and Equity
- Mental Health Resources and Referral Process
- Mental Health Stigma
- Reduction Suicide Awareness and Prevention
- Restorative Justice
- Social-Emotional Learning
- Trauma-Informed Practices
- Use of Web-Based Tech for Trainings, Screening and Reporting
- Vulnerable Populations

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MULTI-TIERED SYSTEM OF SUPPORT, VCOE

Program Outcomes

Youth Mental Health Conference Outcomes

The annual Youth Mental Health Conference offers presentations and breakout sessions to high school students on various mental health and wellness topics. The two-day conference includes breakout sessions on sobriety, mental health stigma, and social media safety. Findings from post-training surveys are presented below.

Statement	% Agree
I learned about stigma/common myths around mental illness.	97%
I feel confident I can talk to my friends about mental health.*	95%
I understand mental health issues better.	96%
I learned about where I can get help for myself or a friend.	93%
I am more willing to ask for help for my own mental health.	96%
I learned about the importance of social media safety and mental health.*	98%

Program Feedback

The following quotes are highlights from surveys from VCOE staff training attendees.

"One important thing I learned at the conference is how to express your emotions through art and that it's okay to be vulnerable.."

"I learned that you deal with mental health in different ways and there are many ways to help."

MULTI-TIERED SYSTEM OF SUPPORT

Conclusion and Recommendations

The MTSS program makes a difference in the lives of youth in Ventura County by connecting students and their families to mental health services in their schools and communities and by educating staff, students, and their families about mental health to increase awareness and reduce stigma.

Through an analysis of the 2024-2025 evaluation results, the following areas for improvement are offered for consideration regarding the MTSS program and its evaluation.

- Standardize Referral Processes and Staff Training: Data show significant inconsistencies in how students access mental health services. A consistent, county-wide approach to staff education and referral protocols is essential to ensure equitable access.
- Address Persistent Funding and Staffing Instability: Delays and reductions in funding created operational challenges across districts, undermining program effectiveness and long-term sustainability.
- Strengthen Parent and Family Engagement Infrastructure: Low parent participation persists despite multiple outreach efforts. Districts should address structural barriers to engagement, rather than relying solely on increased promotional activities.
- Develop Comprehensive Data Collection Standards: Provide districts with additional tools, training, and resources to strengthen data collection methods—such as workshops or Q&A sessions on data management. Also, ensure that VCOE staff have the time, structures, and supports needed to collect outcome surveys after VCOE trainings.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION
VENTURA COUNTY OFFICE OF EDUCATION (VCOE)

Beginning in Spring 2022, Ventura County Behavioral Health allocated funding to the Ventura County Office of Education to implement Wellness Centers in eleven middle school campuses as part of its Prevention and Early Intervention programming within MHSA. These Wellness Centers are classified as Prevention programs under MHSA, which are broadly defined as "a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors." These Wellness Centers began service implementation in the Fall 2022 school year.

Program Strategies

Provides access and linkage to services for those with serious mental illness and serious emotional disturbance.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent, evidence-based trainings to educators to support students from underserved and underrepresented groups.

Program Highlights

21,353 early intervention services were administered†

3,304 mental health screenings were conducted†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION

Wellness Center Goals

1. Prevent mental illness from becoming severe and debilitating
2. Reduce risk factors that negatively affect mental health and academic success
2. Improve access to school-based mental health services

Wellness Center Schools

Districts	Schools
Conejo Valley Unified School District	Century Academy
	Colina Middle School
	Los Cerritos Middle School
	Sequoia Middle School
	Sycamore Middle School
Fillmore Unified School District	Fillmore Middle School
Ojai Unified School District	Nordhoff Junior High School
Oxnard School District	Dr. Manuel M. Lopez Academy
	Fremont Academy
	R.J. Frank Academy
Pleasant Valley School District	Las Colinas Middle School
	Monte Vista Middle School
Santa Paula Unified School District	Isbell Middle School
Ventura County Office of Education	Gateway Community School

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION

Program Activities

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by the Wellness Centers Expansion program staff. Program participants and other community members may participate in these activities and events.

LEA Program Activities by Type	# Activities/ Events
Staff/Student Trainings	350
Family Trainings and Events	107
TOTAL # of Trainings/Events	**457**
	# Early Intervention Services
School-based Individual Services	4,664
School-based Group Services	1,102
Other	15,587
TOTAL # of Early Intervention Services	**21,353**

47,141
participants in program activities†

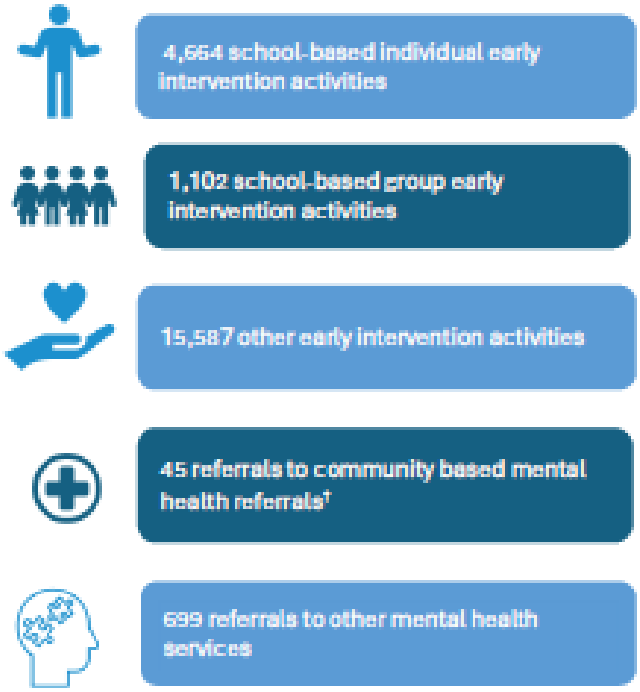
†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION

Program Referrals

Program referrals include mental health care and social supports, such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.



†Number of people reached may be duplicated because individuals could attend multiple activities/events.

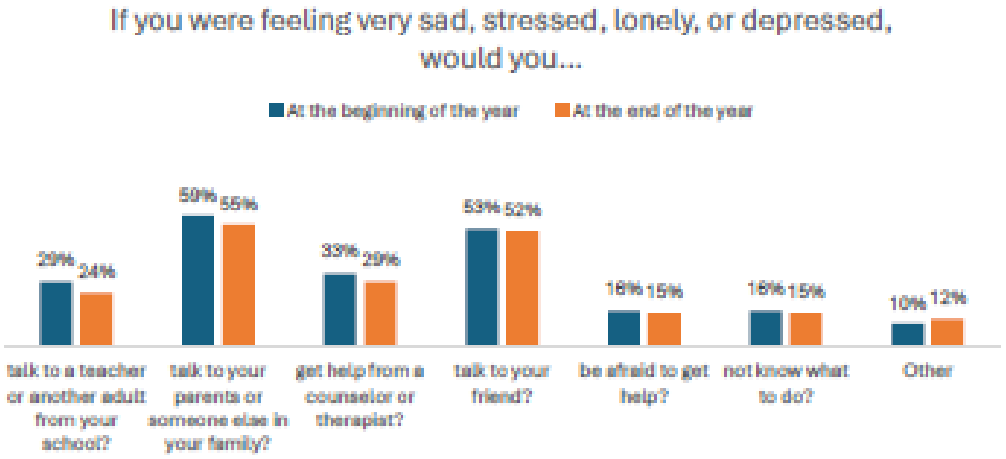
VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION

Program Outcomes

A Mental Health Access and Awareness pre- and post-survey was digitally administered to students to evaluate changes in student awareness of the Wellness Centers and other school-based services, as well as student attitudes toward seeking help for oneself and others, at the beginning and end of the school year. A total of 2,884 students responded to the Access and Awareness pre-survey, and 2,689 students completed the post-survey. Results on awareness of services at the beginning and end of the school year, as well as attitudes toward seeking help for oneself at the same points in time, are presented in the charts below. For all survey results, please refer to the FY 2024-2025 MS Wellness Final Evaluation Report (See **Appendix** _).

Awareness of Services at the Beginning and End of the School Year	% Agree or Strongly Agree at the beginning of year	% Agree or Strongly Agree at the end of year
I am confident I know where to go and how to access mental health services at my school.	80%	81%
If someone close to me had a mental health issue, I would encourage them to seek help.	93%	93%
If someone close to me had a mental health issue, I would listen to them without judging or criticizing.	93%	94%
I know what mental health services are provided at my school.	81%	82%



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS CENTERS EXPANSION

Program Feedback and Successes

Two student Peer Mentor focus groups and four Wellness Coordinator interviews were conducted to gather qualitative feedback on the program. Some of the themes in their responses are reported below.

Strengths of the program

- Provide a safe and supportive space for emotional expression and reduce stigma around mental health.
- Wellness Centers have a direct effect on mental health for students who participate; they offer emotional relief, foster social connections, and help students feel less isolated.

What would make this program better?

- Strict rules around food and phones, lack of privacy when other adults are present, and concerns about confidentiality were barriers to access and trust.
- Increased advertising about the Wellness Center as a place for emotional support, not just activities.

"I think the biggest way the [Wellness Center] helps is with mental health, because I know that the counselors here, they're always helping many students with mental health issues or issues they got at home and stuff like that. And I think that we here, we can help the other students by just being a good role model and helping them when they need it."

"Advertise the Wellness Center more. Advertise that you can come in and talk to people, rather than just activities."

WELLNESS CENTERS EXPANSION

Conclusion and Recommendations

In the third year of implementation, the Middle School Wellness Centers continue to be recognized by students and staff as essential safe spaces that foster emotional expression, provide timely support, and connect students with mental health resources. Qualitative findings from focus groups and interviews underscore that the centers serve as calm, confidential, and welcoming environments where trusted adults and peers help students navigate stressors both inside and outside of school. These findings mirror themes identified in previous years—specifically, the importance of a safe, stigma-free space and the role of Wellness Peers in making mental health conversations approachable, indicating that these strengths remain central and consistent over time.

Students and staff continue to report positive impacts of the Wellness Centers on emotional well-being, social connectedness, and confidence in seeking help. The program has also demonstrated success in reaching marginalized and underserved student populations, providing early intervention, and delivering crisis response. These successes are reinforced by high awareness rates (94% at post-survey) and sustained willingness among students to seek help for themselves or others.

However, like last year, the pre/post survey data show minimal quantitative change in key indicators, such as willingness to seek help and knowledge of where to access services—suggesting that while there are high levels of awareness, there may be limits to the current survey's ability to capture meaningful shifts in student attitudes and behaviors.
Qualitative data indicate ongoing challenges related to staffing capacity, language accessibility, parental engagement, and substance use intervention. Barriers to access, including concerns about confidentiality, inconsistent staff presence, and a lack of privacy, were also noted by students and remain areas of focus.

Key Recommendations:
Based on the challenges identified by participants, several key recommendations can be made to improve the program's effectiveness and better meet the needs of students. Some of these echo or expand upon prior recommendations from previous reports, while others address newly emerging themes:

- **Maintain and Strengthen Core Strengths.** The consistent presence of safe, welcoming, and confidential environments has been the cornerstone of the Wellness Centers' success for three years running. Students continue to identify these qualities as the main reason they seek out the centers. Maintaining this environment—and the trust it fosters—should remain a top priority.
- **Address Barriers to Access and Trust.** While confidentiality concerns and stigma were noted last year, this year's findings provide greater detail: students reported inconsistent staff presence, physical layouts that limit privacy, and ongoing stigma among male students that deters help-seeking. Addressing these specific concerns could help shift willingness-to-seek-help metrics that have remained flat in the survey data.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

- **Enhance Substance Use Prevention and Intervention.** Stakeholders again noted difficulty in reaching students in need of substance use support, an issue flagged in previous years. Despite high overall awareness of the centers, these students often remain disconnected from services. Expanding targeted prevention efforts and integrating substance use education into existing activities could address this gap.
- **Expand Language Accessibility.** As in prior years, language remains a barrier for some families. While Spanish translation/interpretation is available, families who speak other languages remain underserved. This year's stakeholder interviews reinforced the need to expand services to better engage all communities represented in the student population.
- **Increase Parent and Family Engagement.** Low parental awareness and stigma continue to limit student access to services, mirroring last year's findings. Culturally responsive outreach, simplified consent processes, and flexible engagement opportunities could help bridge this gap.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

One Step a La Vez (OSALV) serves multiple populations including the Latino/a community in Fillmore, Piru, and Santa Paula, youth and Transitional Age Youth (TAY) ages 13–25, LGBTQ+ youth, youth in the juvenile justice system, and youth and TAY who are homeless or at risk of homelessness. One Step a La Vez offers a drop-in center for mental health resources, wraparound support, youth leadership activities, LGBTQ+ support groups, and classes on topics related to stress, coping, and wellness.

Program Strategies

Improves timely access and linkages to services for underserved populations by reaching youth, TAY, and Latinos/as who might not otherwise get help.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent and LGBTQ+-sensitive services, workshops, and presentations.

Program Highlights

140 individuals received core program services

165 individuals referred to mental health care and/or social support services

1,821 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

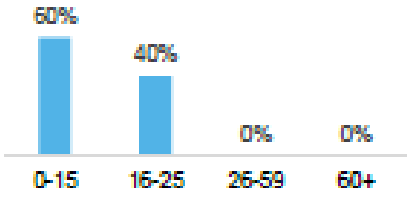
ONE STEP A LA VEZ CONOCIMIENTO

Demographic Data

Race* (n = 139)

American Indian / Alaskan Native	0%
Asian	1%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Latino	98%
White	2%
Another	0%

Age Groups (n = 139)



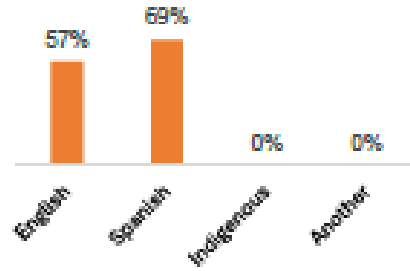
100% Hispanic/Latino

Ethnicity* (n = 133)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	99%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	1%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	1%	

4 did not answer the question.
2 selected "decline to state."

Primary Language* (n = 138)



1 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

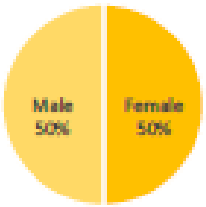
Demographic Data

Current Gender Identity (n = 135)

Female	51%
Male	49%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

4 did not answer this question.

Sex Assigned at Birth (n = 137)



2 did not answer this question.

Sexual Orientation (n = 137)

Bisexual	0%
Gay or Lesbian	0%
Heterosexual or Straight	100%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

2 did not answer this question.

1% of individuals reported having one or more disabilities (n = 139)

No individuals identified as veterans (n = 138)

1 did not answer this question.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Referrals

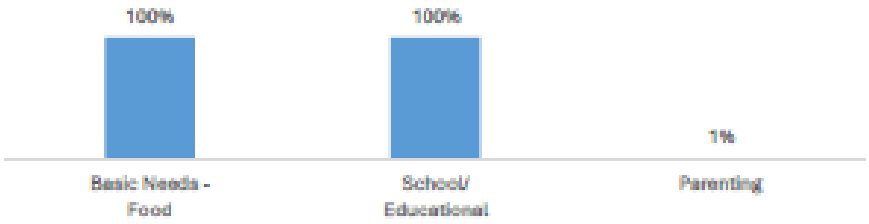
Program referrals include mental health care and social supports, such as food, housing, health insurance, and other essential services. Individuals could be referred to multiple services.

26 individuals referred to mental health care

139 individuals referred to one or more social supports

280 total social support referrals provided

Types of Social Support Referrals*
(n = 280)



*Percentages may exceed 100% because participants could receive more than one referral.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Activities

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by One Step a La Vez program staff.

Program Activities by Type	# Activities/ Events
Celebrations	4
Summer Events	5
Other	6
Community Service	11
Teen Center Attendance	13
Field Trip	19
Food Distribution	38
Training	41
Family Dinner	44
Meetings	65
Support Group	69
TOTAL # of Activities/Events	315

10,602
participants in program activities†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Outreach

Program participants and other community members may participate in these activities and events. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program Outreach by Type	# Activities/ Events
Community Event or Outreach	1
Presentation	3
Interagency Meeting	8
Outreach	16
Meeting	27
TOTAL # of Activities/Events	55

1,821 people reached through outreach events

78% of outreach events conducted in Spanish

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Activity Outcomes

OSALV tracks outcomes of program activities by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they complete a class, training, or presentation. Survey results from these activities are presented in the chart below.

% of Agree or Strongly Agree Responses
Before (n = 80) and After (n = 78-80) Training

Statement	Before	After
I knew/know a lot about the topics of this program.	90%	100%
I knew/know where to go for mental health services.	100%	100%
I knew/know when to ask for help with an emotional problem.	100%	100%
I felt/ feel good about myself.	93%	100%
I felt/feel hopeful when I think about the future.	100%	100%

Participants reported greater knowledge of mental health and improved psychological well-being after completing program activity.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Activity Outcomes: Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The table below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 78-80)

Statement	% Agree
The materials provided were useful.	100%
The program was practical and useful.	100%
I would recommend this program to others.	100%

Participants were highly satisfied with OSALV's program activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Activity Outcomes: Areas of Support

Participants who engaged in programming activities were asked to identify specific areas where they required additional support. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 80)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	88%
My grades in school	86%
My housing situation	11%
My job situation	1%
My relationships with friends and family	35%
My parenting	0%
Staying out of jail or prison	16%
My mental health	41%
Substance use	5%

Participants reported that the primary areas of need were their school attendance and grades.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Overall Program Outcomes

One Step a La Vez tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 44) and Exit (n = 7)[1]

Category	Intake	Exit
Minimal	79%	57%
Mild	14%	29%
Moderate	7%	0%
Severe	0%	14%

Distress levels showed mixed patterns, with minimal distress decreasing from 79% to 57%, while severe distress increased from 0% to 14%. However, these findings should be interpreted with caution due to the low survey completion rate at exit.

Most participants (71%) have been receiving services from OSALV Conocimiento for 7 months or longer.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–58), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Overall Program Outcomes: Satisfaction

Participants of One Step a La Vez were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

# of Participants Who Agree or Strongly Agree
(n = 7)

Statement	# Agree
It is easy to get help at this program.	7
I would recommend this program to a friend or family member.	7
Services are in the language I am most comfortable speaking.	7
Staff respect my cultural background.	7

Participants were highly satisfied with the One Step a La Vez program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Overall Program Outcomes: Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 7)

Before I attended this program, I wanted help with...	# of Participants
My school attendance	3
My grades in school	5
My housing situation	0
My job situation	0
My relationships with friends and family	2
My parenting	0
Staying out of jail or prison	0
My mental health	2
Substance use	0

Participants reported that the primary area of need was their grades in school.

*Counts may exceed total number of participants because each could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ CONOCIMIENTO

Program Feedback and Successes

One Step a La Vez program staff document successes and challenges encountered throughout the fiscal year. Some of their notable experiences are highlighted below.

"Our calendar when it comes to programming is always busy. This is a success because we always have something to offer to our teens, their parents and any community member in the Santa Clara River Valley."

"One big challenge has been transportation. With the amount of teens requesting for a ride 1 vehicle has been challenging. I hope soon we will be able to have another vehicle to better serve our teens at the center."

ONE STEP A LA VEZ CONOCIMIENTO

Conclusion and Recommendations

One Step a La Vez continued to serve their target population, with all participants identifying as Hispanic/Latino children and youth. The program offered diverse activities with widespread reach from summer events and food distributions to meetings and support groups. The majority of these activities were also offered in Spanish. The program addressed client needs by providing referrals to mental health care and social support services. Participants found program activities to be helpful and reported greater knowledge of mental health and improved psychological well-being as a result. Increased post-survey participation in the future can help provide greater insights into program impact.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS (PEARLS)
COUNTY OF VENTURA HUMAN SERVICE AGENCY AREA ON AGING (HSA)

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is an evidence-based case management program for seniors that teaches participants the necessary skills to move forward and make positive changes. PEARLS provides eight sessions over 12 weeks, covering three behavioral approaches to depression management: (1) teaches participants to recognize symptoms of depression and understand the link between unsolved problems and depression, (2) helps participants meet recommended levels of social and physical activity, and (3) helps participants identify and participate in personally pleasurable activities. In addition to the sessions and follow-up phone calls, PEARLS makes assessments to ensure that other potential factors contributing to depression, such as chronic medical conditions, are adequately treated.

Program Strategies

Provides access and linkage to services for older adults by conducting outreach.

Improves timely access to services for underserved populations (older adults) who might not otherwise get help.

Program Highlights

182 individuals received core program services

29 individuals referred to mental health care and/or social support services

3,026 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

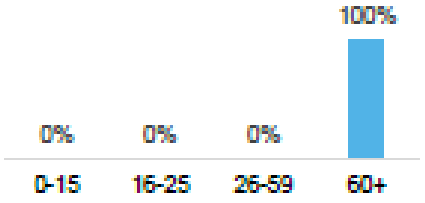
Demographic Data

Race* (n = 160)

American Indian / Alaskan Native	1%
Asian	3%
Black / African American	3%
Native Hawaiian / Other Pacific Islander	1%
Latino	27%
White	69%
Another	0%

5 did not answer this question.
14 selected "decline to state."

Age Groups (n = 177)



2 did not answer this question.

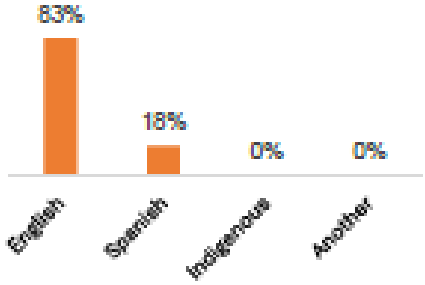
61% Hispanic/Latino
39% Non-Hispanic/Latino

Ethnicity* (n = 74)

Caribbean	0%	Hispanic
Central American	4%	Hispanic
Mexican/Mex.-Am./Chicano	53%	Hispanic
Puerto Rican	1%	Hispanic
South American	3%	Hispanic
Other Hispanic/Latino	0%	Hispanic
African	0%	Non-Hispanic
Asian Indian/South Asian	1%	Non-Hispanic
Cambodian	0%	Non-Hispanic
Chinese	1%	Non-Hispanic
Eastern European	3%	Non-Hispanic
European	22%	Non-Hispanic
Filipino/a	7%	Non-Hispanic
Japanese	1%	Non-Hispanic
Korean	0%	Non-Hispanic
Middle Eastern	3%	Non-Hispanic
Vietnamese	0%	Non-Hispanic
Other Non-Hispanic/Latino	3%	Non-Hispanic
More than one	0%	Non-Hispanic

1 did not answer the question.
104 selected "decline to state."

Primary Language* (n = 173)



2 did not answer this question.
4 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

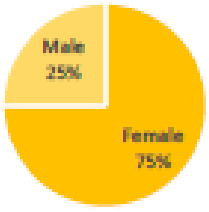
Demographic Data

Current Gender Identity (n = 174)

Female	75%
Male	24%
Transgender	1%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

2 did not answer this question.
3 selected "decline to state."

Sex Assigned at Birth (n = 175)



2 did not answer this question.
2 selected "decline to state."

Sexual Orientation (n = 156)

Bisexual	0%
Gay or Lesbian	0%
Heterosexual or Straight	99%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	1%

Another includes Asexual.
2 did not answer this question.
21 selected "decline to state."

84% of individuals reported having one or more disabilities (n = 172)

2 did not answer this question.
5 selected "decline to state."

11% of individuals identified as veterans (n = 173)

2 did not answer this question.
4 selected "decline to state."

Disability* (n = 145)

Seeing	34%
Hearing	23%
Other Communication	0%
Learning Disability	1%
Developmental Disability	0%
Dementia	1%
Another Mental Disability	1%
Physical Disability	62%
Chronic Health Condition	52%
Another Disability	1%

82 individuals reported more than one disability.

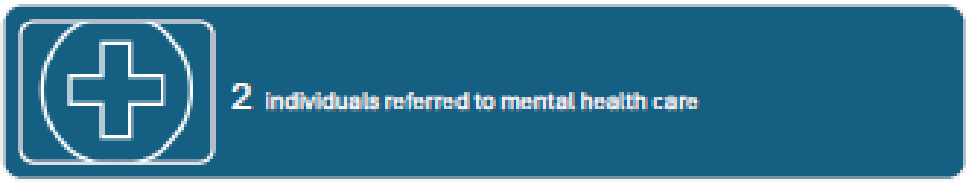
*Percentages may exceed 100% because participants could choose more than one response option.

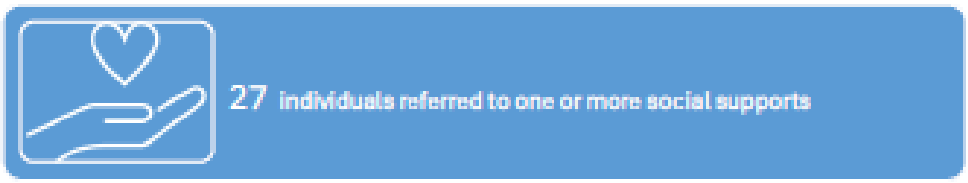
VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

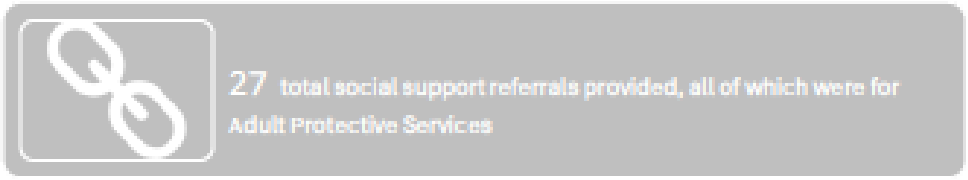
PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Referrals

Program referrals include referrals to mental health care and social supports such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.







VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Activities, Outreach, and Training

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Program to Encourage Active, Rewarding Lives for Seniors program staff. Program participants and other community members may participate in these activities and events. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program Activities by Type	# Activities/ Events
PEARLS Counseling Sessions	183
Presentation	3
Other	22
TOTAL # of Activities/Outreach/Training	208

183 participants in program activities†

es

92% of outreach events conducted in Spanish

3,026 people reached through outreach events

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Outcomes

Program to Encourage Active, Rewarding Lives for Seniors tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 36) and Exit (n = 46)[1]

Category	Intake	Exit
Minimal	53%	52%
Mild	22%	10%
Moderate	17%	23%
Severe	8%	15%

Participants showed mixed outcomes with most (52-53%) reporting stable minimal distress.

Most participants (61%) have been receiving services from Program to Encourage Active, Rewarding Lives for Seniors for 4-6 months.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Satisfaction

Participants of Program to Encourage Active, Rewarding Lives for Seniors were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 44-47)

Statement	% Agree
It is easy to get help at this program.	98%
I would recommend this program to a friend or family member.	98%
Services are in the language I am most comfortable speaking.	98%
Staff respect my cultural background.	95%

Participants were highly satisfied with Program to Encourage Active, Rewarding Lives for Seniors.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 41)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	2%
My grades in school	0%
My housing situation	22%
My job situation	5%
My relationships with friends and family	49%
My parenting	5%
Staying out of jail or prison	10%
My mental health	83%
Substance use	2%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Program Feedback and Successes

Participants who received program services from Program to Encourage Active, Rewarding Lives for Seniors were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 46)

- Communication/ Self-Espression (16)
- Imapct of Individual Staff (14)
- Provided Support and Resources (13)

What would make this program better?
(n = 36)

- Increase Frequency and Duration (21)
- No Recommendations (10)

"Staff are up to speed with full caseloads and also graduating clients."

"It's very good already- love the follow up visits and troubleshooting brainstorming sessions. Maybe have it last longer? More visits. But I will be able to repeat it and I definitely will."

PROGRAM TO ENCOURAGE ACTIVE, REWARDING LIVES FOR SENIORS

Conclusion and Recommendations

PEARLS continues to reach its target population, with all participants identifying as older adults in need of support for their mental health. In addition to program activities, individuals are provided with referrals for mental health and social support as necessary.

The majority of participants were highly satisfied with PEARLS, citing opportunities for self-expression and communication, the impact of program staff, and the support and resources they received among the most helpful aspects of the program. There were no specific recommendations for program improvement; however, participants requested a greater frequency and duration of future programming activities.

Although SOS-10 outcome data showed mixed results, qualitative findings highlight the program's positive impact. Participants felt the program provided them with needed support and resources and improved their overall well-being. Extenuating circumstances beyond the scope of the program may have also contributed to the mixed findings related to participants' distress level.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

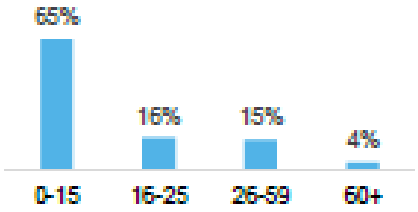
Demographic Data

Race (n = 127)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Latino	100%
White	0%
Another	0%

2 did not answer this question.

Age Groups (n = 129)

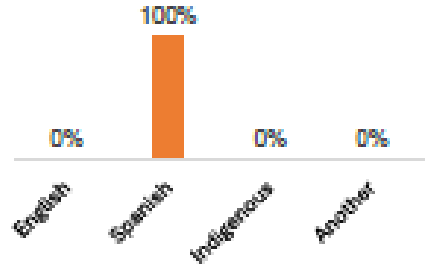


100% Hispanic/Latino

Ethnicity (n = 129)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	100%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

Primary Language (n = 129)

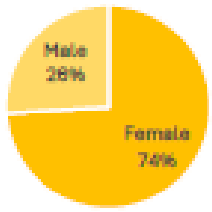


VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Demographic Data

Sex Assigned at Birth
(n = 27)



102 did not answer this question.

No individuals reported having one or more disabilities (n = 129)

No individuals identified as veterans
(n = 129)

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Referrals

Program referrals include referrals to mental health care and social supports such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.

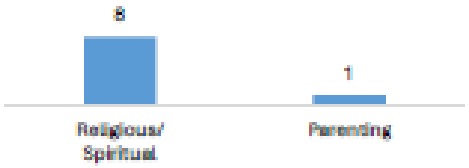
18 individuals referred to mental health care

9 individuals referred to one or more social supports

9 total social support referrals provided

13 individuals were encouraged to access services and follow through via transportation/bus tokens, accompaniment, translation, and reminder calls

Individuals Referred to Social Supports
(n = 9)



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Activities, Outreach, and Trainings

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Project Esperanza program staff. Program participants and other community members may participate in these activities and events. Program outreach encompasses activities designed to promote the program within the community, raise awareness of mental health issues, and connect community members with relevant mental health resources.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Workshop	1
Faith-Based	1
Community Fair or Event	4
Outreach	5
Other	53
Class	259
TOTAL # of Activities/Outreach/Trainings	323

4,484 participants in program activities†

98% of activities offered in Spanish

10,807 people reached through outreach events†

100% of outreach events conducted in Spanish

9,545 materials distributed

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Activity Outcomes

Project Esperanza tracks the outcomes of program activities by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after completing a class, training, or presentation. Survey results from these activities are presented in the chart below.

% of Agreed or Strongly Agreed Responses
Before (n = 13) and After (n = 12-13)

Statement	Before	After
I knew/know a lot about the topics of this program.	23%	100%
I knew/know where to go for mental health services.	38%	100%
I knew/know when to ask for help with an emotional problem.	46%	100%
I felt/ feel good about myself.	69%	100%
I felt/feel hopeful when I think about the future.	69%	100%

Participants reported greater knowledge of mental health and improved psychological well-being after completing program activity.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Activity Outcomes: Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The table below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 13)

Statement	% Agree
The materials provided were useful.	100%
The program was practical and useful.	100%
I would recommend this program to others.	100%

Participants were highly satisfied with Project Esperanza's program activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Activity Outcomes: Areas of Support

Participants who engaged in programming activities were asked to identify specific areas where they required additional support. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 12)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	25%
My grades in school	33%
My housing situation	0%
My job situation	25%
My relationships with friends and family	67%
My parenting	0%
Staying out of jail or prison	0%
My mental health	75%
Substance use	8%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Program Activity Feedback and Successes

Participants who engaged in program activity were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program activity?
(n = 13)

- Stress Management (5)
- Everything (4)

What would make this program activity better?
(n = 12)

- No Recommendations (9)
- More Activities (2)

"Everything was very useful, and more than anything they taught us how to reduce stress."

"Have more activities for children."

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Overall Program Outcomes

Project Esperanza tracks overall program outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 45) and Exit (n = 40)[1]

Category	Intake	Exit
Minimal	98%	100%
Mild	2%	0%
Moderate	0%	0%
Severe	0%	0%

Participants reported experiencing minimal levels of distress, on average, across the two time points.

