COUNTY OF SAN DIEGO

2026-2029

Behavioral Health Services Act Integrated Plan

SAN DIEGO COUNTY

SANDIEGOCOUNTY.GOV

Table of Contents

The Three-Year Integrated Plan follows a standard template that is set by the Department of Health Care Services.

2026 - 2029 Integrated Plan

San Diego County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information .

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
San Diego County

Behavioral Health Agency Name
San Diego County Health and Human Services, Behavioral Health Services

Behavioral Health Agency Mailing Address
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Name

Email

Behavioral Health Services Act (BHSA) Coordinator

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Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

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Medical Director

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County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	15115
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	8508
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	1038
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	415

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	165
Were chronically homeless or experiencing homelessness or at risk of homelessness	469
Were in the juvenile justice system	166
Have reentered the community from a youth correctional facility	217
Were served by the Mental Health Plan and had an open child welfare case	738
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	23

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	1099

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	5752
Received Medi-Cal SMHS	45777
Received DMC or DMC-ODS services	14573
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	5956
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	15233

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	12576
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	6230
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	3946
Were in the justice system (on parole or probation and not currently incarcerated)	6855
Were incarcerated (including state prison and jail)	11094
Reentered the community from state prison or county jail	2367
Received acute psychiatric services	4724

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

12429

Admitted for 14-day and 30-day periods of intensive treatment
2253

Admitted for 180-day post certification intensive treatment
14

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
47

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
192

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
Yes

Please explain
Youth Section (Table 5):
For youth, data related to homelessness is currently limited to living arrangement status that is available in our electronic health record (EHR) (i.e., SmartCare). Given the current data entry fields, the County is unable to reliably identify individuals who are at risk of homelessness. As a result, reported figures related to homelessness reflect only those who are identified as chronically homeless or currently experiencing homelessness according to living arrangement data. These counts should be considered conservative, as youth who may be at risk of homelessness but are not formally identified as such are not included.

Adult Section (Table 6):
Similar to the youth data, the County is unable to identify adults who are at risk of homelessness. Accordingly, homelessness-related figures reflect only individuals identified as chronically homeless or currently experiencing homelessness and may underestimate the total population with housing instability.

Additionally, at this time the County cannot reliably distinguish between sheltered and unsheltered homelessness in the underlying data within the EHR. For purposes of this report, all individuals identified as homeless were categorized as unsheltered. Homeless was defined as having a homeless living arrangement in reporting period. This methodological decision affects both the reported count of individuals experiencing unsheltered homelessness and the count of individuals transitioning from unsheltered homelessness to sheltered settings. For the latter, these were defined as individuals with a homeless living

arrangement during the fiscal year and then had a non-homeless living arrangement after their homeless date in the EHR. These figures should therefore be interpreted with this limitation in mind.

While the DHCS Data Dictionary provided several options for reporting incarceration-related measures, none fully aligned with the intent of this question. The County therefore based its response on the most appropriate available data, with clear documentation of methodology and limitations.

For the number of individuals who were incarcerated, the reported figure represents the number of individuals age 21 and older who had an open assignment, meaning they received a mental health service, within a County-operated jail mental health program during the reporting period. This reflects the jail level of care and includes both outpatient and inpatient mental health services. Outpatient services refer to individuals housed in the general jail population who received mental health services, while inpatient services refer to individuals housed in a secure jail unit for an acute mental health episode.

Please describe the local data used during the planning process

The data used for the Population Served section was pulled from multiple sources to ensure completeness and accuracy. Our primary source was SmartCare, our current electronic health record (EHR); however, because SmartCare did not go live until 9/1/2024, we also relied on our legacy systems — Cerner Community Behavioral Health (CCBH) and San Diego Web Infrastructure for Treatment Services (SanWITS) — to capture historical information, including past living arrangement data.

In addition, we incorporated data provided by Child and Family Well-Being (CFWB) to identify child welfare cases. The Public Service Group's (PSG) grantee list was used to determine client involvement in juvenile justice or probation. We also accessed the ECCO platform, the California Department of Health Care Services (DHCS) required database system for logging and tracking prevention services, to obtain Substance Use Disorder (SUD) prevention data. Finally, information on involuntary holds was sourced from data collected by the County Behavioral Health Services Quality Assurance team for the Lanterman-Petris-Short (LPS) Act programs.

If desired, provide documentation on the local data used during the planning process

Local CARE Act Implementation

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.

Program Portfolio (BHSA-funded and leveraged)

San Diego County CARE participants have "priority routing" into the highest-intensity, community-based services and housing supports. The core components of the 3-year plan include:

• Full Service Partnerships (FSPs) /Assertive Community Treatment (ACT) teams The highest-level outpatient care for adults with SMI, including 24/7 on-call support, psychiatry, medications, care management, connection to benefits, supported employment/education, housing navigation, supported housing, linkage to SUD care, peer services, and payee services.

• Intensive outreach and engagement to support the rapport building process, which is crucial to the success of engaging a respondent in the CARE process, San Diego County amended the In-Home Outreach Teams (IHOT) contract to include outreach and engagement of CARE respondents when the BHS operated CARE Team in unsuccessful in locating the respondent. This allows for greater efforts to be focused on locating and engaging a CARE respondent.

• Housing interventions: dedicated BHSA housing set-aside for rapid rehousing, bridge housing, rental subsidies, operating subsidies, and permanent supportive housing placements; capital and program slots aligned with BHSA's housing category and the Behavioral Health Bond (Homekey+/BHCIP).

• Care navigation & legal coordination: San Diego has created a BHS CARE Team that partners with the court, public defender, and community providers to engage CARE respondents, complete court ordered evaluations and reports, develop CARE Agreements/Plans, monitor progress hearings, and coordinate housing and services throughout the 12-month participation (extendable up to 24 months).

• Co-occurring SUD services: integrated with BHSA (which now includes treatment for substance use conditions and CalAIM-aligned care coordination to ensure seamless access across mental health and SUD.

• Workforce expansion & equity initiatives: BHSA transformation adds accountability and workforce focus; we staff peers, legal support and clerical staff, clinicians, and management prioritized for CARE caseloads.

• Priority access

To operationalize priority access for CARE participants across the continuum (including housing), San Diego County has:

• Developed a contract with an Assertive Community Treatment (ACT) provider specifically for CARE participants. This allows for direct linkage to ACT level treatment through a closed referral system and ongoing extensive care coordination between BHS and the contracted provider.

• Amended the In-Home Outreach Teams (IHOT) contract to include outreach and engagement of CARE respondents when the BHS operated CARE Team in unsuccessful in locating the respondent. This allows for greater efforts to be focused on locating and engaging a CARE respondent.

• Flag CARE participants in the EHR as CARE Respondents/Participants to promote engagement and collaboration with system providers.

• ASO Single Point of Access (SPOA) Prioritization flag and queue CARE respondents to priority intake tracks.

• Court-aligned care coordination: CARE Agreements/Plans must include treatment, stabilizing medications, and housing resources as appropriate; our specialized CARE Assertive Community Treatment program and priority track guarantee service slots so the county can meet court-monitored obligations.

• Data accountability: We will capture housing placements, continuation of treatment, and all other required program metrics and outcomes in line with CARE Act Data Dictionary and DHCS guidance. We will also continue to utilize our existing contract for internal BHS data collection, analysis, and program

improvement recommendations.

Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.

Referral sources and intake channels (embedded in the county's current system):

• Petitions filed to the Superior Court by eligible petitioners (family, first responders, providers, specified system partners). Once the court makes an initial determination, it orders County BH to investigate; the county provides a recommendation within 14 business days or requests a continuance to allow for ongoing attempts to engage the respondent.

• Court-to-court referrals (AOT/Laura's Law, IST) Individuals can be referred to CARE from other court proceedings. BHS takes on the role of evaluating the individual and filing the internal petition for those appropriate for CARE.

• Referrals from LPS-designated facilities: San Diego BHS accepts direct referrals rom LPS designated facilities throughout the system of care. We have developed a Hospital Liaison position within the CARE Team to promote streamlined communication and collaboration with our hospital partners. San Diego BHS had developed our own, streamlined referral form, which is sent directly to a secured email managed by the county-operated CARE team.

• Referrals from Jail: San Diego BHS has developed a process with San Diego Sherrif's office to allow for jail clinicians to refer directly to BHS CARE team rather than filing a petition. This partnership has assisted in connecting more individuals to CARE by relieving Jail staff the administrative burden of completing the petition and the responsibilities of being the original petitioner.

• LPS Step-Down Referrals: San Diego BHS has developed internal processes to screen individuals currently on LPS Conservatorships who have stabilized for CARE Eligibility and file an internal petition, when appropriate.

How we integrate these with existing referral pathways:

• Access and Crisis Line (ACL): San Diego utilizes a 24 hr public access line for information, resources, and connection to services, including CARE Act services.

• Single Point of Access (SPOA) integration: All CARE referrals to treatment providers outside of the designated Assertive Community Treatment team are routed through SPOA with a CARE priority flag to ensure expedited placement into ACT/FSP.

• Court partnership cadence: Regular case conferences before each progress hearing and 60-day reviews (as practiced in San Diego's program) to confirm services delivered and adjust plans.

• Care navigation + legal coordination: Dedicated staff at court self-help centers offer walk-in assistance on completing Judicial Council CARE forms (CARE-100, CARE-101, CARE-102)

• Documentation and data capture: We utilize CARE referral tracking in our EHR (Referral Source/Subtype, Disposition) per Data Dictionary v2.0 guidance, until DHCS final reporting requirements are fully integrated.

Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

Decision process & alternative pathways

When a person appears potentially eligible but a petition is not required or not appropriate, the county will:

1. Apply DHCS standardized screening & transition tools to determine the right delivery system (Managed Care Plan vs. County Mental Health Plan) and ensure timely coordinated care if services must shift.
2. Offer voluntary engagement directly (field-based outreach, mobile crisis, IHOT teams) and route to:

a. ACT or intensive case management, if SMI with homelessness risk and high service intensity is indicated.

b. AOT/Laura's Law (if criteria better match AOT rather than CARE), crisis residential, outpatient clinics, or specialty SUD programs, as clinically appropriate.

c. Housing navigation using BHSA housing interventions (rapid rehousing, bridge/permanent supportive housing) when instability is the primary barrier—leveraging BHSA's housing category and the Behavioral Health Bond programs.

How we confirm and document successful connection for individuals redirected from CARE

• EHR & SPOA records:

-Create a CARE Referral Flag in the EHR to capture Referral type, and record Disposition/Outcome (e.g., "Redirected to ACT," "Connected to AOT," "Referred to SUD services" etc.).

-Log service authorizations, first appointment dates, and encounter notes within EHR to confirm engagement (e.g., intake completed, medication evaluation done, housing assessment initiated). (This aligns with CARE Act data collection/reporting expectations for counties.)

• Housing connection verification: Document housing assessment, referral (e.g., CES/Homekey+/supportive housing provider), placement, subsidy activation, and operating subsidy support as needed, within BHSA housing reporting requirements; include lease or placement confirmations in the case record. (BHSA emphasizes housing outcomes for people at risk/experiencing homelessness.)

• Court communication (if applicable): If the redirection occurred during a court-ordered investigation period, provide the court with a written recommendation within the 14 business-day window, documenting that the individual engaged in appropriate services without the need for a CARE case.

• Quality assurance & reporting: Include redirected-case outcomes in quarterly CARE/BHSA monitoring and submissions, following the CARE Act deadlines and DHCS guidance (counties can claim reimbursement for administrative time spent on CARE data activities).

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?
Yes

Please select which of the following EHRs the county uses
SmartCare

County participates in a Qualified Health Information Organization (QHIO)?
Yes

Please select which QHIO the county participates in
Connex
San Diego Health Connect

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://www.calmhsa.org/interoperability-api/ (for Patient Access API) https://sdcountybhs.com/ProviderDirectoryApi

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 . Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
Yes

Please select all services the county behavioral health system plans to provide under the PATH grant
Case Management Services
Habilitation and Rehabilitation Services
Outreach services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?

Yes

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?
Yes

Please select all set-asides that the county behavioral health system participates in under SUBG
Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E

Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Research
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:

Other Programs and Services

Please describe
Subacute and Long Term Care Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)
a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services

j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
ACT
Clubhouse Services
CSC for FEP
Enhanced CHW Services
FACT
IPS Supported Employment
Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in DMC-ODS Program

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Peer Support Services
Enhanced Community Health Worker (CHW) Services
IPS Supported Employment
Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
Not applicable since SUBG, MHBG, and PATH are already addressed in their respective dedicated sections.

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**

Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Other

Please describe other
written language

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Other

Please describe other
written language

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
None Identified

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Same

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity
Other

Please describe other
primary language

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age
Other

Please describe other
Substance

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County analyzed penetration rates for Specialty Mental Health Services (SMHS), non-SMHS (NSMHS), DMC-ODS SUD treatment, and Initiation and Engagement of Substance Use Disorder – Initiation

(IET-INI) were acquired from public dashboards and Healthcare Effectiveness Data and Information Set (HEDIS) reports developed by California Mental Health Services Authority (CalMHSA). Percent differences less than 5% were excluded from disparity analyses.

• SMHS: Overall penetration rates for adults and children were below the state average. Within the county, lower rates were observed among adults 65+ and adult females, and among children 0–11. Additional disparities were noted among individuals identifying as Hispanic or Asian/Pacific Islander, and for children identified as Other or Unknown race/ethnicity compared with the county overall.

• Non-SMHS: Overall rates for children and adults were above the state average. Compared with the county, lower rates occurred in certain age groups (children 3–11, 18–20; adults 21–32, 69+), among AIAN and Other children, Hispanic and API adults, and those whose written language was non-English. Specific languages with lower rates included Arabic, Cantonese, Farsi, Other Chinese, Russian, Tagalog, and Other non-English languages for children, and Cantonese, Korean, Mandarin, Russian, Spanish, and Tagalog for adults.

• DMC-ODS: Adult penetration rates were below the state average, with disparities among young adults (18–25), older adults (60+), Asian/Pacific Islander (API), Other/Unknown race, and Spanish or Other/Unknown language speakers. Youth rates were generally similar to the state average, though some disparities were observed for females and White youth.

• IET-INI: San Diego County's BHS penetration rates were above the state average, though lower rates were observed among older adults and clients receiving alcohol or other drug treatment, including their respective age subgroups. No meaningful disparities were observed among adults 18–64.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Beginning July 1, 2026, San Diego County Behavioral Health Services (SDCBHS) will strengthen access to care through targeted expansion of crisis, residential, and substance use treatment services informed by penetration data showing utilization below the California average.

Specialty Mental Health Services (SMHS penetration for children in San Diego County (3.0%) is below the statewide average, with lower access among youth ages 0–11, males, and Hispanic and Asian/Pacific Islander children. Adult SMHS penetration (3.2%) is also below the state average, with disparities among adults age 69+, females, and Hispanic and Asian/Pacific Islander individuals. To address these gaps, SDCBHS is expanding crisis and diversionary services that reduce barriers to entry and improve linkage to ongoing care. The Emergency Psychiatric Assessment, Treatment & Healing (EmPATH) model places a

Crisis Stabilization Unit (CSU) directly within the hospital's emergency workflow at Sharp Chula Vista Medical Center, increasing access in the South Bay by providing rapid assessment and stabilization and facilitating timely connection to outpatient and community-based services.
In February 2026, the East Region CSU is anticipated to open and will be fully operational in FY 26-27. This facility will improve geographic equity, serve as a law enforcement drop-off site, and support timely access to SMHS for adults and older adults experiencing acute crises. SDCBHS is also developing a 16-bed Children's Crisis Residential Care (CCRC) program, the first in San Diego County, to expand access to intensive services for children, particularly younger youth, and reduce reliance on inpatient hospitalization.
San Diego County's DMC-ODS adult penetration rate (1.6%) remains below the statewide average, with disparities among transition-age youth (18–25), adults age 60+, Asian/Pacific Islander individuals, and Spanish or non-English speaking populations. To address these gaps, SDCBHS is developing an 89-bed Substance Use Recovery & Treatment Services (SURTS) facility to expand residential treatment capacity. In addition, SDCBHS is expanding withdrawal management services by 44 beds to support the DMC-ODS continuum of care.
Finally, SDCBHS is pursuing Proposition 1/Behavioral Health Continuum Infrastructure Program (BHCIP) Round 2 funding to develop a Behavioral Health Wellness Campus integrating crisis, detox, residential treatment, supportive housing, and wraparound services. Together, these data-driven investments will improve equitable access and reduce fragmentation across the behavioral health continuum.

Please identify the category or categories of funding that the county is using to address the access to care goal

BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Substance Abuse and Mental Health Services Administration(SAMHSA) Projects for Assistance in Transition from Homelessness(PATH)
Community Mental Health Block Grant (MHBG)
Substance Use Block Grant (SUBG)

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Gender
Race or Ethnicity
Other

Please describe other
Other Demographic Characteristics as Described in Disparities Analysis

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Below

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County reviewed data on the unhoused population from the U.S. Department of Housing and Urban Development (HUD) Exchange, California Department of Education, and California Business, Consumer Services and Housing Agency (BCSH) Homeless Data Integration System. Rates with a less than 5 percent difference or <20 cases were excluded. Several disparities were identified:
i. People Experiencing Homelessness (PEH) Point-in-Time Count Rate: The overall rate of PEH in San Diego County was lower than the state average. However, higher rates were observed among adults ages 35+, males, as well as non-Hispanic American Indian and Alaska Native (AIAN), non-Hispanic Pacific Islander, and non-Hispanic Black populations.

ii. Homeless Student Enrollment: The overall rate of K–12 students experiencing homelessness in San Diego County was slightly lower than the state average. Higher rates were observed among non-Hispanic Black, Hispanic/Latino, Pacific Islander, and AIAN students, as well as among English learners, students with disabilities, migrant youth, and youth identifying as non-binary.
iii. PEH with SMI or SUD: While demographic data were not available, overall rates of PEH reporting a substance use disorder (SUD) or serious mental illness (SMI) in San Diego County were both lower than the state and county rates.
iv. Access to Homeless Services: The rate of people accessing homeless services per 10,000 residents in San Diego County was lower than the state average. Disparities were observed by age, gender, and race/ethnicity: individuals aged 18–24 and 65+, females, and those who were Hispanic, non-Hispanic White, or non-Hispanic Asian/Asian American had lower rates than the county.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Beginning July 1, 2026, San Diego County Behavioral Health Services (SDCBHS) will continue strengthening access to services for people experiencing homelessness (PEH) by expanding housing-linked behavioral health supports informed by data showing access below the California average.

San Diego County's rate of PEH accessing services through the Continuum of Care (84.1 per 10,000) remains below the statewide rate (90.2 per 10,000). Disparities are most pronounced among transition-age youth (18–24), older adults age 65+, females, and Asian, Hispanic, and White individuals. These data guide SDCBHS's focus on housing-centered interventions paired with behavioral health services to improve engagement and continuity of care.

SDCBHS continues to leverage California's Homekey program, one of the State's fastest tools for creating permanent and interim housing for individuals experiencing homelessness. Homekey provides capital funding for the acquisition and rehabilitation of properties, while allowing counties to integrate onsite behavioral health services to support housing stability. In 2025, SDCBHS maintained 1,321 Permanent Supportive Housing units across 43 developments, including earlier Homekey projects. Three additional developments, Presidio Palms, Pacific Village, and Abbott Street Apartments, added nearly 250 new units,

expanding service-enriched housing options for individuals with serious mental illness or substance use conditions.

These housing investments are complemented by Behavioral Health Bridge Housing (BHBH), CalAIM Community Supports and Transitional Rent, and BHSA Housing Intervention funding, which together support a continuum of housing and treatment options. Beginning in FY 26–27, SDCBHS is further advancing a comprehensive homelessness strategy leveraging Proposition 1, Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), and BHSA Housing Interventions to expand behavioral health treatment beds, outpatient capacity, and supportive housing, including transitional rent.
Guided by local homelessness data and needs assessments, SDCBHS is prioritizing sub-populations with poorer outcomes, including individuals with co-occurring mental health and substance use disorders, while strengthening partnerships with housing authorities, healthcare providers, and community-based organizations. These coordinated, data-driven efforts are intended to improve access, housing stability, and long-term recovery for people experiencing homelessness.

Please identify the category or categories of funding that the county is using to address the homelessness goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate

and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Below

30-day involuntary detention rates per 10,000
Below

180-day post-certification involuntary detention rates per 10,000
Not Applicable

What disparities did you identify across demographic groups or special populations?
Age

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Above

Permanent Conservatorships
Above

What disparities did you identify across demographic groups or special populations?
None Identified

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Below

Crisis Stabilization

For adults/older adults
Below

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
None Identified

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County identified several differences in these measures, however interpretations for disparities are nuanced.
• Inpatient admin days: Adult admin days were below California (CA) but higher among residents ages 65+; individuals who identified as Black or Other race, and English speakers vs. the county. Youth admin days were below CA but higher among Black and White residents.
• Involuntary detention rate (IDR): The 14-day IDR was below CA, 30-day rate was the same, and 180-day rate was suppressed. Within 14-day IDRs, rates were lower across all age, sex, and race/ethnicity groups. Within 30-day IDRs, rates were higher for ages 65+ and lower for males, females, and White residents.
• Conservatorships: Temporary and permanent conservatorship rates were higher than CA. Although interpretations for disparities are nuanced, temporary rates were higher for ages 25+, as well as Black and White residents, and lower for Asian or Hispanic residents. Permanent rates were higher for ages 25+, females, and Black, White or Other race residents, and lower for residents ages 18-24, males, Asian, and Hispanic residents.

• Crisis intervention: Adult and youth rates were below CA, although interpretations for disparities are nuanced. Higher rates were observed among Black, Other, or Unknown race groups as well as those with English as their written language. All other demographic groups had rates below the county rate.
• Crisis residential treatment: Adult and youth rates were below CA, although interpretations for disparities are nuanced. All demographic rates for both adults and youth were below the state or suppressed.
• Crisis stabilization: Adult rates were below CA; youth rates were above CA, although interpretations for disparities are nuanced. Higher rates were observed among 21-68 year-olds, males, individuals who identified as Black, Unknown, or White, and those who had English or Unknown as their written language. All other demographic groups were below the county rate.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)

Inpatient Services

SDCBHS currently works with two Psychiatric Inpatient Hospitals, San Diego County Psychiatric Hospital (SDCPH) (Adult) and Rady's Child and Adolescent Psychiatry Services (CAPS) (Youth), which enter data directly into the EHR. The remaining Fee-For-Service hospitals coordinate with our contractor, Optum's clinical team, to track utilization and authorize Acute or Administrative bed days based on client need. SDCBHS has multiple reports and dashboards to monitor outcomes for clients utilizing inpatient services, such as total bed days and length of stay.

Involuntary Detentions

Both LPS and Non-LPS facilities are required to submit aggregated quarterly data to our Quality Assurance team for individuals involuntarily admit to their programs or whose hold type escalated. This data is used to build internal and public-facing dashboards that report on involuntary holds, including counts by demographic characteristics and hold reason (MH, SUD, co-occurring, etc.).

Conservatorship

Conservatorship data is tracked within the PanoSoft EHR, with additional data captured in SmartCare to better understand other services received by conserved clients. SDCBHS also maintains supplemental manual tracking tools to support regular reporting on items such as referrals and admissions to conservatorship.

Crisis Intervention

For Psychiatric Emergency Response Team (PERT) and MCRT, data is collected both in the EHR and through program-level tracking processes. This information feeds multiple dashboards used to monitor utilization, timeliness, demographic trends, regional utilization, disposition, diversion rates, and other outcomes.

These data also help demonstrate how early intervention and triage reduce reliance on more acute levels of care.

Crisis Stabilization (CSU)
All Crisis Stabilization Unit programs enter data directly into SmartCare. This data supports dashboards focused on diversion rates, recidivism, service connection post-discharge, utilization trends (including demographics), and estimated cost avoidance related to acute services.

Crisis Residential (CR)
All Crisis Residential programs enter data into the EHR and coordinate with Optum for centralized referrals, placements, and authorizations. Dashboards track utilization, diversion rates, step-down timelines, recidivism, and follow-up services after discharge.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)
San Diego County Behavioral Health Services (SDCBHS) is advancing a coordinated set of strategies to reduce unnecessary institutionalization and address disparities observed in inpatient utilization, involuntary treatment, and conservatorships. Beginning July 1, 2026, these efforts will focus on earlier intervention, expanded step-down capacity, and stronger connections to community-based care.
To address disparities reflected in higher administrative days, conservatorship rates, and longer involuntary treatment episodes among specific adult populations, SDCBHS focuses effort on the Community Assistance, Recovery, and Empowerment (CARE) Act expansion and opting into the 1115 SED/SMI Waiver (BH-CONNECT). These initiatives support court-involved individuals with serious mental illness through structured, community-based treatment plans, housing supports, and care coordination designed to prevent escalation into prolonged inpatient stays and conservatorship when less restrictive alternatives are appropriate.
SDCBHS is also prioritizing opportunities for timely step-down from institutional care by expanding inpatient stabilization capacity with a strong emphasis on discharge planning and linkage to ongoing services. A new 16-bed Psychiatric Health Facility (PHF) on the Tri-City Medical Center campus represents a major milestone for North County and directly addresses gaps in regional inpatient access that can contribute to extended stays or out-of-region placements. The County-funded PHF will provide short-term inpatient psychiatric care with average lengths of stay of five to seven days and a coordinated transition to

outpatient, crisis, and community-based services.
In addition, construction is beginning on a new 12-bed Acute Psychiatric Hospital (APH) at the Edgemoor campus, with groundbreaking planned for January 2026 and completion anticipated in spring 2027. Supported by Behavioral Health Continuum Infrastructure Program (BHCIP) funding, the APH will expand inpatient psychiatric capacity in East County and serve as the anchor hospital for the campus, improving system flow and access for individuals with higher acuity needs.

Please identify the category or categories of funding that the county is using to address the institutionalization goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For juveniles
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County reviewed data from the following sources: the California Department of Health Care

Services (DHCS), CalMHSA, the California Department of Justice Open Justice Dashboard, the California Department of Corrections and Rehabilitation Recidivism Dashboard, and the California Department of State Hospitals Fiscal Year 23–24 Felony Incompetent to Stand Trial Growth Cap Annual Reconciled Data Report. Several disparities were identified:

• Adult and Juvenile Arrest Rates: Overall adult and juvenile arrest rates in San Diego County were lower than the state rates. Among adults, higher rates were observed among individuals ages 20–39, males, and those identifying as Black, Hispanic, or Other race. Lower rates were observed among adults ages 18–19 and 40 and older, females, and White individuals. Among juveniles, higher rates were observed among males and youth identifying as Black, Hispanic, or Other race. Lower rates were observed among females and White youth.

• Adult Recidivism: The overall adult recidivism rate in San Diego County was slightly lower than the state average. Higher rates were observed among adults ages 20–34 and Black adults. Lower rates were observed among adults ages 40 and older, females, and those identifying as White or Asian.

• Incompetent to Stand Trial (IST): The overall rate of individuals deemed Incompetent to Stand Trial in San Diego County was substantially lower than the state average. Subgroup-level data were not available for analyses.

• Across measures, consistent disparities were observed by age, sex, and race/ethnicity. Young adults, males, and individuals identifying as Black, Hispanic, or Other race experienced higher arrest and recidivism rates, while lower rates were observed among older adults, females, and those identifying as White or Asian.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

San Diego County Behavioral Health Services (SDCBHS) is prioritizing targeted strategies to address disparities identified among justice-involved populations, particularly young adults, males, and individuals identifying as Black, Hispanic, or Other race, who experience higher arrest and recidivism rates compared to other groups.

To address these disparities, SDCBHS has opted into the 1115 SED/SMI Waiver (BH-CONNECT) and is preparing to implement high-fidelity Forensic Assertive Community Treatment (FACT). These efforts are designed to provide intensive, community-based behavioral health treatment, care coordination, and housing supports for justice-involved individuals with serious mental illness, with a focus on reducing

recidivism, improving treatment engagement, and preventing deeper system involvement among populations with poorer outcomes.
SDCBHS is also strengthening youth-focused diversion and reentry services. The County's Next Move program, a County-operated outpatient program serving justice-involved youth up to age 21, directly addresses disparities observed among young males and youth of color. Next Move provides mental health, substance use, and competency remediation services through clinics at the Southeastern and North Coastal Live Well Health Centers, utilizing evidence-based practices such as Dialectical Behavior Therapy, Functional Family Therapy, and trauma-focused interventions. The program aligns with California's Justice Involved Initiative Behavioral Health Links program to support seamless transitions from detention to community-based care.
Together, BH-CONNECT participation, preparation for FACT implementation, and expansion of targeted youth programs such as Next Move strengthen cross-system collaboration and provide data-driven, culturally responsive interventions to reduce justice involvement and improve behavioral health outcomes for populations experiencing the greatest disparities.

Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County (SDC) analyzed the point in time (PIT) count for children in foster care on July 1, 2025 (rate per 100,000), open child welfare case SMHS penetration rates from 2022, and child maltreatment substantiations (incidence per 1,000 children) from 2022 and 2024. Several disparities were identified:
• Children in Foster Care: Overall PIT count rates in SDC were below CA. Within SDC, higher rates were seen among individuals identifying as Black or Hispanic, ages 0-5, or ages 16-17, compared to the county rate.
• Open Child Welfare Cases: Overall SMHS penetration rates in SDC were below CA. Within SDC, higher rates were seen among 6-20 year-olds and Black and White race groups.
• Child Maltreatment Substantiations: Overall substantiation incidence rates in SDC were below CA. Rates

were higher among residents who were <2 years old as well as AIAN, Black and Hispanic race groups.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

San Diego County Behavioral Health Services (SDCBHS) works closely with the County's Child and Family Well-Being department to address disparities in foster care, child welfare, and child maltreatment substantiations. While overall rates in San Diego County are below California averages, certain populations experience higher risk: children identifying as Black or Hispanic, ages 0–5 or 16–17, have higher foster care rates; children ages 6–20 and Black or White youth have higher SMHS penetration in open child welfare cases; and substantiation rates are higher among children under 2 years and those identifying as AIAN, Black, or Hispanic.

To address these disparities, SDCBHS has expanded crisis response capacity with the Mobile Crisis Response Team (MCRT) School Pilot Program, launched in partnership with the San Diego County Office of Education. Operating across all public TK–12 districts, MCRT provides rapid, trauma-informed, and youth-centered interventions, offering an alternative to law enforcement responses for students in crisis. Since launch, over 200 school-based referrals have been completed, with 70% resulting in stabilization in place, reducing the likelihood of unnecessary removal from the home.

These interventions target populations with higher observed risk and integrate behavioral health supports directly into the child's school and community environment. By linking crisis services, trauma-informed care, and collaboration with child welfare and education partners, SDCBHS strengthens early intervention, stabilizes youth in place, and supports safer, more equitable outcomes for children experiencing or at risk of foster care placement.

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
None Identified

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
Age

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County reviewed data from the California Department of Health Care Services (DHCS), CalMHSA, County of San Diego HEDIS MY2023 and MY2024 reports, and the UCLA Center for Health Policy Research AskCHIS™ Dashboard. Several disparities were identified:
• FUA-30: County follow-up rates after emergency department visits for substance use were above the state. In Calendar Year (CY) 2023, adults 18 and older had follow-up rates similar to the county overall. In CY 2024, the county rate increased, with adults remaining aligned with the county's rate. Youth data were suppressed due to low counts, preventing subgroup comparison.
• FUM-30: County follow-up rates after emergency department visits for mental illness were below the state rate and median in CY 2022. County rates increased in CY 2023 and again in 2024, rising above the state's previously documented rate. Within the county, follow-up remained lowest among adults 65+, who were below the county rate in 2023 and 2024. Youth (6–17) had substantially higher follow-up in CY 2024, while adults 18–64 were similar to the county overall.
• ATNH: Overall county rates were below the state's rate. Within the county, higher rates occurred among young adults (18–24), adults 45–54 and 55–64, males, and Hispanic individuals. Lower rates were observed among adults 25–34, females, as well as White and Asian adults. Data were suppressed for Black, AIAN, NHPI, and individuals of two or more races.
• Across indicators, county performance improved overall, though disparities persisted by age, sex, and

race/ethnicity. Follow-up after emergency visits (FUM) remained lower among older adults, while higher follow-up was observed among youth. In contrast, unmet need for behavioral health services (ATNH) was greater among young and middle-aged adults, males, and Hispanic individuals, and lower among females and White or Asian adults. Data suppression limited comparisons for several smaller racial and ethnic groups.

San Diego County Behavioral Health Services (BHS) has partnered with Blue Shield Promise and Kaiser Permanente through an Institute for Healthcare Improvement (IHI) Learning Collaborative to pilot a new data-sharing process to improve provider follow-up rates after an emergency department (ED) visit. Historically, BHS has not had timely visibility when clients accessed emergency services for mental health and/or substance use needs, which has limited our ability to follow up right after a client's ED visit. As part of new follow-up protocol, providers are being contacted when their clients have had a recent emergency room visit for a behavioral health concern.

BHS contacts the program manager to request that the program's team connect with the client(s) within 72 hours after receiving the email notification to (1) conduct a brief wellness check and ensure they are aware of available services and supports, and (2) assist them in scheduling a follow-up appointment at your program. This project utilized the Plan-Do-Study-Act (PDSA) quality improvement tool that resulted in the creation of a script. A script was created that providers are asked to utilize when contacting clients. The goal of this new process is to follow up with BHS clients within 72 hours of ED discharge and provide a service within 15 days. This new process started in late April 2026.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

San Diego County Behavioral Health Services (SDCBHS) continues to target untreated behavioral health needs, guided by data showing disparities across age, sex, and race/ethnicity. While follow-up after emergency visits for mental illness (FUM) has improved overall, rates remain lower among adults 65+. Unmet behavioral health needs are higher among young and middle-aged adults, males, and Hispanic individuals, highlighting populations at greatest risk of untreated conditions.

To help address these disparities, San Diego Relay (SD Relay) Program provides 24/7 peer support and navigation for Medi-Cal–eligible patients seen in emergency departments with mental health or substance

use diagnoses, offering up to 90 days of post-discharge support. Since launch, SD Relay has received 150 referrals, engaged 138 patients, and distributed 131 harm reduction kits, with plans to expand to additional hospitals and pursue Medi-Cal certification for long-term sustainability.
SDCBHS also strengthened neighborhood-level engagement through Community Health Workers (CHWs), supporting over 450 community events in 2025 and piloting targeted interventions including follow-up for clients discharged from inpatient care, BH-CONNECT Enhanced CHW services, and naloxone distribution for harm reduction.
Public messaging campaigns under the department's It's Up to Us brand complement these efforts, including youth suicide prevention, overdose prevention, and crisis services awareness campaigns. These initiatives have reached hundreds of thousands of residents and are paired with an updated stakeholder engagement ecosystem launching in 2026 to ensure ongoing community-informed program development. Collectively, these strategies target populations with persistent disparities, reduce barriers to care, and expand access to behavioral health services, strengthening the County's integrated, person-centered system while addressing unmet needs across the continuum.

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is

performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?

Below

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Below

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Below

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Same

For children/youth (specific to Child and Adolescent Well-Care Visits)
Same

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Above

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Below

For children/youth
Above

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Above

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals .

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below

the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Social connection

Social connection

Please describe why this goal was selected
San Diego County Behavioral Health Services (SDCBHS) selected Social Connections as its additional BHSA priority goal based on performance below the statewide benchmark and strong alignment with community and public health (i.e., Community Health Assessment (CHA)/ Community Health Improvement Plan (CHIP) priorities. During countywide community engagement sessions, BHS presented all potential additional goals and facilitated discussion across all regions. Social Connections consistently emerged as a top priority voiced by community members.

In addition, SDCBHS collaborated with our Local Health Jurisdiction, Public Health Services, partners who lead the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) efforts. This shared planning process confirmed that Social Connections aligns with established CHA/CHIP priorities and represents an area where coordinated strategies could meaningfully advance community well-being.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Diego County reviewed results from the 2024 Consumer Perception Survey (CPS) on perceptions of social connectedness, as well as the 2023 California Healthy Kids Survey (CHKS) self-report measure assessing whether secondary students felt they had caring adult relationships at school. Findings showed that in San Diego County youth and families of youth ages 0–17, as well as older adults ages 60 and older, reported higher levels of social connectedness compared to the state, while adults ages 18–59 reported lower levels compared to the state. Additionally, school-aged youth in San Diego County were more likely to report having caring adult relationships at school than youth statewide.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Social connection and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Beginning July 1, 2026, SDCBHS will strengthen systemwide strategies that promote meaningful connection, belonging, and engagement for Medi-Cal beneficiaries, particularly populations experiencing isolation that contribute to health inequities. Efforts will focus on expanding peer-delivered services,

community-based outreach, and recovery-oriented supports that foster sustained social connection across the continuum of care. SDCBHS will also advance culturally responsive engagement strategies through Community Prevention Partnerships (CPPs), workforce development, and public messaging initiatives that reduce stigma and promote connection to services.
Measures where performance falls below the statewide average will be addressed through SDCBHS' established quality and health equity infrastructure, including the Behavioral Health Plan Quality and Health Equity Workplan, equity-focused root cause analysis, and continuous quality improvement processes. Data used to inform this work include the Consumer Perception Survey (CPS), community engagement findings, utilization data, and tools such as the Community Experience Partnership dashboard and Behavioral Health Equity Index. These data sources highlight disparities in perceived social connectedness and inform targeted strategies for improvement. Through coordinated planning, cross-sector collaboration, and data-driven oversight, SDCBHS will strengthen social connection as a core component of recovery, resilience, and whole-person behavioral health outcomes.

Please identify the category or categories of funding that the county is using to address this goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
MHBG
SUBG

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

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Please indicate the type of engagement used to obtain input on the planning process

County outreach through social media
County outreach through townhall meetings
County outreach through traditional media (e.g., television, radio, newspaper)
Focus group discussions
Key informant interviews with subject matter experts
Meeting(s) with county
Provided data to county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

County outreach through social media

Date

4/28/2025

Type of engagement
County outreach through social media

Date
5/5/2025

Type of engagement
County outreach through social media

Date
5/12/2025

Type of engagement
County outreach through social media

Date
5/15/2025

Type of engagement
County outreach through social media

Date
11/3/2025

Type of engagement
County outreach through social media

Date
11/4/2025

Type of engagement
County outreach through social media

Date
11/5/2025

Type of engagement
County outreach through social media

Date
11/13/2025

Type of engagement
County outreach through social media

Date
11/14/2025

Type of engagement
County outreach through social media

Date
12/1/2025

Type of engagement
County outreach through social media

Date
12/12/2025

Type of engagement
County outreach through social media

Date
12/14/2025

Type of engagement
County outreach through townhall meetings

Date
5/1/2025

Type of engagement
County outreach through townhall meetings

Date
5/15/2025

Type of engagement
County outreach through townhall meetings

Date
8/7/2025

Type of engagement
County outreach through townhall meetings

Date
8/12/2025

Type of engagement
County outreach through townhall meetings

Date
8/13/2025

Type of engagement
County outreach through townhall meetings

Date
8/14/2025

Type of engagement
County outreach through townhall meetings

Date
8/15/2025

Type of engagement
County outreach through townhall meetings

Date
9/5/2025

Type of engagement
County outreach through townhall meetings

Date
9/26/2025

Type of engagement
County outreach through townhall meetings

Date
10/8/2025

Type of engagement
County outreach through townhall meetings

Date
10/13/2025

Type of engagement
County outreach through townhall meetings

Date
10/15/2025

Type of engagement
County outreach through townhall meetings

Date
10/16/2025

Type of engagement
County outreach through townhall meetings

Date
10/17/2025

Type of engagement
County outreach through townhall meetings

Date
10/24/2025

Type of engagement
County outreach through townhall meetings

Date
10/27/2026

Type of engagement
County outreach through townhall meetings

Date
10/30/2025

Type of engagement
County outreach through townhall meetings

Date
11/4/2025

Type of engagement
County outreach through townhall meetings

Date
11/5/2025

Type of engagement
County outreach through townhall meetings

Date
11/12/2025

Type of engagement
County outreach through townhall meetings

Date
11/13/2025

Type of engagement
County outreach through townhall meetings

Date
11/19/2025

Type of engagement
County outreach through townhall meetings

Date
11/20/2025

Type of engagement
County outreach through townhall meetings

Date
12/3/2025

Type of engagement
County outreach through townhall meetings

Date
12/5/2025

Type of engagement
County outreach through townhall meetings

Date
12/9/2025

Type of engagement
County outreach through townhall meetings

Date
12/11/2025

Type of engagement
County outreach through townhall meetings

Date
12/16/2025

Type of engagement
County outreach through townhall meetings

Date
12/18/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
10/10/2025

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
11/4/2025

Type of engagement
Focus group discussions

Date
4/24/2025

Type of engagement
Focus group discussions

Date
4/28/2025

Type of engagement
Focus group discussions

Date
4/29/2025

Type of engagement
Focus group discussions

Date
4/30/2025

Type of engagement
Focus group discussions

Date
6/4/2025

Type of engagement
Focus group discussions

Date
7/18/2025

Type of engagement
Focus group discussions

Date
8/5/2025

Type of engagement
Focus group discussions

Date
8/13/2025

Type of engagement
Focus group discussions

Date
9/11/2025

Type of engagement
Focus group discussions

Date
10/30/2025

Type of engagement
Focus group discussions

Date
11/12/2025

Type of engagement
Focus group discussions

Date
11/18/2025

Type of engagement
Focus group discussions

Date
11/19/2025

Type of engagement
Focus group discussions

Date
11/20/2025

Type of engagement
Focus group discussions

Date
11/25/2025

Type of engagement
Key informant interviews with subject matter experts

Date
4/22/2025

Type of engagement
Key informant interviews with subject matter experts

Date
4/28/2025

Type of engagement
Key informant interviews with subject matter experts

Date
4/29/2025

Type of engagement
Key informant interviews with subject matter experts

Date
5/5/2025

Type of engagement
Key informant interviews with subject matter experts

Date
5/20/2025

Type of engagement
Key informant interviews with subject matter experts

Date
7/14/2025

Type of engagement
Key informant interviews with subject matter experts

Date
8/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/4/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/8/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/3/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/4/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/19/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/21/2025

Type of engagement
Key informant interviews with subject matter experts

Date
12/3/2025

Type of engagement
Meeting(s) with county

Date
7/3/2024

Type of engagement
Meeting(s) with county

Date
8/12/2024

Type of engagement
Meeting(s) with county

Date
8/14/2024

Type of engagement
Meeting(s) with county

Date
8/15/2024

Type of engagement
Meeting(s) with county

Date
9/11/2024

Type of engagement
Meeting(s) with county

Date
10/7/2024

Type of engagement
Meeting(s) with county

Date
10/28/2024

Type of engagement
Meeting(s) with county

Date
4/29/2025

Type of engagement
Meeting(s) with county

Date
5/23/2025

Type of engagement
Meeting(s) with county

Date
6/27/2025

Type of engagement
Meeting(s) with county

Date
6/30/2025

Type of engagement
Meeting(s) with county

Date
7/8/2025

Type of engagement
Meeting(s) with county

Date
7/9/2025

Type of engagement
Meeting(s) with county

Date
7/17/2025

Type of engagement
Meeting(s) with county

Date
7/28/2025

Type of engagement
Meeting(s) with county

Date
8/4/2025

Type of engagement
Meeting(s) with county

Date
8/5/2025

Type of engagement
Meeting(s) with county

Date
8/18/2025

Type of engagement
Meeting(s) with county

Date
9/3/2025

Type of engagement
Meeting(s) with county

Date
9/10/2025

Type of engagement
Meeting(s) with county

Date
9/11/2025

Type of engagement
Meeting(s) with county

Date
9/19/2025

Type of engagement
Meeting(s) with county

Date
10/1/2025

Type of engagement
Meeting(s) with county

Date
10/3/2025

Type of engagement
Meeting(s) with county

Date
10/20/2025

Type of engagement
Meeting(s) with county

Date
10/23/2025

Type of engagement
Meeting(s) with county

Date
11/13/2025

Type of engagement
Provided data to county

Date
10/20/2022

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals

A Caring Touch Home Care
Access to Independence
ACTION East, SUD
Alcohol and Drug Services Providers Association
Alliance for Regional Solutions
Alliance Healthcare Foundation
Alpha Project
Alvarado Parkway Institute (API)
Alzheimer's Association of San Diego
American Academy of Pediatrics
American Academy Pediatrics-CA3 Strategic Behavioral Health Initiative
Angels Foster Family Network
Barrio Logan College Institute
Behavioral Health Advisory Board (BHAB)
BHAB Rehab
Blue Shield of California
Blue Shield of California Promise Health Plan
Border View Family YMCA-San Ysidro
BrightLife Kids
California Department of Healthcare Services
California Department of Rehabilitation
California Pan Ethnic Health Network
California School Board Association
California State University San Marcos (CSUSM)
Cardiff School District
Casa de Oro
Center for Community Solutions
Center for Positive Changes
Charlie Health
Children's First Collective
Choice Medical Group
City of Carlsbad
City of Chula Vista
City of Escondido
City of Imperial Beach
City of Oceanside
City of San Diego
Clarvida

Clarvida-Kickstart program
ComForCare (Homecare & Senior Care Services)
Communities Voices
Community Circle East
Community Health Group
Community Health Systems Inc. (CHS)
Community Research Foundation, Inc. (CRF)
Community Resource Center Foundation
Copley-Price Family YMCA
Corporation for Supportive Housing (CSH)
County Juvenile Court
County of San Diego (COSD)
County of San Diego-Adult Protective Services
County of San Diego-Aging and Independence Services (AIS)
County of San Diego-Behavioral Health Services
County of San Diego-Behavioral Health Services (BHS)-Programs and Services
County of San Diego-Child Family Well Being (CFWB)
County of San Diego-Department of Child Support Services
County of San Diego-Live Well San Diego Youth Sector
County of San Diego-Office of Equity and Racial Justice
County of San Diego-Office of Labor Standards and Enforcement (OLSE)
County Supervising Probation Officers' Association
Courage To Call
Crossroads Foundation
CSA San Diego County & Welcome Newcomers
Deaf Community Services-Signs of Life Deaf Recovery
Del Mar Community Connections
Del Mar Union School District
Department of Rehabilitation
Docfully Healthcare
Drug Free Escondido, COMPACT
East County Center for Change
East County Cristian Fellowship
East County Transitional Living Center
Education Begins in the Home
Educational Enrichment Systems
Elder Care
ELUSEN, Inc.
Encinitas Union School District
Episcopal Community Services

Equation Collaborative
Equip Health
EQUUS Workforce Solutions
ESCOKIDS
Escondido Union High School District
Escondido YMCA
Exodus Recovery, Inc.
Fallbrook Regional Health District
Fallbrook Union High School District
Family Health Centers of San Diego (FHCSD)
Father Joe's Villages
Feeding San Diego
Firepit Wellness
First 5 San Diego
Fisher Mental Health Consulting
Fresh Start Surgical Gifts
Fresh Start United States Marines
Gary and Mary West PACE
Genesis Recovery
Getting Education Done
Goodwill Industries of San Diego
Green Oak Ministries
Grossmont Healthcare
Haitian Bridge Alliance, Inc
Harmonium
Headstart
Healing Oaks Clinic-Substance Use Disorder
Health Center Partners of Southern California
Heartland House
Heartland Wellness Recovery Center
Home Start, Inc
Horn of Africa
Housing Innovation Partners (HIP)
Independent Living Association (ILA)
Indian Health Council, Inc.
Innercare
Institute for Public Strategies (IPS)
Institute for Public Strategies (IPS)- BUDI Program
Integrated Health Partners of Southern California
Interfaith Community Services

Jar Insurance
Jewish Family Services of San Diego
Jewish Family Services-Breaking Down Barriers program
Jewish Family Services-Parent Corps Adolescent Family Life Program (AFLP)
Jewish Family Services-Positive Parenting Program
JIREH Providers
Jones Day (Law firm)
Kaiser Permanente (KP)
Karen Organization
Koinonia Family Services
La Maestra Community Health Centers
Lakeside Union School District
Landlord Engagement Specialist with Equitable Solutions HDAP program
Latino 247 Media Group LatinoLYTICS
Legal Aid Society of San Diego (LASSD)
Legal Aid Society of San Diego-Consumer Center for Health Education and Advocacy (CCHEA) program
License to Freedom
Lifeline Community Services
Little Italy Association of San Diego
Logan Heights Community Development Corporation (CDC)
Long-term Care Ombudsmen
Lotus Integrative Counseling
Majdal: Arab Community Center of San Diego
Marcy High School
Maryland Elementary
McAlister Institute
McAlister Institute-East Teen Recovery Center program
McAlister Institute-South Teen Recovery Center program
Metamorphosis
Metropolitan Area Advisory Committee on Anti-Poverty of San Diego County, Inc (MAAC)
Mental Health Services-North Inland Teen Recovery Center
Mid-City CAN
Mira Mesa Senior Center
Mission San Luis Rey Parish-Oceanside
Mixtecos Unidos
Mobile County Public School System
Mobile Crisis Response Team (MCRT)
Mobile Crisis Response Team (MCRT)-Exodus Recovery Program
Molina Healthcare of California
Mosaic Therapy

Motiva Associates
MY Academy
National Alliance on Mental Illness (NAMI)
National Association for the Advancement of Colored People (NAACP) San Diego
National CORE
National School District (National City)
National Shattering Silence Coalition/Waves of Change Consulting
Neighborhood Healthcare
Neighborhood House Association
New Entra Casa
North County Equity and Justice Coalition
North Inland Teen Recovery Center
Oceanside Library
Oceanside Unified School District
Office of Supervisor Lawson Remer
One Safe Place
One Safe Place-District Attorney's Office
Operation Hope North County
Operation Samahan
Optum-Access & Crisis Line (ACL)
Our Lady of Mount Carmel
PACEs Connection
Pacific Clinics ELEVATE Peer support Training and Placement Program
Pacific Health Group
Pacific Housing, Inc.
Pala Band of Mission Indians
Palomar Family Counseling Service
Palomar Health
Palomar Health-Forensic Health and Trauma Recovery Services
Palomar Health-Trauma Recovery Center (TRC)
Paradise Valley Hospital (PVH)
ParentCare
Parenting EQ
Partnership for the Advancement of New Americans (PANA)
People Assisting the Homeless (PATH)
Planned Parenthood
Planned Parenthood of the Pacific Southwest
Policy & Innovation Center (PIC)
Poway Unified School District
Premier Ambulance

Price Philanthropies
Project Next
Public Authority
Rady Children's Health
Rady Children's Health-KidSTART program
Rady Children's Hospital
Rady Children's Hospital-Healthy Development Services (HDS)/Children's Care Connection (C3) program
Rady Children's Hospital-KidSTART Center
Ramona Unified School District
REACH San Diego
Residential Options for Seniors and the Elderly, LLC (ROSE)
Ronald Reagan Community Center
Rotary
Rula
San Diego Community Health Improvement Partners (SD CHIP)
San Diego County District Attorney (SDCDA)
San Diego County Library
San Diego County Office of Education
San Diego District Attorney
San Diego District Attorney-Victim Assistance Program
San Diego Food Bank
San Diego for Every Child
San Diego Freedom Ranch
San Diego Housing Commission (SDHC)
San Diego Innovation High School
San Diego PACE
San Diego Refugee Communities Coalition
San Diego Regional Center-Adult and Forensics Services
San Diego Regional Center-Residential Services
San Diego Sheriff
San Diego State University (SDSU)
San Diego Unified School District
San Diego Unified School District-Mental Health Resource Center
San Diego Unified School District-Mental Health Resource Department
San Diego Union High School District
San Diego Youth Services
San Dieguito Alliance
San Ysidro Health (FQHC)
San Ysidro School District
Santee School District

Saving Lives in Custody CA
SCAN Health Plan
Scripps
SEEP
Senior Tech Support
Serving Seniors
Sharp Healthcare
Slavic Refugee and Immigrant Services
SOAP MAT, LLC
Social Advocates for Youth (SAY) San Diego
South Bay Community Services (SBCS)
Southern California Tribal Chairman's Association (SCTCA)
Southern Caregiver Resource Center
Southern Indian Health Council
Spring Valley Collaborative
State Senator Office of Catherine S. Blakespear
Stepping Stone of San Diego
Strong Hearted Native Women's Coalition (SHNWC)
Suicide Prevention Council-Recovery Residency Association
Survivors of Suicide Loss (SOSL)
Sweetwater Union High School District
Telecare Corporation
The Children's Initiative
The City of Lemon Grove
The Fellowship Center
The Way Back
Tiny Home Central
Townspeople
True Care
TURN Behavioral Health Services (BHS)
TURN BHS Teen Recovery Center
Turning Point Home
Union of Pan Asian Communities (UPAC)
United Women of East Africa
Universidad Popular
University of California San Diego (UCSD)
University of California San Diego-Center for Community Health
University of California San Diego-Department of Psychiatry
University of California San Diego-Health
University of California San Diego-Health Partnership

University of California San Diego-Health Services
University of California San Diego-Moores Cancer Center
University of California San Diego-School of Public Health-Transportation Research and Education for Driving Safety (TREDS) program
University of San Diego
Urban Street Angels
Urban Street Angels-Just Be U Program
VetART
Vision y Compromiso San Diego
Visiting Angels Senior Home Care
Vista Community Clinic
Vista Hill
Vista Hill-Parent Care-Central program
Vista Hill-Parent Care-East program
Vista Hill-Parent Care Family Recovery Center
Vista Hill Foundation
Vista Unified School District
Voices of San Diego
Wakeland Housing and Development Corporation
Women's Resource Center
YMCA
YMCA of San Diego
YMCA of San Diego-Escondido Drop-in Center "Our Safe Place"
Your Safe Place-The San Diego Family Justice Center

{{Full list of dates of stakeholder engagement for each type of engagement is included in uploaded attached documents, as portal would only allow 100 individual entries ***- see Appendix A***}}

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name

	City name
1	City of San Diego
2	City of Chula Vista
3	City of Oceanside
4	City of Escondido
5	City of Carlsbad

Were you able to engage all required stakeholders/groups **in the planning process?**
Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Following the facilitation of input/engagement activities completed by BHS staff and/or contractors, activity details, key learnings, and audience recommendations were documented in activity summaries. Summaries were subsequently provided to programs and services staff/leads in charge of program planning and development to incorporate actionable feedback as appropriate. See uploaded PDF for additional details and examples.

Upload File
136 - CPP Engagement Dates by Type.pdf **-** ***see Appendix A***
140 - Community Planning Process Activity Summaries.pdf **-** ***see Appendix B***

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) **? Additional**

information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans **(MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities**
San Diego County Behavioral Health Services (SDCBHS) engaged with our Local Health Jurisdiction (LHJ) (i.e., County of San Diego Public Health Services), Medi-Cal Managed Care Plans (MCPs), and other system partners by leveraging the County's established Healthy San Diego infrastructure. Through regular, ongoing collaboration with all MCPs operating in San Diego County, SDCBHS used existing forums to share information, align on statewide priorities - including the Behavioral Health Services Act (BHSA) goals - and ensure MCPs were informed of County-identified behavioral health needs and disparities.

SDCBHS coordinated closely with PHS and MCP partners to support data-sharing and alignment across planning efforts. This included regular meetings with PHS to share BHSA updates and behavioral health priorities, presentations during Healthy San Diego Population Health Coalition meetings, and joint community-facing presentations with PHS to communicate BHSA statewide goals and relevant community behavioral health data. To further support aligned planning, BHS co-led a data subcommittee stemming from the Population Health Coalition, with representation from PHS and MCPs, to identify, prioritize, and align data needs supporting BHSA implementation and CHA/CHIP development.

In addition, SDCBHS engaged MCPs through the Healthy San Diego Behavioral Health Quality Improvement Workgroup to discuss MCP Population Health Management (PHM) strategy deliverables, using these discussions to inform MCP planning by presenting statewide behavioral health goals and identifying areas of opportunities for improvement. Additionally, SDCBHS collaborated with PHS to conduct a crosswalk of community-defined goals described in the Community Enrichment Plans - developed from CHA/CHIP findings - to assess alignment with BHSA goals. Results from this informed the selection of the County's additional goal, Social Connection, included in the Integrated Plan.