58% have been receiving services from Project Esperanza for 7months or longer.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Overall Program Outcomes: Satisfaction

Participants of Project Esperanza were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 40)

Statement	% Agree
Staff respect my cultural background.	100%
Services are in the language I am most comfortable speaking.	100%
I would recommend this program to a friend or family member.	100%
It is easy to get help at this program.	100%

Participants were highly satisfied with the Project Esperanza program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Overall Program Outcomes: Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 38)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	29%
My grades in school	42%
My housing situation	0%
My job situation	0%
My relationships with friends and family	50%
My parenting	26%
Staying out of jail or prison	3%
My mental health	89%
Substance use	8%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROJECT ESPERANZA

Overall Program Feedback and Successes

Participants who received program services from Project Esperanza were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 39)

- Engaging in Positive Activities (13)
- Behavior Management (10)
- Maintain/Improve Relationships (10)

What would make this program better?
(n = 37)

- More Activities (17)
- Increased Duration or Frequency (15)

"After 10 sessions, we have finished our Parenting Class program. Participants were grateful and appreciative. They said the class was educational and helpful."

"Esperanza Project Kids participated at Santa Paula Christmas Parade and won trophy for the performance of our kids' dances and Taekwondo acts. It was beautiful to see our kids happy and engaged in the community events."

PROJECT ESPERANZA

Conclusion and Recommendations

Project Esperanza continues to reach their target population. All participants identified as Spanish-speaking Hispanic/Latinos. Program activities were well-attended, and outreach initiatives achieved widespread reach and community engagement. Project Esperanza also served clients by providing referrals for mental health and social support when appropriate.

The program successfully supported individuals with mental health needs, as indicated by all participants reporting minimal levels of distress after program completion. Program activities also contributed to greater mental health awareness and improved psychological well-being. Participants expressed high satisfaction with program services and staff. They found engaging in positive activities, learning about behavior management and how to maintain and improve relationships to be especially helpful. Based on participant feedback, future programming can include a greater variety of activities and provide additional time for participants to engage in these activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM
PROMOTORAS Y PROMOTORES FOUNDATION

The Promoviendo Program, referred to as Promotoras y Promotores Foundation (PyPF), primarily serves immigrant Latina/Hispanic women and their families who are at risk for depression and live throughout Ventura County. The Promoviendo Program facilitates community-based mental health support groups. It provides one-on-one support to empower and help participants reduce stress, manage depression, and improve their quality of life. In addition, the Promoviendo Program conducts outreach and community presentations to promote program services, distribute mental health educational information, increase awareness of local mental health resources, and educate the community on how to recognize signs of suicide risk and the effects of trauma (concept of "Situation, Options, Decide, Act [SODA]"). The Promoviendo Program expanded its reach from twice its original size in FY 22-23 to four times its original size in FY 23-24, thanks to its outreach into areas beyond the Santa Clara Valley, particularly Oxnard and Ventura cities.

Program Strategies

Improves timely access to services for underserved populations throughout Ventura County through referrals to culturally and linguistically appropriate services.

Implements non-stigmatizing and non-discriminatory practices by providing culturally and linguistically competent workshops and presentations.

Program Highlights

144 individuals received core program services

159 individuals referred to mental health care and/or social support services

34,141 individuals reached through outreach events[†]

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Demographic Data

Race* (n = 104)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Latino	100%
White	0%
Another	0%

25 did not answer this question.
14selected "decline to state."

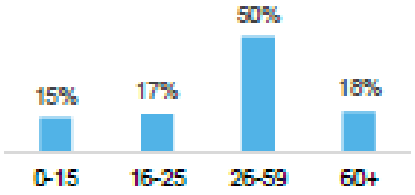
100% Hispanic/Latino

Ethnicity* (n = 111)

Caribbean	0%	Hispanic
Central American	2%	
Mexican/Mex.-Am./Chicano	97%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	1%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

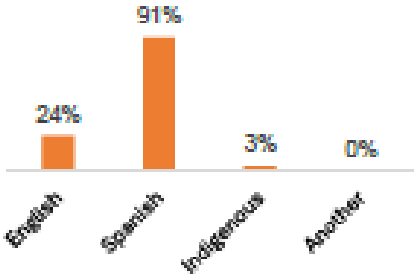
25 did not answer the question.
6 selected "decline to state."

Age Groups (n = 114)



28 did not answer this question.
2 selected "decline to state."

Primary Language* (n = 103)



28 did not answer this question.
6 selected "decline to state."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

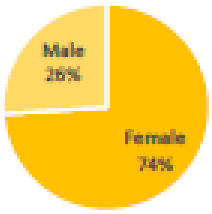
Demographic Data

Current Gender Identity (n = 114)

Female	75%
Male	25%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

28 did not answer this question.
2 selected "decline to state."

Sex Assigned at Birth (n = 116)



28 did not answer this question.
2 selected "decline to state."

Sexual Orientation (n = 104)

Bisexual	1%
Gay or Lesbian	2%
Heterosexual or Straight	97%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

29 did not answer this question.
11 selected "decline to state."

6 of individuals reported having one or more disabilities (n = 96)

29 did not answer this question.
19 selected "decline to state."

No individuals identified as veterans (n = 110)

28 did not answer this question.
6 selected "decline to state."

Disability (n = 7)

Seeing	3
Hearing	0
Other Communication	0
Learning Disability	0
Developmental Disability	0
Dementia	0
Another Mental Disability	1
Physical Disability	3
Chronic Health Condition	0
Another Disability	0

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Referrals

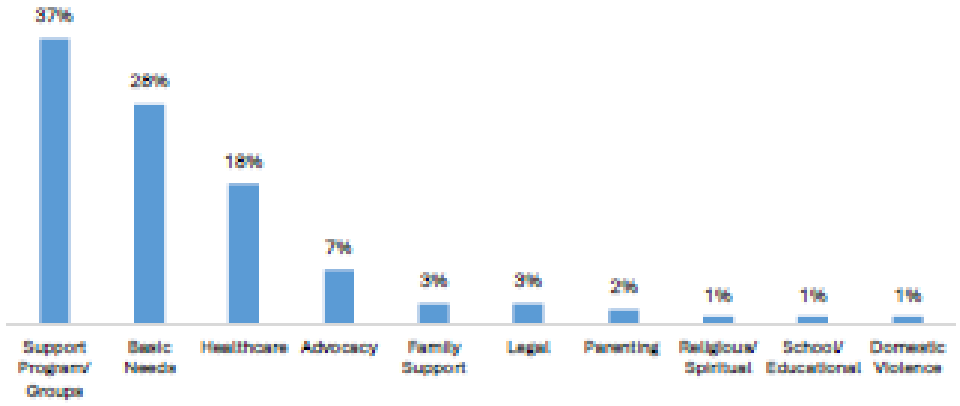
Program referrals include mental health care and social supports, such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.

88 individuals referred to mental health care

71 individuals referred to one or more social supports

116 total social support referrals provided

Types of Social Support Referrals*
(*n* = 116)



*Percentages may exceed 100% because participants could receive more than one referral.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Activities, Outreach, and Trainings

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Promoviendo program staff. Program participants and other community members may participate in these activities and events. Program outreach includes activities to promote the program in the community, increase awareness of mental health, and connect community members with mental health resources.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Presentation	12
Community Fair or Event	77
Support Group	341
Outreach	370
TOTAL # of Activities/Outreach/Trainings	800

3,518 participants in program activities†

100% of activities and outreach offered in Spanish

34,141 people reached through outreach events†

30,204 materials distributed

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Activity Outcomes

The Promoviendo Program tracks outcomes of program activities by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they complete a class, training, or presentation. Survey results from these activities are presented in the chart below.

% of Agree or Strongly Agree Responses
Before (n = 15) and After (n = 15)

Statement	Before	After
I knew/know a lot about the topics of this program.	0%	100%
I knew/know where to go for mental health services.	0%	100%
I knew/know when to ask for help with an emotional problem.	0%	100%
I felt/ feel good about myself.	0%	100%
I felt/feel hopeful when I think about the future.	0%	100%

Participants reported greater knowledge of mental health and improved psychological well-being after completing program activity.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Activity Outcomes: Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The table below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n =15)

Statement	% Agree
The materials provided were useful.	93%
The program was practical and useful.	93%
I would recommend this program to others.	93%

Participants were highly satisfied with Promoviendo's program activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Activity Outcomes: Areas of Support

Participants who engaged in programming activities were asked to identify specific areas where they required additional support. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 15)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	0%
My grades in school	0%
My housing situation	0%
My job situation	7%
My relationships with friends and family	53%
My parenting	27%
Staying out of jail or prison	0%
My mental health	87%
Substance use	0%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Program Activity Feedback and Successes

Participants who engaged in program activity were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program activity?
(n = 15)

- Everything (5)
- Relaxation/Stress Reduction (5)

What would make this program activity better?
(n = 15)

- No Recommendations (12)
- Increased Frequency (3)

"Everything is good."

"Have this kind of information more often."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Overall Program Outcomes

Promoviendo Program tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 44) and Exit (n = 62)[1]

Category	Intake	Exit
Minimal	89%	95%
Mild	9%	5%
Moderate	0%	0%
Severe	2%	0%

Participants reported experiencing minimal levels of distress, on average, across the two time points (Intake: 55, Exit: 56).

Most participants (94%) reported they have been receiving services from PyPF for more than one year.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Overall Program Outcomes: Satisfaction

Participants of Promoviendo Program were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 44)

Statement	% Agree
Staff respect my cultural background.	100%
Services are in the language I am most comfortable speaking.	98%
I would recommend this program to a friend or family member.	100%
It is easy to get help at this program.	100%

Participants were highly satisfied with the Promoviendo Program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PROMOVIENDO PROGRAM

Overall Program Outcomes: Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 34)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	0%
My grades in school	0%
My housing situation	12%
My job situation	6%
My relationships with friends and family	44%
My parenting	0%
Staying out of jail or prison	0%
My mental health	94%
Substance use	0%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

PROMOVIENDO PROGRAM

Overall Program Feedback and Successes

Participants who received program services from Promoviendo Program were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 61)

- Exercises/Relaxation Techniques (35)
- Socialization (20)

What would make this program better?
(n = 57)

- No Recommendations (19)
- Increase Duration/ Frequency (17)
- Program Continuation (16)

"The Promotoras trip to Alice Keck Park with the families was entertaining for the families that participated (…) they all had fun playing games, eating together and interacting with their children. The families comments [they] were happy to have the time together with their children and play games with them. It [was] something that they had not done in a long time."

"Even though immigration arrests are being conducted in the county and states, the Promotoras continue to work and engage with persons and the community. Events have been cancelled because of the fear that persons are going to be deported. As an organization, we continue to do what is best for the community."

PROMOVIENDO PROGRAM

Conclusion and Recommendations

The Promoviendo Program continues to serve their target population, with most participants identifying as Hispanic/Latino females. The program also provides participants with mental health and social referrals when appropriate. Promoviendo program activities contributed to greater awareness of mental health and improved psychological well-being.

The program helped participants maintain minimal levels of distress as evidenced by SOS scores at program intake and exit. The program's retention rate is also high, with 94% of participants reporting they have been receiving services from PyPF for more than one year. This finding further complements participants' high satisfaction ratings of the program. The most helpful aspects of the program were exercises and relaxation techniques, along with opportunities for socialization. Most participants had no suggestions for program improvement, but requested the program be continued and offered more frequently.

*Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY
MIXTECO INDIGENA COMMUNITY ORGANIZATION PROJECT (MICOP)

Mixteco Indigena Community Organizing Project (MICOP)'s Healing the Community facilitates community-based mental health workshops for the Hispanic/Latino and Indigenous communities of Oxnard, El Rio, and Port Hueneme. The program raises awareness of mental health with a focus on the topic of depression and how it impacts Hispanic/Latino and Indigenous communities. MICOP provides culturally relevant, holistic, and traditional Indigenous wellness treatments to relieve symptoms of stress, anxiety, and depression. In addition, the program provides referrals and linkages to mental health providers and other services that are culturally and linguistically appropriate. MICOP also conducts outreach to the community to promote program services, distribute mental health educational information, and increase awareness of other local mental health resources.

Program Strategies

Improves timely access to services for underserved Hispanic/Latino and Indigenous communities in Oxnard, El Rio, and Port Hueneme through referrals to culturally and linguistically appropriate services.

Implements non-stigmatizing and non-discriminatory practices by providing culturally relevant Indigenous wellness treatments and workshops, as well as offering cultural competency training to local service providers.

Program Highlights

267 individuals received core program services

770 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Demographic Data

Race* (n = 263)

American Indian / Alaskan Native	3%
Asian	1%
Black / African American	1%
Native Hawaiian / Other Pacific Islander	1%
Latino	97%
White	2%
Another	<1%

Other includes Indigenous.
1 did not answer this question.
3 selected "decline to state."

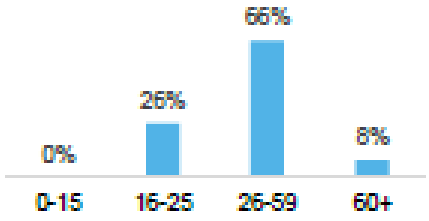
98% Hispanic/Latino
2% Non-Hispanic/Latino

Ethnicity* (n = 261)

Caribbean	0%	Hispanic
Central American	2%	
Mexican/Mex.-Am./Chicano	91%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	7%	
African	1%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	1%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	1%	

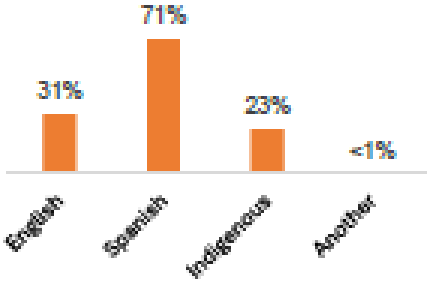
Other Hispanic/Latino includes Mapuche, Mazateca, Salvadorian, Nicaraguense.
4 did not answer the question.
4 selected "decline to state."

Age Groups (n = 266)



1 did not answer this question.

Primary Language* (n = 265)



Another includes Tagalog.
2 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

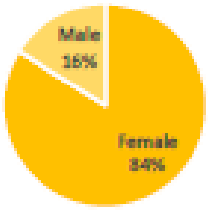
Demographic Data

Current Gender Identity (n = 265)

Female	84%
Male	16%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

1 did not answer this question.
1 selected "decline to state."

Sex Assigned at Birth (n = 266)



1 did not answer this question.

Sexual Orientation* (n = 234)

Bisexual	4%
Gay or Lesbian	2%
Heterosexual or Straight	93%
Queer	0%
Questioning or Unsure	1%
Another Sexual Orientation	1%

2 did not answer this question.
31 selected "decline to state."

6% of individuals reported having one or more disabilities (n = 280)

7 selected "decline to state."

1% of individuals identified as veterans (n = 265)

1 did not answer this question.
1 selected "decline to state."

Disability* (n = 19)

Seeing	63%
Hearing	21%
Other Communication	0%
Learning Disability	11%
Developmental Disability	5%
Dementia	0%
Another Mental Disability	0%
Physical Disability	21%
Chronic Health Condition	32%
Another Disability	0%

7 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Program Activities, Outreach, and Training

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Healing the Community program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Training by Type	# Activities/ Events
Support Group	11
Education	1
Community Fair or Event	10
TOTAL # of Activities/Outreach/Training	22

75 participants in program activities†

100% of activities and outreach offered in Spanish

770 people reached through outreach events

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Program Outcomes

Healing The Community tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post) before and after receiving services. Survey results are presented in the chart below.

% of Agreed or Strongly Agreed Responses
Before (n = 151-156) and After (n = 151-154) Program

Statement	Before	After
I knew/know a lot about the topics of this program.	65%	90%
I knew/know where to go for mental health services.	84%	94%
I knew/know when to ask for help with an emotional problem.	85%	94%
I felt/ feel good about myself.	90%	97%
I felt/feel hopeful when I think about the future.	90%	97%

Participants reported greater knowledge of mental health and improved psychological well-being after completing the program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Program Satisfaction

Participants of Healing the Community were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 154-157)

Statement	% Agree
Materials were useful.	95%
Program was practical and useful.	95%
I would recommend this program to others.	95%

Participants were highly satisfied with the Healing the Community program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 110)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	35%
My grades in school	36%
My housing situation	35%
My job situation	27%
My relationships with friends and family	41%
My parenting	20%
Staying out of jail or prison	5%
My mental health	94%
Substance use	6%

Participants reported that the primary area of need was their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THE COMMUNITY

Program Feedback and Successes

Participants who received program services from Healing the Community were asked to provide additional feedback through two open-ended response questions in post-test surveys. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 124)

- Relaxation and Stress Relief (35)
- Learning about Benefits of Plants and Herbs (31)

What would make this program better?
(n = 98)

- Increased Program Reach, Duration, and Frequency (36)
- No Recommendations (32)
- Expanded Content (19)

"Our program has recently gotten more community interested in the work we do. We have presented to different schools and youth. They always seem eager to learn and always have questions for us about healing and traditional indigenous practices."

"We (...) have had a challenging time completing posttests, but it's a task we're on working on to get them all completed by the end of January."

HEALING THE COMMUNITY

Conclusion and Recommendations

MICOP's Healing the Community program continues to serve its intended population, with almost all participants identifying as Hispanic/Latino. The program primarily served individuals who needed help with their mental health through various program activities such as support groups, education, and community fairs/events—all of which were offered in Spanish.

Outcome data demonstrated that Healing the Community successfully increased participants' awareness of mental health, including when and where to seek help if needed. Participants also reported greater psychological well-being after completing the program. They found the program to be particularly helpful for promoting relaxation and reducing stress. Participants were highly satisfied with the program, with many also providing general positive feedback and suggesting no areas for improvement.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TRI-COUNTY GLAD

Tri-County GLAD serves Deaf and Hard of Hearing (DHH) individuals of all ages. The program offers educational workshops and training about mental health topics, provides community organizations with information on the mental health needs of the DHH community, and supplies referrals to mental health care. Tri-County GLAD also supports DHH individuals in accessing early intervention services by reducing language barriers. However, due to the small number of participants served by the program's early intervention component, no data is reported here.

Program Strategies

Increases recognition of early signs of mental illness by providing trainings to educators and other potential responders.

Implements non-stigmatizing and non-discriminatory practices by dispelling myths about DHH individuals and sharing information about DHH in English and Spanish.

Program Highlights

49 individuals received core program services

49 individuals referred to mental health care and/or social support services

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

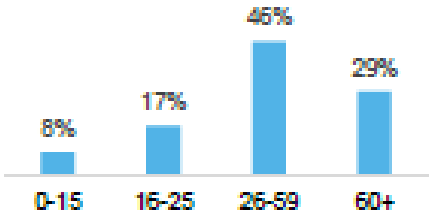
TRI-COUNTY GLAD

Demographic Data

Race* (n = 49)

American Indian / Alaskan Native	0%
Asian	16%
Black / African American	4%
Native Hawaiian / Other Pacific Islander	2%
Latino	53%
White	27%
Another	0%

Age Groups (n = 48)



1 did not answer this question.

53% Hispanic/Latino
47% Non-Hispanic/Latino

Ethnicity* (n = 47)

Hispanic

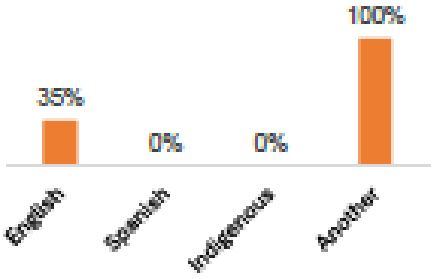
Caribbean	0%
Central American	4%
Mexican/Mex.-Am./Chicano	49%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%

Non-Hispanic

African	0%
Asian Indian/South Asian	2%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	28%
Filipino/a	11%
Japanese	2%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	4%
More than one	0%

Other includes Pacific Islander.
2 did not answer the question.

Primary Language* (n = 49)



Another includes American Sign Language (ASL).

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

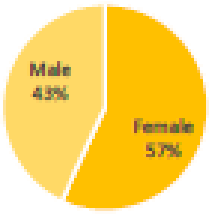
TRI-COUNTY GLAD

Demographic Data

Current Gender Identity (n = 49)

Female	57%
Male	43%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

Sex Assigned at Birth (n = 49)



Sexual Orientation (n = 49)

Bisexual	0%
Gay or Lesbian	4%
Heterosexual or Straight	96%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

No individuals identified as veterans (n = 49)

100% of individuals reported having one or more disabilities (n = 49)

Disability* (n = 49)

Seeing	6%
Hearing	100%
Other Communication	0%
Learning Disability	0%
Developmental Disability	0%
Dementia	0%
Another Mental Disability	0%
Physical Disability	0%
Chronic Health Condition	0%
Another Disability	0%

4 individuals reported more than one disability.

*May include duplicate users.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

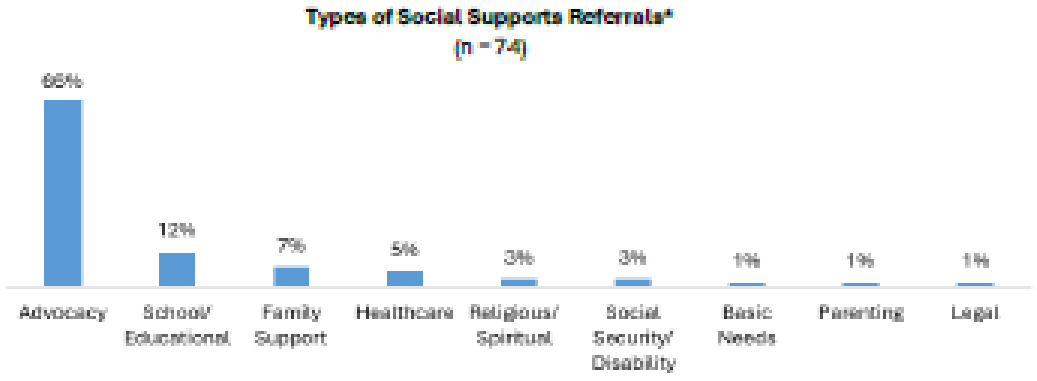
TRI-COUNTY GLAD

Program Referrals

Program referrals include referrals to mental health care and social supports such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.

49 individuals referred to one or more social supports

74 total social support referrals provided, 49 of which provided advocacy services



*May include duplicate users.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TRI-COUNTY GLAD

Program Activities

Program activities include training and workshops facilitated by Tri-County GLAD program staff. Program participants and other community members may participate in these activities and events.

Program Activities by Type	# Activities/ Events
Training/Workshop	19
TOTAL # of Activities/Events	19

168 counseling sessions

469 participants in program activities†

100% of program activities offered in American Sign Language

†May include duplicate users.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TRI-COUNTY GLAD

Program Outcomes

Tri-County GLAD tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they complete a class, training, or presentation. Survey results from these activities are presented in the chart below.

% of Agree or Strongly Agree Responses
Before (n = 47-48) and After (n = 48) Training

Statement	Before	After
I knew/know a lot about the topics of this training/class.	25%	81%
I knew/know where to go for mental health services.	77%	96%
I knew/know when to ask for help with an emotional problem.	88%	98%
I felt/ feel good about myself.	98%	100%
I felt/feel hopeful when I think about the future.	98%	96%

Participants reported greater knowledge of mental health and improved psychological well-being after completing the program.

*May include duplicate users.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TRI-COUNTY GLAD

Program Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The table below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 48)

Statement	% Agree
The materials provided were useful.	92%
The program was practical and useful.	96%
I would recommend this program to others.	96%

Participants were highly satisfied with Tri-County GLAD.

*May include duplicate users.

TRI-COUNTY GLAD

Areas of Support

Participants who engaged in programming activities were asked to identify specific areas where they required additional support. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 22)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	0%
My grades in school	0%
My housing situation	5%
My job situation	32%
My relationships with friends and family	27%
My parenting	18%
Staying out of jail or prison	0%
My mental health	36%
Substance use	0%

Participants reported that the primary area of need was their mental health.

*May include duplicate users.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

TRI-COUNTY GLAD

Program Feedback and Successes

Participants who received program services from Tri-County GLAD were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 37)

- Learning about the DHH Community (18)
- Information about Services and Resources(12)

What would make this program better?
(n = 26)

- No Recommendations (14)
- Program Expansion (4)

"I really enjoyed getting more insight into the experience of the deaf community and learning about the resources available for families with deaf children."

"More outreach, more visibility in community."

*May include duplicate users.

TRI-COUNTY GLAD

Conclusion and Recommendations

Tri-County GLAD continues to serve DDH individuals of all ages. The program provides educational training workshops on mental health and individual counseling sessions. Program participants also receive referrals to various social support services as needed. Notably, all participants received referrals for advocacy services.

The program is successfully implementing their activities and achieving widespread reach. Participants reported greater knowledge of mental health and improved psychological well-being after completing the program. Further, participants were highly satisfied with their experience and suggested expanding the program with the addition of more staff and outreach.

*May include duplicate users.

WELLNESS EVERYDAY AND STAY MEDIA CAMPAIGN
IDEA ENGINEERING, INC.

Wellness Everyday offers universal prevention messaging about mental health and suicide prevention throughout Ventura County, via traditional, digital, and location-based media channels. The Wellness Everyday/Salud Siempre website, available in English and Spanish, provides educational information about mental health and wellness, suicide prevention, and contact/referral information for local resources/supports (including some MHSA-funded programs). Additionally, Wellness Everyday media messaging has been used to support MHSA's Community Planning Process efforts, directing Ventura County residents to register for public hearings and review documents on the Ventura County Behavioral Health website. While Wellness Everyday and the "STAY" (Suicide Prevention) Media Campaign are separate programs, FY 24-25 data have been combined into this report.

Program Strategies

Distributes mental health and wellness advertisements in English and Spanish both through traditional media such as radio, transit and newspapers, and through digital media such as social media advertising and targeted website advertisements, as well as location-based messaging such as posters and ad boards in local businesses (laundromats, nail salons, barbershops, clinics).

Provides mental health and wellness information and resources in English and Spanish through the Wellness Everyday/Salud Siempre website.

Program Highlights

42,525 Wellness Everyday/Salud Siempre website users*

12 Social and digital media campaigns delivered in English and/or Spanish

43,525 Minimum clicks on English and Spanish digital advertisements*

18,296,670 Total media impressions for MHSA and STAY/Suicide Prevention Campaigns*

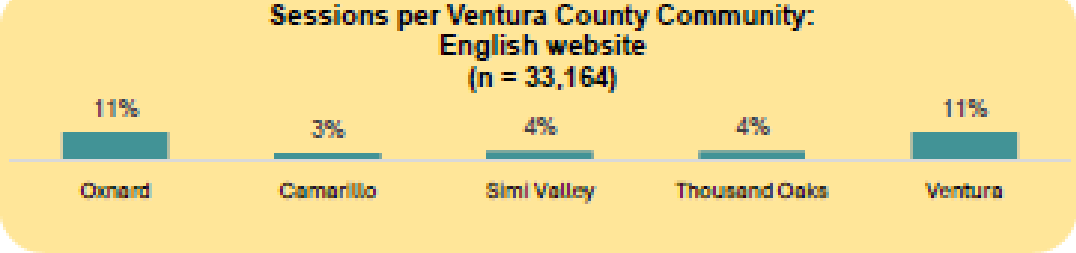
59,923 Website page views from MHSA and STAY/Suicide Prevention Media Campaigns

*May include duplicate users.

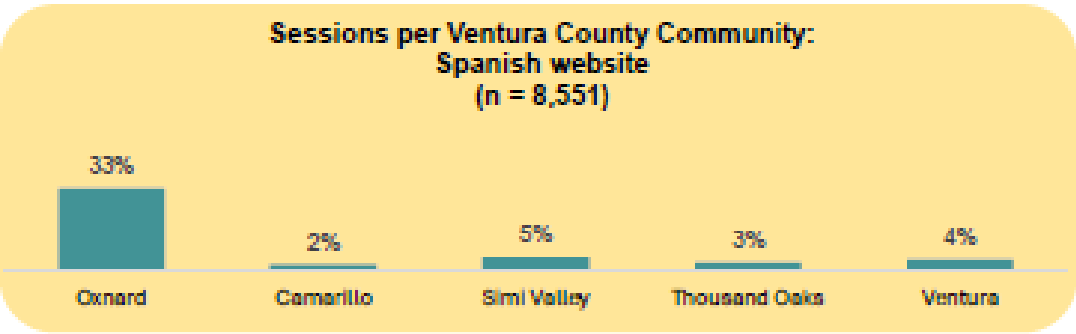
WELLNESS EVERYDAY

Demographic Data*

At least 34% of all English website sessions were accessed by an individual while in Ventura County†



At least 47% of all Spanish website sessions were accessed by an individual while in Ventura County†



The Wellness Everyday/Salud Siempre website is unable to capture detailed demographic data about users. In lieu of standardized demographic information aligned with PEI regulations, data about geographic location (note that website traffic reports include all of California) and device type are presented for fiscal year 2024-2025 website sessions. Data are presented separately for the English and Spanish versions of the website.

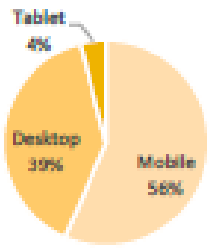
*May include duplicate users.
†Ventura County residents commuting outside of the County may affect the tracking of location-based metrics. Beyond this, privacy and technological restrictions affect the capacity to collect accurate geographical data. Given the local resources contained on the website, and local targeting of media, it can be reasonably assumed that the vast majority of website visitors are local to Ventura County.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

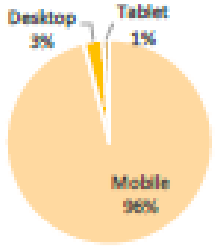
WELLNESS EVERYDAY

Users by Device Type

Users by Device Type: English website* (n = 33,164)



Users by Device Type: Spanish website (n = 8,851)

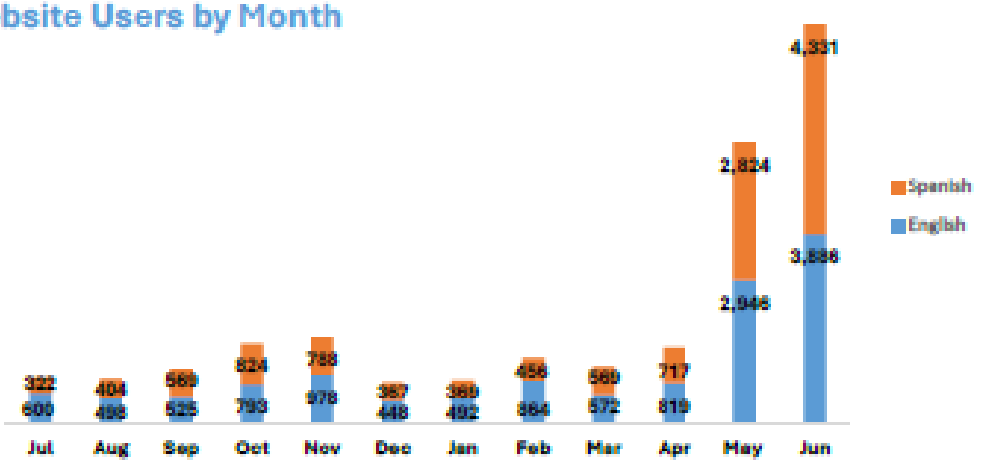


Website Traffic

en — **33,164** people visited the English website in FY 24-25

es — **8,851** people visited the Spanish website in FY 24-25

Website Users by Month



Monthly totals reflect estimated user counts for each month. These would include any duplicate users who visited the site in different months. The chart shows steady engagement throughout the year with a significant spike in May and June, when English users increased from under 1,000 monthly visitors to nearly 4,000, and Spanish users similarly surged to over 4,000. This increase is primarily due to an increase in media spend during those two months.

*May include duplicate viewers who saw multiple campaigns or viewed the advertisements on screen more than one. Estimated number of people viewing ads is not available for all digital media channels.
†Clicks led to the Wellness Everyday/Salud Siempre website, the VCBH website, or online registration pages for community events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WELLNESS EVERYDAY

Digital Advertisements

More than **4.7 M** English advertisements were on screen†

More than **2.9 M** Spanish advertisements were on screen†

21,319 English advertisements were clicked*

22,206 Spanish advertisements were clicked*

Media Source	Impressions
Facebook & Instagram	4,533,709
TikTok	1,003,651
YouTube	56,178
Online Video	918,353
Digital Display	506,573
Streaming TV	725,069
Subtotal	**7,743,533**

Traditional Advertisements

4,066,537
Print impressions

3,599,100
Radio impressions

2,887,500
Posters & Ad Boards

Total Digital and Traditional Impressions
18,296,670

*May include duplicate viewers who saw multiple campaigns or viewed the advertisements on screen more than one. Estimated number of people viewing ads is not available for all digital media channels.
†Clicks led to the Wellness Everyday/Salud Siempre website, the VCBH website, or online registration pages for community events.

WELLNESS EVERYDAY

Conclusions and Recommendations

The Wellness Everyday program and the STAY (Suicide Prevention) Media Campaign have implemented prevention messaging regarding mental health and suicide throughout Ventura County, utilizing traditional, digital, and location-based media channels. The bilingual website, Wellness Everyday/Salud Siempre, serves as a resource for individuals seeking educational information about mental health and wellness, suicide prevention, and local support services. The program reached 42,525 website users and generated over 18.2 million media impressions, indicating strong community engagement.

The data also show engagement across both English and Spanish-language platforms, with the program's outreach strategies including 12 media campaigns that have reached diverse populations. The MHSA and STAY/Suicide Prevention media campaigns generated nearly 60,000 website page views for the Wellness Everyday/Salud Siempre website, while digital advertisements received over 43,000 clicks. These results indicate that community members are accessing mental health resources intended for different age groups on topics such as coping with anger and suicide prevention.

Outcome and satisfaction data are not collected for this program. However, available metrics suggest that Ventura County community members use Wellness Everyday/Salud Siempre for information on mental and behavioral health and engage with the media advertisements. Website traffic data and digital media campaign metrics are regularly examined to ensure that at-risk groups receive culturally and linguistically appropriate information, with messages tailored to target audiences. Continued monitoring ensures that Ventura County residents have access to mental health and wellness information online, with media outreach increasing visibility of these resources.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO
CATALYST CHURCH

Ignite Conocimiento at Catalyst Church in Ventura County is a community-driven program designed to address the lasting effects of Adverse Childhood Experiences (ACEs). With a focus on healing and resilience, the program provides a safe space for individuals and families to explore the emotional, mental, and physical impacts of ACEs. By integrating trauma-informed care with faith-based principles, Ignite Conocimiento offers a holistic approach to breaking cycles of trauma and promoting long-term well-being. Through a combination of educational workshops, counseling, and community engagement, the program empowers participants to overcome past adversities and build a foundation for healthier, more resilient futures.

Program Strategies

Provides trauma-informed education and counseling by offering workshops and one-on-one counseling to help participants understand and heal from the effects of ACEs.

Engages the community and promotes outreach by building strong community connections to create a support network and promote prevention strategies for families and local leaders.

Program Highlights

72 individuals received core program services

12 individuals referred to mental health care and/or social support services

1,031 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

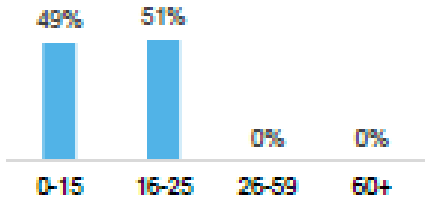
IGNITE CONOCIMIENTO

Demographic Data

Race* (n = 72)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	3%
Native Hawaiian / Other Pacific Islander	3%
Latino	93%
White	7%
Another	0%

Age Groups (n = 71)



1 did not answer this question.

100% Hispanic/Latino

Ethnicity* (n = 67)

Hispanic

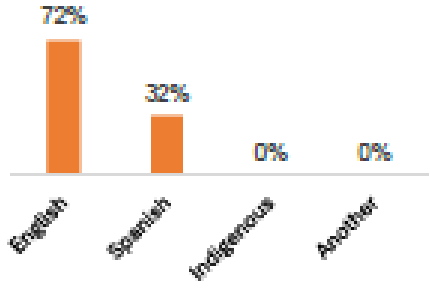
Caribbean	0%
Central American	3%
Mexican/Mex.-Am./Chicano	96%
Puerto Rican	0%
South American	1%
Other Hispanic/Latino	0%

Non-Hispanic

African	0%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	0%
Filipino/a	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
More than one	0%

5 did not answer the question.

Primary Language* (n = 71)



1 did not answer this question.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

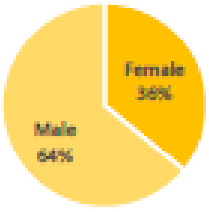
Demographic Data

Current Gender Identity (n = 70)

Female	37%
Male	63%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

2 did not answer this question.

Sex Assigned at Birth (n = 72)



Sexual Orientation (n = 64)

Bisexual	9%
Gay or Lesbian	0%
Heterosexual or Straight	89%
Queer	0%
Questioning or Unsure	2%
Another Sexual Orientation	0%

1 did not answer this question.
7 selected "decline to state."

16% of individuals reported having one or more disabilities (n = 69)

1 did not answer this question.
2 selected "decline to state."

Disability* (n = 9)

Seeing	2
Hearing	1
Other Communication	0
Learning Disability	6
Developmental Disability	0
Dementia	0
Another Mental Disability	1
Physical Disability	0
Chronic Health Condition	0
Another Disability	0

1 individual reported more than one disability.

*Count may exceed number of participants because each could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Program Referrals

Program referrals include mental health care and social supports, such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.

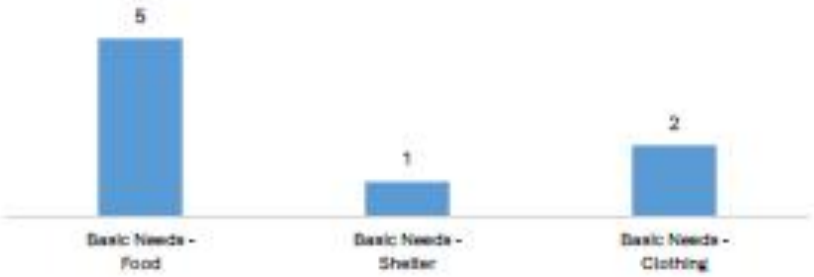
5 individuals referred to mental health care

7 individuals referred to one or more social supports

8 total social support referrals provided

1 individual was encouraged to access services and follow through via transportation/bus tokens, accompaniment, translation, and reminder calls

Types of Social Support Referrals
(n = 8)



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Program Activities, Outreach, and Training

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Ignite Conocimiento program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health, and connect community members with mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, Training by Type	# Activities/ Events
Community Service Activity	1
Summer Event	1
Community Fair or Event	1
Field Trip	2
Training/Workshop	3
Other	4
Outreach	5
Meeting	9
Dinner	51
TOTAL # of Activities/Outreach/Training	77

2,709 participants in program activities†

83% of outreach events conducted in Spanish

1,031 people reached through outreach events

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Program Activity Outcomes

Ignite Conocimiento tracks outcomes of program activities by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they complete a class, training, or presentation. Survey results from these activities are presented in the chart below.

% of Agreed or Strongly Agreed Responses
Before (n = 96-97) and After (n = 97) Program

Statement	Before	After
I knew/know a lot about the topics of this program.	70%	94%
I knew/know where to go for mental health services.	89%	95%
I knew/know when to ask for help with an emotional problem.	94%	96%
I felt/ feel good about myself.	93%	96%
I felt/feel hopeful when I think about the future.	90%	93%

Participants reported greater knowledge of mental health and improved psychological well-being after completing program activity.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Program Activity Outcomes: Satisfaction

Participants were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The table below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 95-97)

Statement	% Agree
The materials provided were useful.	93%
The program was practical and useful.	93%
I would recommend this program to others.	93%

Participants were highly satisfied with Ignite Conocimiento's program activities.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Program Activity Outcomes: Areas of Support

Participants who engaged in programming activities were asked to identify specific areas where they required additional support. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 82)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	41%
My grades in school	70%
My housing situation	15%
My job situation	7%
My relationships with friends and family	46%
My parenting	5%
Staying out of jail or prison	17%
My mental health	51%
Substance use	16%

Participants reported that the primary area of need was their grades in school.

*Percentages may exceed 100% because participants could choose more than one response option.

IGNITE CONOCIMIENTO

Program Activity Feedback and Successes

Participants who engaged in program activity were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program activity?
(n = 87)

- Helpfulness/Supportiveness of Program and Staff (34)
- Meeting friends/ Socializing (15)

What would make this program activity better?
(n = 69)

- No Recommendations (40)
- More Events/ Activities (12)

"The support and love they give is comforting and helped me grow and become more social."

"I think having more activities and doing things to help our community will help us get closer as a group."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Overall Program Outcomes

Ignite Conocimiento tracks outcomes for program participants (e.g., individuals who attend the drop-in center). These outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being and lower levels of distress. The chart below compares intake and exit scores.

Categorization of SOS-10 Scores at Intake (n = 54) and Exit (n = 17)[2]

Category	Intake	Exit
Minimal	85%	82%
Mild	9%	18%
Moderate	6%	0%
Severe	0%	0%

Survey data indicate that participants maintained stable, minimal distress levels throughout program participation.*

Most participants (82%) have been receiving services from Ignite for 7 months or longer.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.
*Exit survey response rate was 31% (n=17 of 54 intake participants). Findings may not be representative of all program participants

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Overall Program Outcomes: Satisfaction

Participants of Ignite Conocimiento were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 17)

Statement	% Agree
Staff respect my cultural background.	100%
Services are in the language I am most comfortable speaking.	100%
I would recommend this program to a friend or family member.	100%
It is easy to get help at this program.	100%

Participants were highly satisfied with the Ignite Conocimiento program.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Overall Program Outcomes: Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 17)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	35%
My grades in school	76%
My housing situation	6%
My job situation	0%
My relationships with friends and family	35%
My parenting	0%
Staying out of jail or prison	6%
My mental health	41%
Substance use	6%

Participants reported that the primary area of need was their grades in school.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

IGNITE CONOCIMIENTO

Overall Program Feedback and Successes

Participants who received program services from Ignite Conocimiento were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 17)

- Supportive Staff/ Environment (11)
- Socializing (4)

What would make this program better?
(n = 16)

- No Recommendations (12)
- More Program Offerings (4)

"We had 21 students successfully complete the 7 weeks of activities and attended our trip to Disney. This was many of the students' first time at any amusement park and being so far from home. Many of the students have been weighed down by the social political changes, school and family issues that it was a joy to see them drop their guards and spend the day being kids!"

"We have a group of students who have expressed concern, fear and anxiety over their families immigration status. This constant threat to their families is resulting in missed school, lower family income due to fear of being at work, lack of proper health care and less attendance to Ignite. We've done our best to connect student and their families with services (...)"

IGNITE CONOCIMIENTO

Conclusion and Recommendations

Ignite Conocimiento has demonstrated substantial success in fostering healing and resilience among participants affected by Adverse Childhood Experiences (ACEs). The program's trauma-informed, faith-based approach has created a safe, supportive environment, reflected in participants' high satisfaction levels and low psychological distress scores. Participants highly value the supportive staff, environment, and opportunities to socialize, all of which were identified as key strengths of the program.

The program also meets participants' needs and expectations, as evidenced by the minimal feedback regarding program improvements. Most participants did not offer specific recommendations, stating they were happy with how the program is currently offered. Minor suggestions to build on these strengths and further enhance participant experience include more field trips, guest speakers, and events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS
NAMBA PERFORMING ARTS

NAMBA Flamenco Dance, Theater for Wellness provides a space for creative expression to children and adults of all ages in underserved areas of Ventura through flamenco dance classes and mental health performance shows.

Program Strategies

Stigma and Discrimination reduction

Program Highlights

57 individuals received core program services

901 individuals reached through outreach events[1]

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

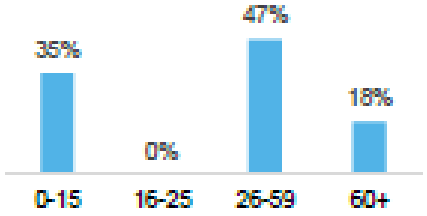
Demographic Data

Race* (n = 52)

American Indian / Alaskan Native	6%
Asian	10%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	63%
White	37%
Another	2%

Others is not specified.
2 did not answer this question.
3 selected "decline to state."

Age Groups (n = 55)



0 did not answer this question.
2 selected "decline to state."

65% Hispanic/Latino
40% Non-Hispanic/Latino

Ethnicity* (n = 41)

Hispanic

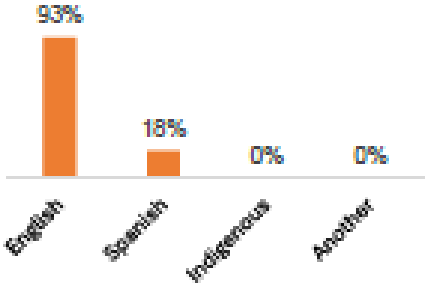
Caribbean	2%
Central American	5%
Mexican/Mex.-Am./Chicano	54%
Puerto Rican	0%
South American	2%
Other Hispanic/Latino	2%

Non-Hispanic

African	2%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	7%
European	22%
Filipino/a	5%
Japanese	2%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	2%
More than one	10%

Other Hispanic/Latino includes Cuban and Non-Hispanic/Latino include Spanish.
13 did not answer the question.
4 selected "decline to state."

Primary Language* (n = 56)



1 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

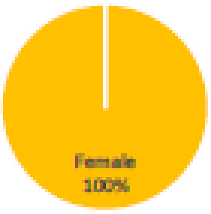
Demographic Data

Current Gender Identity* (n = 49)

Female	100%
Male	0%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

0 did not answer this question.
8 selected "decline to state."

Sex Assigned at Birth (n = 50)



0 did not answer this question.
7 selected "decline to state."

Sexual Orientation* (n = 36)

Bisexual	0%
Gay or Lesbian	0%
Heterosexual or Straight	100%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

0 did not answer this question.
21 selected "decline to state."

11% of individuals reported having one or more disabilities (n = 57)

0 did not answer this question.
0 selected "decline to state."

0% of individuals identified as veterans (n = 49)

0 did not answer this question.
8 selected "decline to state."

Disability (n = 6)

Seeing	0
Hearing	0
Other Communication	1
Learning Disability	1
Developmental Disability	0
Dementia	0
Another Mental Disability	1
Physical Disability	3
Chronic Health Condition	1
Another Disability	0

1 individual reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Program Activities, Outreach, and Training

Program activities include classes and presentations facilitated by NAMBA Flamenco Dance, Theater for Wellness program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Class	34
Presentations	3
TOTAL # of Activities/Outreach/Trainings	37

901 total participants reached †

95% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Program Outcomes

NAMBA Flamenco Dance, Theater for Wellness tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 59) and Exit (n = 26)[1]

Category	Intake	Exit
Minimal	93%	82%
Mild	5%	11%
Moderate	0%	0%
Severe	2%	7%

Most participants maintained minimal distress levels (93% at intake, 82% at exit), though mild distress increased from 5% to 11% and severe distress increased from 2% to 7%; exit data represent 47% of intake participants.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Program Satisfaction

Participants of NAMBA Flamenco Dance, Theater for Wellness were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 28)

Statement	% Strongly Agree/Agree
It is easy to get help at this program.	86%
I would recommend this program to a friend or family member.	82%
Services are in the language I am most comfortable speaking.	86%
Staff respect my cultural background.	86%

Participants were largely satisfied with the NAMBA Flamenco Dance, Theater for Wellness program.

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 24)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	8%
My grades in school	8%
My housing situation	0%
My job situation	4%
My relationships with friends and family	58%
My parenting	8%
Staying out of jail or prison	4%
My mental health	71%
Substance use	8%

Participants reported that the primary areas of need were their mental health and relationship with friends and family.

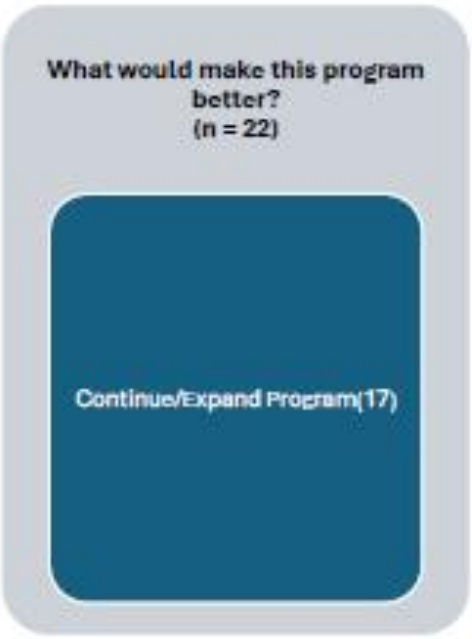
*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Program Feedback and Successes

Participants who received program services from NAMBA Flamenco Dance, Theater for Wellness were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.



"This is a fantastic program! She has learned a new skill, flamenco dancing from an incredible teacher, and has established friendships with many of the girls. She has gained increased exposure to the Spanish culture and her language skills in both Spanish and English have improved."

"It's great and I would love it to have extended hours. More classes and more frequently"

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NAMBA FLAMENCO DANCE, THEATER FOR WELLNESS

Conclusion and Recommendations

The NAMBA Flamenco Dance, Theater for Wellness successfully provided a space for creative expression to children and adults of all ages in underserved areas of Ventura, using flamenco dance classes and mental health performance shows as its core strategy for stigma and discrimination reduction. By offering a unique artistic outlet and addressing mental health openly through performance, the program countered existing stigmas and fostered an environment of acceptance. The program demonstrated a commitment to accessible and culturally responsive services, with 86% of participants confirming that staff respect their cultural background and that services were provided in the language they preferred. This high level of satisfaction was reflected in participant comments that praised the teacher's expertise and positive energy and described the class environment as an "enjoyment and a relaxed safe place."

An area of future improvement may include enhancing the program's offered activities as numerous participants requested more frequent classes during the week. Overall, the program provided students with a culturally relevant space for artistic development while promoting mental health awareness and reducing stigma through performance.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB
AMPLIFY THE ARTS

Girls Rock SB hosts girls and gender-expansive youth in grades 6th to 12th for a weekend centered around exploring their identities, interests, and well-being through music, creative arts, and mentorship. Through various artistic workshops and wellness activities, youth cultivate technical art skills, connections with peers, empathy, and self-discovery.

Program Strategies

Provides access and linkage to services

Stigma and discrimination reduction

Program Highlights

130 individuals received core program services

120 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

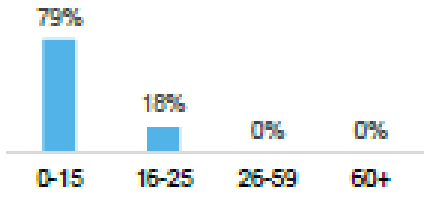
Demographic Data

Race* (n = 121)

American Indian / Alaskan Native	7%
Asian / Asian American	8%
Black / African American	16%
Native Hawaiian / Other Pacific Islander	2%
Hispanic / Latino	31%
White	51%
Another	8%

6 did not answer this question.
3 selected "decline to state."

Age Groups (n = 125)



6 did not answer this question.
1 selected "decline to state."

48% Hispanic/Latino
72% Non-Hispanic/Latino

Ethnicity* (n = 85)

Hispanic

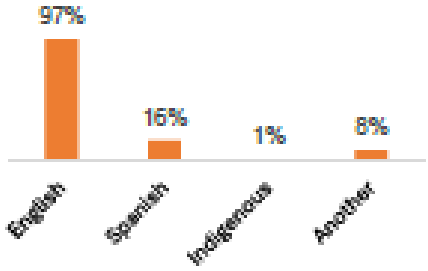
Caribbean	4%
Central American	1%
Mexican/Mex.-Am./Chicano	31%
Puerto Rican	2%
South American	6%
Other Hispanic/Latino	5%

Non-Hispanic

African	14%
Asian Indian/South Asian	4%
Cambodian	1%
Chinese	7%
Eastern European	4%
European	24%
Filipino/a	2%
Japanese	4%
Korean	4%
Middle Eastern	8%
Vietnamese	1%
Other Non-Hispanic/Latino	0%
More than one	11%

Other Hispanic/Latino include Nicaguan, Guatemalan, Salvadoran.
35 did not answer the question.
10 selected "decline to state."

Primary Language* (n = 123)



7 did not answer this question.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Demographic Data

Current Gender Identity (n = 117)	
Female	92%
Male	3%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	4%

11 did not answer this question.
2 selected "decline to state."

Disability* (n = 23)	
Seeing	17%
Hearing	9%
Other Communication	0%
Learning Disability	48%
Developmental Disability	0%
Dementia	0%
Another Mental Disability	4%
Physical Disability	13%
Chronic Health Condition	0%
Another Disability	26%

3 individuals reported more than one disability.

21% individuals reported having one or more disabilities

18 did not answer this question.
10 selected "decline to state."
N=102

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Program Activities, Outreach, and Trainings

Program activities include events facilitated by Girls Rock SB program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health, and connect community members with mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Training by Type	# Activities/ Events
Amplify Wellness Weekend	1
TOTAL # of Activities/Outreach/Training	1

120 total participants reached†

0% of program activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Program Outcomes

Girls Rock SB tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they receive services. Survey results are presented in the chart below.

% of Strongly Agree and Agree Responses Before and After Program
(n = 123 - 130)

Statement	Intake	Exit
I knew/know a lot about the topics of this program.	52%	84%
I knew/know where to go for mental health services.	58%	78%
I knew/know when to ask for help with an emotional problem.	68%	79%
I felt/feel good about myself.	78%	86%
I felt/feel hopeful when I thought/think about the future.	71%	81%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Program Satisfaction

Participants of Girls Rock SB were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 124 - 130)

Statement	% Strongly Agree/Agree
The materials provided were useful.	97%
The program was practical and useful.	89%
I would recommend this program to others.	90%

Participants were highly satisfied with the Girls Rock SB program.

GIRLS ROCK SB

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 80)

Before I attended this program, I wanted help with...	# of Participants
My school attendance	26%
My grades in school	39%
My housing situation	16%
My job situation	16%
My relationships with friends and family	56%
My parenting	8%
Staying out of jail or prison	13%
My mental health	50%
Substance use	9%

Participants reported that the primary areas of need were their relationships with friends and family and their mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Program Feedback and Successes

Participants who received program services from Girls Rock SB were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program? (n = 107)

- Social Connection and Friendship Building (46)
- Supportive Staff and Caring Environment (28)

What would make this program better? (n = 106)

- Expand Activity Selections and Program Length (30)
- More Leisure Time and Breaks (28)

"The most helpful thing is making friends, usually people are very nice and you can find someone to connect."

"To improve this program, it would be most helpful that there are activities for people at all levels in the arts."

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

GIRLS ROCK SB

Conclusion and Recommendations

Girls Rock SB hosted girls and gender-expansive youth in grades 6th to 12th for a weekend retreat centered around exploring their identities, interests, and well-being through music, creative arts, and mentorship. The program provided artistic workshops and wellness activities where youth cultivated technical art skills, connections with peers, empathy, and self-discovery. The program also integrated 40 foster youth as part of this wellness weekend, with participants reporting that the level of support received exceeded what they normally receive. Program outcomes showed positive changes, with participants' knowledge about program topics increasing from 52% to 84%, and awareness of where to go for mental health services increasing from 58% to 78%. Self-esteem measures showed improvement, with participants feeling good about themselves increasing from 78% to 86% and feeling hopeful about the future increasing from 71% to 81%.

Participants most valued making friends and connecting with peers, supportive staff and a caring environment, and building confidence through activities like the ropes course. Many noted feeling safe and accepted, with several emphasizing the importance of inclusive practices like respecting pronouns. The main area for improvement was scheduling. Participants requested more free time and cabin breaks, and other concerns included better communication about schedules, pre-registration for electives, and clearer instructions. Participants also wanted more activity options and increased capacity in popular workshops. Program staff shared the retreat served 120 youth, exceeding their typical 50-85 participants, and that smaller groups would allow for better mentorship. Overall, the program provided creative expression and wellness support to youth, particularly foster youth, while improving their knowledge of mental health resources and self-awareness.

*Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS
DE COLORES MULTICULTURAL FOLK ARTS, INC.

De Colores Multicultural Folk Arts, Inc. engaged older adults and youth, often grandparents and their grandchildren, in intergenerational multimedia art classes, cooking classes, and storytelling activities and movement to foster confidence, social connections, and community well-being.

Program Strategies

Provides access and linkages to services.

Program Highlights

194 individuals received core program services

2 individuals referred to mental health care and/or social support services

657 individuals reached through outreach events[†]

[†]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Demographic Data

Race* (n = 108)

American Indian / Alaskan Native	6%
Asian	1%
Black / African American	3%
Native Hawaiian / Other Pacific Islander	1%
Hispanic / Latino	69%
White	26%
Another	1%

81 did not answer this question.
5 selected "decline to state."

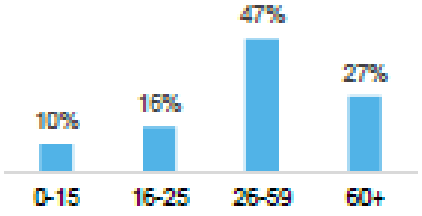
85% Hispanic/Latino
18% Non-Hispanic/Latino

Ethnicity* (n = 85)

Caribbean	0%	Hispanic
Central American	4%	
Mexican/Mex.-Am./Chicano	78%	
Puerto Rican	2%	
South American	0%	
Other Hispanic/Latino	1%	
African	2%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	7%	
European	8%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

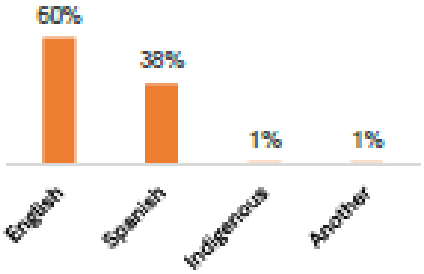
Other Hispanic/Latino includes Chamoru.
103 did not answer the question.
6 selected "decline to state."

Age Groups (n = 116)



75 did not answer this question.
3 selected "decline to state."

Primary Language* (n = 118)



74 did not answer this question.
2 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

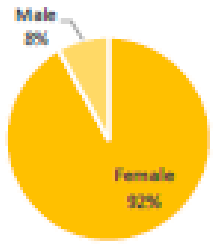
Demographic Data

Current Gender Identity (n = 112)

Female	90%
Male	8%
Transgender	0%
Genderqueer	2%
Questioning or Unsure	0%
Another Gender Identity	0%

79 did not answer this question.
3 selected "decline to state."

Sex Assigned at Birth (n = 116)



76 did not answer this question.
2 selected "decline to state."

Sexual Orientation (n = 93)

Bisexual	6%
Gay or Lesbian	9%
Heterosexual or Straight	82%
Queer	1%
Questioning or Unsure	1%
Another Sexual Orientation	1%

96 did not answer this question.
5 selected "decline to state."

15% of individuals reported having one or more disabilities (n = 105)

79 did not answer this question.
7 selected "decline to state."

4% of individuals identified as veterans (n = 112)

80 did not answer this question.
2 selected "decline to state."

Disability* (n = 21)

Seeing	33%
Hearing	19%
Other Communication	0%
Learning Disability	19%
Developmental Disability	0%
Dementia	0%
Another Mental Disability	5%
Physical Disability	14%
Chronic Health Condition	29%
Another Disability	14%

3 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Program Activities, Outreach, and Training

Program activities include various traditional cultural arts, music, and cooking workshops facilitated by Healing Through The Arts program staff. Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Training by Type	# Activities/ Events
Kids Festival	1
Sewing Class	6
Writing Workshop	5
Storytelling Workshop	4
Music Workshop	10
Art Workshop and Class	8
Cooking and Kitchen Workshop	8
TOTAL # of Activities/Outreach/Training	**42**

657 total participants reached[1]

93% of program activities offered in Spanish

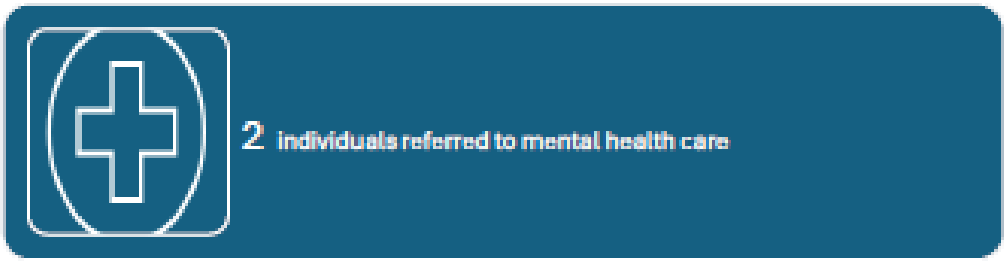
[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Program Referrals

Program referrals include referrals to mental health care and social support such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.



[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Program Outcomes

Healing Through the Arts tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they receive services. Survey results are presented in the chart below.

% of Strongly Agree and Agree Responses Before and After Program
(n = 171 - 191)

Statement	Intake	Exit
I knew/know a lot about the topic of this program.	58%	88%
I knew/know where to go for mental health services.	69%	85%
I knew/know when to ask for help with an emotional problem.	73%	86%
I felt/feel good about myself.	87%	92%
I felt/feel hopeful when I thought/think about the future.	83%	93%

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Program Satisfaction

Participants of Healing Through the Arts were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 191 - 193)

Statement	% Strongly Agree/Agree
Materials provided were useful.	91%
The program was practical and useful.	92%
I would recommend this program to others.	91%

Participants were highly satisfied with the Healing Through The Arts program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 81)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	6%
My grades in school	7%
My housing situation	19%
My job situation	22%
My relationships with friends and family	54%
My parenting	14%
Staying out of jail or prison	2%
My mental health	57%
Substance use	5%

Participants reported that the primary areas of need were their mental health and their relationships with friends and family.

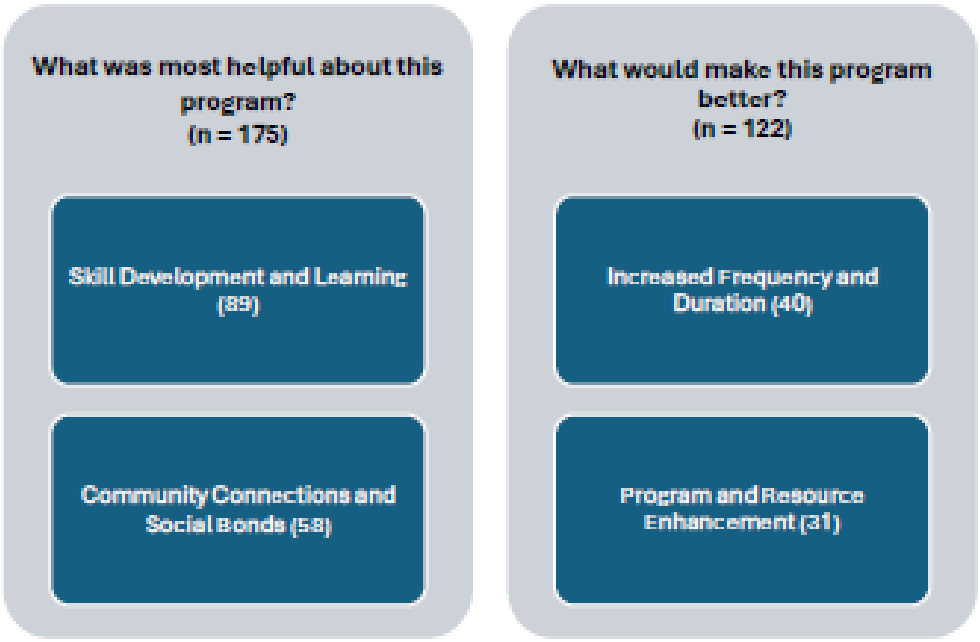
*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

HEALING THROUGH THE ARTS

Program Feedback and Successes

Participants who received program services from Healing Through the Arts were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.



"Community involvement. Sharing a new learning experience with my child. Appreciate our culture by learning something from it."

"Having the classes more often to help retain learned information."

HEALING THROUGH THE ARTS

Conclusion and Recommendations

De Colores Multicultural Folk Arts engaged older adults and youth, often grandparents and their grandchildren, in intergenerational multimedia art classes, sewing workshops, cooking classes, music instruction, poetry writing, drumming circles, kitchen gardening, and storytelling activities to foster confidence, social connections, and community well-being. The program enhanced timely access to services for underserved populations by offering programming in Spanish and accommodating speakers of Indigenous languages. Outcomes demonstrated improvements across multiple domains: participants showed marked gains in knowledge about program topics and awareness of mental health resources, as well as meaningful increases in self-esteem and hope, and growth in technical skills. Notably, workshops facilitated intergenerational family collaboration, with families expressing pride in their completed projects.

An area of future improvement includes addressing logistical challenges such as ensuring adequate supplies and equipment for workshops, particularly cooking utensils and sewing machines. Additionally, coordinating multi-age groups within single workshops presented difficulties, as activities designed for older youth sometimes did not engage younger children or toddlers accompanying their families. Overall, the program offered meaningful opportunities for intergenerational learning and cultural expression, while fostering community resilience and reducing social isolation among Spanish-speaking families.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB
AUTISM SOCIETY VENTURA COUNTY

"Everyone Has a Story" is a bi-monthly book club and writing workshop for disabled and neurodivergent adults, families, and caretakers. The workshop enables participants to tell their stories in their own words and discuss literature related to disability. Program participants develop a sense of community, improved confidence and mental health, and are exposed to literature centering authors and characters reflective of themselves.

Program Strategies

Stigma and discrimination reduction

Program Highlights

35 individuals received core program services

24,374 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

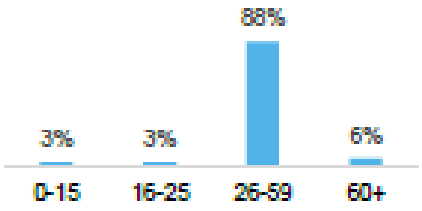
Demographic Data

Race* (n = 35)

American Indian / Alaskan Native	3%
Asian or Asian American	3%
Black / African American	9%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	26%
White	69%
Another	0%

0 did not answer this question.
0 selected "decline to state."

Age Groups (n = 34)



1 did not answer this question.
0 selected "decline to state."