Finally, SDCBHS has begun leveraging the County-LHJ-MCP Collaboration Toolkit to further strengthen alignment across CHA, CHIP, and Integrated Plan processes and will continue refining these collaborative, data-informed, and stakeholder-driven approaches moving forward.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
Yes

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Access to Care
Care Experience
Engagement in School
Engagement in Work
Homelessness
Institutionalization
Justice Involvement
Overdoses
Prevention of Co-Occurring Physical Health Conditions
Quality of Life
Removal of Children from Home
Social Connection
Suicides
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Access to Care
Care Experience

Engagement in School
Engagement in Work
Homelessness
Institutionalization
Justice Involvement
Overdoses
Prevention of Co-Occurring Physical Health Conditions
Quality of Life
Removal of Children from Home
Social Connection
Suicides
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

reviewed behavioral health priorities by San Diego County region and identified shared areas of concern to integrate into recommended goal to be added for Statewide Behavioral Health goals.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

At this time San Diego County Behavioral Health Services (SDCBHS) has engaged with all Medi-Cal Managed Care Plans (MCPs) operating in San Diego County through our existing Healthy San Diego infrastructure, which includes regular collaboration among the County, MCPs, and other system partners. SDCBHS has used these established forums to share information, align on statewide priorities, and ensure MCPs are informed of County identified behavioral health needs. As MCPs are still awaiting further guidance from DHCS regarding Community Reinvestment Funds, engagement to date has focused on information-sharing and early alignment rather than formal co-planning or finalized reinvestment decisions. Any future planning will continue to be coordinated with MCPs as state guidance is released.

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

SDCBHS has presented MCPs with an overview of the BHSA Priority Statewide Goals, including key disparities and opportunities for improvement informed by the BHSA community planning process and stakeholder engagement. These discussions were intended to inform MCP Community Reinvestment planning by highlighting areas where reinvestment could complement BHSA priorities, such as improving access to care and reducing untreated behavioral health needs. While MCP Community Reinvestment Plans are still under development pending DHCS guidance, SDCBHS anticipates future MCP activities will build on this shared understanding of BHSA priorities and be coordinated through Healthy San Diego and other established partnership structures to align with the County's Integrated Plan.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment
3/17/2026

Date the stakeholder comment period closed
4/15/2026

Date of behavioral health board public hearing on draft IP
5/7/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
Link

Please provide the link to the public posting
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/bhsa.html

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
https://engage.sandiegocounty.gov/bhsa-integrated-plan

Please select the process by which the draft plan was circulated to stakeholders

Public posting
Email outreach
Other

Attach email

30-Day Public Hearing Notice - BHSA IP 2026.pdf *- see Appendix C*

Please specify the other process the draft plan was circulated to stakeholders

The draft plan was posted online and promoted via a variety of existing communication channels, including but not limited to, BHS distribution lists, Live Well San Diego newsletter blasts, County News Center articles, social media, existing meeting (e.g. BHAB and Live Well San Diego Community Leadership Team meetings). Additionally, follow-up discussions were coordinated in a variety of community-based meetings (e.g. NAMI Peer Council) to solicit further dialogue and input.

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback || Summarize the substantive revisions recommended this stakeholder during the comment period

{see following pages " BHSA Integrated Plan Public Comment: Key Themes Raised & Recommendations"}

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

{see following pages " Recommendations Received from the Behavioral Health Advisory Board (BHAB)"}

-See Appendix D for full public comment received

BHSA Integrated Plan Public Comment:
Key Themes Raised & Recommendations

BHSA Stakeholder Group	Recommendations Received During Public Comment Period
Eligible adults and older adults (individuals with lived experience)	Adults and older adults with lived experience said it is hard to get the right help during and after a mental health crisis. They shared concerns about getting into Full Service Partnerships, finding services after crises, and understanding their rights while in treatment. Many asked for more peer support, especially in hospitals, clearer roles for peer specialists, and better support for caregivers. They also want easier access to services, more housing and community programs, smoother transitions after hospital care, and dedicated services and funding for older adults.
Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience)	Families said they need clearer information, easier navigation tools, and stronger roles in treatment decisions when their loved ones are struggling. Many asked for better caregiver supports, including parenting programs, restored services for older adult caregivers, and ways to help family members who cannot consent to treatment due to their mental state. They also want smoother care transitions, more access to treatment, and help before crises occur. Some families suggested new tools, like an app that lets children and caregivers check in on each other's mental health, to support early intervention and communication.
Youths (individuals with lived experience) or youth mental health organizations	Youth and youth serving groups said services need to be easier to access, more youth friendly, and offered in safe spaces where young people feel welcome. They asked for more early intervention, including support for children ages 0–5, school-based programs, and parenting education that can prevent problems before they grow. Many stressed the need for youth led decision-making, age specific data reporting, and culturally relevant services, especially for LGBTQ+ youth and foster youth. They also shared concerns about low funding for children's services and emphasized the need for programs that keep youth out of the justice system and reduce family separation.
Providers of mental health services and substance use disorder treatment services	Providers said the behavioral health system is stretched thin and needs clearer rules, stable funding, and stronger care transitions to better support clients. They raised concerns about FSP funding changes, the lack of services for primary SUD populations, and the limited capacity to treat people who need higher intensity care. Many highlighted serious workforce shortages, administrative burdens, and the need for better training, especially around Medi-Cal transitions. Providers also asked for programs that address social isolation, more housing and supports for adults 65 and older, and better coordination across County systems to prevent clients from cycling through crises.
Public safety partners, including county juvenile justice agencies	Public safety partners said the County needs stronger coordination between jail mental health care, crisis response teams, and outpatient services so people do not keep cycling through the justice system. They raised concerns about poor treatment quality in jails, the high number of deaths in custody, and the lack of consistent tracking to understand whether interventions are working. Many emphasized the need for better crisis response options that rely less on law enforcement, along with stronger support for re-entry and services for people who have been incarcerated. They also highlighted the importance of culturally responsive crisis care and programs that prevent youth justice involvement, such as initiatives like End Girls Incarceration.
Local education agencies	Local education agencies said they need stronger school-based mental health supports and earlier identification of students who may be struggling. They want more staff, better partnerships, and services that are culturally responsive and accessible to all students, including those with private insurance or without documentation. Many emphasized that students do not always feel safe asking for help at school, and more prevention programs are needed, including supports in early childhood education settings. Schools also asked for expanded behavioral health programs beyond current TK–12 pilots to reduce stigma and help students get care faster.
Higher education partners	Higher education partners said the County should support stronger workforce pipelines, including scholarships, training programs, and partnerships that address shortages in the behavioral health field. They also emphasized the need for accurate, easy to understand public documents and clearer explanations of funding and planning decisions. Many highlighted the importance of prevention and wellness programs for transitional age youth, including better

	support for students with private insurance who often fall through the cracks. They urged the County to maintain transparency and long-term consistency in its behavioral health efforts.
Early childhood organizations	Early childhood organizations said the County is not meeting the needs of children ages 0–5, who are often left out of data, services, and planning. They asked for more prevention programs, parenting education, and early intervention supports that help families before problems grow. Many also raised concerns about the lack of information and services for young children experiencing homelessness or trauma. They emphasized that investing in early childhood mental health specialists and family-based supports is essential to prevent larger challenges later on.
Local public health jurisdictions	Local public health agencies said the County needs stronger prevention efforts and better coordination with housing, health, and other upstream factors that shape behavioral health. They want clear, measurable goals that align BHSA planning with actual implementation and progress tracking. Many also asked for better public communication, including county-wide messaging, improved data systems, public dashboards, and clearer reporting on homelessness and unmet need. They emphasized that transparency and strong partnerships with hospitals and community systems are essential for improving outcomes.
County social services and child welfare agencies	County social services and child welfare agencies said the County needs stronger prevention efforts, including parenting supports and financial help for families so children can stay safely at home. They want clearer information about how unmet need is measured and more transparency in planning, data use, and program changes. Many emphasized the importance of close coordination between behavioral health and child welfare, especially when families face poverty, trauma, or housing instability. They also asked that former foster youth be recognized as a priority population needing focused support.
Labor representative organizations	Labor representatives said the behavioral health workforce is struggling with staffing shortages, burnout, and limited training opportunities. They want fair hiring practices, job stability, and stronger professional development pathways, including nursing career supports and scholarships. Many also recommended flexible and part-time employment options to help with recruitment and retention. Overall, they emphasized that new funding models must support a stable, well-trained workforce that can meet growing community needs.
Veterans	Veterans said the County should prioritize permanent supportive housing, including hotel and motel conversions, to help veterans stay stable during recovery. They want mental health and housing services that reflect the unique experiences and stresses veterans face after military service. Many also asked the County to make veterans a priority category in housing programs and to strengthen coordination with agencies that serve veterans. Overall, they emphasized that safe, long-term housing is essential for better mental health outcomes.
Representatives from veterans' organizations	Representatives from veterans' organizations said the County should make permanent supportive housing for homeless veterans a top priority. They asked for dedicated housing investments, better alignment of capital projects, and stronger coordination with state programs like CalAIM. Many stressed that targeted funding is needed because veteran homelessness continues to grow. They also highlighted the cost-effectiveness of SRO-style housing and urged closer County and State collaboration to expand veteran housing options.
Health care organizations, including hospitals	Health care organizations said there are not enough psychiatric beds or staff to meet community needs, and new staffing laws like AB 116 are creating added pressure. They stressed the need for strong care transitions, especially for people who come to emergency rooms during a mental health or substance use crisis, so they can be linked quickly to ongoing care at FQHCs or CCBHCs. Hospitals also asked for better data sharing systems and clearer rules around privacy and electronic medical records. They emphasized that maintaining inpatient capacity and adding more long-term care options are essential to reduce repeated crises and improve patient outcomes.
Health care service plans (MCPs)	Health care service plans said they need better alignment between BHSA services and Medi-Cal financing, especially as CalAIM changes how services are billed and delivered. They highlighted the "insurance gap," where families with private insurance still cannot access specialty programs like intensive outpatient treatment. MCPs also asked for more technical assistance to help community-based organizations with contracting, billing readiness, and PAVE registration. Overall, they want clearer coordination across County and state systems to reduce coverage

	gaps and improve access to care.
Tribal and Indian Health Program design	Tribal and Indian Health Program representatives said the County did not meaningfully engage with all 18 federally recognized tribes and must build real partnership in planning and decision-making. They asked for culturally responsive services, tribal specific prevention strategies, and engagement pathways that reflect each tribe's unique needs. Many also stressed that tribes face serious funding limits and cannot meet community needs without stronger County collaboration. Overall, they want a coordinated approach that respects tribal sovereignty and ensures tribes are fully included in BHSA planning and implementation.
Five most populous cities	The five largest cities said they need stronger coordination with the County on crisis response, housing siting, and diversion programs. They want clearer alignment between BHSA planning and the responsibilities cities hold for homelessness services, emergency response, and local implementation. Many stressed the need for shared data, better collaboration on housing development, and consistent communication across agencies. Overall, the cities emphasized that addressing homelessness and behavioral health requires joint planning, shared resources, and cross agency cooperation.
Area agencies on aging	Area agencies on aging said the County does not provide enough mental health services designed specifically for adults 60 and older. They raised concerns about the loss of caregiver support programs and the lack of services that reduce social isolation, depression, and loneliness. Many noted that older adults are often grouped with all adults over 21, which causes their unique needs to be overlooked. They emphasized the need for geriatric focused programs, stronger caregiver supports, and more outreach to isolated older adults.
Independent living centers	Independent living centers said people with disabilities need better support to navigate the behavioral health system and move smoothly between services. They emphasized that adults with serious mental illness often lack stable residential options and face long waitlists or limited access to adult residential facilities. Many also noted gaps in housing and services for people with primary substance use disorders. Overall, they called for more accessible, inclusive housing and programs that help people live safely and independently in their communities.
Continuums of care / homeless provider community	Homeless service providers said the County needs to prioritize housing interventions and better include families experiencing homelessness in planning and services. They raised strong concerns about inaccurate housing data and said the County may be overestimating available units, especially for people leaving hospitals, jails, detox, or crisis care. Providers stressed the need for more recovery housing, transitional rent programs, and on-site behavioral health supports so people can stay stable after placement. They also emphasized that housing efforts must be closely coordinated across behavioral health, cities, and homelessness systems to be effective.
Regional centers	Regional centers said the County needs stronger coordination to support people with developmental disabilities and neurocognitive disorders, especially those experiencing homelessness. They highlighted major gaps in services for autistic adults, individuals with major neurocognitive disorder, and youth with complex developmental and mental health needs. Many also called for more wellness centers, caregiver supports, and early family focused services. They emphasized that without better cross system collaboration, people with complex disabilities will continue to fall through the cracks.
Emergency medical services	Emergency medical services staff said they need better coordination with crisis response teams like PERT and MCRT because they often respond to mental health related emergencies without enough behavioral health trained support. They worry about unsafe crisis responses and say families sometimes avoid calling 911 because they fear unpredictable outcomes. Many emphasized the need for stronger follow-up after emergency mental health visits, especially for older adults and people with serious illness. They also noted that clubhouses and culturally competent providers play an important role in helping people stay connected and recover safely in the community.
Community-based organizations serving culturally and linguistically diverse	Community based organizations said the County must invest more in culturally rooted programs, multilingual outreach, and prevention services that meet the needs of diverse communities. They asked for clearer goals and stronger accountability around workforce diversity, along with more patient rights and advocacy supports. Many groups emphasized that trusted CBOs reach families who face language, cultural, or immigration related barriers and are often missed by

constituents	traditional systems. They also highlighted the need for trauma-informed services, navigation support for newcomer and refugee communities, and stable funding for community led healing programs.
Representatives from youth from historically marginalized communities	Youth from historically marginalized communities said they need services that respect their cultures and identities. They asked for safe, welcoming places to get help without stigma or fear. Many wanted support to start earlier—not only during a crisis—and for youth to have a real voice in decisions that affect them. They also pointed out gaps in school and community services, especially for LGBTQ+, immigrant, refugee, and foster youth.
Organizations specializing in underserved racially and ethnically diverse communities	Organizations that work with underserved racially and ethnically diverse communities asked for stronger community involvement in planning and decision-making. They stressed the need for outreach through trusted messengers, more transparency about how community input is used, and hiring more bilingual and culturally competent staff. Many comments focused on fairness and equity in workforce practices, with a small number expressing concerns that diversity efforts could feel unfair to some groups. Overall, they supported expanding community driven programs that better reflect the needs and voices of diverse communities.
Representatives from LGBTQ+ communities	Representatives from LGBTQ+ communities emphasized the need for safe, identity affirming places to get behavioral health support. They stressed the importance of culturally competent and trauma-informed care, along with early help—not just crisis services. Several comments highlighted worries that queer and trans youth may be overlooked without explicit protections and trained providers. Some also shared concerns about feeling unsafe or stigmatized when accessing government run programs.
Victims of domestic violence and sexual abuse	Representatives for survivors of domestic violence and sexual abuse emphasized the need for safe, confidential, and trauma-informed services. They highlighted how housing instability makes recovery harder and asked for stronger housing supports within prevention and intervention programs. Many comments stressed the importance of early help, especially for immigrant and refugee families who may face extra barriers. They also called for better coordination between behavioral health, crisis response, and shelter services so survivors can access support without repeating their stories or risking further harm.
People with lived experience of homelessness	People with lived experience of homelessness highlighted the need for stable, safe housing paired with behavioral health support. They stressed the importance of smooth transitions after leaving hospitals, jails, or crisis programs so people are not discharged back onto the streets. Many emphasized the need to include families experiencing homelessness, who often face unique barriers and safety concerns. They also called for more sober living options and services that understand the trauma of being unhoused.

Recommendations Received from the Behavioral Health Advisory Board (BHAB)
May 7, 2026

	BHAB Comment	BHS Response
1.	Connection between feedback and what is changing is unclear	• BHS will continue strengthening how stakeholder feedback is reflected in implementation planning, service coordination efforts, and future BHSA updates. Feedback received through the Community Planning Process helped reinforce priorities related to access, crisis response, housing, care coordination, and support for people with the most complex behavioral health needs. Presentation of information is limited to a statewide template.
2.	IP does not yet show how the system will work differently for the people who rely on it the most, especially those who move between crisis services, homelessness, and the justice system.	• Increased investment in crisis services, housing, and specific evidence-based practices for people with SMI and justice-involvement (FACT) • Some of the initiatives/services that address these issues are funded outside of BHSA
3.	Stakeholders described weak follow-through as they move between programs and systems, a lack of accountability for whether services are actually helping, and a disconnect between the problems identified in the Plan and the solutions that are proposed.	• BHS recognizes the importance of stronger transitions and continuity of care across crisis services, hospitalization, housing, justice-related systems, and ongoing treatment. BHSA and BH-CONNECT initiatives support expanded use of evidence-based practices, standardized levels of care, step-down services, and community-based supports intended to improve long-term stabilization and continuity of care. • At our most complex levels of care funded by BHSA, FSP, the state strengthens the step-down continuum by requiring a standard LOC tool and specific step-down services. Additionally, BHSA enhances our ability to provide patch funding for ASPs, which are a critical step-down resource between subacute care and the community.
4.	There is also a lack of clarity around how major changes, including Enhanced Care Management (ECM) and BHSA, will work in practice.	• BHS continues to work collaboratively with Managed Care Plans (MCPs), providers, and system partners to strengthen care coordination and implementation of ECM and BHSA-related changes. Additional state guidance and operational development are still occurring in several areas statewide. • Programs connect clients to their Health Plan for benefits and care coordination, including ECM (health plan benefit).
5.	Taken together, these concerns (3&4 above) point to a larger issue: there is no clear way to understand whether people are doing better over time. The Plan does not explain how outcomes will be tracked across crisis services, custody, housing, and ongoing care. This makes it difficult to know whether the system is improving or just continuing to operate as it does today	• BHSA places increased emphasis on statewide outcomes, accountability, and evidence-based practices. BHS continues to expand data-sharing, reporting, and coordination efforts intended to better understand service outcomes and improve continuity of care over time. Additional statewide reporting guidance is still being developed by DHCS. • BHSA strengthens service effectiveness by implementing high-fidelity EBPs which will be tracked and reported on at the state level.
6.	The Plan does a strong job identifying disparities across age, race and ethnicity, and language. However, the responses to those disparities are often general and not clearly tied back to what was identified. There needs to be a more direct connection between the disparities described and the actions the County plans to take,	• BHS remains committed to advancing culturally responsive and linguistically appropriate services. County providers are required to follow Cultural Competence and CLAS standards, including language access requirements, workforce development expectations, and ongoing community engagement efforts intended to better inform services for diverse populations.

	including specific approaches to language access and culturally appropriate care.	• DHCS also requires counties to implement Cultural Competence Plans. San Diego County monitors implementation of cultural responsiveness by ensuring services are provided in threshold languages, ensuring staff are reflective of the community we serve, ensuring provider staff are trained in cultural competencies and ensuring that outreach and engagement to diverse communities provide input and feedback to the County on its services.
7.	The IP also does not fully address behavioral health care in custody or what happens when people leave jail and return to the community. This includes both the quality of care provided while in custody and the lack of clear transitions back into community-based treatment. Without stronger connections between these parts of the system, people will continue to cycle through the same patterns the Plan is trying to change.	• While behavioral health services within custody settings involve multiple systems and agencies, BHS will continue to partner on transition and reentry coordination efforts. Initiatives such as CalAIM Justice-Involved (JI) services are intended to strengthen connections between custody settings and community-based behavioral health care following release. This Initiative will go live in adult jails later this year and will provide 90 day in-reach services to enhance transitions to the BHS community system of care. CalAIM JI initiative has already gone live in juvenile facilities.
8.	Care coordination is another area that needs more clarity. The Plan relies heavily on models like ECM, but feedback from providers and community members suggests that these services are inconsistent and often not enough for people with serious mental illness. It is not clear what level of support individuals can expect or how coordination will work between County services and managed care.	• BHS recognizes ongoing concerns regarding care coordination and transitions between systems. BHS programs are expected to coordinate with ECM providers, Managed Care Plans (MCPs), and other partners to support continuity of care, and implementation efforts in this area continue to evolve statewide. • New processes, such as TOC and MCCP, support transitions of care
9.	Early intervention is mentioned but not clearly developed as a strategy. Recent changes to contracts and programs raise questions about whether the system has lost capacity in areas that were previously supported through grants. The Plan should more clearly describe how individuals who are not currently engaged in care will be identified and supported earlier. This includes expanding field-based outreach and engagement, particularly for individuals experiencing homelessness with serious mental illness or substance use disorders.	• Under BHSA, Early Intervention includes services focused on access, outreach, stabilization, diversion, and earlier identification of behavioral health needs. BHS continues to support crisis response, school-linked services, field-based outreach, and evidence-based practices intended to engage individuals earlier and reduce escalation to more intensive levels of care. • Includes CSUs/ESUs and MCRT/PERT, in addition to school-based MH services that support early identification and treatment of behavioral health conditions, as well as Evidenced-based models of care like CSC-FEP. • Services such as IHOT and enhanced targeted outreach as part of Assertive Field Based Initiation of Substance Use Treatment (AFBI) also provide outreach.
10.	The Plan should also consider how voluntary, field-based treatment can be used more consistently, and where appropriate, how existing authorities can support earlier intervention before individuals cycle into crisis, hospitalization, or the justice system.	• A continued focus is on services that stabilize behavioral health crisis and divert from unnecessary levels of care. Crisis services, such as MCRT, PERT and CSUs/ESUs are examples. This is a core principle across all local Optimal Care Pathway (OCP) models. • IHOT provides outreach and engagement services to connect individuals to AOT and CARE for active community engagement and stabilization in the community. • New Assertive Field Based Initiation of Substance Use Treatment (AFBI) services will provide outreach and linkage to SU/MAT services and the addition of Mobile NTP will also provide field-based services.
11.	IP includes summaries of stakeholder input, it does not clearly show how that input changed the Plan. There should be a more direct connection between what was heard from the community and what is being proposed,	• Community feedback informed both development of the Integrated Plan and ongoing implementation planning efforts. BHS will continue using stakeholder engagement processes, implementation collaboratives, advisory

	as well as a clear plan for continuing to gather and use feedback during implementation.	structures, and future BHSA updates to gather feedback and help inform system improvement efforts over time.
12.	Please add following comments into pages 29, 43,164 and 176: The county will study the homeless population to determine the percentage experiencing an SMI or SUD. The county will consider the use of outpatient field teams to treat this population, voluntarily, in the field.	• The Integrated Plan reflects current operational, clinical, and statutory frameworks established through BHSA and related state guidance. BHS continues to use service delivery, outreach, housing, and care coordination data to better understand the needs of individuals experiencing homelessness and behavioral health conditions.
13.	Please add these comments into page 30: The county will pursue outpatient conservatorships when the level of care allows	• Conservatorship-related services and placement decisions are governed through existing legal and clinical processes. Individuals under conservatorship may receive services in community-based settings when clinically appropriate and consistent with court-ordered levels of care.
14.	Please add these comments Into page 34: Utilize electronic medical record sharing to facilitate voluntary and involuntary administration of medication as soon as possible in the hold sequences.	• BHS data sharing initiatives are in line with state mandates.
15.	Please add these comments into page 34: The county will support and encourage the crisis response teams of the cities within the county. The county will grant authority to these crisis response teams to initiate 5150 holds	• Existing Mobile Crisis Response Team (MCRT) and Psychiatric Emergency Response Team (PERT) models already include authority and processes consistent with applicable state law and crisis response responsibilities.
16.	Please add these comments Into page 37: Look for and implement field-based programs to identify gravely disabled or SUD people and pursue voluntary administration of medication in the field, and possibly involuntary administration of medication in the field within the guidance of the law and ethical medical practices. Our goal is to identify and treat the gravely disabled homeless people before they are arrested thus reducing all upstream numbers of justice involved individuals.	• BHS continues to support outreach, engagement, crisis stabilization, and voluntary treatment approaches intended to connect individuals to appropriate behavioral health services in community settings. Any involuntary treatment processes must follow existing legal, clinical, and due process requirements. • BHS is adding a mobile NTP to provide MAT services in the community for those who agree to voluntary services.
17.	Please add these comments Into pages 101-130 as is appropriate under Early Intervention (EI): Early intervention strategies will include efforts to identify gravely disabled people who are experiencing homelessness, pursue voluntary field treatment, or involuntary treatment if necessary. This would reduce all upstream numbers of justice involved, experiencing or at risk of experiencing homelessness, non-competent to stand trial people sent to a state mental hospital, and in justice involved reentry numbers.	• Early Intervention strategies within BHSA focus on outreach, engagement, stabilization, diversion, and earlier identification of behavioral health needs. BHS continues to support field-based outreach and community-based service models intended to reduce escalation to more intensive levels of care whenever possible.
18.	Please add these comments Into page 43: Broaden the use of the term “Any Person” under WIC 5201 to allow more and easier access to help through mandated Evaluations of people suffering with a mental disorder.	• Existing evaluation and intervention processes are governed by state law and established clinical and legal standards. The Integrated Plan reflects current statutory and operational frameworks applicable to behavioral health services.
19.	Intensive Out-Patient Programs (IOP) - IOPs are an incredible resource for people living with SMI, particularly after hospitalization while transitioning back into the community. Some San Deigo county examples include Sharp Mesa-Vista, Alvardo Parkway Institute, and Sharp Grossmont. However, Medi-Cal does not	• There will be a total of 35 Medi-Cal Intensive Outpatient Program/Partial Hospitalization Program slots in North, Central and East regions available this summer.

	currently cover these programs (at least as it relates to mental health, there may be SUD IOP programs Medi-Cal covers). I heard from many community members the value IOP had for them and also heard about the difficulty accessing these services. I've seen older adults in my program benefit tremendously from these programs when they've been able to access them through Medicare, but there are not options for these services for our members that are not yet eligible for Medicare. I can also speak from personal experience for the value of these programs in providing support and reducing re-hospitalization having been a part of an IOP program as a consumer	
20.	Enhanced Care Management (ECM) - The county has been increasingly been encouraging the use of ECMs. While the concept of ECM is wonderful, in practice, it is currently not meeting the needs of many people living with SMI. ECMs, in my experience, largely are able to schedule appointments and help setup transportation, but they do not attend or go into appointments with their clients. This leads to people living with SMI not ever making it to appointments/feeling intimidated or unsure of what to do inside of appointments/leaving appointments without important information on next steps. Most ECMs have been very difficult to reach with any consistency, even during moments of urgency, both for the client and for other professionals trying to coordinate. And many ECMs do not have extensive experience working with/knowledge around SMI. My program has been repeatedly encouraged to use ECMs for our members' physical health needs, but attempts to do so have been largely ineffective	• BHS recognizes ongoing stakeholder concerns related to ECM implementation and care coordination experiences. BHS will continue partnering with Managed Care Plans (MCPs), providers, and system partners to support coordination efforts and improve continuity of care for individuals with complex behavioral health needs.
21.	Desire For More Support to be Successful in the Community - Many people expressed feeling as though they were left to fend for themselves after hospitalization. Being told to schedule follow-up appointments, but essentially feeling left alone. People described the value of "having a hand to hold" as they navigate returning to the community. This could be field based FSPs, peer support, or an area where IOP would be valuable. Peer involvement at each step of the recovery process was requested. I believe this also aligns with what ECM would look like if it were functioning ideally.	• This feedback highlights the importance of strong care coordination, peer support, and continuity of care following hospitalization and during transitions back into the community. These themes continue to inform implementation discussions across multiple service and care coordination models.
22.	Lack of Board and Cares for Low-Income Individuals, Lack of Support at ILFs - My program supports members at many board and cares and ILFs. The lack of board and cares for low-income people is a consistent issue to providing safety when members leave the hospital. Many board and cares cost upwards of $3,000 a month for a shared room, something completely outside the means of members of our program/people on Medi-Cal as a whole (Medi-Cal's income limit is generally around $1,900 per month). Most of the members of my program live on Supplemental Security Insurance (SSI), which is generally about $1,200 per month. A person on SSI	• This is a significant barrier that BHS is aware of, and a key component of our OCP modeling. This is why we've focused on increasing capacity for ASP patches- to supplement the federal rate- and pursued and promoted both CCE and BHBH grant funding to both sustain and build capacity for board and cares that serve members with SMI and SSI. • Broader advocacy efforts are needed to advance rate parity in this area. • Targeted investment in these areas is essential to advance rate parity and ensure the long-term sustainability of the interventions outlined in our BHSA Housing plan.

	cannot have more than $2,000 of total assets to receive these benefits. Some board and cares have an "SSI rate" where they will charge roughly $1,300 a month for a shared room. SSI adjusts the total SSI received by such a person to roughly $1,400 per month, leaving about $100 total per month for a person living in a board and care after their rent in covered. Most board and cares do not have this type of accommodation. This leads to our members often being discharged unsafely to an ILF after hospitalization due to lack of supportive housing options, despite advocacy from my program that a member needs a higher level of care. ILFs, as they are currently, have very little (if any) support for people living with SMI, and in many situations can be a trigger. The biggest issue is only board and cares and levels of care higher than that can assist people with medications	
23.	Lack of Engagement Activities at Board and Cares - Most board and cares have few, if any, activities for residents. Most people living in board and cares have limited ability to leave the facility, and it's very damaging to one's mental health essentially being in one place every day with the only activity available being watching TV. People request more games, arts and crafts, exercise programs, and ways to have community outings	• CDSS governs licensed Board and Cares, so activities/programs within the board and cares are not something we can directly impact. • Clubhouses are a great option for board and care residents with behavioral health conditions and offer lots of structured activities during the day that residents could participate in.
24.	Lack of Support, Grocery Stores, Community Resources Near Low-Income Housing - Many board and cares, ILFs, and SROs are located in areas where grocery stores, parks, and other positive community resources are not easily accessible. Particularly for the older adult population I work with, if the nearest bus stop is a mile away, it is unreachable given limited mobility. In addition, many people with SMI struggle to use the bus and are at increased risk of victimization on public transportation. This leads to many of our members to lean on nearby liquor stores/smoke shops that deplete their already limited funds, are risks for triggering unhealthy coping skills like alcohol use, and usually result in less healthy options for food/drinks. It also leads to lack of community integration	• This feedback reflects broader social and environmental factors that can significantly impact behavioral health and recovery. While many of these issues extend beyond the direct authority of BHS, BHS continues to participate in cross-system partnerships and planning efforts intended to improve community supports and overall well-being.
25.	Trauma Inflicted by the System - I heard from many people in listening sessions, from members of my program, and have experienced personally trauma from the behavioral health system. This trauma largely relates to forced treatment, restraints, and seclusion. When a system that is meant to help people in crisis is responsible for trauma, it is extremely hard to rebuild trust and engage in a positive way with the system. It becomes an enormous barrier to recovery. I strongly encourage forced treatment, restraints, and seclusion being a truly last resort in situations that are immediate safety risks. This is not currently the case	• BHS recognizes the importance of trauma-informed care and ongoing efforts to reduce re-traumatization within behavioral health settings. State and federal regulations establish requirements related to safety interventions, and BHS continues to support approaches focused on least restrictive care whenever possible.
26.	Lack of Clarity, Guidelines, Standardization - Many changes are coming or starting to take effect, and there's a lack of information around how they are meant to be/going to be implemented. For example, my program	• Several questions within this comment. All High Fidelity EBP requirements are state-defined (staffing, caseloads, requirements) and can be found in the BH-CONNECT and BHSA policy manuals.

	will be transitioning to a level 2 FSP in less than 3 months. My administrators are currently trying to design a program without specifics even as basic on what our staffing level will be and what positions we are able to have at the program (will we have a housing coordinator, intake specialist, etc). There is meant to be housing assistance available now through Medi-Cal, but in speaking with Medi-Cal representatives, we have largely been told they are unfamiliar with this program or don't know who to connect us to to obtain this support. Changes to Medi-Cal and SNAP currently lack details on what will qualify a person for an exemption to things like work requirements and how this will be verified. This uncertainty is difficult for staff, but it is extremely challenging for our members living with SMI and has frequently led to exacerbated symptoms when access to housing and benefits are seemingly at risk	• Any contract that is implementing an EBP will be provided TA and guidance through the fidelity process by the COE, and there are timeframes set forth by DHCS for the provider to meet the fidelity standards. • (H&H) Sounds like seeking guidance on Transitional Rent benefit. Managed Care Plans (MCPs) are the ultimate authorizing entities, but they are still in the early stages of building their provider networks and operational workflows for these specific benefits.
27.	Lack of Options for People Losing Medi-Cal/SNAP - It appears there are few resources available for people living with SMI that may lose access to coverage through Medi-Cal. FQHCs, while extremely valuable, are not currently setup to treat SMI. How will people living with SMI that are, for instance, victims of human trafficking set to lose access to benefits, receive the support they need? Food banks are already having difficulty meeting demand, how will low-income people that lose access to SNAP consistently meet their basic needs?	• This feedback reflects broader policy and social service issues that involve multiple systems and funding structures beyond the direct authority of BHS. BHS continues to coordinate with community partners and other systems where appropriate to support individuals with complex behavioral health and social support needs.
28.	Disparities in Access to Care for both older adults and youth, particularly for non-English language. The solution described is to, "To address these gaps, SDCBHS is expanding crisis and diversionary services that reduce barriers to entry and improve linkage to ongoing care." (pg. 24). While adding additional entry points, the outlined solutions do not address the need for services in different languages.	• All BHS providers are required to follow CLAS standards, which ensures culturally and linguistically appropriate services.
29.	Page 84- The plan notes collaboration with Healthy San Diego. Which date of HSD was BHSA and the IP presented for engagement versus simply a report out that it was happening? The direct collaboration between the county BHP and MCPs should happen before guidance from the state.	• Initial engagement and information-sharing occurred in October 2026. Ongoing efforts related to BHSA implementation are anticipated moving forward given the existing convening of key stakeholders and representation of MCPs. Collaboration with MCPs, providers, and system partners will also continue through forthcoming BHS collaboratives throughout implementation as additional state guidance and operational requirements evolve.
30.	Why are the state measures starting on page 44 all "not applicable?"	• These were optional measures.
31.	Page 88- care continuum section is "marked complete" but has no information.	• "Marked complete" indicates the budget template was uploaded and completed. For responses to this section, refer to the IP budget template.
32.	Page 92- only 17% of county contracted providers have contracts with MCPs- this seems very low and could contribute to breakdowns in transitions of care. How are	• Managed Care Plan (MCP) investments and contracting decisions are administered outside of direct BHS oversight. BHS continues encouraging providers to diversify revenue streams and strengthen coordination with MCPs to support

	the programs benefiting from ECM and CS investments (pg. 189) if they aren't contracted with MCPs?	continuity of care and implementation of CalAIM-related services.
33.	Early Intervention Programs- Why are many operating without using EBPs? Why were there no additional opportunities identified for EI?	• There are specific, state-identified EBP models that are required as part of BHSA and/or BH-CONNECT (ACT, FACT, CSC-FEP, HFW, Clubhouses, IPS, PCIT, MST, FFT), and then evidence-based practices that providers may use within their treatment programs with members and families. BHS contractors operating Medi-Cal treatment programs typically determine the specific EBPs they will use in therapy- BHS does not prescribe the specific EBP this if there is no superseding requirement.
34.	Page 192- good call out for what the community has been asking for. More of this and more specificity. "For the last three years, stakeholders have consistently identified the following areas as priorities for enhancement within San Diego County's continuum of care: Accessibility; Care Coordination and Navigation; Community Outreach and Education; Crisis Response Services; Culturally Appropriate and Affirming Care; Support for People Experiencing Homelessness; Services for Youth and Transition Age Youth(TAY); and Workforce Capacity and Diversity."	• BHS appreciates the feedback regarding the importance of clearly connecting stakeholder priorities to implementation efforts. These focus areas helped inform ongoing planning, engagement, and system improvement discussions related to BHSA implementation and future updates.
35.	Page 192 has a comment about the importance of ACEs, but there was a recently terminated contract for ACEs?	• ACES as a screening tool and the ACES Prevention program for Fathers are two different things. ACES is a screening tool that can be used in many different settings and the specific contracts that are sunsetting are parenting programs.
36.	In the community engagement summaries, there are really rich feedback reports, but I don't see that feedback directly incorporated into the plan itself or informing future work as it's currently outlined. Is there a way to include the voices of these stakeholders in a more meaningful way?	• Stakeholder feedback gathered through the Community Planning Process informed development of the Integrated Plan and will also inform ongoing implementation coordination efforts. BHS will continue using community engagement summaries, implementation collaboratives, advisory structures, and future BHSA updates to strengthen transparency and support ongoing stakeholder involvement over time.
37.	Where is the UCSD CPP report?	• Reporting requirements and Community Planning Process (CPP) expectations under BHSA differ significantly from prior MHSA processes and reporting structures. During previous MHSA cycles, contracted partners supported BHS CPP-related activities and provided stakeholder input and recommendations to the department. Under the current BHSA process, feedback and recommendations gathered through contractor-supported activities were synthesized alongside input received through broader CPP activities conducted by BHS and other contracted partners. • BHS incorporated Community Engagement Activity Summaries into the Integrated Plan appendices to provide details of activities conducted following approval by the Behavioral Health Advisory Board (BHAB) in September 2025.
38.	There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful.	• BHS continues to build data infrastructure to advance information sharing and track members over time
39.	The poor quality of behavioral health services in the County jails has been documented by the Grand Jury, the	• Behavioral health services within custody settings involve multiple systems and agencies beyond the direct authority

	State legislature audit, the League of Women Voters, and many other entities. Deaths have occurred in custody as a result of the SDSO policies and procedures and the county has paid out upwards of $100 million in lawsuits in a 10 year period. The State must consider the quality of services as the incarcerated person re-enters the community as they likely will be more acute.	of BHS. BHS continues to participate in transition and reentry coordination efforts intended to support continuity of care as individuals return to community-based settings.

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

164 - Quality Improvement Work Plan FY 2025-27, new version 4-21-26.pdf - *see Appendix E*

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

Yes

For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027

164 - Quality Improvement Work Plan FY 2025-27, new version 4-21-26.pdf - *see Appendix E*

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	**Number of contracted BHSA provider locations**
Mental Health (MH) services only	124
Substance Use Disorder (SUD) services only	3
Both MH and SUD services	9

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	114
DMC/DMC-ODS only	3
Both SMHS and DMC/DMC-ODS systems	9

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

17

Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs

County BHSA Coordinator will leverage current MCP related resources and develop additional materials needed to educate the BHS provider network regarding MCP contracting opportunities. Coordinator will work collectively with provider contract monitors to discuss how contracting with MCPs can lead to seamless services to shared Medi-Cal members, as providers can bill to either the BHP or MCP for SMHS and NSMHS accordingly. With this knowledge, contract monitors will be required to have continued conversations with BHSA funded provider locations in an effort to enhance rates of MCP contracting. Coordinator will track the rates over time and identify and implement additional targeted and/or systemic interventions as needed based on the data.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.
Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)
Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Children's System of Care (non-Full Service Partnership (FSP))
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care .

Please select the service types provided under Program

Mental health services

Please describe the specific services provided
Intensive/Structured Outpatient program using Multisystemic Therapy (MST) model (Program: Sexual Treatment, Education, and Prevention Services (STEPS)).

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	79
FY 2027 – 2028	84
FY 2028 – 2029	88

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for STEPS assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care .

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Therapeutic Behavioral Services (TBS) provides critical short term one-to-one behavioral intervention services for children up to 21 years old, who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	293
FY 2027 – 2028	311
FY 2028 – 2029	327

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for TBS assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Mental health services

Please describe the specific services provided

Biopsychosocial Rehabilitation (BPSR)Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to adults age 18 and above who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.

Program names:

- Central Region BPSR WRC-Areta Crowell (ACC)
- North Central Region BPSR WRC (Douglas Young clinic)
- Service for Victims of Trauma and Torture
- North Inland Mental Health Clinic
- Vista/North Coastal Mental Health Clinic
- Promise Wellness Center
- Maria Sardinas WRC BPSR
- South Bay Guidance Center BPSR-South Region
- Healing Oaks Clinic
- BPSR for Central/North Central for Latino & TAY (Alianza)
- Heartland Center-East Region BPSR
- BPSR (CTC)

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	9021
FY 2027 – 2028	10631
FY 2028 – 2029	12083

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

For this initial Integrated Plan, projections for our adult clinics and BPSR programs assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we seek to rebalance engagement in more intensive, community-based programs against lower acuity outpatient care to best meet the needs of our members.

BPSR numbers are pulled from EHR and represent clients served in FY24-25, those numbers were then used as base for projections for future FYs.

Growth rates for all adult, non-FSP programs were set to 50% of the targeted growth rate for adult FSP programs. For adult FSP programs, the 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS. The year-over-year growth rate allows the County to reach that 5-year target on a trajectory that is financially sustainable.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Program name: Jane Westin Center
Program Description: Program provides a Short-Doyle Medi-Cal certified mental health walk-in outpatient clinic (walk-in outpatient mental health assessments and psychiatric consultation, medication management services; crisis intervention and case management brokerage)

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1555
FY 2027 – 2028	1832
FY 2028 – 2029	2083

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
For this initial Integrated Plan, projections for the Jane Westin Center assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we seek to rebalance engagement in more intensive, community-based programs against lower acuity outpatient care to best meet the needs of our members.
Numbers are pulled from EHR and represent clients served in FY24-25, those numbers were then used as base for projections for future FYs

Growth rates for all adult, non-FSP programs were set to 50% of the targeted growth rate for adult FSP programs. For adult FSP programs, the 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS. The year-over-year growth rate allows the County to reach that 5-year target on a trajectory that is financially sustainable.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Mental health services

Please describe the specific services provided
Program name: Accessible Depression and Anxiety Peripartum Treatment (ADAPT)
Program Description: The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program provides services to adult residents (18 years of age and older) of San Diego County who have a peripartum mood disorder, including individuals with a serious mental illness, individuals experiencing postpartum psychosis, and those who may have co-occurring substance use. Specific services include screening and assessment for mental health and co-occurring substance use issues, specialty mental health services to individuals with perinatal depression and anxiety, in-home services, medication support services, care coordination, and peer support.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	258
FY 2027 – 2028	304
FY 2028 – 2029	346

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

For this initial Integrated Plan, projections for our Peripartum Outpatient program assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we seek to rebalance engagement in more intensive, community-based programs against lower acuity outpatient care to best meet the needs of our members.

Numbers are pulled from EHR and represent clients served in FY24-25, those numbers were then used as base for projections for future FYs

Growth rates for all adult, non-FSP programs were set to 50% of the targeted growth rate for adult FSP programs. For adult FSP programs, the 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS. The year-over-year growth rate allows the County to reach that 5-year target on a trajectory that is financially sustainable.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program name: NAI CAC

Program description: A certified outpatient behavioral health program and provide a full range of outpatient diagnostic and treatment services and intensive case management to stabilize high risk youth, adolescents, and young adults up to age 18, who are leaving a psychiatric hospital and/or the Emergency Screening Unit (ESU) and in need of follow-up services to divert or prevent readmission to acute care services

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

This program aims to aid in the stabilization of high-risk youth and adolescents who are in need of treatment services and intensive case management to divert or prevent readmission to acute care services. SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific are incorporated when appropriate. For example, for this program the IP CANS Early Childhood module is utilized to evaluate progress in life functioning, risk behaviors, and child behavioral & emotional needs. The Periodic Symptoms Checklist (PSC) is utilized to evaluate caregivers reported improvement levels when the child is 3 years or older. The total score evaluates emotional, behavioral, and attentional concerns and how the child's overall functioning is improved over time. Additionally, connections/access to prosocial activities and to behavioral health services are tracked.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	230
FY 2027 – 2028	244
FY 2028 – 2029	257

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for NAI CAC assume that the numbers of youth served will grow proportionately to growth across outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Program name: Native American Prevention and Early Intervention (PEI) Services, Dreamweavers
Program description: This is a Community Defined Evidence Practice (CDEP) that provides community defined early intervention services and substance misuse prevention services for American Indian/Alaska Native individuals of all ages who are from tribal communities within San Diego County. The program includes elder navigator services, outreach and prevention education services, brief mental health intervention services and substance misuse prevention through culturally responsive services to enhance individual, family, and community wellness.

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

The Native American Early Intervention Services program specifically aims to address disproportionate behavioral health impacts driven in part by historical and generational trauma and socioeconomic disparities. The program provides culturally responsive and linguistically appropriate early intervention services, including outreach, access and linkage to care, and early intervention treatment, incorporating community-defined evidence practices (CDEPs) for American Indian/Alaska Native/Native American (AI/AN/NA) individuals across the lifespan in San Diego County.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated as appropriate. For this program, the County will also utilize a mixed-methods approach to data collection, including structured data elements, participant self-report, and qualitative feedback, with outcome measurement implemented in a culturally responsive and trauma-informed manner.
For CDEP elements, where appropriate, validated tools may be used; however, the program prioritizes culturally grounded measures developed in collaboration with Native American community stakeholders to ensure cultural validity and relevance. Data will be reviewed on an ongoing basis to support continuous quality improvement and alignment with BHSA Early Intervention goals.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	589
FY 2027 – 2028	695
FY 2028 – 2029	789

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

For this initial Integrated Plan, projections for the Native American PEI program assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we seek to rebalance engagement in more intensive, community-based programs against lower acuity outpatient care to best meet the needs of our members.

Dreamweavers served 120 individuals in FY24-25 per EHR. The data source is mHOMs. Growth rates for all non-FSP programs serving adults were set to 50% of targeted growth rate for adult FSP 1 and 2 models (ACT, FACT, ICM). Adult FSP 1&2 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS, which allows the county to reach the 5-year target on a trajectory that is financially sustainable. Clubhouses do not have a community need target that has been provided by CalMHSA and DHCS, and for IPS, the 5-year target is 20% of community need identified for San Diego which reflects an 1100% increase from current capacity. It's important to note that IPS represents two separate benefits- IPS for SUD and IPS for SMH. IPS and Clubhouse targets will continue to be reviewed and adjusted as the new benefit is implemented and year one baseline data is established.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to

meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Crisis Stabilization Units (CSUs) provide care for adults that have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug induced problems, serving as alternative to Behavioral Health Unit (BHU) admissions.
Crisis stabilization unit services provide mental health and substance use disorder services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impacts of suicide, return to use of illicit substances or misuse of prescription drugs, and/or accidental overdose/poisoning. These services are designed to address co-occurring mental health and substance use issues.

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
divert or prevent readmission to acute care services

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	6447
FY 2027 – 2028	7023
FY 2028 – 2029	7502

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

For this initial Integrated Plan, projections for our adult CSUs assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we work to right size and optimize utilization of this relatively new resource in our care continuum.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program Name: ECS - Para Las Familias
Program Description: This program serves seriously emotionally disturbed children 0-5 years old and their families

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
San Diego County Behavioral Health Services (SDCBHS) uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate. For this program, outcomes are tailored to the developmental needs of young children (ages 0–5), who are most commonly diagnosed with Other/Excluded disorders and Stressor- and Adjustment-related disorders. For example, the Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	202
FY 2027 – 2028	215
FY 2028 – 2029	226

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Para Las Familias assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program Name: Incredible Years (Childnet)
Program Description: This program serves seriously emotionally disturbed children 0-5 years old and their families

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

Incredible Years

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Incredible Years

Please describe intended outcomes of the program or service

San Diego County Behavioral Health Services uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate. For this program, outcomes are tailored to the developmental needs of young children (ages 0–5), who are most commonly diagnosed with Other/Excluded disorders and Stressor- and Adjustment-related disorders. For example, the Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	112
FY 2027 – 2028	119
FY 2028 – 2029	125

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Incredible Years assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name
Program name: KidSTART Clinic & Caregiver Wellness Program
Program description: This program serves seriously emotionally disturbed children 0-5 years old and their families

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply
Parent Child Interaction Therapy (PCIT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
PCIT

Please describe intended outcomes of the program or service
San Diego County Behavioral Health Services uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate. For this program, outcomes are tailored to the developmental needs of young children (ages 0–5), who are most commonly diagnosed with

Other/Excluded disorders and Stressor- and Adjustment-related disorders. For example, the Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	211
FY 2027 – 2028	224
FY 2028 – 2029	235

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for KidSTART assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: New Alternatives Inc (NAI) Children and Youth Crisis Stabilization Unit
Program description: Program provides screening for children and youth in crisis and includes a crisis stabilization unit.

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures - such as successful linkages following crisis or ED encounters - are incorporated when appropriate.

The Children and Youth Crisis Stabilization Unit specifically addresses the needs of children and youth at high risk of crises or actively experiencing a behavioral health crisis. Services include mental health and substance use interventions that prevent, respond to, and treat crises, while establishing direct linkages to ongoing community-based treatment to support stabilization and continuity of care.

Outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1437
FY 2027 – 2028	1916
FY 2028 – 2029	2254

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Children and Youth Crisis Stabilization Units (CSUs) were specifically calculated within the OCP based on best practice youth crisis continuum data from other states with the goal of diverting youth from hospital emergency departments.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: North Coastal and Regional Mobile Crisis Response Teams (MCRTs)
Program description: Non-Law Enforcement Mobile Crisis Response Team (MCRTs)

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

The Mobile Crisis Response Team (MCRT) specifically supports these outcomes by responding to individuals across the lifespan experiencing behavioral health crises in the community. MCRT aims to reduce suicide and self-harm, overdose, prolonged suffering, and unnecessary incarceration by providing timely, individualized assessment and brief intervention tailored to the needs of individuals at high risk of or actively experiencing a crisis. The program connects individuals to appropriate behavioral health services and is designed to prevent conditions from becoming more severe while reducing disparities in access to care. When transport to the emergency department is necessary, MCRT conducts follow-up to coordinate access to ongoing treatment and support continuity of care. Program performance is tracked through key

measures, including response times, service dispositions, and successful connections to behavioral health treatment services.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	7374
FY 2027 – 2028	8264
FY 2028 – 2029	9166

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for MCRT combine the anticipated growth rate across youth and adult mobile response. Youth projections reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, youth mobile crisis projections were specifically calculated within the OCP based on best practice youth crisis continuum data from other states.

Adult projections assume a growth rate equivalent to 50% of the anticipated growth in our FSP programs as we continue ongoing efforts to optimize crisis response across various resources in the continuum.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program name: Comprehensive Assessment and Stabilization Services (CASS)
Program description: provides outpatient mental health services including a comprehensive behavioral health assessment, individual and family therapy, case management, individual rehab and psychiatric services/med management for children and youth placed by Child Welfare in a resource family home and at risk of change or placement disruption

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support children, youth and families with child welfare involvement and therefore trauma consideration is a focal point of treatment. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	163
FY 2027 – 2028	173
FY 2028 – 2029	181

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for CASS assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program Name: Center for Child and Youth Psychiatry (CCYP)
Program Description: Provides outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices and technology at multiple locations in the County of San Diego.

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support children and youth with complex psychotropic medication needs. The goal is to achieve stabilization and no longer require specialty mental health services to manage psychotropic medication needs. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	677
FY 2027 – 2028	720
FY 2028 – 2029	756

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for CCYP assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: Connections Community Counseling
Program description: Countywide Outpatient Behavioral Health Services for Runaway/Homeless Youth

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program aims to support youth presenting with SMHS needs who are homeless or at risk of homelessness, with goal of stabilizing mental health needs and housing security. The Integrated Practice

Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	170
FY 2027 – 2028	181
FY 2028 – 2029	190

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Community Connections Counseling and Countywide Outpatient for Runaway Youth assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name

Program Name: Foster Family Agency Stabilization and Treatment (FFAST)
Program Description: Provides a full range of Title 9 outpatient diagnostic and treatment services including Therapeutic Family Care (TFC) Services to children and youth

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support children, youth and families with child welfare involvement and

therefore trauma consideration is a focal point of treatment. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	148
FY 2027 – 2028	157
FY 2028 – 2029	165

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for FFAST assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program Name: I CARE
Program Description: Provides individual/group/family services to youth at risk of CSEC.(Commercially Sexually Exploited Children).

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support youth who have experienced or are at risk of commercial sexual

exploitation and the trauma impacts. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	87
FY 2027 – 2028	92
FY 2028 – 2029	97

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for I CARE assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: Incredible Families
Program description: Provides outpatient behavioral health services for children 2-14 involved with the Child and Family Well Being (child welfare) department who are in the process of family reunification.

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support children, youth and families with child welfare involvement and

therefore trauma consideration is a focal point of treatment. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	87
FY 2027 – 2028	92
FY 2028 – 2029	97

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Incredible Families assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: Our Safe Place
Program Description: Provides individual/group/family services to Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) children and youth provided at schools, home, or office/clinic location.

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support youth presenting with SMHS needs who identify as LGBTQIA+ or

are exploring their sexual orientation and/or gender identity. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	76
FY 2027 – 2028	81
FY 2028 – 2029	85

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for Our Safe Place assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: Psychiatric Emergency Response Team Services (PERT)
Program Description: Services contributes to the well-being of individuals experiencing a mental health crisis who have come in contact with law enforcement, with the goal of more humane and effective handling of incidents involving law enforcement officers and individuals with mental illness, developmental disabilities and /or substance use disorders.

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional

program-specific measures - such as successful linkages following crisis or ED encounters - are incorporated when appropriate.

The Psychiatric Emergency Response Team (PERT) supports these outcomes by responding to imminent crisis situations where safety is a concern. The program pairs a clinician with a law enforcement officer to provide on-site assessment, brief intervention, and linkage to behavioral health services for individuals experiencing a psychiatric emergency. Serving children and youth, adults, and older adults, PERT aims to reduce suicide and self-harm, overdose, prolonged suffering, and unnecessary incarceration by ensuring timely, coordinated crisis response and connection to appropriate care.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	7723
FY 2027 – 2028	8413
FY 2028 – 2029	8987

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
For this initial Integrated Plan, adult projections assume a growth rate equivalent to 50% of the anticipated growth in our FSP programs as we continue ongoing efforts to optimize crisis response across various resources in the continuum.
Growth rates for all adult, non-FSP programs were set to 50% of targeted growth rate for adult FSP 1 and 2 models (ACT, FACT, ICM). Adult FSP 1&2 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS, which allows the county to reach the 5-year target on a trajectory that is financially sustainable. Clubhouses do not have a community need target that has been

provided by CalMHSA and DHCS, and for IPS, the 5-year target is 20% of community need identified for San Diego which reflects an 1100% increase from current capacity. It's important to note that IPS represents two separate benefits- IPS for SUD and IPS for SMH. IPS and Clubhouse targets will continue to be reviewed and adjusted as the new benefit is implemented and year one baseline data is established.
We use an internal call log maintained by the PERT administrative team that is provided to us on a monthly basis. During the development of the Optimal Care Pathways (OCP), we incorporated the role of PERT as one element of the broader crisis continuum focused on hospital diversion, including MCRT, CSUs, and crisis residential facilities. Current projections for PERT were also developed to ensure alignment with the assumption that approximately 50% of FSP clients would be engaged through other programs within the system of care.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Program name: (CY-SD) Placement Stabilization Services Polinsky Children's Center
Program Description: Short term outpatient services to children and youth who are brought in for protective issues identified by Child and Family Well-Being (CFWB).