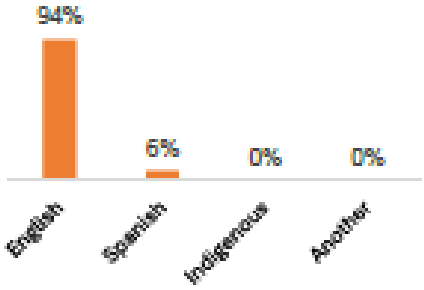
34% Hispanic/Latino
69% Non-Hispanic/Latino

Ethnicity* (n = 23)

Caribbean	4%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	30%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	4%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	4%	
European	57%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	4%	
More than one	4%	

Other Non-Hispanic/Latino includes Spanish.
12 did not answer the question.
0 selected "decline to state."

Primary Language* (n = 35)



0 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

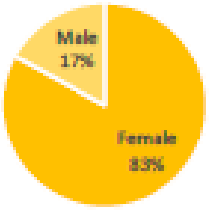
Demographic Data

Current Gender Identity* (n = 35)

Female	63%
Male	20%
Transgender	3%
Genderqueer	14%
Questioning or Unsure	14%
Another Gender Identity	11%

0 did not answer this question.
0 selected "decline to state."

Sex Assigned at Birth (n = 35)



0 did not answer this question.
0 selected "decline to state."

Sexual Orientation* (n = 33)

Bisexual	39%
Gay or Lesbian	6%
Heterosexual or Straight	55%
Queer	24%
Questioning or Unsure	6%
Another Sexual Orientation	9%

1 did not answer this question.
1 selected "decline to state."

66% of individuals reported having one or more disabilities (n = 35)

0 did not answer this question.
0 selected "decline to state."

0% of individuals identified as veterans (n = 35)

0 did not answer this question.
0 selected "decline to state."

Disability* (n = 23)

Seeing	22%
Hearing	35%
Other Communication	17%
Learning Disability	39%
Developmental Disability	30%
Dementia	0%
Another Mental Disability	9%
Physical Disability	0%
Chronic Health Condition	30%
Another Disability	22%

13 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Program Activities, Outreach, and Training

Program activities include community fair/events, workshops, education trainings, and field trips facilitated by Everyone Has a Story Book Club program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members are welcome to participate in these activities and events.

Program Activities, Outreach, and Training by Type	# Activities/ Events
Community Fair	23
Workshop	39
Education Training	5
Field Trip	1
TOTAL # of Activities/Outreach/Training	68

24,374 total participants reached†

12% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Program Outcomes

Everyone Has a Story Book Club tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 34) and Exit (n = 6)[†]

Category	Intake	Exit**
Minimal (60-40)	62%	67%
Mild (39-33)	18%	0%
Moderate (32-23)	18%	33%
Severe (22-0)	3%	0%

On average, 65% of participants reported experiencing minimal levels of distress across the two time points.

[†]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.
**Due to the small sample size, findings should be interpreted with caution. Results may not be generalizable to the broader program participants and should be considered exploratory in nature.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Program Satisfaction

Participants of Everyone Has a Story Book Club were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

# of Participants Who Strongly Agree and Agree**
(n = 6)

Statement	# Strongly Agree/Agree
It is easy to get help at this program.	6
I would recommend this program to a friend or family member.	6
Services are in the language I am most comfortable speaking.	6
Staff respect my cultural background.	6

Participants were highly satisfied with Everyone Has a Story Book Club.

**Due to the small sample size, findings should be interpreted with caution. Results may not be generalizable to the broader program participants and should be considered exploratory in nature.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support**
(n = 6)

Before I attended this program, I wanted help with...	# of Participants
My school attendance	0
My grades in school	0
My housing situation	0
My job situation	1
My relationships with friends and family	5
My parenting	1
Staying out of jail or prison	1
My mental health	4
Substance use	1

Participants reported that the primary area of need was relationships with friends and family.

**Due to the small sample size, findings should be interpreted with caution. Results may not be generalizable to the broader program participants and should be considered exploratory in nature.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Program Feedback and Successes

Participants who received program services from Everyone Has a Story Book Club were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 6)

- Social Connection/Engagement (4)
- Books (3)

What would make this program better?
(n = 6)

- Expanded Reach (2)
- Relationship-Building with Facilitators (2)

"It's been a fun experience to be around other Autistic people. Also, I'm not very social so it ensures that I talk to people outside my home regularly. It also helps me feel productive in life, having a book to read and something I can accomplish."

"Being fully funded so that we know the group can continue forever."

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EVERYONE HAS A STORY BOOK CLUB

Conclusion and Recommendations

Everyone Has a Story Book Club continued to foster a supportive community for disabled and neurodivergent adults, families, and caretakers, providing a safe space to share personal stories and engage with literature that reflects their lived experiences. The bi-monthly book club and writing workshop successfully addressed the reduction of stigma and discrimination by focusing on the voices and perspectives of people with disabilities through both reading and creative expression. Participants expressed complete satisfaction with the program, with 100% of surveyed participants indicating they would recommend the program to others and found it easy to access help when needed. Additionally, all participants reported that services were provided in their preferred language and that staff respected their cultural backgrounds, demonstrating the program's commitment to culturally responsive and accessible services.

An area of future improvement includes increasing data collection efforts to expand participation and ensure diverse representation within the group. Overall, the program demonstrated a meaningful impact in building confidence, reducing isolation, and creating opportunities for individuals with disabilities and neurodiversity to see themselves represented in literature and their community.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS
CHILDHOOD MATTERS

Childhood Matters provides educational classes to vulnerable communities by empowering parents and caregivers with the skills and knowledge needed to positively interact with their children through play. The program focuses on parent-child bonding, fostering sensory and social emotional, and identifying signs and symptoms of mental health in young children.

Program Strategies

Improve timely access to services for families in underserved populations.

Program Highlights

63 individuals received core program services

1 individual referred to mental health care and/or social support services

347 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Demographic Data

Race* (n = 60)

American Indian / Alaskan Native	2%
Asian	12%
Black / African American	3%
Native Hawaiian / Other Pacific Islander	3%
Hispanic / Latino	63%
White	23%
Another	0%

3 did not answer this question.
1 selected "decline to state."

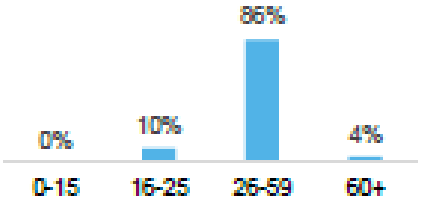
71% Hispanic/Latino
34% Non-Hispanic/Latino

Ethnicity* (n = 58)

Caribbean	2%	Hispanic
Central American	2%	
Mexican/Mex.-Am./Chicano	67%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	5%	Non-Hispanic
Asian Indian/South Asian	2%	
Cambodian	0%	
Chinese	3%	
Eastern European	2%	
European	10%	
Filipino/a	0%	
Japanese	0%	
Korean	7%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	5%	
More than one	5%	

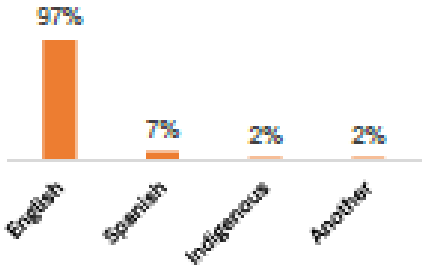
Other Non-Hispanic/Latino include Thai and Spanish.
4 did not answer the question.
1 selected "decline to state."

Age Groups (n = 49)



13 did not answer this question.
2 selected "decline to state."

Primary Language* (n = 61)



Another includes Korean.
2 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

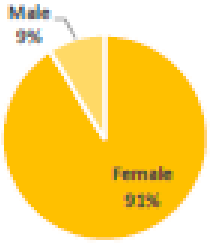
Demographic Data

Current Gender Identity* (n = 56)

Female	91%
Male	9%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

7 did not answer this question.
0 selected "decline to state."

Sex Assigned at Birth (n = 56)



7 did not answer this question.
0 selected "decline to state."

Sexual Orientation* (n = 52)

Bisexual	8%
Gay or Lesbian	0%
Heterosexual or Straight	92%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

8 did not answer this question.
3 selected "decline to state."

16% of individuals reported having one or more disabilities (n = 61)

0 did not answer this question.
2 selected "decline to state."

8% of individuals identified as veterans (n = 53)

9 did not answer this question.
1 selected "decline to state."

Disability (n = 9)

Seeing	6
Hearing	2
Other Communication	0
Learning Disability	1
Developmental Disability	0
Dementia	0
Another Mental Disability	2
Physical Disability	0
Chronic Health Condition	0
Another Disability	1

2 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Program Activities, Outreach, and Training

Program activities include educational classes facilitated by the Playful Bonds program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Class	54
TOTAL # of Activities/Outreach/Trainings	54

347 total participants reached †

0% of activities offered in Spanish

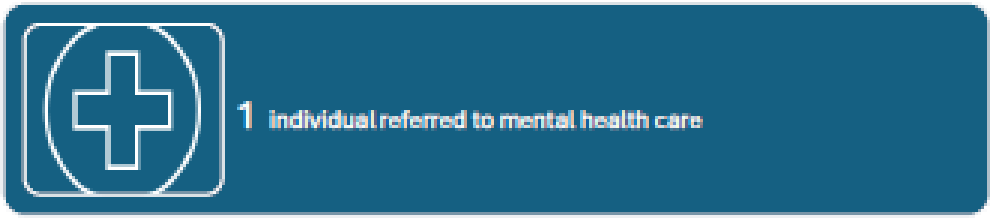
†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Program Referrals

Program referrals include mental health care and social supports, such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Program Outcomes

Playful Bonds tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 65) and Exit (n = 62)[1]

Category	Intake	Exit
Minimal (60-40)	95%	87%
Mild (39-33)	3%	8%
Moderate (32-23)	0%	3%
Severe (22-0)	2%	2%

On average, 91% of participants reported minimal levels of distress across the two time points.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Program Satisfaction

Participants of Playful Bonds were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 59-60)

Statement	% Strongly Agree/Agree
It is easy to get help at this program	98%
I would recommend this program to a friend or family member	98%
Services are in the language I am most comfortable speaking	98%
Staff respect my cultural background	98%

Participants were highly satisfied with Playful Bonds program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 47)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	0%
My grades in school	0%
My housing situation	0%
My job situation	0%
My relationships with friends and family	17%
My parenting	72%
Staying out of jail or prison	2%
My mental health	38%
Substance use	2%

Participants reported that the primary area of need was their parenting and mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PLAYFUL BONDS

Program Feedback and Successes

Participants who received program services from Playful Bonds were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 61)

- Learning about Activities/Educational Play (38)
- Socializing (18)

What would make this program better?
(n = 44)

- Adapt/Expand Program Structure (21)
- More Varied Activities (6)

"Learned strategies and skills to engage my child in activities that support her development, social skills, and motor skills. Having access to these resources in our community has made a huge impact on my child's development."

"Providing parents with an agenda of the activities for the week and the goals that the activities are supporting"

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

PLAYFUL BONDS

Conclusion and Recommendations

Through Playful Bonds, Childhood Matters successfully reached its target population of vulnerable families, empowering parents and caregivers with essential skills to support their children's development through play-based interactions. The program demonstrated strong engagement with families seeking to strengthen parent-child bonding and enhance their understanding of early childhood mental health indicators. Participants expressed high satisfaction with the program services and staff, with feedback consistently highlighting the quality of instruction and materials provided.

An area of future improvement may include expanding program accessibility by offering classes more frequently throughout the week and potentially extending sessions to weekends to accommodate working parents. Additionally, increasing the variety of activities and providing parents with agendas in advance with learning objectives could further enhance the program's impact. Overall, participants reported meaningful outcomes in their children's development, with families gaining confidence in supporting sensory and social-emotional growth during their child's critical early years.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LITTLE LISTENERS
NO LIMITS THEATER GROUP INC., DBA NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Little Listeners provides knowledge, skills, and inspiration to deaf youth and their siblings through career exploration via hands-on curriculum and parent support groups. Additionally, the program raises awareness about effective communication strategies with deaf individuals, fostering a more inclusive and informed community.

Program Strategies

Improves access and linkage to treatment

Sigma and Discrimination reduction

Program Highlights

57 individuals received core program services

1,021 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Demographic Data

Race* (n = 56)

American Indian / Alaskan Native	2%
Asian	13%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	4%
Hispanic / Latino	77%
White	14%
Another	2%

Others is not specified
1 did not answer this question.
0 selected "decline to state."

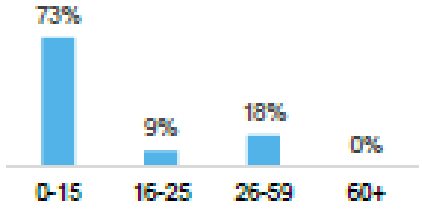
77% Hispanic/Latino
41% Non-Hispanic/Latino

Ethnicity* (n = 53)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	60%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	17%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	9%	
Eastern European	0%	
European	9%	
Filipino/a	4%	
Japanese	0%	
Korean	0%	
Middle Eastern	2%	
Vietnamese	0%	
Other Non-Hispanic/Latino	17%	
More than one	8%	

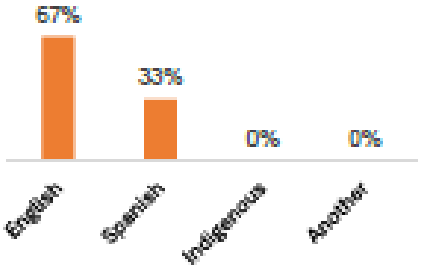
Others are not specified.
4 did not answer the question.
0 selected "decline to state."

Age Groups (n = 56)



1 did not answer this question.
0 selected "decline to state."

Primary Language* (n = 51)



6 did not answer this question.
0 selected "decline to state."

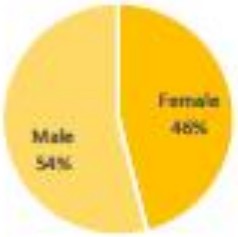
*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Demographic Data

Sex Assigned at Birth
(n = 56)



1 did not answer this question.
0 selected "decline to state."

Disability* (n = 46)

Seeing	2%
Hearing	100%
Other Communication	0%
Learning Disability	0%
Developmental Disability	0%
Dementia	0%
Another Mental Disability	0%
Physical Disability	0%
Chronic Health Condition	0%
Another Disability	0%

1 individual reported more than one disability.

84% of individuals reported having one or more disabilities (n = 56)

2 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Program Activities

Program activities include support groups, workshops, and presentations, facilitated by Little Listeners program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health, and connect community members with mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Support Groups	6
Workshops	19
Presentations	11
TOTAL # of Activities//Outreach/Trainings	36

1,021 total participants reached†

58% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Program Outcomes

The Little Listeners tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 23) and Exit (n = 29)[a]

Category	Intake	Exit
Minimal (60-40)	96%	83%
Mild (39-33)	0%	7%
Moderate (32-23)	4%	0%
Severe (22-0)	0%	10%

Among survey respondents, minimal distress decreased from 96% to 83%, while 17% reported mild or severe distress at exit compared to 4% at intake.

[a]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Program Satisfaction

Participants of Little Listeners were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 29)

Statement	% Strongly Agree/Agree
It is easy to get help at this program.	93%
I would recommend this program to a friend or family member.	93%
Services are in the language I am most comfortable speaking.	93%
Staff respect my cultural background.	93%

Participants were highly satisfied with the Little Listeners Program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 20)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	45%
My grades in school	25%
My housing situation	30%
My job situation	20%
My relationships with friends and family	40%
My parenting	50%
Staying out of jail or prison	10%
My mental health	25%
Substance use	10%

Participants reported that the primary area of needs were their parenting and school attendance.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Program Feedback and Successes

Participants who received program services from Little Listeners were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 24)

- Speech Services (14)
- Education/Resources (7)

What would make this program better?
(n = 20)

- More Frequent Sessions (6)
- Additional Services (5)

"Being able to hear my daughter say new words/sentences. She gets very motivated at times with her therapist. Also getting good advice to do at home with her."

"The program is amazing and has grown so much. It would be nice to have in-person parent classes. It would also be nice to have a family day to meet other parents and kids."

NO LIMITS FOR DEAF CHILDREN AND FAMILIES

Conclusion and Recommendations

Little Listeners provided deaf youth and their siblings with hands-on curriculum, individualized therapy services, and parent support groups. The program addressed stigma and discrimination reduction by raising awareness about effective communication strategies with deaf individuals. Additionally, the program improved access and linkage to treatment by connecting families with resources and support networks, particularly regarding school services and accommodations. Participants reported high satisfaction with program services, with 93% indicating they would recommend the program to others, found it easy to access help, received services in their preferred language, and felt staff respected their cultural backgrounds. Participants valued the one-on-one attention for speech development, practical guidance for home activities, and opportunities to connect with other families.

External stressors during may have contributed to the observed changes in distress levels, particularly the increase in severe distress from 0% to 10% and the shift in mild distress categories. Families faced significant challenges related to policy changes and increased enforcement activity in their communities, which created heightened fear and uncertainty for parents and children. Given these contextual factors, it is recommended that providers incorporate stress management methods and techniques into program services to help families better cope and build resilience.

Another area of future improvement may include increasing session frequency, as participants requested more days per week. Additionally, participants suggested offering in-person parent classes and family events to strengthen community connections. Expanding the program's reach to serve more families and incorporating extracurricular activities such as theater, sports, and music in various communities would also enhance the program's impact. Overall, the program provided essential speech and literacy services to deaf youth while equipping parents with practical strategies and a supportive community.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS
NYELAND PROMISE

Comadres Unidas assists Latina women farm workers in Nyeland Acres to reduce stress, anxiety, and depression by providing yoga, educational workshops, art classes and music. Program participants also engage in new experiences, like going to a movie theater and developing friendships with community peers.

Program Strategies

Improves access and linkage to services

Improve timely access linkage to services for underserved populations.

Program Highlights

36 individuals received core program services

685 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Demographic Data

Race* (n = 34)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	97%
White	3%
Another	0%

1 did not answer this question.
1 selected "decline to state."

100% Hispanic/Latino
0% Non-Hispanic/Latino

Ethnicity* (n = 34)

Hispanic

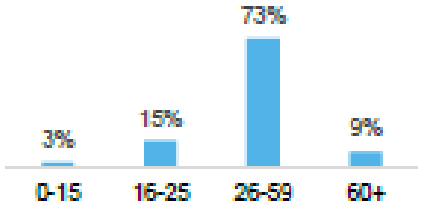
Caribbean	0%
Central American	3%
Mexican/Mex.-Am./Chicano	97%
Puerto Rican	0%
South American	0%
Other Hispanic/Latino	0%

Non-Hispanic

African	0%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	0%
Filipino/a	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
More than one	0%

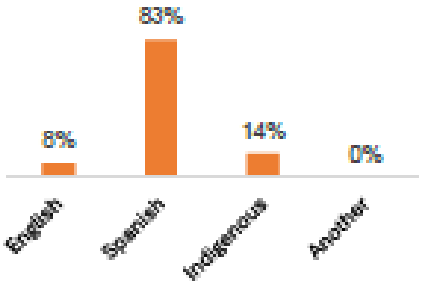
2 did not answer the question.
0 selected "decline to state."

Age Groups (n = 33)



3 did not answer this question.
0 selected "decline to state."

Primary Language* (n = 36)



0 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

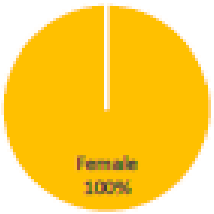
Demographic Data

Current Gender Identity* (n = 35)

Female	100%
Male	0%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

1 did not answer this question.
0 selected "decline to state."

Sex Assigned at Birth (n = 35)



1 did not answer this question.
0 selected "decline to state."

Sexual Orientation* (n = 34)

Bisexual	6%
Gay or Lesbian	0%
Heterosexual or Straight	94%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

0 did not answer this question.
2 selected "decline to state."

8% of individuals reported having one or more disabilities (n = 36)

0 did not answer this question.
0 selected "decline to state."

3% of individuals identified as veterans (n = 33)

3 did not answer this question.
0 selected "decline to state."

Disability (n = 3)

Seeing	1
Hearing	1
Other Communication	0
Learning Disability	2
Developmental Disability	0
Dementia	0
Another Mental Disability	0
Physical Disability	1
Chronic Health Condition	0
Another Disability	1

1 individual reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Program Activities, Outreach, and Trainings

Program activities include classes, community fair/events, general meetings, presentations, and workshops facilitated by Comadres Unidas program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Community Fair/Event	2
Class	16
General Meeting	1
Presentation	1
Workshop	9
TOTAL # of Activities/Outreach/Trainings	29

685 total participants reached†

100% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Program Outcomes

Comadres Unidas tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 34) and Exit (n = 26)[1]

Category	Intake	Exit
Minimal (60-40)	88%	96%
Mild (39-33)	3%	0%
Moderate (32-23)	6%	4%
Severe (22-0)	3%	0%

Distress levels improved, with minimal distress increasing from 88% to 96% and severe distress declining to 0% at exit.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Program Satisfaction

Participants of Comadres Unidas were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 25)

Statement	% Strongly Agree/Agree
Staff respect my cultural background.	100%
Services are in the language I am most comfortable speaking.	100%
I would recommend this program to a friend or family member.	100%
It is easy to get help at this program.	100%

Participants were highly satisfied with the Comadres Unidas program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 23)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	70%
My grades in school	43%
My housing situation	13%
My job situation	26%
My relationships with friends and family	78%
My parenting	30%
Staying out of jail or prison	9%
My mental health	87%
Substance use	0%

Participants reported that the primary areas of need were their mental health and relationships with friends and family.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Program Feedback and Successes

Participants who received program services from Comadres Unidas were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 23)

- Socialization/Community (18)
- Exercise/Health Benefits (7)

What would make this program better?
(n = 21)

- Continue/Expand Program (17)

"This program has been helpful for me in learning techniques and exercises to feel better physically and mentally and making new friends."

"Bring more activities to the community, including youth, children, and adults."

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMADRES UNIDAS

Conclusion and Recommendations

Comadres Unidas engaged Latina women farmworkers in Nyeland Acres through yoga, educational workshops, art classes, and music activities to reduce stress, anxiety, and depression. The program improved access and linkage to services for underserved populations by providing culturally relevant programming and connecting participants with community resources. Participants also attended community outings, such as movie theaters, and developed friendships with peers. They reported high satisfaction with the program, with 100% indicating they would recommend the program to others, found it easy to access help, received services in their preferred language, and felt staff respected their cultural backgrounds.

An area of future improvement may include expanding program frequency and variety, as participants requested more days of activities per week, particularly Zumba classes. Additionally, participants suggested including activities for parents and children to participate in together and incorporating youth and families into community events. Overall, the program provided wellness services and opportunities for social connection to Latina farmworkers in Nyeland Acres.

[illegible] reached may be duplicated because individuals could attend multiple activities/events

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS
TWO TREES COMMUNITY

Westside Wellness is a prevention program designed to help Latinas/Latinos ages 9-15 and parents of youth cope with suicidal ideation and prevent self-harm. The program consists of support groups where youth can talk about problems among peers of similar backgrounds and focus on mindfulness practices, emotion regulation, interpersonal skills, and distress tolerance skills. Group therapy is based on Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). CBT focuses on how thoughts and behaviors influence each other and is beneficial for anxiety and obsessive-compulsive disorders. DBT focuses on mindfulness practice and emotion regulation and is helping to reduce suicidal ideation and self-harm.

Program Strategies

Improves timely access to services for underserved populations

Provides access and linkage to services

Program Highlights

41 individuals received core program services

2 individuals referred to mental health care and/or social support services

312 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Demographic Data

Race* (n = 41)

American Indian / Alaskan Native	7%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	95%
White	5%
Another	0%

0 did not answer this question.
0 selected "decline to state."

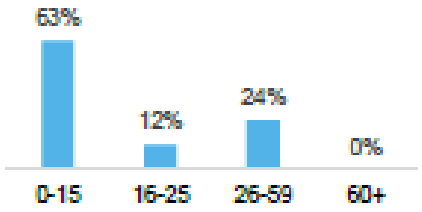
100% Hispanic/Latino
0% Non-Hispanic/Latino

Ethnicity* (n = 38)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	97%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	3%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

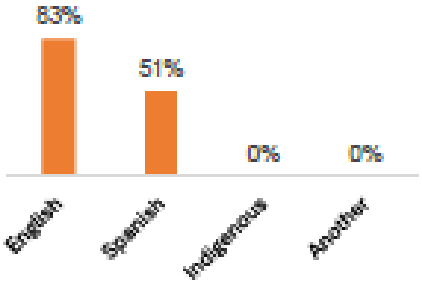
Other is Peruvian Mexican.
1 did not answer the question.
2 selected "decline to state."

Age Groups (n = 41)



0 did not answer this question.
0 selected "decline to state."

Primary Language* (n = 41)



0 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

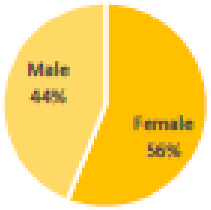
Demographic Data

Current Gender Identity* (n = 39)

Female	59%
Male	36%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	5%
Another Gender Identity	0%

0 did not answer this question.
2 selected "decline to state."

Sex Assigned at Birth (n = 41)



0 did not answer this question.
0 selected "decline to state."

Sexual Orientation* (n = 30)

Bisexual	7%
Gay or Lesbian	0%
Heterosexual or Straight	87%
Queer	3%
Questioning or Unsure	3%
Another Sexual Orientation	3%

1 did not answer this question.
10 selected "decline to state."

13% of individuals reported having one or more disabilities (n = 40)

0 did not answer this question.
1 selected "decline to state."

2% of individuals identified as veterans (n = 41)

0 did not answer this question.
0 selected "decline to state."

Disability (n = 5)

Seeing	1
Hearing	0
Other Communication	0
Learning Disability	4
Developmental Disability	0
Dementia	0
Another Mental Disability	1
Physical Disability	1
Chronic Health Condition	0
Another Disability	4

3 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Program Activities

Program activities include support groups facilitated by the Westside Wellness program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities by Type	# Activities/ Events
Support Group	38
TOTAL # of Activities	38

312 total participants reached†

37% of activities offered in Spanish

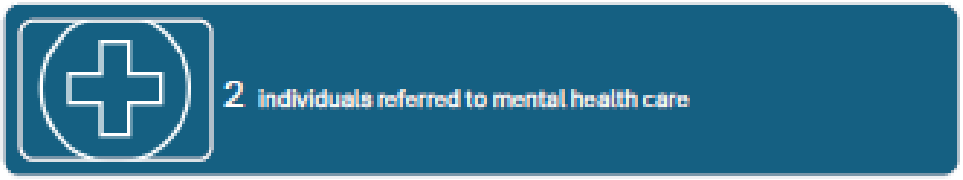
†Number of people reached may be duplicated because individuals could attend multiple activities/events.

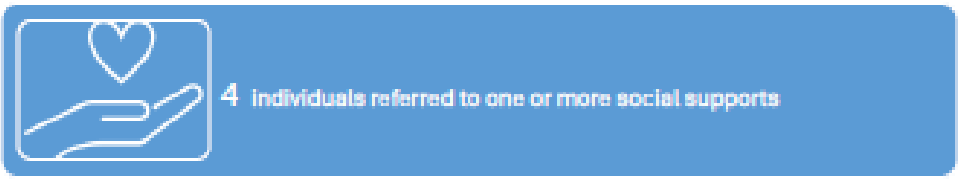
VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

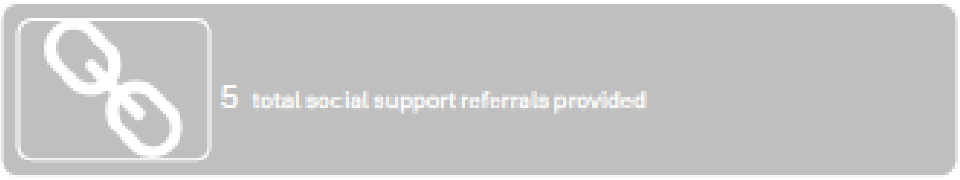
WESTSIDE WELLNESS

Program Referrals

Program referrals include referrals to mental health care and social supports such as food, housing, health insurance, and other support services. Individuals could be referred to multiple services.







VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Program Outcomes

Westside Wellness tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 63) and Exit (n = 47)[1]

Category	Intake	Exit
Minimal (60-40)	59%	60%
Mild (39-33)	17%	19%
Moderate (32-23)	22%	11%
Severe (22-0)	2%	11%

Minimal distress remained stable at approximately 60%, moderate distress decreased from 22% to 11%, while severe distress increased from 2% to 11%.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–58), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Program Satisfaction

Participants of Westside Wellness were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 46-47)

Statement	% Strongly Agree/Agree
Staff respect my cultural background.	98%
Services are in the language I am most comfortable speaking.	98%
I would recommend this program to a friend or family member.	96%
It is easy to get help at this program.	98%

Participants were highly satisfied with the Westside Wellness program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 38)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	16%
My grades in school	24%
My housing situation	18%
My job situation	18%
My relationships with friends and family	63%
My parenting	26%
Staying out of jail or prison	13%
My mental health	79%
Substance use	16%

Participants reported that the primary areas of need were their mental health and relationships with friends and family.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Program Feedback and Successes

Participants who received program services from Westside Wellness were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 43)

- Socialization (10)
- Learning New Skills/Strategies (7)

What would make this program better?
(n = 38)

- Expand Programming (14)
- More Learning Activites (8)

"The talking, getting out of the house, and building new relationships."

"To offer more of these classes would be helpful."

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

WESTSIDE WELLNESS

Conclusion and Recommendations

Westside Wellness provided 38 support group sessions for Latino youth ages 9-15 and their parents to address suicidal ideation and self-harm. The support groups improved timely access to mental health services for underserved populations by creating spaces where youth could discuss problems with peers of similar backgrounds. The program used Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) techniques to teach mindfulness practices, emotion regulation, interpersonal skills, and distress tolerance skills to help reduce suicidal ideation and self-harm. Participants reported high satisfaction, with 96% indicating they would recommend the program to others, and 98% reporting it was easy to access help, services were provided in their preferred language, and staff respected their cultural backgrounds.

An area of future improvement may include extending program duration, as participants requested longer sessions and additional months of programming. Additionally, participants suggested increasing enrollment to spread awareness about mental health resources. Some participants recommended separating groups by age and maturity level to facilitate more focused discussions and provide interpretation services to enhance accessibility. Overall, the program offered mental health support and skill-building to Latino youth and families in underserved communities.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM
BOYS & GIRLS CLUBS OF GREATER OXNARD AND PORT HUENEME

The Be Kind Program engages underserved youth ages 6-18 through workshops. Topics include developing an understanding of the value, impact, and importance of kindness; understanding respect, empathy, and consideration; developing strategies to understand their thoughts and emotions; and understanding the power of being present in the moment. Participants receive materials to continue these practices and build upon learned skills, as well as resources and linkages for mental health wellness.

Program Strategies

Stigma and discrimination reduction

Program Highlights

28 individuals received core program services

211 individuals reached through outreach events[1]

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Demographic Data

Race* (n = 27)

American Indian / Alaskan Native	7%
Asian	0%
Black / African American	7%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	93%
White	4%
Another	0%

0 did not answer this question.
1 selected "decline to state."

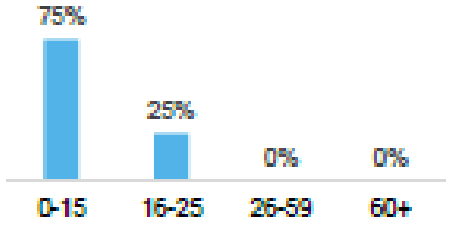
98% Hispanic/Latino
12% Non-Hispanic/Latino

Ethnicity* (n = 27)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	96%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	4%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	4%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	4%	
More than one	7%	

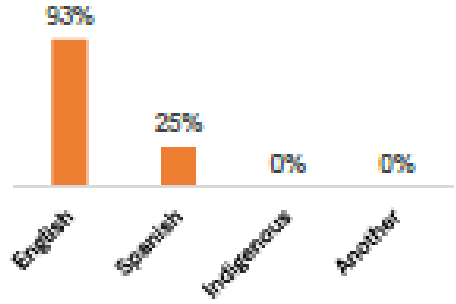
Other Non-Hispanic/Latino includes Native Hawaiian.
0 did not answer the question.
1 selected "decline to state."

Age Groups (n = 28)



0 did not answer this question.
0 selected "decline to state."

Primary Language* (n = 28)



0 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

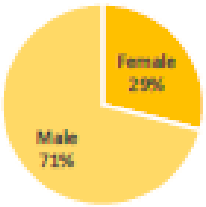
Demographic Data

Current Gender Identity* (n = 28)

Female	25%
Male	75%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

0 did not answer this question.
0 selected "decline to state."

Sex Assigned at Birth (n = 28)



0 did not answer this question.
0 selected "decline to state."

Sexual Orientation* (n = 27)

Bisexual	11%
Gay or Lesbian	0%
Heterosexual or Straight	89%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

0 did not answer this question.
1 selected "decline to state."

14% of individuals reported having one or more disabilities (n = 28)

0 did not answer this question.
0 selected "decline to state."

4% of individuals identified as veterans (n = 28)

0 did not answer this question.
0 selected "decline to state."