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

The program specifically aims to support children, youth and families with child welfare involvement and therefore trauma consideration is a focal point of treatment. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	199
FY 2027 – 2028	211
FY 2028 – 2029	222

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for the Polinsky Children's Center assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

SBCS Corporation
Sweetwater
VIVA Counseling
Family Wellness Center - East County Outpatient Program
East County Behavioral Health Clinic
CHAP-IDEA-MERIT Wellness Center
TIDES School-Based Outpatient Services
Community Circle Central/East (FSP)
Cornerstone School-Based Outpatient Services
North County Outpatient School Based Services

San Diego Outpatient Program
Crossroads
Douglas Young
Nueva Vista
Mobile Assessment Services Team
Central Outpatient Psychiatry
Central--East-South (CES)
Children's Mental Health
North/N coastal & Fallbrook
No. Inland Outpatient Psychiatry
No Coastal Outpatient Pscyhiatry
Learning Assistance Center Esc & NoInland
Community & School Based Counseling
San Ysidro School Based Outpatient
ChildNET

Please select which of the three EI components are included as part of the program or service

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

SchooLink specifically aims to support children, youth with specialty mental health needs, with common presenting concerns including stressors & adjustment disorders, depressive disorders, and anxiety disorders. The Integrated Practice Child and Adolescent Needs and Strengths (IP CANS) Early Childhood module is used to assess progress in life functioning, risk behaviors, and behavioral and emotional needs. Additionally, for children ages 3 and older, the Pediatric Symptom Checklist (PSC) is used to assess caregiver-reported improvements. The total score captures changes in emotional, behavioral, and attentional concerns, providing a measure of the child's overall functioning over time.

These outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	7548
FY 2027 – 2028	8019
FY 2028 – 2029	8420

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections for services provided reflect year-over-year growth rates established as part of BHS's Youth Optimal Care Pathways (OCP) analysis. The OCP incorporates academic research, best practice benchmarks, and the experience of national, state, and local programs to estimate community need for BHS services by level of care and define achievable engagement rates. For this initial Integrated Plan, projections for School Based Outpatient Services assume that the numbers of youth served will grow proportionate to growth across all early intervention and outpatient services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Project In-Reach Ministries

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
SDCBHS uses a comprehensive, data-driven planning and oversight process to align services, contracts, and funding with the needs of priority populations identified through local needs analysis, including individuals with unmet need, youth, and underserved communities. Intended outcomes focus on improving access, quality, and continuity of care, with a strong focus on reducing disparities and advancing equitable service delivery.

Outcomes are assessed at both the system and member levels. System-level outcomes include quality metrics, contract monitoring results, access indicators, and performance trends tracked through QAPI and population health processes. Member-level outcomes are measured through a coordinated framework aligned with State requirements, including COE-defined measures for EBPs, LOCUS for determining and transitioning levels of care, and validated assessment tools that measure change over time. Additional program-specific measures are incorporated when appropriate.

Project In-Reach Ministry (PIRM) supports these outcomes by serving individuals in San Diego County detention facilities, including all adult and youth facilities for (21 and over), San Diego residents returning from out of county detention who meet CAL AIM eligibility, San Diego residents returning from CDCR

facilities who meet CAL AIM eligibility, and incarcerated adults in County facilities diagnosed with serious mental illness (SMI).

Eligibility is temporarily expanded (Nov 1, 2023 – Jun 30, 2026) for adults with mild to moderate mental illness, including those with co-occurring substance use issues.

PIRM provides short-term counseling, peer support, recovery services, case management, and linkage to ongoing services for up to 120 days post release. PIRM provides linkages and referrals to community based organizations, including faith based and cultural organizations.

All clients requesting faith-based linkages are connected to the congregation of their choice. All linkages and referrals are documented in the client's record.

Services continue without interruption if a participant is transferred between San Diego County detention facilities, where PIRM will follow the participant to their location. Cases may be closed when goals are met and linked to a BH provider, the participant is uncooperative or declines services

Overall outcomes are supported by integrated data systems such as SmartCare, which enable ongoing monitoring, equity-focused resource allocation, and continuous quality improvement. This infrastructure strengthens the County's ability to track progress, identify gaps, and ensure alignment with BHSA priorities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	204
FY 2027 – 2028	241

Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	273

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

For this initial Integrated Plan, projections for Project In-Reach assume a growth rate equal to 50 percent of the anticipated growth of our FSP programs as we seek to rebalance engagement in more intensive, community-based programs against lower acuity outpatient care to best meet the needs of our members.

Growth rates for all adult, non-FSP programs were set to 50% of the targeted growth rate for adult FSP programs. For adult FSP programs, the 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS. The year-over-year growth rate allows the County to reach that 5-year target on a trajectory that is financially sustainable.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name

Kickstart

CSC program description

The program provides early intervention services for the prevention of psychosis to youth and TAY, ages 10-25, with signs and symptoms of early psychosis. Kickstart provides three service components: education to community members to help identify and connect youth and TAY to early intervention services, screening and assessment of at-risk youth, and intensive treatment for youth that are at risk of the development of psychosis. Treatment includes psychoeducational classes, multi-family groups, support services, and other needed behavioral health interventions. This program provides home and community-based services.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	423
Number of Uninsured Individuals	52

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	51
Number of Teams Needed to Serve Total Eligible Population	12

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	21	25	34
Total Number of Teams	5	6	8

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
SAMHSA, Medi-Cal

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
In-Home Outreach Team

Please describe the program or activity
In Home Outreach Team (IHOT) provides outreach to directly reach and engage individuals who may benefit from behavioral health services and engagement to support and encourage ongoing participation of the eligible population in behavioral health treatment to include Peer Support Services, access and

linkage, and treatment services to help avert the development of severe and disabling conditions, discourage risky behaviors and support individuals in maintaining healthy lifestyles. The program assists in enrolling individuals in an FSP and ensures access to food, clothing, and basic necessities to support the immediate needs of an individual.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	617
FY 2027 – 2028	656
FY 2028 – 2029	689

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs

Adult projections assume a growth rate equivalent to 50% of the anticipated growth in our FSP programs as we continue ongoing efforts to optimize crisis response across various resources in the continuum.
IHOT numbers are pulled from EHR and represent clients served in FY24-25, those numbers were then used as base for projections for future FYs.
Growth rates for all adult, non-FSP programs were set to 50% of the targeted growth rate for adult FSP programs. For adult FSP programs, the 5-year target was set to 100% of the identified community need for San Diego County provided by CalMHSA and DHCS. The year-over-year growth rate allows the County to reach that 5-year target on a trajectory that is financially sustainable.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the

following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
San Diego State University (SDSU) Research Foundation – Cultural Responsiveness Academy: BBS licenses, Board of Registered Nursing and SUD counselors and Rosemarie Sachs via Regional Training Center for Motivational Interviewing training: BBS licenses only

Please select which of the following categories the activity falls under
Continuing Education

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Trainings offered through the Cultural Responsiveness Academy (CRA) focus on diversity and disparities that impact the behavioral health system of care. For example, CRA offers regular trainings on Transgender, Gender Diverse, Intersex Cultural Competency.
Thie motivational interviewing training includes a culturally responsive lens when practicing the skill.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
• Non-clinical internships and apprenticeships are managed through BHS Communication and Engagement (C&E). • New programs are being developed by the Workforce INN Program, currently

monitored by C&E. • HCO WET Team receives requests for clinical internships

Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
BHS promotes internship opportunities across local universities who hold a clinical counseling, marriage family therapy and social work Master's program. Additionally, BHS partners with SDSU to complete interviews for the public behavioral health stipend program to recruit MSW students who are representative of the communities that we serve.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name
The ELEVATE Behavioral Health Workforce Fund, a MHSA-encumbered INN project continuing under the Behavioral Health Services Act as part of Behavioral Health Services and Supports-Workforce, Education, and Training, will be offering a renewable training fund. The Workforce INN's renewable training fund program will be monitored by the Communication & Engagement (C&E) team. This program allows students pursuing their degree to accept a zero percent interest rate student loan to support their education, reducing financial burden.

Please select which of the following categories the activity falls under
Loan Repayment

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Workforce-related investments described in the draft Integrated Plan reflect implementation of recommendations identified through the County's 2022 Behavioral Health Workforce Shortage Assessment, which identified priority strategies including strengthening workforce pipelines, expanding training capacity, supporting participation by community-based organizations in Medi-Cal behavioral health service delivery, and improving workforce retention across the behavioral health continuum. These strategies are intended to support increased participation by providers who reflect the cultural, linguistic, and geographic diversity of the communities served. Investments such as the ELEVATE Behavioral Health Workforce Fund support workforce pipeline development, training, and retention within the specialty behavioral health delivery system, including career advancement opportunities for individuals with lived experience through the Peer Specialist Upskilling Program. These efforts help strengthen representation of individuals with community-based experience and support development of recovery-oriented workforce roles that reflect the populations served. Complementing these specialty workforce investments, the San Diego County Board of Supervisors approved a $10 million investment to support Medi-Cal training and technical assistance for community-based organizations interested in completing Medi-Cal behavioral health certifications. This effort supports participation by trusted community-based providers serving historically underserved populations and helps expand geographic and culturally responsive service capacity across the behavioral health continuum. Additional workforce pipeline strategies are also underway through development of the Behavioral Health Apprenticeship Network (BHAN) Committee, an industry-led employer forum facilitated by LAUNCH and comprised of industry partners, union representatives, and educators. Initial apprenticeship occupations are expected to include Substance Use Disorder Counselors, Social and Human Services Assistants (including case managers and outreach workers), Community Health Workers, and Wellness Coaches. These apprenticeship pathways are intended to expand entry points into behavioral health careers and support workforce diversification across multiple service roles. Together, these coordinated workforce investments support increased participation by community-based providers, individuals with lived experience, and early-career trainees entering the behavioral health workforce, strengthening culturally responsive and geographically distributed service capacity as BHSA implementation moves forward.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health

Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
County Behavioral Health Services Staff are reimbursed for licensing and certification fees, upon request.

Please select which of the following categories the activity falls under
Professional Licensing and/or Certification Testing and Fees

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Reimbursement of professional licensing fees helps retain our already diverse clinical workforce.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button.
For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name

Workforce Innovation (INN) project through ELEVATE Behavioral Health Workforce Fund will have a stipend program available for clinical interns. This will be monitored by the C&E team.

Please select which of the following categories the activity falls under
Retention Incentives and Stipends

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The County Behavioral Health System has undertaken several efforts to address disparities in the behavioral health workforce and strengthen workforce diversity. In 2022, the County partnered with the San Diego Workforce Partnership to conduct a regional behavioral health workforce assessment examining factors contributing to workforce shortages and barriers to entry for diverse populations. Findings from this assessment continue to inform the County's workforce development strategies. The County has also launched its ELEVATE Behavioral Health Workforce Fund, a $75 million, five-year MHSA Innovation project approved by the California Department of Health Care Services. As the County transitions from MHSA to BHSA, ELEVATE will continue to serve as a key strategy to strengthen workforce pathways and support individuals entering and advancing in the behavioral health field. In addition, the Healthcare Oversight (HCO) Workforce Education and Training (WET) team conducts workforce recruitment presentations in partnership with the San Diego County Office of Education (SDCOE), including virtual presentations that help reach students in rural communities. The County is also in the process of procuring a vendor(s) to support a Board-directed initiative to provide Medi-Cal training and technical assistance to community-based organizations who already provide or are poised to provide mild-to-moderate behavioral health supports. The vendor(s) will assist local organizations interested in Medi-Cal behavioral health certifications and participation in the behavioral health delivery system. Though focused on the non-specialty side of the system, this effort will help expand opportunities for culturally and linguistically responsive providers and support the broader behavioral health care system.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the

following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Clinical Internships: BHS has established placement agreements with 14 universities for graduate level clinical internships. In FY 25-26, 4 interns were accepted for placement. In FY 24-25, staff spend 217 hours supervising a total of 7 clinical interns. Data for FY 25-26 is not available until the end of the fiscal year.

Please select which of the following categories the activity falls under
Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Staff are providing clinical supervision to diverse graduate students who have an interest in working in public behavioral health and underserved communities. This process allows for students to have a well-rounded and supportive clinical supervision experience.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Workforce Training

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Efforts to address disparity:
Healthcare Oversight (HCO) WET team has provided workforce recruitment presentations to various high schools in San Diego County in collaboration with the San Diego County Office of Education (SDCOE). In some instances, presentations were offered virtually in order to reach our rural communities broadcasting to classrooms.

Program Description:
BHS workforce team (WET) provides a minimum of 8 trainings per fiscal year to support DMC-ODS program training requirements. BHS supports the recruitment of high school, community college, undergraduate and graduate students. To increase behavioral health interest from high school students, BHS in partnership with the San Diego County Office of Education (SDCOE) provided workforce presentations to 10 schools (approx. 600 students) throughout San Diego County in FY 24-25 to engage high school students' interest in public behavioral health County BHS clinical staff are offered clinical supervision toward their BBS licensure and psychologist licensure through The Knowledge Center contracted staff and a BHS contract for clinical supervision through the Regional Training Center. There are currently 10 staff who are receiving clinical supervision through TKC and 7 staff receiving clinical supervision through BHS contracted supervisor.
The University of California San Diego (UCSD) Community Psychiatry Program continues to support post-graduate education and trains psychiatry residents/fellows and psychiatric mental health nurse practitioner trainees to advance the concepts of Community Psychiatry and promote work in community-based settings. The program also places psychiatric mental health nurse practitioner (PMHNP) trainees side-by-side with Psychiatry Residents throughout the entire program. In FY 23-24, UCSD CPP had 8 Psychiatry Residents and 5 PMHNP students enrolled. Of the 21 psychiatry resident graduates and 57 PMHNP students, 19 and 52 continue to work in a public behavioral health setting respectively.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties

must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

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Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	7092
Number of Uninsured Individuals	1045
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	2522

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	881
Number of Uninsured Individuals	129

FACT Eligible Population (ACT with Justice-System Involvement)	**Estimates**
Number of Medi-Cal Enrolled Individuals	440
Number of Uninsured Individuals	65

ACT/FACT Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	160
Number of Teams Needed to Serve Total Eligible Population	16

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	360	330	290
Total Number of Teams	36	33	29

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	5770
Number of Uninsured Individuals	851

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	265
Number of Teams Needed to Serve Total Eligible Population	53

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	80	130	180
Total Number of Teams	16	26	36

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1963
Number of Uninsured Individuals	381

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	736
Number of Teams Needed to Serve Total Eligible Population	15

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	45	52	57

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	2	3	3

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	10416
Number of Uninsured Individuals	1575

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	750
Number of Teams Needed to Serve Total Eligible Population	300

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	51	76	101
Total Number of Teams	20	30	40

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
Live Well San Diego Vision: The County of San Diego, Health and Human Services Agency (HHSA), supports the Live Well San Diego vision of Building Better Health, Living Safely, and Thriving. Live Well San Diego, developed by the County of San Diego, is a comprehensive, innovative regional vision that combines the efforts of partners inside and outside County government to help all residents be healthy, safe and thriving. All HHSA partners and contractors, to the extent feasible, are expected to advance this vision. Building Better Health focuses on improving the health of residents and supporting healthy choices. Living Safely seeks to ensure residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies. Thriving focuses on promoting a region in which residents can enjoy
the highest quality of life.

A Trauma-Informed System: HHSA is committed to becoming a Trauma-Informed System as part of its effort to build a better service delivery system. All programs operated and supported by HHSA shall be part of a Trauma-Informed System, which includes providing trauma-informed services and maintaining a trauma-informed workforce. It is an approach for engaging individuals – staff, clients, partners, and the community – and recognizing that trauma and chronic stress influence coping strategies and behavior. Trauma-informed systems and services minimize the risk of re-traumatizing individuals and/or families, and promote safety, self-care, and resiliency.

Please describe the county's efforts to reduce disparities among FSP participants

San Diego County Behavioral Health Services (SDCBHS) addresses disparities through a coordinated, data-driven, and equity-focused approach that aligns planning, service delivery, and system transformation.

SDCBHS uses a structured two-year planning cycle to assess community needs, align service line contracts, and monitor quality and equity outcomes across the behavioral health network. This process incorporates stakeholder feedback, satisfaction surveys, utilization data, and community indicators, along with local tools such as the Community Experience Partnership dashboards, Behavioral Health Equity Index, and Service Planning Tool. Dedicated data teams support this work through analyses of disparities by population and geography, informing continuous quality improvement for FSP services.

Additionally, SDCBHS is investing in development of systemwide infrastructure, including implementation of SmartCare, a unified electronic health record and case management system. SmartCare improves data consistency, billing accuracy, care coordination, and outcome tracking, strengthening the County's ability to monitor disparities and ensure timely, person-centered, evidence-based care for FSP participants.

SDCBHS also aligns FSP services with broader transformation efforts under BHSA, CalAIM, and BH-CONNECT, applying a population health lens to prioritize communities experiencing the greatest disparities. Strategies include equity-weighted service evaluation, equitable contracting practices, culturally competent workforce development, and budget approaches that better align resources with need.

Finally, the County addresses disparities by expanding access across the continuum of care - through crisis stabilization, supportive housing, community outreach, justice-involved programs, and peer and community health worker initiatives - helping ensure FSP participants are connected to appropriate, coordinated supports regardless of where they enter the system.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Social connection

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

The County plans on ensuring FSP ICM clients receive engagement attempts if they are not participating in services. FSP ICM programs will have processes related to how often engagement will occur and processes to step down or discharge clients due to no contact after reasonable engagement attempts are made. Enrolled clients who are difficult to engage, will have face to face visits in their preferred location. The FSP ICM program will connect with family and friends, with current release of information in place, to assist with engagement of the individual.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

N/A

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

Transition and stand up of standalone FSP ICM teams, Inclusion of FSP ICM as step down to an ACT program (hybrid programs), strengthening current ACT teams to meet tools for measurement of ACT (TMACT) fidelity.

Please indicate whether the county FSP program will include any of the following optional and allowable services

yes, see choices selected below

Primary substance use disorder (SUD) FSPs
Yes

If Yes, please describe
Assertive Initiation of SUD treatment

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
Field based outreach in the community such as locations identified as having high use, emergency departments

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
Activities related to assertive field-based initiation of substance use disorder treatment

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth **in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**

In, or at-risk of being in, the juvenile justice system
San Diego County Behavioral Health Services (SDCBHS) used a data-driven and cross-system planning approach to incorporate the needs of children and youth who are justice-involved or at risk of justice involvement into the development of our FSP program. County epidemiologic and utilization data identified disparities among justice-involved populations, particularly young adults, males, and youth

identifying as Black, Hispanic, or Other race, who experience higher rates of arrest, recidivism, and poorer behavioral health outcomes.

SDCBHS engaged partners across the juvenile justice and youth-serving systems to review system gaps, diversion opportunities, and reentry barriers. School district partners and others were consulted to strengthen prevention and early identification strategies. Community-based providers serving justice-involved youth also contributed frontline insight regarding service engagement barriers and transition challenges.

Data findings, stakeholder input, and research on diversion and recidivism reduction informed participation in BH-CONNECT and preparation for high-fidelity FACT implementation, as well continuation of youth-focused programs. These efforts ensure FSP services prioritize diversion, continuity of care, culturally responsive interventions, and cross-system coordination to reduce justice involvement and improve long-term behavioral health outcomes.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

SDCBHS considered the needs of LGBTQ+ children and youth through equity-focused data analysis, community engagement, and consultation with organizations serving LGBTQ+ populations. Satisfaction surveys, community dashboards, and equity indices highlighted disparities in engagement and safety for youth experiencing stigma, discrimination, and intersecting system involvement.
Stakeholder engagement included collaboration with community organizations and contracted providers. These organizations provided feedback on culturally responsive service design, affirming environments, and trauma-informed care needs.

SDCBHS also engaged school districts and youth advocacy organizations to ensure alignment with best practices for youth development and inclusion.

Lastly, SDCBHS' broader investments in data infrastructure and standardized workflows further support the County's ability to monitor outcomes for LGBTQ+ youth and continuously refine FSP services to improve engagement, safety, and effectiveness.

These activities informed FSP planning by emphasizing culturally responsive, trauma-informed, and youth-centered service models, workforce development focused on cultural competence, and equitable contracting and funding strategies.

In the child welfare system
Similar to above, SDCBHS incorporated the needs of children and youth involved in the child welfare system through data informed planning and close collaboration with child-serving agencies. Utilization patterns and community data demonstrated elevated behavioral health needs and service disruption risks among youth in foster care or receiving child welfare services.

SDCBHS engaged County of San Diego departments and contracted providers to identify care coordination gaps and opportunities for family-centered supports. Collaboration with several providers supported integration of early identification and developmental services.

Feedback from community-based youth organizations and school partners informed FSP design elements emphasizing care continuity across placements, family engagement, trauma informed interventions, and coordination between behavioral health and child welfare case management.

Lastly, investments in SmartCare and efforts toward data exchange further support outcome tracking across systems, strengthening the County's ability to provide stable, coordinated FSP services for child welfare-involved youth.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
SDCBHS incorporated the needs of older adults into FSP development through data analysis, community engagement, and equity-focused planning. Data indicated increasing behavioral health needs among older adults, particularly those experiencing housing instability, untreated behavioral health conditions, and social isolation.

Stakeholder engagement included collaboration with various County Departments and contracted providers that serve the older adult population.

Housing and community partners such as the San Diego Housing Commission (SDHC) and housing providers were consulted to address housing stability and supportive service needs.

Findings informed FSP service design emphasizing care coordination, integration with physical health providers, housing stabilization, caregiver support, and improved transition planning.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Similar to above, SDCBHS considered the needs of LGBTQ+ adults in FSP planning through review of data, stakeholder engagement processes, and equitable service planning. Disparities in service engagement and access among LGBTQ+ adults were reviewed using the Behavioral Health Equity Index and other local tools.

Stakeholder engagement included collaboration with various providers and partners, who provided insight into culturally responsive care, stigma reduction, and community trust-building strategies for our LGBTQ+ adults.

Community engagement and data review further supported the development of culturally competent workforce strategies, equitable contracting practices, and trauma-informed, affirming service models for LGBTQ+ adults.

In, or are at risk of being in, the justice system
SDCBHS used arrest, recidivism, and behavioral health utilization data to identify disparities among justice-involved adults, particularly among individuals identifying as Black, Hispanic, or Other race. These findings helped inform targeted expansion of intensive community-based treatment models within FSP planning.

Cross-sector engagement included collaboration with the various County departments and community providers serving individuals transitioning from custody. Housing and reentry partners were also engaged to address stabilization needs post release.

Participation in BH-CONNECT and preparation for high-fidelity FACT implementation were informed by research on recidivism reduction and stakeholder input.

These activities ensure adult FSP services prioritize diversion, stabilization, housing support, culturally responsive care, and reduced justice system involvement for individuals with serious behavioral health needs.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program

requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

1) NTPs, Substance Use (SU) Outpatient and perinatal
2) MCRT

Program descriptions

1) Provide non-billable outreach to providers and clients.
2) Provide outreach and referrals to individuals in crisis with SU needs

Current funding source

1) DMC-ODS, Realignment
2) Realignment

BHSA changes to existing programs to meet BHSA requirements

1) Use BHSA to reimburse targeted outreach and include data tracking and more deliberate outreach to areas in need.
2) N/A

Expected timeline of operation

1) Immediate (in operation)
2) Immediate (in operation)

Mobile-field based programs

Existing programs

None

Program descriptions
N/A

Current funding source
N/A

BHSA changes to existing programs to meet BHSA requirements
Add Mobile NTP vehicle to local NTP contract.

Expected timeline of operation
December 2026

Open-access clinics

Existing programs
NTPs, SU Outpatient and perinatal

Program descriptions
For OP1, all 11 NTPs and 10 of SU OP programs provide MAT same day.
The County of San Diego's local outpatient substance use and narcotic treatment programs are equipped and staffed to be able to provide same day assessment and access to MAT as clinically indicated to adult clients. Members can be seen on the same day they drop in or request to be seen. MAT is provided same day via in-house prescriber, telehealth or referral to a FQHC (Federally Qualified Health Center).

Current funding source
DMC-ODS, Realignment

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
Immediate (in operation)

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs

1) Naloxone Distribution
2) SU Outreach

Program descriptions

1) Data driven street outreach to engage directly with individuals in environments that increase their vulnerability to overdose (e.g. encampments, shelters, other public spaces)

Planned funding

1) OSF
2) MAA, BHSA

Planned operations

1) Include new component in upcoming procurement.
2) Use BHSA to reimburse targeted outreach and include data tracking and more deliberate outreach to areas in need. Add new positions into existing contracts.

Expected timeline of implementation

1) Anticipated start date 7/1/2026
2) FY 26/27 – planning
FY 27/28 – initial launch
FY 28/29 – review/expand

Mobile-field based programs

New programs

Mobile NTP

Program descriptions

Mobile vehicle will visit DHCS approved locations on a weekly basis to provide field based, immediate access to MAT and SU services.

Planned funding
DMC-ODS, BHSA

Planned operations
Amended existing NTP contract to cover the Mobile Unit.

Expected timeline of implementation
Anticipated 1 Mobile NTP starting December 2026

Open-access clinics

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
To assess the gap between current county medication-assisted treatment (MAT) resources and the resources required to meet estimated needs, the County will implement a data-driven, equity-focused approach that integrates utilization and population level data. This assessment will estimate current system capacity, identify disparities in access and utilization, and inform strategic service planning to meet the needs of the community for MAT.

• Utilization data from existing MAT providers and programs will be used to establish a baseline of available resources, including the service locations by zip code, number and type of providers, medications offered (e.g., methadone, buprenorphine, naltrexone), and total clients served. Analyses will examine client characteristics by race/ethnicity, gender, age, and geography, enabling the County to assess utilization patterns and capacity through a health equity lens across the system of care.
• Epidemiologic data will help estimate the underlying need for MAT services using both quantitative and qualitative measures. Quantitative measures will include data on individuals who visited an emergency department or were hospitalized for opioid use disorder (OUD) or opioid overdose in the past year, stratified by zip code, and limited to Medi-Cal eligible individuals to highlight our service population. Qualitative input gathered from community engagement sessions will be incorporated to capture resident and stakeholder perspectives on MAT resource gaps and barriers to care.

Through a comprehensive review of data and community feedback, the County will compare existing MAT resources with estimated need to identify areas where capacity can be expanded, access barriers can be improved, and investments are most needed to ensure equitable access to MAT resources across San Diego County.

Select the following practices the county will implement to ensure same day access to MAT

Contract directly with MAT providers in the County
Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
Leverage telehealth model(s)

What forms of MAT will the county provide utilizing the strategies selected above?

Buprenorphine
Methadone
Naltrexone
Other

Please specify other forms of MAT

Brixadi only if approved for DMC by DHCS

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Medium gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Large gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Medium gap

(Interim) Single room occupancy units
Medium gap

Accessory dwelling units, including junior accessory dwelling units
Large gap

(Permanent) Tiny homes
Large gap

Shared housing
Small gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Small gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Small gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Medium gap

License-exempt room and board
Small gap

Hotel and Motel stays
Small gap

Non-congregate interim housing models
Medium gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Medium gap

Recuperative Care
Medium gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Large gap

Peer Respite
Large gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Partnership/vouchers (SDHC), Regional Task Force on Homelessness (RTFH), local Public Housing Authorities, community-based organizations. Data sharing agreements will need to be developed. The question needs to be threaded with the Fiscal Team, as well. Homeless Housing, Assistance and Prevention (HHAP) 6, BHBH Grant, Community Care Expansion - Prevention (CCE-P), Homekey, and Homekey+.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
The County will coordinate BHSA Housing Interventions with existing funding sources to expand the housing continuum and prevent duplication. Medi-Cal Community Supports Housing Trio will be used first for housing navigation, tenancy support, deposits, and transitional rent, with BHS and MCPs coordinating referrals to ensure proper sequencing of funds. Realignment funds and Behavioral Health Bridge Housing will continue supporting interim housing, providing low-barrier options while individuals work toward

permanent housing. BHSA will then fill the remaining gaps by covering non-Medi-Cal-eligible costs.

To expand permanent supportive housing, BHS will continue to work with local and county housing authority to maintain its partnership with SDHC and support Homekey+ projects, including a new development where the County is contributing capital, BHSA operating funds for up to 40 units, and ongoing behavioral health services. PATH Grant funding will further support outreach and engagement, and BHS is exploring leveraging existing outreach teams to strengthen these efforts for BHSA-eligible individuals.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?

• Pair housing with voluntary supportive services.
• Assess an individual's needs and refer to appropriate level of supportive services. Supportive services are offered on a continuum designed to meet a client's need at any given point in time.

When a housing need is identified, as clinically indicated, County staff first refer individuals to their MCP to authorize Community Supports such as Housing Transition Navigation, Housing Deposits, and Tenancy Sustaining Services. A housing support plan guides the assessment of needs and the permanent housing pathway. If Medi-Cal benefits are unavailable, BHSA Housing Interventions provide the necessary housing supports.
The County uses its network of Independent Living Association housing, permanent supportive housing units, and licensed board-and-care facilities as long-term BHSA-funded placements, paired with voluntary supportive services. Coordination with the CoC and CES ensures appropriate prioritization and matching for PSH placements.

After placement or during move-in, individuals are connected to voluntary ongoing supports, including tenancy support, case management, peer services, and behavioral health treatment to ensure long-term stability beyond short-term benefits like Transitional Rent. The County offers tiered service levels, ranging from light-touch to intensive ACT/ICM, to match clinical and tenancy needs. Regular reassessments ensure service intensity adjusts over time, helping prevent eviction and support sustained housing retention.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

• Homekey developments provide supportive services in PSH settings. Plan is to work with MCPs to provide outreach, navigation, and housing placement.
• The County offers tenant peer supportive services for those residing in PSH developments. Depending on

an individual's need they will be referred to a higher level of service (i.e., FSP).

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

• Pair housing with voluntary supportive services, such as ACT and FSP ICM services.
• Coordination with MCPs to enhance access to Community Supports.

The County will ensure all BHSA Housing Intervention settings provide access to clinical and supportive services by pairing housing with voluntary onsite engagement and structured referral workflows. At sites like Starling Place, staff will maintain a consistent onsite presence, build rapport, deliver enrichment activities, and identify emerging behavioral health or tenancy needs. When clinical care is needed, staff make warm handoffs to FSP/ICM, ACT, or other behavioral health providers and follow up to confirm service connection.

To enhance access to Community Supports, staff refer eligible residents to MCPs and also deliver housing-related Community Supports directly, including navigation, deposits, and tenancy-sustaining services, where appropriate. Coordination with Property Management, BHS providers, and MCPs ensures continuity of support. This integrated workflow ensures residents in all BHSA-funded settings can access both clinical care and ongoing supportive services that promote long-term housing stability.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

• Verify SMI or SU criteria (via BHA). Confirm homelessness (risk) status via the Coordinated Entry System (CES). Identify priority populations. Create a mechanism to document screening and eligibility.
• The County is exploring options to include BHSA eligibility in EHR. This would allow for streamline assessment of eligible BHSA Housing Intervention eligibility and referrals.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only **?**

Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system

Activities included stakeholder engagement, cross-system collaboration, and review of relevant data and prior planning input. Behavioral Health Services (BHS) conducted engagement sessions with community-based organizations, providers, and partners serving youth across systems, including those supporting justice-involved youth, LGBTQ+ youth, and youth connected to the child welfare system. BHS also consulted with County peers, including within the Child and Family Well-Being, Medical Care Services, and Public Health Services departments, to incorporate cross-department perspectives. Planning was further informed by prior MHSA Community Planning Process input and analysis of youth homelessness data from the Regional Task Force on Homelessness' Youth Homeless Demonstration Program (YHDP).

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

Activities included stakeholder engagement, cross-system collaboration, and review of relevant data and prior planning input. Behavioral Health Services (BHS) conducted engagement sessions with community-based organizations, providers, and partners serving youth across systems, including those supporting justice-involved youth, LGBTQ+ youth, and youth connected to the child welfare system. BHS also consulted with County peers, including within the Child and Family Well-Being, Medical Care Services, and Public Health Services departments, to incorporate cross-department perspectives. Planning was further informed by prior MHSA Community Planning Process input and analysis of youth homelessness data from the Regional Task Force on Homelessness' Youth Homeless Demonstration Program (YHDP).

In the child welfare system

Activities included stakeholder engagement, cross-system collaboration, and review of relevant data and prior planning input. Behavioral Health Services (BHS) conducted engagement sessions with community-based organizations, providers, and partners serving youth across systems, including those supporting justice-involved youth, LGBTQ+ youth, and youth connected to the child welfare system. BHS also consulted with County peers, including within the Child and Family Well-Being, Medical Care Services, and Public Health Services departments, to incorporate cross-department perspectives. Planning was further informed by prior MHSA Community Planning Process input and analysis of youth homelessness data from the Regional Task Force on Homelessness' Youth Homeless Demonstration Program (YHDP).

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
Review/analysis of clinical and Population Health data, as well as engagement with Older Adult stakeholders will be utilized to develop the services.

In, or are at risk of being in, the justice system
Review/analysis of clinical and Population Health data will be utilized to develop the services as well as engagement with justice-involved stakeholders.

In underserved communities
Review/analysis of clinical and Population Health data will be utilized to develop the services as well as engagement with community-based organizations serving diverse populations.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?
The County will coordinate with the Continuum of Care (CoC) by using the CES/HMIS referral system, operated by RTFH as the HMIS Lead, as the official front door for BHSA Housing Interventions tied to Homekey+. When Property Management notifies the County or the service provider of an available unit, staff request a CES referral from RTFH through the HMIS-based matching workflow. RTFH generates the match based on unit size, household composition, and CES prioritization. The County will work with RTFH to develop BHSA-specific criteria in the HMIS system to identify BHSA-eligible individuals before authorizing Housing Interventions.

Currently, a similar process is used for Homekey and NPLH units. Once a referral is received, workflows are followed, including timely outreach, documentation in HMIS, and coordinated communication with the matched individual's outreach worker or case manager. The service provider collaborates to ensure warm handoffs, confirm behavioral health needs, and connect individuals to voluntary clinical or supportive services upon lease-up. All coordination is recorded in HMIS and reinforced through regular meetings between BHS, the service provider, RTFH, Property Management, and Asset Management. This structure ensures BHSA Housing Interventions are fully integrated within the behavioral health continuum and aligned with the CoC's coordinated entry process.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC
Cross-County and community engagement started and will continue with the local Continuum of Care. Engagement with CoC partners occurs through existing regional and community-based meetings. Meeting examples include BHS Housing Council meetings and Live Well San Diego Community Leadership Team meetings. Meetings support alignment between behavioral health services and the broader homelessness response system.

Public Housing Agency
Cross-County and community engagement started and will continue with local Public Housing Agencies (e.g.County Housing Authority and San Diego Housing Commission). Engagement with Public Housing Agency partners occurs through existing regional and community-based meetings. Meeting examples include BHS Housing Council meetings and Live Well San Diego Community Leadership Team meetings. Meetings support alignment between behavioral health services and the broader homelessness response system.

MCPs
Cross-County and health system engagement has started and will continue with Medi-Cal Managed Care Plans. Behavioral Health Services engages MCP partners through regional, County, and community-based meetings such as Healthy San Diego meetings and its related subcommittee convenings and County Public Health Services Population Health Coalition meetings, which support alignment and coordination across Medi-Cal programs.

ECM and Community Supports Providers
Cross-County and health system engagement has started and will continue with Enhanced Care Management and Community Supports providers. Behavioral Health Services engages these partners through existing coordination venues, including Healthy San Diego meetings and Live Well San Diego Community Leadership Teams, supporting alignment between behavioral health services and Medi-Cal housing-related supports.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
N/A

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?
• Homekey+ is under development in collaboration with HCDS and SDHC.
• The County is working with Public Housing Authorities to provide supportive services for BHSA-eligible

individuals who reside in Homekey+ properties. The County is in the process of determining referral pathways with the local Coc.
• Housing and Homelessness (H&H) is working on establishing the at-risk criteria for HK+ residents at Starling Place.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?
We plan on using it all on our programs. With American Rescue Plan Act (ARPA) funding expiring, it will help us to continue our Housing Our Youth, Regional Housing Assistance and Local Rental Subsidies programs.

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
2672

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
290

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
2382

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
The County estimates annual rental subsidies and the number of individuals served using local cost data, established rent assumptions, and known program commitments. For permanent housing, the County relies on confirmed BHSA-supported units, including 250 Flexible Housing Pool subsidies and 40 Starling Place Homekey+ operating subsidies, for a total of 290 permanent slots.

For interim housing, the County uses local interim housing cost data, applying the County's average interim rate of $1,650 per month and the BHSA allowed six-month duration, resulting in an estimated $9,900 per placement. The County then divides the total interim rental subsidy budget of $23.6 million by the per-placement cost to project approximately 2,382 interim placements annually.

This results in an estimated 2,672 individuals being served each year across interim and permanent settings.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Yes, via recovery residences that focus on families.
BHS is in the process of developing rental subsidies for Homekey+ funded-units. Pending final BHSA fiscal mapping.
BHS will be supporting 40 units at a Homekey+ funded property in the City of San Diego with operating subsides. BHS will be developing a Flex Housing Pool Pilot to support 250 ACT level clients via a rental payment.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Tenant-based
Project-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
BHS is working to develop a Flexible Housing Pool (FHP) Pilot which will run for one year. Managed Care Plans, FHP administer, CoC, and County departments are involved in developing the pilot. Lessons learned will inform the development of a long-term Flexible Housing Pool.

Total number of units funded with BHSA Housing Interventions per year
4305

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
45

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Operating subsidies to support permanent supportive housing

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
No

Total number of units funded with BHSA Housing Interventions per year
40

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
290

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
This intervention uses BHSA Housing Interventions funds to provide flexible rental assistance and stabilization supports that help clients obtain and maintain housing. Funding will support 40 BHSA subsidies dedicated to Homekey+ units, ensuring ongoing rental and operating support for formerly homeless individuals with significant behavioral health needs. In addition, the county will invest in a 250-subsidy flexible pool for Assertive Community Treatment (ACT) clients in FY 26–27, allowing subsidies to be tailored in amount and duration to client needs, and to be layered with other housing and service resources to promote long-term housing stability.

Total number of units funded with BHSA Housing Interventions per year
290

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
250

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Participant Assistance Funds seek to remove barriers to housing and support people in meeting their immediate housing needs. Examples include rent and utility arrears and moderate furniture.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
250

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Housing Transition Navigation Services (HTNS) assist with navigation, housing search, landlord coordination, and lease-up support required to move behavioral health referrals efficiently into scattered-site market-rate units. Housing Tenancy Sustaining Services (HTSS) provide ongoing tenancy support, landlord engagement, and early intervention to address issues that could jeopardize housing stability once individuals are housed.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
These activities are now funded by Managed Care Plans (MCPs), so have to follow sequencing of funding.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
No

Please explain why the county is not providing this intervention
In order to sustain treatment services BHS does not plan to fund capital development using BHSA in the first year, but will continue to assess funds in future fiscal years. Additionally, the County is looking at alternative methods to increase housing stock outside of capital development (i.e., Flexible Housing Pool and operating subsidies).

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Plans to use BHSA Housing Interventions funding in FY 28-29 when BHBH funding ends.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
No

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?

• To support the Transitional Rent referral process, individuals will need to have a Housing Support Plan in place, which will be developed by a Housing Transition Navigation Services (HTNS) Community Support provider. The HTNS provider will confirm BHSA eligibility and, if not already in place, work with the individual's program to refer to housing-related Community Supports. If an individual is not connected to a BHS-funded program, they will need to be referred to an outpatient clinic for assessment and program referral.

• Additionally, the County of San Diego worked collaboratively with the local Managed Care Plans to develop Community Support (CS) referral forms to support direct referrals. These forms, along with the CS policy guide, MCP email addresses and member services phone numbers are posted on the BHS public website used by BHS network providers for ease of reference. Reminders regarding these resources are included in general provider communications as well.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

BHS has been working with Managed Care Plans to map Transitional Rent referral pathways, including the development of a Flexible Housing Pool. BHS will communicate updates via an external website and ongoing information notices.

BHS coordinates closely with MCPs through regular meetings and the joint development of referral workflows, including ongoing discussions around ways in which referrals can be streamlined, such as the development of a pre-screener and alignment with Housing Support Plans and Transitional Rent referrals across all four managed care plans for ease of access and understanding to our joint members. To ensure MCPs are aware of the BHSA Housing Interventions provider network, BHS will share the provider list for the Flexible Housing Pool pilot. The selection of the Flexible Housing Pool pilot Administrator was guided by MCP feedback. Initial BHSA HI referrals will route through the County's Single Point of Access, which will support the Flex Pool Administrator and ensure consistent coordination with MCPs.

Referral pathways are currently under development and are planned for finalization by July 1 as part of the Flexible Housing Pool pilot rollout.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
The County is working on establishing processes for warm handoffs and care coordination from Community Supports to BHSA funded services which match an individual's appropriate level of care. BHS is in the process of making updates to the EHR (i.e., tracking of individuals experiencing chronic homeless) to better support informed decision making.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
Yes

What role does the county behavioral health system plan to have in the Flex Pool?
Funder

Have you identified an Operator of the Flex Pool?
Yes

What organization is serving as the Operator?
Brilliant Corners

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies
Operating Subsidies

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
County BHS is planning to launch a Flexible Housing Pool (FHP) Pilot to serve 250 ACT level clients. This is in partnership with MCPs. In addition, County staff are going through the FHP technical assistance (TA) process provided by DHCS to stand up a long-term program.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?
Yes

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?

Behavioral Health Services and Supports

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

The Public Behavioral Health Workforce Retention and Development Program, known locally as the ELEVATE Behavioral Health Workforce Fund (ELEVATE), is a MHSA-encumbered INN project continuing under the Behavioral Health Services Act as part of Behavioral Health Services and Supports-Workforce, Education, and Training. ELEVATE is structured as a set of new workforce pipeline and incentive programs (e.g., zero-interest "Pay It Forward" loans, registered apprenticeships, paid internships, peer workforce training grants, and psychiatric nurse practitioner expansion supports) designed to test approaches for reducing cost/entry barriers and increasing completion-to-employment pathways in public behavioral health. Each of these programs has clear, trackable participation and placement elements (training slots, internships, apprenticeships, loan recipients), the County and its implementation partners can measure outcomes like recruitment, completion, placement into public behavioral health roles, and retention, helping inform "what works" for scaling workforce modernization strategies (including pathways for peers/CHWs and other in-demand roles).

Please describe intended outcomes of the project

The intended outcomes of the ELEVATE Behavioral Health Workforce Fund are to strengthen and modernize the public behavioral health workforce in order to improve access, equity, and service quality across San Diego County. The initiative seeks to expand workforce capacity in high-need roles, improve recruitment and retention, and develop sustainable career pathways into public behavioral health professions. Through targeted investments in training, education, and workforce supports, the project aims to increase the availability of culturally and linguistically responsive providers, reduce workforce shortages that impact service access, and enhance the system's ability to meet the needs of individuals with serious mental illness, serious substance use disorders, and co-occurring conditions.

Overall, the intended outcome is a more stable, diverse, and well-prepared behavioral health workforce that can support long-term system transformation under BHSA.

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
8

Upload any data source(s) used to determine vacancy rate
303 - San Diego Behavioral Health Worker Shortage 2022 Full Report.pdf - *See Appendix G*
301 - HR Report for Assessing Workforce Gaps_Vacant and Filled Positions Oct 2025.xlsx - *See Appendix F*

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Psychologist
Nurse practitioner
Physician
Psychiatrist
Other qualified provider

Please describe any other key workforce gaps in the county
San Diego County continues to face significant shortages across multiple behavioral health roles, including licensed clinicians, psychiatric nurses, and peer support specialists. A needs assessment conducted by San Diego Workforce Partnership in 2022 unveiled San Diego County needs approximately 18,500 new behavioral health professionals by 2027 to meet growing service demand in the region. Key gaps identified in the Behavioral Health Workforce Shortage Report included limited diversity among providers, which impacts culturally responsive care, insufficient pipelines for entry-level and mid-career professionals, and administrative and compliance expertise for smaller community-based organizations seeking Medi-Cal

certification. Recruitment and retention challenges in high-acuity settings also remain a critical concern.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Workforce needs will expand significantly over the next three fiscal years due to Behavioral Health Transformation (BHT) and BH-CONNECT requirements for evidence-based practices. There will be increased demand for peer support specialists and culturally competent providers, as well as greater emphasis on data-driven care coordination and integrated service delivery. Additionally, technical and administrative capacity among community-based organizations will need to grow to participate in Medi-Cal networks. Our current strategy includes leveraging two key initiatives: 1) our ELEVATE Behavioral Health Workforce Fund and 2) increasing supports for community-based behavioral health providers delivering non-specialty, Medi-Cal funded behavioral health services to successfully enroll in the State's Medi-Cal Program to broaden and diversify our continuum of care. ELEVATE Behavioral Health Workforce Fund uses $75 million in MHSA Innovation funds to support training, tuition, and recruitment through programs like zero-interest loans, paid internships, nurse practitioner grants, and peer support training to attract and retain workers in public behavioral health. The County is also actively soliciting for a contractor who will provide Medi-Cal Training and Technical Assistance to prepare community-based behavioral health providers for compliance and operational readiness.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

The County will advertise opportunities to apply for the scholarship and encourage staff to apply. Additionally, the County is leveraging the BH-CONNECT workforce initiative indirectly by aligning its local ELEVATE Behavioral Health Workforce Fund program with the State's Behavioral Health Scholarship

Program, which provides scholarships directly to individuals rather than to counties. Through ELEVATE Behavioral Health Workforce Fund, the County is establishing a renewable tuition and training fund and offering paid internships, apprenticeships, peer workforce training, and zero-interest financing to support individuals pursuing behavioral health careers and to strengthen pathways into BH-CONNECT–eligible education and training programs.
Through ELEVATE Behavioral Health Workforce Fund, the County is conducting outreach to academic institutions, community colleges, and community-based partners to connect students and trainees with scholarship opportunities, while also coordinating with County-operated and contracted Medi-Cal safety-net providers to ensure appropriate supervision, onboarding, and placement capacity for individuals completing required service obligations. Together, these activities expand the pool of qualified scholarship applicants, align scholarship utilization with local workforce priorities, and improve recruitment, placement, and retention of behavioral health professionals within San Diego County's public behavioral health system.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
The County will advertise opportunities to apply for the loan payment program and encourage staff to apply.
Additionally, the County is leveraging the BH-CONNECT workforce initiative indirectly by aligning its local ELEVATE Behavioral Health Workforce Fund with the State's Behavioral Health Student Loan Payment Program, which provides loan repayment awards directly to individual professionals rather than to counties. Through ELEVATE Behavioral Health Workforce Fund, the County is implementing strategies to reduce financial barriers for behavioral health professionals and to complement state loan repayment incentives, particularly for hard-to-recruit and retain roles within the Medi-Cal safety net. These strategies include supporting workforce recruitment and retention efforts, coordinating with County-operated and contracted providers that serve as eligible employment settings, and building organizational capacity to effectively use loan repayment as a retention tool. In addition, ELEVATE's Employer Learning Community provides technical assistance to agencies on understanding, promoting, and leveraging state and federal loan repayment programs as part of broader compensation and retention strategies. Together, these activities help maximize utilization of BH-CONNECT loan repayment resources in San Diego County and strengthen long-term workforce stability within the public behavioral health system.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
The County will advertise opportunities to apply for the training program and encourage providers to apply. Additionally, the County is leveraging the BH-CONNECT workforce initiative indirectly by aligning local workforce and provider capacity-building efforts with the State's Behavioral Health Community-Based Provider Training Program, which supports training and technical assistance for community-based organizations serving Medi-Cal populations. The County's is actively soliciting for a contractor to provide Medi-Cal Training and Technical Assistance Services, which directly advances the goal of the State's training program by providing structured training and technical assistance to community-based providers to support Medi-Cal certification, service delivery readiness, and administrative and clinical capacity. This local effort also includes the establishment of a learning collaborative to promote peer learning, shared problem-solving, and sustainable practice improvement. Additionally, these activities will integrate with the County's ELEVATE Behavioral Health Workforce Fund, which supports workforce upskilling and pipeline development to ensure training investments translate into long-term workforce stability. Together, these efforts align local capacity-building strategies with BH-CONNECT program goals and maximize the impact of state workforce resources within San Diego County.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
Other efforts underway include San Diego County's ELEVATE Behavioral Health Workforce Fund (MHSA Innovation Program), which offers tuition support, upskilling, and retention strategies; the ELEVATE Employer Learning Community, which provides monthly sessions for employers to share best practices and access technical assistance; and the active Request for Proposal at the time of this plan for Medi-Cal Training and Technical Assistance Services, which will expand the provider network for mild-to-moderate care, reducing pressure on specialty services and improving equity. San Diego County is also developing a learning collaborative for CBOs to navigate Medi-Cal enrollment and compliance and focusing on

increasing peer support certification and representation of Black, Indigenous, and People of Color (BIPOC) providers.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
San Diego Integrated-Plan-Budget-Template_v3 FY26-27 to 28-29 Final.xlsx - *See Appendix H*

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

Full Service Partnership (FSP)
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

Housing Interventions
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

Enter date of last prudent reserve assessment
11/7/2025

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

FSP
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

Housing Interventions
Not applicable. County's Prudent Reserve does not exceed the DHCS Prudent Reserve Maximum calculation.

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Behavioral Health Director Certification.pdf - *See Appendix J*

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
CAO signed certification.pdf - *See Appendix K*

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section - *will be in Appendix L*

Please upload the completed Board of supervisor certification template

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Requests

Funding Transfer Request

Please enter the proposed allocation adjustments to the tables below

	Plan year one	Plan year two	Plan year three
Behavioral Health Services and Supports (Base 35%)	45	45	45
Full Service Partnership (Base 35%)	28	28	28
Housing Intervention (Base 30%)	27	27	27
Housing Interventions for Outreach and Engagement	0	0	0

Behavioral Health Services and Supports Transfers

Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	19222628	18982338	18855820
Dollars transferred from Housing Intervention	8238269	8135288	8081066
Dollars transferred into Full Service Partnerships	0	0	0
Dollars transferred into Housing Intervention	0	0	0

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

San Diego County Behavioral Health Services (BHS) requests approval to transfer 7% from Full Service Partnerships (FSP) and 3% from Housing Interventions (HI) into Behavioral Health Services and Supports (BHSS) to address urgent system-level needs.

BHSS is the foundation of the County's behavioral health system, accounting for more than two-thirds of the 75,000 individuals who received services in FY24–25. These programs include outpatient services, early intervention, and crisis response, all of which play a critical role in preventing escalation into more intensive and costlier levels of care. In 2024, San Diego experienced over 7,000 ED visits involving serious mental

illness and nearly 8,000 visits for substance use disorder, demonstrating the growing need for earlier, community-based interventions that reduce Emergency Department (ED) reliance and support recovery. During the Community Planning Process (CPP) community members consistently expressed the importance of behavioral health-led crisis services—such as Mobile Crisis Response Teams (MCRTs) and Crisis Stabilization Units (CSUs)—instead of law enforcement-led responses, emphasizing the need for timely and accessible behavioral health care that can address needs before they escalate into emergencies. In FY24–25 alone, CSUs served 8,057 individuals and MCRTs responded to 6,324 crises, underscoring the high utilization of BHSS crisis programs.

From a fiscal perspective, this shift is also critical: projected Behavioral Health Services and Supports (BHSS) expenditures for FY26–27 would exceed available funding by $20M. Without a reallocation, this deficit risks creating bottlenecks in care and pushing more individuals into costlier emergency and inpatient systems. Overall, the transfer ensures continuity of critical services, fiscal balance, and alignment with statewide initiatives including California Advancing and Innovating Medi-Cal (CalAIM), National Committee for Quality Assurance (NCQA) quality standards, and Proposition 1's emphasis on integrated, community-based services.

Full Service Partnership Transfers

Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Behavioral Health Services and Supports	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred from Housing Intervention	0	0	0
Dollars transferred into Behavioral Health Services and Supports	19222628	18982338	18855820
Dollars transferred into Housing Intervention	0	0	0

For Full Service Partnership, please include a rationale for the funding allocation transfer request

Full Service Partnerships (FSP) are essential to San Diego County's behavioral health system, providing intensive wraparound care and housing supports to individuals with the most severe and complex needs. These programs remain a priority, and the County is committed to maintaining their strength and effectiveness. However, analysis confirms that a modest 7% reallocation to BHSS will not compromise FSP sustainability. FSPs benefit from diversified funding streams, including Medi-Cal Enhanced Care Management (ECM), Community Supports, and Proposition 1 investments. This ensures that the program remains well-funded and resilient despite the proposed transfer.

The proposed reallocation represents approximately $19.2M annually between FY26–29, a relatively small portion of the overall FSP budget. By strategically reinvesting these funds into BHSS, the County can improve upstream prevention and intervention, thereby reducing the number of individuals who eventually require FSP-level intensity. Securing BHSS capacity—especially outpatient and crisis services—lessens the demand on FSP by providing timely care before conditions escalate. In this way, the reallocation directly benefits FSP by relieving system pressures and ensuring that intensive services are preserved for those who need them most.

Ultimately, the modest transfer does not weaken FSP but strengthens the overall continuum of care by addressing service gaps earlier. This enhances system sustainability, reduces reliance on emergency and inpatient care, and supports the County's long-term goal of providing a balanced, integrated behavioral health system.

Housing Interventions Transfers

Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred into Behavioral Health Services and Support	8238269	8135288	8081066

	Plan year one	Plan year two	Plan year three
Dollars transferred into Full Service Partnerships	0	0	0

For Housing Intervention, please include a rationale for the funding allocation transfer request

Housing Interventions (HI) are a cornerstone of recovery, supporting stability and long-term health outcomes for individuals living with serious mental illness or substance use disorder. San Diego County recognizes the essential role housing plays in recovery and remains committed to sustaining and expanding housing supports. The proposed 3% reallocation to BHSS is minimal-approximately $8.2M annually between FY2026-29 and will not diminish the County's ability to deliver housing interventions.

San Diego County will continue to invest in housing through a variety of robust funding sources, including Mental Health Services Act (MHSA), Proposition 1, and local partnerships. These funding streams, coupled with the County's ongoing commitment, ensure that housing supports remain viable and effective even with the modest transfer. Importantly, stakeholders have consistently emphasized that housing and treatment must go hand in hand. Without strong behavioral health services, housing alone cannot meet the full spectrum of client needs. This reallocation ensures that the treatment and service side of the continuum is adequately resourced.

The BHSS investments will reduce reliance on emergency departments, maintain access to crisis services, and provide timely outpatient care-all of which directly support the effectiveness of housing interventions. By addressing behavioral health needs more effectively, individuals are better able to maintain housing stability, achieve recovery goals, and avoid repeated cycles of crisis and homelessness. Thus, the reallocation not only protects but also enhances the overall integration of housing and treatment supports in the County.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?

For the last three years, stakeholders have consistently identified the following areas as priorities for enhancement within San Diego County’s continuum of care: Accessibility; Care Coordination and Navigation; Community Outreach and Education; Crisis Response Services; Culturally Appropriate and Affirming Care; Support for People Experiencing Homelessness; Services for Youth and Transition Age Youth

(TAY); and Workforce Capacity and Diversity. These areas highlight complex, longstanding systemic challenges and are also congruent with Statewide Behavioral Health goals. Expansion of BHSS to fund investments in the following would meaningfully elevate recommendations from stakeholders to help directly address these priorities, while also expanding equity, and building a stronger behavioral health system:

- Crisis Response: Expanding community-supported services (e.g., Mobile Crisis Response Teams, 24/7 drop-in centers, and Crisis Stabilization Units. Upstream prevention efforts reduce reliance on emergency departments and intensive services.
- Equity & Access: Enhancing culturally appropriate services, addressing language barriers, and expanding collaborations with community- and faith-based organizations to reach high-need populations.
- Integrated Care: Advancing treatment models addressing co-occurring mental health and substance use disorders, aligned with CalAIM, NCQA accreditation, and Prop 1 initiatives.
- System Coordination: Strengthening communication protocols and cross-system collaboration among providers, crisis teams, and law enforcement to improve care coordination and accountability.

Such targeted investments also support community-led initiatives, adapt for socio-economic shifts, help address overwhelming service demands, and enable significant enhancement to our capacity to serve residents effectively and compassionately. More details and recommendations may be found in APPENDIX G of San Diego County's most recent MHSA Annual Update.

FY 25-26 MHSA Public Comment:
For many years, stakeholders have expressed the need for all children and youth to have access to mental and behavioral health services that meet them where they are, including screening practices in place to identify early onset of mental health issues. To ensure a true continuum of care and mental health equity for all (children / youth to adults), children and youth should have access to mental and behavioral health support, especially in community-based settings that offer positive childhood experiences proven to mitigate the effects of adverse childhood experiences (ACEs). Without this transfer request, programs will not be able to meet this demand.

Please include local data supporting the funding transfer request, file upload
MHSA's Appendix G - FY 24-25 CE-CPP Report - Combined.pdf - *see Appendix I*

APPENDIX A

Community Planning Process
Engagement Dates by Type

San Diego County Behavioral Health Dates Of Stakeholder Engagement For Each Type Of Engagement

County outreach through social media (12):

04/28/2025
05/05/2025
05/12/2025
05/15/2025
11/03/2025
11/04/2025
11/05/2025
11/13/2025
11/14/2025
12/01/2025
12/12/2025
12/14/2025

County outreach through townhall meetings (37):

05/01/2025
05/15/2025
08/07/2025
08/12/2025
08/13/2025
08/14/2025
08/15/2025
09/05/2025
09/26/2025
10/08/2025
10/13/2025
10/15/2025
10/15/2025
10/16/2025
10/17/2025
10/24/2025
10/27/2025
10/30/2025
11/04/2025
11/04/2025
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11/13/2025
11/19/2025

11/19/2025
11/20/2025
12/03/2025
12/03/2025
12/05/2025
12/09/2025
12/09/2025
12/11/2025
12/11/2025
12/16/2025
12/18/2025
12/18/2025

County outreach through traditional media (e.g., television, radio, newspaper) (2):

10/10/2025
11/04/2025

Focus Group Discussions (18):

04/24/2025
04/28/2025
04/29/2025
04/29/2025
04/30/2025
06/04/2025
07/18/2025
08/05/2025
08/13/2025
09/11/2025
10/30/2025
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Key informant interviews with subject matter experts (16):

04/22/2025
04/22/2025
04/28/2025
04/29/2025
05/05/2025
05/20/2025
07/14/2025

08/06/2025
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11/21/2025
12/03/2025

Meeting(s) with county (27):

07/03/2024
08/12/2024
08/14/2024
08/15/2024
09/11/2024
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10/28/2024
04/29/2025
05/23/2025
06/27/2025
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11/13/2025

Provided data to county (2):

- 10/20/2022

- 07/18/2025

Public e-mail inbox submission (19):

- 04/01/2025
- 04/21/2025
- 05/13/2025
- 07/09/2025
- 07/17/2025
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Distribution List Sign-Up Form
Email:

- 07/17/2025
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- 02/02/2026

Survey participation (322):

- 10/21/2025
- 10/23/2025
- 10/31/2025
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- 01/01/2026

Training, education, and outreach related to community planning (9):

- 05/20/2025
- 09/27/2025
- 10/07/2025
- 10/11/2025
- 10/25/2025
- 11/08/2025
- 11/17/2025
- 11/22/2025
- 12/09/2025

Workgroups and committee meetings (8):

- 12/05/2024
- 01/27/2025
- 06/23/2025
- 08/07/2025
- 08/07/2025
- 10/13/2025
- 10/27/2025
- 01/27/2026

Other (2):
LIVE WELL SAN DIEGO
Youth Sector (1): 06/04/2025
CLT Data Workshops (5): 07/09/2025; 07/17/2025; 07/28/2025; 09/03/2025; 10/01/2025
Live Well Advance (1): 10/22/2025
Regional Newsletter Submissions (2): 10/30/2025; 12/11/2025

APPENDIX B

Community Planning Process
Activity Summaries

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the April 24, 2025, focus group with Transitional-Aged Youth (TAY), reflecting their perspectives to inform the development of the Youth Optimal Care Pathways (OCP) framework, which aims to remove barriers, expand access, and ensure timely support for long-term youth wellness. Findings from this engagement will also be utilized to inform the County's Behavioral Health Service Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	Youth Optimal Care Pathways Transitional Aged Youth: Kickstart Program
Format	☐ In-Person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** Thursday, April 24, 2025 **Time:** 2:00 PM – 3:30 PM **Location:** Zoom
Participation	90-Minute Discussion: • 4 youth participants • 5 discussion questions with facilitated open discussion

Summary of Engagement Activity

In April 2025, Behavioral Health Services (BHS), in collaboration with the University of California San Diego (UCSD) Health Partnership, hosted a virtual focus group with transitional age youth (TAY) from Kickstart Program to gather insights from their experiences, needs, and recommendations to improve behavioral health services.

The focus group offered youth a safe environment to voice barriers to accessing care and identify strategies for accessing the right services at the right time. The session began with an introduction by BHS, which included an icebreaker to build comfort, followed by a UCSD-facilitated discussion guided by 5 core questions, and concluded with a reflective prompt encouraging participants to share a recent experience that brought them joy or support.

Input from the session will help inform specialty mental health and substance use disorder priorities, services, and investments in the region's first Behavioral Health Services Act (BHSA) Integrated Plan for the Fiscal Years 2026-2029. It will also shape the Youth Optimal Care Pathways (OCP) framework, ensuring that future behavioral health strategies and youth-focused supports (ages 0-25) reflect community-identified needs in San Diego County.

Input Session Questions:

1. Can any of you think of a time when you/someone you know received what you felt was high quality care from a doctor, clinician, therapist, or medical provider?
2. Do you recall a time when you or someone you know needed care and didn't get it, or the experience wasn't so great?
3. How do you think your support circle, including friends, family, schools, and adult advocates, can better support youth experiencing mental health and/or substance use challenges?
4. If you had the chance to improve mental health and substance use services for youth, what would you change?
5. Can you share a recent moment of joy or connection you've experienced in your community?

Key Learnings

- **Consistent Services Help Youth Feel Supported During Crisis or Hospitalization**
  Youth highly value accessible, supportive, and consistent mental health services that provide practical coping strategies and create a safe, non-judgmental environment. Positive experiences at Kickstart and Rady's Children's Hospital showed that youth felt supported, cared for, and safe during hospitalization or episodes of distress, highlighting the importance of consistency and practical guidance in care.

- **Long Waitlists and Insurance Limits Delay Mental Health Support**
  Barriers such as long waitlists, limited therapy options, insurance restrictions, and consent requirements can delay timely and effective mental health care. These challenges are especially difficult for young people whose parents may face language barriers or who are unable to provide immediate support. Participants described frequent hospitalizations, difficulty finding programs, and delays in care due to insurance limits, long waitlists (8–12 months), or the need for parental consent, which made consistent treatment challenging.

- **Fostering Comfort and Connection in Care is Important When Serving Youth**
  Youth-centered care is most effective when providers reflect youth identities, build trusting relationships, and use small supportive actions to make youth feel valued, understood, and comfortable. Participants shared casual conversation, positive affirmations, and welcoming environments (e.g., friendly and genuine tone) helped them engage in treatment. Physical and sensory aspects of care also matter; being placed in empty or "quiet" rooms during panic attacks sometimes increases anxiety. Youth emphasized the importance of safe, welcoming, and non-isolating spaces.

Audience Recommendations

- **Increase Youth-Friendly Mental Health Service and Flexible Pathways to Care**
  Participants shared a need to expand youth-friendly mental health services by shortening wait times, adding more therapy appointments, and offering programs with flexible ways to get care. Youth also said that needing parent approval can sometimes delay help for those under 18 and stress the importance of having immediate support during a crisis.

- **Enhance Culturally and Linguistically Responsive Care**
  Increase culturally and linguistically responsive care by hiring providers who reflect the backgrounds of the youth served and by offering services in multiple languages. Language barriers and lack of identity representation make it harder for youth to fully engage in care.

- **Expand Accessible Support Through Schools and Community Outreach**
  Boost school-based mental health programs and community outreach to create trusted spaces where youth feel heard, supported, and encouraged to seek help. Embedding therapy services in schools, raising awareness of available support, and using more relaxed relationship-based approaches can help youth feel more comfortable, get involved, and receive help earlier.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the April 28, 2025, focus group with transitional-aged youth (TAY), reflecting their perspectives to inform the development of the Youth Optimal Care Pathways (OCP) framework, which aims to remove barriers, expand access, and ensure timely support for long-term youth wellness. Findings from this engagement will also be utilized to inform the County's Behavioral Health Service Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	Youth OCP TAY: Urban Street Angels Just Be U Program
Format	☐ In-Person ☒ Virtual ☐ Hybrid
Activity Details	**Date**: Monday, April 28, 2025, **Time**: 11:30 AM – 12:10 PM **Location:** Zoom
Participation	40 min virtual session: • 5 youth participants, 10-25 years old • 5 discussion questions

Summary of Engagement Activity

In April 2025, Behavioral Health Services (BHS), in collaboration with University of California San Diego (UCSD) Health Partnership, hosted a virtual focus group with transitional age youth (TAY) from Urban Street Angels - Just Be U Program to gather insights on their experiences, needs, and recommendations for behavioral health services.

The focus group offered youth a safe environment to voice barriers to care and identify strategies for accessing the right services at the right time. The session began with an introduction by BHS, including an icebreaker to build comfort, followed by a UCSD-facilitated discussion guided by 5 core questions, and concluded with a reflective prompt encouraging participants to share a recent experience that brought them joy or support.

Input from this session will help inform specialty mental health and substance use disorder priorities, services, and investments in the region's first Behavioral Health Services Act (BHSA) Integrated Plan for the Fiscal Years 2026-2029. It will also shape the Youth Optimal Care Pathways (OCP) framework, ensuring that future behavioral health strategies and youth-focused supports (ages 0-25) reflect community-identified needs in San Diego County.

Input Session Questions:

1. Can any of you think of a time when you/someone you know received what you felt was high quality care from a doctor, clinician, therapist, or medical provider?
2. Do you recall a time when you or someone you know needed care and didn't get it, or the experience wasn't so great?
3. How do you think your support circle, including friends, family, schools, and adult advocates, can better support youth experiencing mental health and/or substance use challenges?
4. If you had the chance to improve mental health and substance use services for youth, what would you change?
5. Can you share a recent moment of joy or connection you've experienced in your community?

Key Learnings

- **Youth Thrive in Welcoming, Holistic Support Systems**
  Youth value inclusive, supportive, and comprehensive services that address multiple aspects of their lives, including mental health, housing, and community engagement. Positive experiences were reported with Urban Street Angels, crisis houses, and case management teams, where participants felt cared for, supported, and part of a community. Activities like beach trips and casual interactions with staff enhanced feelings of inclusion and trust.

- **Youth Face Unique Barriers to Stability and Require Timely Access to Care**
  Access to stable housing, timely services, and basic needs is a major barrier for youth, with long wait times, inconsistent intake processes, and transportation challenges limiting their ability to get help. Participants described months-long waits for housing, being turned away from crisis houses for not being "in crisis enough," and difficulties traveling to pharmacies for medications. Mismanagement of personal belongings during intake also negatively affected experiences.

- **Schools are Crucial Hubs for Support**
  Schools and structured programs play a critical role in youth mental health, yet there is a need for more mental health staff, after-school programs, and proactive observation of students' social and emotional well-being. Youth highlighted the importance of having therapists in schools, teachers trained to recognize warning signs, safe after-school programs, and monitoring of social dynamics, bullying, and online activity to support students better.

Audience Recommendations

- **Expand and Standardize Youth-Centered Crisis Housing and Supports**
  Participants shared the need to broaden and standardize crisis housing and shelter programs so youth can get help quickly, stay safe, and have opportunities to grow and connect with their community. They suggested adding more crisis beds, combining housing with skill-building and community activities, and updating intake processes to focus on youth who really need support.

- **Streamline Access to Basic Needs and Healthcare Services**
  Improve access to basic needs and healthcare by providing transportation, Electronic Benefit Transfer (EBT) benefits, and pharmacy delivery to help youth get the support they need. Make sure youth can get medications, meals, and essential services without long trips or complicated paperwork.

- **Strengthen School-Based Mental Health and After-School Supports**
  Improve school-based mental health support and after-school programs to better support youth wellbeing and safety. Hire more school therapists, train staff to notice bullying and mental health challenges, offer safe after-school activities, and provide extra help for youth who don't have strong family or community support.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the April 29, 2025, and the April 30, 2025, input sessions with community members from parts of San Diego County including East, South, and North. The sessions provided an overview of County behavioral health crisis response services and gathered participant insights to guide future public messaging strategies.

Section	Details
Engagement Title	LET'S TALK ABOUT...Crisis Response Services in San Diego County
Format	☐ In-Person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** • April 29, 2025, North and South County • April 30, 2025, East County **Time:** • 9:30 AM-10:30 AM North County • 1:00 PM-2:30PM South County • 9:00 AM-10:30AM East County **Location:** Zoom
Participation	90-min discussion: • 10 attendees at sessions • 5 discussion questions • Comments submitted through Mentimeter • Comments through open discussion & Zoom chat

Summary of Engagement Activity

The County of San Diego Behavioral Health Services (BHS), in collaboration with the University of California San Diego (UCSD) Health Partnership, hosted three virtual Public Messaging Input Sessions on Tuesday, April 29, 2025, and Wednesday, April 30, 2025.

Across all sessions, a total of 10 community members from East, South, and North County San Diego participated, sharing their perspectives and lived experiences to help shape recommendations that will guide future outreach and messaging.

Participating Organizations Included:

- Community Health Systems Inc. (CHS)
- City of Imperial Beach
- National Association for the Advancement of Colored People (NAACP) San Diego
- Strong Hearted Native Women's Coalition (SHNWC)
- San Diego County District Attorney (SDCDA)

At each session, BHS Programs and Services - Case Management and Crisis team, presented an overview of key crisis response services, including 988, the San Diego Access & Crisis Line (ACL), Crisis Stabilization Units (CSU), and Mobile Crisis Response Teams (MCRT). UCSD then facilitated an input session using both open discussion and the interactive tool Mentimeter to gather feedback. Participants shared varying levels of familiarity with the services, raised areas of concern, and emphasized the importance of culturally responsive and accessible communication.

Feedback from these sessions will help inform the County's future public messaging strategies, ensuring that communications are community-driven, reflective of diverse needs, and positioned to connect residents with the right behavioral health services at the right time. Additionally, community input will help inform specialty mental health and substance use disorder services, including key priorities and investments in the region's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029, ensuring future behavioral health strategies reflect community-identified needs.

Input Session Questions:

1. Before today, how familiar were you with the services shared?
2. What is something that is unclear or concerns you about the service/resource?
3. What would encourage you or someone you know to use this service/resource?
4. What channels (re: placement/activation) would be best in reaching people in your community about these services?
5. What other suggestions do you have that could help make outreach and messaging around these services more useful for your community?

Key Learnings

- **Knowledge Gaps Limit Access to Resources**
  Participants demonstrated varied familiarity with behavioral health crisis services. Many were unaware of the existing CSUs or how MCRT teams operate, particularly for youth-focused CSUs. Despite participants knowing about crisis services in other counties, they were often unsure of local availability, hours of operation, or how to navigate access to these services. Questions about billing and insurance coverage were common, with uncertainty about whether services were free, whether Medi-Cal was required, and how private insurance or lack of insurance would affect care. These gaps were seen as barriers to engagement, highlighting the need for clear, accessible, and culturally responsive information that explains what services exist, how to access them, and who is eligible.

- **Privacy and Safety Concerns Influence Engagement**
  Safety, trust, and confidentiality emerged as central factors in participants' willingness to use services. Concerns included being seen in public while engaging with MCRT teams, potential reporting to authorities, and fear related to immigration status. Participants emphasized that these fears could deter people from seeking help. Across regions, the BHS team clarified that services are safe, confidential, and available to all, regardless of documentation status, but participants stressed that these assurances need to be consistently communicated.

- **Trusted Culturally Relevant Messengers Increase Reach**
  Participants consistently noted that outreach is most effective when delivered by trusted community members and in familiar, culturally relevant spaces. Promotoras/Promotores, school staff, healthcare providers, community leaders, and individuals with lived experience were identified as credible messengers who can normalize help-seeking. Outreach strategies suggested included schools, churches, wellness fairs, salons, barber shops, and public safety meetings, where the community naturally gathers. Regional nuances were also noted: North County emphasized youth-focused outreach, South County highlighted culturally specific spaces and language access, and East County focused on rural and remote communities. These insights indicate that engaging trusted messengers in locations where people already feel comfortable is key to building awareness and encouraging the use of services.

Audience Recommendations

- **Enhance Clarity and Accessibility of Service Information**
  Participants recommended sharing clear information about available services, including how to access them, operating hours, eligibility, and billing. Describe services in ways that are easy to understand for diverse populations, including neurodivergent individuals and people with disabilities. Use simple, visually clear messaging with practical examples to show how youth and families can get care. Provide information in multiple languages and formats through trusted community spaces like schools, health fairs, and local organizations to make it easier to understand and use.

- **Emphasize Safety and Confidentiality in Outreach and Delivery**
  Clearly communicate that services are private, safe, and accessible to everyone, regardless of documentation or insurance status. Highlight flexible options like private consultations or home visits can address concerns about exposure. Emphasizing confidentiality and safety in all materials and staff messaging can reduce fear and encourage engagement, especially among vulnerable populations.

- **Leverage Community Networks and Trusted Messengers for Outreach**
  Engage trusted community members to raise awareness and encourage use of services. Use schools, churches, community-based organizations, and local events as key places to reach diverse populations. Involve Promotoras/Promotores, healthcare providers, community leaders, and individuals with lived experience to build credibility and normalize seeking help. Tailor outreach strategies to regional and cultural needs, such as youth-focused programs in North County, culturally specific spaces in South County, and rural access points in East County. Leverage informal gatherings, wellness fairs, and public safety meetings to introduce services in settings where people already feel comfortable, increasing both reach and trust.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the Thursday, May 1, 2025, input session between the County of San Diego Housing Council, Behavioral Health Services (BHS), housing stakeholders, and community members, examining how the Behavioral Health Services Act (BHSA) will shape housing policies.

Section	Details
Engagement Title	Housing Council Listening Session
Format	☒ In-Person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Thursday, May 1, 2025 **Time:** 10:30 AM-11:30 AM **Location:** County of San Diego Housing and Community Development Services (HCDS), 3989 Ruffin Rd, San Diego, CA, 92123

Participation	60-min discussion:
	• Nearly 40 attendees
	• 4 discussion questions
	• 200+ comments received:
	  ○ 163 comments submitted through Mentimeter
	  ○ 40 comments through open discussion

Summary of Engagement Activity

On May 1, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with the University of California San Diego (UCSD) Health Partnership, hosted a listening session during the BHS Housing Council Retreat at the San Diego County Housing and Community Development Services (HCDS) building. The Housing Council provides guidance on the design, implementation, and evaluation of housing interventions to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity. This session was designed to gather early input to inform the development of the County's first Behavioral Health Services Act (BHSA) Integrated Plan for the Fiscal Years 2026-2029. Input session questions were formulated based on prior input and work of the Council, including the 2022-2027 Strategic Housing Plan.

Approximately 40 participants attended the retreat, including the Council's 10 voting members and representatives from community-based organizations, housing developers, advocacy groups, and government and non-government agencies.

Participating Organizations Included:

- National CORE
- Alpha Project
- Vista Hill
- Corporation for Supportive Housing (CSH)
- Legal Aid Society
- Jewish Family Services of San Diego
- Mobile Crisis Response Team (MCRT) Exodus Recovery
- San Diego Housing Commission (SDHC)
- Clarvida
- Wakeland Housing and Development Corporation
- Housing Innovation Partners (HIP)
- Community Health Improvement Partners (CHIP)
- Turn BHS
- National Alliance of Mental Illness (NAMI) San Diego
- Access to Independence
- Townspeople
- Telecare Corporation
- Father Joe's Villages
- Community Research Foundation, Inc. (CRF)

The session opened with an overview of BHSA, followed by a 45-minute discussion facilitated by UCSD. Nearly 200 comments were submitted through Mentimeter, in addition to verbal responses shared during the discussion, reflecting a wide range of perspectives and experiences. Conversations centered on opportunities and challenges across the housing and behavioral health systems, with an emphasis on policy flexibility, cultural responsiveness, and the inclusion of individuals with lived experience in shaping future strategies. Participants offered insights into system-level barriers and shared recommendations aimed at strengthening service accessibility, promoting collaboration, and expanding supportive housing solutions for individuals with complex behavioral health needs.

Input Session Questions:

1. Where in current service and/or housing systems are the most rigid policies (and how do they impact individuals with complex behavioral health needs)?
2. Given those policies, where are opportunities for flexibility or improvement?
3. Recommendations for making services more accessible and culturally aware for individuals with lived experience?
4. How can individuals with lived experience help shape policies and practices in both housing and behavioral health systems?
5. To help inform the BHSA integrated plan, what additional housing-related perspectives, data, stakeholders, or information need to be considered?

Key Learnings

- **Rigid Policies Create Barriers to Stable and Accessible Housing**
  Barriers include eligibility rules, funding limits, and a mismatch of services when complex health needs exist. Eligibility rules like Coordinated Entry Systems (CES) matching, Housing and Urban Development restrictions, and felony exclusions all prevent access. Funding limits further narrow eligibility: for example, Supplemental Security Insurance (SSI) excludes board and care for high-need individuals. Service mismatch makes housing waits too long for clients with specialized care needs that require access to Assertive Community Treatment (ACT), and Full-Service Partnership (FSP).

- **Employment is Core to Housing Stability**
  Participants strongly tied long-term stability to meaningful employment, not just short-term jobs to retain benefits. Calls for integrating supported employment and peer employment into housing strategies were repeated.

- **Mobile and On-Site Services are Critical**
  Another major theme was the need to meet people where they are: in Permanent Supportive Housing (PSH) communities, recovery residences, and community hubs. Recommendations included exploring more mobile intake/assessment teams, medical and behavioral health services at housing sites, and mobile response units dedicated to PSH.

- **Opportunities for Flexibility and System Improvement in Accessing Housing**
  Streamlining is needed to make multiple applications and ensure that long timelines do not hinder access to housing. Additional alignment between BHS and Managed Care Plans (MCP) is needed to prevent delays in support. Low-barrier housing access is needed so those most in need are not excluded and have quick housing options.

- **Integrate and Value Peers and Individuals' Lived Experience More**
  Peers can build trust and have better responsiveness with residents when they are present. People with lived experience are meaningful role models and should help design and shape policy. Participants emphasized expanding peer roles beyond advisory ones to paid leadership positions. Other suggestions included having peers staff property front desks, embedding peers in design and policy decisions, and creating career ladders. Strong emphasis was placed on compensation and avoiding tokenization. Career pathways with compensation for peers as support staff could increase engagement.

- **Cultural Responsiveness & Specialized Teams**
  Community members identified the importance of investment in culturally specific providers and hiring a diverse workforce. Examples included Spanish-speaking ACT teams, culturally tailored peer navigators, and housing providers rooted in community trust.

- **Creative Access & Engagement Models**
  Participants expressed a desire to perhaps see wellness kiosks (similar to like in convenience stores), mobile resource buses, texting platforms, and libraries as service hubs. These approaches were seen as essential for lowering barriers and reaching harder-to-engage populations.

- **Bridge & Shared Housing Opportunities**
  Participants saw value in shared housing and recuperative care as transitional steps toward permanent housing. Emphasis on designing these models with resident input to build skills and stability.

- **Landlord & Property Engagement**
  Strong calls for landlord engagement programs to reduce stigma and streamline approvals. Suggestions included incentive programs, education campaigns, and stronger collaboration with property managers.

- **Data & Accountability**
  Participants wanted better data on housing retention, disenrollment, and service integration outcomes, and requested feedback loops showing how their input shaped County action.

Audience Recommendations

- **Dedicate Funding for Capital Development**
  Expanding housing is critical to stability and recovery in our region. Under BHSA guidelines, 30% of funds must support Housing Interventions, with up to 25% of that dedicated to capital development. Community members recommend using the full 25% for projects that increase Permanent Supportive Housing and recapitalize programs like No Place Like Home, in partnership with County Housing and Development Services. Families, older adults, and individuals with complex behavioral health needs need safe, dignified, and affordable housing options.

- **Prioritize Retention and Prevention Supports**
  Participants emphasized that housing success depends not only on placement but on ongoing support that prevents loss of housing. They recommended dedicated funding and staffing for on-site behavioral health and clinical services, such as having therapists or crisis-response staff available at housing sites. This would help address rising acuity levels, reduce evictions due to unmet behavioral health needs, and improve service flow. Transition supports for those leaving or being evicted from PSH were also strongly encouraged.

- **Expand Transitional and Flexible Housing Models**
  There is a critical gap between temporary and permanent housing, recommending the development of transitional, tenant-based models connected to service providers. These “bridge” options would allow earlier intervention when housing instability arises and prevents clients from cycling back into homelessness.

- **Strengthen Navigation and Re-Engagement Pathways**
  Participants identified challenges in navigating services after housing placement. They recommended clearer navigation tools, such as visual flowcharts or resource maps that show re-engagement points, service options, and contact methods. Multiple touchpoints and skill-based trainings were also suggested for staff and residents to improve navigation, re-entry into care, and re-engagement with the broader community. It was also recommended that development companies and/or property management staff be included in engagement activities to support planning given their understanding of the property itself.

- **Increase Flexibility in Service Acceptance and Engagement**
  Participants urged a voluntary, person-centered approach to service delivery. Encouraging voluntary, active engagement, rather than conditional service requirements, was viewed as essential for sustaining housing and rebuilding trust among residents.

- **Integrate Life Skills and Educational Supports into Housing Programs**
  Suggestions included offering on-site skill-building opportunities such as cooking, budgeting, and community engagement workshops. These activities were viewed as both engagement tools and essential supports for maintaining housing stability.

- **Invest in Workforce Retention and Capacity**
  Staff turnover and burnout were cited as ongoing challenges that weaken continuity of care. Participants recommended investments in workforce development, retention incentives, and training tailored to serving individuals with higher levels of behavioral health acuity.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes key insights from the input activity held on May 15, 2025, at the "Let's Talk About: Connecting South Bay to Mental Health Resources," community event, and offers recommendations to improve access, reduce stigma, and support culturally affirming behavioral health engagement in the South Region. Findings from this engagement will also be utilized to inform the County's Behavioral Health Service Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	Let's Talk About: Connecting South Bay to Mental Health Resources
Format	☒ In-person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Thursday, May 15, 2025 **Time:** 5:30 PM-7:00PM **Location:** MAAC Project Community Center - 1387 Third Ave, Chula Vista, CA 91911
Participation	90-Minute Engagement: • 23 attendees • Three 5-min posterboard rotations (3 discussion questions) • Over 40 open-discussion comments received

Summary of Engagement Activity

On May 15, 2025, Behavioral Health Services (BHS), in partnership with the Metropolitan Area Advisory Committee on Anti-Poverty of San Diego County, Inc. (MAAC), utilized the MAAC Community Center in Chula Vista to host an in-person community event titled *"Let's Talk About: Connecting South Bay to Mental Health Resources."* This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

The event engaged 23 community members and featured seven exhibitors, including both County and community-based providers.

Participating Organizations Included:

- Metropolitan Area Advisory Committee on Anti-Poverty of San Diego County, Inc (MAAC)
- Optum—Access & Crisis Line (ACL)
- Survivors of Suicide Loss (SOSL)
- Mobile Crisis Response Team (MCRT)
- South Bay Community Services (SBCS)
- Jewish Family Services—Breaking Down Barriers
- Mid-City CAN
- NAMI San Diego
- County Of San Diego, Aging and Independence Services
- Equip Health

The event offered a panel discussion featuring representatives from the Access and Crisis Line (ACL), Mobile Crisis Response Teams (MCRT), Survivors of Suicide Loss (SOSL), and South Bay Community Services (SBCS), moderated by an Outreach Coordinator from Breaking Down Barriers (BDB) from Jewish Family Services (JFS). Following the panel, attendees participated in an interactive posterboard rotation activity facilitated by County staff, during which they responded to three discussion questions and contributed over 40 open-ended comments.

Input Session Questions:

1. Which of these specific mental health topics are most important in your community?
2. What are the biggest mental health or substance use challenges or related needs in your community?
3. What programs or workshops would you recommend to effectively engage the South Region in discussions about mental health?

Key Learnings

- **Community Members Value Mental Health Care**
  Community members viewed mental health topics as interconnected and of great importance. In particular, the audience voiced that with mental health challenges the community seeks culturally affirming care, greater workforce capacity, and improved pathways to the right services.

- **Equitable Access & Structural Support Challenges to Care**
  Structural barriers such as stigma, language access, housing instability, transportation, and long wait-times significantly impact the ability of residents to seek and sustain behavioral health support. Additional barriers to care include navigation of complex health care and lack of accessibility for those who may have a disability also serve as a deterrent to accessing support. Linguistic access, cultural affirmation, peer involvement, and stigma reduction are essential to building trust and participation.

- **Reducing Stigma Through Inclusive, Community-Centered Engagement**
  Audience members shared a strong preference for trauma-informed, peer-led, and culturally rooted engagement approaches that reduce stigma, promote trust, and reflect lived experiences from within the community. Services must minimize re-traumatization and foster psychological safety for individuals and families.

- **Family and Community Empowerment**
  Community members seek family-centered supports, experiential programming, and opportunities for leadership and connection to strengthen prevention and long-term resilience of those faced with behavioral health challenges.

- **Integrated, Community Driven Behavioral Health Care**
  Community members prioritize accessible, coordinated mental health and substance use services grounded in lived experience.

Audience Recommendations

- **Develop Hub Model for Accessing Support**
  Participants shared the need to develop a "one-stop-shop" behavioral health model to address co-occurring conditions. Streamlining the intake processes to make it easier for people to get care is vital. Provide navigation support to help clients access eligibility-based services.

- **Address Structural and Practical Barriers to Access**
  Reduce transportation challenges, housing instability, long wait times, and limited disability accommodations as persistent barriers to engaging in behavioral health services. Reducing these barriers is critical to improving access, continuity of care, and equity across populations.

- **Strengthen Culturally and Linguistically Responsive Services**
  Increase services that are linguistically accessible and culturally affirming. Representation among providers, multilingual resources, and partnerships with trusted community organizations were seen as essential to building trust and increasing engagement.

- **Center Trauma-Informed, Low-Barrier, and Stigma-Reducing Approaches**
  Create spaces that feel safe and supportive, especially for people who have experienced trauma. Use easy-to-access, welcoming, and hands-on approaches to make talking about mental health feel normal and help reduce stigma.

- **Promote Family-Centered and Community Empowerment Approaches**
  Include families and caregivers as key partners in prevention and early intervention. Create opportunities that foster community connection, shared ownership, and empowerment for strengthening resilience and supporting long-term wellness outcomes whenever possible. Programs that reflect community-identified priorities and incorporate lived experience are viewed as more responsive, relevant, and effective.

- **Incorporate Non-Clinical Approaches to Healing**
  Create community-based activities and programs that use storytelling, art, recreation, nature, and trusted messengers to encourage open conversations about mental health, especially for families, youth, and underserved populations.

- **Invest in Crisis Response Services & Behavioral Health Workforce**
  Expand South Bay's crisis response capacity by strengthening Mobile Crisis Response Teams (MCRT) and Psychiatric Emergency Response Teams (PERT), providing first responder training, and increasing workforce capacity and diversity to meet community needs.

- **Additional Goals: Engagement in Schools and Social Connections**
  For the "specific mental health goals most important," to the audience, they identified two main areas of interest. These areas include, "Help connecting to the right mental health care (Navigation Support)," and "Mental health workforce capacity and diversity (Workforce Challenges and Representation)."

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Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes key insights from a Youth Optimal Care Pathways Listening Session and offers recommendations for developing a Youth Behavioral Health Continuum Framework that promotes resiliency and well-being among youth in San Diego County. Findings from this engagement will also be utilized to inform the County's Behavioral Health Service Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	Youth Optimal Care Pathways (OCP) Listening Session
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** June 4, 2025 **Time:** 5:00 PM-6:00 PM, 5:30 PM-7:00 PM **Location:** Zoom
Participation	60-min virtual listening session: • 10 attendees • 7 discussion questions facilitated by UC San Diego • Mentimeter responses and open discussion

Summary of Engagement Activity

On June 4, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with the University of California San Diego (UCSD) Health Partnership, hosted a virtual listening session with 10 youth from the *Live Well San Diego* Youth Sector. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Transitional Aged Youth (TAY) participants brought diverse identities, backgrounds, and lived experiences, offering valuable insight into the behavioral health needs of young people today.

The session began with an icebreaker and a presentation from the BHS Communication and Engagement (C&E) team, introducing the team's mission and community outreach efforts. The UCSD team then facilitated a discussion guided by seven key questions, encouraging youth to participate through open dialogue and/or by using the interactive digital platform Mentimeter. The session explored the challenges youth face in accessing behavioral health services and strategies to better connect individuals to the right care at the right time, supporting their long-term well-being. The session concluded with a resource overview from the C&E team, highlighting available mental health and substance use prevention tools for youth.

Insights gathered from this session will also inform the development of a Behavioral Health Continuum Framework for children, youth, and transitional-age youth (ages 0-25) in San Diego County. The framework will strengthen care pathways by improving access to timely, appropriate services that are responsive to both clinical needs and the broader social factors influencing mental health such as anxiety, depression, bullying, suicide risk, and the impact of social media. Shaped by the lived experiences of youth, this effort promotes a more equitable and sustainable care system by designing services that reflect community needs, strengthening ties to natural supports, and expanding diverse care options.

Input Session Questions:

1. What trusted spaces in your community do youth turn to when they're struggling or seeking out more information? What do you believe are the most effective ways of reaching youth about mental health/substance use?
2. In your opinion, what do you see as the greatest concerns for youth related to mental health and substance use today?
3. What might prevent youth experiencing mental health and/or substance use challenges from getting the help they need in your community?
4. Can any of you think of a time when you/someone you know received what you felt was high quality care from a doctor, clinician, therapist, or medical provider? What made that a quality experience?
5. Do you recall a time when you or someone you know needed care and didn't get it, or the experience wasn't so great? What were the factors that made it a negative experience?
6. How do you think your support circle, including friends, family, schools, and adult advocates, can better support youth experiencing mental health and/or substance use challenges?
7. If you had the chance to improve mental health and substance use services for youth, what would you change?

Key Learnings

- **Youth Identify Trusted Spaces for Behavioral Health Support**
  Youth identified safe places such as schools, community organizations, wellness centers, libraries, social media, and trusted adults like teachers and coaches when seeking out additional information or support reflective of behavioral health.

- **School Site Personnel are Valued, but Limited**
  While school counselors are valued, participants expressed that they find them inaccessible due to limited availability or concerns about confidentiality.

- **Youth Face Various Barriers that Prevent Them from Seeking Help**
  Many shared that cultural stigma, fear of judgment from family, financial constraints, and limited awareness of available services prevent them from seeking help.

- **Quality Healthcare Experiences are Rooted in Representation & Understanding**
  Positive experiences with healthcare providers are rooted in empathy, cultural understanding, and being treated as whole individuals. Youth value providers who listen without rushing and reflect their identities in terms of race, gender, and lived experience. Feeling seen and respected encourages engagement in care.

- **The Cost of Being Dismissed: Barriers to Youth Help-Seeking Behaviors**
  Youth shared that feeling dismissed or misunderstood by adults or healthcare providers, especially during their first attempts to seek help, undermines their sense of autonomy and discourages them from advocating for themselves or seeking support in the future.

- **The Weight of Expectations: Anxiety and Isolation Among Youth**
  Youth reported experiencing anxiety, depression, isolation, and suicidal ideation, often linked to academic pressure, social expectations, uncertainty about the future, and the influence of social media. Many struggle silently and are unsure who to trust or how to seek help.

- **Substance Use as a Coping Mechanism**
  Vaping and substance use are widespread and normalized among youth, sometimes starting as early as elementary school. Many turn to these substances to escape stress, but their addictive qualities make it difficult to quit or help others do so.

Audience Recommendations

- **Empowering Youth Through Peer-Led Support Programs**
  Participants shared the need to expand peer-led supports, including student ambassador programs, peer support circles, and workshops. Offer programs that teach youth how to hold space for each other. Provide workshops that help youth facilitate supportive conversations.

- **Bolster the Behavioral Health Workforce with Cultural Competency**
  Improve the quality and access of behavioral health services by training providers in empathy and cultural sensitivity. Expand affordable, identity-affirming services for youth. Teach early mental health education that covers anxiety, depression, and social pressures, and involve families to help reduce stigma.

- **Integrate Behavioral Health Initiatives Year-Round**
  Provide consistent, year-round school mental health supports that go beyond one-time events. Expand access to free or low-cost services and offer options for anonymity to meet ongoing and diverse needs. Build on current initiatives, like mental health days and motivational speakers, to create more comprehensive support for youth.

- **Create Non-clinical Safe Places and Practices to Normalize Behavioral Health** Identify and create non-clinical support spaces such as clubs, art programs, sports, and volunteer opportunities to help youth build connection and resilience. Use creative outlets like art as powerful tools for mental health, giving youth alternative ways to express emotions and process difficult experiences without relying on words.

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Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the July 9, 2025, collaborative planning session between the *Live Well San Diego (LWSD)* North Central Leadership Team, Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHS Data Presentation for LWSD North Central Region Community Leadership Team Meeting
Format	☒In-person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Wednesday, July 9, 2025 **Time:** 11:30 AM – 12:30 PM **Location:** Live Well Support Center - 5469 Kearny Villa Road, San Diego, CA 92123
Participation	**Participants:** • 41 Community members & County staff participated in this activity. • 5 breakout groups. • 4 discussion questions supported by poster board sticky notes, activity sheet, and open discussions.

Summary of Engagement Activity

On July 9, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) team and BHS Population Health Unit collaborated with the Live Well San Diego North Central Leadership Team to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 41 participants attended the data presentation, including the Leadership Councils members and diverse mix of community-based, healthcare, educational, faith-based, and social service stakeholders.

Participating Organizations Included:

- Our Lady of Mount Carmel
- Southern Caregiver Resource Center
- Angels Foster Family Network
- Social Advocates for Youth (SAY) San Diego
- Harmonium, Inc.
- University of California San Diego (UCSD), School of Public Health, Transportation Research and Education for Driving Safety (TREDS)
- Family Health Centers of San Diego (FHCSD)
- TURN, Behavioral Health Services
- San Diego State University (SDSU)
- Planned Parenthood
- Department of Rehabilitation
- MY Academy
- Alzheimer's Association
- Neighborhood House Association
- Molina Healthcare

The session began with C&E providing an overview of BHSA and its impact on BHS activities, followed by the BHS Population Health Unit sharing regional, County, and state behavioral health related data, including information on self-harm, suicide, overdose, and substance use. Following the presentation, community members participated in small-group discussions facilitated by the C&E team, focusing on disparities in mental health and substance use outcomes, barriers to care, and opportunities for collaboration between the County and community to enhance wellbeing. The session concluded with participants sharing closing reflections and voting on the State's "Additional Goals" to highlight priorities for future data workshops.

Input Session Questions:

1. What do you consider the biggest disparity or difference in health outcomes when it comes to mental health/substance use in this region, from the data shared today?
2. What factors do you feel contribute to these disparities/gaps? From your perspective, are there certain populations or communities more impacted than others? (What are barriers for people getting the support they need – consider access, cultural norms/traditions etc.)?
3. How can the County and community work together to address disparities or gaps to improve mental health and wellbeing? (Consider available resources, existing programs/services, accessible information, trusted members of the community).
4. Cast a vote for what you would like the County to focus on for future behavioral health data sets.

Key Learnings

- **Awareness, Access, and Stigma**
  Participants emphasized that limited awareness of behavioral health services and restricted access often lead to crises in the community. Stigma around seeking support, particularly within specific cultural or community groups, prevents individuals from utilizing available resources. Groups such as immigrants, military populations, and some cultural communities noted that seeking help is often discouraged, further limiting engagement with support systems. Overall, these factors create significant barriers to early intervention and contribute to disparities in service utilization.

- **Population Specific Vulnerabilities**
  Stakeholders highlighted that youth and LGBTQIA+ populations face unique vulnerabilities, including bullying, peer pressure, trauma, and unsafe social environments. Foster youth and unhoused youth reported low trust in support systems, with foster parents expressing fear of negative consequences if children access services. Participants also noted disparities affecting racial and ethnic minority groups, including Black, Native/Indigenous, and Latinx/Hispanic populations. These population-specific challenges contribute to gaps in service engagement and data reporting, emphasizing the need for targeted interventions.

- **Substance Use and Safety Risks**
  Participants noted that substance use and related safety risks are significant contributors to disparities in behavioral health outcomes. Youth exposure to drugs, drink spiking, and unsafe environments were emphasized as increasing concerns, alongside sexual assault risks. Drug overdoses among youth, particularly ages 10–17, were identified as a pressing problem affecting community health. These patterns demonstrate the need for both prevention-focused programs and enhanced monitoring of emerging substance-related risks.

- **Mental Health and Suicide Risks**
  Stakeholders consistently highlighted concerns around suicide ideation and deaths among youth, elderly populations, and foster children. Access to firearms, social isolation, and other environmental factors were identified as contributors to suicide risk. These concerns indicate that mental health interventions must be responsive to age-specific and population-specific needs, and early intervention is critical. Addressing these risks requires integrated strategies that combine prevention, support, and community engagement.

- **Structural and Socioeconomic Barriers**
  Participants noted that financial hardship, limited parental supervision, and lack of extracurricular opportunities impact youth behavioral health outcomes. Geographic disparities, including reduced reach in areas like Kearny Mesa and Peninsula, limit access to care. Socioeconomic status and cost of care were repeatedly cited as barriers affecting multiple populations, including older adults and military families. These structural inequities create disparities that must be addressed in program planning and resource allocation.

- **Data Gaps and Trust**
  Stakeholders raised concerns about how behavioral health data is collected and whether it reflects community needs. Populations such as youth, justice-involved individuals, and marginalized groups may be underrepresented due to mistrust or confidentiality concerns. Participants emphasized that without community trust, data may be incomplete or inaccurate. Addressing these gaps requires strategies that prioritize transparency, engagement, and inclusive data collection methods.

- **Collaborative Solutions**
  Participants highlighted the importance of community-informed strategies to address gaps, including education, outreach, and intergenerational programming. Safe spaces, interactive events, and partnerships with schools, faith-based organizations, and affinity groups were suggested to enhance engagement. Stakeholders emphasized the value of ongoing training, trauma-informed care, and harm reduction initiatives. These collaborative approaches were seen as essential to improving service access, behavioral health outcomes, and long-term community wellness.

Audience Recommendations

- **Community Awareness and Engagement Strategies**
  Enhance awareness and reduce stigma by ensuring communities know about behavioral health services and feel safe using them. Participants highlighted that lack of awareness and access contributes to crises, while stigma prevents help-seeking, particularly in immigrant, military, and culturally diverse populations. Culturally informed outreach, multilingual materials, and stigma-sensitive messaging are critical for improving engagement. Building these foundations supports more equitable access and utilization of services.

- **Targeted Supports for Priority Populations**
  Target programs to address the unique vulnerabilities of youth, LGBTQIA+ individuals, foster youth, and unhoused populations. Stakeholders emphasized that trauma, bullying, peer pressure, and unsafe environments significantly impact these groups. Racial and ethnic minority populations, including Black, Native/Indigenous, and Latinx/Hispanic communities, were also identified as particularly vulnerable. Tailored interventions are needed to support these populations and improve behavioral health outcomes.

- **Risk Reduction and Prevention Initiatives**
  Address substance use and safety risks by focusing on prevention, harm reduction, and monitoring environmental factors whenever possible. Participants noted drug overdoses, youth exposure to drugs, drink spiking, and unsafe party settings as urgent concerns. Sexual assault risks and firearm access were also emphasized. Programs must incorporate strategies to mitigate these risks while engaging youth in safe, supportive environments.

- **Early Intervention and Crisis Prevention Efforts**
  Strengthen mental health interventions and suicide prevention initiatives by addressing high-risk populations and contributing factors. Participants highlighted suicide ideation and deaths among youth, older adults, and foster children, noting that social isolation, trauma, and firearm access exacerbate risks. Timely, age-appropriate, and population-specific interventions were emphasized as critical. Early intervention and community-based support are essential to reduce behavioral health disparities.

- **Access-Oriented Service and Resource Allocation**
  Mitigate structural and socioeconomic barriers by improving accessibility and resource availability for underserved populations. Stakeholders noted financial hardship, limited parental supervision, lack of extracurricular activities, and geographic disparities as significant challenges. Systemic inequities and cost of care further affect older adults, military families, and other vulnerable populations. Programs must integrate flexible, affordable, and accessible strategies to address these disparities.

- **Inclusive Data Practices and Community Trust-Building**
  Improve data collection and trust by engaging communities transparently and inclusively. Participants emphasized that youth, justice-involved individuals, and marginalized groups are often underrepresented in data due to lack of trust. Confidentiality, transparency, and community engagement were repeatedly highlighted as critical factors. Strengthening trust ensures more accurate reporting and informs effective planning and services.

- **Partnership Development and Community Co-Design**
  Expand collaborative partnerships and community-engaged strategies to improve program reach and impact. Participants highlighted that partnerships with schools, faith-based organizations, senior centers/intergenerational programs, and affinity groups increase engagement. Structured events, safe spaces, and interactive programming, such as Parks After Dark or nature-based initiatives, were suggested to encourage participation. Ongoing training and education for caregivers and community members further support sustainability and effectiveness.

- **Additional Goals: Engagement in Schools and Social Connections**
  For the State's "Additional Goal," the audience identified two main areas they would like to see prioritized regarding the local County performance on population-level goals vs. the State. These two measures included "*Engagement in Schools,*" as well as "*Social Connections.*"

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the July 17, 2025, collaborative planning session between the *Live Well San Diego* (LWSD) East Region Leadership Team, Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHS Data Presentation for LWSD East Region Community Leadership Team Meeting
Format	☒ In-person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Thursday, July 17, 2025 **Time:** 10:30 AM – 12:00 PM **Location:** County of San Diego East Region Public Health Center- 367 N. Magnolia Ave, Magnolia Room, El Cajon, CA, 92020
Participation	**Participants:** • 51 community members and County staff. • 6 break out groups. • 4 discussion questions supported by poster board sticky notes, activity sheet, and open discussions.

Summary of Engagement Activity

On July 17, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) team and BHS Population Health Unit collaborated with the Live Well San Diego East Region Leadership Team to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 51 participants attended the data presentation, including representation from a broad range of stakeholders, including healthcare providers, youth and family services, educational institutions, community-based wellness and prevention programs, and County staff.

Participating Organizations Included:

- San Diego Youth Services
- Institute of Public Strategies
- Exodus Recovery, Inc.
- Courage To Call, TURN Behavioral Health Services
- Family Health Centers of San Diego
- Neighborhood Healthcare
- Vista Hill
- License to Freedom
- McAllister Institute
- Grossmont Healthcare
- Blue Shield California
- Pacific Health Group
- Institute of Public Strategies (IPS)
- SAY San Diego
- Lakeside Union School District
- IPS BUDI Program

The session began with C&E providing an overview of BHSA and its impact on BHS activities, followed by the BHS Population Health Unit sharing state and regional behavioral health related data, including information on self-harm, suicide, overdose, and substance use. Following the presentation, community members participated in small-group discussions facilitated by the C&E team, focusing on disparities in mental health and substance use outcomes, barriers to care, and opportunities for collaboration between the County and community to enhance wellbeing. The session concluded with participants sharing closing reflections and voting on the State's "Additional Goals" to highlight priorities for future data workshops.

Input Session Questions:

1. What do you consider the biggest disparity or difference in health outcomes when it comes to mental health/substance use in this region, from the data shared today?
2. What factors do you feel contribute to these disparities/gaps? From your perspective, are there certain populations or communities more impacted than others? (What are barriers for people getting the support they need - consider access, cultural norms/traditions, etc.).
3. How can the County and community work together to address these disparities or gaps to improve mental health and wellbeing? (Consider available resources, existing programs/services, accessible information, trusted members of the community, etc.).
4. Cast a vote for what you would like the County to focus on for future behavioral health data sets.

Key Learnings

- **Closing Gaps in Behavioral Health for Underserved Communities**
  Attendees highlighted significant disparities in mental health and substance use outcomes for certain groups including older adults, service members and veterans, people in rural areas, youth (especially LGBTQIA+ youth), and communities of color such as Black/African American and American Indian/Alaska Native residents. These challenges often occur because of their far proximity to local behavioral health services, lack of culturally appropriate resources and/or lack of services provided in native language, stigma reflective of behavioral health, and lack of access to prevention and crisis supports. Targeted outreach in reaching these groups and building trust is a key theme.

- **Address Housing Instability and Basic Needs as Core Behavioral Health Factors**
  Individuals shared that housing instability and unmet basic needs strongly influence behavioral health outcomes and whether individuals are represented in data systems, resulting in the undercounting of unhoused and economically marginalized populations.

- **Communities Face Systemic and Cultural Barriers to Care**
  The audience voiced that several ongoing challenges contribute to behavioral health disparities including cultural beliefs that discourage open conversations about mental health within certain communities. Other systemic barriers include limited transportation and public transportation infrastructure challenges, insurance gaps, provider shortages, and limited hours for services. Additionally, audience members shared that the healthcare system was often challenging in navigating access to services. These barriers continue to disrupt care and make it challenging for vulnerable populations to effectively access the support they need.

- **Shift from Crisis-Driven Systems to Diversify Community Response**
  Behavioral health systems and data sets remain heavily centered on crisis response, limiting the County's ability to detect early risk factors and intervene before individuals require emergency or inpatient care. Audience suggestions also include expanding mobile outreach services, creating centralized resource hubs for behavioral health specifically positioned to support underserved areas like Mountain Empire and Grossmont School District, and further developing crisis stabilization services/facilities would be beneficial.

- **Growing Concern of Law Enforcement in Accessing Services**
  Individuals shared that fear related to immigration enforcement deters individuals from seeking behavioral health care and felt that there is insufficient funding for frontline staff and community programs to address these challenges. Community partners emphasized the need for collaborative approaches that increase trust and accessibility, such as enhancing education for parents and youth on behavioral health while leveraging trusted community and faith-based organizations in the process.

- **Adapt Data Systems to Fast Changing Local Trends**
  The audience desires improving data transparency by providing more "real-time" resource mapping of behavioral health related events to better guide coordinated prevention and intervention efforts. Rapid shifts in substance use patterns outpace current data collection and reporting systems, delaying timely prevention, harm reduction, and response efforts. Fragmented data across healthcare, education, housing, and community-based systems prevents a comprehensive understanding of behavioral health needs. This also includes incomplete data among immigrant and marginalized communities. Finally, individuals shared aggregated regional data obscures neighborhood-level differences, limiting the County's ability to design place-based and culturally tailored interventions.

Audience Recommendations

- **Shift Towards Early Interventions and Stigma Reduction**
  Participants desire partnerships with schools, shelters, senior centers, outreach teams, and community-based organizations to capture early and preventative indicators. Individuals stressed to reduce stigma by framing behavioral health services and data efforts around prevention, wellness, and connection rather than crisis alone.

- **Expand Mental Health Services in Rural Communities**
  Individuals expressed the need to increase the availability of crisis stabilization units, mobile mental health teams, and language services in rural and high-need communities like Mountain Empire, Lemon Grove, and Spring Valley. Expanding services can reduce geographic and cultural barriers to care. Provide targeted support to ensure communities with the greatest need can access timely mental health help.

- **Remove Structural Barriers to Access and Engagement**
  Improve access by investing in mobile, community-based, and low-barrier service models that address transportation, insurance, and scheduling challenges. Partner with schools, faith-based groups, and trusted local organizations to deliver preventative education, reduce stigma around mental health and harm reduction, and meet residents where they are through both in-person and virtual engagement strategies.

- **Develop Real-Time Resource Mapping and Response**
  Create and maintain a centralized, real-time resource map and data dashboard that works with the Coordinated Information Exchange (CIE) to simplify referrals, track available services, and make information easy for the community and residents to access. Additionally, individuals shared their desire to utilize "hot maps" with feedback loops to capture emerging substance use trends and community-level insights.

- **Improve Geographic Specific Planning**
  Disaggregate data at the neighborhood and sub regional level to support place-based planning and equitable resource allocation. Also, break down data silos by establishing cross-sector data-sharing and learning collaboratives across healthcare, education, housing, and community systems.

- **Address Housing Instability and Basic Needs**
  Integrate housing status, basic needs access, and service barriers as standard variables across County behavioral health data sets.

- **Strengthen Cultural and Linguistic Services**
  Strengthen cultural and linguistic responsiveness through expanded translation services, bilingual staff, and culturally matched providers. Leverage trusted messengers, cultural brokers, and lived-experience advocates to build trust, increase participation in behavioral health services, and improve data quality.

- **Additional Goals: Engagement in Schools and Social Connections**
  For the State's "Additional Goal," the audience identified two main areas they would like to see prioritized regarding the local County performance on population-level goals vs. the State. These two measures included "*Engagement in Schools,*" as well as "*Social Connections.*"

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the July 28, 2025, collaborative planning session between the *Live Well San Diego* (LWSD) Central Region Leadership Team, Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHS Data Presentation for LWSD Central Region Community Leadership Team Meeting
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** Monday, July 28, 2025 **Time:** 1:30 PM-3:30 PM **Location:** Zoom
Participation	**Participants:** • 68 community members and County staff • 7 break out groups • 4 questions with facilitated open discussions

Summary of Engagement Activity

On July 28, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) team and BHS Population Health Unit collaborated with the Live Well San Diego Central Region Leadership Team to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 68 participants attended the input session, including the Central Leadership Team and representatives from community-based organizations, advocacy groups, and government and non-government agencies.

Participating Organizations Included:

- University of California San Diego (UCSD) Health
- Goodwill Industries of San Diego
- Logan Heights Community Development Corporation (CDC)
- Docfully Healthcare
- Alzheimer's Association
- Legal Aid Society of San Diego (LASSD)
- SAY San Diego
- San Diego PACE
- JIREH Providers
- California State University San Marcos (CSUSM)
- TURN Behavioral Health Services
- The Children's Initiative
- ELUSEN, Inc.

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

The session opened with an overview of Behavioral Health Services Act (BHSA) by the C&E team, followed by a data presentation from BHS Population Health Unit highlighting state and regional trends in self-harm, suicide, overdose, and substance use. Afterward, community members participated in small-group discussions led by C&E to identify key disparities, barriers, and opportunities for collaboration to improve mental health and wellbeing. The session concluded with attendees sharing reflections and voting on "Additional Goals" from the State's list of measures to prioritize for future data workshops.

Input Session Questions:

1. What do you consider the biggest disparity or difference in health outcomes when it comes to mental health/substance use in this region, from the data shared today?
2. What factors do you feel contribute to these disparities/gaps? From your perspective, are there certain populations or communities more impacted than others? (What are barriers for people getting the support they need - consider access, cultural norms/traditions, etc.).
3. How can the County and community work together to address these disparities or gaps to improve mental health and wellbeing? (Consider available resources, existing programs/services, accessible information, trusted members of the community, etc.).
4. Cast a vote for what you would like the County to focus on for future behavioral health data sets.

Key Learnings

- **Gaps in Behavioral Health Data and Analysis**
  Participants expressed behavioral health data is misrepresented or only telling part of the story, as the data shared is believed to be overly crisis-focused and lacking in cultural/regional context. Additionally, participants request to incorporate recent arrivals (refugees or migrants) into the regional data sets presented. Without filtering this data into smaller demographics/populations and/or smaller regional representation, service providers within the region are limited in their ability to collectively amass early intervention and culturally relevant responses to support residents.

- **Workforce Mental Health and Readiness**
  Participants highlighted the need to examine mental health challenges within the workforce and explore linkages between school-based supports (such as IEPs) and readiness for employment. Employer-based mental health programs were suggested to normalize help-seeking and reduce stigma in professional environments.

- **Access and Equity Barriers Prevent Community Members from Seeking Care**
  Stigma was identified by participants as a major barrier related to seeking out and receiving behavioral health care. Community members also voiced challenges in receiving care in a timely manner, with contributing factors of mistrust of institutions, lack of transportation, language barriers, and costs (especially for rural, immigrant, unhoused, LGBTQ+, and communities of color). Individuals also shared service providers lack representation to reflect the many diverse cultural backgrounds and/or lived experience indicative of these highly impacted groups within the region.