Disability (n = 4)

Seeing	1
Hearing	1
Other Communication	0
Learning Disability	2
Developmental Disability	0
Dementia	0
Another Mental Disability	0
Physical Disability	0
Chronic Health Condition	0
Another Disability	0

0 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Program Activities, Outreach, and Training

Program activities include workshops and events facilitated by Be Kind Program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, and Training by Type	# Activities/ Events
Workshop	29
Event	1
TOTAL # of Activities/Outreach/Trainings	30

211 total participants reached†

0% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Program Outcomes

The Be Kind Program tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 26) and Exit (n = 17)[1]

Category	Intake	Exit
Minimal (60-40)	35%	94%
Mild (39-33)	23%	0%
Moderate (32-23)	31%	6%
Severe (22-0)	12%	0%

On average, 65% of participants reported experiencing minimal levels of distress across the two time points. Notably, the program demonstrated exceptional positive movement, with minimal distress increasing significantly, while moderate and severe distress dropped substantially by exit.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–59), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Program Satisfaction

Participants of Be Kind Program were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 15-16)

Statement	% Strongly Agree/Agree
It is easy to get help at this program.	87%
I would recommend this program to a friend or family member.	93%
Services are in the language I am most comfortable speaking.	94%
Staff respect my cultural background.	100%

Participants were highly satisfied with the Be Kind Program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 16)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	31%
My grades in school	6%
My housing situation	25%
My job situation	0%
My relationships with friends and family	63%
My parenting	13%
Staying out of jail or prison	44%
My mental health	63%
Substance use	19%

Participants reported that the primary areas of need were their relationships with friends and family and mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Program Feedback and Successes

Participants who received program services from Be Kind Program were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 16)

- Discussions/Reflections (5)
- Social Skill Development (4)

What would make this program better?
(n = 17)

- Program Expansion (5)
- More Activities (5)

"When we talk about everything we learned, and it was hopeful"

"Talking about each problem at each school"

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

BE KIND PROGRAM

Conclusion and Recommendations

The Be Kind Program successfully engaged underserved youth aged 6-18 in workshops focused on developing kindness, empathy, and emotional regulation skills. The program effectively addressed the reduction of stigma and discrimination by equipping young participants with tools to understand their thoughts and emotions, while fostering respect and consideration for others. This was further reflected in the program's exceptional SOS outcome scores, where minimal distress increased significantly from 35% at intake to 94% at exit, while moderate and severe distress both dropped substantially by exit. Participants expressed high levels of satisfaction with the program, with 93% indicating that they would recommend it to others, and 100% reporting that the staff respected their cultural backgrounds.

An area of future improvement could include multimedia instructional methods by incorporating more experiential learning opportunities, such as field trips, to increase engagement. Additionally, participants suggested expanding the number of sessions and topics covered, as well as providing refreshments during workshops to create a more welcoming environment. Overall, the program demonstrated meaningful impact by providing youth with both immediate skills for emotional wellness and ongoing resources for continued mental health support, including materials to practice learned strategies and linkages to additional mental health services.

[*]Percentages may exceed 100% because participants could choose more than one response option.
[†]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY BIRD COPING SKILLS
VENTURA COUNTY GIRL SCOUTS

The Girl Scouts' Early Bird Skills' "Be a Better You" kit empowered young girls by teaching them essential tools for emotional well-being and resilience. Participants learned to effectively manage stress and difficult situations using a range of strategies, including breathing exercises, physical activity, positive self-talk, and more. The "Be a Better You" Kit ensured girls had resources to practice these skills with the support of adults or peers, culminating in a sticker reward for skill mastery, all while emphasizing the importance of mental health and self-care.

Program Strategies

Provide strategies for managing stress and navigating life challenges

Program Highlights

5,600 individuals received core program services

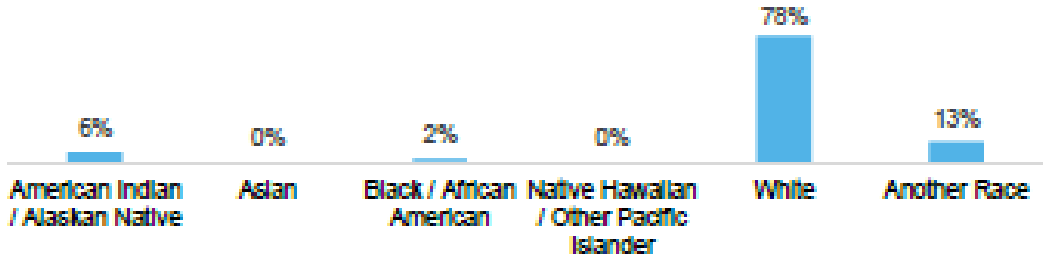
[1]Percentages may exceed 100% because participants could choose more than one response option.
[2]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY BIRD COPING SKILLS

Demographic Data

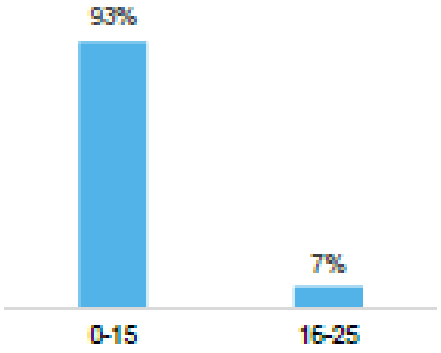
Race (n = 853)



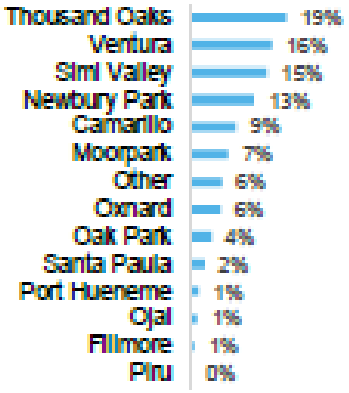
Ethnicity* (n = 841)

19% Hispanic/Latino
81% Non-Hispanic/Latino

Age Groups (n = 1,486)



City of Residence (n = 1,486)



*Percentages may exceed 100% because participants could choose more than one response option.
†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY BIRD COPING SKILLS

Program Outcomes

The Girl Scouts' Early Bird Skills program tracks outcomes through participant self-assessment of their knowledge and skill application after using the "Be a Better You" kit. Survey results are presented in the tables below.

% of Participants with Knowledge/Some Knowledge of Coping Skills Before Using "Be a Better You" Kit (n = 26-27)

Coping Skill	% Knowledge/Some Knowledge
Breathing exercises	89%
Exercise	96%
Creating artwork	96%
Reading a book	96%
Playing a game	81%
Yoga and stretching	92%
Playing music	88%
Watching a funny video	69%
Learning positive self-talk	81%
Asking for help	92%
Creating a "calm down" kit	63%
Engaging in problem-solving	69%

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY BIRD COPING SKILLS

% of Participants Reporting Confidence in Emotional Management and Help-Seeking (n = 26-27)

Skill or Behavioral Intention	% Yes or Definitely
I feel like I know what to do when something makes me upset	88%
I feel like I can ask for help if something is bothering me	96%
If my friend needed help, I would share the skills I have learned	74%

Program Satisfaction

Participants who engaged with the Early Bird Skills "Be a Better You" kit were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who agreed with each statement.

% of Participants Who Agreed (n = 26)

Statement	% Agree
The Coping Skills Kit helped me be a better me.	69%
I feel confident using the skill(s) I learned.	81%
I think my friends would like this program.	81%

Participants were satisfied with Early Birds Skills "Be a Better You" kit.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY BIRD COPING SKILLS

Conclusion and Recommendations

The Girl Scouts' Early Bird Skills "Be a Better You" kit reached approximately 5,600 young girls, providing them with essential strategies to navigate their emotional well-being. The outcome results were highly encouraging, indicating majority of participants were able to manage challenging feelings, willingly seek support, and share new skills with others after completing the kit lessons. Participants were also satisfied with the kit. Data is currently being collected for the "Be Tolerant, Be Kind, Celebrate Who We Are" kit, which emphasizes positive affirmations and tolerance, fostering kindness and understanding among participants. These outcomes will be shared in the next reporting cycle.

Future recommendations for the Early Bird Skills program include collecting more detailed demographic data and increasing survey completion rates. These enhancements will provide a more precise understanding of the population served and the program's success.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

EARLY INTERVENTION

The purpose of the Early Intervention component of MHSA is to intervene early in the emergence of symptoms of mental illness to reduce negative outcomes and foster positive recovery and functional outcomes. Ventura County funds seven Early Intervention programs that provide crisis stabilization, family support, group and individual therapy, assessment and screening, educational and vocational services, and outreach and education. These Early Intervention services promote wellness, foster health, and prevent suffering that can result from untreated mental illness. Early Intervention programs may include services to the family and caregivers of the person with early onset of a mental illness. A total of 819 individuals were served in Early Intervention programs in FY 2024–2025.

Early Intervention Program Descriptions

COMPASS: A short-term residential program for youth ages 12 to 17 transferring from the Crisis Stabilization Unit. Services include individual and family therapy, case management, psychiatric care, medication support and assessment to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community.

Mental Health First Aid: Provides training to identify, understand and respond to mental health and substance use challenges.

One Step a la Vez Bienestar: Offers assessment, individual therapy, case management, group sessions, and care coordination to you 12-19 years at risk of or experiencing mental health issues.

Primary Care Program: Provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers.

Pathways of Hope: Provides alternative therapeutic practices, community building, and guidance to higher education opportunities to youth exposed to trauma.

Tri-County Glad – Early Intervention and Supporting Services: Supports the deaf and hard of hearing in accessing early intervention mental health services by reducing language barriers.

Ventura County Power Over Prodromal Psychosis (VCPOP, formerly EDIPP): Conducts community outreach and education to community members about early warning signs of psychosis; provides a two-year intervention program with services and supports.

819	individuals received core program services[+]
2	individuals referred to mental health care and/or social support services[+]
600	individuals reached through outreach events[+]

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Early Intervention Programs: Demographics of Participants

Ethnicity*	(n = 407)
Hispanic	80%
Non-Hispanic	20%
More than one ethnicity	1%
Declined to answer: 5	

Age§	(n = 472)
0–15	13%
16–25	60%
26–59	27%
60+	1%
Declined to answer: 14	

Primary Language*	(n = 653)
English	64%
Spanish	33%
Indigenous	2%
Another language	<1%
Declined to answer: 0	

Sex Assigned at Birth§	(n = 360)
Female	71%
Male	29%
Declined to answer: 0	

Sexual Orientation	(n = 303)
Bisexual	5%
Gay or Lesbian	3%
Heterosexual or Straight	90%
Queer	<1%
Questioning or Unsure	0%
Another sexual orientation	2%
Declined to answer: 18	

Hispanic Ethnicities^			(n = 53)
Mexican	89%	South American	4%
Central American	4%	Caribbean	2%
Puerto Rican	0%	Another Hispanic	2%

Non-Hispanic Ethnicities^			(n = 8)
African	0%	Asian Indian/ South Asian	0%
Cambodian	0%	Chinese	0%
Eastern European	0%	European	88%
Filipino	0%	Japanese	0%
Korean	0%	Middle Eastern	0%
Vietnamese	0%	Another Non-Hispanic	13%

Race*	(n = 473)
American Indian/Alaska Native	2%
Asian	1%
Black/African American	2%
Hispanic/Latino	10%
Native Hawaiian/Pacific Islander	<1%
White	59%
Another race	24%
More than one	1%
Declined to answer: 3	

Current Gender Identity	(n = 326)
Female	46%
Male	51%
Genderqueer	<1%
Questioning or Unsure	0%
Transgender	2%
Another gender identity	1%
Declined to answer: 1	

City of Residence§					(n = 66)
Camarillo	8%	Fillmore	29%	Moorpark	0%
Newbury Park	0%	Oak Park	0%	Ojai	3%
Oxnard	26%	Piru	0%	Port Hueneme	3%
Santa Paula	5%	Simi Valley	0%	Thousand Oaks	0%
Ventura	27%	Other	0%		

*Percentages may add to or exceed 100% because participants could choose more than one response option.
§Age and city of residence data were not reported for Primary Care Program. Assigned sex and city of residence data were not reported for COMPASS and VCPOP.
^Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMPASS
SENECA FAMILY OF AGENCIES

Comprehensive Assessment and Stabilization Services (COMPASS) is a short-term residential program offered as part of the continuum of care for youth ages 12 to 17 transferring from the Crisis Stabilization Unit and Ventura County Behavioral Health clinics. This program provides comprehensive clinical services to assist youth and their caregivers in gaining the stability and skills needed to safely return to the community. Services include individual and family therapy, case management, psychiatric care, medication support and assessment. The goals of the program are to provide safety and containment while identifying the determinants of the current crisis, assist youth and caregivers in the development of alternative skills and replacement behaviors, create comprehensive aftercare plans that include community linkages, and provide in-depth evaluations that will guide treatment and/or placement decisions along with long-term treatment recommendations. A psychiatrist or tele-psychiatrist is on call 24/7.

Program Strategies

Increases access and linkage to treatment for youth with severe mental illness by stabilizing those in crisis and providing mental health care.

Improves timely access to services for underserved populations by focusing on youth in an essential window of time to prevent and intervene in mental illness.

Program Highlights

18 individuals received core program services

16 days, average length of stay

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

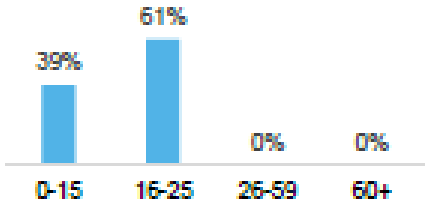
COMPASS

Demographic Data

Race (n = 18)

American Indian / Alaskan Native	17%
Asian	%
Black / African American	6%
Native Hawaiian / Other Pacific Islander	0%
Latino	0%
White	38%
Another	39%

Age Groups (n = 18)

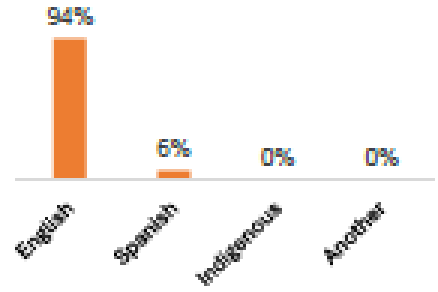


Ethnicity
(n = 18)

53% Hispanic/Latino
47% Non-Hispanic/Latino

No individuals identified as veterans
(n = 18)

Primary Language (n = 18)



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMPASS

Demographic Data

Current Gender Identity (n = 18)	
Female	77%
Male	17%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	6%

Sexual Orientation (n = 4)	
Bisexual	0
Gay or Lesbian	1
Heterosexual or Straight	3
Queer	0
Questioning or Unsure	0
Another Sexual Orientation	0

14 unknown/not reported.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMPASS

Program Activities

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by COMPASS program staff. Program participants and their support system may participate in these activities and events.

Program Activities by Type	# Activities/ Events	Average # of Participants
Assessments/Evaluation	556	1.3
Crisis Intervention	848	1.4
Mental Health Evaluation and Management	1,611	1.2
Individual/Group Therapy	95	1.0
Medication Management	588	1.4
Psychotherapy	910	1.3
Plan Development	308	1.4
Outreach	320	1.2
Paperwork Completion	217	1.4
Rehab Service	452	1.3
Targeted Case Management	308	1.4
Transportation/Travel	235	1.2
Whatever It Takes Support	116	1.0
Other*	2,974	1.3
TOTAL # of Activities/Events	9,514	

COMPASS had **12,280** service/activity contacts in FY 2024 – 2025†

*Service/activity contacts represent the number of times individuals engaged with program activities/events.

*Therapeutic, prophylactic, or diag injection-subcutaneous or intramuscular; behavioral health prevention education service-prev; client non-billable enc must document; consult, interactive complexity; medical team conference, participation by non-physician (TTF with pt and/or family; Pt and/or fam not present); medical team conference, participation by physician (pr and/or fam not present); non-billable attempted contact; office consultation for new or established patient; office or other outpatient visit for established patient; of new patient; prolonged clinical staff service, first hour; prolonged group service(s) beyond the maximum time; prolonged office or other outpatient E&M service(s) beyond the maximum time; psychoeducational service; self-help/peer services; subsequent hospital care, per day, for the E&M of a patient; telephone E&M service

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

COMPASS

Conclusion and Recommendations

The COMPASS program continues to effectively serve as a critical bridge for youth transitioning from crisis care to community re-entry. The program offers a safe and structured environment with targeted clinical support for youth ages 12 to 17. COMPASS is successfully addressing immediate crisis and long-term stabilization as demonstrated by the high utilization of mental health evaluation/management, psychotherapy, and crisis intervention services.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

The One Step a la Vez Bienestar program offers services including assessment, individual therapy, case management, group sessions and care coordination to support 12-19-year-olds at risk of or with emerging mental health issues, including those with early depression or anxiety. Most participants originated from the OSALV Conocimiento drop-in program and were assessed on the PHQ-9 scale and other indicators for the Bienestar program. Therapy and case management are short-term (fewer than 18 months) with the goal of preventing more severe, long-term mental health issues.

Program Strategies

Preventing more severe mental health issues among underserved populations by reaching youth, TAY, and Latinos/as who might not otherwise get help.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent and LGBTQ+-sensitive services, workshops, and presentations.

Program Highlights

21 individuals received core program services

2 individuals were referred to mental health care and/or social support services

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

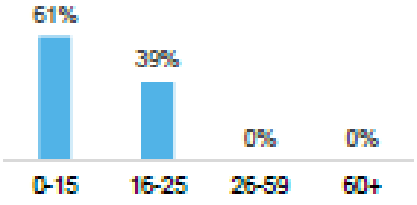
ONE STEP A LA VEZ BIENESTAR

Demographic Data

Race (n = 18)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Latino	100%
White	0%
Another	0%

Age Groups (n = 18)

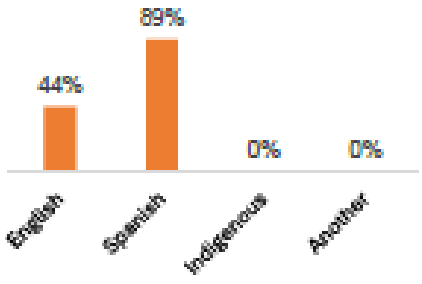


100% Hispanic/Latino

Ethnicity (n = 18)

Caribbean	0%	Hispanic
Central American	0%	
Mexican/Mex.-Am./Chicano	100%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	0%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

Primary Language* (n = 18)



*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

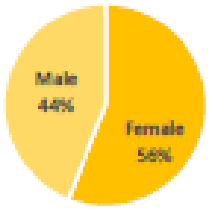
Demographic Data

Current Gender Identity (n = 17)

Female	59%
Male	41%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

1 did not answer this question.

Sex Assigned at Birth (n = 18)



Sexual Orientation (n = 18)

Bisexual	0%
Gay or Lesbian	0%
Heterosexual or Straight	100%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

No individuals reported having a disability (n = 18)

No individuals identified as veterans (n = 18)

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Program Referrals

Program referrals include referrals to mental health care and social supports such as food, housing, health insurance, and other essential services. Individuals could be referred to multiple services.

2 individuals referred to mental health care

Program Activities

Program activities include support groups, staff training, and field trips.

Program Activities by Type	# Activities/ Events
Celebration	1
Food Distribution	2
Field Trip	3
Staff Training	4
Support Group	14
TOTAL # of Activities/Events	24

es

38% of activities offered in Spanish

43 participants in program activities†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Program Outcomes

One Step a La Vez tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Patient Health Questionnaire-9 (PHQ-9), a 9-item measure of depression symptom severity. Higher scores on this measure indicate greater severity of depressive symptoms. Only intake scores were available at this time in the program.

Categorization of PHQ-9 Scores at Intake (n = 22)[1]

Category	Intake
Minimal	36%
Mild	14%
Moderate	36%
Moderately Severe	9%
Severe	5%

On average, participants reported experiencing mild or moderate levels of depression at program intake.

[1]Total score on the PHQ-9 ranges from 0–27 and scores are categorized as minimal (0–4), mild (5–9), moderate (10–14), or moderately severe (15–19), and severe (20–27) levels of depression. Exit data were not available for this evaluation period, limiting assessment of program outcomes.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Program Outcomes

Participant outcomes are also assessed at program entry and exit using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower psychological distress. Only exit scores were available at this time in the program.

Categorization of SOS-10 Scores at Exit (n = 14)[1]

Category	Exit
Minimal	7%
Mild	21%
Moderate	50%
Severe	21%

At program exit, half of participants reported moderate distress levels, with an additional 21% reporting severe distress.

Half of the participants have been receiving services from OSALV Bienestar between 4 months to 1 year.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress. Intake data were not available for this evaluation period.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Program Satisfaction

Participants of One Step a La Vez Bienestar were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n =14)

Statement	% Agree
It is easy to get help at this program.	100%
I would recommend this program to a friend or family member.	100%
Services are in the language I am most comfortable speaking.	100%
Staff respect my cultural background.	100%

Participants were highly satisfied with the One Step a La Vez Bienestar program.

ONE STEP A LA VEZ BIENESTAR

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 14)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	79%
My grades in school	71%
My housing situation	21%
My job situation	7%
My relationships with friends and family	64%
My parenting	0%
Staying out of jail or prison	50%
My mental health	79%
Substance use	14%

Participants reported that the primary areas of need were their school attendance and mental health.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Program Feedback and Successes

Program participants were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by themes, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program activity?
(n = 14)

- Talking to Someone/ Advice (9)
- Feeling Understood/ Accepted (4)

What would make this program activity better?
(n = 8)

- No Recommendations (7)

"[The] program has benefited me and given a positive impact on me and my mental health."

"Bienestar program has helped me regulate my emotions and has provided (...) someone for me to talk to and has helped keep my grades on track and as well as keeping me updated on what is happening at the One Step."

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ONE STEP A LA VEZ BIENESTAR

Conclusion and Recommendations

One Step a La Vez Bienestar continued to serve their target population, with all participants identifying as Hispanic/Latino children and youth. The program offered various activities such as field trips and support groups. Many of these activities were also offered in Spanish. Participants were experiencing mild levels of depressive symptoms upon entry into the program from OSALV Conocimiento. Program staff work diligently to build trust and rapport with youth, leading to positive outcomes as indicated by participant testimonies. One Step a La Vez Bienestar can bolster these testimonies with quantitative data from the PHQ-9 and SOS-10 at program entry and exit.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM
CLINICAS DEL CAMINO REAL, INC.

Primary Care Program provides assessment, individual and group therapy, case management, and care coordination between primary health and behavioral health providers. Primary Care Program works with clients ages 12 and older who may be experiencing depression and/or anxiety and is able to refer them to appropriate mental health services in a timely manner. They can also provide immediate interventions to reduce clients' risks of developing other severe mental health conditions. Additionally, the program provides evidence-based services to individuals who would otherwise not have access by delivering services at multiple locations throughout Ventura County, with the goal of increasing service access to underserved populations, including those who do not have reliable transportation.

Program Strategies

Provides access and linkage to services through screening assessment, referrals to appropriate treatment, and care coordination.

Improves timely access to services for underserved populations by providing services at 16 locations across the county.

Program Highlights

296 individuals received core program services

5 point decrease in average participant depression severity scores on the PHQ-9 measure

4.4 point decrease in average participant anxiety severity scores on the GAD measure

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM

Demographic Data

Race* (n = 183)

American Indian / Alaskan Native	0%
Asian/Pacific Islander	1%
Black / African American	1%
Native Hawaiian	0%
White (include Hispanic)	96%
More than one race	2%
Another	0%

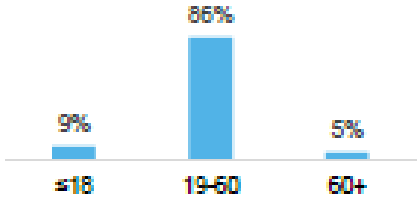
113 unknown/not reported.

Ethnicity
(n = 117)

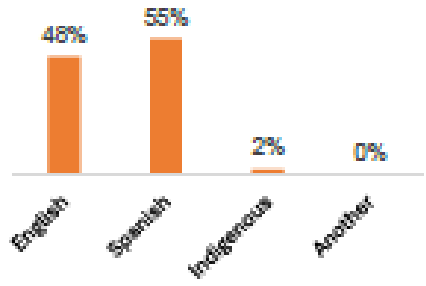
83% Hispanic/Latino
17% Non-Hispanic/Latino

179 not available.

Age Groups (n = 296)



Primary Language* (n = 296)



*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM

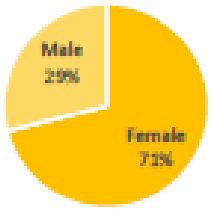
Demographic Data

Current Gender Identity (n = 97)

Female	82%
Male	18%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

199 not available.

Sex Assigned at Birth (n = 295)



1 Unknown.

Sexual Orientation (n = 225)

Bisexual	5%
Gay or Lesbian	3%
Heterosexual or Straight	90%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	2%

71 not available.

<1% of individuals identified as veterans (n = 281)

15 not collected.

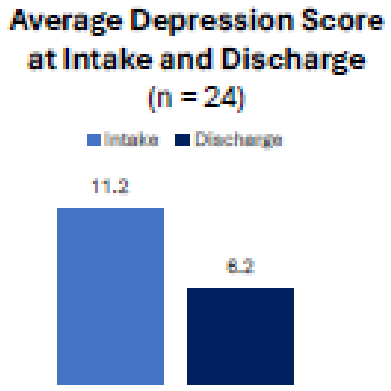
VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

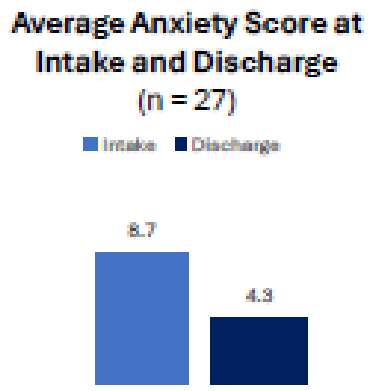
PRIMARY CARE PROGRAM

Program Outcomes

Primary Care Program tracks outcomes using the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder scale (GAD-7) as measures of depression and generalized anxiety, respectively. Average scores across participants at intake and discharge are summarized below for patients discharged from services in FY 2023–2024.

- At intake, average PHQ-9 scores suggest that, overall, participants had moderate levels of depression, but at discharge there were mild levels of depression. Participants experienced a 5-point decrease in depression symptoms.
- At intake, average GAD-7 scores suggest that, overall, participants had moderate levels of anxiety, but at discharge there were minimal to no levels of anxiety. Participants experienced a 4.4-point decrease in anxiety symptoms.





VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM

EMDR Treatment

Clinicas Primary Care is in the process of spearheading its program for Eye Movement Desensitization and Reprocessing (EMDR). EMDR is an evidenced-based psychotherapy designed to alleviate the distress of complex trauma such as PTSD, depression, panic attacks, and other severe disorders. It involves recalling traumatic events while engaging in bilateral stimulation, such as side-to-side eye movements, tapping, or audio tones. This helps reprocess memories, reduce past disturbing memories, and induce healing.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PRIMARY CARE PROGRAM

Conclusion and Recommendations

Primary Care Program serves clients from various backgrounds throughout Ventura County by providing initial assessments, individual therapy, and case management. Their services successfully supported individuals with anxiety and depression. Outcome measures indicated that participants experienced lower levels of both depression and anxiety upon discharge from the program, though the sample size of participants who completed PHQ-9 and GAD-7 is smaller compared to the total number of program participants.

Future recommendations for the program include encouraging more participants to complete outcome measures and collecting additional demographic information. Expanding outcome data collection to more participants would further strengthen program impact and more comprehensive demographic information can provide insights into who the program serves and whether there are any gaps in program reach.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Mental Health First Aid Training (MHFA) is a nationally respected, evidence-based skills-based training course that teaches participants to identify, understand and respond to mental health and substance use challenges. Its prevention and early intervention, outreach and awareness, and destigmatizing conversations and terminology build trust to address barriers across generations and throughout the community. MHFA may be utilized by any facilitator, including all types of licensed and unlicensed professionals, paraprofessionals, peers, and advocates. The course is offered in English and Spanish.

Program Strategies

Provides First Aiders with the skills to identify when someone is experiencing mental health or substance use challenges.

Training equips First Aiders with the tools and confidence to talk about mental health, enabling them to provide first level support to someone in need.

Program Highlights

180 individuals received core program services

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Demographic Data

Trainees were asked about various background information to generate greater insight into the reach of the training and provide context for the findings reported. Most of the demographic information reported below is from surveys distributed by VCBH. The age group, highest level of schooling, and prior level of mental health training data are from the MHFA survey. Nearly half (48%) of trainees work in the field of architecture and engineering. Many of these trainees have either experienced mental health challenges personally (37%) or are supporting a family member with a mental health challenge (52%). Additional background information is presented below.

Race* (n = 26)

American Indian / Alaskan Native	4%
Asian	0%
Black / African American	4%
Native Hawaiian / Other Pacific Islander	0%
Latino	57%
White	2%
Another	<1%

2 did not answer the question.
2 selected "decline to state."

77% Hispanic/Latino
32% Non-Hispanic/Latino

Ethnicity* (n = 22)

Hispanic

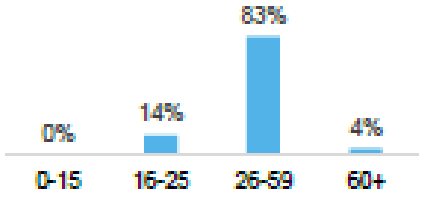
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	68%
Puerto Rican	0%
South American	9%
Other Hispanic/Latino	5%

Non-Hispanic

African	0%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	27%
Filipino/a	0%
Japanese	0%
Korean	0%
Middle Eastern	0%
Vietnamese	0%
Other Non-Hispanic/Latino	5%

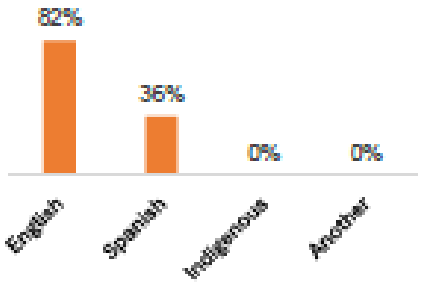
Other Hispanic/Latino includes Cuban
Other Non-Hispanic/Latino includes Caucasian
3 did not answer the question.
5 selected "decline to state."

Age Groups (n = 139)



14 selected "decline to state."

Primary Language* (n = 28)



2 did not answer the question.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

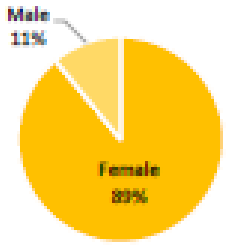
Demographic Data

Current Gender Identity (n = 27)

Female	85%
Male	11%
Transgender	0%
Genderqueer	4%
Questioning or Unsure	0%
Another Gender Identity	0%

2 did not answer this question.
1 selected "decline to state."

Sex Assigned at Birth (n = 27)



3 did not answer this question.

Sexual Orientation (n = 24)

Bisexual	0%
Gay or Lesbian	4%
Heterosexual or Straight	96%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

3 did not answer this question.
3 selected "decline to state."

7% of individuals reported having one or more disabilities (n = 27)

2 did not answer this question.
1 selected "decline to state."

7% of individuals identified as veterans (n = 28)

2 did not answer this question.

Disability (n = 2)

Seeing	0
Hearing	0
Other Communication	0
Learning Disability	0
Developmental Disability	0
Dementia	0
Another Mental Disability	0
Physical Disability	0
Chronic Health Condition	2
Another Disability	0

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Demographic Data

Highest Level of Schooling (n = 151)

High School	6%
Some College	12%
Associate Degree	15%
Vocational School Certificate	3%
Bachelor's Degree	32%
Some Graduate School	7%
Graduate Degree	25%

2 selected "decline to state."

Prior Level of Mental Health Training (n = 151)

No previous MH training	17%
A few talks/ presentations	28%
Several trainings/ workshops	48%
Graduate degree and/or license in MH	7%

2 selected "decline to state."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Training Outcomes

MHFA tracks outcomes related to stigma and discrimination. Participants were asked to report on their perceptions of mental health struggles and those affected from two perspectives (retrospective pre/post): before and after training. Comparisons of participants' perceptions before and after the program are presented in the table below.

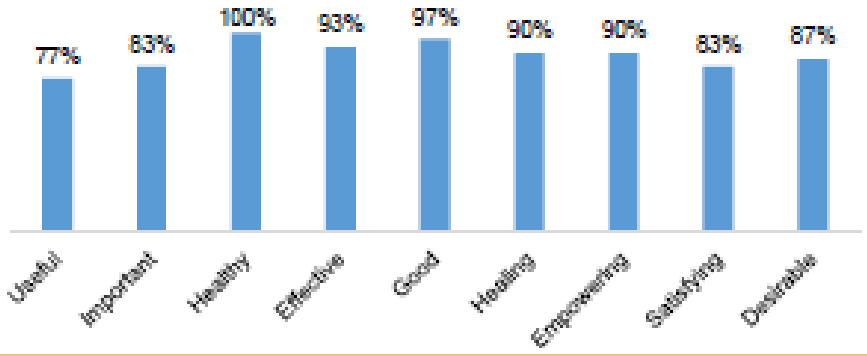
% of Participants who Responded "Yes" Before (n = 30) and After (n = 30)

Statement	Before	After
I know where to go for mental health services near me.	70%	97%
I thought people should share about their mental health struggles.	67%	83%
I would feel embarrassed about having personal mental health issues.	23%	7%
I thought the behavior of people with mental illness was unpredictable.	43%	27%
I was scared of people with mental illness.	17%	10%

On average, participants reported less stigmatizing and discriminatory views at the conclusion of MHFA trainings.