- **Desire to Learn How Environmental Factors Correlate to Behavioral Health**
  The audience expressed a desire for more education about how environmental factors such as housing instability, socioeconomic hardship, COVID-19's lasting impact influence these behavioral health data sets. In particular, there was a desire to better understand how these conditions intersect with the shared data reflective of behavioral health challenges, including mental health risks, high suicide rates among specific groups (older men, LGBTQ+, veterans), and substance use overdose trends (e.g., fentanyl, cannabis).

Audience Recommendations

- **Expand Culturally Appropriate Behavioral Health Interventions**
  Participants shared the need to build trust and cultural relevance into all behavioral health programs. Design programs and services with cultural practices at the forefront. Including individuals with lived experience can ensure programs reflect real-life perspectives. Partner with community members for representation of cultures and experience, reduce stigma, and increase engagement.

- **Strengthen Key Community Partnerships**
  Improve early detection by working with trusted local programs, schools, parents, and caregivers to spot behavioral health needs sooner. This is inclusive of culturally sensitive practices that can make prevention more effective.

- **Focus Data to Subregional Approach**
  Use data-driven, prevention-focused strategies whenever possible to divide the region into smaller subgroups or subregions and align interventions with the specific needs of each group. Define and share clear prevention metrics that can support the community to take proactive steps and reduce reliance on crisis-driven approaches.

- **Advance Workforce Mental Health Initiatives**
  Explore programs that address mental health challenges in workplace settings and strengthen linkages between school-based supports (such as IEPs) and workforce readiness. Develop employer-based mental health programs to normalize help-seeking and reduce stigma in professional environments. Engage local employers in collaborative planning to align strategies with workforce needs.

- **Enhance Substance Use Monitoring and Communication**
  Improve classification and reporting of overdose and substance-related incidents, reconcile perceived fentanyl trends with data, and include clear explanatory notes in future presentations. Collect and analyze community feedback on Narcan use by non-health professionals. Create a public dashboard to track substance use trends and prevention efforts over time.

- **Additional Goals: Engagement in Schools and Social Connections**
  For the State's "Additional Goal," the audience identified two main areas they would like to see prioritized regarding the local County performance on population-level goals vs. the State. These two measures leaned heavily to include the data reflective of "*Engagement in Schools,*" as well as "*Social Connections.*"

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report highlights key learnings and recommendations from a virtual session held on August 12, 2025, where members of AAP-CA3's Strategic Behavioral Health Initiative shared insights to help shape the Youth Optimal Care Pathways (OCP) and Behavioral Health Services Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	Youth Optimal Care Pathways Discussion with AAP-CA3's Strategic Behavioral Health Initiative
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** Tuesday, August 12, 2025, **Time**: 12:00 pm – 1:30 pm **Location:** Zoom
Participation	90 min virtual session: • 20 attendees • 4-5 discussion questions • Input through open discussion, Zoom chat, and Mentimeter

Summary of Engagement Activity

On August 12, 2025, the Behavioral Health Services (BHS) Communication and Engagement team hosted a virtual Youth Optimal Care Pathways (OCP) input session with pediatricians, medical professionals, and community stakeholders from the American Academy of Pediatrics, California Chapter 3 (AAP-CA3) – Strategic Behavioral Health Initiative (SBHI). The Youth OCP model aims to strengthen behavioral health services for children, youth, and transition-age youth (ages 0–25) by addressing service gaps, promoting early intervention and prevention, and ensuring services are aligned with community needs. This session was also designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 20 participants in attendance represented funders, policy makers, healthcare providers, and community organizations focused on advancing child, youth, and family health in San Diego County.

Participating Organizations Included:

- Alliance Healthcare Foundation
- Policy & Innovation Center (PIC)
- American Academy Pediatrics-CA3 Strategic Behavioral Health Initiative
- YMCA of San Diego
- San Diego Community Health Improvement Partners (SD CHIP)
- McAlister Institute
- Harmonium
- Retired SDCC
- Vista Hill
- Children's First Collective
- Price Philanthropies
- San Diego for Every Child
- Rady's Children's Hospital
- KidSTART Center at Rady Children's Hospital

Dr. Nicole Esposito, BHS Chief Population Health Officer, opened the session by highlighting SBHI's significant achievements and introducing the development of the Youth OCP model. Following this overview, a 45-minute discussion was facilitated by BHS through questions informed by previous research by AAP-CA3's SBHI. Input was gathered through open dialogue, Zoom chat, and Mentimeter, fostering an engaging and collaborative discussion that included perspectives on state-level prevention priorities, funding barriers within the care system, opportunities for community hub models, and challenges with school district Fee Schedule adoption for behavioral health services. The session closed with BHS outlining next steps, including continued stakeholder engagement and integration of community feedback into upcoming planning efforts. Insights from this session will inform both the Youth OCP Framework and the County's first BHSA Integrated Plan.

Input Session Questions:

1. What prevention opportunities would you prioritize for us to collectively advocate for adoption at the State level?
2. Which parts of the care continuum are more vulnerable to payer roadblocks?
3. What Community Based Organizations (CBOs) have adopted a hub-like model with shared administration similar to an integrated practice association? What other technical/ operational needs among CBOs that still need to be resolved for them to achieve successful outcomes in such a model?
4. What barriers/concerns are you aware of among school districts that have yet to adopt the Fee Schedule? How can we encourage more districts to opt in?

Key Learnings

- **Early Childhood and Caregiver Support Must be Prioritized**
  Participants highlighted that young children (ages 0 to 5) as well as their caregivers are often left out of prevention frameworks, even though caregiver mental health directly shapes child outcomes. Individuals pointed to universal behavioral health and developmental screening in pediatric care, early childhood mental health (ECMH) consultation in childcare and preschool settings, and reflective supervision for providers as essential strategies to strengthen families and prevent workforce burnout.

- **Technology and Social Media are Fueling Rising Behavioral Health Needs in Youth**
  Smartphones and social media contribute to isolation, anxiety, and behavioral health related concerns. Participants called for both policy restrictions (e.g., delayed access, school-based phone limits) and broader efforts such as parent education and public messaging campaigns to shift norms. They also emphasized the protective role of in-person connection through outdoor activities, arts, and sports while raising concerns that inequitable access leaves many low-income families without these critical supports.

- **Pediatricians are Central, but Overburdened, Entry Points for Behavioral Health**
  Families often turn to pediatricians first, but providers reported being overwhelmed by demand and limited by payer carve-outs, meaning certain behavioral health services are managed separately by insurers or managed care plans, which creates extra steps and delays for families. Participants noted that without stronger integration with schools and community-based organizations, pediatricians cannot consistently connect children to timely behavioral health care.

- **Workforce Shortages, Payer Restrictions, and System Gaps Contribute to Access Barriers**
  Participants described persistent challenges in recruiting and retaining qualified behavioral health specialists, particularly for substance use and mild-to-moderate needs. Limited reimbursement for prevention and specialty services further fragments the continuum of care, producing inequities and delays in timely access.

- **Collaborative Hub-and-Spoke Models Show Promise but Require Stable Infrastructure**
  Participants pointed to models such as the San Diego Wellness Collaborative and AAP-CA3 First Steps, which reduce administrative burdens, strengthen contracting, and support shared referral systems. However, they emphasized that these approaches only work if supported by stable funding, robust data systems, and neutral backbone organizations that safeguard data and ensure cross-system coordination.

- **Many School Districts Lack the Capacity to Implement the Fee Schedule Directly**
  While some larger school districts can bill directly under the Medi-Cal Fee Schedule, most small and mid-sized districts lack the administrative infrastructure, staffing, or financial resources to do so. Participants emphasized that partnerships with community-based organizations (CBOs) help schools expand behavioral health access without operating as full-service providers, but long-term sustainability depends on adequate reimbursement rates, workforce pipelines, and alignment with managed care systems. Without this support, schools remain hesitant to take on the administrative and operational burdens of direct billing.

Audience Recommendations

- **Advocate for Early Childhood and Caregiver Mental Health**
  Participants shared the need to advance a statewide prevention strategy that prioritizes early childhood and caregiver mental health. Additionally, individuals voiced their desire to increase funding for dyadic and family-centered interventions. Community members advocate to provide mental health supports for caregivers as well as implement universal screening to ensure early interventions are holistic, developmentally appropriate, and reduce behavioral and developmental risks for children.

- **Advocate for Policy & Data Collection on Youth Smartphone Use**
  Create consistent statewide policies and collect data on youth smartphone use. Set clear limits on smartphone use during the school day while on school campus. Support these limits with parent education campaigns to delay when kids get personal devices. Track results to show what works and guide wider adoption.

- **Expand Equitable Access to Enrichment and Connection Opportunities**
  Utilize outdoor play, arts, music, sports, and camps as key prevention strategies whenever possible. Provide dedicated funding to ensure low-income families and under-resourced districts can access these programs. Support social-emotional development, build relationships, and strengthen resilience through these activities. In the future BHSA framework, prevention funding will no longer be under local control as these funds will be allocated to the state level under California Department of Health Care Services (DHCS). Additionally, funding dedicated to early intervention must meet certain criteria to primarily reach those with clinical early indicators or clinical risk of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

- **Integrate Pediatric Care, Schools, & Community in a Gateway to Behavioral Health**
  Strengthen cross-system integration by including pediatricians as key partners. Provide resources to help pediatricians serve as effective entry points for behavioral health. Create formal referral pathways to schools and community-based organizations. Support these efforts with structured cross-sector collaboration and training.

- **Expanding Access Through Workforce and Community Partnerships**
  Reduce payer and workforce barriers while supporting sustainable community-based organization (CBO) models. Expand Medi-Cal reimbursement to non-licensed roles under supervision. Fund universal behavioral health screening for children and caregivers. Invest in a pediatric workforce pipeline. Support hub-and-spoke models with backbone organizations to manage contracts, align reimbursement rates with CBO costs, and strengthen school-community partnerships.

- **Integrate Cultural Practices and Data Sharing to Better Inform Care Continuum**
  Promote culturally responsive, community-informed practices and robust data systems. Behavioral health programs should pair evidence-based interventions with culturally responsive, community-informed approaches. Neutral coordinating entities should facilitate shared referral pathways, administrative support, data security, and cross-system data sharing to improve service coordination, guide planning, and ensure equitable access for youth and families facing systemic barriers.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the August 13, 2025, input session with caregivers, family members, and National Alliance on Mental Illness (NAMI) staff who support youth when faced with behavioral health challenges. Reflecting on their lived experience, this audience informed the development of the Youth Optimal Care Pathways (OCP) framework, which aims to remove barriers, expand access, and ensure timely support for long-term youth wellness. Findings from this engagement will also be utilized to inform the County's Behavioral Health Service Act (BHSA) Integrated Plan (IP).

Section	Details
Engagement Title	NAMI Caregivers & Families Input Session
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** Wednesday, August 13, 2025 **Time:** 6:00 PM-7:30 PM **Virtual Location:** Zoom
Participation	**Participants:** • 15 attendees • 7 discussion questions • Comments submitted through Mentimeter and open discussion

Summary of Engagement Activity

On August 13, 2025, the County of San Diego, Behavioral Health Services (BHS) hosted a virtual Input Session co-facilitated in partnership with the University of California San Diego (UCSD) Health Partnership with caregivers, family members, and National Alliance on Mental Illness (NAMI) staff who support youth when faced with behavioral health challenges. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

The session began with brief audience introductions, followed by a high-level overview of data reflecting the behavioral health challenges faced by youth (ages 0 to 25), creating a shared understanding of the need for Youth Optimal Care Pathways (Youth OCP). Following a description and timeline of the intended Youth OCP framework, the BHS facilitation team turned over the discussion to UCSD to facilitate the seven scripted questions for audience members. UCSD provided a Mentimeter virtual platform to capture audience feedback during the discussion with the key stakeholders in attendance, as well as elicited conversation following each question from participants. The questions primarily focused on the audience's understanding of youth experiences concerning mental health and substance use challenges. Through discussion, the audience shared their suggestions on how to best engage youth, identified trusted spaces and what makes adult allies effective, and how to best support youth to access and continue accessing treatment and support. Additionally, the audience shared their collective thoughts and recommendations on improving the care experience for youth offering additional ways to support youth with their final recommendations.

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Input from this session will help inform specialty mental health and substance use disorder priorities, services, and investments in the region's first Behavioral Health Services Act (BHSA) Integrated Plan as well as inform the Youth Optimal Care Pathways (OCP) framework, ensuring that future behavioral health strategies and youth-focused supports (ages 0-25) reflect community-identified needs in San Diego County.

Input Session Questions:

1. What trusted spaces in your community do youth turn to when they're struggling or seeking out more information? What do you believe are the most effective ways of reaching youth about mental health/substance use?
2. In your opinion, what do you see as the greatest concerns for youth related to mental health and substance use today?
3. What might prevent youth experiencing mental health and/or substance use challenges from getting the help they need in your community?
4. Can any of you think of a time when you/someone you know received what you felt was high quality care from a doctor, clinician, therapist, or medical provider? What made that a quality experience?
5. Do you recall a time when you or someone you know needed care and didn't get it, or the experience wasn't so great? What were the factors that made it a negative experience?
6. How do you think your support circle, including friends, family, schools, and adult advocates, can better support youth experiencing mental health and/or substance use challenges?
7. If you had the chance to improve mental health and substance use services for youth, what would you change?

Key Learnings

- **Trusted and Relatable Connections are Critical for Youth Engagement**
  Youth most often turn to trusted adults with lived experiences, peers, and school counselors for mental health or substance use support. Locations where youth seek support also include wellness centers. Online interest-based groups and social media platforms (TikTok) hold value for their fast, relatable content despite recognition that sources are not always trustworthy.

- **Stigma, Fear of Judgment, and Lack of Awareness Remain Major Barriers**
  Youth may avoid seeking help due to cultural stigmas, fear of being judged or "outed," feelings of being a burden, confidentiality concerns, or a general lack of knowledge of existing resources.

- **Culturally Appropriate Care Yields Best Results for Families and Youth**
  High-quality care is defined by respect, cultural understanding, and empowerment. Families and youth valued providers who listened without judgment offered choices while respecting their individual identities as well as cultural backgrounds.

- **Stress-Related Pressures are the Dominant Mental Health Concern for Youth**
  Participants repeatedly identified stress as a central issue affecting youth, often alongside academic pressure, trauma, anxiety, and financial problems. They also pointed to isolation, weakened friendships, and the impact of strained or disrupted supportive relationships as contributing factors to youth stress. Participants raised concern about increasing rates of suicide, rising substance use across multiple substances, and the ease of accessing substances as compounding these pressures. Additional stressors named included housing instability and homelessness particularly the lack of support after youth turn 18 as well as challenges faced by neurodiverse and LGBTQIA+ youth, including lack of appropriate or affirming care. Together, participants described a landscape in which multiple overlapping stressors are affecting youth mental health and increasing vulnerability to substance use.

- **Empowering Youth Through Honest Dialogue: Respect, Clarity, and Real Voices**
  Individuals emphasized that youth respond better when they are spoken to plainly and honestly rather than through scare-based or punitive approaches, explicitly noting “not DARE” as an example of what does not work. They stressed the importance of not talking down to youth or trying to “find their level,” and instead being forthright while treating youth like adults so they feel respected. Participants also highlighted that information should be easy to access, clearly stated, and shared without judgment, and that engagement increases when youth see real people such as peers, young adults, role models, or people with lived experience talk openly about mental health and substance use through videos, social media, or group conversations

- **Words Matter: Let’s Talk About Mental Health and Substance Use**
  Participants emphasized that youth are often unaware that what they are experiencing is a mental health or substance use challenge until someone else names it, noting that “exposure to the topics” helps put words to struggles youth may otherwise internalize or dismiss. Participants highlighted schools and families as key settings for this exposure, pointing to proactive discussions in classrooms, school wellness spaces, and at home as opportunities to normalize these conversations.

Audience Recommendations

- **Expand Youth Centered School Wellness Supports**
  Participants shared the need to embed proactive, culturally competent supports in schools and community spaces that are co-designed by youth to make them less intimidating. Expand wellness centers to provide accessible support. Develop peer-led programs to give youth opportunities to connect and help each other. Implement evidence-based initiatives directly in schools to serve as reliable resources for youth and parents.

- **Reduce Stigma with Trusted Voices**
  Normalize open conversations and reduce stigma through the voices of those with lived experience. Train and involve trusted adult allies, peers, and role models able to share their personal experiences and foster safe discussions.

- **Improve Equitable and Inclusive Access to Care**
  Reduce barriers by making sure services are covered by insurance, available in multiple languages, while meeting the needs of neurodivergent communities and establishing youth-informed quality standards.

- **Normalize Mental Health and Substance Use Through Proactive Education**
  Integrate ongoing, proactive conversations about mental health and substance use into schools, families, and community settings, as participants emphasized that youth often do not recognize their struggles until they are named. Exposure to these topics helps youth develop language for their experiences and increases awareness of when and how to seek support.

- **Support Adults to Proactively Engage and Follow Up with Youth**
  Equip parents, caregivers, educators, and adult advocates with tools to consistently initiate conversations and check-ins, as participants emphasized that youth benefit when adults reach out repeatedly rather than waiting for youth to ask for help. Training should emphasize asking open-ended questions, offering specific support, and maintaining follow-up.

- **Address Structural Stressors That Compound Mental Health Challenges**
  Design services and cross-system collaborations that respond to the stressors participants named, including academic pressure, housing instability, financial strain, isolation, and lack of support after age 18. Participants highlighted the need for coordination across education, housing, health, and re-entry systems to reduce overlapping stressors that worsen mental health and substance use outcomes.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the August 14, 2025, collaborative planning session between the San Diego Refugee Communities Coalition (SDRCC), the California Pan-Ethnic Health Network (CPEHN), Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	Behavioral Health Services Act Discussion with San Diego Refugee Communities Coalition & California Pan-Ethnic Health Network
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date**: Thursday, August 14th, 2025 **Time**: 1:00 PM – 2:30 PM **Virtual Location:** Zoom
Participation	90-Minute Engagement: • 20 community members and County staff • 4 discussion questions supported by Zoom chat and open discussion

Summary of Engagement Activity

On August 14, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) unit collaborated with the San Diego Refugee Communities Coalition (SDRCC) and the California Pan-Ethnic Health Network (CPEHN) to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Participating Organizations Included:

- California Pan Ethnic Health Network
- San Diego Refugee Communities Coalition
- UCSD Center for Community Health (CCH)
- Karen Organization
- Horn of Africa
- Slavic Refugee and Immigrant Services
- Haitian Bridge Alliance, Inc
- Partnership for the Advancement of New Americans (PANA)
- United Women of East Africa
- Majdal: Arab Community Center of San Diego

The session began with a welcome from BHS C&E followed by a round of introductions from audience members. BHS staff then provided an overview of BHSA and its impact on BHS activities, followed by the BHS staff overviewing behavioral health data, including information on self-harm, suicide, overdose, and substance use.

After the data presentation, audience members participated in discussions led by the BHS C&E team. These conversations focused on identifying key disparities in mental health and substance use outcomes, exploring barriers, and generating ideas on how the County and community can work together to improve mental health and wellbeing. The session ended with attendees sharing final reflections and casting a vote on "Additional Goals," from the State's predetermined list of measures to share what they would like prioritized in future data workshops. This community input will help inform specialty mental health and substance use disorder services, priorities, and investments in the region's first BHSA Integrated Plan.

Input Session Questions:

1. What do you consider the biggest health disparity or difference in health outcomes when it comes to mental health/substance use in this region/among this community, from the information shared?
2. What factors do you feel contribute to these health disparities/gaps? From your perspective, are there certain populations or communities more impacted than others?
3. How can the County and community work together to address these disparities or gaps to improve mental health and well-being?
4. Cast a vote for what you would like the County to focus on for our future behavioral health data sets that we share in the future.

Key Learnings

- **Need for Culturally Responsive and Representative Services**
  Participants emphasized the need for more culturally responsive services, including diverse representation among providers, greater language accessibility, and awareness of cultural perspectives. Distinct cultural considerations within immigrant and refugee communities were also highlighted as requiring tailored approaches.

- **Desire for Simplified and Standardized Access to Care**
  Community members frequently noted the need for more straightforward and standardized access to services, so individuals don't feel like they are "jumping through hoops." Barriers such as complex system navigation, high costs/unknown insurance coverage, and physical access challenges were identified as key obstacles that should be reduced to make support easier to obtain.

- **Intergenerational Attitudes and Stigma Serve as Barriers**
  The audience highlighted the influence of intergenerational attitudes toward behavioral health, noting that youth are often impacted by the beliefs and stigma held by parents and elders. This gap in understanding and openness within the home can create barriers for youth in seeking support and discussing their mental health needs.

- **Lack of Healthy Coping Skills May Lead to Substance Use**
  Participants expressed concern about persistent substance use and overdose challenges, noting that overdose data remains disheartening and that a lack of healthy coping mechanisms may be pushing some community members toward substance use. Substance use stigma, especially within faith-based and newcomer communities, makes it difficult to address the issue openly.

Audience Recommendations

- **Engage Trusted Messengers and Community Liaisons**
  Participants shared the need to engage trusted messengers or community liaisons who represent specific cultures instead of relying on outsourced interpreter services. Hire culturally knowledgeable representatives within organizations can build trust. Ensure accurate communication by using staff who understand the community. Foster stronger connections with the communities being served through these embedded representatives.

- **Expand Language Access and Train Community Organizations**
  Increase access to services and resources by offering them in multiple languages and training community organizations through a train-the-trainer approach. Simplify the process of getting help by partnering with local groups to share behavioral health information. Additionally, support residents in accessing these resources by providing access points in trusted locations where formal systems have limited reach. Hire dual-role staff (e.g., front desk + interpreter) and bilingual providers to build trust and improve service delivery.

- **Create Safe and Culturally Grounded Spaces for Dialogue**
  Promote spaces that normalize and destigmatize mental health by treating it as equally important as physical health. Focus on home and family environments to address intergenerational, religious, and cultural influences that shape attitudes toward behavioral health.

- **Normalize Mental Health and Promote Whole-Person Health**
  Provide regular mental health “check-ins” and treat mental health with the same importance as physical health. Combine mental health support with fitness programs, YMCA memberships, exercise opportunities, or community clubs to make care more approachable and reduce stigma. Connect behavioral health care with broader social needs, such as safety, affordability, and overall well-being, to support holistic, preventive approaches that address the whole person.

- **Additional Goals: Care Experience and Engagement in Schools**
  For the State's "Additional Goal," the audience identified a focus on one main area they would like to see prioritized regarding the local County performance on population-level goals vs. the State. This measure included the "Care Experience," specifically, they would like to learn about the care experience related to the cultural experience in this measure. The only additional measure the audience mentioned a slight interest in was "Engagement in Schools," but overwhelmingly, the audience was primarily focused on the "Care Experience."

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the September 3, 2025, collaborative planning session between the *Live Well San Diego* (LWSD) North County Region Leadership Team, Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHS Data Presentation for LWSD North County Community Leadership Team Meeting
Format	☒ In-person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Wednesday, September 3, 2025 **Time:** 10:00 AM-12:00 PM **Location:** North Inland Live Well Center at 649 W Mission Ave Escondido, CA 92025
Participation	90-Minute Engagement: • 105 community members and County staff • 10 break out groups • 4 questions with facilitated open discussions

Summary of Engagement Activity

On September 3, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) team and BHS Population Health Unit collaborated with the Live Well San Diego North County Region Leadership Team to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 105 participants attended the data presentation, including the Leadership Councils members. Organizations in attendance represented a broad network of stakeholders spanning healthcare and behavioral health providers, educational institutions, local government agencies, community-based and faith-based organizations, social service and workforce programs, public safety, housing and food security initiatives, and advocacy groups serving diverse regional populations.

Participating Organizations Included:

- Southern Caregiver Resource Center
- Student, San Diego State University
- San Diego Sheriff
- Union of Pan Asian Communities
- County Of San Diego (COSD), Office of Labor Standards and Enforcement (OLSE),
- San Diego Food Bank
- Planned Parenthood
- Drug Free Escondido
- Lifeline Community Services
- Neighborhood Healthcare
- Fallbrook Regional Health District
- City of Oceanside
- University of California San Diego (UCSD), Moores Cancer Center
- Fresh Start Surgical Gifts
- Oceanside Library
- Feeding San Diego, Feeding Seniors
- Blue Shield of California
- Community Resource Center
- Foundation Mixtecos Unidos
- University of California, San Diego (UCSD), Grad Student
- Universidad Popular
- ComForCare, Homecare & Senior Care Services
- Premier Ambulance
- Neighborhood House Association
- City of Carlsbad
- California Department of Rehabilitation
- San Ysidro Health Center
- Exodus Recovery
- Fresh Start
- United States Marines
- True Care
- San Diego Innovation High School
- Interfaith Community Services
- Latino 247 Media Group LatinoLYTICS
- Getting Education Done
- Vista Community Clinic
- Education Begins in the Home
- Community Health Systems INC
- California Department of Healthcare Services
- Drug Free Escondido, COMPACT
- California State University San Marcos
- Pacific Housing, Inc.
- Interfaith Services
- Equation Collaborative
- Educational Enrichment Systems
- Project Next
- Fallbrook Union High School District
- Operation Hope North County
- Jar Insurance
- YMCA SD
- Family Health Centers San Diego (FHCSD)
- PATH
- TURN Behavioral Health Services
- EQUUS Workforce Solutions
- Alliance for Regional Solutions

The session began with C&E providing an overview of BHSA and its impact on BHS activities, followed by the BHS Population Health Unit sharing state and regional behavioral health data, including information on self-harm, suicide, overdose, and substance use. Following the presentation, community members participated in small-group discussions facilitated by the C&E team, focusing on disparities in mental health and substance use outcomes, barriers to care, and opportunities for collaboration between the County and community to enhance wellbeing. The session ended with attendees sharing final reflections and casting a vote on "Additional Goals," from the State's predetermined list of measures to share what they would like prioritized in future data workshops.

Input Session Questions:

1. What do you consider the biggest disparity or difference in health outcomes when it comes to mental health/substance use in this region, from the data shared today?
2. What factors do you feel contribute to these disparities/gaps? From your perspective, are there certain populations or communities more impacted than others? (What are barriers for people getting the support they need - consider access, cultural norms/traditions, etc.).
3. How can the County and community work together to address these disparities or gaps to improve mental health and wellbeing? (Consider available resources, existing programs/services, accessible information, trusted members of the community, etc.).
4. Cast a vote for what you would like the County to focus on for future behavioral health data sets.

Key Learnings

- **Breaking Barriers: Tackling Everyday Challenges to Behavioral Health Access**
  The audience expressed concern around social determinants of health that directly shape access to behavioral health services. Environmental factors such as balancing basic needs with competing wellbeing priorities, the high cost of living, and limited transportation — including the lack of age-friendly options — were seen as prominent barriers. Location-based accessibility challenges, particularly in rural areas, further compound disparities, while costs tied to insurance coverage and shifting political priorities add instability and stress. Participants noted that these factors often create a ripple effect, where financial strain and unmet basic needs heighten behavioral health challenges while also limiting the ability to seek timely care.

- **Military-Affiliated Populations Are Underrepresented**
  Community members voiced concern that military-affiliated individuals are not adequately reflected in regional mental health data or outcomes. Participants emphasized the need for better visibility, representation, and understanding of this group's unique treatment access, utilization, and challenges to ensure tailored support.

- **Access, Equity, and Regional Gaps Limit Support**
  Sociocultural barriers, including stigma by age, gender, and culture, as well as language differences, limit care-seeking. Rural and semi-rural areas face limited services and long wait times, while even affluent communities like Carlsbad show unexpected disparities. Across the region, transportation, digital literacy, provider shortages, and lack of culturally responsive services restrict timely and equitable access.

- **Older Adults, Youth, and LGBTQIA+ Face the Highest Risk and Impact**
  Community members noted the high impact on older adults across the regions mental health data, particularly in relation to serious mental illness, emergency department visits, and death rates. This was followed by a concern for the high trend of impact amongst youth, foster youth, and LGBTQIA+ identifying youth across mental health and substance use regional data. There was a desire to further understand age disparity and differences in outreach amongst youth and senior populations.

Audience Recommendations

- **Expand Access and Flexibility Across Channels**
  Participants shared the need to expand access to mental health and substance use services by meeting people where they are—physically, culturally, and digitally. Use mobile units, after-hours programs, peer-led groups, multilingual resources, digital tools, and non-digital community programs to reach more people. Focus outreach on seniors, youth, and marginalized populations in both rural and urban areas. Reduce service deserts and minimize long wait times for increased access to care.

- **Integrate Basic Needs and Social Determinants into Care**
  Address the root social and structural causes of mental health challenges by integrating behavioral health care with support for housing, food, insurance, and financial stability. Design programs that consider the "domino effect" of financial strain, isolation, and stress. Ensure services are culturally competent, identity-affirming, and tailored to the needs of specific communities, including LGBTQIA+, immigrant and refugee, and military populations.

- **Strengthen Partnerships, Cultural Competence, and Data-Driven Targeting**
  Invest in local partnerships whenever possible with schools, faith-based organizations, community programs, parents, and caregivers to deliver trusted, community-rooted services. Build culturally responsive programming, train providers in cultural competence, and embed trusted messengers to reduce stigma.

- **Additional Goals: Engagement in Schools and Social Connections**
  For the State's "Additional Goal," the audience identified two main areas they would like to see prioritized regarding the local County performance on population-level goals vs. the State. These two measures included "*Engagement in Schools,*" as well as "*Social Connections.*"

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the October 1, 2025, collaborative planning session between the *Live Well San Diego* (LWSD) South Region Community Leadership Team, Behavioral Health Services (BHS), and community members, focusing on mental health and substance use data, key challenges, and program planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHS Data Presentation for LWSD South Region Community Leadership Team Meeting
Format	☐ In-person ☑ Virtual ☐ Hybrid
Activity Details	**Date:** Wednesday, October 1, 2025 **Time:** 9:30 AM-10:30 AM **Location:** Microsoft Teams

Participation	60-minute Engagement:
	• 33 community members and County staff
	• 4 questions with facilitated open discussions
	• Approximately 70 comments received
	  ○ Approximately 45 comments via Microsoft Whiteboard
	  ○ 25 comments through open discussion

Summary of Engagement Activity

On October 1, 2025, the Behavioral Health Services (BHS) Communication & Engagement (C&E) team and BHS Population Health Unit collaborated with the Live Well San Diego South Region Community Leadership Team's Behavioral & Mental Health Workgroup to engage community members in collaborative planning under the new Behavioral Health Services Act (BHSA), a California state initiative. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 33 participants attended the session, including the South Region Community Leadership Teams members, representatives from community-based organizations, government and non-government agencies.

Participating Organizations Included:

- Harmonium
- PACEs Connection
- Parenting EQ
- Rotary
- BrightLife Kids
- Molina Healthcare of California
- San Diego County Library
- Department Of Rehabilitation
- Senior Tech Support
- Episcopal Community Services
- Independent Living Association (ILA)
- San Diego Community Health Improvement Partners (SD CHIP)

The session began with C&E providing an overview of BHSA and its impact on BHS activities, followed by the BHS Population Health Unit sharing state and regional behavioral health data, including information on self-harm, suicide, overdose, and substance use. After the presentation, community members joined a virtual discussion led by the C&E team. This conversation focused on identifying key disparities in mental health and substance use outcomes, exploring barriers, and generating ideas on how the County and community can work together to improve mental health and wellbeing. Audience comments were transcribed to Microsoft Teams Whiteboard sticky notes from verbal responses and Microsoft Teams written comments as a mechanism to capture session feedback. The session ended with attendees sharing final reflections and casting a vote on "Additional Goals," from the State's predetermined list of measures to share what they would like prioritized in future data workshops.

Input Session Questions:

1. What do you consider the biggest disparity or difference in health outcomes when it comes to mental health/substance use in this region, from the data shared today?
2. What factors do you feel contribute to these disparities/gaps? From your perspective, are there certain populations or communities more impacted than others? (What are barriers for people getting the support they need - consider access, cultural norms/traditions, etc.).
3. How can the County and community work together to address these disparities or gaps to improve mental health and wellbeing? (Consider available resources, existing programs/services, accessible information, trusted members of the community, etc.).
4. Cast a vote for what you would like the County to focus on for future behavioral health data sets.

Key Learnings

- **From Outreach to Impact: Strengthening Community Connections**
  In comparison to other regions, the audience felt that the South region faces a unique barrier in terms of population specific engagement, specifically how to bridge targeted outreach efforts and services (free health education and digital health education classes) to their intended audience (senior populations and lower income populations) to increase service usage and event attendance. The group, by large part, indicated that many community members were unaware of these programs and services and that navigators or trusted messengers would be imperative to bridge this gap.

- **Need for Improved Access, Equity, and Relationship Building to Reduce Barriers**
  Sociocultural barriers in the region include topic-based stigma, stigma related to power imbalances, cultural differences, language barriers, and lack of trust and empathy. The audience focused discussion on an increased demand for building trust with community members by bringing services and education directly to community members, eliminating as many accessibility barriers as possible.

- **Digital Literacy and Connectivity are Barriers to Older Adults in South Region**
  Participants emphasized the importance of tailoring approaches to serving aging, older adults, and senior populations in the South region. Discussions highlighted the growing importance of digital connectivity and digital literacy as key factors in maintaining social connection, access to services, and overall mental well-being. Ultimately, technology can serve as a barrier to accessing behavioral health services because of challenges getting online and navigating these resources.

- **Supporting Youth Well-Being Through Tailored Approaches**
  The audience recognized the importance of tailoring approaches to serve youth and young adult populations in the South region. Discussions included developing messaging in consideration of the mental well-being of youth along the age spectrum beginning from early childhood to young adulthood and highlighted the significance of safe spaces and trusted peers when accessing support.

Audience Recommendations

- **Improve Clarity on Data and Representation**
  Participants shared the need to provide clear guidance on how data, policies, and research shape regional behavioral health services. Clarify the differences between prevention and early intervention. Integrate emerging research and frameworks into County planning. Communicate how upcoming policy or funding changes will affect service access and eligibility across communities.

- **Address Policy Changes and Program Implementation**
  Evaluate which programs and resources in the South region will continue once the Behavioral Health Services Act (BHSA) takes effect. Support solutions-oriented programs that show positive results, such as using Community Health Workers for outreach and education. Participate in Community Collaborative meetings that can strengthen peer networks.

- **Expand Future Approaches and Solutions**
  Include lived experience and survivor-led voices in service design and delivery of behavioral health programs and services. Center equity-led policies and integrate equity principles across all behavioral health systems. Prioritize comprehensive, holistic approaches by using a socio-ecological model and strengthening care management practices to address disparities and improve mental health and overall well-being.

- **Additional Goals: Quality of Life and Social Connections**
  For the State's "Additional Goal," the audience identified two main areas they would like to see prioritized regarding the local County performance on population-level goals vs. the State. These two measures included "*Quality of Life,*" as well as "*Social Connections.*"

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the Monday, October 13, 2025, input session between the County of San Diego Behavioral Health Services (BHS), the Behavioral Health Advisory Board (BHAB), Continuum of Care (CoC) stakeholders, and community members, to examine how the Behavioral Health Services Act (BHSA) can support and strengthen pathways across the CoC for children, youth, and adults impacted by alcohol and other drugs.

Section	Details
Engagement Title	BHAB Pathways to Continuum of Care for Children, Youth, and Adults Impacted by Alcohol and Other Drugs Subcommittee Listening Session
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Monday, October 13, 2025 **Time:** 3:00 PM-4:30 PM **Location:** Zoom

Participation	90-minute Engagement:
	• 13 attendees
	• 2 breakout rooms
	• 5 discussion questions
	  ○ 53 Comments submitted through Mentimeter
	  ○ 78 Comments through open discussion

Summary of Engagement Activity

On Monday, October 13, 2025, the County of San Diego Behavioral Health Services (BHS), in partnership with the University of California San Diego (UCSD) Health Partnership, hosted a virtual input session during the BHAB Pathways to CoC for Children, Youth, and Adults Impacted by Alcohol and Other Drugs Subcommittee meeting. The session aimed to gather input to improve access, coordination, and engagement across the substance use disorder (SUD) continuum of care and inform the BHSA 2026-2029 Integrated Plan draft.

Approximately 13 participants attended, including six (6) BHAB members and representatives from recovery service providers, youth and family support programs, wellness programs, housing programs, advocacy and trauma-informed groups, and local government representatives. Participants brought perspectives from clinical practice, lived experience, family advocacy, and systems navigation.

Participating Organizations Included:

- Genesis Recovery
- REACH San Diego
- Harmonium
- Firepit Wellness
- East County Transitional Living Center
- PACEs Connection
- The City of Lemon Grove

The 90-minute virtual session included a 15-minute overview of BHSA, followed by a 55-minute discussion facilitated by the UCSD Health Partnership. Feedback was collected through Mentimeter (53 written comments) and verbal discussion (approximately 78 comments) across five key questions related to care coordination, community outreach, and innovation in service delivery.

Input Session Questions:

1. Within the substance use disorder (SUD) continuum of care, what specific gaps/barriers do you see helping people navigate or access these services?
2. How can BHS improve community outreach & messaging to help individuals and families affected by SUD better understand and access available services?
3. While funding and flexibility are limited, what creative/practical ideas would you suggest to help connect people easily to the right level of care?
4. What would make it easier and more meaningful for consumers, families, and partners to join SUD discussions (i.e., meeting formats, timing, supports)?
5. Looking across the SUD continuum of care, what needs or priorities would you most want BHS to keep in mind?

Key Learnings

- **SUD Treatment System is Fragmented and Lacks Coordination Between Providers**
  Participants described the SUD system as fragmented, with limited coordination and inconsistent warm handoffs between detox, residential, outpatient, and Medication Assisted Treatment (MAT) services. Long wait times, insurance barriers, and disconnected systems further delay care and contribute to service gaps and relapse risks.

- **Housing Insecurity is a Barrier to Recovery**
  Housing insecurity was identified as a critical barrier to recovery. Participants emphasized that treatment success and sustained recovery depend on safe and stable housing. Attendees called for housing to be integrated as a fundamental part of the care continuum.

- **Mistrust and Stigma Prevent Individuals from Seeking Care**
  Stakeholders shared that mistrust and stigma continue to prevent individuals and families from seeking help or engaging with County behavioral health services. Attendees identified peer-led outreach and trauma-informed engagements as key strategies to rebuild trust and normalize seeking help.

- **Need for Consistent Workforce Development and Quality Oversight**
  Audience members noted inconsistencies in provider training, cultural responsiveness, and service quality. Gaps in trauma-informed care and empathy contribute to negative client experiences. Participants called for stronger workforce accountability, standardized training, and trauma informed practices to ensure consistency and quality across the SUD system.

- **Community Engagement Needs to be Bi-Directional**
  Attendees expressed that community engagement often feels one-way and lacks follow-up. The audience recommends more interactive, discussion-based forums that include lived experience voices and provide clear feedback loops showing how community input shapes decision-making.

Audience Recommendations

- **Streamline Access and System Navigation to Help Clients Connect to Services**
  Participants shared the need to simplify how individuals enter and move through the substance use disorder (SUD) system. Create a single, centralized access point supported by trained navigators to connect clients quickly to services. Share real-time data between providers to ensure warm handoffs and maintain continuity of care across all levels of treatment and recovery.

- **Stable Housing is Essential to Recovery**
  Integrate stable housing supports directly into treatment and aftercare plans to sustain recovery. Strengthen collaboration between behavioral health providers, housing agencies, and case managers to ensure housing stability before, during, and after treatment, promoting better long-term outcomes.

- **Develop Culturally Relevant Communication in Building Trust to Reduce Stigma**
  Deliver communication and messaging that is empathetic, bilingual, and culturally grounded through trusted peers and community leaders. Launch public education campaigns across local media to increase awareness of services and promote acceptance of recovery and treatment.

- **Design Culturally Grounded, Family Inclusive Care**
  Create programs that reflect cultural values and include family in the recovery process. Partner with cultural organizations, provide translation and interpretation services, and address systemic barriers to ensure care is equitable, accessible, and responsive to diverse communities.

- **Strengthen Workforce Development and Quality Oversight**
  Bolster staff capacity and accountability by expanding training in empathy, trauma-informed care, and cultural humility. Implement consistent program oversight and standardize quality measures to ensure safety, professionalism, and equitable service delivery.

- **Expand Meaningful Community Engagement**
  Provide engagement opportunities at flexible times, in accessible locations, and through hybrid formats to increase community participation. Focus on dialogue instead of just presentations. Include facilitators with lived experience. Give clear follow-up on how feedback shapes County decisions. Maintain consistent, relationship-based engagements to build stronger community partnerships and trust.

- **Invest in Prevention and Early Intervention**
  Individuals urged the investment in early prevention and intervention strategies to spot behavioral health challenges sooner. Include prevention education in schools, community programs, and healthcare settings. Coordinate efforts with housing, social services, and family supports to address root causes before crises happen. Within the future BHSA framework, prevention funding will no longer be under local control as these funds will be allocated to the state level by the California Department of Health Care Services (DHCS). Additionally, funding dedicated to early intervention must meet certain criteria to primarily reach those with clinical early indicators or clinical risk of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the October 16, 2025, Behavioral Health Services Act (BHSA) Virtual Input Session at the Healthy San Diego Behavioral Health Operations Subcommittee meeting. The session engaged Medi-Cal Managed Care Plan representatives and key stakeholders to provide feedback on service access, data alignment, and cross-system collaboration to inform the County's first BHSA Integrated Plan (2026–2029).

Section	Details
Engagement Title	Behavioral Health Services Act (BHSA) Input Session at the Healthy San Diego Behavioral Health Operations Subcommittee
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Thursday, October 16, 2025 **Time:** 1:00 PM – 2:30 PM **Location:** Zoom
Participation	90-min discussion: • 30 attendees • 5 discussion questions • Nearly 70 comments submitted through Mentimeter and open discussion

Summary of Engagement Activity

On October 16, 2025, the County of San Diego Behavioral Health Services (BHS) and University of California San Diego (UCSD) Health Partnership hosted a BHSA virtual input session at the Healthy San Diego Behavioral Health Operations Subcommittee meeting. The subcommittee is a collaborative forum of County staff, Medi-Cal Managed Care Plans (MCPs), providers, and community partners that works to improve coordination, access, and quality of behavioral and physical health services for Medi-Cal members in San Diego County. The session gathered input on key operational and strategic priorities, including service access, data alignment, and cross-system collaboration, to inform the County's first BHSA Integrated Plan (2026–2029). Input session questions were tailored and developed based on guidance from the Behavioral Health Operations Subcommittee.

Approximately 30 participants attended, including representatives from MCPs, their Behavioral Health Plan Liaisons, Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Liaisons, and key County staff involved in behavioral health operations and planning.

Participating Organizations Included:

- Optum
- Blue Shield Promise
- Kaiser Permanente
- SCAN Health Plan
- Molina Healthcare of California
- Community Health Group
- Alcohol and Drug Services Providers Association (ADSPA)

The session began with an overview of BHSA, followed by a 50-minute discussion facilitated by UCSD Health Partnership. Nearly 70 comments were submitted through both Mentimeter and verbal discussion. Conversations centered on improving system navigation, coordination, and accountability between Medi-Cal Managed Care Plans (MCPs) and Behavioral Health Services (BHS). Participants emphasized the need for stronger data integration, dedicated care navigation roles, flexible community-based services, and innovative engagement strategies to better reach and support diverse populations.

Input Session Questions:

1. What opportunities exist to improve access and care navigation so members can more easily connect with the appropriate level of care early on?
2. Which populations face the greatest challenges in accessing or staying engaged behavioral health care, and how might we collaborate to close these gaps?
3. Where do you see opportunities to better align around these or other quality improvement initiatives, and how might we use this information together to support common goals?
4. How do these services intersect with behavioral health care, and where could stronger coordination help reduce separation and improve the member experience?
5. What opportunities exist to enhance collaboration for smoother coordination, better member experiences, and shared accountability between MCPs and the County?

Key Learnings

- **Improving Patient Navigation Through Integrated Crisis Lines and Data Sharing**
  Several participants noted that a more robust and integrated Access and Crisis Line would improve navigation. Participants also called for more real-time data sharing and communication between MCPs and BHS to identify which patients are in which system and to coordinate follow-up care after emergency department or inpatient discharge.

- **Building Stronger Links Between Agencies for Seamless Care**
  Participants supported the idea of dedicated navigators and expanded coordination meetings with the County to improve connections to services. Participants discussed shared consultation resources for high-need or complex individual cases and clearly defined points of contact between agencies. These measures aim to improve handoffs, reduce gaps in service, and ensure that individuals receiving care do not “fall through the cracks.”

- **Hard-to-Engage Populations Need Flexible Outreach**
  Participants identified specific groups that face the greatest barriers: transitional-age youth (TAY), foster youth, unhoused individuals, people in rural areas, and those lacking transportation or digital access. Participants brainstormed potential solutions including mobile and after-hours services, co-locating or providing care within community settings, and using peer and physical outreach with potential incentives for participation.

- **Aligning MCPs, BHS, and State Through Interoperable Data Systems**
  Stakeholders emphasized the importance of stronger alignment across Medi-Cal Managed Care Plans (MCPs), Behavioral Health Services (BHS), and the State to reduce duplication and streamline quality improvement efforts. They noted that each entity often works toward similar goals, but through separate processes and reporting systems. To address this, participants discussed creating interoperable data systems, technology that allows organizations to securely share information and track outcomes across programs.

- **Integrating ECM and CS to Reduce Fragmentation and Improve Care**
  Participants viewed Enhance Care Management (ECM) and Community Supports (CS) as integral parts of behavioral health care. MCPs emphasized that these services already help with transitions into and out of specialty mental health and substance use services. Community members highlighted the need for centralized contracting through BHS and cross-training providers to reduce fragmentation and improve member experience.

- **Desire for Expanded Collaboration Between MCPs and BHS to Address Behavioral Health Needs**
  MCPs appreciated existing monthly coordination meetings with BHS, but saw potential to deepen collaboration through joint review of member feedback, shared data analysis, and cross-agency problem-solving in multidisciplinary team environment. Several attendees mentioned building a “safe space” to surface challenges constructively, identify solutions, and foster shared accountability for outcomes.

- **Need for Innovation to Improve Engagement with Hard-to-Reach Populations**
  Participants suggested using creative outreach strategies, including social media, youth-led content, community events, and incentives to reach members who are harder to engage. They also discussed refining Access and Crisis Line scripts, investing in navigators, and ensuring members have a single, clear place to learn about available services.

Audience Recommendations

- **Enhance Member Education and Outreach**
  Participants recommended developing clear, consistent messaging to help members navigate the behavioral health system, including distinctions between MCP and County services. Joint trainings for outreach teams and leveraging trusted community channels were highlighted as points that can increase awareness and engagement.

- **Implement Dedicated Care Navigation Roles**
  Create navigator or “bridge” personnel to assist members in connecting across MCP and County systems, especially after emergency department visits or inpatient stays, improving continuity of care and reducing drop-offs.

- **Expand Flexible, Community-Based Services**
  Increase mobile and co-located services, after-hours appointments, and peer-led outreach to better reach underserved populations, including TAY, foster youth, unhoused individuals, and rural residents. Incentive-based engagement strategies were also suggested to boost participation.

- **Strengthen Data Sharing, System Integration, and Accountability**
  Establish interoperable data systems and real-time information sharing between MCPs and the County (BHS). Centralize contracting for ECM and Community Supports where feasible to improve alignment and reduce fragmentation across care pathways.

- **Clarify Roles, Responsibilities, and Accountability**
  Provide clearer guidance from DHCS on MCP and County scopes of services to minimize overlap and confusion. Utilize grievance data and member feedback to identify service gaps, coordinate improvements, and ensure accountability across systems.

- **Formalize Collaborative Structures and Communication Channels**
  Maintain monthly coordination meetings, create forums for joint problem-solving, and establish safe spaces for honest dialogue to address system challenges and develop actionable solutions.

- **Innovative Engagement and Feedback Strategies**
  Support youth-led campaigns, social media outreach, community events, and incentive programs tied to engagement metrics. Ensure stakeholders see how their input informs BHSA planning by providing transparent follow-up and closing the feedback loop.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the Friday, October 17, 2025, input session between members of the Hospital Association of San Diego and Imperial Counties (HASD&IC) and County of San Diego Behavioral Health Services (BHS), examining how the Behavioral Health Services Act (BHSA) will shape policies.

Section	Details
Engagement Title	Hospital Association of San Diego and Imperial Counties Listening Session
Format	☐ In-person ☒ Virtual ☐ Hybrid
Activity Details	**Date:** Friday, October 17, 2025 **Time:** 9:00 AM-10:00 AM **Location:** Zoom
Participation	60-min discussion: • Nearly 24 attendees • 6 discussion questions • 100 comments received: ○ 62 comments submitted through Mentimeter

Summary of Engagement Activity

On October 17, 2025, the County of San Diego Behavioral Health Services (BHS) hosted a listening session in collaboration with the Hospital Association of San Diego and Imperial Counties. The Hospital Association of San Diego and Imperial Counties (HASD&IC) is a non-profit organization representing 38 hospitals and integrated health systems in the two-county region that works to advance the interests of hospitals in San Diego and Imperial counties. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 24 participants attended the listening session, including the HASD&IC association members, hospital staff and representatives, community members from San Diego County, community members from Imperial County, and government and non-government agencies.

Participating Organizations Included:

- Paradise Valley Hospital – Bayview Crisis Stabilization Unit
- Rady Children's Health San Diego
- Rady Children's Hospital San Diego
- Scripps Health
- Alvarado Parkway Institute
- SHARP Chula Vista Hospital
- SHARP Grossmont Hospital
- SHARP Mesa Vista Hospital
- UC San Diego Health
- UC San Diego Hillcrest Medical Center – Emergency and Inpatient Departments
- UC San Diego La Jolla – Emergency and Inpatient Department

The session opened with an overview of BHSA, followed by a 45-minute discussion facilitated by Behavioral Health Services. Nearly 100 comments were submitted through Mentimeter, in addition to verbal responses shared during the discussion, reflecting a wide range of perspectives and experiences. Conversations centered on opportunities and challenges across the hospital and behavioral health systems, with an emphasis on expanding funding opportunities, establishing long-term support systems, and building care tailored for the treatment of unhoused patients, Medi-Cal insured patients, and youth/transitional age youth. Participants offered insights into system-level barriers and shared recommendations aimed at strengthening service accessibility, promoting collaboration, and expanding long term care solutions for individuals with behavioral health needs.

Input Session Questions:

1. From the hospital perspective, what are the greatest challenges or priorities when it comes to behavioral health in our region? Why?
2. Given new BHSA components and no added funding, what should the County prioritize to best reduce hospital strain and improve patient care?
3. What barriers remain in linking patients to support upon discharge, & which practices or partnerships could improve transitions & crisis diversion?
4. With BHSA's focus on youth, transitional age youth (TAY), and people experiencing homelessness, what challenges stand out and what system-level solutions could address them?
5. What workforce challenges are you seeing most acutely, and what kinds of partnerships or strategies could help both hospitals and the County?
6. Is there anything else you'd like to share or recommend to the County as it prepares its first BHSA Integrated Plan?

Key Learnings

- **Hospitals Face Challenges when Transitioning Individuals out of Care**
  From the hospital perspective, challenges include creating direct, timely, collaborative and effective transitions of care for unhoused patients experiencing behavioral health or substance use disorder-related challenges. Hospitals have noted challenges in securing placements in shelter beds or long-term crisis beds in a patients' transition of care from emergency department (ED) or inpatient care settings (inpatient acute care, or inpatient behavioral health units). Prioritizing timely access to long term beds after transitioning out of ED care, providing step down options, identifying clear pathways for transitions of care, increasing collaboration and communication between parties involved in transitions of care, and increasing number of available shelter beds and mental health rehabilitation center beds, would help address the long waitlists and limited number of available bed placements that hospitals may face while transitioning unhoused patients out of ED care.

- **Broadening Support and Resources for Medi-Cal-Insured Individuals**
  Participants emphasized the greatest need for behavioral health patients in hospital settings is to increase options for patients transitioning out of ED care into long term care. Audience identified that increasing the following services need to be prioritized: County Residential Treatment beds, Step Down Resources from hospitalization, Board and Care beds, Shelter beds, Long Term Care beds, Recuperative Care Unit (RCU) beds, and Institution for Mental Disease (IMD) beds. To divert patients from putting an increased demand on long term care, participants also repeated the need to increase mobile response teams and crisis stabilization unit teams to expand their capacity for placements while diverting away from ED visits and stays.

- **Expanding Behavioral Health Funding and Resources for Medi-Cal Patients**
  Stakeholders identified the need for expanding and funding options specifically for Medi-Cal insured patients seeking behavioral health care and treatment. Calls for Intensive Outpatient Program (IOP) resources, Partial Hospitalization Programs (PHP), and voluntary inpatient detox programs funded for Medi-Cal insured patients were repeated.

- **Strong Desire for Streamlined Services and Improved Case Management**
  Streamlining direct hand-offs of patients from inpatient to outpatient and long-term care settings was a repeated concern raised by participants, including having integrated medical records available to all parties involved in patient care. Participants also emphasized the importance of case management in a patients care journey. Specifically, they identified a strong need to ensure early onset involvement of case management, preferably prior to a patient's discharge to ensure timely and prepared connection to post ED/inpatient care.

- **Need for More Youth and Transitional Age Youth (TAY) Programs**
  To better support Youth and TAY, audience members expressed the need for funding Intensive Outpatient Programs (IOP), Crisis Beds, and Short-Term Crisis Housing, specifically for the TAY population. To better support an unhoused patient, participants expressed advocating for treatment first models and longer term stays at housing sites.

- **Individuals in the Behavioral Health Workforce Face Various Challenges**
  Finally, participants expressed the most pressing workforce challenges in the behavioral health system including staff shortages, burnout, inadequate compensation, and limited training opportunities—particularly for early-career clinicians and specialized roles such as psychiatrists and psychiatric nurse practitioners. These issues are compounded by weak coordination between mental health, substance use, and medical services, reducing overall system effectiveness.

Audience Recommendations

- **Standardized Data Requests**
  Participants shared the need to advocate for hospitals to use a single, standardized method for entering and submitting data in response to State and County program requests under updated mental health and behavioral health laws. Implement a standardized electronic data platform to streamline data entry. Reduce administrative burdens and ensure compliance with reporting requirements.

- **Increase Investment in Behavioral Health Workforce**
  Developing a targeted workforce investment and partnership initiatives—such as increased funding for clinical training programs, accommodating pay scales for professionals in the region, stipends for pre-licensure supervision, and stronger collaborations between hospitals, the County, Federally Qualified Health Centers (FQHCs), and private providers—to build and retain a more sustainable, skilled, and integrated behavioral health workforce. Create more programs like ELEVATE, that can grow local behavioral health staffing, as an innovative approach to establishing a strong behavioral health workforce pipeline.

- **Provide Follow up in the Development of the Integrated Plan**
  Provide regular follow-up to the HASD&IC throughout the development of the County's first BHSA Integrated Plan. Communicate key updates and clarify where funding will ultimately be allocated to ensure transparency and informed stakeholder engagement.

- **Integrate Artificial Intelligence (AI) to Enhance Care**
  Explore the adoption of Artificial Intelligence and large language models as tools to enhance care coordination, improve data integration, and strengthen communication across behavioral health systems.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the Wednesday, October 22, 2025, input session between the County of San Diego, Behavioral Health Services (BHS) and community members attending the 2025 Live Well Advance Conference & School Summit, focusing on identifying behavioral health (BH) needs and improving care under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	Transforming Behavioral Health Together: Proposition 1 & San Diego County's 2026–2029 Behavioral Health Services Act Integrated Plan
Format	☒ In-Person ☐ Virtual ☐ Hybrid
Activity Details	**Date:** Wednesday, October 22, 2025 **Time:** 1:15 PM-2:00 PM **Location:** San Diego Convention Center, 111 Harbor Dr, San Diego, CA 92101

Participation	45-min discussion:
	• Approximately 125 attendees
	• 3 discussion questions
	• 200+ comments received:
	  ○ 162 comments submitted through Mentimeter
	  ○ 36 written comments submitted through session handouts
	  ○ 12 comments received through open discussion

Summary of Engagement Activity

On October 22, 2025, the County of San Diego Behavioral Health Services (BHS), hosted a breakout session during the 2025 Live Well Advance Conference and School Summit. The 2025 Live Well Advance hosted 1918 attendees, 39 breakout sessions, and 78 exhibitors. The Live Well Advance is an annual conference that brings partners and stakeholders together to network, learn about new tools and best practices, and participate in breakout sessions. Leaders from every sector come together to participate in efforts to advance the shared vision of a healthy, safe, and thriving San Diego region.

This BHSA session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029. Participants reflected a variety of industries and sectors including government employees, Community Based Organizations (CBO's), Healthcare providers, and more. Approximately 125 participants attended the BHS breakout session. Additionally, BHS staff supported two exhibitor booths which received more than 150+ engagements with attendees during exhibitor sessions.

The breakout session opened with a 10-minute overview of BHSA, followed by a 35-minute discussion facilitated by BHS. Nearly 200+ comments were submitted through Mentimeter, in addition to verbal responses shared during the table-top discussions, reflecting a wide range of perspectives and experiences. This session was designed to gather early input to inform the development of the County's first Behavioral Health Services Act (BHSA) Integrated Plan for fiscal years 2026-2029.

Discussions underscored significant barriers to behavioral health access, including system complexity, limited availability, affordability, transportation challenges, and stigma, particularly for marginalized and linguistically diverse communities. Participants emphasized the importance of trust-building, cultural and linguistically responsive care, and integrated peers and lived experience to reduce disengagement and system avoidance. Stakeholders recommend flexible, community-based service delivery, stronger partnerships with trusted organizations and schools, and sustained workforce investment, to improve access, continuity, and long-term behavioral health outcomes.

Input Session Questions:

1. What makes it hardest for people in your community to get help or stay connected to behavioral health care?

2. How can programs and staff better reflect and respect the cultures and lived experiences of our diverse communities?

3. How can we help more people learn about and access support early—before challenges become crises?

Key Learnings

- **Barriers to Accessibility of Behavioral Health Services**
  Barriers repeatedly identified by participants included: lack of access to behavioral health services in general, not knowing where to start to receive behavioral health resources or services, not knowing how to navigate behavioral health resources and services. Additionally, the audience shared barriers also included prioritizing basic needs over behavioral health needs, long wait times and/or waiting lists for behavioral health services, and lack of beds for those receiving behavioral health treatment. Finally, they shared the overall cost/coverage/lack of insurance for behavioral health treatment, lack of transportation, and lack of behavioral health services that offer 24/7 and weekend hours of coverage ultimately stood as impediments to accessing care.

- **Building Trust is Integral to Providing Consistent Care**
  Being intentional throughout the process of care and focusing on building trust with the community was central to conversation points. Participants shared the importance of keeping behavioral health services or resources as positive experiences came back to the "touch points" of how they were received by navigators of care as well as care providers. Initial interaction with a resource is especially important in creating a positive impression, building trust and encouraging individuals to continue with their care.

- **Stigma Prevents Help-Seeking Behavior and Maintaining Ongoing Care**
  Cultural stigma, generational shame/stigma, and fear of being judged by others can prevent help-seeking behaviors across diverse communities. Participants specifically shared that people with lived experience of homelessness, substance use disorder (SUD), or those with a dual-diagnosis may feel that their current condition is a negative reflection of themselves, which stops them from seeking care due to this perceived blemish thus further perpetuating stigma rather than addressing and prioritizing their mental health needs.

- **Integrate and Value Peers and Individuals' Lived Experience**
  Peers, community rooted representatives, and people with lived experience are meaningful role models and trusted members for community engagement. Participants emphasized the utilization of paid positions and trainings for Community Health Workers (CHW), Peer Support Specialists (PSS), and staff with lived experience and/or who are reflective of the communities they are serving.

- **Linguistic Barriers Prevent Individuals from Seeking Care**
  Language barriers and lack of culturally aligned materials hinder understanding of services. Communities desire staff and outreach workers who reflect their culture, language, and lived experience. Participants suggested contracting or hiring more bilingual/multilingual behavioral health outreach workers and behavioral health providers, with equitable pay, compensating for their translation services on top of their regular services.

- **Desire for Improved Cultural Responsiveness & Specialized Teams**
  Strong emphasis was placed on staffing linguistic and culturally diverse and responsive teams that reflect the communities they are serving, (e.g., tribal, LGBTQ+, refugee, immigrant, AAPI, Latino). Furthermore, integrating cultural practices and traditional healing practices into standards of BH services. Examples shared included multilingual-speaking Assertive Community Treatment (ACT) teams, culturally tailored peer navigators, and housing providers rooted in community trust.

- **Cultivate and Retain Behavioral Health Workforce**
  Participants expressed a desire to support behavioral health workforce development and retention by offering fair pay for all levels of providers from peer support specialists to degreed and licensed professionals, providing salaries that are competitive with private organizations, and equitable to the cost of living in San Diego County. Participants also highlighted that staff who live in the communities they serve often experience additional stress and risk of burnout.

- **Utilize Community Spaces to Increase Awareness about Available Resources**
  Participants expressed a desire to embed behavioral health resources and behavioral health providers into the settings that community members regularly gather and frequent. For example, adult community members may value locations such as libraries, grocery stores, office centers, and primary care provider offices. For children and youth, these trusted spaces may include school settings, day care centers, parks or sport facilities, libraries, and pediatrician or primary care provider offices.

- **Engagement within Schools can Normalize Behavioral Health and Reduce Stigma**
  Many participants in attendance of the input session spoke with perspectives from the school and youth-based background, as the session was held at a conference serving school-engaged community members. Participants shared the need to create high-level partnerships with the San Diego County Office of Education, community colleges, and universities in the region. Furthermore, to integrate education around mental health and behavioral health in a stigma-reducing and safer manner – for families, parents, students, and peers.

Audience Recommendations

- **Addressing Fear, Trust, and System Avoidance in a Challenging Political Climate**
  Participants shared the need to address fears related to immigration enforcement, data privacy, and authority presence. Communicate clearly about confidentiality, safe access points, and community-based service delivery. Maintain engagement and ensure uninterrupted access to care.

- **Develop Programs to Promote Behavioral Health Education**
  Develop specialty programs that address the needs and perspectives of individuals living with neurodivergence. Incorporate dual-diagnosis support beyond SUD or Severe Mental Illness (SMI). Implement Social-Emotional Learning (SEL) curricula, integrate behavioral health concepts and coping skills into age-appropriate school programs, and apply Trauma-Informed Care practices to enhance outcomes.

- **Increase Accessible, Flexible, and Community-Based Care Delivery**
  Expand in-person, walk-in, school-based, telehealth, and hybrid options with flexible hours, including evenings and weekends, and offer accommodations for those who may face barriers seeking care. For example, addressing transportation barriers with shuttle services, vouchers or mobile application outreach and engaging with community-based organizations to ensure continuity of care and improving handoffs between services.

- **Strengthen Partnerships with Trusted Community Organizations and Hubs**
  Leverage Community Based Organizations (CBOs), faith-based organizations, cultural centers, and local programs as primary points of engagement. Uplifting and resourcing trusted community partners strengthens outreach, relevance, and long-term wellness. Participants shared the following names of organizations or programs in the San Diego region that they feel are effectively engaging in behavioral health and/or outreach: Karen Organization of San Diego (serving refugee population) and Bayside Community Center (serving older adults within Linda Vista area).

- **Develop Integrated Care Addressing Social Determinants of Health**
  Integrate behavioral health services with housing, food security, and income support, and legal or reentry services. Reduce criminalization of homelessness and strengthen social supports/public benefits to improve long-term outcomes and stability.

- **Enhance Cultural and Linguistic Responsiveness**
  Increase hiring bilingual/multilingual staff and staff with lived experience from the communities served. Develop culturally tailored programs, materials, and campaigns in consultation with community leaders. Train all staff in trauma-informed care, cultural humility, and community-specific practices. Offer safe spaces for clients to express themselves in culturally and gender-appropriate settings.

- **Promote and Develop Behavioral Health Workforce Grounded in Lived Experience and Community Representation**
  Expand hiring pipelines leadership pathways and paid roles for people with lived experience, and community members. Support workforce sustainability through scholarships, internships, and mentorship programs to grow a diverse, sustainable behavioral health workforce. Maintain ongoing support for staff by offering trainings, certifications, shadowing opportunities, professional development specific to population needs, and implement staff support programs to reduce burnout and ensure high-quality care delivery.

- **Introduce and Sustain Additional Youth and School-Centered Behavioral Health Engagement**
  Integrate screenings, Social Emotional Learning (SEL) curricula, coping skills, behavioral health screenings and education in schools, clinics, workplaces, and community centers. Offer workshops, school-based programs and resources for youth, students, parents, peers and families can help normalize mental health and support.

- **Integrate and Value Peers and Individuals' Lived Experience**
  Engage peers, community-rooted representatives, and individuals with lived experience as trusted role models to strengthen community engagement. Create paid positions and provide training for Community Health Workers (CHWs), Peer Support Specialists (PSS), and staff who reflect the communities they serve to enhance trust and program effectiveness.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report presents a summary of the Behavioral Health Services Act (BHSA) Virtual Input Session held on October 27, 2025, hosted by Behavioral Health Services (BHS) as part of BHAB's Re-entry Support for Justice-Involved Youth and Adults Subcommittee. The session convened medical and behavioral health professionals, along with key community stakeholders, to gather input on early intervention and community-based prevention strategies, continuity and coordination of care, and long-term stability and recovery supports for justice-involved individuals.

Section	Details
Engagement Title	Behavioral Health Services Act (BHSA) Input Session Behavioral Health Advisory Board (BHAB) Re-entry Support for Justice Involved Youth and Adults Subcommittee
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Monday, October 27, 2025 **Time:** 3:30 PM – 5:00 PM **Location:** Zoom
Participation	90-min discussion: • 30 attendees • 7 discussion questions • 115 comments submitted through Mentimeter and open discussion • 2 Breakout Rooms

Summary of Engagement Activity

On October 27, 2025, the County of San Diego Behavioral Health Services (BHS) and University of California San Diego (UCSD) Health Partnership hosted a BHSA virtual input session during BHAB's Re-entry Support for Justice-Involved Youth and Adults Subcommittee meeting. The subcommittee serves as a collaborative forum to convene County staff, providers, and community partners focused on improving re-entry outcomes, coordination of care, and access to behavioral health services for justice-involved youth and adults in San Diego County. The session gathered input on key priorities, including early intervention and community-based prevention strategies, continuity and coordination of care, and long-term stability and recovery supports, to inform the County's first BHSA Integrated Plan (2026–2029). Input session questions were developed with guidance from the Subcommittee to align with its strategic focus on re-entry and justice-involved populations.

Approximately 30 participants attended, including representatives from medical and behavioral health providers, community-based organizations, and key County staff involved in justice-involved behavioral health planning and services.

Participating Organizations Included:

- BHAB Rehab
- North County Equity and Justice Coalition
- REACH SD
- San Diego District Attorney
- Saving Lives in Custody CA
- University of California San Diego

The session began with an overview of the Behavioral Health Services Act (BHSA), followed by a 50-minute discussion facilitated by UCSD Health Partnership. A total of 115 comments were submitted through Mentimeter and verbal discussion. Participants focused on strategies to enhance system navigation, coordination, and accountability for justice-involved youth and adults, emphasizing the need for stronger transitions for continuity of care, improving accessibility, expanding services, and innovating engagement strategies to better reach and support vulnerable populations.

Input Session Questions:

1. What outreach strategies or community partnerships could help connect people to support before a behavioral health or criminal legal crisis?
2. What could make transitions from custody to community-based care more consistent and reliable?
3. What housing supports or partnerships best help justice-involved people stay stable and connected to care?
4. What follow-up practices or supports best help people stay engaged, and how could we make those easier to sustain?
5. What helps people access support early and avoid system involvement?
6. For those who have had system involvement, what approaches or supports help them maintain recovery and stability afterward?
7. As the County prepares for BHSA in 2026, what else should BHS consider to better support the behavioral health needs of those at risk of or with prior justice involvement?

Key Learnings

- **Successful Transitions Require Continuity of Care**
  Participants emphasized that successful transitions for justice-involved individuals rely on connecting people to care before they are released and ensuring consistent follow-ups afterward. Early engagement, such as in-custody assessments, pre-release enrollment in treatment programs, and pairing people with reentry case managers or peer specialists, was seen as essential to prevent individuals from “falling through the cracks.” They expressed that limited coordination between County systems, community providers, hospitals, and justice agencies often disrupts care. As a result, justice-involved individuals must repeatedly share their stories and manage their own follow-up, increasing the risk of missed appointments and relapse.

- **Systemic Barriers to Timely and Inclusive Behavioral Health Care**
  Stakeholders noted that access to behavioral health care remains challenging across all levels of the system. Long wait times, complicated referral processes, and limited outreach capacity often prevent people from getting timely support during which time crises may escalate. Participants described that many facilities, including withdrawal management and recuperative care programs, are not ADA-compliant or fail to provide support for individuals. In addition, people with both mental health and substance use disorders often face exclusion from services in both systems, leaving them without the care they need.

- **Need to Expand Accessible Housing Solutions for Justice-Involved Individuals**
  Participants valued additional housing support options that are tailored to youth and adults seeking re-entry support. They discussed making stable housing more available, including sober living and tiny home options. Additionally, the audience discussed creating housing standards and accommodations that are tailored to the specific needs of justice-involved people. They explained preference for rehabilitation and support programs that are in or near housing facilities to remove barriers to accessing essential resources. Finally, participants expressed need to review current and new housing plans to ensure that they are accessible to individuals with physical and mental disabilities.

- **Desire for Wrap-Around Services and Comprehensive Follow Up**
  Individuals reported interest in additional, more accessible social services to transition out of the justice system. This included case management and peer support services that are specific to the justice-involved population. The audience shared services are especially important to participants who require basic necessities and behavioral health support. Participants explained that all services should include more consistent follow-up with the justice-involved population to decrease loss of care amongst service enrollees. Additionally, participants stated that in-person, drop-in approaches to services may incentivize engagement.

- **Coordination with Assertive Community Treatment and Housing Partners can Contribute to Successful Re-Entry**
  Stakeholders value data sharing across all sectors to ensure shared accountability. The need to strengthen partnerships within the justice involved system and incorporating community participatory practices within correctional settings to support re-entry and continuity of care. Strengthening engagement with the Assertive Community Treatment (ACT) teams before release presents a valuable opportunity to provide intensive, coordinated, and person-centered support for individuals with complex needs. In addition, collaboration with housing partners and the County to develop tiny home initiatives presents a viable approach to addressing housing instability after release from correctional settings.

- **Bolster Continuity of Care Through Peer Support, Data Sharing, and Telehealth**
  Respondents suggested the inclusion of more peer support specialists as a critical strategy for fostering trust, improving engagement, and supporting successful community reintegration. Establishing more frequent and consistent communication post-release is essential to maintaining continuity of care and preventing service gaps. There is a need for enhanced data collection on client engagement to better understand participation trends and inform program improvements. They shared expanding telehealth services can further increase accessibility, particularly for individuals facing transportation or geographic barriers.

Audience Recommendations

- **Improve Transitions and Continuity of Care**
  Participants shared the need to standardize pre-release engagement protocols to connect individuals to care and pair them with a navigator or peer support before release. Develop a centralized data-sharing system, modeled on Los Angeles County's bed-tracking tool, to improve coordination and referrals. Invest in sustained funding for peer re-entry specialists. Track follow-up outcomes to support successful transitions and ensure continuity of care.

- **Broaden Accessibility to Behavioral Health Services**
  Create an easy-to-use online portal for service navigation and appointment scheduling to improve access. Fund outreach and engagement services to support earlier intervention. Require programs to serve individuals with co-occurring mental health and substance use disorders, and audit facilities regularly for ADA compliance to ensure equitable access for all.

- **Redesigning Housing as Accessible Hubs for Re-Entry Support**
  Build and redesign housing supports that address the needs of justice-involved individuals while meeting high accessibility standards. Transform housing and sober living facilities into hubs where the re-entry population can access essential services, lowering barriers to stable housing and support.

- **Strengthen Data Sharing, System Integration, and Accountability**
  Design interoperable data systems and enable real-time information sharing between Managed Care Providers (MCP), correctional centers, and the County. Enhance data collection on client engagement and Mobile Crisis Response Team (MCRT) access to assess outcomes and inform program improvements.

- **Formalize Collaboration and Communication between Stakeholders**
  Establish regular forums for service providers, the sheriff's department, peer supports, and the justice-involved community to share information, identify needs, and address gaps in support. Coordinate stakeholder involvement to ensure the holistic needs of the re-entry population are met effectively.

- **Building Consistent Care Pathways with Peer Support and Telehealth**
  Expand the pool of peer support specialists to strengthen engagement and promote successful community reintegration. Establish frequent, consistent post-release communication to ensure continuity of care. Increase telehealth services to enhance accessibility and reduce barriers to care.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the Thursday, October 30, 2025, input session between the County of San Diego Caregiver Coalition, Behavioral Health Services (BHS), caregivers, their family, and community members, examining how the Behavioral Health Services Act (BHSA) will shape area agencies, government, organizations, and healthcare plan providers that impact caregiving.

Section	Details
Engagement Title	Transforming Behavioral Health Together: Proposition 1 – Caregiver Coalition Meeting
Format	☒ In-person ☐Virtual ☐Hybrid
Activity Details	**Date:** Thursday, October 30, 2025 **Time:** 11:00 AM-12:30 PM **Location:** Hillcrest/Knox Branch Library, 215 W Washington St, San Diego, CA 92103
Participation	60-min Discussion: • 21 attendees • 4 of discussion questions • 35 of total comments

Summary of Engagement Activity

On October 30, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with the Caregiver Coalition hosted an input session during the Caregiver Coalition's monthly meeting. The Caregiver Coalition's mission is to identify and address the needs of caregivers through education, support, advocacy efforts, and collaboration of a broad coalition of membership to improve the life of caregivers, their families, and the community. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 21 attendees participated in this session representing community-based organizations (CBO's) including those who cater to caregivers as well as older adults.

Participating Organizations Included:

- UCSD Health Services
- AIS Advisory Council
- Southern Caregiver Resource Center
- Visiting Angels Senior Home Care
- Long-term Care Ombudsmen
- Alzheimer's Association of San Diego
- Public Authority
- Elder Care
- Comfort Care
- Gary and Mary West Pace

The session opened with an overview of BHSA, followed by a 30-minute discussion facilitated by BHS. Nearly 35 comments were submitted verbally and through written responses on a handout sheet, reflecting a wide range of perspectives and experiences. Conversations centered on improving early intervention, client navigation of healthcare systems, and access to behavioral health services through culturally responsive, community-based approaches that build trust and reduce stigma. Participants identified key challenges including fragmented systems, limited navigation support, long wait times, low health literacy, and insufficient follow-up especially for caregivers of older adults.

Input Session Questions:

1. How can we help more people learn about and access support early—before challenges become crisis?
2. What early intervention services would help older adults and people with disabilities access or stay connected to specialty behavioral health care?
3. What would "navigational support," look like for an older adult or individual living with a disability seeking behavioral health support?
4. Anything else you would like us to know as we create the Integrated Plan (IP)?

Key Learnings

- **Relationship Building with Community Based Organizations is Integral to Developing Trust Within Communities**
  Participants consistently emphasized that trust develops through relationships with community-based organizations (CBOs), not through centralized systems alone. Embedding County Behavioral Health Services staff within trusted organizations like Union of Pan Asian Communities (UPAC), senior centers, and caregiver-serving nonprofits allows services to feel familiar rather than intimidating. When navigation occurs inside spaces people already trust, stigma decreases and engagement increases.

- **Navigation is Relationship Based**
  Navigation was repeatedly described as a relationship, not a referral. Older adults and people with disabilities often disengage when support ends after a single interaction or handoff. Continuous follow-up, consistency in navigators, and proactive check-ins help individuals stay connected through complex systems.

- **Navigation Quality Matters**
  Stakeholders shared that inadequately trained navigators or enhanced care managers can erode trust quickly. When referrals are unclear or poorly explained, individuals may disengage entirely and avoid future help-seeking. One negative experience can undo months of outreach and relationship-building.

- **Stigma Prevents Early Engagement**
  Stigma continues to prevent early engagement, particularly among older adults, caregivers, and communities of color. Participants stressed that clinical language often increases resistance rather than reducing it. Peer-led and culturally grounded approaches were consistently viewed as more effective than professional-only outreach

- **Misinterpretation of Behavioral Health Needs**
  Many communities do not conceptualize distress as "mental health," but instead experience it as physical symptoms, anxiety, grief, or existential pain. This disconnect leads to underreporting of behavioral health needs and delayed care. Language and outreach must reflect how people describe their lived experiences.

- **Caregivers are Essential Allies Who Often Need Support Themselves**
  Caregivers—many of whom are older adults themselves—carry significant emotional and behavioral health burdens. Stakeholders noted high rates of depression, burnout, and stress, particularly among dementia caregivers. Without caregiver support, individuals receiving care are far more likely to experience crises or institutionalization.

- **Health Literacy Barriers**
  Flyers, brochures, and resource guides are frequently written above the reading level of intended audiences. Older adults and caregivers need materials that are visually clear, written in plain language, and easy to act on. Poor health literacy limits access even when services are technically available.

- **Service Delays Cause Drop-Off**
  Long wait times, unclear eligibility, and fragmented systems often cause individuals to disengage before services begin. Stakeholders described situations where people were discharged or ready for help but fell through gaps. Without interim support, early intervention opportunities are lost.

- **Proactive Connection Programs Prevent Crisis**
  Programs like ElderHelp's R-U-Ok daily phone call and intergenerational call programs were highlighted as effective early intervention tools. Regular check-ins normalize connection and allow needs to surface before they escalate. Participants emphasized that caregivers currently lack comparable proactive outreach.

- **Cross-Sector Collaboration is Needed to Meet the Needs of Older Adults and Individuals with Disabilities**
  No single agency or system can meet the layered needs of older adults and people with disabilities. Participants stressed that meaningful integration requires shared ownership, County-funded connector roles, and strong cross-sector collaboration. Community partners must be supported—not replaced—for integration to succeed.

Audience Recommendations

- **Fund and Place Community-Embedded Navigators**
  Participants shared the need to invest in and place County behavioral health navigators within community-based organizations where trust is already established. Assign navigators as consistent points of contact across behavioral health, medical, transportation, and social services. Track outcomes to reduce stigma and improve follow-through with services.

- **Expand Long-Term Navigation Models**
  Ensure navigation includes follow-up warm handoffs, and sustained continuity over time. Assign a single navigator whenever possible to reduce confusion and avoid retelling of personal histories. Leverage relationship-based navigation for increase in client retention and overall outcomes.

- **Invest in Strong Training and Oversight**
  Allocate resources to develop and implement comprehensive training for navigators, Enhanced Care Management (ECM) providers, and referral staff. Incorporate cultural humility, disability awareness, and an in-depth understanding of referral programs into the curriculum. Build staff skills to enhance navigation quality, safeguard client trust, and prevent disengagement.

- **Grow Network of Peer Navigators and Community Health Workers**
  Expand peer-to-peer navigation by engaging CHWs, Promotoras/es, and individuals with lived experience. Leverage these models to reduce stigma, normalize help-seeking, and enhance engagement beyond clinical outreach alone. Adopt volunteer or stipend-based approaches to strengthen sustainability and maximize program impact.

- **Utilize Trusted-Spaces for Community Outreach**
  Conduct outreach in trusted community settings, including schools, libraries, senior centers, churches, and local groups. Utilize after-work social media campaigns to reach working caregivers and intergenerational families. Engage school systems to normalize mental health discussions and increase community awareness and participation.

- **Plain Language Communication**
  Develop materials that use simple language, large fonts, visuals, and step-by-step instructions. Produce simplified versions alongside official resources so providers can explain options in under five minutes. Prioritize health literacy as a core strategy to improve access and enhance understanding for all clients.

- **Expand Proactive Check-In Programs**
  Increase R-U-OK style check-in programs and design caregiver-specific versions. Implement regular outreach to reduce isolation and identify needs early. Ensure caregivers receive the same proactive support as care recipients to strengthen wellbeing and enhance overall care outcomes.

- **Invest in Caregiver Mental Health**
  Individuals seek to restore and expand caregiver-focused early intervention programs addressing depression, stress, and behavioral management. Reintegrate effective programs such as El CALMA and Caregiver TLC. Supporting caregivers can improve outcomes, reduce system strain, and strengthen overall care for both caregivers and care recipients. Within the future BHSA framework, prevention funding will no longer be under local control as these funds will be allocated to the state level under California Department of Health Care Services (DHCS). Additionally, funding dedicated to early intervention must meet certain criteria to primarily reach those with clinical early indicators or clinical risk of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

- **Integrate Practical Supports**
  Prioritize transportation and technology access as core navigation functions. Equip navigators to assist with ride coordination, eligibility, and accessible technology such as Caption Call or large-button devices. Provide practical supports to enable follow-through and strengthen client engagement.

- **Support and Coordinate Community Efforts**
  Audience members seek the County's coordination of funding opportunities and support community-led efforts instead of duplicating them. Individuals desire the County to serve as a connector across systems to enable trusted partners to lead collaborative engagement and planning in developing accountability structures that can strengthen impact and equity.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the November 4, 2025, community input session led by County of San Diego Behavioral Health Services (BHS), with participation from community members and service providers, examining crisis services under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHSA Input Session: Crisis Services Engagement Summary
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** November 4, 2025 **Time:** Morning 10:00 AM-11:30 AM, Evening 5:30 PM-7:00 PM **Location:** Zoom

Participation	90-Minute Discussions:
	• 40 attendees
	• 6 discussion questions
	• 101 total comments
	  ○ 88 comments submitted through Mentimeter
	  ○ 13 comments through open discussion

Summary of Engagement Activity

On November 4, 2025, the County of San Diego Behavioral Health Services (BHS) led a virtual community input session to address crisis services needs for people with behavioral health needs under the Behavioral Health Services Act (BHSA). This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Across both morning and evening sessions, approximately 40 participants attended including a mix of healthcare providers, social service agencies, behavioral health advocates, and academic representatives.

Participating Organizations Included:

- Serving Seniors
- Office of Supervisor Lawson-Remer
- University of California San Diego
- Charlie Health
- Fisher Mental Health Consulting
- National Shattering Silence Coalition
- Waves of Change Consulting
- National Alliance on Mental Illness
- La Maestra Community Health Centers
- Southern Caregiver Resource Center

The session opened with an overview of BHSA, followed by a 45-minute discussion facilitated by BHS staff. Nearly 101 comments were submitted through digital discussion, chat comments, and Mentimeter. Participants discussed the need for clinically informed, coordinated behavioral health services that respond effectively during crises and continue through recovery, emphasizing trust-building crisis response, timely follow-up, and stable supportive housing. They highlighted the importance of family inclusion, well-trained peer and clinical supports, and clear, accessible pathways that help individuals and caregivers navigate care, reduce repeated crises, and support long-term wellness outcomes.

Input Session Questions:

1. What would help people feel safer reaching out to crisis services earlier, before things become an emergency?
2. What kinds of navigation or coordination help do people need to find and connect with ongoing care after a crisis?
3. What would help people stay engaged in follow-up care or recovery supports after a behavioral health crisis?
4. What challenges make follow-up supports like case management or outpatient care hard to use or continue?
5. How could County-funded crisis and treatment services coordinate more effectively to support people after a crisis?
6. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Re-establishing Trust within Crisis Response to Develop Help-Seeking Behaviors**
  Participants consistently described fear and distrust of crisis response teams due to experiences involving law enforcement-led responses, lack of clinicians, and jail transport instead of hospital care. These experiences create lasting trauma and discourage individuals and families from calling for help until situations escalate into true emergencies. Rebuilding trust will require clinician-led crisis responses, clear accountability standards, transparent follow-up, and visible commitment to trauma-informed, medical, not punitive, interventions.

- **Design Crisis Response to Prioritize Care Over Enforcement**
  A clear pattern emerged showing that the involvement of police without clinicians, especially when body cameras are absent, heightens fear, stigma, and harm, particularly for people with Serious Mental Illness (SMI), immigrants, and communities of color. Participants emphasized that law enforcement-driven responses often escalate rather than stabilize crises and lead to unnecessary incarceration. Outcomes can improve by expanding clinician-led mobile teams, integrating paramedics and behavioral health professionals, and clearly defining when law enforcement involvement is clinically justified.

- **Anosognosia Must be Formally Recognized and Addressed Across Crisis, Treatment, and Recovery Systems**
  Stakeholders identified anosognosia, a neuropsychiatric condition where a person is unaware of or denies their own disability or illness, as a primary reason individuals with SMI cannot engage in voluntary services, comply with outpatient care, or agree to hospitalization. Current service models that rely on voluntary participation unintentionally exclude the sickest individuals and allow clinical deterioration. Integrate anosognosia into eligibility criteria, training, and care pathways, including earlier use of involuntary evaluation and treatment as a medical intervention rather than a failure of engagement.

- **Stigma of Involuntary Care is Contributing to Worse Outcomes and Should be Replaced with a Compassionate Medical Framework**
  Participants strongly rejected the framing of involuntary care as "coercive," noting that avoidance of needed treatment often leads to jail, homelessness, overdose, or death. Families emphasized that forced care, when clinically indicated, is often the only alternative to prolonged suffering and system cycling. Reframing involuntary care as time-limited, compassionate, and recovery-oriented could enable earlier intervention and reduce long-term system costs and human harm.

- **Families are Essential Partners in Care and Should be Systematically Included**
  Across all discussion areas, families reported being dismissed, blamed, or blocked by misapplication of HIPAA (Health Insurance Portability and Accountability Act), even though they often serve as the primary caregivers and system navigators. This exclusion weakens crisis assessments, discharge planning, and long-term engagement. Implement clear family-inclusive policies, training staff on appropriate information-sharing, and treating family input as critical clinical data rather than interference.

- **Post-Crisis Care Currently Lacks Coordination, Consistency, and Accountability Undermining Recovery**
  Participants described discharge planning as fragmented and dependent on individual hospital social workers, with families left to navigate complex systems using minimal information. This results in missed connections to housing, substance use treatment, and higher levels of care, increasing the likelihood of relapses and re-hospitalization. A centralized, accountable post-crisis navigation model with proactive follow-up could significantly improve continuity and long-term stability.

- **Supportive Housing with Embedded Services is Foundational to Recovery and Crisis Prevention**
  Stakeholders identified stable, service-rich housing as essential for engagement in treatment, medication adherence, and long-term wellness. Temporary placements such as shelters or motels were widely viewed as destabilizing and ineffective, particularly for people with SMI. Investing in clinically informed supportive housing, including protections against eviction during symptom exacerbation, is a critical strategy for reducing repeated crises and system cycling.

- **Building Skilled Peer Support for Better Care and Connection Requires Training**
  Participants emphasized that peer support can significantly improve engagement when peers are well trained in psychosis, anosognosia, family dynamics, and appropriate escalation to higher levels of care. However, inconsistent training and ideological opposition to involuntary treatment can unintentionally delay needed care. Strengthening peer roles through standardized training, clinical supervision, and collaboration with families can maximize their effectiveness and safety.

- **After Crisis, Support Requires Active, Ongoing Outreach—Not Just Referrals**
  Stakeholders agreed that brief phone check-ins or referral lists are insufficient after a behavioral health crisis, particularly for individuals with cognitive impairment, homelessness, or limited access to technology. Early, frequent, and in-person follow-up, especially in the first days after discharge, was identified as a key strategy for preventing disengagement. Participants discussed prioritizing models that emphasize assertive outreach, accompaniment to appointments, and continuity of relationships.

- **Language, Framing, and Messaging Shape Culture, Stigma, and Service Utilization**
  Participants highlighted how terms such as “behavioral,” “prevention,” and “coercion” reinforce misconceptions that SMI are choices rather than brain-based medical conditions. Individuals shared that this language affects public attitudes, policy decisions, and whether families and individuals feel safe seeking care. Aligning messaging with medical, recovery-oriented language can reduce stigma, improve trust, and support earlier and more effective intervention.

Audience Recommendations

- **Integrate Recognition of Anosognosia into Eligibility, Assessment, and Treatment Pathways**
  Participants shared the need to include recognition of “anosognosia” in County-funded program assessments, service eligibility, and clinical decision-making. This would allow earlier access to involuntary evaluation and treatment when clinically needed to support individuals with severe mental illness who cannot engage voluntarily. Moreover, this would align services with the realities of severe mental illness to improve access for those most at risk and reduce long-term decline. Measures will also need to be created to monitor implementation to ensure proper use and continuity of care.

- **Redesign Crisis Response to be Clinically Led, Transparent, and Accountable**
  Prioritize medical and clinical care in behavioral health crisis responses to minimize trauma and rebuild trust. Require clinician presence on crisis response teams whenever feasible and clearly define when law enforcement involvement is appropriate. Establish accountability standards, including documentation, supervision, and follow-up, to prevent unnecessary jail transport. Strengthen clinical leadership in crisis response to improve safety, reduce repeat crises, and encourage earlier help-seeking.

- **Make Compassionate Involuntary Care a Standard Part of the Continuum**
  Adopt clear guidance, staff training, and public messaging that frame involuntary care as a time-limited, medically necessary intervention rather than a punitive or failed approach. Integrate compassionate involuntary care options within the broader behavioral health continuum to prevent crisis escalation. Monitor outcomes to reduce homelessness, incarceration, overdose, and family burnout while supporting long-term recovery.

- **Establish a Standardized, Proactive Post-Crisis Navigation and Follow-Up Model**
  Implement a standardized post-crisis transition model in which every individual leaving crisis care is assigned a trained navigator or care coordinator. Ensure active follow-up, timely appointment linkage, and coordination across housing, treatment, and benefits. Prioritize proactive engagement during the initial weeks following a crisis to reduce disengagement and prevent repeat hospitalizations.

- **Expand Supportive Housing with Clinical Care for Stability and Recovery**
  Prioritize supportive housing models that include services as a key part of recovery. Provide on-site clinical care, help with medications, peer support, and protections against eviction or program discharge during times of symptom worsening. Invest in housing that promotes stability and healing to reduce repeated crises, use of emergency services, and cycling through the system.

- **Strengthen Peer and Navigator Roles Through Standardized Training, Supervision, and Workforce Stability**
  Standardize training requirements for peers and navigators, with emphasis on psychosis, anosognosia, family engagement, and appropriate escalation to higher levels of care. Ensure ongoing supervision, clear role alignment with clinical teams, and competitive compensation to reduce turnover. Strengthen workforce stability to improve continuity of care, cross-disciplinary collaboration, and long-term engagement.

- **Formalize Family Inclusion as a Core Component of Service Delivery**
  Establish clear policies and training to support appropriate information-sharing, family engagement, and caregiver support across all levels of care. Integrate families as partners in crisis response, discharge planning, and ongoing care while maintaining privacy and consent requirements. Strengthen assessments, improve continuity of care, and promote long-term wellness for both individuals and caregivers through sustained family partnership.

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Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the November 12, 2025, community input sessions led by County of San Diego Behavioral Health Services (BHS), with participation from community members and housing stakeholders, examining housing intervention needs, barriers, and support for people with behavioral health needs under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHSA Input Session: Housing Interventions Engagement Summary
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** November 12, 2025 **Time:** 10:00 AM-11:30 AM, 5:30 PM-7:00 PM **Location:** Zoom

Participation	90-Minute Discussions:
	• 45 attendees
	• 4 discussion questions
	• 100 total comments
	  ○ 79 comments submitted through Mentimeter
	  ○ 21 comments through open discussion

Summary of Engagement Activity

On November 12, 2025, County of San Diego BHS led a community input session to discuss the Behavioral Health Services Act (BHSA), housing interventions, and housing needs of people experiencing behavioral health challenges. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Across both morning and evening sessions, approximately 45 participants attended including a mix of healthcare providers, housing and development organizations, social service agencies, behavioral health advocates, and academic representatives.

Participating Organizations Included:

- UCSD Health
- Serving Seniors
- Tiny Home Central
- Wakeland Housing and Development Corporation
- National Alliance on Mental Illness (NAMI)
- Union of Pan Asian Communities (UPAC)
- Home Start, Inc
- San Diego State University (SDSU)
- Kaiser Permanente
- San Diego Housing Commission

The session opened with an overview of BHSA, followed by a 45-minute discussion facilitated by BHS staff. Nearly 100 comments were submitted through digital discussion, chat comments, and Mentimeter. Participants discussed the importance of providing ongoing, flexible support and integrated services to help people maintain stable housing. They also highlighted the value of peer connections, community engagement, and accessible pathways to resources across different housing options.

Input Session Questions:

1. What types of housing or housing supports help people experiencing behavioral health challenges feel safe, stable, and connected in their community?
2. What kinds of help make it easier for people experiencing behavioral health challenges to stay housed once they have a place to live?
3. What challenges or barriers make it harder for people experiencing behavioral health challenges to find or keep housing?
4. How can housing programs and housing-related supports be designed or delivered in ways that better support people's behavioral health and well-being?

Key Learnings

- **Embedding Ongoing Support and Case Management in Housing Programs**
  Stakeholders emphasized that many residents need practical, individualized assistance to adjust to housing, including support with budgeting, cooking, cleaning, and navigating daily responsibilities. This reflects a broader need for ongoing case management and care coordination that does not end after initial placement. Participants noted that without these supports, tenants often struggle with stress, relapse, or misunderstandings about how to manage a home, increasing risk for eviction. These insights highlight the importance of designing programs that embed continuous, flexible, and responsive supports within all housing models.

- **Integrated Clinical and Non-Clinical Services are Essential for Long-Term Stability and Eviction Prevention**
  Community input highlighted that behavioral health care, stress-management support, harm reduction, and access to food and health resources must be easy to access and coordinated. People described that services need to respond quickly to changing needs, with the ability to escalate care before a crisis occurs. Stakeholders repeatedly tied eviction prevention to early intervention delivered by case managers, wellness coordinators, and peers. These insights point to program models that prioritize integration across clinical and non-clinical teams and reduce barriers to whole-person support.

- **Peer Support is a Vital Stabilizing Force Strengthening Trust, Engagement, and Recovery**
  Participants stressed that peer staff offer unique value through relational support, shared lived experience, and flexible engagement—not easily replicated by clinical roles. Peer-led services, tenant councils, and peer respite programs were highlighted as essential components of successful housing environments. The presence of peers was tied to reduced isolation, improved retention, and more consistent participation in services. These learnings affirm the need for program designs that embed peers across the housing continuum and elevate their leadership roles.

- **Connection, Belonging, and Community Engagement are Central to Helping People Remain Housed**
  Stakeholders described that people stay stable when they have meaningful places to go, opportunities for social connection, and supportive networks such as clubhouses, faith communities, and social groups. Isolation was identified as a major risk factor, and community-building activities were viewed as essential—not optional—to long-term recovery. Opportunities for part-time employment or vocational activities were seen as pathways to purpose and identity. These insights reinforce that housing programs should integrate community engagement strategies as core components of service delivery.

- **A Full Continuum of Housing Options is Necessary to Support Individuals Through Fluctuating Needs and Life Transitions**
  Individuals emphasized that people require different levels of support at different points in their recovery and that transitions between crisis housing, transitional housing, and PSH must be smooth and timely. Stakeholders voiced concerns that limited emergency and transitional options leave hospitals, law enforcement, and PERT unable to place individuals in crisis into safe settings. They emphasized that “Housing First should not be housing only,” and that access to services across the continuum must remain strong. This learning points to the importance of planning for flexible, connected, and adequately resourced housing pathways.

- **Dignified, Safe, and Affordable Housing Environments are Foundational to Recovery and Long-Term Wellbeing**
  Community input highlighted the importance of clean, well-managed units, tenant rights protections, and responsive property management practices. People repeatedly stated that safety, privacy, and respect directly influence their mental health and ability to stabilize. Prevention supports such as rental subsidies, advocacy, and eviction diversion were seen as equally important as clinical care. This insight underscores the need for program policies that protect tenant dignity while ensuring stable, affordable housing options.

- **Access to Services Remains Limited by High Eligibility Thresholds and Insufficient Housing Supply**
  Participants expressed frustration with restrictive criteria that prevent individuals from receiving help before reaching crisis. Limited emergency housing and too few affordable units, especially for families, create bottlenecks across the system. Stakeholders called for lower-barrier entry points and expanded housing stock to meet the actual needs of residents. This learning points to the need for system-level reforms that improve accessibility and reduce administrative hurdles.

Audience Recommendations

- **Expand Ongoing, Individualized Support Services Including Life-Skills Coaching, Recovery Planning, and Mobile Case Management**
  Audience seeks to provide tenants with practical housing support starting on day one, including support with budgeting, home management, daily living skills, and goal-setting. Revitalize structured programs like Wellness Recovery Action Plan (WRAP) and embed them consistently across housing settings. Deploy mobile and on-site case management teams to conduct regular check-ins, track progress, and intervene early. Monitor outcomes to reduce preventable crises and support long-term housing stability.

- **Strengthen Integrated Clinical and Non-Clinical Supports that Address the Full Spectrum of Tenant Needs**
  Invest in service models that combine behavioral health care, food access, stress management, harm reduction, and crisis navigation under a coordinated system. Provide early and responsive support to prevent evictions, recognizing that clinical care alone is not enough. Create flexible pathways to higher levels of care without requiring individuals to fail first. Monitor program outcomes to ensure holistic approaches promote stability and shared responsibility across disciplines.

- **Expanding Peer Roles Across Care Continuum for Lasting Impact**
  Leverage peers to build trust, increase engagement, and strengthen community connections within housing and behavioral health programs. Develop structured peer-led pathways, including on-site peer support, peer councils, social groups, and leadership programs. Collaborate with workforce partners to improve peer training and create career advancement opportunities. Integrate peers across the service continuum to support person-centered environments. Monitor outcomes to measure impact on client engagement and community cohesion.

- **Affordable and Supportive Housing Supply is Needed to Support Long-Term Stability**
  Families, older adults, and individuals with complex behavioral health needs require a broader range of safe, dignified, and affordable housing options. Stakeholders discussed the role and importance expansion of housing stock plays in strengthening supportive infrastructure in the region to enable stability and recovery. BHSA requires 30% of funds be dedicated to Housing Interventions and limits capital development to 25% of that allocation. Some participants recommend prioritizing capital investments within this allowance and strongly emphasized capital uses such as expanding unit availability and recapitalizing existing supportive housing programs (e.g., No Place Like Home).

- **Invest in Community-Building Infrastructure, Wellness Spaces, and Opportunities for Meaningful Engagement**
  Design housing programs with built-in pathways to social connection, including partnerships with clubhouses, cultural community spaces, faith-based groups, and wellness centers. Provide reliable daytime activities and supportive employment opportunities to reduce isolation. Integrate vocational pathways, such as part-time jobs and peer workforce training, to help tenants maintain purpose and stability. Monitor program outcomes to ensure these investments strengthen the social foundations of recovery and promote long-term engagement.

- **Develop Clear, Accessible Navigation Tools for Housing and Services, Including Flow Charts with Contacts and Eligibility Details**
  Provide families, crisis responders, hospitals, and CBOs with clear, accessible guidance on available housing options and how to access them. Develop resources such as flow charts that include programs, contact information, and clear eligibility criteria. Utilizing these tools can reduce confusion, improve transitions, and match individuals to appropriate levels of care more quickly. Monitor usage and outcomes to support system-wide coordination and minimize delays in service connection.

- **Increase Flexibility in Funding, Referral Processes, and Eligibility Pathways Across BHS, CBOs, and Partner Agencies**
  Broaden referral pathways and lower entry thresholds to address service gaps and enable early intervention. Structure funding to support collaborative approaches between the County and community partners. Reduce administrative barriers to improve access and decrease crisis-driven use of services. Monitor outcomes to ensure flexibility aligns supports with actual community needs.

- **Expand and Stabilize Affordable and Supportive Housing Supply, Including Recapitalizing Key Programs like No Place Like Home**
  Direct available housing funds toward stabilizing existing supportive housing programs and expanding unit availability. Increase access to safe, dignified, and affordable housing options for families, older adults, and individuals with complex behavioral health needs. Prioritize non-clinical housing services, including tenant advocacy, landlord engagement, and voluntary supportive services, to prevent evictions. Monitor outcomes to ensure expanded housing stock and strengthened supportive infrastructure contribute to long-term regional stability.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the November 19, 2025, input session hosted by the County of San Diego Behavioral Health Services (BHS) focusing on substance use disorder (SUD) services to inform planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHSA Input Session: Substance Use Disorder
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date**: November 19, 2025 **Time**: 10:00 AM – 11:30 AM, 5:30 PM – 7:00 PM **Location**: Zoom
Participation	90-Minute Discussions: • 51 of attendees across both sessions • 5 discussion questions • Approximately 60 total comments through Mentimeter in addition to verbal discussion

Summary of Engagement Activity

On November 19, 2025, the County of San Diego Behavioral Health Services (BHS) hosted a virtual stakeholder session to gather input on improving access, delivery, and cultural responsiveness of substance use treatment and recovery supports. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 51 participants attended both sessions. Participants included providers of mental health or SUD services and individuals with lived experience of substance use or behavioral health diagnosis.

Participating Organizations Included:

- McAlister Inc, East Teen Recovery Ctr
- McAlister Inc, South Teen Recovery Ctr
- BHS Outpatient 1 & 2
- BHS SUD Residential Programs
- BHS HCO (Health Care Operations)
- Equitable Solutions HDAP Program
- Pacific Clinics – ELEVATE Peer Support Training and Placement Program
- MHS North Inland Teen Recovery Center
- TURN Teen Recovery Center
- Oceanside Comprehensive Treatment Center (CTC)
- North County Lifeline Inc
- University of California San Diego
- Vista Hill
- Haitian Bridge Alliance, Inc
- Vista Community Clinic
- National Alliance on Mental Illness
- Legal Aid Society of San Diego
- Kaiser Permanente
- San Diego American Indian Health Center
- Fisher Mental Health Consulting
- Lake County Behavioral Health
- A New PATH
- Union of Pan Asian Communities

The session opened with an overview of BHSA and SUD services, followed by a 45-minute discussion facilitated by BHS staff. Participants submitted nearly 60 Mentimeter comments and shared verbal input, highlighting barriers such as transportation, language access, and service navigation. Discussions focused on low-barrier access, culturally responsive and peer-led supports, and integration of mental health and housing services, with recommendations for expanding recovery pathways, strengthening outreach, and improving system coordination for individuals with complex behavioral health needs.

Input Session Questions:

1. What kinds of supports or services help people in your community reduce or stop harmful substance use?
2. How can we make substance-use services easier to access, especially for those not already connected to care?
3. What prevention or recovery programs feel most culturally relevant or community-driven?
4. How can BHSA help bridge gaps between substance-use treatment, housing, and behavioral health care?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Low Barrier Access Helps Reduce Harmful Substance Use**
  Participants consistently emphasized that low-barrier treatment models, such as walk-in detox, same-day Medication Assisted Treatment (MAT), minimal paperwork, easy admissions, and acceptance without insurance or referrals, help people reduce or stop harmful substance use. Community members identified a need for a clear, accessible "front door" to services, while also stressing the importance of maintaining multiple entry points so individuals are not forced through a single pathway. Stakeholders emphasized that virtual services, telecare, and online resources expand access, particularly for individuals not already connected to care. Participants highlighted that transportation barriers, especially for youth, directly limit access to substance use services.

- **Community Based Outreach is Integral to Reach Underserved Populations**
  Individuals emphasized placing substance use staff and peer supports directly in the community, including streets, canyons, homeless encampments, libraries, shelters, clubhouses, and meal sites can be the bridge to connecting a community member to SUD resources and services. They highlighted street-based outreach and Naloxone distribution as effective ways to engage people who are not seeking traditional services. Stakeholders emphasized meeting people where they are, including addressing basic needs such as food, shelter, and transportation before expecting readiness for treatment.

- **Housing Stability & Recovery Supports Help Individuals Maintain Stability**
  Audience members emphasized that recovery residences are a critical support for individuals in treatment but noted that current funding is limited. Individuals shared that rigid housing timelines and eligibility rules can destabilize clients and lead to program switching. Stakeholders emphasized the importance of integrating housing navigation into substance use treatment and strengthening warm handoffs to housing supports. Participants highlighted transportation to recovery housing and in-person recovery groups as a necessary support.

- **Desire for Culturally Responsive Treatment**
  Participants emphasized that individuals are more likely to engage in services when they feel respected, not judged, and understood within their own cultural values and language. Community members highlighted that evidence-based practices are not normed for culturally diverse populations, making flexibility in service delivery critical. Stakeholders consistently raised language access as a barrier, particularly delays caused by limited availability of Spanish-speaking clinicians. The audience emphasized that having providers who speak the client's language is more culturally appropriate and effective than relying on translators.

Audience Recommendations

- **Expand Low-Barrier Access**
  Community members shared their desire to see investments in and scale low-barrier substance use treatment models by supporting walk-in services, same-day MAT, minimal paperwork, and acceptance without insurance, while maintaining multiple entry points rather than a single access pathway. This includes expanding virtual and telecare options and address transportation barriers, particularly for youth, to ensure services are accessible to individuals not already connected to care.

- **Strengthen Community Based Outreach and Engagement**
  Support and fund community-based outreach models that place substance use staff and peer supports in locations where individuals already gather, including encampments, shelters, libraries, and meal sites. Prioritize outreach approaches that include naloxone distribution, peer engagement, and support for basic needs such as food, shelter, and transportation to build trust and engagement before treatment readiness.

- **Improve Housing Stability and Recovery Supports**
  Expand and stabilize funding for recovery residences and align housing policies to reduce rigid timelines and eligibility barriers that disrupt care. Integrate housing navigation into substance use treatment and strengthen warm handoffs between treatment, recovery housing, and long-term housing options, including transportation support to recovery housing and in-person recovery services.

- **Advance Culturally Responsive Care**
  Maintain flexibility in program requirements to allow culturally responsive service delivery and prioritize recruitment and retention of multilingual clinicians. Invest in language-concordant care models rather than reliance on translators to reduce delays and improve engagement, and support provider practices that emphasize respect, non-judgmental engagement, and cultural relevance.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the November 20, 2025, community input session between the County of San Diego Behavioral Health Services (BHS) and Integrated Heath Partners (IHP) of Southern California, focusing on identifying behavioral health (BH) needs and improving continuums of care under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	Integrated Health Partners Behavioral Health Workgroup
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Thursday, November 20, 2025 **Time:** 4:00PM – 5:00PM **Location:** Microsoft Teams
Participation	45-minute discussion: • 24 attendees • 5 discussion questions • 25 digital comments in addition to verbal discussion

Summary of Engagement Activity

On November 20, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with Integrated Health Partners (IHP), hosted a virtual community input session to address behavioral health needs and planning under the Behavioral Health Services Act (BHSA). Integrated Health Partners is a Federally Qualified Health Center (FQHC) controlled clinically integrated network dedicated to advancing value-based care and payment reform for underserved populations in San Diego and Riverside counties. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan for the Fiscal Years 2026-2029.

Approximately 24 participants attended the session, including BHS staff, IHP members, and representatives from various community-based organizations, advocacy groups, and government and non-government agencies.

Participating Organizations Included:

- Choice Medical Group
- Health Center Partners of Southern California
- Health Quality Partners of Southern California
- Indian Health Council, Inc.
- Innercare
- Integrated Health Partners of Southern California
- Jones Day
- Operation Samahan
- Planned Parenthood of the Pacific Southwest
- Rula
- San Ysidro Health
- Southern Indian Health Council

The session opened with an overview of BHSA, followed by a community discussion facilitated by BHS. Nearly 25 comments were submitted digitally through Mentimeter and Microsoft Teams chat, in addition to verbal responses shared during the session. The discussion explored challenges in behavioral health care and shared hopes for improvements under BHSA. Participants offered personal insight based on lived experience, and shared recommendations aimed at strengthening communication, streamlining processes, and making care more accessible and culturally responsive.

Input Session Questions:

1. What supports or workflows would help your clinics/centers identify rising behavioral health (BH) needs earlier and link patients more effectively to specialty BH care?
2. What improvements could we explore as a behavioral health provider (BHP) to help make referrals from your clinics/center to specialty behavioral health care smoother?
3. What training or tools would help your staff better identify and connect patients needing specialty behavioral health care?
4. Which populations you serve face the biggest barriers to entering specialty behavioral health care, and what supports would help improve access?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Gaps in Communication and Coordination are Barriers to Care**
  Stakeholders emphasized that direct points of contact, fewer touch points, and reliable communication channels are essential for maintaining a continuum of care. Participants stated that clear communication is essential to ensure that individuals receive the specialty care that they need.

- **Complex Referral Processes and Navigating Systems are Barriers to Care**
  Audience Members discussed complex referral processes and difficulty navigating different portals and systems as major barriers that prevent clients from seeking care. Participants discussed early identification to ensure that individuals with acute behavioral health needs can receive appropriate care.

- **Need for Comprehensive Training and Tools for Providers**
  Individuals emphasized that information on program criteria and admission is often not up to date, which can lead to challenges when trying to connect a client with appropriate care. Participants discussed the need for evidence-based training and education for staff regarding accessible programs, services, and resources made available at the County.

- **Specific Populations face Different Barriers to Care**
  Community members also identified unhoused individuals, tribal communities, people experiencing severe mental illness, individuals with histories of violent offenses, uninsured individuals, and LGBTQ+ community members as populations that face significant barriers to accessing specialty behavioral health care. Language, accessibility and transportation limitations were also identified as major contributors to these barriers.

- **Building Behavioral Health Systems Rooted in Cultural Competence**
  Participants urged the importance of adopting culturally responsive perspectives for the diverse communities served, with an emphasis on including tribal communities in care plans. For example, incorporating tribal healing practices into behavioral health care.

Audience Recommendations

- **Strengthen Care Continuity Through Dedicated Communication Channels**
  Participants seek to strengthen communication by designating points of contact at County-operated programs to act as a liaison between organizations and ensure direct communication for referrals, treatment updates, and discharge coordination.

- **Streamline Referral Processes and Navigation Systems**
  Centralize referral processes and adopt a hub model to streamline system navigation by consolidating applications, criteria, and contact information into a single system. Provide frequent updates about any changes in program admission criteria. Integrate early identification screening to ensure that individuals with acute behavioral health needs receive appropriate care.

- **Improve Staff Training and Education**
  Provide evidence-based training and resources for staff. Develop a resource hub or forum for providers that keeps program service descriptions, referral pathways, program criteria, and contact information updated and accessible.

- **Address Population Specific Barriers**
  Expand transportation supports, such as providing bus passes or driving-app vouchers, to address barriers for youth, unhoused, and rural clients. Increase language support and employ staff representative of the County's diverse populations. Increase childcare support for single parents who are in treatment.

- **Advancing Tribal Partnerships for Holistic Behavioral Health Solutions**
  Increase tribal community's role in developing health care plans for community members. Incorporate traditional healing in behavioral health care. Provide comprehensive education and training for tribe members.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the December 3, 2025, community virtual input session between the County of San Diego, Behavioral Health Services (BHS) staff and community members focusing on cultivating and expanding the behavioral health workforce under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHSA Input Session: Behavioral Health Workforce
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** December 03, 2025 **Time:** 10:00 AM – 11:30 AM, 5:30 PM – 7:00 PM **Location:** Zoom
Participation	90-Minute Discussions: • 42 Participants • 5 Discussion Questions • 63 total comments from Mentimeter

Summary of Engagement Activity

On December 3, 2025, County of San Diego BHS (BHS) hosted two community input session to discuss the Behavioral Health Services Act (BHSA), and focused discussions on cultivating and expanding the behavioral health workforce. This session was designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 42 participants attended both sessions, including representatives from academic institutions, foundations, behavioral health service providers, housing and homelessness agencies, and individuals with lived experience.