Participants also reported their perceptions on seeking professional help for mental health struggles after completing MHFA trainings. Participants were presented with different adjectives to describe help-seeking. The percentage of participants who selected each adjective is presented in the chart below.

Perceptions on Help-Seeking (n = 29-30)



Overall, participants reported highly favorable views on seeking professional help for mental health struggles.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Training Outcomes

Participants who attended MHFA trainings were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 30)

Statement	% Agree
The materials provided were useful.	90%
The program was practical and useful.	93%
I would recommend this program to others.	93%

Participants were very satisfied with MHFA trainings.

Participants who attended MHFA trainings were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 23)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	4%
My grades in school	0%
My housing situation	0%
My job situation	57%
My relationships with friends and family	39%
My parenting	13%
Staying out of jail or prison	0%
My mental health	48%
Substance use	0%

Participants reported that the primary areas of need were their job situation and mental health.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Knowledge Outcomes

Trainees are asked questions to evaluate their knowledge of MHFA at two time points (before and after the training). Comparisons of these scores are presented in the tables below.

Knowledge of MHFA Before and After Training

MHFA Knowledge	Before (N=155)	After (N=102)
First aid is not complete until the First Aider has used all the steps of the action plan.	15%	3%
First Aiders do not need to use every step of the action plan if they are not called for in the circumstances.	43%	89%
If a First Aider forgets to complete a step, they must go back to it to ensure first aid was given appropriately.	5%	-
The action plan must be performed in a linear pattern.	37%	8%

Which of the following may be an early indicator that a child/youth/someone is experiencing a mental health or substance use challenge?	Before (N=155)	After (N=102)
Difficulty remaining focused and maintaining concentration across a variety of tasks and settings.	79%	89%
Difficulty separating from loved ones.	1%	-
Difficulty separating from parents on the first day of school.	1%	1%
Occasionally losing temper when things do not go their way.	17%	9%
Sometimes struggling to complete an undesirable task.	2%	1%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

The most common protective factor for youth resilience is...	Before (N=60)	After (N=31)
At least one relationship with a supportive adult.	98%	100%
Success on a sports team.	2%	-

Which of the following is NOT a key factor of recovery?	Before (N=104)	After (N=71)
Community ties	8%	3%
Home life and family relationships	2%	-
Location of a job	88%	96%
Physical health	2%	1%

Which of the following actions are within the scope of a First Aider?	Before (N=154)	After (N=102)
Diagnosing what kind of mental health disorder a person has.	1%	2%
Listening non-judgmentally to a person with a mental health or substance use challenge.	97%	98%
Telling a person to stop treatments prescribed by a doctor.	2%	-

How can a First Aider cope with feelings of discomfort or frustration associated with providing first aid?	Before (N=154)	After (N=102)
Establishing a self-care plan before providing MHFA to cope with any feelings that may arise after the MHFA event.	99%	99%
Searching online for suggestions to relieve stress.	1%	1%

Trainees demonstrated greater knowledge of MHFA concepts after completing the training.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Trainees were also asked about their beliefs on mental health and substance use challenges, as well as their role in assisting others with these challenges. Their responses are presented in the tables below.

Please select the response that best describes your level of agreement.	% Agree Before (N=183)	% Agree After (N=102)
I should take action to help youth/someone I work with to address their mental health or substance use challenge(s).	68%	78%
I should reach out and express my concerns to youth/someone I work with that might be experiencing mental health or substance use challenge(s).	63%	86%
I should listen without expressing my judgment to youth/someone I suspect of experiencing a mental health or substance use challenge(s).	92%	96%

Please select the response that best describes HOW DIFFICULT it is for you to perform the action.	% Difficult Before (N=183)	% Difficult After (N=102)
Referring a youth/someone showing signs and symptoms of a mental health or substance use challenge(s) to practical resources (e.g., self-help information, crisis hotline number)	25%	22%
Referring a youth/someone experiencing a mental health or substance use challenge(s) to a health professional	28%	24%

Please select the response that best describes YOUR OPINION about how likely it would be for anyone with mental health or substance use challenge(s) to respond to a specific action of yours.	% Likely Before (N=183)	% Likely After (N=102)
If I express my concerns to a youth/someone about the mental health signs and symptoms that they are experiencing, it will help that youth/person to seek timely support.	38%	70%
If I give information about mental health professionals to a youth/someone experiencing mental health or substance use challenge(s), it will assist that youth/person to get help.	51%	77%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Please select the response that best describes your level of agreement.	% Agree Before (N=153)	% Agree After (N=102)
I am confident that I can have a supportive conversation with a youth/someone about mental health or substance use challenges.	67%	95%
I am confident that I can ask a youth/someone directly whether they are considering killing themselves.	54%	87%
I am confident that I can respond to a substance use crisis including an overdose and know what to do to keep a youth/someone safe.	46%	89%

Trainees reported greater confidence about their role in assisting others experiencing a mental health or substance use challenge.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Trainees rated their knowledge level and likelihood of completing specific actions at two time points: before and after completing the MHFA course (retrospective pre- and post-tests). Comparisons of their responses between the two timepoints are presented below.

Level of Knowledge	% High Before (N=33-104)	% High After (N=29-100)
Describe the purpose of Youth/Adult MHFA and the role of the First Aider	35%	77%
Recognize the signs and symptoms of mental health or substance use challenges that may impact youth/an individual	38%	70%
Explain the impact of traumatic experiences and the role of resilience on adolescent development	36%	62%
Explain ways in which a First Aider may cope with feelings of discomfort in providing MHFA	37%	75%

Likelihood of Completing Action	% High Before (N=104)	% High After (N=93)
Have a supportive conversation with a youth/someone experiencing signs and symptom(s) of a mental health or substance use challenge or crisis	51%	85%
Use the ALGEE action plan to connect a youth/someone experiencing signs and symptom(s) of a mental health or substance use challenge or crisis to appropriate help or resources	43%	86%

Trainees demonstrated greater knowledge and were more likely to help someone displaying signs of a MH crisis after completing the MHFA course.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Trainees were asked to share their opinions on various mental health-related topics. Their responses are presented in the tables below.

Please select the response that best describes your level of agreement.	% Agree (N=47-183)
It is not a good idea to ask someone if they are feeling suicidal in case you put the idea into his or her head.	4%
Depression tends to show up earlier in a young person's life than anxiety.	21%
If a young person experiences a trauma, it is best to make him or her talk about it as soon as possible.	23%
They may not need it right away, but eventually everyone with a mental health problem needs professional treatment.	66%
Knowledge about the impact of medication for youth is limited compared to what we know about adults.	38%
It is best to get a person having a panic attack to breathe into a paper bag.	18%
A first-aider can distinguish a panic attack from a heart attack.	35%
Exercise can help relieve depressive and anxiety disorders.	95%
Schizophrenia is a relatively common diagnosis for youth under the age of 18 (Schizophrenia is one of the most common MH disorders).	27%
It is best not to try to reason with people having delusions.	50%
People who talk about suicide don't complete suicide.	3%
When talking to someone about suicide, it is best to be indirect and not use the word "kill" so that you don't upset the person.	28%
Trauma is a risk factor in almost every type of mental illness.	64%
Spirituality can be a protective factor – keeping a young person from developing a mental illness or minimizing the impact of the illness.	43%

Please select the response that best describes your level of agreement.	% Agree (N=106)
Males complete suicide four times more frequently than females.	63%
Antidepressant medication works right away.	0%
People with psychosis usually come from dysfunctional families.	9%
Psychosis is a lifelong illness.	15%
People with psychosis are more at risk of being victims of violent crime.	66%
Smoking is much more common among people with mental health problems.	46%

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Trainees were asked to rate their overall experience and impression of the training, including how relevant they found it to their work and to the populations they serve. Their responses to these questions are presented below. Additionally, most trainees (66%) heard about the course through in-person or virtual events/conferences they attended. Their primary reason (65%) for taking the course was because it was recommended or required by their employer/organization. The majority of trainees reported that it was easy (58%) to enroll in the course.

Overall response to the course	(N=147)
This course did not have enough activities and information to prepare me to be a First Aider	1%
This course has better prepared me for the work that I do professionally	37%
This course was helpful and informative	60%
Other	1%

83% of respondents felt there was adequate opportunity to practice the skills learned (n=101)

95% of respondents felt the scenarios were relevant to the populations they serve (n=101)

82% of respondents rated their experience navigating the online coursework as easy (n=87)

83% of respondents did not find the pace of the course to be too fast or too slow (n=84)

95% of respondents received access to the online MHFA USA manual (n=87)

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Training Satisfaction

Overall opinion of course	%Yes (N=87)
Is the content accessible to your typical audience?	77%
Do the chapters offer useful, practical guidance that First Aiders an implement right away?	91%
Is there any language a reader might find stigmatizing?	9%
Is the content clear and easy to understand?	92%

Presenter Satisfaction	Presenter 1 %Agree (N=101)	Presenter 2 %Agree (N=98)
The instructor's presentation skills were engaging and approachable.	91%	90%
The instructor demonstrated knowledge of the material presented.	93%	93%
The instructor facilitated activities and discussion in a clear and effective manner.	90%	89%
Did presenter provide feedback on your achievement of the learning objectives?	88%	84%

Trainees were highly satisfied with the MHFA training and rated both the overall course and presenters very favorably.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MENTAL HEALTH FIRST AID

Training Feedback and Successes

Participants who attended MHFA trainings were asked to provide additional feedback about what was most and least helpful about the training. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was MOST helpful about this program?
(n = 101)

- Interactive/Group Activities/Scenarios (54)
- ALGEE Framework (18)
- Recognizing Signs and Symptoms (10)

What was LEAST helpful about this program?
(n = 60)

- Nothing - All Helpful (23)
- Course Content/Format (13)
- Pace/Duration of Course (6)

"Having the scenarios was helpful because it put into practice the lessons we learned throughout the course."

"I cannot find one thing that was not helpful."

MENTAL HEALTH FIRST AID

Conclusion and Recommendations

MHFA is an evidence-based skills-based training course that teaches participants to identify, understand and respond to mental health and substance use challenges. The training resulted in greater knowledge of MHFA-related concepts, including how to use the different steps of the action plan, the scope of a First Aider, how to identify signs and symptoms of mental health struggles, and an understanding of protective factors and key factors of recovery.

Trainees reported greater confidence in their role as First Aiders after completing the training. Respondents agreed they should take action, reach out, and listen to those suspected of experiencing a mental health or substance use challenge. Trainees also felt that by expressing concerns and providing resources, they could help a person in need receive timely support.

Trainees were highly satisfied with both the overall course and the presenters who facilitated the training. The majority of respondents agreed they had adequate time to practice the skills they learned. Trainees found the interactive activities and scenarios to be the most helpful aspect of the course. Many also recommended that future trainings provide additional time for practicing the skills taught and opportunities to learn more about how the training content can be applied to real-world settings.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS OF HOPE
VENTURA COUNTY FAMILY JUSTICE CENTER FOUNDATION

The Pathways of Hope program aims to serve youth healing from trauma from exposure to domestic violence by providing alternative therapeutic practices, community building, and guidance to higher education opportunities. Therapeutic sessions involve the support of therapy horses to reduce stress and anxiety, build rapport with mental health professionals, and increase socialization among other participants. Through strong relationships with each family, individualized outreach will occur. All youth have been exposed to traumas, including domestic violence and sexual assault. Each participant resides in a household where the annual income is less than $13,000. The parents and guardians of these children have minimum-wage jobs either in the fields, restaurants, or retail.

Program Strategies

Provides access and linkage to treatment

Improves timely access to services for underserved populations

Stigma and discrimination reduction

Program Highlights

27 individuals received core program services

600 individuals reached through outreach events†

†Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

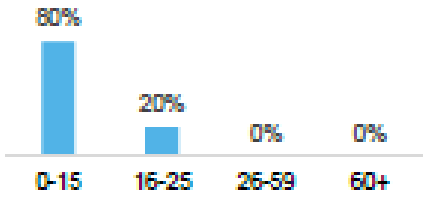
Demographic Data

Race* (n = 19)

American Indian / Alaskan Native	0%
Asian	0%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	79%
White	26%
Another	0%

7 did not answer this question.
1 selected "decline to state."

Age Groups (n = 20)



7 did not answer this question.
0 selected "decline to state."

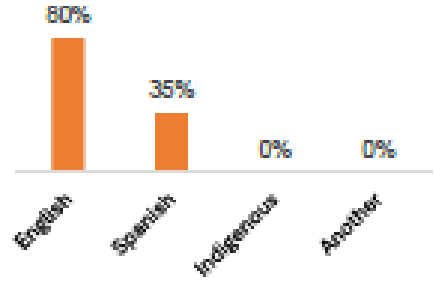
94% Hispanic/Latino
6% Non-Hispanic/Latino

Ethnicity* (n = 17)

Caribbean	0%	Hispanic
Central American	12%	
Mexican/Mex.-Am./Chicano	82%	
Puerto Rican	0%	
South American	0%	
Other Hispanic/Latino	0%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	0%	
European	6%	
Filipino/a	0%	
Japanese	0%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	0%	
More than one	0%	

10 did not answer the question.
0 selected "decline to state."

Primary Language* (n = 20)



7 did not answer this question.
0 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

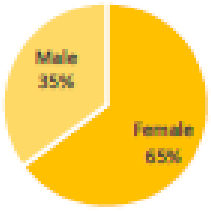
Demographic Data

Current Gender Identity (n = 20)

Female	65%
Male	35%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

7 did not answer this question.
0 selected "decline to state."

Sex Assigned at Birth (n = 20)



7 did not answer this question.
0 selected "decline to state."

Sexual Orientation (n = 7)

Bisexual	1
Gay or Lesbian	0
Heterosexual or Straight	5
Queer	1
Questioning or Unsure	0
Another Sexual Orientation	0

7 did not answer this question.
13 selected "decline to state."

24% of individuals reported having one or more disabilities (n = 17)

7 did not answer this question.
3 selected "decline to state."

0% of individuals identified as veterans (n = 20)

7 did not answer this question.
0 selected "decline to state."

Disability (n = 4)

Seeing	1
Hearing	0
Other Communication	0
Learning Disability	1
Developmental Disability	2
Dementia	0
Another Mental Disability	1
Physical Disability	0
Chronic Health Condition	0
Another Disability	0

1 individual reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

Program Activities and Outreach

Program activities include support groups and educations facilitated by Pathways of Hope program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program participants and other community members may participate in these activities and events.

Program Activities by Type	# Activities/ Events
Support Group	22
Education	3
TOTAL # of Activities/Outreach	**25**

600 total participants reached†

8% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

Program Outcomes

Pathways to Hope tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points (intake and exit) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 17) and Exit (n = 22)[1]

Category	Intake	Exit
Minimal	59%	100%
Mild	29%	0%
Moderate	6%	0%
Severe	6%	0%

Participants showed favorable outcomes, with all indicating minimal levels of distress (59-100%).

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

Program Satisfaction

Participants of Pathways to Hope were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 21)

Statement	% Strongly Agree/Agree
It is easy to get help at this program.	90%
I would recommend this program to a friend or family member.	100%
Services are in the language I am most comfortable speaking.	100%
Staff respect my cultural background.	100%

Participants were highly satisfied with Pathways to Hope program.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 20)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	30%
My grades in school	70%
My housing situation	15%
My job situation	0%
My relationships with friends and family	70%
My parenting	0%
Staying out of jail or prison	0%
My mental health	70%
Substance use	0%

Participants reported that the primary areas of need were their mental health, relationships with friends and family, and grades in school.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

PATHWAYS TO HOPE

Program Feedback and Successes

Participants who received program services from Pathways to Hope were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 22)

- Horses (17)
- Building Relationships/Socializing (8)

What would make this program better?
(n = 13)

- Interesting in Returning (9)
- More Time with Horses (4)

"I can be myself and not be judged. I have made friends and feel save. Horses make me feel calm and happy."

"Being able to come back, and I would like to ride horses too"

*Percentages may exceed 100% because participants could choose more than one response option.

PATHWAYS TO HOPE

Conclusion and Recommendations

The Pathways to Hope program provided therapeutic support for youth healing from trauma due to exposure to domestic violence. The program used alternative therapeutic practices involving therapy horses to reduce stress and anxiety, build rapport with mental health professionals, and strengthen peer connections among participants from low-income households. Psychological well-being improved significantly, with all participants in the moderate and severe distress categories at intake moving to minimal distress by program completion. Participants reported high satisfaction, with 100% indicating they would recommend the program to others, 100% reporting services were provided in their preferred language and staff respected their cultural backgrounds, and 90% finding it easy to access help.

Future improvements may include expanding outreach to increase enrollment and raise awareness about trauma-informed mental health resources for families affected by domestic violence. Program staff identified transportation capacity as a limitation, noting that additional vehicles could allow the program to serve more youth. Given that many youths arrive with limited awareness of mental health vocabulary and coping tools, staff also suggested incorporating more reflection activities and visual tools to help participants process emotions. Overall, the program provided mental health support and skill-building through therapeutic sessions with horses to youth and families in underserved communities, healing from domestic violence.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VENTURA COUNTY POWER OVER PSYCHOSIS (VCPOP)

Ventura County Power Over Psychosis (VCPOP) conducts community outreach and education to community members about early warning signs of psychosis and provides a four-year intervention program with services and supports including psychiatric assessment, medication management, individual therapy, educational/vocational services, case management, multi-family groups, and peer skill-building groups.

Program Strategies

Provides intensive support and education to individuals and their support systems to reduce stress and manage symptoms.

Increases recognition of early signs of psychosis through outreach and trainings to community members including school staff, clinicians, spiritual leaders, and police.

Program Highlights

277 individuals received core program services

187 days, average length of stay

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VENTURA COUNTY POWER OVER PSYCHOSIS

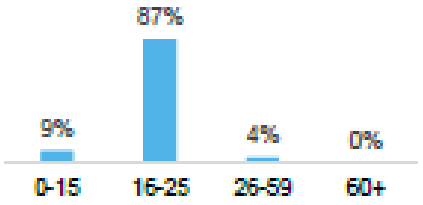
Demographic Data

Race (n = 203)

American Indian / Alaskan Native	2%
Asian	2%
Black / African American	3%
Native Hawaiian / Other Pacific Islander	<1%
White	39%
Another	53%

74 unknown/not reported.

Age Groups (n = 277)



Ethnicity
(n = 214)

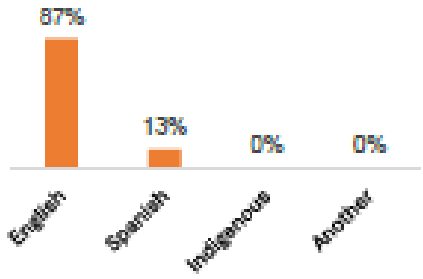
79% Hispanic/Latino
21% Non-Hispanic/Latino

63 unknown/not reported

No individuals identified as veterans
(n = 64)

213 unknown/not reported

Primary Language (n = 245)



32 unknown/not reported

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VENTURA COUNTY POWER OVER PSYCHOSIS

Demographic Data

Current Gender Identity (n = 247)	
Female	45%
Male	53%
Transgender	2%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

30 unknown/not reported.

Sexual Orientation (n = 25)	
Bisexual	8%
Gay or Lesbian	%
Heterosexual or Straight	84%
Queer	%
Questioning or Unsure	%
Another Sexual Orientation	8%

250 unknown/not reported.
2 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VENTURA COUNTY POWER OVER PSYCHOSIS

Program Services

Program services include classes, meetings, support groups, trainings, and workshops facilitated by Ventura County Power Over Psychosis program staff. Program participants and other community members may participate in these services.

Program Services by Type	# of Services
Assessments/Evaluation	1,364
Case Management	248
Crisis Intervention	1,939
Individual/Group Therapy	979
Mental Health Evaluation and Management	1,994
Medication Management	508
Psychotherapy	1,331
Plan Development	393
Outreach	511
Paperwork Completion	245
Rehab	511
Targeted Case Management	257
Transportation/Travel	425
Whatever It Takes Support	254
Interpretation	325
Other*	5,323
TOTAL # of Services	16,665

VCPOP had **196,898** service contacts in FY 2024 – 2025†

*Service/activity contacts represent the number of times individuals engaged with program activities/events.
(Therapeutic, prophylactic, or diag injection-subcutaneous or intramuscular; adult residential (geriatric, non-geriatric); behavioral health prevention education service-peer; client non-billable srvc must document; general hospital inpatient; administrative day; general psychiatric inpatient; interactive complexity; medical team conference (participation by non-physician (FTF with pt and/or family; pt and/or fam not present); medical team conference, participation by physician (pt and/or fam not present); non billable attempted contact; observation or inpatient hospital care, including admit/dc same date; office or other outpatient visit (sf) an established patient; of new patient); prolonged clinical staff service first hour; prolonged office or other outpatient E/M service(s) beyond the maximum time; psychiatric hospital inpatient; administrative day; psychoeducational service; residential SUD; residential withdrawal management; self-help/peer services

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VENTURA COUNTY POWER OVER PSYCHOSIS

Conclusion and Recommendations

Ventura County's Power Over Psychosis program continues to make impressive strides by supporting individuals at risk for psychosis through comprehensive community outreach and robust, multi-faceted support services. Its focus on early intervention, particularly among young adults aged 12 to 25, aligns with the demographic most vulnerable to early psychosis. The wide reach of program activities such as mental health evaluation and management, crisis intervention, and psychotherapy highlights the program's commitment to early intervention in psychosis and preventing future progression of psychosis.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

OTHER PEI PROGRAMS

The programs under Other PEI Programs encompass the core program categories of Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction, as well as Suicide Prevention (optional) and Improving Timely Access to Services for Underserved Populations (optional) programs. All programs in this section focus primarily on training potential first responders—including educators, students, law enforcement personnel, first responders, people with lived experience, and other community members—about ways to recognize and respond effectively to early signs of mental illness. Programs also seek to combat negative perceptions about, misinformation and/or stigma associated with having a mental illness or seeking help for mental illness.

A total of 2,546 individuals were served by Other PEI Programs during FY 2024-2025. Other PEI Programs include the following program categories:

Outreach for Increasing Recognition of Early Signs of Mental Illness programs train potential responders to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

Access and Linkage to Treatment programs connect individuals with severe mental illness to medical care and treatment as early in the onset of these conditions as practicable. These programs focus on screening, assessment, referral, telephone helplines, and mobile response.

Stigma and Discrimination Reduction programs reduce negative attitudes, beliefs, stereotypes, and discrimination toward those with mental illness or seeking mental health services and increase dignity, inclusion, and equity for individuals with mental illness and their families.

Suicide Prevention programs provide organized activities to prevent suicide because of mental illness.

Other PEI Program Descriptions

Andela! Wellness and Creativity for Everyone: Offers culturally relevant mental health information and wellness activities for low-income, underserved Latino youth and families.

Crisis Intervention Team (CIT): Provides training for first responders to assess and compassionately and effectively assist people in mental health crisis through de-escalation, reduced use of force, and collaboration with consumers, families, the community, and other stakeholders.

Diversity Collective: Hosts weekly support groups for LGBTQ+ youth, TAY, and their allies, and promotes cultural competency and other mental health trainings to schools and agencies to raise awareness of LGBTQ+ mental health needs.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Logrando Bienestar: Helps youth and adults in the Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services to support productive, healthy lifestyles.

VCBH Suicide Prevention: Provides resources to advance awareness and knowledge of suicide and related topics.

2,546	individuals received core program services*
2,223	individuals referred to mental health care and/or social support services*
49,011	individuals reached through outreach events*

*Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Other PEI Programs: Demographics of Participants

Ethnicity*[1]	(n = 1,570)
Hispanic	84%
Non-Hispanic	15%
More than one ethnicity	1%
Declined to answer: 33	

Age	(n = 2,861)
0–15	38%
16–25	22%
26–59	34%
60+	6%
Declined to answer: 10	

Primary Language*	(n = 2,750)
English	63%
Spanish	34%
Indigenous	1%
Another language	1%
Declined to answer: 7	

Sex Assigned at Birth[1]	(n = 529)
Female	67%
Male	33%
Declined to answer: 10	

Sexual Orientation[1]	(n = 514)
Bisexual	11%
Gay or Lesbian	5%
Heterosexual or Straight	72%
Queer	9%
Questioning or Unsure	1%
Another sexual orientation	3%
Declined to answer: 55	

Hispanic Ethnicities^			(n = 363)
Mexican	89%	South American	2%
Central American	2%	Caribbean	1%
Puerto Rican	2%	Another Hispanic	4%

Non-Hispanic Ethnicities^			(n = 122)
African	7%	Asian Indian/ South Asian	0%
Cambodian	0%	Chinese	0%
Eastern European	5%	European	48%
Filipino	12%	Japanese	4%
Korean	0%	Middle Eastern	2%
Vietnamese	9%	Another Non-Hispanic	11%

Race*	(n = 2,201)
American Indian/Alaska Native	2%
Asian	3%
Black/African American	2%
Hispanic/Latino	32%
Native Hawaiian/Pacific Islander	1%
White	41%
Another race	19%
More than one	1%
Declined to answer: 26	

Current Gender Identity	(n = 2,376)
Female	64%
Male	34%
Genderqueer	1%
Questioning or Unsure	<1%
Transgender	1%
Another gender identity	1%
Declined to answer: 11	

City of Residence[1]					(n = 396)
Camarillo	10%	Fillmore	3%	Moorpark	2%
Newbury Park	0%	Oak Park	0%	Ojai	1%
Oxnard	59%	Piru	0%	Port Hueneme	4%
Santa Paula	1%	Simi Valley	1%	Thousand Oaks	1%
Ventura	17%	Other	2%		

*Percentages may add to or exceed 100% because participants could choose more than one response option.
[1]Ethnicity and sexual orientation data not available for Suicide Prevention. Sex assigned at birth not available for Logrando Bienestar and Suicide Prevention. City of residence data is not available for CIT, Logrando Bienestar, and Suicide Prevention
^Percentages and counts reflect the number of individuals who selected each Hispanic or Non-Hispanic Ethnicity.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM
VENTURA COUNTY LAW ENFORCEMENT

The Crisis Intervention Team (CIT) is a mental health training program for first responders throughout Ventura County. Since its inception, the CIT Academy has provided trainings to 2,488 first responders to help assess and assist people in mental health crises compassionately and effectively. The four primary goals of the CIT program are to reduce the intensity of a crisis using de-escalation strategies, reduce the necessity of use-of-force, promote pre-custody diversion, and collaborate with mental health consumers, their families, the community, and other stakeholders to build and support a vibrant and accessible crisis system.

Program Strategies

Provides training to first responders to increase recognition of early signs of mental illness and how to respond to crises effectively.

Implements non-stigmatizing and non-discriminatory practices by providing culturally competent trainings to first responders.

Program Highlights

142 individuals received core program services (attended CIT Academy trainings)

2,223 individuals experiencing a mental health problem or crisis served†

6,796 individuals reached through other program activities†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Demographic Data

Race (n = 111)

American Indian / Alaskan Native	2%
Asian	1%
Black / African American	0%
Native Hawaiian / Other Pacific Islander	1%
White	63%
Another	21%
More than one	12%

15 did not answer this question.
7 selected "decline to state."

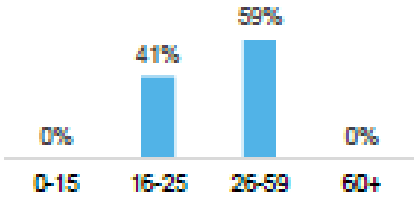
79% Hispanic/Latino
21% Non-Hispanic/Latino

Ethnicity (n = 107)

Caribbean	1%	Hispanic
Central American	1%	
Mexican/Mex.-Am./Chicano	61%	
Puerto Rican	1%	
South American	1%	
Other Hispanic/Latino	11%	
More than one	4%	
African	0%	Non-Hispanic
Asian Indian/South Asian	0%	
Cambodian	0%	
Chinese	0%	
Eastern European	3%	
European	12%	
Filipino/a	1%	
Japanese	1%	
Korean	0%	
Middle Eastern	0%	
Vietnamese	0%	
Other Non-Hispanic/Latino	7%	
More than one	7%	

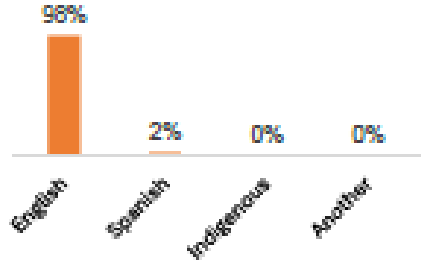
25 did not answer the question.
1 selected "decline to state."

Age Groups (n = 116)



14 did not answer this question.
3 selected "decline to state."

Primary Language (n = 117)



14 did not answer this question.
3 selected "decline to state."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

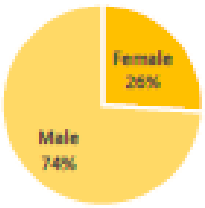
Demographic Data

Current Gender Identity (n = 113)

Female	27%
Male	73%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%

16 did not answer this question.
4 selected "decline to state."

Sex Assigned at Birth (n = 118)



14 did not answer this question.
1 selected "decline to state."

Sexual Orientation (n = 113)

Bisexual	0%
Gay or Lesbian	2%
Heterosexual or Straight	97%
Queer	1%
Questioning or Unsure	0%
Another Sexual Orientation	0%

14 did not answer this question.
6 selected "decline to state."

No individuals reported having a disability (n = 117)

13 did not answer this question.
3 selected "decline to state."

10% of individuals identified as veterans (n = 118)

14 did not answer this question.
1 selected "decline to state."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Activities

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by CIT program staff. Program participants and other community members may participate in these activities and events.

Program Activities by Type	# Activities/ Events
Update Class	3
Brief Training	4
Basic Law Enforcement Training	13
Other Training	37
Other Presentation	56
TOTAL # of Activities/Events	113

6,796
participants in program activities†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

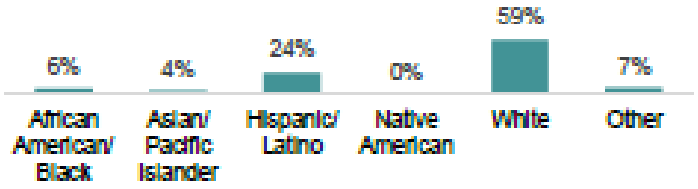
VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

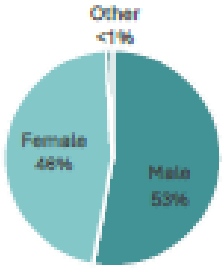
CIT Card Information

Ventura County first responders document encounters with individuals experiencing a mental health issue or crisis by submitting CIT Event Cards. These cards include individuals' demographic information, the city where the incident occurred, and the disposition or service provided. First responder personnel completed 2,223 CIT cards in FY 2024–2025.

Subject Race (n = 2,184)



Subject Gender (n = 2,206)



8% of individuals encountered were homeless

2% of individuals encountered were veterans

Disposition or Service (n = 2,114)

Disposition/Service Type	% of CIT Cards
Contact Only	56%
Hospital	32%
#5150/#5585	9%
Voluntary IPU	2%
Incarcerated	1%

City of Incident (n = 2,223)

City	% of CIT Cards
Camarillo	15%
Fillmore	3%
Moorpark	4%
Ojai	4%
Oxnard	3%
Port Hueneme	2%
Santa Paula	1%
Simi Valley	13%
Thousand Oaks	36%
Ventura	12%
County Wide	6%
Other	1%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Outcomes: Stigma & Discrimination Reduction

CIT monitors program outcomes by surveying CIT Academy trainees on topics such as stigma, discrimination, and racial bias at two time points: before and after the training. The charts below present results from the past fiscal year.

Stigma & Discrimination Reduction

% Strongly Agree and Agree, Before (n=139-140) and After (n=122)

Statement	Intake	Exit
I would be willing to talk to a friend or a family member if I was experiencing emotional distress.	79%	92%
I would be willing to seek support from a mental health professional if I thought I needed it.	80%	89%
I would be willing to actively and compassionately listen to someone in distress.	97%	97%
I would be willing to take action to prevent discrimination against people with mental illness.	93%	93%
I would be willing to socialize with someone who had a serious mental illness.	61%	71%
I would be willing to work closely on a job with someone who had a serious mental illness.	48%	67%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Outcomes: Training Evaluation Survey

Implicit Racial Bias Training

% Strongly Agree and Agree, Before (n=139-140) and After (n=120-122)

Statement	Intake	Exit
I have negative biases against other racial groups.	3%	2%
Whether I want it or not, my spontaneous reactions towards people are racially biased.	1%	2%
I have an unintentional racial bias in my first reactions towards strangers.	4%	2%
I show no racial bias in my reactions towards other people.	67%	66%
My automatic reactions towards other people are racially biased.	2%	1%
When I observe my own spontaneous reactions when meeting strangers, I see no racial bias.	68%	69%
My immediate feelings when I encounter new people often show racial biases.	3%	2%
My first reactions to other people are not influenced by their racial background.	73%	75%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Outcomes: Follow-up Survey

Approximately six months after CIT Academy training, trainees were asked to take a follow-up survey. Questions on this survey were designed to measure the outcomes of CIT Academy training, including the frequency with which trainees have implemented techniques learned from the training and their overall perceptions of the training. Results from this survey are presented below.