Participating Organizations Included:

- University of California San Diego Department of Psychiatry
- Alliance Healthcare Foundation
- TURN Behavioral Health Services
- Tiny Home Central
- McAllister Institute
- Southern Caregiver Resource Center
- San Diego Housing Commission
- Policy and Innovation Center

The sessions opened with an overview of BHSA, followed by a community discussion facilitated by BHS staff. Nearly 63 comments were submitted digitally through Mentimeter, in addition to verbal discussion. Participants shared insights on workforce development needs, recruitment and retention strategies, training pathways, and cross-sector collaboration to support a sustainable and responsive behavioral health workforce in San Diego County.

Input Session Questions:

1. What supports or strategies would make behavioral health careers more accessible or appealing in your community?
2. What kinds of training, mentorship, or workplace supports help staff stay and thrive in behavioral health roles?
3. How can we expand opportunities for people with lived experience, bilingual skills, or cultural expertise to enter the field?
4. What partnerships (schools, employers, CBOs, or community groups) could help strengthen behavioral health career pathways?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Desire for Support Throughout Continuum of Care**
  Participants emphasized that individuals move between mild, moderate, and severe levels of care over time, and that systems must support step-down care when individuals with severe mental illness (SMI) are stable. Participants stated that prevention, early intervention, and mild-to-moderate services are essential to avoid crisis escalation and overreliance on higher-acuity systems.

- **Workforce Development, Retention, and Sustainability Can Be Improved with Competitive Pay, Benefits, and Room for Advancement**
  Stakeholders identified that competitive pay, benefits, and room for advancement are necessary to attract and retain behavioral health workers. Reasonable caseloads, manageable workloads, and access to self-care were identified as critical to preventing burnout. They also shared the need for more supervision opportunities to obtain licensing hours across a wider range of service settings. Loan forgiveness, scholarships, tuition stipends, and paid internships were repeatedly named as essential workforce supports.

- **Peer Support is a Career Path for Individuals with Lived Experience**
  Group members emphasized that many community members are unaware that peer support specialists are a legitimate career with advancement opportunities. They stressed the importance of funding peer-run organizations and reviving and expanding the Wellness Recovery Action Plan (WRAP). Participants also underscored that employees with lived experience must be allowed to receive services themselves without penalty. Part-time roles were identified as important for peer support specialists, especially those balancing recovery, caregiving, or other responsibilities.

- **Building Behavioral Health Careers Through Early Outreach and Strategic Partnerships**
  Individuals discussed the need to showcase behavioral health careers from peer support roles through doctoral-level professions. Early outreach starting in middle school was repeatedly identified as critical to building a sustainable workforce. Stakeholders highlighted the importance of partnerships with community colleges, universities, and non-traditional educational institutions. Focus groups with youth were suggested to understand barriers and motivations related to entering behavioral health careers.

- **Need for Culturally Responsive and Equitable Community Engagement**
  Finally, participants called for advancing culturally responsive services beyond traditional evidence-based practice frameworks. Stakeholders emphasized the need for culturally and linguistically appropriate opportunities. Community members expressed that current campaigns do not always reflect community values or feel welcoming. Stigma reduction is a key strategy for workforce recruitment and service engagement.

Audience Recommendations

- **Integrating Step-Down Care and Early Mental Health Support Across All Ages**
  Audience members shared that BHSA planning explicitly supports step-down care and continuity across acuity levels. This should include infant and early childhood mental health services in planning and funding models, even when they do not fit traditional billing categories. Providing wellness programs in schools from grades K-12 teaching emotional learning and coping skills is also a positive measure in supporting youth mental health.

- **Strengthen Workforce Sustainability and Retention**
  Align contracts and funding with realistic caseload limits, supervision capacity, and staff well-being. Expand paid internships, apprenticeships, and “earn-and-learn” models to reduce workforce attrition. Increase access to qualified supervisors and standardize supervision quality to support licensure pathways.

- **Expand Peer-Led and Recovery Oriented Services**
  Invest in peer mentorship models and career ladders for individuals with lived experience. Include dedicated funding for peer-run organizations and Wellness Recovery Action Plan (WRAP) implementation across community and school settings. Ensure employment policies support workers with lived experience, including access to services and flexible schedules.

- **Build Clear Career Pathways and Early Workforce Pipelines**
  Create clear, visible career pathways that span entry-level to licensed roles. Partner with schools, community colleges, and workforce agencies to expand early exposure and non-traditional education routes. Engage youth directly to inform workforce outreach and messaging strategies.

- **Advance Cultural Responsiveness, Equity, and Community Engagement**
  Review and adapt evidence-based practices through a cultural responsiveness lens. Develop community-informed outreach and stigma-reduction campaigns. Strengthen partnerships with culturally rooted organizations, caregivers, and advocacy groups such as National Alliance on Mental Illness (NAMI).

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the December 5, 2025, Behavioral Health Services Act (BHSA) input session between the County of San Diego, Behavioral Health Services (BHS) and San Diego State University's (SDSU) Master of Social Work (MSW) Training Program focusing on cultivating and expanding the behavioral health workforce under BHSA.

Section	Details
Engagement Title	BHSA Input Session: SDSU MSW Training Program
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Friday, December 5, 2025 **Time:** 1:00 PM – 2:00 PM **Location:** Zoom
Participation	60-Minute Discussion: • 20 attendees • 5 discussion questions • 32 comments through Mentimeter in addition to verbal discussion

Summary of Engagement Activity

On December 5, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with San Diego State University's (SDSU), Master of Social Work (MSW) Training Program, hosted a virtual community input session for students serving in behavioral health, social services, and community health professional programs. This session was designed to gather stakeholder insights to cultivate and expand the behavioral health workforce under the Behavioral Health Services Act (BHSA) Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 20 participants attended the session, including BHS staff and MSW students with placements in various organizations.

Placement Organizations Included:

- San Diego County Psychiatric Hospital
- NextMove
- University of California San Diego Health – Hillcrest
- Union of Pan Asian Communities Counseling and Treatment Center
- Integrated Health Partners at Father Joe's Villages
- San Diego County Probation Department – Integrated Healthcare Services Unit
- San Diego City College
- Rady Children's Chadwick Center Trauma Counseling Department
- TAY Specific ACT Program through Catalyst Clarvida
- Riverside Desert Crisis Stabilization Unit in Palm Springs

The session opened with an overview of the BHSA IP, followed by a 30-minute facilitated discussion led by BHS. Participants contributed 32 comments through Mentimeter, alongside verbal and chat responses shared during the discussion. Conversations focused on strategies to strengthen behavioral health career pathways, support workforce retention, expand opportunities for individuals with lived experience or cultural expertise, and foster community partnerships.

Input Session Questions:

1. What supports or strategies would make behavioral health careers more accessible or appealing in your community?
2. What kinds of training, mentorship, or workplace supports help staff stay and thrive in behavioral health roles?
3. How can we expand opportunities for people with lived experience, bilingual skills, or cultural expertise to enter the field?
4. What partnerships (schools, employers, CBOs, or community groups) could help strengthen behavioral health career pathways?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Mentorship, Financial Assistance, and Outreach for Behavioral Health Pathways**
  Participants stated that behavioral health careers are more accessible when new staff are paired with assigned mentors, internships are paid, and financial assistance is available for those facing educational or loan barriers. Participants emphasized that promoting behavioral health career paths in high schools, community colleges, and community centers can raise awareness and interest.

- **Supportive Management Helps Staff Thrive in Behavioral Health Roles**
  Audience members emphasized the importance of structured individual and group supervision, supportive and flexible management, and open communication to help staff navigate challenges. Compassionate management, appreciation, trauma-informed workplaces, and safe spaces to debrief were identified as key factors to prevent burnout. Participants also shared that team activities and informal check-ins with supervisors can help staff feel less isolated and better equipped to manage work related stress.

- **Promoting a Culturally Responsive Behavioral Health Workforce Can Improve Engagement in Underrepresented Communities**
  Stakeholders emphasized the importance of a culturally responsive workforce by citing the need for multilingual services, partnership with trusted community organizations, and expansion of peer support roles. They discussed framing behavioral health careers in culturally responsive ways, such as by acknowledging stigma, recognizing holistic health frameworks, and presenting positions as opportunities to uplift communities, can increase recruitment and engagement for underrepresented communities.

- **Safe-Space Community-Based Outreach Boosts Behavioral Health Awareness**
  Participants described schools, community centers, and food banks as accessible and trusted spaces to increase familiarity with behavioral health services. Participants emphasized embedding behavioral health resources in schools is a particularly important pathway for students whose parents may lack familiarity or time to navigate such services independently.

Audience Recommendations

- **Expand Access to Behavioral Health Careers**
  Participants recommended promoting behavioral health careers through partnerships with schools, community centers, and outreach efforts in underserved communities to increase awareness amongst youth. Providing paid internships, financial assistance, and formal mentorship programs for professional students was also suggested.

- **Create Inclusive and Culturally Responsive Behavioral Health Career Pathways**
  Expand peer support roles, create multilingual outreach efforts, and reduce educational barriers to enable more community members to enter the behavioral health workforce. Partner with trusted community organizations to position behavioral health careers as opportunities to uplift communities and address stigma.

- **Strengthen Workplace Support and Increase Staff Retention by Providing Structured Supervision and Opportunities for Reflection**
  Establish regular staff support groups and reflective activities to reduce isolation and mitigate burnout. Implement structured individual and group supervision with clear expectations and measurable outcomes. Cultivate supportive and flexible leadership, and create safe, accessible spaces for staff to debrief and discuss work-related challenges. Monitor staff engagement and well-being to ensure these practices effectively support workforce retention and resilience.

- **Promote Behavioral Health Career Pathways in Trusted Community Spaces**
  Embed behavioral health resources in familiar community, school, and family settings to increase accessible, approachable services for youth and families. Integrate structured exposure to behavioral health careers in these settings to foster sustained interest among youth. Track participation and engagement to evaluate the impact on service utilization and workforce development.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the December 9, 2025, community input session between the County of San Diego Behavioral Health Services (BHS) and community members focusing on early intervention planning under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	BHSA Input Session: Early Intervention
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** December 9, 2025 **Time:** Morning 10:00 AM – 11:30 AM, Evening 5:30 PM – 7:30 PM **Location:** Zoom
Participation	Participation: • 75 attendees • 5 of discussion questions • 34 comments through Mentimeter, in addition to verbal discussion

Summary of Engagement Activity

On December 9, 2025, the County of San Diego Behavioral Health Services hosted two virtual community input sessions to gather stakeholder perspectives to inform the development of the early intervention under the Behavioral Health Services Act (BHSA) Integrated Plan (IP) for the Fiscal Years 2026-2029.

Approximately 75 participants attended both sessions, including families, caregivers, community-based service providers, school staff, and individuals with lived experience.

Participating Organizations Included:

- Charlie Health
- Union of Pan Asian Communities
- American Academy of Pediatrics - CA3
- San Diego Unified Schools District Mental Health Resource Center
- Jewish Family Services Positive Parenting Program
- San Diego Youth Services
- South Bay Community Services
- Harmonium Inc.
- Rady Children's Hospital KidSTART
- YMCA
- One Safe Place
- First 5
- CoSD Children and Family Wellbeing
- CoSD Behavioral Health Services
- CoSD Programs & Services

The session opened with an overview of BHSA and early intervention, followed by a facilitated community discussion led by BHS staff. Participants contributed both verbally and through the chat, providing insights on family engagement, early identification, prevention, and intervention strategies. The discussion explored topics including early screening and school-based mental health supports, culturally appropriate responses, loss of prevention funding, need to strengthen early intervention, improving coordination between systems, and sustaining funding.

Input Session Questions:

1. What helps youth and families notice early mental health concerns and know where to seek help?
2. What approaches or partnerships could we continue building on to help schools/orgs connect youth to early mental health care?
3. How can early clinical supports feel welcoming, respectful, and culturally aligned for communities?
4. What early mental health supports should the State focus on to better meet the needs of San Diego County youth and families?
5. Any other feedback you would like to share with Behavioral Health Services for the BHSA Integrated Plan?

Key Learnings

- **Early Screening and School-Based Systems are Essential Entry Points to Care**
  Participants strongly supported continued and expanded early mental health screening, including universal screening tools and prevention & early intervention (PEI) supported Screening to Care programs. Stakeholders also emphasized embedding mental health supports into school systems through integrated curricula, standardized referral protocols, and immediate connection to services when risk is identified. The group shared that schools alone cannot be responsible for prevention and early intervention and that broader community investment is required. Within the future BHSA framework, prevention funding will no longer be under local control as these funds will be allocated to the state level under California Department of Health Care Services (DHCS). Additionally, funding dedicated to early intervention must meet certain criteria to primarily reach those with clinical early indicators or clinical risk of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

- **Prevention and Early Intervention are Community-Wide Responsibilities**
  Audience members shared that prevention and early intervention should not be limited to Medi-Cal eligible students and should be available to all youth. Contributors emphasized that PEI efforts reflect a broader investment in the long-term health and wellness of children and communities. Community members repeatedly highlighted that prevention funding is critical to maintaining stability and reducing downstream system involvement.

- **Fragmented Systems Put Children at Risk of Falling Through the Cracks**
  Participants emphasized that fragmented service delivery between counties, schools, and state systems creates gaps in care. Attendees expressed a strong desire for a cohesive and comprehensive system of care that maintains prevention and early intervention together. Advocates raised concerns about parallel systems operating without sufficient coordination or guidance for providers.

- **Desire for Sustained Investment in PEI and Early Childhood Prevention**
  Participants emphasized that PEI fills a critical gap by preventing escalation, reducing trauma, and keeping families stable in their homes, schools, and communities. Individuals stressed that not investing in prevention and early intervention is equivalent to delaying problems that will surface later at higher cost. Representatives specifically advocated for proportional or increased investment in birth-to-five prevention, noting its high return on investment.

Audience Recommendations

- **Expand Early Screening and School Based Systems**
  Participants advocate for embedding mental health into school systems using integrated social-emotional learning curricula. Related efforts would include expanding universal screening tools to identify early signs of mental health concerns and standardizing referral protocols to enable teachers and counselors to connect students to services immediately when risk is identified.

- **Strengthen Prevention and Early Intervention in Communities**
  While prevention funds will be appropriated at a state level, audience members shared their desire for prevention and early intervention supports to all youth, not just Medi-Cal-eligible students, to be sustained locally through other means, if possible. They seek broader community investment to support the long-term health and wellness of children and youth. Sustaining and increasing funding for prevention and early intervention efforts helps maintain family stability by addressing a critical gap that prevents escalation and reduces trauma. Also, participants noted the need to direct proportional or increased funding for youth, zero-to-five, as a way to protect early childhood prevention efforts to avoid future higher-cost interventions, such as Emergency Room visits, preschool expulsions, and child welfare involvement.

- **Improve Coordination between Systems**
  Ensure prevention and early intervention remain connected and cohesive across County, school, and state systems. Provide clear guidance and coordination for providers navigating parallel systems so children and families do not fall through service gaps.

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Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes the December 11, 2025, virtual input session between the County of San Diego Behavioral Health Services (BHS) and the Alcohol and Drug Service Providers Association (ADSPA), focusing addressing substance use disorder (SUD) concerns under the Behavioral Health Services Act (BHSA).

Section	Details
Engagement Title	Alcohol and Drug Service Providers Association (ADSPA)
Format	☐ In-person ☒Virtual ☐Hybrid
Activity Details	**Date:** Thursday, December 11, 2025 **Time:** 10:30AM – 11:30AM **Location:** Zoom

Participation	Participation:
	• 52 attendees
	• 5 discussion questions
	• 100+ comments received:
	  ○ 92 comments submitted through Mentimeter
	  ○ 10 comments through open discussion

Summary of Engagement Activity

On December 11, 2025, the County of San Diego Behavioral Health Services (BHS), in collaboration with Alcohol and Drug Service Providers Association (ADSPA), hosted a virtual community input session focused on addressing substance use disorder (SUD) concerns. This session was designed to gather stakeholder insights to shape the County's first Behavioral Health Services Acts (BHSA) Integrated Plan (IP) for Fiscal Years 2026 – 2029.

Approximately 52 participants attended the session, including behavioral health service providers and housing and homelessness agencies. Organizations in attendance represented a broad cross-section of substance use disorder treatment providers, recovery residences, family and youth services, culturally specific and Deaf-serving programs, housing and transitional support organizations, Medication Assisted Treatment (MAT) providers, and community-based behavioral health agencies serving diverse populations across San Diego County.

Participating Organizations Included:

- New Entra Casa
- The Way Back
- McAlister Institute
- Healing Oaks Clinic SUD
- South County Center for Change
- Jewish Family Service
- Turning Point Home
- SOAP MAT, LLC.
- ACTION East SUD
- Union of Pan Asian Communities
- Heartland House
- East County Center for Change
- North Inland Teen Recovery Center
- Crossroads Foundation
- ParentCare
- Signs of Life Deaf Recovery
- Family Health Centers of San Diego
- San Diego Freedom Ranch
- TURN Behavioral Health Services

The session opened with an overview of BHSA, followed by a community discussion facilitated by BHS staff. Participants made recommendations through Mentimeter, Zoom chat, and verbal discussion. Participants emphasized low-barrier access, family and community supports, stable housing, flexible services, and integrated wraparound care to improve engagement and recovery. Insights focused on strengthening coordination, transparency, and workforce capacity to support long-term stabilization for individuals with complex behavioral health and housing needs.

Input Session Questions:

1. What low-barrier or community-based supports help people with emerging SUD concerns feel comfortable with seeking help earlier?
2. What approaches or partnerships could we strengthen locally to support people and families affected by substance use disorders or engaged in recovery?
3. What early supports could help people with SUD or other behavioral health concerns, who are also facing instability, stay connected before needs escalate?
4. What kinds of intensive wraparound supports help people with serious SUD and housing challenges move toward stability?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Low-Barrier Access and Simplified Entry Points are Integral to Early Intervention** Participants emphasized that first-time enrollment programs and recovery residences with minimal paperwork allow individuals to enter care when motivation is high. Participants mentioned that delays, complex intake procedures, and long waitlists were noted as barriers that cause disengagement before treatment begins. Immediate, low-threshold entry points are essential for early help-seeking.

- **Family and Collaterals Support Are Critical for Recovery**
  Families are critical partners in recovery, even when clients are not yet enrolled. Stakeholders highlighted trauma-informed family coaching, drop-in centers, and outreach to caregivers of individuals in encampments as essential. Participants suggested early family support improves navigation, crisis prevention, and long-term recovery outcomes.

- **Desire for Improved Equity and Access in SUD Care**
  Many participants stressed that uninsured, underinsured, or immigration-limited populations face barriers to SUD services. Income-based thresholds (e.g., under 200% Federal Poverty Level) and funding for individuals with documentation challenges reduce gaps in care. Participants emphasized the need to ensure these populations can access recovery programs as vital to prevent disengagement and crisis.

- **Community-Based Partnerships are Important for Sustained Engagement**
  Many community organizations, including bilingual family education programs, veteran coalitions, and NAMI San Diego, were highlighted as key partners. Participants emphasized that these partners provide trust, cultural relevance, and outreach capacity systems alone cannot replicate. Participants stressed that discontinuing these partnerships could disrupt engagement for high-need populations.

- **Housing is a Foundation for Recovery**
  Stable housing allows clients to focus on recovery and maintain family stability. Recovery residences, transitional sober living, and Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) supported placements were cited as critical but underfunded tools. Participants mentioned that integrated housing and care reduce crises and improve engagement in behavioral health services.

- **Rapid Access to Services is Crucial to SUD Care**
  Same-day or next-day intake and pre-funded admission pathways were noted as crucial. Bridge services between detox and residential programs maintain engagement when waitlists exist. Participants suggested rapid access prevents relapse, disengagement, and escalation of SUD or behavioral health crises.

- **Warm, Person-Centered Engagement is Crucial for Sustained Engagement**
  Live human contact, afternoon/evening check-ins, and relational outreach were repeatedly highlighted. Automated systems and impersonal communication were described as barriers to engagement. Participants emphasized that personal connection builds trust, reduces dropout, and improves follow-through during transitions.

- **Expanded and Flexible Service Hours**
  Opioid Treatment Programs (OTP) and outpatient services need evening and weekend availability. Flexible scheduling aligns with work, transportation, and family obligations. Stakeholders emphasized that service availability must match clients' real-world schedules to maintain retention.

- **Wraparound Supports Must Address Client Needs, Not Just SUD Care**
  Participants stressed combining behavioral health, medical care, recovery services, housing, and social supports to meet complex client needs. Examples included MAT, structured recovery residences, employment support, and child reunification services. Siloed services risk gaps, dropout, or relapse.

- **Desire for Transparency in Funding, Policy, and Workforce Capacity**
  Stakeholders stressed the need for clear communication on MHSA to BHSA funding allocations, Residential SUD categorization, and Drug Medi-Cal Organized Delivery System (DMC-ODS) reimbursement rates. Understanding funding and policy structures supports planning, program expansion, and workforce development is of utmost importance. Participants shared transparency strengthens provider confidence, accountability, and system-wide coordination.

Audience Recommendations

- **Streamline Enrollment Strategies**
  Participants recommend implementing walk-in and same-day enrollment for first-time SUD clients. Reduce paperwork intake requirements during admission and prioritize speed over documentation. Community partners should publicize low-barrier access points to ensure awareness among vulnerable populations.

- **Strengthen Early Family Engagement Initiatives**
  Employ trauma-informed family coaching, drop-in education centers, and bilingual support groups to address family needs. Allocate funding for these services regardless of client enrollment to ensure equitable access. Systematically engage families living in encampments or transitional housing and connect them with appropriate resources through outreach teams.

- **Expand Equity-Focused Access and Coverage Policies**
  Adopt income-based eligibility thresholds (e.g., under 200% FPL) for all county-funded SUD programs to promote equitable access. Establish safeguards to ensure that immigration status, documentation requirements, or Medi-Cal redetermination processes do not impede service access. Maintain sufficient capacity to serve uninsured and underinsured populations, with the goal of closing gaps in care and ensuring continuity of services.

- **Sustain and Support Community Partnerships**
  Secure ongoing funding to support effective community-based organizations. Providers desire to establish and maintain formal Memorandum of Understanding (MOUs) and referral agreements with outreach teams, housing providers, and veteran/military support networks to strengthen service coordination. Sustaining these investments can ensure continuity of culturally responsive services for high-need populations and minimizing service gaps.

- **Integrate Housing and Recovery Services**
  Intentionally connect behavioral health and housing leaders to collaboratively plan and fund family-inclusive recovery housing, transitional sober living, and recovery residences. Providers can collaborate with housing navigators and Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) workers to structure placements. Prioritize stable housing as an integral component of recovery planning.

- **Ensure Rapid Intake and Bridge Services**
  Develop same-day or expedited intake pathways for detox, residential, and transitional services. Maintain pre-funded admission options and bridge services between levels of care. Rapid linkage is examined as a factor that may impact both the risk of relapse and client trust in the system.

- **Implement Personalized Engagement Practices**
  Providers should staff live phone lines and offer afternoon/evening check-ins. Ensure outreach teams maintain consistent relational contact rather than relying solely on automated systems. Additionally, participants seek funding to support staffing models that support personalized engagement during critical touchpoints.

- **Offer Expanded and Flexible and Accessible Service Hours**
  Extend facility operating hours into evenings and weekends for Opioid Treatment Programs (OTP), outpatient, and wraparound programs. Align provider schedules with client availability, including work and family obligations. Incentivize programs through BHS and funders that demonstrate flexible and accessible service delivery.

- **Develop Holistic, Multidisciplinary Support Models**
  Establish multidisciplinary teams that combine behavioral health, medical, recovery, housing, and social service specialists. Incorporate MAT, structured recovery residences, employment support, and child reunification services into programs. Fund and monitor these integrated programs through BHS to reduce siloed care and support relapse prevention.

- **Increase Transparency in Funding and Workforce Planning**
  Publish clear guidance on MHSA to BHSA funding allocations, Residential SUD categorization, and DMC-ODS reimbursement rates. Ensure providers understand how funding impacts program sustainability and staffing needs. Communicate transparently to support workforce planning, system coordination, and informed program expansion.

Please note: *This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities*

Community Engagement Activity Summary: Behavioral Health Services Act (BHSA)

Overview: This report summarizes three input sessions (virtual and in-person) held on December 16th and 18th, 2025, by the County of San Diego Behavioral Health Services (BHS) and in partnership with One Safe Place and community-based organizations. These sessions were convened to gather community-based insights on behavioral health needs of survivors of domestic violence and sexual assault and the community providers who support this community.

Section	Details
Engagement Title	BHSA Input Session: Survivors of DV/SA & Support Providers
Format	☒ In-person ☒Virtual ☐Hybrid
Activity Details	**Date**: December 16, 2025 (Virtual) **Time**: 12:00 pm – 1:00 pm **Location**: Zoom --- **Date:** December 18, 2025 (In-person) **Time:** South: 1:00 PM – 2:00 PM, North: 3:00 PM – 4:00 PM **Location**: • South: One Safe Place South: 301 Mile of Cars Way, National City, CA 91950 • North: One Safe Place North: 1050 Los Vallecitos Blvd, San Marcos, CA 92069

Participation	60-minute Discussions:
	• 43 attendees across three sessions
	• 5 discussion questions
	• Approximately 70 total comments
	  ○ 20 total comments through Mentimeter
	  ○ 50 verbal comments

Summary of Engagement Activity

On December 16th and 18th, 2025, the County of San Diego Behavioral Health Services (BHS) convened input sessions through a series of virtual and in-person input sessions. The virtual session was held solely by BHS while the in-person sessions were hosted in partnership with One Safe Place and their community provider meetings to gather feedback on improving access, coordination, and effectiveness of behavioral health services for survivors of domestic violence and relationship violence. These sessions were designed to gather early input and inform the development of the County's first BHSA Integrated Plan (IP) for the Fiscal Years 2026-2029.

Participants included victim advocates, behavioral health providers, case managers, and community-based organizations serving survivors across the lifespan.

Participating Organizations Included:

- One Safe Place
- One Safe Place – District Attorney
- Palomar Health – Forensic Health & Trauma Recovery Services
- San Diego District Attorney Victim Assistance Program
- Women's Resource Center
- Adult Protective Services
- San Diego State University
- Lotus Integrative Counseling
- Mosaic Therapy
- University of San Diego
- Your Safe Place – The San Diego Family Justice Center
- COSD Department of Child Support Services
- Esco Kids
- Center for Community Solutions

The sessions opened with an overview of BHSA while explaining the purpose of the Integrated Plan (IP), followed by a 30-minute facilitated discussion led by Behavioral Health Services (BHS) staff. Participants shared verbal input, as well as Mentimeter and chat-based responses throughout the sessions. Discussions centered on the need for centralized and co-located services, trauma-informed and survivor-centered case management, rapid access to behavioral health care, and stabilization of basic needs including housing, food, transportation and safety.

Input Session Questions:

1. What supports help survivors of sexual or relationship violence access or stay connected to behavioral health services?
2. What can be done to overcome barriers that make it harder for survivors of sexual or relationship violence to access or stay connected to services?
3. What intensive or wraparound supports help people with lived experience of sexual or relationship violence move toward stability?
4. How could specialty behavioral health services better coordinate with medical care, victim advocacy, or housing while respecting safety and choice?
5. Anything else you would like to share with BHS for the BHSA Integrated Plan?

Key Learnings

- **Centralizing Hub-Based Models can Improve Survivor Engagement and Safety**
  Participants consistently stated that survivors are more likely to access and remain engaged in behavioral health services when they can enter through a centralized, single point of access rather than navigating multiple disconnected programs. Having all core services in one location, such as family justice center or hub-based models, reduces drop-off, increases feelings of safety, and minimizes the need for survivors to repeatedly explain their experiences.

- **Trauma-Informed Case Management is Integral to the Healing Process**
  Respondents emphasized the importance of a dedicated, trauma-informed case manager or navigator who remains a consistent point of contact throughout the survivor's healing process. Participants distinguished trauma-informed case management from general navigation, noting that effective navigators must understand trauma responses, recovery timelines, and survivor readiness rather than relying on rigid service expectations.

- **Quick Access to Behavioral Health Services is Critical After an Incident**
  Stakeholders stressed that rapid access to trauma-focused therapy shortly after an incident is critical, noting that long waitlists or delayed intakes often result in missed intervention windows and disengagement. Both short-term crisis intervention and longer-term therapy are necessary, emphasizing that trust-building alone often takes more than the commonly available limited number of sessions.

- **Unmet Basic Needs Can Prevent Survivors from Seeking Care**
  Individuals consistently stated that unmet basic needs such as food, housing, utilities, hygiene, and safety prevent survivors from engaging meaningfully in behavioral health services. Providing basic needs support alongside therapy, rather than sequentially, improves engagement and reduces crisis-driven decision-making.

- **Transportation Remains an Ongoing Barrier to Care**
  Participants repeatedly identified transportation as a persistent barrier, emphasizing the need for ongoing transportation support for therapy, medical care, court appearances, housing appointments, and follow-up services rather than one-time assistance. Flexible transportation options such as gas cards, rideshare services, bus passes, or paid transportation are essential for older adults, families, youth, and survivors with complex schedules.

- **Strong Desire for Flexible and Holistic Approach to Wraparound Services**
  Participants emphasized that wraparound services are most effective when they integrate behavioral health care with housing support, medical coordination, benefits access, childcare, education, and financial stabilization. Flexible financial assistance such as emergency housing gaps, utility support, medication costs, or short-term hotel stays help survivors stay engaged in care and avoid destabilizing crises. Empowerment-based approaches, including survivor choice, motivational interviewing, and voluntary participation, support long-term engagement better than compliance-driven requirements.

Audience Recommendations

- **Expand Integrated Housing and Service Hubs**
  Participants seek to develop trauma-informed, survivor-specific housing pathways, including options for medically fragile or otherwise ineligible individuals, coordinated with behavioral health, medical, and advocacy services. They recommend investments in centralized, hub-based models such as family justice centers that co-locate housing, healthcare, legal advocacy, and comprehensive wraparound supports like childcare, education, employment readiness, financial assistance, and medical follow-up. Integrated approaches can be associated with reduced barriers, greater continuity of care, and more streamlined service pathways for survivors.

- **Implement Single Point of Contact, Trauma-Informed Case Management**
  Designate permanent advocates or care coordinators as consistent points of contact for survivors across behavioral health, medical, advocacy, and housing systems. These individuals should track service histories, coordinate referrals, and maintain trusted relationships, ensuring continuity and reducing repetition. Fund these roles as core services with specialized training in sexual assault, intimate partner violence, and recovery timelines to enhance survivor-centered support.

- **Ensure Flexible Therapy Access and Streamline Administrative Processes**
  Support survivors with timely access to therapy through rapid intake, same-day or near-term appointments, and extended session limits when clinically recommended. Streamline administrative processes to minimize waitlists and prevent disengagement. Flexible access can support continuity for survivors facing housing, transportation, or family-related barriers.

- **Expand Transportation to Support Survivor Needs**
  Provide ongoing, flexible transportation assistance to cover repeated appointments, court proceedings, therapy sessions, and other survivor needs. Options may include rideshare, gas cards, and public transit support. Transportation reliability can affect appointment attendance, continuity of services, and overall engagement across systems.

- **Formalize Cross-System Coordination and Shared Tools**
  Establish regular coordination meetings among behavioral health, medical, housing, and advocacy agencies to share updates on services, eligibility, and referral pathways in multidisciplinary team format. Develop shared tools such as updated contact lists, referral maps, and eligibility guides accessible to all staff. Interagency relationships and shared resources may influence efficiency, duplication, and the likelihood of service gaps for survivors.

- **Uphold Survivor Choice, Informed Consent, and Confidentiality**
  All coordination and referrals must prioritize survivor autonomy, safety, and confidentiality. Survivors should control which providers communicate and what information is shared. Consider centering survivor choice as a strategy to support trust, engagement, and survivor-led decision-making in recovery.

- **Reduce Reliance on Law Enforcement and Expand Crisis Options**
  Develop non-punitive, community-based pathways for survivors in crisis, reducing the need for law enforcement involvement. Centralized contact points, such as 988 or specialized hotlines, can provide confidential, coordinated support. Examine service systems opportunities to limit punitive touchpoints to support safety and engagement.

- **Promote Sustainable, Culturally Competent, and Innovative Partnerships**
  Prioritize long-term funding for core services such as advocacy, case management, peer support, and cross-system coordination. Invest in culturally competent providers and flexible contracting with specialized partners to expand reach, responsiveness, and inclusivity. Proactively align policies, maintain stable programs, and encourage innovative partnerships to strengthen the BHSA system and ensure consistent, survivor-centered care.

***Please note**: This document provides a high-level summary of key learnings and preliminary recommendations from session audience members. It does not represent a comprehensive analysis of all feedback received, nor does it reflect consensus of participants or final funding determinations. The insights included from the session are intended to help guide future BHS policies and/or actions that address community needs. This summary may be updated to reflect additional input or evolving priorities.*

APPENDIX C

30 Day Public Hearing Notice

Sent to members of the public

(Individuals who opted to sign up for our BHSA newsletter distribution list on the BHSA webpage; These community members reflected service providers, family members, county staff, participants of CPP engagements and more)

From: HHSA, BHSEngage <BHSEngage.HHSA@sdcounty.ca.gov>
Sent: Wednesday, March 18, 2026 10:22 AM
To: HHSA, BHSEngage <BHSEngage.HHSA@sdcounty.ca.gov>
Subject: Help Shape San Diego County's BHSA Integrated Plan

Greetings,

Thank you for signing up to receive **Behavioral Health Services Act (BHSA)** updates from the County of San Diego Behavioral Health Services (BHS).

***

THE BHSA PUBLIC COMMENT PERIOD IS OFFICIALLY ONLINE:
San Diego County is holding a 30-day public review and comment period for the BHSA IP for FY 2026-2029. Community members, providers, and partners are invited to review the plan and share feedback during the 30-Day public comment period.
Public comment period is open from March 17, 2026 – April 15, 2026. Below are the various ways a community member can provide feedback:

- **Engage San Diego County**- online platform that allows you to review and provide public comment directly to the draft BHSA IP.
- Visit the **County's BHSA Webpage** to download a copy of the draft BHSA IP and share your feedback in our **BHSA Integrated Plan 30-Day Public Comment Form.**
- Call phone number **619-584-5063 or Toll-Free: 888-977-6763** to share your feedback with our dedicated voicemail.
- Finally, you may email: **Engage.BHS@sdcounty.ca.gov** to share your thoughts as well.

ENGAGE SAN DIEGO COUNTY
BHS invites you to explore the **Engage San Diego County BHSA Integrated Plan website** where the draft BHSA Integrated Plan is now posted. We encourage you to **register** for this platform in order to provide public comment. In this process, we you will create a brief profile and once logged in each of your comments will become publicly viewable in the actual document attributed to the certain section or page you are reviewing. This process is similar to providing a post or comment in the same way you provide a comment within a pdf document. To see the draft BHSA IP, please scroll down the page.

ALL OTHER METHODS
For those of you who prefer to provide public comment via the BHSA Integrated Plan 30-Day Public Comment Form, phone call, or email, we encourage you to download and review the draft BHSA Integrated Plan and share your comments in detailed fashion referring to specific parts of the draft BHSA IP.

For additional details, please review the BHSA Public Hearing Notice (attached) and continue to review ongoing BHSA updates, frequently asked questions, and engagement materials at bit.ly/BHSA_BHS.

Accessibility & Support
Disability-related accommodations, language interpretation (including American Sign Language), and written materials in alternative languages and formats are available upon request. Please submit your

request at least 72 hours in advance of the event to Engage.BHS@sdcounty.ca.gov or by calling (619) 854-1363.

We value your input and look forward to working together to shape how San Diego County brings BHSA to life in ways that best serve our diverse communities.

Warm regards,

Community Outreach & Engagement
Strategy & Finance - Communication and Engagement
County of San Diego Behavioral Health Services

CS

If you no longer wish to receive correspondence on BHSA-related activities and information, please reply "Remove" so we can remove you from our mailing list.

Sent to All BHS staff, BHAB and MHCA/ADSPA

From: Milton, Betty <Betty.Milton@sdcounty.ca.gov>
Sent: Tuesday, March 17, 2026 8:23 AM
Subject: 30-Day Public Review and Comment Period | BHSA Integrated Plan

Bcc'd to BHS All Staff, BHAB, and MHCA/ADSPA

Sent on behalf of Nadia Privara Brahms, Director, Behavioral Health Services

NOTICE OF INITIATION OF 30-DAY PUBLIC REVIEW AND COMMENT PERIOD
RE: BHSA INTEGRATED PLAN

Dear Community Members and Stakeholders,

The County of San Diego is holding a 30-day public review and comment period for the Behavioral Health Services Act (BHSA) Integrated Plan (IP) for Fiscal Years 2026-2029. The BHSA three-year Integrated Plan outlines the intended use of funds and a budget for specialty behavioral health programs, as well as demographic descriptions, community needs, and statewide goals.

The review period begins March 17, 2026, and ends April 15, 2026. Final public comments will be heard at the Behavioral Health Advisory Board (BHAB) meeting on May 7, 2026. The BHSA IP is planned to go before the County of San Diego Board of Supervisors on May 19, 2026, for their review and approval, as required by the State.

Behavioral Health Services will implement the new BHSA Integrated Plan on July 1, 2026. BHSA requires new programming, adjustments to existing services, expanded reporting and data requirements, and enhanced community engagement. These changes will affect our local behavioral health network and include more comprehensive financial reporting across all behavioral health funding sources.

The BHSA Integrated Plan can be found on the Engage San Diego County webpage, or via the QR code below. Public comments can be submitted directly on Engage San Diego County or by using the BHSA comment/question voice message line or e-mail address below.

Behavioral Health Services Act Public Comment	
Engage San Diego County: BHSA Integrated Plan	
Phone	619-584-5063 / Toll-Free: 888-977-6763
Email	Engage.BHS@sdcounty.ca.gov

Public hearing details will be posted on the BHAB webpage prior to May 7.

Nadia Privara Brahms, MPA, Director
Behavioral Health Services
County of San Diego

{this was the one page attached to emails}

NOTICE OF INITIATION OF 30-DAY PUBLIC REVIEW AND COMMENT PERIOD

RE: BHSA INTEGRATED PLAN

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Behavioral Health Services Act Public Comment	
Engage San Diego County: BHSA Integrated Plan	
Phone	619-584-5063 / Toll-Free: 888-977-6763
Email	Engage.BHS@sdcounty.ca.gov

Public hearing details will be posted on the BHAB webpage prior to May 7.

NADIA PRIVARA BRAHMS, MPA, Director
Behavioral Health Services
County of San Diego

APPENDIX D

Public Comments

Stakeholder Feedback on the Draft Integrated Plan

The following feedback was received between March 17, 2026, and May 7, 2026, through multiple opportunities for community and stakeholder input related to the draft Integrated Plan review process, including:

- Community meetings and stakeholder discussions
- Digital engagement platform (Engage San Diego)
- Online feedback forms (Smartsheet)
- Public Hearing with the Behavioral Health Advisory Board (BHAB)
- Voicemails
- Email submissions including letters from organizations

Community Meetings and Stakeholder Discussions
Total: 158

All Responses

- (Peer support specialists) Need measures to ensure part time positions (due to needing to stay on SSI and other reasons)
- (Peer support specialists) Need to maintain authenticity in peer support amidst process of Medi-Cal billing
- (Peer support specialists support) community linkages
- (Peer support specialists support) community education about what sorts of therapeutic techniques and services are offered in facilities
- Agree with recovery and social connection needed. Maintaining effectiveness and authenticity of relationships even with medical billing
- Agree with peer respites (this was included in the IP)
- Does the IP increase or decrease support for involuntary treatment options?
- TAY representation missing from BHAB. Given the docus on children and youth, and the shift away from HHSA, how will BHS continue youth engagement and services.
- Were stakeholders consulted for Older Adults?
- How to distinguish between prevention and early intervention?
- Funds should go to increasing treatment beds at all levels of the continuum of care rather than temporary CSU's
- CPP- is that what UCSD does?
- Where is the data on performance outcomes of CSU's?
- Opportunity for BHS to create alignment across stakeholders to demonstrate how well we collectively achieve goals.
- CPP is not just community input, it should involve collaborating with stakeholders to develop a plan.
- The community doesn't have a clear process for staying informed, so people don't know what to expect throughout the year. The report doesn't explain how the CPP is being planned, which makes it difficult to give meaningful feedback. There are many

ways this could be improved, and there's concern that an important opportunity for community engagement is being missed.

- Request for more opportunities in the next three years for CPP input
- The ability to view all public comments provided by individuals. Not seeing these prevents like-minded people to share their perspective, which seems to defeat the intent of the process.
- I noticed that the Community Program Planning report that was conducted by UCSD, everything other than the event descriptions is missing, including the analysis and recommendations. Can we get a copy of that report including the analysis and recommendations?
- I understand that we are budgeting $12.5 million for community program planning process. Where is the plan for this CPP effort in this report? I noticed that there are different elements referenced in the document as submitted via spreadsheet, etc.
- Population goals are central to the shift from MHSA to BHSA. Our work needs to be aligned with how we will move those goals in a measurable way. The goals should guide the entire planning and implementation process. It is important that we identify which goals we aim to impact and specify the exact targets we plan to achieve. Using general terms like "above" or "below" is no longer sufficient – we need to name concrete, measurable outcomes.
- That the county clarifies the population health goals in BHSA are in the IP and how they relate to community input, as well as ensuring that people county-wide are aware of goals. Ensure program efficacy beyond what the state's current benchmarks are.
- Focusing services on County specific needs while placing increased value on local community input.
- Summarized versions of each section. Acknowledging that the full 500-page IP is difficult to review in the entirety for many of our community members and presents barriers for ppl unable to read fully.
- Continued transparency about quality improvement and grievance follow ups.
- Clear outlined sections on what grievance follow-ups look like for clients and how BHS will solicit feedback from those people who filed grievances during key CPP periods.
- It is important that BHS connects with all 18 federally recognized tribes; based on current reports, BHS has only engaged with one out of eighteen
- BHS can attend a meeting that includes all tribal leadership to present on BHSA IP input, given the IP impacts child and family well-being work and is someone adjacent work
- Under MHSA prevention and intervention were combined decisions were made on this, even though some programs are actually early prevention and not prevention. Will that be revisited?
- How is the program's cultural responsiveness practice assessed? Or identified?
- Were behavioral health staff and support teams included in the total number for each convening and/or in the aggregate number engaged
- Is there any areas where BHS is looking to get feedback in the Integrated Plan?

- Program eliminations occurred long before the community engagement process was completed. Will there be modifications made in those early decisions based on the community engagement feedback
- Need for housing services for unhoused population.
- Housing interventions funding used for capital funding (to build housing).
- Housing and services for people who are experiencing homelessness, which are well covered by Housing Interventions and the FSP funding.
- I would like to see some of the Housing Interventions funding used for capital funding (to build housing), but I understand that it is unlikely given the need for additional BHSS funding.
- Include services for youth who have private insurance.
- Substance use treatment service specifically inpatient treatment is part of services that are needed for community youth.
- Accessibility of services for youth in the community who have private insurance and don't usually qualify as “uninsured or Medi-Cal” clients. These youth seem to fall through the cracks.
- How do changes to Medi-Cal impact projections in funding for BHSA considering less people qualify for services?
- A non-identified tracking system that follows persons with SMI through the system. This includes Justice partners and contractors.
- Utilizing non-identified tracking across platforms to track whether or not someone is benefiting from services and if the services are making a difference across sectors
- How will BHS decide how to integrate recommendations?
- Does the plan include a strategy to address the inpatient substance abuse needs we currently have as SUD no longer has an inpatient substance abuse program?
- How does Assertive Field Based Initiation of SUD Treatment differ from current programs?
- Ensuring substance use treatment services, specifically inpatient treatment, is part of a service that is needed for community youth.
- Need to listen to the community and make those recommendations a priority.
- We don’t know the efficacy of a program unless we can keep track of it
- A non-identified tracking system that follows persons with SMI through the system. This includes Justice partners and contractors.
- COVID showed how mental health is so vital where outreach and early intervention is important and a key.
- Recommend strong connections within school system for early signs and early interventions.
- Early Intervention (EI) really stands out and get services going.
- SUD also important b/c not many services for youth; we’ve lost many providers.
- Funding for apps and smartphones for EI
- Importance of social media reach
- All families use that for communication (cell phones)

- App to log it w/ services in local area, remain in private; privately reach out for help
- EI important especially those grandparents raising grandchildren
- Can be combative and that's what EI is so important and that is why support is so critical
- EI and Housing and Service Providers and Medi-Cal physical services are being hit hardest
- Need more housing
- As youth age out, do youth qualify for extended foster care at 18? Housing is important; what housing options available to them to assist them?
- Youth w/ sex offenses may have high mental health needs and needs as a result of the sexual assault trauma they may have suffered
- They don't qualify for services and get denied for services because of the risk they may pose to other youth (youth with sex offenses)
- Creating youth centered solutions
- Lack of youth led decision-making opportunities
- Want to see input and that young people are also deciding what these policies are shaping up to be
- Not always seeing youth in those (decision making) spaces
- Want to see more investment in community led providers who are already implementing solutions and find ways to allocate more funds to CBO's instead of County.
- They're already doing the work without funding support so it's important to support CBO's as they often are filling the gap.
- They're also the most culturally relevant for their own communities.
- End Girls Incarceration (name of program)- County in 2023, was awarded $153k to end Girls incarceration
- BHS does sit on JCC (juvenile justice spaces)
- CBO's there needs to be collaboration across departmental agencies
- Ending Girls Incarceration, locally, we need money, housing, and culturally responsive supports for this initiative to do this work
- We need BHS' commitment and budget allocations (End Girls Incarceration)
- We need support in this initiative
- Making policy or priority together
- Community input is important
- Continued input, feedback from community is important and data analysis to ensure funds are being spent effectively
- Community led implementation of these services
- Substance treatment without comorbidity
- Paid internships for peers after peer training
- Graduates need to be mentored by old-time mentors, they need to be walking the new graduates to become adjusted with the job.
- Needs for Peer leadership training

- Part time PSS positions
- Support for Recovery innovations peer leadership training
- Robust peer network that supports outreach done by professionals
- When in hospitals, having people really listen and take the time to talk. It makes a difference
- Peer support in hospitals
- Social activities have helped support mental health recovery.
- Having continuous points of touch as going through the system.
- Cognitive Behavioral Therapy Intensive Outpatient Program (COG IOP) solidified recovery and providing access to this.
- Friends and Family support group at Sharp Mesa Vista was impactful, which helps continue the discussion and connection with people.
- Step down from hospital through IOP has been majorly helpful for people.
- Things that help me most were clubhouses because they help me get out of the house so I don't isolate
- When in hospitals, having people really listen and take the time to talk makes a difference.
- Clubhouses being open for more than just job creating (which is the current focus).
- Peer support recovery navigators helping someone who is discharging from a facility.
- The programs that helped me were IOP, but it was difficult to access and it was through my healthcare provider and not the County. I'm not sure what I would have qualified for through the County.
- Wellness centers in addition to Clubhouses are needed for socialization and just plain fun and support especially for folks who are newly diagnosed and ready for work and the structure/attendance
- Clubhouses like the Meeting Place as an access points to services and tailored to specific needs and populations most especially for those newly diagnosed
- Wellness Centers could have holistic programs and art or writing classes whatever the community decides they want
- Wellness centers can promote recovery – groups, classes, therapy. Does not currently happen during work order day.
- We need to move beyond the Medi-Cal box for peer support. Right now, peers are often forced into rigid, roles under clinical supervision that don't allow for the flexibility we need to manage our own wellness and chronic conditions. I'd love to see the County fund peer-led wellness hubs that offer flexible schedules aside from part-time opportunities. This would allow us to use our expertise to build community and social connection without being tied to a rigid 8-5 clinical schedule.
- Create a hospital that you want to be at. A welcoming place that people want to go to and hopefully as a transition. Also, group therapy supported her recovery because it made her not feel alone.
- Group therapy can be challenging in inpatient setting. But it was important part of recovery because was able to learn from others and be part of a bigger community and

learn coping strategies from clinicians and other patients. Wasn't done enough when he was hospitalized but at the time it was good.

- Getting support between different organizations during the transition period.
- Sharp Mesa Vista helped me or my loved ones.
- Regular therapy with counselor that stays the same, doesn't rotate out
- Medi-Cal not funding IOPs is ridiculous. Can you see how many lives and how much money could be saved? Just to emphasize.
- Help with healthy eating and exercise (maybe in the clubhouses)
- This has helped friends in other countries, in particular 2nd story in Santa Cruz County.
- When I said crisis intervention, I was referring to peer run respite. I'm looking forward to this coming to our county.
- First medication and restraints and isolations are all things that have major negative impact on treatment. It is overutilized and it can break down trust in the system.
- Doctor insensitivity and lack of time spent (with patient) yet diagnosing and prescribing anyway.
- Needed a PSS when in crisis, thought I was alone.
- When in hospitals, have people really listen and take the time to talk. It makes a difference.
- Peer support recovery navigators helping someone who is discharging from a facility.
- Being involved in getting feedback to the county when something isn't working with programs
- Group therapy because I felt like I wasn't alone
- Yeah, not seeing doctor at In-patient where a woman was at
- No access to garden area, too much cement
- Medi-Cal (not) funding IOPs is ridiculous. Can you see how many lives and how much money could be saved. Just to emphasize.
- We need to address the 'insurance gap.' Many families with private insurance cannot find specialized services like IOP for their children because their providers don't offer it. Will the BHSA Integrated Plan include 'Safety Net' provisions or universal peer-led navigation to help these families find care when private insurance fails them? They also don't cover family therapy either and I know there are a lot of families that need that too. I was never able to find this either.
- BHS Services for older adults are lacking. Create older adult wellness centers.
- Community integration for older adults is extremely beneficial from a mental health perspective and for keeping people as part of their community.
- Desire to better understand how "unmet need" is calculated
- Need clarity on what data sets are used and how the determination is made.
- Suggest exploring the methodology behind unmet need as part of future planning.
- (Seeking) Public data and dashboards available for monitoring progress, successes, and areas needing further improvement.
- Emphasis on the need for stronger Application Programming Interfaces (API) coordination for acute hospitals.

- Maintaining a focus on County–hospital partnerships is crucial for supporting the health and wellbeing of clients.
- In-person hospitals need to be there for individuals in our community.
- While the goal is to reduce avoidable hospitalizations, inpatient hospitals remain essential to serve community needs.
- Lack of discussion on long term care beds
- How care coordination and placement of patients can be improved?
- Addressing challenges with unfunded patients as people lose Medi-Cal
- (BHSA) Seems to have a lot of investment in the front end, but we need more investment in the continuum of care.
- Include pathways for nurses to help free standing psych hospitals with recruiting and training staff to meet new state ratio regulations.
- Interest in pathways for nurses to support freestanding psychiatric hospitals with recruitment and training to meet new state staffing ratios.
- Nurses are finding it challenging to see how they fit within the ELEVATE Fund, so guidance or expanded support may be helpful.
- If a hospital meets a certain threshold for providing MediCal services, would nurses be eligible for loan forgiveness?
- Answer given: Hospitals with a contracted behavioral health unit would fall under the criteria allowing nurses to qualify.
- Does Elevate have anything to do with supporting nurses? All of our sites are working to upstaff/upskill, but these are tough roles for nurses.
- Look to see if a presentation at Hospital Partners Meeting would be helpful.
- How will ongoing updates be provided and how will opportunities be provided to pivot the plan if needed?
- Hoping to see more access to residential facilities in Mental Health (MH) and Substance Use Disorder (SUD), including data from facilities
- A gap in service was analyzed (several autistics/MH) for individuals over the age of 18.
- Culturally appropriate facilities, treatment modalities, recognized tribal based practices, community-based healing to get recognized by the county at all levels to see within the BHSA plan
- Hoping to see more data supporting Mental Health and Substance Use Disorder from facilities
- Having the opportunity to give feedback on the current feedback (data shared by the County) and reporting that's coming to us
- Based on the timeline these comments won't go to where they need to go, having enough time to review and provide feedback to the County - we're put in a place where we have a lack of information to provide staff or provide information to the community
- 18 tribes in the region all have unique needs, such as prevention, care, and treatment, which are currently dealing with limited funding.
- Improvement needed in vocalizing from County of San Diego what tribes are being impacted or seeing before the BHSA plan is integrated.

- Audience member's team is struggling with connecting with grant COR to see what the reporting or agreement will look like within contracts through services in components of BHS
- For instance, at the end of the fiscal year, there should be an opportunity to review and sign contracts. This should be a mutually beneficial partnership with the entity.

Digital Engagement Platform (Engage San Diego)
Total: 72

All Responses

- Is this number inclusive of acute psychiatric hospitalizations with voluntary legal status? Is this number inclusive of acute psychiatric services at hospitals that do not utilize SmartCare?
- Why are the involuntary hold numbers different from the involuntary hold numbers reported in this DHCS report? https://www.dhcs.ca.gov/formsandpubs/forms/Documents/2025-LANTERMAN-PETRISSHORT-ACT-ANNUAL-REPORT.pdf
- Welfare and Institutions Code 5200 can increase the penetration rate in populations that are unable to provide for their basic needs, particularly those who have not been durably linked to care through 5150 interventions or incarceration.https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=2.&article=2. Up until at least 2020, San Diego County had operational processes for court-ordered mental health evaluations. This is an important intervention point for those who need the most support.
- The DHCS Assisted Living Waiver Program is an available option for housing individuals with severe mental illness who require the support of an adult residential facility. For instance, Los Angeles County utilizes the program for adults with severe mental illness, using the designation "mental health facility." San Diego County does not utilize this program for housing adults with severe mental illness in adult residential facilities. https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-RCFE-ARF.aspx
- How many individuals with Medi-Cal who were subject to incompetency proceedings received acute or outpatient San Diego County behavioral health services during the six month period prior to their arrest? How many individuals with Medi-Cal who were treated in a hospital ED for a substance use disorder or mental health disorder were linked to behavioral health treatment at the time of discharge?
- How many of these individuals are able to safely transition to FQHC or CCBHC?
- FSP ICM should also have processes to increase the behavioral health support when individuals with severe mental illness are not engaging. This could be a sign of deterioration and discharge could be harmful.
- There are individuals with severe substance use disorders who would benefit from an ACT level of care. San Diego County does not have existing programs for individuals with a standalone or primary severe substance use disorder. This reallocation will make treating these individuals in an ACT level of care more difficult. How many individuals

are rejected from an ACT level of care due to determination that the individual has a primary or standalone severe substance use disorder?

- The total “other county behavioral health agency services/activities” is 5% of the total “other county expenditures.” As this category includes "Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, and Court Diversion Programs," these programs serve some of the most vulnerable individuals in San Diego County. Does the current allocation adequately prioritize this population, especially in the context of prior audit findings? https://www.sandiegocounty.gov/content/dam/sdc/auditor/audit/fy1920/Public%20Administrator%20Guardian%20Conservator%20Performance%20Audit.pdf
- There are individuals with severe substance use disorders who are denied FSP services but require higher level of care than currently offered in the community. Allocating $0 to this population does not reflect the community need.
- I couldn't agree more. Expanding eligibility with SB 43 does not work unless we invest in the infrastructure to support this population.
- I think this is critical. I also think the needs of those who are homeless due to major neurocognitive disorder (MND) need to be addressed. This is dementia, but not just for memory issues. Often, they become homeless because their illness make it difficult for them to accept voluntary help and maintain socially acceptable behaviors.
- I think this is critical. I also think the needs of those who are homeless due to major neurocognitive disorder (MND) need to be addressed. This is dementia, but not just for memory issues. Often, they become homeless because their illness make it difficult for them to accept voluntary help and maintain socially acceptable behaviors.
- Concur 100%. Current mental health services are available only to those who have the neurological capability of asking or agreeing to participate in them. Those with anosognosia are treated as non-compliant when they should instead be regarded as someone who has another layer of psychiatric disability that needs a higher level of wrap around services.
- Concur. Families should be viewed as partners as much as possible. They have much greater insight into how the individual is decompensating, especially outside of controlled settings. That insight can make all the difference in finding a meaningful way to connect with the individual and identifying the right course of treatment.
- Each time we have had to call 911 in 2025 for my cousin we feared that a negative outcome could occur, especially if he felt confronted. This is why we always asked for PERT or MCRT to come as well -- but they were never available, we were told. I made it clear each time that he suffered from severe mental illness but he would be taken to jail and there was no consideration, as far as I could tell, for his mental state.
- We need to move past the notion that all mandated treatment is of the ilk of Hollywood's One Flew Over the Cuckoos Nest. The most compassionate thing we can do for some severely ill people is to take care of them when they are incapable of seeing how sick they truly are. My mother and my brother's lives were saved because of mandated treatment that neither sought out on their own.