% of Strongly Agree and Agree
(n = 28-29)

As a result of CIT training...	% Agree
I am better able to recognize the signs and symptoms of a mental health disorder among individuals that I encounter in the community.	79%
I can more effectively communicate with persons displaying signs of a mental health disorder.	79%
I am more comfortable interacting with persons displaying signs of a mental health disorder.	86%
I am better able to defuse aggression before it becomes violence.	79%
I feel more prepared to respond to an incident involving a person engaging in self-harming behavior or threatening suicide.	72%
I have more useful skills for managing any type of mental health crisis effectively.	76%

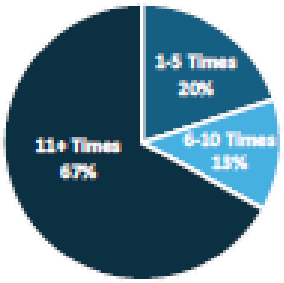
CIT training...	% Agree
Increases law enforcement officer safety	71%
Increases the safety of those affected by mental health conditions	82%
Better prepares law enforcement officers to handle crises involving individuals with a mental health disorder	89%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

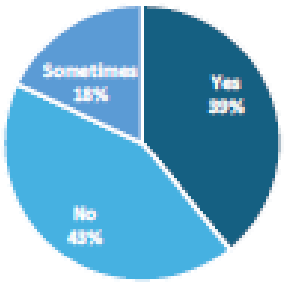
CRISIS INTERVENTION TEAM

Program Outcomes: Follow-up Survey

How many times have you used de-escalation techniques taught in CIT Training?
(n = 30)

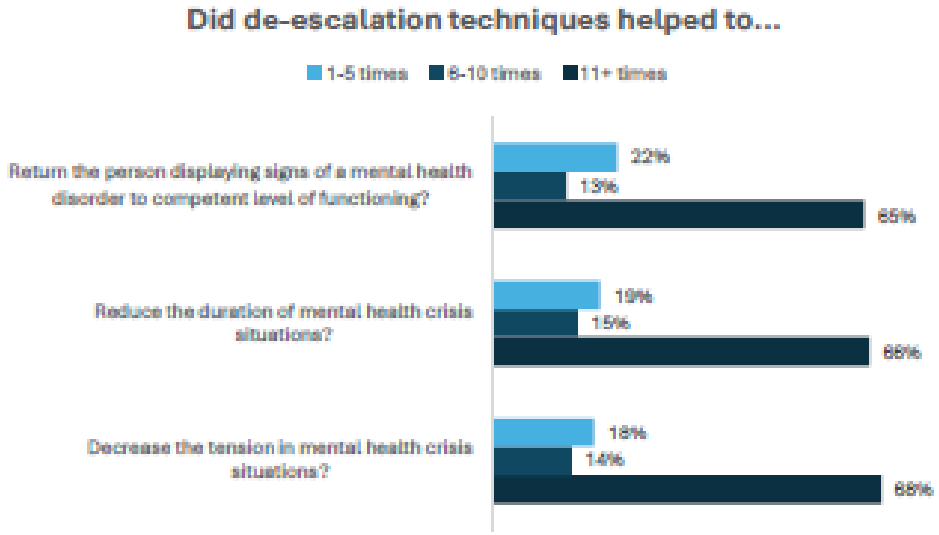


Do you complete a CIT Event Card after each encounter with a person displaying signs of a mental health disorder?
(n = 28)



*The primary reason for not completing a CIT card was because the individual encountered was in custody.

% of Yes Responses Based on Number of Times De-Escalation Techniques were Used
(n = 23–28)



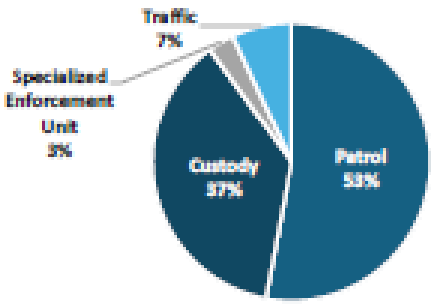
CRISIS INTERVENTION TEAM

Program Outcomes: Follow-up Survey Respondent Characteristics

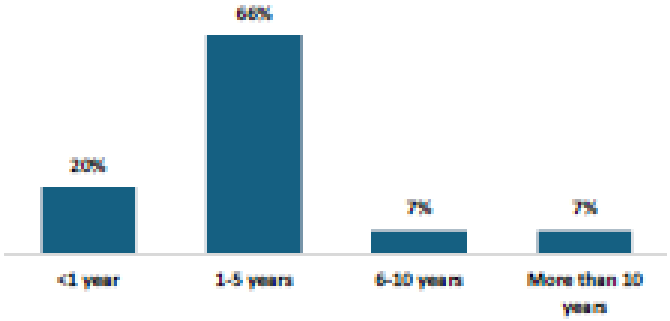
Current Employer (n = 30)	
City Police Dept	50%
Federal Police Agency	7%
Other LE Agency	3%
Sheriff's Office	33%
State Police Agency	7%

Rank Classification (n = 30)	
Officer/Deputy	80%
PSO/CSO/SST	10%
Senior Ofc., Dep., or Corporal	3%
Sergeant	7%

Current Assignment (n = 30)



Years in Law Enforcement (n = 30)



VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Satisfaction

Participants of Crisis Intervention Team trainings were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with the satisfaction statement, and the percentage of participants who indicated yes to the statement related to sharing skills they have learned.

% of Participants Who Agreed
(n = 27-28)

Statement	% Agree/ Yes
Are you satisfied with the training you received	100%
Have you shared any of the skills or strategies you learned in CIT training with other law enforcement officers?	70%

Participants were highly satisfied with the Crisis Intervention Team program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Program Feedback and Successes

Participants who received program services from CIT were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 75)

- Knowledge of Resources/ Tools/Skills (23)
- Learned how to Respond in Crisis Situations (20)
- Broadened Perspective (12)

What would make this program better?
(n = 74)

- No Recommendations (36)
- More Scenario-Based Training (21)

"Amazing knowledge, incredibly useful! Will be spreading the information to my junior guys on communication techniques"

"I would suggest more live action scenarios ..."

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

CRISIS INTERVENTION TEAM

Conclusion and Recommendations

The CIT program has demonstrated consistent effectiveness in training Ventura County first responders to handle mental health crises with empathy and skill. Trainees reported fewer stigmatizing attitudes and less racial bias following the CIT academy. For example, they reported greater willingness to take action to prevent discrimination, were more willing to socialize, and work with someone with a serious mental illness. Furthermore, fewer trainees reported having negative biases against other racial groups. CIT academy also helped trainees feel more comfortable interacting with persons displaying signs of a mental illness. Trainees strongly agreed that the training helps better prepare law enforcement to handle crises involving individuals with mental illness.

More than half of the trainees who completed the follow-up survey reported using the techniques they learned from CIT at least 10 times or more. De-escalation techniques have helped reduce the duration and tension experienced in crises. All trainees who completed the survey reported being satisfied with the program, with more than half stating that they had shared the skills they learned with others in their field. CIT academy helped trainees develop knowledge of resources and skills, learn how to respond to crises, and broaden their perspectives. Many participants were satisfied with how the program was delivered, although some suggested incorporating more scenario-based training in the future.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE
RAINBOW UMBRELLA + PRIDE

Diversity Collective is an affirming and welcoming space for LGBTQ+ youth ages 13 to 23 and their allies, including peers, family, educators, and agency staff. Diversity Collective's trainings employ a variety of methods and activities to shift attitudes, enhance knowledge, and modify behaviors concerning the diagnosis of mental illness, living with mental health conditions, and seeking mental health services and then measure that impact through a validated instrument, the Mental Help Seeking Attitudes Scale (Hammer, Parent, & Spiker, 2018). The program's activities and events include interactive workshops that provide education on mental health issues specific to the LGBTQ+ community, peer support groups to share experiences and coping strategies, resilience and empowerment exercises tailored to address the unique challenges faced by LGBTQ+ individuals, and advocacy skills training to promote access to mental health services. Diversity Collection conducts P.R.I.D.E. (Parents & Professionals' Responsibility for Inclusion, Diversity, and Equity) trainings for Ventura County schools and community members.

Program Strategies

Improves timely access to services for underserved populations by providing social and emotional support and connections to mental health care to LGBTQ+ youth.

Implements non-stigmatizing and non-discriminatory practices by providing LGBTQ+ cultural competency trainings to potential responders and agency staff.

Program Highlights

113 individuals received core program services

8,015 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

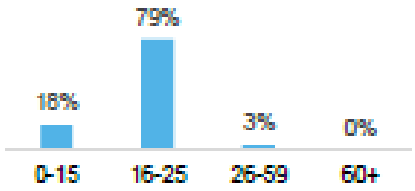
Demographic Data

Race* (n = 110)

American Indian / Alaskan Native	0%
Asian	4%
Black / African American	2%
Native Hawaiian / Other Pacific Islander	2%
Latino	44%
White	51%
Another	0%
More than one	5%

3 selected "decline to state."

Age Groups (n = 108)



5 did not answer this question.

69% Hispanic/Latino
33% Non-Hispanic/Latino

Ethnicity* (n = 75)

Hispanic

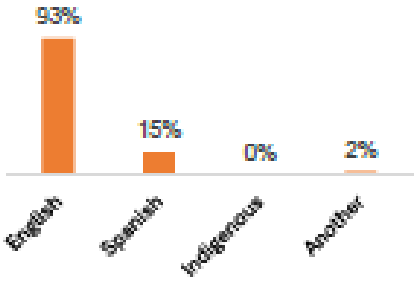
Caribbean	0%
Central American	0%
Mexican/Mex.-Am./Chicano	98%
Puerto Rican	0%
South American	2%
Other Hispanic/Latino	0%

Non-Hispanic

African	4%
Asian Indian/South Asian	0%
Cambodian	0%
Chinese	0%
Eastern European	0%
European	80%
Filipino/a	12%
Japanese	0%
Korean	0%
Middle Eastern	4%
Vietnamese	0%
Other Non-Hispanic/Latino	0%
More than one	3%

19 did not answer the question.
19 selected "decline to state."

Primary Language* (n = 109)



Another includes Japanese.
3 did not answer this question.
1 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

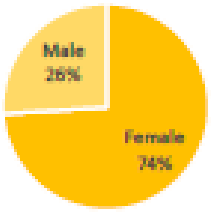
Demographic Data

Current Gender Identity (n = 98)

Female	45%
Male	21%
Transgender	17%
Genderqueer	7%
Questioning or Unsure	6%
Another Gender Identity	4%

12 did not answer this question.
3 selected "decline to state."

Sex Assigned at Birth (n = 104)



3 did not answer this question.
6 selected "decline to state."

Sexual Orientation* (n = 105)

Bisexual	27%
Gay or Lesbian	15%
Heterosexual or Straight	28%
Queer	20%
Questioning or Unsure	4%
Another Sexual Orientation	10%

Another includes aromantic asexual (aroace) and pansexual
3 did not answer this question.
5 selected "decline to state."

16% of individuals reported having one or more disabilities (n = 97)

8 did not answer this question.
8 selected "decline to state."

0% of individuals identified as veterans (n = 111)

1 did not answer this question.
1 selected "decline to state."

Disability* (n = 26)

Seeing	38%
Hearing	4%
Other Communication	0%
Learning Disability	31%
Developmental Disability	15%
Dementia	0%
Another Mental Disability	12%
Physical Disability	0%
Chronic Health Condition	0%
Another Disability	8%

2 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activities, Outreach, and Training

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Diversity Collective program staff. Program participants and other community members may participate in these activities and events. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources. Training on recognizing early signs of mental illness was conducted with potential responders (e.g., parents, educators/teachers, students, community members).

Program Activities by Type	# Activities/ Events
Support Group	50
Community Fair or Event	16
PRIDE Training	12
Outreach	6
Presentation	5
Education	3
Training/Workshop	2
Drop-In Program	1
Field Trip	1
Meeting	1
TOTAL # of Activities/Outreach/Training	**97**

524 participants in program activities†

es

72% of outreach events conducted in Spanish

224 participants trained

es

8% of trainings conducted in Spanish

14,838 materials distributed

†Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activity Outcomes

Diversity Collective tracks outcomes related to stigma and discrimination. Participants were asked to report on their perceptions of mental health struggles and those affected from two perspectives (retrospective pre/post): before and after training. Comparisons of participants' perceptions before and after the program are presented in the table below.

% of Participants who Responded "Yes" Before (n = 79-81) and After (n = 80-82)

Statement	Before	After
I know where to go for mental health services near me.	73%	93%
I thought people should share about their mental health struggles.	64%	84%
I would feel embarrassed about having personal mental health issues.	19%	14%
I thought the behavior of people with mental illness was unpredictable.	35%	25%
I was scared of people with mental illness.	11%	7%

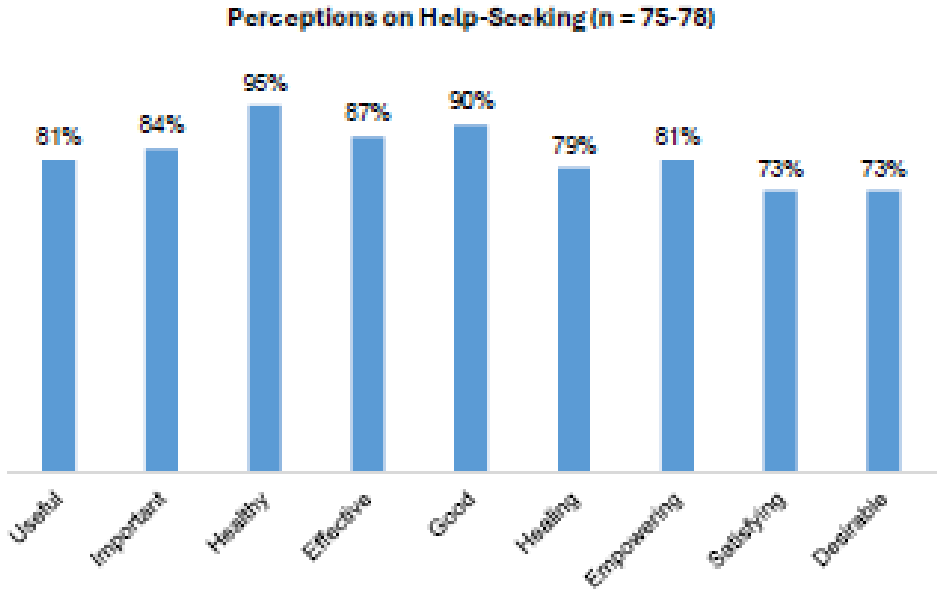
On average, participants reported less stigmatizing and discriminatory views at the conclusion of PRIDE trainings.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activity Outcomes

Participants also reported their perceptions on seeking professional help for mental health struggles after completing PRIDE trainings. Participants were presented with different adjectives to describe help-seeking. The percentage of participants who selected each adjective is presented in the chart below.



Overall, participants reported highly favorable views on seeking professional help for mental health struggles.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activity Outcomes: Satisfaction

Participants who attended PRIDE trainings were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 82)

Statement	% Agree
The materials provided were useful.	89%
The program was practical and useful.	90%
I would recommend this program to others.	90%

Participants were very satisfied with Diversity Collective's PRIDE trainings.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activity Outcomes: Areas of Support

Participants who attended PRIDE trainings were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 51)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	6%
My grades in school	4%
My housing situation	2%
My job situation	53%
My relationships with friends and family	43%
My parenting	29%
Staying out of jail or prison	2%
My mental health	33%
Substance use	4%

Participants reported that the primary area of need was their job situation.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Program Activity Feedback and Successes

Participants who attended PRIDE trainings were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 72)

- Learning Experience (20)
- Mental-Health Related Topics (18)
- Increased Knowledge and Awareness (18)

What would make this program better?
(n = 48)

- Provide Resources/ Additional Follow-Up (15)
- No Recommendations (11)
- Extend Training to Others (4)

"New knowledge on how to assess and help someone suffering from a mental health crisis."

"Continue to come to our classrooms! Students need you."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Overall Program Outcomes

Diversity Collective tracks outcomes by surveying participants who receive services offered by the organization. Participant outcomes are assessed at two time points: intake (beginning of fiscal year or program entry) and exit (program departure or end of fiscal year) using the Schwartz Outcome Scale (SOS-10), a 10-item measure of psychological health. Higher scores on this measure indicate greater psychological well-being/lower levels of distress. Comparisons of intake and exit scores are presented in the chart below.

Categorization of SOS-10 Scores at Intake (n = 11) and Exit (n = 10)[1]

Category	Intake	Exit
Minimal	55%	10%
Mild	18%	10%
Moderate	18%	70%
Severe	9%	10%

The proportion of participants reporting minimal distress dropped from 55% to 10%, while moderate distress increased from 18% to 70% between intake and exit.

Most participants (70%) have been receiving services from Diversity Collective for 7 months or longer.

[1]Total score on the SOS-10 ranges from 0–60 and scores are categorized as minimal (40–60), mild (33–39), moderate (23–32), or severe (1–22) levels of distress.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Overall Program Satisfaction

Participants of Diversity Collective were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agree or Strongly Agree
(n = 10)

Statement	% Agree
It is easy to get help at this program.	100%
I would recommend this program to a friend or family member.	100%
Services are in the language I am most comfortable speaking.	100%
Staff respect my cultural background.	100%

Participants were highly satisfied with the Diversity Collective program.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Overall Program Outcomes: Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 9)

Before I attended this program, I wanted help with...	# of Participants^
My school attendance	0
My grades in school	1
My housing situation	1
My job situation	0
My relationships with friends and family	3
My parenting	0
Staying out of jail or prison	0
My mental health	8
Substance use	0

Participants reported that the primary area of need was mental health.

*Counts may exceed number of participants because each could choose more than one response option.
^Actual counts rather than percentages are reported given the small sample of respondents (n=9). These findings should be interpreted carefully and may not represent broader trends.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Overall Program Feedback and Successes

Participants who received program services from Diversity Collective were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 9)

- Socialization (6)
- Positive/Welcoming Environment (5)

What would make this program better?
(n = 9)

- No Recommendations (5)
- More Resources (2)
- Better Refereshments (2)

"We have a CLU Master's student who is gaining practicum hours with DCVC and our youth. The Rainbow Umbrella group has been very receptive to her, and she is bringing a lot of her knowledge as an educator to the group - like games about resiliency, writing, etc."

"Staff was notified that one of the Rainbow Umbrella youths died by suicide. We waited to tell the group until (...) we could have a therapist from New Beginnings in the room to help process the news and answer questions. We also passed out information about their memorial, in case any of the youth wanted to go and get some closure."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

DIVERSITY COLLECTIVE

Conclusion and Recommendations

Diversity Collective provides programming for LGBTQ+ youth and their allies through a diverse array of activities, including PRIDE trainings, interactive workshops, peer support groups, and advocacy skills sessions. The program offers holistic support tailored to the unique needs of the LGBTQ+ community, addressing mental health stigma and discrimination while fostering more favorable attitudes towards help-seeking.

Participants expressed strong appreciation for the program, particularly valuing opportunities to socialize with peers and the safe space where they could explore their identities and feel accepted. Satisfaction survey respondents highlighted the impact of program staff and the support and resources they received as among the most helpful aspects of the program. Participants requested greater frequency and duration of programming activities rather than identifying specific areas for improvement.

During the evaluation period, the program experienced the tragic loss of a participant to suicide. All outcome data must be interpreted within the context of this profound loss and its impact on the program community. Clinical outcome data shows that 70% of participants who completed exit assessments reported moderate distress, compared to 18% at intake, while minimal distress decreased from 55% to 10%. This change in distress levels reflects the grief and trauma experienced by the program community following the loss of their peer.

Standard program effectiveness conclusions are not appropriate given the critical incident that occurred during the evaluation period.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE OXNARD PERFORMING ARTS CENTER CORPORATION (OPAC)

The Art is Wellness Club offers in-person and online wellness activities for low-income, underserved Latino youth and families in Oxnard. The program combines creative experiences—such as drum circles, dancing, gardening, and button-making—with access to culturally relevant mental health information. Resource tables and displays highlight support for underserved communities. For those unable to attend in person, OPAC provides a dedicated mental health section on its website, featuring easy-to-follow videos and art therapy activities.

Program Strategies

Stigma and discrimination reduction

Program Highlights

343 individuals received core program services

59 individuals reached through outreach events†

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Demographic Data

Race* (n = 307)

American Indian / Alaskan Native	4%
Asian / Asian American	5%
Black / African American	4%
Native Hawaiian / Other Pacific Islander	0%
Hispanic / Latino	73%
White	20%
Another	5%

30 did not answer this question.
6 selected "decline to state."

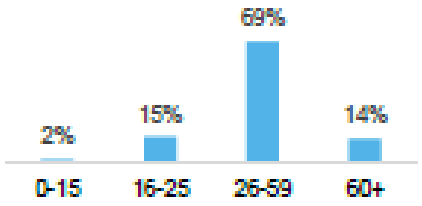
75% Hispanic/Latino
18% Non-Hispanic/Latino

Ethnicity* (n = 301)

Caribbean	1%	Hispanic
Central American	3%	Hispanic
Mexican/Mex.-Am./Chicano	68%	Hispanic
Puerto Rican	1%	Hispanic
South American	2%	Hispanic
Other Hispanic/Latino	0%	Hispanic
African	3%	Non-Hispanic
Asian Indian/South Asian	0%	Non-Hispanic
Cambodian	0%	Non-Hispanic
Chinese	0%	Non-Hispanic
Eastern European	1%	Non-Hispanic
European	9%	Non-Hispanic
Filipino/a	4%	Non-Hispanic
Japanese	1%	Non-Hispanic
Korean	0%	Non-Hispanic
Middle Eastern	0%	Non-Hispanic
Vietnamese	0%	Non-Hispanic
Other Non-Hispanic/Latino	0%	Non-Hispanic
More than one	4%	Non-Hispanic

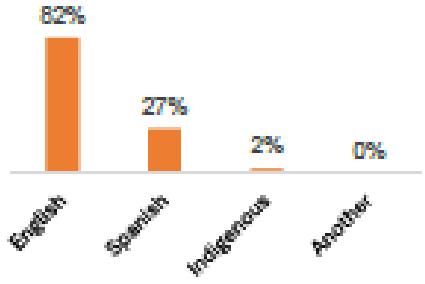
38 did not answer the question.
6 selected "decline to state."

Age Groups (n = 316)



28 did not answer this question.
1 selected "decline to state."

Primary Language* (n = 316)



28 did not answer this question.
1 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

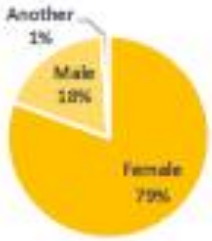
Demographic Data

Current Gender Identity (n = 313)

Female	75%
Male	18%
Transgender	1%
Genderqueer	3%
Questioning or Unsure	0%
Another Gender Identity	1%

26 did not answer this question.
4 selected "decline to state."

Sex Assigned at Birth (n = 314)



26 did not answer this question.
3 selected "decline to state."

Sexual Orientation (n = 282)

Bisexual	10%
Gay or Lesbian	2%
Heterosexual or Straight	68%
Queer	8%
Questioning or Unsure	0%
Another Sexual Orientation	1%

30 did not answer this question.
31 selected "decline to state."

12% of individuals reported having one or more disabilities (n = 313)

15 did not answer this question.
15 selected "decline to state."

2% of individuals identified as veterans (n = 307)

33 did not answer this question.
3 selected "decline to state."

Disability* (n = 53)

Seeing	15%
Hearing	8%
Other Communication	0%
Learning Disability	13%
Developmental Disability	8%
Dementia	0%
Another Mental Disability	0%
Physical Disability	19%
Chronic Health Condition	13%
Another Disability	11%

5 individuals reported more than one disability.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Program Activities, Outreach, and Training

Program activities include community fairs, education, workshops, and classes facilitated by the Andale! Wellness and Creativity for Everyone program staff. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources

Program participants and other community members may participate in these activities and events.

Program Activities, Outreach, Trainings by Type	# Activities/ Events
Community Fair/Event	41
Class	2
Education	3
Other: Mental Health Outreach	13
TOTAL # of Activities/Outreach/Training	59

58,906 total participants reached†

44% of activities offered in Spanish

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Andale! Wellness and Creativity for Everyone

Program Outcomes

Andale! Wellness and Creativity for Everyone tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they received services. Survey results are presented in the chart below.

% of Strongly Agree and Agree Responses Before and After Program
(n = 328- 335)

Statement	Intake	Exit
I knew/know a lot about the topic of this program.	57%	93%
I knew/know where to go for mental health services.	67%	93%
I knew/know when to ask for help with an emotional problem.	78%	93%
I felt/ feel good about myself.	89%	98%
I felt/feel hopeful when I think about the future.	86%	97%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Program Satisfaction

Participants of Andale! Wellness and Creativity for Everyone were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Strongly Agree and Agree
(n = 334 – 336)

Statement	% Strongly Agree/Agree
The materials provided were useful.	98%
The program was practical and useful.	98%
I would recommend this program to others.	98%

Participants were highly satisfied with the Andale! Wellness and Creativity for Everyone program.

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

% of Participants Who Need Support*
(n = 199)

Before I attended this program, I wanted help with...	% of Participants
My school attendance	6%
My grades in school	7%
My housing situation	13%
My job situation	17%
My relationships with friends and family	49%
My parenting	20%
Staying out of jail or prison	6%
My mental health	79%
Substance use	7%

Participants reported that the primary areas of need were their mental health and their relationships with friends and family.

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Program Feedback and Successes

Participants who received program services from Andale! Wellness and Creativity for Everyone were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 306)

- Mental Health and Relaxation Benefits (121)
- Activities and Personal Growth (100)

What would make this program better?
(n = 218)

- Program Continuation and Increased Frequency (67)
- Enhanced Physical Environment and Logistics (64)

"I liked everything, the day was perfect and beautiful and made the sound bath class relax me that I love it so much. I would like for this class to continue."

"To have the workshop more often so we can learn more."

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.
[2]Number of individuals reached includes both exact counts and estimated ranges. Analysis for ranges were calculated using midpoint values (e.g., 150-200 = 175). Approximately 5% of outreach events (2 out of 40) used estimates rather than exact counts.

ANDALE! WELLNESS AND CREATIVITY FOR EVERYONE

Conclusion and Recommendations

The Art is Wellness Club engaged low-income Latino youth and families in Oxnard through wellness activities, including drum circles, dancing, gardening, yoga, and button-making. The program aimed to reduce stigma and discrimination by providing mental health information and resources in accessible, culturally appropriate formats at community events and through an online platform featuring videos and art therapy activities.

The program demonstrated strong community reach, with approximately 2,000 attendees at its Dia de los Muertos Celebration, where information on mental health apps and support services was distributed. Participants reported high satisfaction with the program's practicality and usefulness, indicating they would recommend it to others and found program materials valuable. Program outcomes showed improvements across multiple measures. Participants demonstrated marked increases in knowledge about program topics and awareness of mental health service resources. Self-esteem and hope measures also improved, with participants reporting enhanced feelings of self-worth and optimism about the future.

An area of future improvement includes increasing program frequency, as participants consistently requested more sessions throughout the year, particularly for yoga and dance classes. Additionally, participants suggested expanding outreach efforts to raise awareness and attendance, as some events experienced lower turnout. Participants also shared some logistical improvements, such as providing shade for outdoor events, ensuring adequate equipment like yoga mats, and addressing sound equipment for instructors, would enhance their experience. Overall, the program offered accessible wellness activities and mental health resources to Latino families in Oxnard through community events.

[1]Number of people reached may be duplicated because individuals could attend multiple activities/events.
[2]Number of individuals reached includes both exact counts and estimated ranges. Analysis for ranges were calculated using midpoint values (e.g., 150-200 = 175). Approximately 5% of outreach events (2 out of 40) used estimates rather than exact counts.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

The Logrando Bienestar program is designed to help the Latino community understand the importance of mental and emotional health, with the goal of helping individuals access services for productive and healthy lifestyles. Logrando Bienestar walks participants through the process of getting well. The program serves youth and adults countywide.

Program Strategies

Improves timely access to services for underserved populations countywide through referrals to culturally and linguistically appropriate services.

Implements normative and cultural values to reduce stigmatization and increase workshop participation.

Program Highlights

1,693 individuals received core program services

34,141 individuals reached through outreach events†^

†Number of people reached may be duplicated because individuals could attend multiple activities/events.
^Number of individuals reached includes both exact counts and estimated ranges. Analysis for ranges were calculated using midpoint values (e.g., 150-200 = 175). Approximately 5% of outreach events (2 out of 40) used estimates rather than exact counts.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

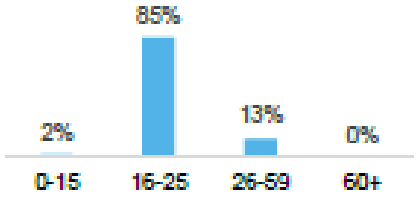
Demographic Data

Race* (n = 951)

American Indian / Alaskan Native	1%
Asian	2%
Black / African American	2%
Native Hawaiian / Other Pacific Islander	<1%
White	56%
Another	39%

742 did not answer this question.

Age Groups (n = 1,693)

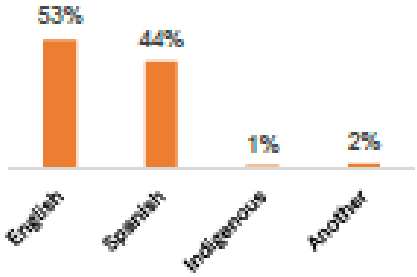


89% Hispanic/Latino
11% Non-Hispanic/Latino
(n=1,100)

No individuals identified as veterans
(n = 178)

1,515 did not answer this question.

Primary Language (n = 1,527)



Another includes American Sign Language, Samoan.
166 did not answer this question.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

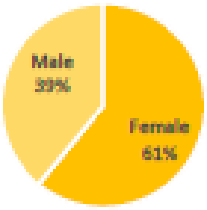
LOGRANDO BIENESTAR

Demographic Data

Current Gender Identity (n = 1,248)	
Female	61%
Male	38%
Transgender	<1%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	<1%

445 did not answer this question.

Sex Assigned at Birth† (n = 1,686)



7 did not answer this question.

Sexual Orientation (n = 46)	
Bisexual	0%
Gay or Lesbian	2%
Heterosexual or Straight	98%
Queer	0%
Questioning or Unsure	0%
Another Sexual Orientation	0%

1,633 did not answer this question.
14 selected "decline to state."

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Program Activities, Outreach, and Training

Program activities include classes, meetings, support groups, trainings, and workshops facilitated by Logrando Bienestar program staff. Program participants and other community members may participate in these activities and events. Program outreach includes activities to promote the program in the community, increase awareness of mental health and link community members to mental health resources.

Program Activities, Outreach, and Trainings by Type	# Activities/ Events
Field Trip	4
Presentation	12
Community Fair or Event	77
Support Group	337
Outreach	370
TOTAL # of Activities/Outreach/Trainings	**800**

3,518 participants in program activities†

100% of program activities and outreach events conducted in Spanish

34,141 people reached through outreach events†

30,204 materials distributed

†Number of people reached may be duplicated because individuals could attend multiple activities/events.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Program Outcomes

Logrando Bienestar tracks program outcomes by asking participants to self-assess their knowledge from two perspectives (retrospective pre/post): before and after they receive services. Survey results are presented in the table below.

% of Yes Responses Before (n = 14-15) and After (n = 13-14) Program

Statement	Before	After
I knew that stress could affect mental health	93%	**100%**
I could recognize the signs of mental illness	80%	**92%**
I knew that mental illness could happen at any age	93%	**93%**
I knew that mental illness was a real medical illness	100%	**100%**
I was comfortable providing mental health resources to friends or family	71%	**93%**
I was comfortable seeking mental health support	71%	**93%**
I knew where mental health services were in my community	60%	**93%**

Participants reported greater knowledge and understanding of mental health after the program or services.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Program Satisfaction

Participants of Logrando Bienestar were asked to indicate the extent to which they agreed or disagreed with several satisfaction-related statements. The chart below shows the percentage of participants who strongly agreed or agreed with each statement.

% of Participants Who Agreed or Strongly Agreed
(n = 13-15)

Statement	% Strongly Agree/Agree
Materials provided were useful.	87%
The program was practical and useful.	92%
I would recommend this program to others.	86%

Participants were highly satisfied with Logrando Bienestar's program.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Areas of Support

Participants were asked to select areas in which they needed additional support from a list of options. The table below displays all statement response options and the percentage of participants who indicated they needed help in each area.

# of Participants Who Need Support*
(n = 5)

Before I attended this program, I wanted help with...	# of Participants[2]
My school attendance	0
My grades in school	0
My housing situation	0
My job situation	1
My relationships with friends and family	3
My parenting	0
Staying out of jail or prison	1
My mental health	1
Substance use	0

*Percentages may exceed 100% because participants could choose more than one response option.
[2]Counts are reported rather than percentages due to small sample size (n=5). Results should be interpreted with caution and are not generalizable to the broader program population.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

LOGRANDO BIENESTAR

Program Feedback and Successes

Participants who received program services from Logrando Bienestar were asked to provide additional feedback through two open-ended response questions. Their comments were grouped by theme, and the top responses are presented below. The number of people who commented under each response category is shown in parentheses.

What was most helpful about this program?
(n = 12)

- Time presentation was offered (7)
- Content covered during the program or services (5)

What would make this program better?
(n = 6)

- No specific recommendations(3)
- Program expansion (3)

LOGRANDO BIENESTAR

Conclusion and Recommendations

Logrando Bienestar continues to serve its intended population, with nearly 90% of program participants identifying as Hispanic/Latino. The program offers various program activities including workshops, trainings, and outreach events. Data on program outcomes revealed that participants have developed greater knowledge and understanding of mental illness, including how to recognize signs/symptoms, awareness of contributing factors, and where to seek help if needed.

Participants were highly satisfied with the program, finding it to be both practical and useful. Recommendations for program improvement include various aspects of program expansion, such as the use of testimonies and having longer presentations. The program can also benefit from narrative data on successes and challenges to provide greater context for and complement existing quantitative outcome data.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS
VENTURA COUNTY BEHAVIORAL HEALTH (VCBH)

Ventura County Behavioral Health (VCBH)'s Suicide Prevention Efforts and Events support community outreach, education, and intervention through the VCBH Suicide Prevention Council, Access/Crisis Line, in-person presentations/trainings, webinars, resource tabling, e-newsletters, STAY suicide prevention public service campaign, community events, and collaboration with local stakeholders.

Program Strategies

Enhance interagency and community collaboration to identify, develop, and implement effective suicide prevention strategies

Increase knowledge and awareness of suicide risks and resources

Program Highlights

Approximately **255** individuals engaged in program activities

652 individuals engaged in suicide prevention trainings and events

SUICIDE PREVENTION EFFORTS & EVENTS

Demographic Data

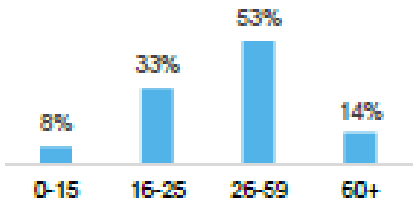
Demographics of participants who filled out a survey after engaging with a suicide prevention related activity. This includes various events and trainings. A total of 652 respondents filled out a demographic survey.

Race* (n = 625)

American Indian / Alaskan Native	3%
Asian / Asian American	3%
Black / African American	2%
Native Hawaiian / Other Pacific Islander	1%
Hispanic/Latino	68%
White	32%
More Than One	1%
Another	0%

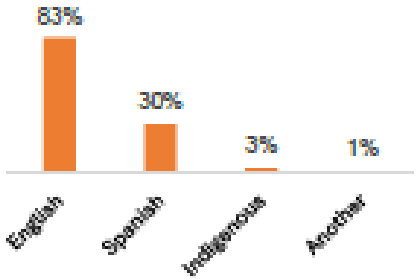
Other includes Lebanese/French.
17 did not answer this question.
10 selected "decline to state."

Age Groups (n = 619)



27 did not answer this question.
6 selected "decline to state."

Primary Language* (n = 552)



Another includes American Sign Language, Tagalog, Portuguese, and Gujarati.
98 did not answer this question.
2 selected "decline to state."

Current Gender Identity (n = 620)

Female	72%
Male	27%
Transgender	0%
Genderqueer	1%
Questioning or Unsure	0%
Another Gender Identity	0%

30 did not answer this question.
2 selected "decline to state."

*Percentages may exceed 100% because participants could choose more than one response option.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Program Activities: Community Events

Suicide Prevention provides events for community members focused on raising awareness about suicide, local resources, and mental well-being. Suicide Prevention has partnered with key stakeholders, such as the American Foundation for Suicide Prevention, 988, and MHSOAC, among others, for resource tabling, community presentations, prevention walks, and a Suicide Fatality Review Process. The table below lists community events and the number of participants.

Program Activities by Type	# of Participants
9th Annual Suicide Prevention Symposium	150
Mental Health Symposium	105
TOTAL # of Activities/Events	**255**

Community Event Satisfaction

Attendees of the 9th Annual Suicide Prevention and Mental Health Symposiums were asked to rate various aspects of the events on a scale of "Very Good" to "Very Poor." The chart below shows the percentage of participants who responded "Good" or "Very Good" for each event component.

RATINGS OF COMMUNITY EVENT COMPONENTS

(n =106-176)

Program Activities by Type	# of Participants
Speakers	98%
Resources provided	99%
Registration process	93%
Event venue	98%
Event date and time	96%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Program Satisfaction

Participants were asked to reflect on their knowledge before and after attending the 9th Annual Suicide Prevention Symposium and the Mental Health Symposium. The chart below presents survey results showing the percentage of participants who strongly agreed or agreed with each statement.

% of Strongly Agree and Agree Responses Before and After Events
(n = 111)

Statement	Before	After
I knew/know about support services for individuals experiencing suicidal thoughts or showing warning signs of suicide.	91%	98%
I would be comfortable supporting friends and family experiencing suicidal thoughts or showing warning signs of suicide.	86%	97%
I would be comfortable reaching out to a friend or family member if I have thoughts about suicide.	76%	89%
I would be comfortable reaching out to a professional or calling a hotline if I have thoughts about suicide.	73%	91%

Participants were highly satisfied with Suicide Prevention community events.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Program Satisfaction: Suicide Prevention Council

The Suicide Prevention Council, made up of stakeholders from across Ventura County, is committed to reducing suicides. The council's mission is to offer support and hope to those at risk or impacted by suicide by raising public awareness, identifying resources, providing education, and promoting innovative prevention and intervention efforts.

During FY 2024-2025, the Council met regularly, with an average of 30 attendees. Meetings included updates on Council activities, announcements from local organizations (e.g., upcoming events, volunteer opportunities, workshops, etc.), and educational presentations. Below is a summary of all the presentations shared.

Guest Speaker	Presentation
Rio Lorenzo, Director and Kuni Mi Coordinator, MICOP Behavioral Wellness	08/14/2024 **Topic:** Culturally Responsive Youth Suicide Prevention for Indigenous Communities
Adriana Almazan, Suicide Prevention Trainer Better in Community Consulting Maya Zumaya, Suicide Prevention Trainer MZ Independent Consulting	10/09/2024 **Topic:** Suicide Prevention Training – How to Make Our Community Safer
Andrea Craig, MSW/ACSW, Grief & Bereavement Counselor, Livingston Memorial Visting Nurse Association & Hospice	11/13/2024 **Topic:** Grief, Bereavement, and Postvention Support Services
Grant LaVigna, LMFT, Camarillo Private Practice Community Activist & Board Member Autism Society Ventura County	02/05/2025 **Topic:** Addressing Neurodiversity, Stigma, and Suicide Awareness
Roger Horne, Communications Manager & Jason Sagar, Case Management Programs Manager County of Ventura Human Services Agency, Area Agency on Aging	05/07/2025 **Topic:** Suicide Prevention Efforts & Older Adults

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Program Satisfaction: 988 Suicide & Crisis Lifeline

The 988 Suicide & Crisis Lifeline is a free, confidential, and multilingual resource available to anyone in distress*. Trained crisis counselors are available 24/7 to provide immediate emotional support via phone, text, and online chat to Ventura County residents. They also assist in connecting individuals at risk of suicide to local mental health resources and services. The information below highlights the number of contacts (calls, texts, and chats) originating from Ventura County July 2024 to June 2025.

The 988 Suicide & Crisis Lifeline is an expansive network of over 200 crisis contact centers across the United States. Didi Hirsch Mental Health Services is the 988 crises contact center for Ventura County, partnering with the VCBH Crisis Team for warm handoffs when indicated.

27,944 988 Suicide & Crisis Lifeline Contacts

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Trainings

Question, Persuade, and Refer (QPR) Gatekeeper Training

The QPR Gatekeeper Training is a suicide prevention training program that teaches people how to recognize warning signs of a suicidal crisis, understand the common causes of suicidal behavior, and provide an emergency mental health intervention to someone who may be suicidal, regardless of their background. Participants were asked to report on their perceptions of suicide prevention from two perspectives (retrospective pre/post): before and after training. Comparisons of participants' pre- and post-ratings are presented in the tables below.

Self-Rated Knowledge Levels*
Before (n=78-83) and After (n = 74-75) QPR Training

Statement	Before	After
Facts concerning suicide prevention	26%	80%
Warning signs of suicide	31%	69%
How to ask someone about suicide	24%	80%
Persuading someone to get help	31%	72%
How to get help for someone	27%	76%
Information about local resources	17%	61%

**Percentage of participants rating knowledge as "High"*

Confidence Toward Suicide Intervention*
Before (n= 35-37) and After (n = 75) QPR Training

Statement	Before	After
I feel that asking someone about suicide is appropriate.	44%	69%
I feel likely to ask someone if they are thinking of suicide.	47%	68%

**Percentage of participants rating knowledge as "Always"*

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

LivingWorks safeTALK training.

LivingWorks safeTALK is a four-hour training that equips participants to be more alert to someone thinking of suicide and better able to connect them with further help. The chart below shows the percentage of participants who strongly agreed or agreed with each statement following the training.

% of Strongly Agree and Agree Responses After Training
(n = 36-37)

Statement	% Strongly Agree/Agree
My trainer was prepared and familiar with the material.	97%
My trainer encouraged participation and respected all responses.	100%
I feel prepared now to talk directly and openly to a person about their thoughts of suicide.	97%

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Program Successes and Learnings

Attendees at the 9th Annual Suicide Prevention and Mental Health Symposiums were asked to provide additional feedback, including the usefulness and value of the events as well as areas of improvement. Their comments were categorized into themes, and theme descriptions are presented below.

High perceived value and relevance	Participants consistently rated both symposiums as valuable, relevant, and worth recommending to others.
Panels and lived-experience speakers had the greatest impact	Attendees most frequently cited expert panels and personal stories as the most useful and meaningful components.
Increased knowledge and comfort with suicide prevention	Participants reported greater awareness of resources and increased confidence in discussing suicide and supporting others.
Strong value placed on resource-sharing and collaboration	Many participants highlighted learning about local resources and connecting with other agencies and professionals.
Events promoted connection and shared purpose	Feedback emphasized feeling less isolated and more supported through open dialogue and collective learning.
Ongoing demand for continued education	Many attendees expressed interest in additional training and future symposiums.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SUICIDE PREVENTION EFFORTS & EVENTS

Conclusions

VCBH Suicide Prevention Efforts and Events demonstrate a multi-faceted approach to addressing suicide through stakeholder engagement and resource distribution across the county.

The 2023-2028 Suicide Prevention Strategic Plan provides a framework for reducing suicides through the identification of priority populations, mapping of local trends in suicide ideation and behaviors, and implementation of prevention, intervention, and postvention strategies. Council Implementation Workgroups continue advancing the plan's goals and objectives.

Community events created engaging spaces for over 1,100 youth and adults to discuss mental well-being, local resources, and tailored support for specific populations. Positive feedback from respondents highlights the events' value, supporting the need for more gatherings across the County to boost community awareness and knowledge on critical topics in suicide prevention. Satisfaction data from symposium attendees showed highly positive ratings for event components. Pre- and post-event surveys demonstrated measurable knowledge increases, with participants reporting higher understanding of suicide warning signs, local resources, and intervention strategies after attendance.

Both prevention trainings demonstrated measurable impact across multiple domains. QPR training participants showed increased self-rated knowledge in recognizing suicide warning signs, understanding causes of suicidal behavior, and knowing how to connect individuals to resources. Confidence in suicide intervention also increased, with post-training participants reporting higher rates of "always" confident responses compared to pre-training. SafeTALK training participants similarly reported increased confidence in identifying suicide risk and connecting individuals to help.

The 988 Suicide & Crisis Lifeline continues to provide 24/7 multilingual crisis support and connections to mental health services for Ventura County residents through phone, text, and online chat. A total of 27,944 contacts were made from July 2024 to June 2025, underscoring the importance of maintaining and expanding hotline capacity to meet demand and ensure that all calls, texts, and chats are handled efficiently. Enhanced tracking and analysis of hotline data could further inform VCBH on specific needs within Ventura County, enabling targeted outreach to at-risk populations and reinforcing the hotline's role as a preventive measure against suicide. Creating a Suicide Fatality Review Team with partnering agencies would be beneficial to inform suicide prevention efforts and decrease suicide risk in the community.

Recommendations

1. **Expand community engagement**
   Increase the number and geographic reach of community events to ensure equitable access to suicide prevention education and resources, especially in underserved areas.
2. **Enhance gatekeeper training**

Offer more in-person, evidence-based suicide prevention trainings for community members, educators, and service providers to build confidence in identifying and responding to suicidal behaviors.

3. **Strengthen data-driven strategies**
   Partner with the Medical Examiner's Office, Ventura County Public Health, and other agencies to create a Suicide Fatality Review Team that analyzes data, identifies gaps, and informs targeted interventions for high-risk populations.
4. **Promote 988 lifeline awareness**
   Continue outreach campaigns to raise awareness of the 988 suicide & crisis lifeline, using multilingual and culturally responsive messaging.
5. **Leverage technology and analytics**
   Expand tracking and analysis of hotline, training, and event data to identify gaps, measure impact, and refine prevention, intervention, and postvention strategies.
6. **Support council workgroups**
   Sustain and strengthen suicide prevention council workgroups to advance the strategic plan's goals and maintain coordinated, cross-sector collaboration.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

APPENDIX A. CATEGORIES OF VCBH PEI PROGRAMS

Program/Provider	FY 24-26 PEI Program Categories						
	Prevention	Early Intervention	Outreach for Increasing Recognition of Early Signs of Mental Illness	Stigma & Discrimination Reduction	Access and Linkage to Treatment	Suicide Prevention[1]	Improving Timely Access to Services for Underserved Populations[2]
Multi-Tiered System of Support Ventura County Office of Education	■						
Wellness Centers Expansion Ventura County Office of Education	■						
One Step a La Vez (OSALV) Conocimiento	■						
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) County of Ventura Human Service Agency Area (HSA)	■						
Project Esperanza Our Lady of Guadalupe Parish	■						
Promoviendo Program Promotoras y Promotores Foundation (PYPF)	■						
Healing the Community Mixteco Indigena Community Organization Project (MICOP)	■						
Tri-County GLAD	■						
Wellness Everyday and STAY Media Campaign Idea Engineering, Inc	■						
Ignite Conocimiento Catalyst Church	■						
NAMBA Rock and Roll High Performing Arts Space Inc.	■						
Girls Rock SB Amplify Arts Project	■						
Healing Through the Arts De Colores Multicultural Folk Arts, Inc.	■						
Everyone has a Story Book Club Autism Society Ventura County	■						
Playful Bonds Childhood Matters	■						

No Limits Theater Group Inc., DBA No Limits for Deaf Children and Families							
Comadres Unidas Nyeland Promise							
Westside Wellness Two Trees Community							
Be Kind Program Boys & Girls Clubs of Greater Oxnard and Port Hueneme							
Girl Scouts							
COMPASS Seneca Family of Agencies							
One Step a La Vez (OSALV) Bienestar							
Primary Care Program Clinicas del Camino Real, Inc.							
Tri-County Glad Early Intervention and Supporting Services							
Ventura County Power Over Psychosis (VCPOP) Ventura County Behavioral Health							
Mental Health First Aid (MHFA)							
VC Family Justice Therapy Horse Program							
Crisis Intervention Team (CIT) Ventura County Law Enforcement							
Diversity Collective Rainbow Umbrella + P.R.I.D.E							
Andale! Wellness and Creativity for Everyone Oxnard Performing Arts Center Corporation (OPAC)							
Logrando Bienestar Ventura County Behavioral Health							
Suicide Prevention Ventura County Behavioral Health							

APPENDIX B. FY 24–25 NUMBERS SERVED

FY 24–25 Number of Participants Served by Program and Category

Program	Number of Participants
Prevention Programs	**87,606**
Girls Rock SB (Amplify the Arts)	130
Everyone Has a Story Bookclub (Autism Society)	35
Be Kind Program (Boys and Girls Club)	28
Playful Bonds (Childhood Matters)	63
Early Birds Coping Skills (Girl Scouts)	5,600
Healing through the Arts (De Colores)	194
Ignite Conocimiento (Catalyst Church)	72
Little Listeners (No Limits)	57
Mixteco Indigena Community Organization Project (MICOP)	267
Multi-Tiered System of Support (MTSS) – VCOE	59,029
NAMBA Flamenco Dance, Theater for Wellness	57
Comadres Unidas (Nyeland Promise)	36
One Step a La Vez Conocimiento	140
Program to Encourage Active, Rewarding Lives for Seniors	182
Project Esperanza	129
Promotoras Conexión Program	144
Tri-County GLAD	49
Wellness Centers	21,353
Westside Wellness (Two Trees)	41
Early Intervention Programs	**819**
COMPASS	18
Mental Health First Aid	180
One Step a La Vez Bienestar	21
Pathways to Hope (VC Family Justice)	27
Primary Care Program (Clinicas)	296

Ventura County Power Over Prodromal Psychosis (VCPOP)	277
Other PEI Programs	**2,546**
Crisis Intervention Team (CIT)	142
Diversity Collective	113
Logrando Bienestar	1,693
Andale! Wellness and Creativity for Everyone	343
Suicide Prevention	255
Total:	**90,971**

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

FY 24–25 Number of Participants Served by City of Residence[1]

Geographic Area	Number of Participants Served	% of Total
Camarillo	224	7%
Fillmore	195	6%
Moorpark	134	4%
Newbury Park	200	6%
Oak Park	58	2%
Ojai	29	1%
Oxnard	819	24%
Piru	10	<1%
Port Hueneme	92	3%
Santa Paula	419	12%
Simi Valley	254	8%
Thousand Oaks	308	9%
Ventura	520	15%
Other	112	3%
Total with available city of residence data:	3,374	

[1]City of residence data is not available for Crisis Intervention Training, Logrando Bienestar, Multi-Tiered System of Support VCOE, Primary Care Program, Suicide Prevention, VCPOP, Wellness Centers, and Wellness Everyday.

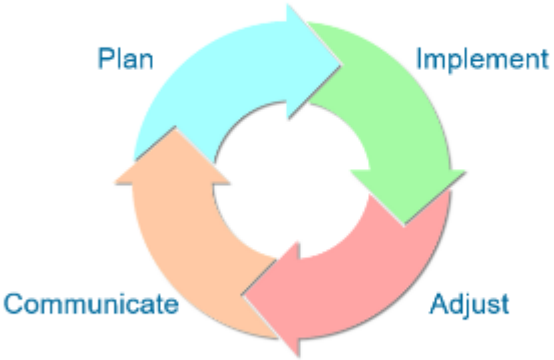
VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

February 2026

MENTAL HEALTH SERVICES ACT (MHSA) COMMUNITY PLANNING PROCESS (CPP)

Close out of the 3-Year MHSA Plan

MHSA Planning Process Changes



- Final report on the 2023-2026 MHSA plan
- All MHSA money becomes BHSA money with three time-limited exceptions
- Additional allocations and changes are made in the BHSA Integrated Plan
- Community Planning Process is required every three years no longer annual

VENTURA COUNTY BEHAVIORAL HEALTH

7

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

What does the MHSA Annual Update Process look like?

Local Planning Process

VENTURA COUNTY BEHAVIORAL HEALTH

3

Reviewing the last MHSA 3-year plan

- Began with a 30 million one-time allocation
- 8 Projects that are not yet reported on but are still planned to launch under BHSA
- Comprehensive community planning process
- Rolling over unspent MHSA money into BHSA categories under the one-time flexibility

VENTURA COUNTY BEHAVIORAL HEALTH

4

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

2022 Community Need Assessment - Final MHSA Results

Housing	• Buildings • Services • Units	Home Key Plus, Vagabond, rental subsides, increase in staff.
Expansion of Services and Treatment types	• Staff • Buildings • Services	Infrastructure upgrades for offices, CBOs, board and cares, offices, security, visibility and over 27 vehicles and expansion of clinic space in East County
Access	• Timing • Immediate or Urgent Care	A new CSU set to open, Additional CRT contract, and patient navigator pilot
Outreach and Education	• Knowing when, where, and how to access services.	Two new providers brought online to increase access referrals and community education. Vibewell, a Countywide mental health awareness campaign through the arts.
Alternatives to VCBH	• Mild to moderate care • Services partners	Over 20 new providers brought online to provided Early Intervention and treatment services

VENTURA COUNTY BEHAVIORAL HEALTH

5

MHSA to BHSA

MHSA (2004-2025)

- Mental Health Services Act
- Funded by 1% tax on income over $1 million annually
- Focus: Serious mental illness (SMI) and prevention
- Provided community-based mental health services with targeted focus on Prevention
- Created continuum of prevention, early intervention, and innovative programs
- Planning focused exclusively on MHSA dollars

BHSA (Effective 2026)

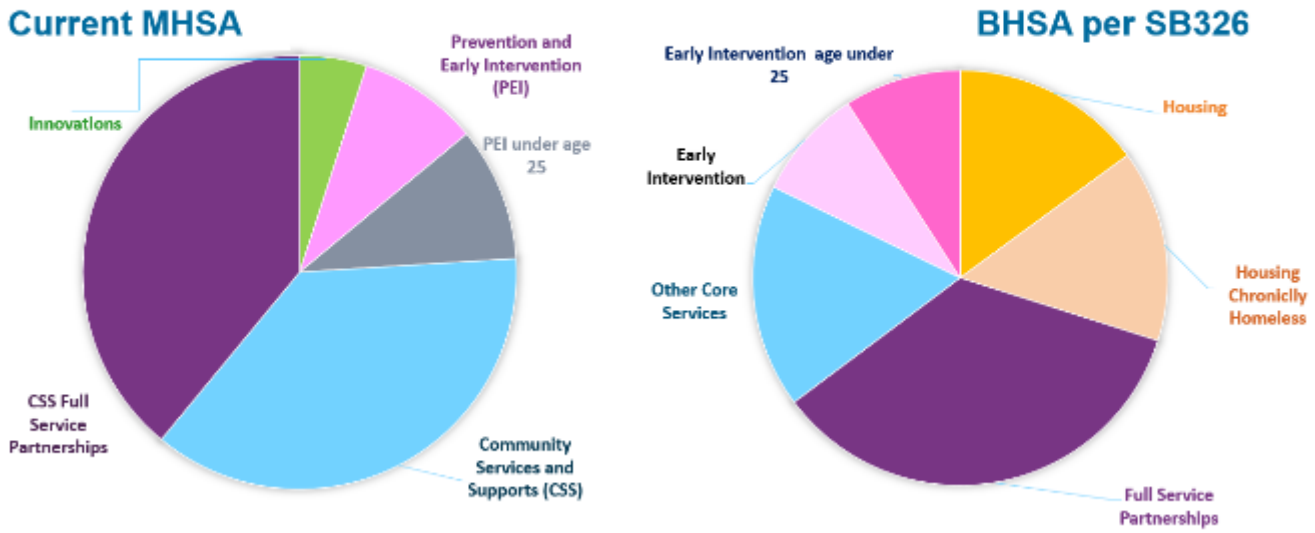
- Behavioral Health Services Act **NEW NAME**
- Same funding source (millionaire's tax)
- Expanded scope: Mental health + substance use disorders **EXPANDED**
- Prioritizes high-need populations: homelessness, justice-involved, at-risk individuals
- Enhanced housing interventions and workforce expansion
- Comprehensive reporting on ALL funding sources (local, state, federal) **ENHANCED**

VENTURA COUNTY BEHAVIORAL HEALTH

6

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

MHSA to BHSA Updated Spending Percentages



Review and Next Steps to close out MHSA 3-Year Plan

1. Continue to receive feedback on MHSA projects
   - **Deadline:** March 20th

2. Public Comment Window: Post the adjustment report to the public
   - MHSA Public Review Period **April –May** *(BHSA IP Public Window launches March 16)*
     - Announced at BHABs and posted to VCBH Website

3. Public Hearing for MHSA 3-year plan Mid-year adjustment
   - Monday May 18th 2pm-3:30pm

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Please fill out a survey

English:

https://www.surveymonkey.com/r/FY25-26CPPspr_En

Spanish:

https://www.surveymonkey.com/r/FY25-26CPPprim_Sp

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

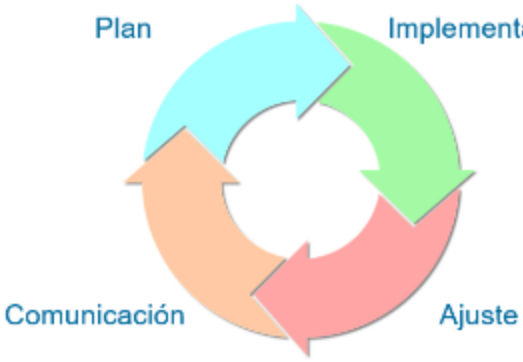
Febrero de 2026

PROCESO DE PLANIFICACIÓN COMUNITARIA (CPP, POR SUS SIGLAS EN INGLÉS) DE LA LEY DE SERVICIOS DE SALUD MENTAL (MHSA, MENTAL HEALTH SERVICES ACT)

Cierre del Plan de 3 años de la MHSA

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Cambios en el Proceso de Planificación de la MHSA



- Informe final sobre el plan de la MHSA de 2023-2026.
- Todo el dinero de la MHSA se convierte en dinero de la Ley de Servicios de Salud Conductual (BHSA, Behavioral Health Services Act) con tres excepciones de duración limitada.
- Se realizan asignaciones adicionales y cambios en el Plan Integrado de la BHSA.
- El proceso de Planificación Comunitaria se requiere cada tres años; ya no de forma anual.

VENTURA COUNTY BEHAVIORAL HEALTH

2

¿Cómo es el proceso de actualización anual de la MHSA?

Proceso de planificación local de la BHSA

1. Presentación de cambios al plan a las partes interesadas.
2. Comentarios de la comunidad.
3. Publicación por un periodo de 30 días.
4. Audiencia pública.
5. Aprobación de la Junta de Supervisores.

VENTURA COUNTY BEHAVIORAL HEALTH

3

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Revisión del último plan de 3 años de la MHSA

- Comenzó con una asignación única de USD 30 millones.
- 8 proyectos sobre los que aún no se ha informado, pero que se están poniendo en marcha según lo previsto.
- Proceso integral de planificación comunitaria.
- Traspaso de fondos no gastados de la MHSA a las categorías de la BHSA bajo la flexibilidad por única vez.

Evaluación de necesidad de la comunidad de 2022 - Resultados finales de la MHSA

Vivienda	• Edificios • Servicios • Unidades	Home Key Plus, Vagabond, subsidios de renta y aumento de personal.
Expansión de servicios y tipos de tratamiento	• Personal • Edificios • Servicios	Mejoras de infraestructura para oficinas, organizaciones comunitarias, centros de alojamiento y cuidado, seguridad, visibilidad y más de 27 vehículos, junto con la expansión del espacio clínico en el este del condado.
Acceso	• Plazos • Cuidados inmediatos o urgentes	Una nueva Unidad de Estabilización de Crisis (CSU, Crisis Stabilization Unit) próxima a inaugurarse, un contrato adicional de tratamiento residencial comunitario (CRT, Community Residential Treatment) y un programa piloto para los guías de los pacientes.
Alcance comunitario y educación	• Saber cuándo, dónde y cómo acceder a los servicios.	Dos nuevos proveedores incorporados para aumentar el acceso a derivaciones y la educación comunitaria. Vibewell, una campaña de concientización sobre salud mental a través de las artes en todo el condado.
Alternativas para VCBH	• Cuidados leves a moderados • Colaboradores de servicios	Más de 20 nuevos proveedores incorporados para brindar servicios de intervención temprana y tratamiento.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

De la MHSA a la BHSA

MHSA (2004-2025)

- Ley de Servicios de Salud Mental.
- Financiada por un impuesto del 1 % sobre los ingresos anuales superiores a USD 1 millón.
- Enfoque: enfermedades mentales graves y prevención.
- Proporcionó servicios de salud mental basados en la comunidad con un enfoque específico en la prevención.
- Se creó un continuo de prevención, intervención temprana y programas innovadores.
- La planificación se centró exclusivamente en los fondos de la MHSA.

BHSA (a partir de 2026)

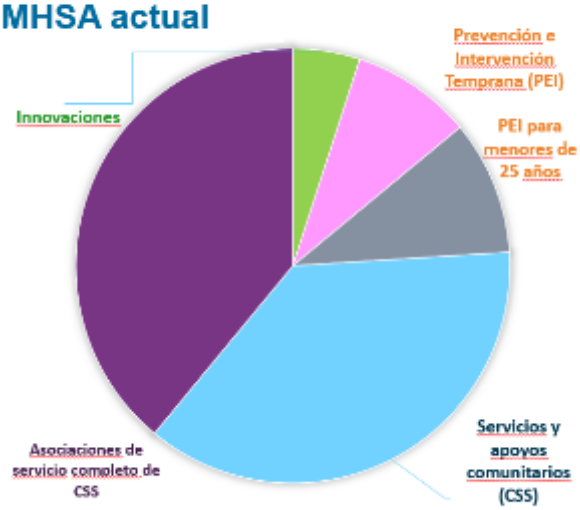
- Ley de Servicios de Salud Conductual **NUEVO NOMBRE.**
- Misma fuente de financiamiento (impuesto a los millonarios).
- Alcance ampliado: salud mental + trastornos por uso de sustancias **AMPLIADO.**
- Prioriza a las poblaciones de alta necesidad: personas sin hogar, personas involucradas en el sistema de justicia e individuos en riesgo.
- Intervenciones de vivienda mejoradas y expansión de la fuerza laboral.
- **MEJORA** de informes exhaustivos sobre TODAS las fuentes de financiamiento (locales, estatales, federales).

VENTURA COUNTY BEHAVIORAL HEALTH

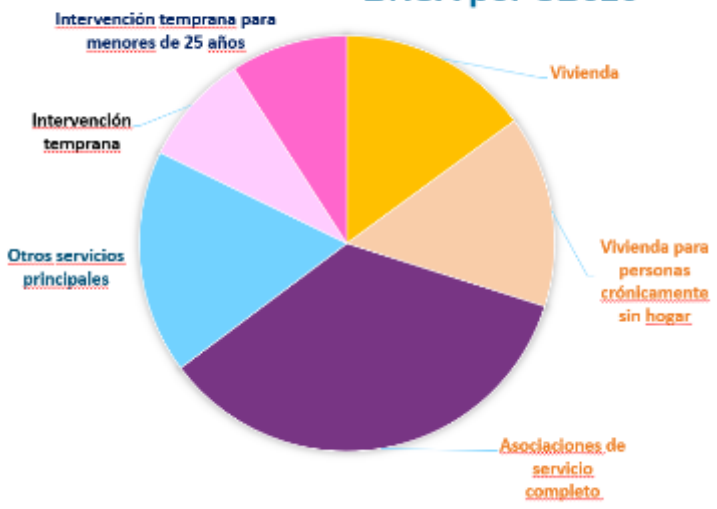
6

Actualización de los porcentajes de gasto de la MHSA a la BHSA

MHSA actual



BHSA por SB326



VENTURA COUNTY BEHAVIORAL HEALTH

Modernizando nuestro Sistema de Salud Conductual - Salud y Servicios Humanos de California

7

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Revisión y próximos pasos para el cierre del plan de 3 años de la MHSA

1. Continuaremos recibiendo comentarios sobre los proyectos de la MHSA.
   - **Fecha límite:** 20 de marzo

2. Periodo de comentarios públicos: publicación del informe de ajustes para el público.
   - Período de revisión pública de la MHSA **Abril-Mayo** *(periodo público para el Plan Integrado (IP) de la BHSA inicia el 16 de marzo).*
     - Anunciado en las juntas de la BHAB y publicado en el sitio web del Departamento de Salud Mental y Tratamiento del Uso de Sustancias (VCBH, Ventura County Behavioral Health).

3. Audiencia pública para el ajuste de mitad de año del plan de 3 años de la MHSA.
   - Lunes 18 de mayo de 2:00 p. m. a 3:30 p. m.

VENTURA COUNTY BEHAVIORAL HEALTH

Los fechas están planificadas y sujetas a cambios.

8

Por favor, conteste la encuesta.

Inglés:

https://www.surveymonkey.com/r/FY25-26CPPspr_En

Español:

https://www.surveymonkey.com/r/FY25-26CPPprim_Sp

VENTURA COUNTY BEHAVIORAL HEALTH

9