- Agree 100%. My brother, who suffered from schizophrenia and bipolar disorder, was able to live in a section 8 apartment and on his own for nearly 20 years because of the nearly daily day treatment activities he participated in through Bayview Clubhouse and others. These were literally a lifeline for him. They would engage him, give him purpose and a sense of value. The Therapeutic Recreation program through the City's Park and Rec Department was also very helpful by offering social activities like dances and sports. Collectively these also offer another way to monitor how the client is doing and to trigger early intervention when warning signs are seen.
- It should also be easier for families to seek out interventions on behalf of their loved ones. The current process is a maze. The crisis line is helpful but needs to be augmented by public education and outreach about how to get help. A roadmap of services available with hone numbers and websites would be very helpful. Otherwise you are left to just start knocking on doors and hoping you are finding the right ones. Sometimes you are told who to contact instead, in my experience, and other times you are simply told just to call 911 when the situation escalates again.
- According to the FY 25-26 Mental Health Services Act Annual Update, Therapeutic Behavioral Services (TBS), Incredible Years, and Family Therapy are classified as full-service partnership programs (page 42). According to the FY 26-29 Integrated Plan for San Diego County, Therapeutic Behavioral Services (TBS) (page 97) and Incredible Years (107) are classified as non-full-service partnership programs. Family Therapy is no longer listed at all as a supported program. 1. What led to the category change of TBS and Incredible Years in FY 26-29?
- According to the FY 25-26 Mental Health Services Act Annual Update, Therapeutic Behavioral Services (TBS), Incredible Years, and Family Therapy are classified as full-service partnership programs (page 42). According to the FY 26-29 Integrated Plan for San Diego County, Therapeutic Behavioral Services (TBS) (page 97) and Incredible Years (107) are classified as non-full-service partnership programs. Family Therapy is no longer listed at all as a supported program. 2. Why was Family Therapy classified as a full-service partnership program in FY 25-26?
- During FY 23-24 in San Diego County, 3,278 adults (page 191) and 7,575 children (page 180) were served in full-service partnerships in San Diego County. This is a total of 10,853 individuals. According to the FY 26-29 Integrated Plan for San Diego County, a total of 1,255 children/TAY and 6,325 adults/older adults (page 494) are projected to be served in full-service partnership programs in Year 1 (FY 26-27). This is a total of 7,580 individuals. Interestingly, according to the State of California Accountability website, 4,788 people are receiving full-service partnership behavioral health services (as of February 26, 2026). 1. Why is there such a difference between the yearly figures of 23-24 and 26-27? What population does the State of California Accountability website measure? (1/2 parts)
- During FY 23-24 in San Diego County, 3,278 adults (page 191) and 7,575 children (page 180) were served in full-service partnerships in San Diego County. This is a total of 10,853 individuals. According to the FY 26-29 Integrated Plan for San Diego County, a total of 1,255 children/TAY and 6,325 adults/older adults (page 494) are projected to

be served in full-service partnership programs in Year 1 (FY 26-27). This is a total of 7,580 individuals. Interestingly, according to the State of California Accountability website, 4,788 people are receiving full-service partnership behavioral health services (as of February 26, 2026). 2. According to the Integrated Plan equation used to calculate the projected number of individuals served in FSP programs, how many individuals are currently served in FSP programs? (2/2 parts)

- Can you define what services are provided in this category?
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 1. How did BHS determine that services provided to individuals presumptively eligible for a full-service partnership (currently experiencing unsheltered homelessness; transitioning from a locked setting; frequent involuntary holds, transitioning after six months or more in state prison or county jail) are less urgent than programs subsidized by Behavioral Health Services and Supports (BHSS)? (1/6 parts)
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 2. How did BHS determine that housing interventions for those chronically homeless are less urgent than programs subsidized by BHSS? (2/6 parts)
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 3. How many referrals were received for full-service partnership programs that did not lead to linkage to an FSP program? (3/6 parts)
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 4. How many individuals have been denied for FSP programs because they were determined to have a primary or standalone severe substance use disorder? (4/6 parts)
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 5. How many individuals were disenrolled because of lack of engagement? How many of these individuals were previously on conservatorship? (5/6 parts)
- Behavioral Health Services requests transferring 7% from Full-Service Partnerships and 3% from Housing Interventions into Behavioral Health Services and Supports to address “urgent system-level needs.” This equates to $27,460,897. 6. What are the steps required for the State to approve this transfer request? (6/6 parts)
- “Diverse” means Nonwhite, since White people are the only group that cannot be considered "diverse." Therefore this reimbursement specifically discriminates against, and disadvantages, the White population in this - in the document's own words - "already diverse" (AKA, already sufficiently Nonwhite) workforce. That is not a method

of ensuring equal opportunity and the policy should be struck from policy going forward. Everyone should be provided equal opportunities, not just Nonwhite people - especially if they are already well-represented, as is indicated in the document.

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- “Diversity” and "diversification" are synonymous with White erasure. County funds should not be used to disadvantage one specific demographic, including the White community. There are no legitimate barriers to employment for any group that must be overcome by giving special treatment to Nonwhites in the hiring and promotions processes. Claiming to be Equal Opportunity and "against racial discrimination" while simultaneously pursuing "diversification" is a contradiction. These programs that discriminate against the White population of San Diego County should be discontinued. Nobody deserves a job more than any other just because of the way they were born.
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- “Counties should incorporate efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce…" When a "diverse" individual is placed into a role because they are "diverse," they are replacing a "non-diverse" individual because they are White. Can someone explain how that is not a deliberate effort to achieve White erasure?
- “Counties should incorporate efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce…” When a "diverse" individual is placed into a role because they are "diverse," they are replacing a "non-diverse" individual because they are White. Can someone explain how that is not a deliberate effort to achieve White erasure?
- A workforce can only become "more diverse" by becoming less White and more Nonwhite. How will the county achieve a "more diverse" workforce without actively discriminating against White people?
- A workforce can only become "more diverse" by becoming less White and more Nonwhite. How will the county achieve a "more diverse" workforce without actively discriminating against White people?

- How is "improved equity" measured? Is race a factor? If so, which groups benefit from improved "equity" and at which group's expense is "improved equity" achieved?
- How is "improved equity" measured? Is race a factor? If so, which groups benefit from improved "equity" and at which group's expense is "improved equity" achieved?
- There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful
- There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful
- The poor quality of behavioral health services in the County jails has been documented by the Grand Jury, the State legislature audit, the League of Women Voters, and many other entities. Deaths have occurred in custody as a result of the SDSO policies and procedures and the county has paid out upwards of $100 million in lawsuits in a 10 year period. The State must consider the quality of services as the incarcerated person re-enters the community as they likely will be more acute.
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- First, the final plan would be stronger if it clearly showed how community input shaped the document. A simple summary of major themes heard, what changed in response, and what did not change (with rationale) would help demonstrate that the Community Planning Process was meaningful rather than procedural. Second, I encourage the County to specify a limited set of measurable outcomes for each major priority area, not only activities or service volumes. Public reporting over time should focus on whether people are actually doing better and gaining timely access to appropriate care, with results stratified where possible by age, race/ethnicity, language, geography, and other populations experiencing disparities. Client perspective should be included through self-report measures that are recovery-based. Third, I hope the County will strengthen the role of lived-experience voices not only during planning, but during implementation and monitoring. Clients, family members, and community members with direct experience should have an ongoing role in reviewing progress and informing course correction. Finally, I encourage the County to emphasize continuity across systems and transition points. Many of the most important gaps occur not within a single program, but between crisis response, outpatient care, housing supports, SUD treatment, justice-related services, and follow-up after acute episodes. The plan will be most meaningful if it can show how those handoffs will improve over time. Thank you for the opportunity to comment.

- Please spell out acronyms
- How will County specifically address lower penetration rates for SMHS among infants and children 0 - 11 and their caregivers?
- How will county specifically address lower rates of Non SMHS for age groups 3 - 11 and 18 - 20?
- The county is silent about parents/caregivers with infants and children 0 - 18 experiencing homelessness. County needs to expand beyond individuals or PEH and include reporting for families experiencing homelessness. Where does county report on parents/caregivers and families experiencing homelessness and what services, supports, and facilities are available to them?
- With certain populations experiencing higher risks like children identifying as Black or Hispanic 0 - 5 and children under 2 years, proposed efforts focusing on MCRT School Pilot Program TK - 12 does not adequate address need in the 0 - 3 and under 2 populations. At the least, programming needs to expand to include early child education, early child care, and preschools.
- There is a gap in reporting when we look at females 25 - 34. Of these females who are in child-bearing age, how many are parents/caregivers? How is the county addressing needs for people in the context of family and community? Do assessment and intake processes determine if individuals are caregivers/parents and if their children ages 0 - 5, in particular, need supports and services as well?
- BIG PICTURE FEEDBACK: Older adults are referenced across multiple measure domains, community engagement summaries, and program planning sections as a priority group experiencing disparities. However, older adults receive comparatively little to no (unless I missed something) targeted intervention specificity relative to youth and racial/ethnic subgroups. STRENGTHS of current plan draft: - The current draft accurately reflects older adults (although variably defined, 60+, 65+, 69+) as a disparity subgroup across multiple measure domains (DMC-ODS, SMHS, FUM, homeless service access, etc) - references older adult stakeholder engagement in planning processes (e.g., Housing Interventions), common care challenges that I see with my patients (e.g., digital divide, caregiver burden, stigma, etc.), and aspirational goals around housing and service providers GAPS in current plan draft: - current draft does not disaggregate budget or enrollment targets for adults vs. older adults in any place that I can find (e.g. age 21 years old to 100 years old are lumped into one category) - I could not find any detailed operations regarding the aspirational goals, e.g., I could not find a single funded intervention or specific program name in the plan that specifically targets 60+ - social isolation in older adults is a significant risk factor for serious mental illness and suicide but I do not see any specific funded program response in the formal plan sections - the need for caregiver support for older adults was expressed by many community members and organizations but does not appear as a funded initiative and I no longer see any of the critical organizations who provide this named in the document
- Specialty Mental Health Services - Section Access to Care, Disparities, p 21-25 - older adults 69+ named as a subgroup with lower access, but there is no specific intervention named for adults 69+ in the Specialty Mental Health Services response

- DMC-ODS (Substance Use)- Section Access to Care, Disparities, p 24-25 - older adults named as disparity population, but the investments are framed as addressing the entire population without any specifically designed or targeted interventions for adults 60+
- Section Access to Care, Disparities, p 24-25 - lower penetration rates among older adults receiving AOD treatment compared to different subgroups but no specific action targeting older adults in the IET-INI response
- - Access to Care: 65+ among lower rates of access to homeless services. - Yet Cross Measures and planned actions do not specify age-specific housing or homeless services intervention targeting older adults 65+ (including no plan for how shelters can serve older adult experiencing homelessness who needs help with activities with daily living; which shelters in San Diego County can serve older adults experiencing homelessness who need help with activities of daily living?)
- Follow-up After ED Visit for Mental Illness (FUM) Section Untreated Behavioral Health Conditions, Disparities Analysis (p. 42-43) and Planned Actions (p.43) - Follow-up remains lowest among adults 65+, but older adults are not named as a targeted subgroup in any of the planned actions
- This is one of the most substantive older adult-specific passages as it describes incorporating older adult needs into FSP development through data analysis, stakeholder engagement, and FSP service design with caregiver support. - This is descriptive of a planning process but it doesn't specify any services, dollars, or targets for older adults within FSP. My patients have previously depended on many of these service providers (the community engagement and input sections talking about these various programs, which can be life-altering and life-saving, are important)
- Plan states that engagement with older adult stakeholders "will be utilized to develop the services" though there is no specific Housing Intervention programming for older adults
- Disparities in older adult behavioral health are documented throughout this draft across many domains (DMC-ODS, SMHS, FUM, homeless service access, etc); and community engagement has extensively detailed how important it is to not only continue those services that have been provided in the past but to augment them. (see Caregiver Coalition provides detailed examples of how and why, p.292-293 and Affordable and supportive housing is needed for older adults with complex BH needs p.305-306, etc.)YET there is not a single dollar in the budget that I can find that is specifically allotted to older adults (All 21 year old plus are effectively grouped together). I highly recommend that we be intentional about budgeting and planning to serve the unique needs of older adults, which is the fastest growing demographic in San Diego and fastest growing segment of our homeless population. It will be much more efficient to do this proactively than reactively.
- Part Time Professional positions should be considered. There are skilled professionals that are specifically interested in Part Time work.
- Page 1 - I did a word search for subjects that are important to me and found that these subjects don't exist in your plan: patient rights and patient advocacy. I won't presume that you did not touch on those subjects because it has been difficult to navigate

through this document. What I would like to do is explain why those topics are just as important as any you will address.1) First, I am aware that this is an area of concern for the county. If we do not address the loss of liberty of individuals who sometimes cannot speak for themselves, it appears that it still remains a secret and contributes to the continuing stigma of mental health in our society. 2) You will find the following all present in every hospital in this county: trauma, stigma, and even abuse. The degree varies among hospitals and types of patients. The patients that are able to speak up for themselves in what staff members consider a socially appropriate way may be treated fine. However, patients tell me, and I have seen, patients who demand their liberty or communicate with emotions, are "agitated" or annoying, will often be treated poorly, especially if they are refusing medication. Medieval tactics are still used in hospitals, often before alternative means are attempted. Forced injections of medication, where patients underwear of often forceful pulled down, physical restraint by holding and mechanical restraints, painful 4-point restraints holding someone down with the purpose of helping them calm down? Seclusion - a cruel form of punishment where a patient is not allowed to leave a room and is not sure when they will be. Supposedly another way to "help" them calm down. These methods are not supposed to be used unless a person is in immediate danger of harming themselves or others. Unfortunately, these "tools" are also used to quiet someone who is "agitated" or to punish someone who has attempted to elope. This has been testified to in multiple legal hearings. I am hopeful that universal recovery education for staff will help these facilities to treat their patients in a humane manner, as other methods appear not to have made much of an impact. I also think County BHS should focus more on the people languishing in long-term locked facilities. Some have been there for years. It is truly a crime to keep people locked up when the have done nothing wrong except experience an illness. State laws have served to support this inhumane deprivation of rights, but our County should aim to brainstorm alternative methods that give people the care they need and preserve their dignity and freedom. When someone is "physically" ill, they are treated warmly and given special treatment. They are given a comfortable adjustable bed and their own phone and TV, as well as bedside service.. When they are "mentally" ill they are basically arrested, forcefully put in handcuffs and given a room with basically a flat Vinyl mat. I could go on, but it's exhausting. Finally, when I mentioned the police treatment, that should make it clear how important the MCRT is for transportation. I am aware that the state is attempting to remove funding and behavioral health directors have rightfully advocated against it.

- It is not adequate to lump 'under 21' all together as an age range. In doing so, not only are the needs and services of young children completely lost in the data, but it also tends to capture only acute and crisis care, rather than preventative measures and overall behavioral health. Ideally, this would include disaggregated data for ages: 0-5; 6-12; 13-18; and 19-26. (A baby step in this could be starting with 0-5, 6-18, and 19+.) Disaggregating the data would more accurately capture the age-specific services, and deficit of services, within each of these nuanced and different periods of life. For example, the diagnosis and treatment of a 3-year-old, even in crisis, looks dramatically different than that of a 20 or even 13-year-old. Considering younger children requires

that we include an entirely new and different set of systems for data gathering, and that requires cross-department and cross-community collaboration. This must be done to ensure that we are, in fact, considering and serving all San Diegans and not shirking a responsibility to serve young children, kids, youth, and transition-age youth simply because it falls outside of data that's been captured and what's been done, historically.

- You should identify the age range for adults and for older adults. There are mental health conditions that are more prominent among older adults such as depression, dementia and the negative mental health associated with isolation and loneliness, especially among older adult family caregivers.
- While this data is incredibly important, it reinforces the suggestion that age-data must be disaggregated, because young children are not captured in acute care statistics like this, and we are capturing no equivalent for them in another system of care. The case is also made with all of the above listed data that there is an overemphasis on crisis and acute care over preventative or care in the mild to moderate range. Investments in those preventative spaces can help keep a child, youth, or TAY from escalating to a crisis further along in their life, but if we are not capturing that data, we have no baseline of how we are meeting those needs or what the jump from mild/moderate to crisis services is.
- The criteria for adults and older adults seem to be more in line with issues/concerns for "adults". It would be helpful to see the data under the criteria separated by age ranges.
- Social connectedness is extremely important. Research demonstrates that assessing for risk of loneliness and isolation is paramount for older adults, and especially for the older adult caregiving population, due to the many negative health outcomes that are linked with loneliness and social isolation, including depression, increased mortality, decreased sleep quality, cognitive decline, and decreased physical and mental quality of life (Musich, et al, 2015). There are 490,000 adult and older adult family caregivers in San Diego County, over 50% provide to individuals with Alzheimer's disease or related dementias. Data from Southern Caregiver Resource Centers demonstrates that between January 1, 2023 – September 30, 2025, family caregivers reported the following: 33% experienced clinical depression using the Patient Health Questionnaire 9-item (PHQ-9) screening tool. 13% experienced moderate to severe depressive symptoms. 18% experienced significant loneliness and isolation using the Caregiver UCLA Loneliness 3-Item Scale. 24% experienced high caregiver burden scores using the Caregiver Zarit Burden Scale. The IP does not include any programs that address the serious mental health needs of family caregivers that are needed to keep adults and older adults with dementia safe and out of institutions. Southern Caregiver Resource Center offers several evidence-based programs, including Caregiver TLC: Thrive, Learn & Connect (CG TLC), Cuidando Juntos, and CALMA which have demonstrated to significantly reduce depression, caregiver burden, and loneliness through social connection, and improve overall health and mental health among family caregivers. Southern Caregiver Resource Center's programs have need terminated by SDCBHS effective 6/30/2026 and should be reinstated.

- Unfortunately, decisions to eliminate effective programs that had been offered to the community for over 17 years were made without any prior consultation with the provider. Example, Southern Caregiver Resource Center received a letter from the County in October 2025 informing the agency that their highly effective evidence-based psychoeducational programs (CALMA and CG TLC) delivered under the PEI Caregiver Support Services contract (#568046) would be eliminated effective 6/30/2026 with no prior warning or discussion or even transition planning. Southern Caregiver Resource Center has been a contractor for BHS since 2009. SDCBHS should have discussions with longtime community partners/stakeholders/contractors before making final decisions as they have a negative impact on the organizations and consumers who rely on the services.
- Stakeholder feedback was solicited for the IP which had already been developed. Feedback provided that was not part of the IP's priorities was not included, and stakeholders were told to advocate with California Department of Public Health. Please put more weight on the feedback from longtime community partners and stakeholders in future IP development.
- Under the IP's BHSS EI programs, there are 30 programs for children/youth, approximately 4 programs SMI (non-age specific), 2 programs for adults, and Zero EI programs older adults. There is also one (1) PEI community-defined program (Native American Dream Weavers) being included in the IP. Riverside County's IP includes Cognitive Behavioral Therapy for Late Life Depression (CBTLLD) and Program to Encourage Active and Rewarding Lives (PEARLS). Each County has some discretion regarding the EI programs to include under local BHSS. SDCBHS should include evidence-based and community-defined programs specifically designed for older adults including adult and older adult caregivers who experience high levels of depression, loneliness, generalized anxiety disorders, and adjustment disorders which qualify as a priority population (W&I Code section 14184.402, subdivision (c) and implemented in DHCS guidance [13]).
- Trauma informed care is very important to the success of mental health programs. It recognizes that trauma and chronic stress (like that experienced by adult and older adult family caregivers) influence coping strategies and behaviors. Southern Caregiver Resource Center, along with Justice in Aging and thirty-two (32) California based organizations believe that the BHSA has an opportunity to address the behavioral health needs of older adults and address long-standing barriers to care for this population. It is essential that older adults are prioritized at every stage of BHSA implementation. We request reconsideration along with the following: 1. Include adult and older adult family caregivers who suffer from or are at great risk of distress (like moderate to severe depression, adjustment disorders, or generalized anxiety disorders) (W&I Code section 14184.402, subdivision (c) and implemented in DHCS guidance [13]), as a priority population in the County Integrated Plan (IP).
- This section indicates an increase in behavioral health needs among older adults, including untreated behavioral health conditions and social isolation. However, it does not indicate any specific programs to address the increased needs of older adults or

funding. The current SDCBHS plan does not include any specific EI older adult program to be funded by BHSS locally. It is an opportunity for our county to carve out funding to address the mental health needs of older adults and their family caregivers.

Online Feedback Forms (Smartsheet)
Total: 7

All Responses

- Dear Behavioral Health Advisory Board (BHAB), Please edit this comment form to correct the Fiscal Year (FY) 2026-29[sic] to Behavioral Health Services Act (BHSA) Integrated Plan FY 2026-27. The dates from 2026 to 2029 is a period of three years rather than one fiscal year from 2026 to 2027. Please also prioritize a Balanced Budget, and greater Wellness and Integrative Health for adults and children. I like the HHSA LiveWell San Diego model. This BHSA IP draft resembles the prior documents from 2022 to 2025 attached in the Appendices. Please continue the positive improvements.
- Dear Behavioral Health Advisory Board (BHAB), Please edit this comment form to correct the Fiscal Year (FY) 2026-29[sic] to Behavioral Health Services Act (BHSA) Integrated Plan FY 2026-27. The dates from 2026 to 2029 is a period of three years rather than one fiscal year from 2026 to 2027. Please also prioritize a Balanced Budget, and greater Wellness and Integrative Health for adults and children. I like the HHSA LiveWell San Diego model. This BHSA IP draft resembles the prior documents from 2022 to 2025 attached in the Appendices. Please continue the positive improvements.
- BHSA funding directed towards behavioral health services and supports is just as important as the other two categories. Community-based organizations such as The Veteran's Art Project (VetArt) are at the forefront of behavioral health/ emotional and social wellness and should be prioritized as such.
- BHSA funding directed towards behavioral health services and supports is just as important as the other two categories. Community-based organizations such as The Veteran's Art Project (VetArt) are at the forefront of behavioral health/ emotional and social wellness and should be prioritized as such.
- After reviewing the plan and seeing that parenting education is not included despite there being questions about justice-involvement among youth and the removal of children from the home, there should have been more consideration of including parenting education. While yes, it's great to fund interventions for youth directly but without providing support and education for parents/caregivers on how to self-regulate and manage maladaptive behavior it is not looking at the whole picture for what youth experience at home. While they may be receiving supportive intervention services, if the adults in their lives are not provided with spaces to discuss parenting challenges and learn new ways of communicating it makes it challenging for youth to be able to succeed. Low-income caregivers and parents will be left without accessible resources to support improving parent/caregiver-child relationships which directly help prevent the removal of children from the home and youth becoming justice involved. In addition

to that Head Starts and Early Childhood Education sites have state requirements for parenting education that parenting programs previously funded through MHSA would support in reaching more families and children. Without the parenting education programs that can provide services at no-cost, there is a gap in available programs to help these sites meet their requirements. These sites are already navigating funding constraints and now they will need to think about how to pay for parenting education in order to meet their state requirements.

- Ayani Hashi and Spshelle Gordon conducted a mental health workshop on healthy communication and relationships for the Haitian Community of IRC that was translated by an interpreter for non-English speaking participants. We were able to leave county-approved BHSA flyers for IRC staff. Feedback from the Haitian cohort consisted of:1. The family is stressed out. All the family. We don't have anywhere to go. It's cramped and disordered in our house. I wish there was a place where we can go to feel better, so we can relax so we can feel better. I hope the city implements this. (Therapy and third spaces for the community would be nice). 2. I would love it if the city had a place for children who need therapy so they can create a good environment for my child so he can socialize better. I struggle looking after him. He needs help.3. I would like the city host etiquette and communication classes, facial expressions and even skills on how to speak would be nice for those of us who are new to the country. 4. I would love it if the city could help us with lawyers that are free or at low cost so we can take faster routes to citizenship since so many people don't understand us.5. Have a place where parents and kids can approach each other and have direct contact to resources for our community given all the issues we are dealing with in our community. A place where people can help us seriously. We support to find employment opportunities. Also, housing and legal support. We cannot get housing without employment and many of us struggle with this first area.6. All of us have struggles situations, we all struggle with depression, and we know everybody especially here (IRC class) is living in stressful situations. We want a place where we can get therapy for parents, for adults of the Haitian community. People who understand our language.7. I wish we had behavior and etiquette classes for when it comes generational struggles and communication struggles between immigrant parents and their children since the laws here are different. We want parenting classes, family classes. It would be helpful since we come from a different culture and country, different education and laws. There are many misunderstandings. We want to prevent bad things from happening to us because we don't understand that. (Integration classes) 8. I hope the county can keep funding classes like the ones by BDB which are free and helpful for us. We need it. 9. So grateful to be part of the decisions on this. I want the county to offer us resources when we have issues between family, emotions, stress, immigration. I feel like we are not connected to these services in a way we can understand.10. Everything is so expensive. Rent is so high and we cannot even afford to pay even when we work. Its even worse when so many of us have work permits but we cannot get hired anywhere. I wish we had resources to get us to housing because we wait on the list for years. I wish there were special programs for us so we can get a fast track to housing and rent that is adjusted for us since it's so hard for us right now.11. Rent is so expensive. For one room

apartment it costs about $2085 dollars. As immigrants we barely have income to survive. Is there a way for the county to give us low-income housing so we can have better living conditions.

- hey all if you would to submit your own public comment here is the notes from our team. reminder today is the very last day to submit: BDB, Vanessa and Spshelle's Department Early intervention = children and youth
  New Definition of Early Intervention services includes direct services for children and youth who are "at-risk" of a mental health condition but are NOT YET displaying symptoms (i.e. indicated n prevention) (WIC 5840) so I know when implementing I know that counties are not required to eliminate all programs they had previously categorized as prevention. There is space room and opportunity for flexibility within the new early intervention definition to translate many program models into indicated prevention. Feedback: It is important to focus on community centered interventions based on community populations Examples: Having diverse providers who speak multiple languages (and regional dialects) Loop in/identify additional supports/organizations that are culturally informed such as nonprofits, schools, community events, parent groups, community gardens, walking groups (adding physical movement to support with mental health) You will miss queer communities if our comments aren't considered as it remains/becomes more dangerous to be identified through the government/programs for queer/trans identities under the threat of the current administration - while queer identities have disproportionately high instances of mental health symptoms, therefore the queer/trans youth are in categories of high risk before showing symptoms. Moving beyond individual therapy as a default - like having community healing circles, group support. Though we are refocusing on direct service, some communities don't relate to some of the interventions / approaches to care. It is important that care is reflective of what communities want and pay them accordingly i. examples: a. Working with cultural practitioners b. Curanderismo c. Spiritual/Faith leaders Building up diverse workforce and do outreach, so communities know about scholarship opportunities i. examples: a. Adding pathways in the mental health field. ie: San Diego City College Mental Health Work Certificate. But incentivizing it for people that speak other languages b. increase training (or even funds for non-licensed clinicians. Build a broader culturally rooted workforce (i.e. community health workers, peer support/specialists, etc) in order to expand who can give support. c. More awareness and increased opportunities for interest free loans (Ex: SD Pay It Forward Loan Program & Indian Health Services Loan Repayment program).
  Focus on supportive services to build trust with the youth (ex: before/after-school programs, Expand language around housing interventions (consider early interventions and people at risk of being unhoused - for example to incorporate individuals who may be more transient living between homes, sleeping on couches, multi generational homes due to housing costs such as invisible homelessness, those with SUD, LGBT homeless youth, those in DV/ IPV situations etc...).

Public Hearing with the Behavioral Health Advisory Board (BHAB)

Total: 30

All Responses

- I've been a San Diego resident since 1989, founder of soberwars.com, and an advisor to SD Sober Living. I moved here from Ireland at 15, opened a bar, have been in the bar and nightclub business then moved into a different career. Me getting sober with the support in my community took me from a very dark place to lasting recovery. So, I watched the city change over the last 30 years. I've been a regular on Mission Beach Boardwalk and I can see a decline based on permissive, kind of, policies, which is fine to a certain extent, but when you get into housing, if you're kind of rejecting providing finding for sober living homes you're basically just, in my view, creating a flop house. So AB255 was a rare piece of common-sense legislation. It would have given a direct, would direct you to just 10% of housing funds toward people who want a drug and alcohol-free environment to rebuild their lives.
- Hi, I want to say that whether I'm completely happy with the 3-year plan or not, I'm excited about it. And that's because. I'm from San Diego Peers we've been ensured that the community planning will continue throughout, and that's important because we didn't feel included at first, but I want to thank Kat Briggs and her team for respecting us and including us when she recognized that we hadn't been. So, as I've been involved in the system, I've sadly found that, especially in the important area of, if we want our community to succeed, we can't just be a part of the feedback process. We need to be actually peers leading and being… creating, and of course, running some peer programs because if we're expected to use the programs, you want them to be successful. People aren't going to just go when they're supposed to, and you know. I work in the inpatient business, and there's a lot of not so nice things going on there, so we need to fix those. And it's because of stigma. Nobody wants to be accused of stigma, but it's most effective in exclusion, and that is what's happening here. No leaders. Most important thing is what I hear from family members and providers is this person has failed in the system. Is that true? Or has this system failed that person? And that's what I want all of us here in this room to address. Thank you.
- It's a privilege to be here today, and I'm hugely grateful for the opportunity for such accomplished speakers and kids and community leaders. I have been especially eager to become involved with the BHAB Board. I sincerely hope to contribute in the near future so I can bring the insight, perspective, and knowledge gained here back to my community in a meaningful way. Thank you.
- I am concerned that as the city moves forward with potentially permitting pot shops and consumption lounges in the unincorporated areas of our county that it's crucial that this body address the realities of detrimental impacts that these products have on kids and youth mental health. Two weeks ago, a UC San Diego study titles Pot's Impact of Kids was published, where researchers followed more than 11,000 children nationwide starting at ages 9 and 10 over a seven-year period. Researchers used repeated cognitive testing to measure skills like memory, attention, and processing speed. Things like recalling word lists, identifying patterns quickly, and sequencing information. And

what they found is a public health crisis among our young people. All adolescents who use marijuana showed a consistently slower place of cognitive development compared to their peers. And this study stands out because it did not rely solely on self-reporting, it included toxicology testing, like hair, urine, and saliva samples. And found that above 1 in 3 youth did not disclose their marijuana use. So that has serious consequences for how we understand the scope of the situation. So, I just urge this body to prioritize having these discussions about the negative impacts marijuana has on the developing brain.

- I am a California Medical Peer Support Specialist. I'm looking for work in the North County area. The outreach I've been doing for 3 years in North County has allowed me to identify the areas that need to be addressed in better reaching the unhoused, addicted, trafficked, and mentally ill population. I would like to share my experience in solution-building ideas to this board to better utilize the California Medical Peer Support Rule and how to bill hours direct to Medi-Cal. Thank you.
- I am here because my husband had a stroke and now has dementia which has slowly taken away from me, piece by piece. I became his caregiver overnight, and I started disappearing too. I was exhausted, overwhelmed, and felt like I was losing my mind. Then I connected with Southern Caregivers Resource Centers (SCRC), they helped me togethering when I was falling apart. They gave me the support and guidance I needed to keep going. For now, these vital programs are being eliminated. San Diego County is throwing out and canceling this and BHS has made it clear that counties are not even responsible for these types of programs. That is unacceptable. Turning your backs on caregivers who need this type of support on those who are elderly sick and struggling with dementia. I can not throw up my hands and walk away from providing care. I am asking you, keep in mind the caregivers who are the backbone of the care system, please do not cancel these programs. Thank you. - Leonor Garrison
- Hello, I am the president and CEO of Southern Caregiver Research Center. Today I am here to speak on behalf of the 490,000 family caregivers in San Diego County, half who are older adults themselves providing care for older adults suffering from Alzheimer's disease or related disorders. I reviewed the Integrated Plan and was shocked that there was no early intervention programs designated for older adults or older adult family caregivers. This is disappointing. My father-in-law, Bill, is an 80-year old Vietnam veteran who became the caregiver of my mother-in-law, Henrietta, who suffered from Alzheimer's. Within 2 years he lost himself. He became isolated, overwhelmed, and clinically depressed, and even suicidal. He participated in our Caregiver support services program, which helped him immensely with his depression, and to provide care for himself and his wife. I know BHS has said that they are no longer responsible for these types of programs, but Riverside County has two programs. specifically designed for older adults. Thank you and hope we can count of your leadership to support family caregivers and older adults.
- Good afternoon Chair members. I'm the Program Supervisor for Breaking Down Barriers at Jewish Family Services here to support a community-centered approach to early intervention on the Behavioral Health Services Act. Research is clear. Most behavioral

health conditions begin before adulthood. Children are less costly to serve, more responsive to care, and early support prevents later involvement in crisis systems, homelessness, child welfare, and injustice systems. Early intervention must be rooted in the communities they serve. Investing in multilingual, culturally competent providers, and partnering with trusted spaces like schools and community organizations that exist. Services should extend beyond individual therapy to include group support, peer models, and culturally grounded practices. We must intentionally reach higher-risk populations, including queer and trans youth and foster youth, ensuring services are inclusive and affirming. A diverse, community-rooted workforce is essential, supporting peer specialists, community health workers, and cultural practitioners with expanded training and financial incentives for multicultural providers. Thank you for your time for this matter.

- I am very interested in the peer-run respite program. I want to make sure that it's done as peers want it to be. There's a specific way that it needs to be done non-clinically, and also where the peer respite is located is very important. It should be done, well not just a private home, but a home, and not located in a place where clinical things are performed because the people coming will feel like they're coming to be clinical-sized or something. That's very important and it's a very effective crisis prevention program. One other thing, I guess that's mainly it is crisis prevention, and that not only saves lives but money. People come before they're at the point when people are taken. Thank you.
- Hello everyone, good afternoon. I'm concerned that the planning system is broken here. The actual planning process happens between September and March, and what we're looking at now is the 500-page plan that you're going to review, and I'm sure most of us can't read it and complete because it was very difficult at best, because it was a form filled out rather than a plan that could be useful. It's difficult to hear community members asking for support of programs and services when the decisions have already been made, they're already in the plan, this is what we're getting for the next three years. This is a $4 billion process. We have 6 people giving public comments for 1 minute, this is not a collaborative planning system. Thank you.
- Good afternoon and I'm here on behalf of the Strategic Behavioral Health Initiative, a central coordinating body across multi-sectoral organizations towards transforming the pediatric behavioral health system in San Diego. We're here as partners in this work. However, based on our in-depth analysis of the plan, we do have a few concerns we'd like to share, and we did share an issue brief with you all today. Children and youth represent 37.7% of individuals served across San Diego's behavioral health continuum. I received less than 19% of the total system spending and this decreases to 17% in year 2 and 16.7% in year 3 in the plan. That is the lowest share of any major County in California. Based on the BHSA Integrated Plan's on the 8th largest California counties, the average is 30%. The proposed BHSA integrated plan cuts children and youth funding by $17.2 million over 3 years. By simultaneously increasing the investment in adults services by $10 million. Thank you.
- I am here to ask that the integrated plan be rejected in its current form. The plan shows a 7% shift from full-service partnerships and a 3% shift from housing interventions. This

is combined $27 million. This large loss of funds would negatively impact the seriously mental ill in our community. The vulnerable population is already shortchanged. The behavioral health director also indicates that the County does not have authority to pursue ACT FSP-level services for people with primary or standalone substance use abuse disorders. I believe this is inconsistent with current state statute. Lastly, the plan indicates the full-service partnerships for individuals with primary substance use disorders will be created. However, with no explanation, there appears to be $0 allocated to this population. Thank you.

- I second June's ask that you reject this plan. The shift that 7% shift from FSP and the 3% shift from housing interventions is $27 million. That is going to seriously affect our most ill people that are on the streets and in homes. We should learn from the way the MHSA funds were misspent, that we don't want that. This is supposed to go to the most serious ill in our state and that FSPs and the housing interventions are so important for people to use to continue to live in recovery with some kind of meaningful life. Thank you.
- I am the immediate past chair of ADSPA, and I'm also a representative of the Mental Health Contractor Association. I have a few comments. One that I also agree that this plan does not fund early childhood mental health at the level that is needed, especially for families that have a behavioral health issue. My other comment is that recently I heard that Action East and Action Central, which are co-occurring programs for clients with substance use and mental health are closing, which is very concerning. The third comment was in the BHSA plan, there was a comment about SUD providers not being coordinated, and I just wanted to confirm that we are a very cohesive group. We do warm handoffs very well, and I just wanted to kind of say that, too. Thank you.
- Good afternoon. I appreciate the county's efforts to address behavioral health, but I'm concerned that this plan fails to directly address one of the fastest growing mental health risks impacting youth and vulnerable adults, which is high-potency marijuana and cannabis-related mental health conditions. The presentation repeatedly references substance use disorders, crisis care, psychosis, suicide prevention, and youth behavioral health and yet cannabis is never specifically mentioned. At the same time, San Diego County and the state continue expanding access and commercialization of high-potency THC products. We cannot ignore the growing body of research linking heavy cannabis use, especially among adolescents and youth adults to anxiety, depression, psychosis, schizophrenia, suicidality, and completed suicides in vulnerable adults individuals. If we're serious about prevention, prevention must include honest public education and early intervention around marijuana-related mental health harms. Thank you.
- Good afternoon, I'm representing San Diego Sober Living. I currently house approximately 80 people. San Diego County has made a major investment in behavioral health, and we appreciate that. But I also want to be clear that treatment without safe housing is incomplete, and housing without treatment and accountability is often not enough. The highest risk period is not when people enter detox or treatment, it is when they leave. With IOP and sober living working together, people have a real chance. As

someone who's working directly in sober living, I see people who want help but cannot afford safe housing. These are not people who need less support, they need the right support at the right time. My request today is simple. Please make sure the funding reaches the providers and programs that serve people after crisis, after detox, jail, and homelessness, and during the daily work of recovery. We need more funding for IOP, and we need more funding for sober living. Thank you for your time and service for our community.

- Hello, I'm also from SDSL. I actually went through the program, I've been through IOP, I've been through rehab. It has definitely affected my life in a more positive way. I did a lot of jail time, I was back and forth, and then I eventually decided to go to a IOP, and I had been sober living for over a year and a half now. I am currently a manager. My life has changed completely, and I feel extremely more successful because of the programs that were allocated to me while I was trying to get clean and because of sober living, I am able to stay clean and I am ready to move. I will be on my own eventually, I do have five kids. I am actively participating in their activities while staying clean and it is because of Sober Living. Thank you.
- Hi, I'm a client at San Diego Sober Living, and I just wanted to say that I came here recently from Massachusetts, and I actually struggle with insurance and struggle for funding to get into Sober Living. If it wasn't for Nick and his program, I wouldn't have had a place to stay and I would have been homeless. I have dual diagnosis of substance abuse and mental health condition as well, I would say probably about 70-80% of people who are incarcerated is because of substance abuse issues and mental health, you know, problems or disorders. Funding would help the people tremendously, such as myself to be a productive member of society. I go to meetings, I'm sober, I live in sober living, and this is helping me be a productive member of society, helped me to obtain employment and be around good people. Funding would be greatly appreciated. Thank you for your time.
- Hi, I am also a client at San Diego Sober Living and if it wasn't for his program, I'd probably wouldn't be clean either. I had just came out of incarceration, so the program helped me a lot and without their funding, I wouldn't be here today. Thank you.
- Priority for the BHAB in the past, and what's standing out to me is addressing the in-custody deaths. In regard to the justice involved, I'm just trying to understand, it's not addressed under BHSA, but it's- it will have to be a cross-system collaboration to address the services needed for prevention in that, or to address the services needed to reduce that number. I also want to understand how that priority- is it a different system or is it under the BHSA, because I'm not understanding how it's reflected.
- I'd like to understand more about the adjustments to the allocations. You mentioned that there was a specific targeted strategy to make those adjustments. How was it determined that SPs would be reduced by amount they were, housing reduced by the amount. I understand that BHSS is very important but what were the specific factors? My understanding is that this is very prescriptive in terms of where the money could go. Is there a possibility, if there's a determination later on to say that a certain area needed more attention, that there could be adjustments to the funding?

- I want to thank Janice Reynosos for bringing up the issue of deaths in custody and people with behavioral health problems. It is really an epidemic and I would urge BHS to collaborate with the Sheriff's Department, because these are the same folks who are cycling in and out of jail, in and out of programs, and it costs a lot of money to keep doing that. There's got to be a better way, but only with collaboration. And I know there's turf wars over funding and when we have two entities that have the exact same, or very similar funding, and there's never enough money to go around, I acknowledge that, but in any case I do think we could amp ump cooperation with the Sheriff's Department. I'll do my part in bringing that back to them as well. But the question I have, okay, so in the Union Tribune today there was an article on how many detentions there have been in San Diego in the last fourteen months. 16,000. Imagine, that's such a gigantic number. 16,000 people have been detained, and clearly not all of them were parents, but many of them were parents. And I see it my community that families are struggling with their mental health. Now folks are afraid to go out of the house. They're being detained on the street. The only way they can get services for behavioral health is at school, or in the community… almost all these folks, none of them have Medi-Cal. So how are we going to serve this population? And for school based mental health programs, how is BHS measuring the current need per school site or school district?
- When you think of what's happening now in, like, enhanced care management, community health work, or these different funding sources that are somewhat through CalAIM and Medi-Cal, and what we're moving to, does it affect any of those, or are those remaining the same? Are they somehow intertwined? Full Service Providers – Will the County take lead on this or will it be contracted?
- Is this all going to be Housing First? Like augmented services programs, where you're going to keep people in the houses? A lot of times, these individuals are using substances. Are we just going to give them money and let them keep using in the households? And a lot of time when we put people in these apartment houses, these apartments end up really hating the people that come in because there's nobody looking after them and they turn these apartments into drug dens. I just got real concerns about housing first and that's all that matters. During the COVID hotels we let them drink, we let them bring marijuana into that hotel. Then we have deaths. And we told them and the lawyer said we can't do that them, we can't make sure they don't use. And they stopped this whole thing. Look, we're the one's who did the training, which goes to the hotel.
- My question is a clarifying question about the components that are marked as outside of the scope of BHS. Components like crisis alternatives, housing stability, and workforce, when it seems like three slides before that there were… in the public comment key things in the third column there's outside scope of BHS. One of the things here… crisis alternatives, recovery alternatives, and yet three slides before in response to a public comment, it was highlighting the implementation of mobile crisis response teams, CSUs and crisis infrastructure. Same thing with workforce. The elevate program and investment in workforce is a priority. Housing stability and supportive housing expansion. 30% or 28% is towards the housing interventions. I guess I'm confused

about where is it within the scope of BHS and reflected in the investments of the programs that I think we are most proud of in our county, like mobile crisis response teams, things like that, and the things that are outside the scope of BHS that require collaboration, that I would say leadership rom BHS to identify the collaborators as needed, such as with the jails and incarceration. For that other question, where that is one of the key outcomes that we've identified for the state that we're measuring is incarceration. And yet, collaboration with the Sheriff's Department is going to be a key to reducing deaths in incarceration. Would like clarification on those inside, outside. Do you know what I was talking about though, the bullets say, they say workforce so we're doing a lot of workforce, they say crisis intervention so we're doing a lot of crisis intervention, but it doesn't say prevention when those are programs that are being sunset due to the movement of funding to the state. I would consider that to be outside the scope of BHS for certain things based on the shifting and funding priorities but not necessarily the crisis alternatives or substance use disorder eligibility. The expansion of the substance use disorder is an addition for BHSA. It might just be that there are bullets on this slide. I appreciate a thoughtful response, but you don't need to have a response entirely in the moment. If you need more time to think about it and make sure we're really understanding what is within the scope and what requires what is outside the scope and I would call on BHS to be a leader in convening the collaboration that needs to happen at one of our next meetings, we're going to have a housing panel, because it is so intersectional and requires the cross sector collaboration. And that's what I understood from the state in the shift from MHSA to BHSA. No more finger pointing. We actually need to care for our population. We have a charge here to take that to heart and not say this outside of our bucket. We can call to the table these other players, and whether BHAB needs to play a role in that as a community partner, we are happy to do so. Maybe we could be involved in the outcomes, the sharing there, to share questions where we're below the mark."

- The BHSA is about 20% of the total budget, is that correct? So, the things that are in here that we want in the system that isn't paid for, or allowed for, through BHSA. Could conceivably be paid through the rest of the system since its only 21%. My concern is that we don't have transition training from how people are going to move from this place to this place over here and that should have started a while ago. What this new system is, why it's happening what we doing, how is it going to happen? Those little trainings over and over and over again, so people aren't here saying what? What are we doing? What part is BHSA? I mean to tell the truth, we've been talking about MHSA the entire time it was MHSA. What does MHSA do? Then there's continuing education training. I don't hear it being compensated someplace else in the system. So after we move the system to being by itself, I don't hear how we're continually training our system on how to provide services in these new ways. I don't mean Medi-Cal, or technical training. It's more of the softer trainings, and it's more of the continuing education training. I did not hear, I don't know if I should've heard, but I was to hear personally, CCRT in some places in this system. CCRT has had an amazing role in how we provide services in this system of care and not having it present makes me feel like it's disappearing. When we don't call out a structural piece of our system of care, it get's lost."

- My question is any issues with multi factorials? I would like to ask, in BHS understanding, what are the reasons we are not meeting the state average? Is it money, workforce, or someone else's responsibility?
- How is this 3-year plan going to affect the integration plan going to affect that aspect? It's helpful but these are key fundamental areas.
- One thing I would like to highlight is the value of field-based programs. A lot of people I work with that experience SMI. It's a very big barrier to try to find their own way to get to services, and I found it very, very helpful for these people to have a hand to hold after hospitalization.
- MAY 7, 2026 BEHAVIORAL HEALTH ADVISORY BOARD (BHAB) ACTION ITEM APPROVE BHAB RECOMMENDATIONS TO THE DEPARTMENT REGARDING THE DRAFT BHSA INTEGRATED PLAN FOLLOWING THE PUBLIC HEARING. To: San Diego County Behavioral Health Services (BHS) and Board of Supervisors (BOS) From: Behavioral Health Advisory Board (BHAB) Date: May 7, 2026 Subject: BHAB Feedback on the Draft 2026–2029 BHSA Integrated Plan. This memo provides BHAB's high-level feedback on the draft 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan (IP). It is meant to accompany the detailed comments submitted by Board members and community stakeholders and to highlight the key issues that should be addressed before adoption. The IP reflects significant work and includes several important investments. At the same time, it was difficult for both Board members and the community to fully engage with the document. Parts of the Plan are hard to follow, the page numbers were not visible, and some sections are marked "not applicable" without explanation, and it is not always clear what is actually changing as a result of this Plan. While stakeholder feedback is summarized, the connection between the feedback and the proposed solutions is unclear. More importantly, the IP does not yet show how the system will work differently for the people who rely on it the most, especially those who move between crisis services, homelessness, and the justice system. Across stakeholder input, the same concerns came up repeatedly. People described weak follow through as they move between programs and systems, a lack of accountability for whether services are actually helping, and a disconnect between the problems identified in the Plan and the solutions that are proposed. There is also a lack of clarity around how major changes, including Enhanced Care Management (ECM) and BHSA, will work in practice. Taken together, these concerns point to a larger issue: there is no clear way to understand whether people are doing better over time. The Plan does not explain how outcomes will be tracked across crisis services, custody, housing, and ongoing care. This makes it difficult to know whether the system is improving or just continuing to operate as it does today. The Plan does a strong job identifying disparities across age, race and ethnicity, and language. However, the responses to those disparities are often general and not clearly tied back to what was identified. There needs to be a more direct connection between the disparities described and the actions the County plans to take, including specific approaches to language access and culturally appropriate care. THEREFORE, recommended that BHAB vote to approve the BHAB Recommendations to the Department Regarding the

Draft BHSA Integrated Plan following the Public Hearing. The IP also does not fully address behavioral health care in custody or what happens when people leave jail and return to the community. This includes both the quality of care provided while in custody and the lack of clear transitions back into community-based treatment. Without stronger connections between these parts of the system, people will continue to cycle through the same patterns the Plan is trying to change. Care coordination is another area that needs more clarity. The Plan relies heavily on models like ECM, but feedback from providers and community members suggests that these services are inconsistent and often not enough for people with serious mental illness. It is not clear what level of support individuals can expect or how coordination will work between County services and managed care. Early intervention is mentioned but not clearly developed as a strategy. Recent changes to contracts and programs raise questions about whether the system has lost capacity in areas that were previously supported through grants. The Plan should more clearly describe how individuals who are not currently engaged in care will be identified and supported earlier. This includes expanding field-based outreach and engagement, particularly for individuals experiencing homelessness with serious mental illness or substance use disorders. The Plan should also consider how voluntary, field-based treatment can be used more consistently, and where appropriate, how existing authorities can support earlier intervention before individuals cycle into crisis, hospitalization, or the justice system. Finally, while the IP includes summaries of stakeholder input, it does not clearly show how that input changed the Plan. There should be a more direct connection between what was heard from the community and what is being proposed, as well as a clear plan for continuing to gather and use feedback during implementation. The IP sets a direction, but it does not yet provide enough clarity on how outcomes will improve for the people most affected by the system. These issues should be addressed before adoption or clearly incorporated into implementation moving forward. Addressing the comments summarized above and in their raw form below will make the Plan more practical and increase the likelihood that these investments lead to real improvements in access, continuity, and outcomes. BHAB will continue to stay engaged as implementation moves forward. Thank you, San Diego County Behavioral Health Advisory Board. It is THEREFORE, recommended that BHAB vote to approve the BHAB Recommendations to the Department Regarding the Draft BHSA Integrated Plan following the Public Hearing. BHAB Member 1 Comments: The following comments have estimated page numbers, however since the draft IP does not contain page numbers these numbers may be approximal rather than specific. These comments were generated after 60 hours of exposure to and personal interviews of dozens of stakeholders including practitioners, family members, crisis team members and first responders whose lives are devoted to helping the targeted care population specified in Prop 1 and BHSA, including my own personal study of Prop 1, BHSA and studying the entire 500 page draft IP, and my involvement in our Ad Hoc BHSA Subcommittee composed of 4 BHAB members, 4 staff members and 4 community members. It is my belief that these comments, if included in the BHS IP will serve as a written guide to BHS in our common pursuit of reaching these specified unreached or under reached

people suffering with SMI and/or SUDs for the next three years. Robert Alm. Please add these comments: Into pages 29, 43,164 and 176: The county will study the homeless population to determine the percentage experiencing an SMI or SUD. The county will consider the use of outpatient field teams to treat this population, voluntarily, in the field. Into page 30: The county will pursue outpatient conservatorships when the level of care allows. Into page 34: Utilize electronic medical record sharing to facilitate voluntary and involuntary administration of medication as soon as possible in the hold sequences. Into page 34: The county will support and encourage the crisis response teams of the cities within the county. The county will grant authority to these crisis response teams to initiate 5150 holds. Into page 37: Look for and implement field-based programs to identify gravely disabled or SUD people and pursue voluntary administration of medication in the field, and possibly involuntary administration of medication in the field within the guidance of the law and ethical medical practices. Our goal is to identify and treat the gravely disabled homeless people before they are arrested thus reducing all upstream numbers of justice involved individuals. Into pages 101-130 as is appropriate under Early Intervention (EI): Early intervention strategies will include efforts to identify gravely disabled people who are experiencing homelessness, pursue voluntary field treatment, or involuntary treatment if necessary. This would reduce all upstream numbers of justice involved, experiencing or at risk of experiencing homelessness, noncompetent to stand trial people sent to a state mental hospital, and in justice involved reentry numbers. Into page 43: Broaden the use of the term “Any Person” under WIC 5201 to allow more and easier access to help through mandated Evaluations of people suffering with a mental disorder. BHAB Member 2 Comments: Below is feedback regarding the IP. For context, this information has been gathered through a combination of two listening sessions hosted by the county for people with lived experience as consumers of San Diego county behavioral health services, conversation with colleagues and my own experiences working in strengths-based behavioral case management for low income older adults living with SMI, conversations with administrators at my program, and my own lived experience as a consumer and family member. I appreciate you both taking the time to review and consolidate information on behalf of the board. Intensive Out-Patient Programs (IOP) - IOPs are an incredible resource for people living with SMI, particularly after hospitalization while transitioning back into the community. Some San Deigo county examples include Sharp Mesa-Vista, Alvardo Parkway Institute, and Sharp Grossmont. However, Medi-Cal does not currently cover these programs (at least as it relates to mental health, there may be SUD IOP programs MediCal covers). I heard from many community members the value IOP had for them and also heard about the difficulty accessing these services. I've seen older adults in my program benefit tremendously from these programs when they've been able to access them through Medicare, but there are not options for these services for our members that are not yet eligible for Medicare. I can also speak from personal experience for the value of these programs in providing support and reducing re-hospitalization having been a part of an IOP program as a consumer, Enhanced Care Management (ECM) - The county has been increasingly been encouraging the use of ECMs. While the concept of ECM is wonderful, in practice, it is currently not meeting

the needs of many people living with SMI. ECMs, in my experience, largely are able to schedule appointments and help setup transportation, but they do not attend or go into appointments with their clients. This leads to people living with SMI not ever making it to appointments/feeling intimidated or unsure of what to do inside of appointments/leaving appointments without important information on next steps. Most ECMs have been very difficult to reach with any consistency, even during moments of urgency, both for the client and for other professionals trying to coordinate. And many ECMs do not have extensive experience working with/knowledge around SMI. My program has been repeatedly encouraged to use ECMs for our members' physical health needs, but attempts to do so have been largely ineffective, Desire For More Support to be Successful in the Community - Many people expressed feeling as though they were left to fend for themselves after hospitalization. Being told to schedule follow-up appointments, but essentially feeling left alone. People described the value of "having a hand to hold" as they navigate returning to the community. This could be field based FSPs, peer support, or an area where IOP would be valuable. Peer involvement at each step of the recovery process was requested. I believe this also aligns with what ECM would look like if it were functioning ideally, Lack of Board and Cares for Low-Income Individuals, Lack of Support at ILFs - My program supports members at many board and cares and ILFs. The lack of board and cares for low-income people is a consistent issue to providing safety when members leave the hospital. Many board and cares cost upwards of $3,000 a month for a shared room, something completely outside the means of members of our program/people on Medi-Cal as a whole (Medi-Cal's income limit is generally around $1,900 per month). Most of the members of my program live on Supplemental Security Insurance (SSI), which is generally about $1,200 per month. A person on SSI cannot have more than $2,000 of total assets to receive these benefits. Some board and cares have an "SSI rate" where they will charge roughly $1,300 a month for a shared room. SSI adjusts the total SSI received by such a person to roughly $1,400 per month, leaving about $100 total per month for a person living in a board and care after their rent in covered. Most board and cares do not have this type of accommodation. This leads to our members often being discharged unsafely to an ILF after hospitalization due to lack of supportive housing options, despite advocacy from my program that a member needs a higher level of care. ILFs, as they are currently, have very little (if any) support for people living with SMI, and in many situations can be a trigger. The biggest issue is only board and cares and levels of care higher than that can assist people with medications, Lack of Engagement Activities at Board and Cares - Most board and cares have few, if any, activities for residents. Most people living in board and cares have limited ability to leave the facility, and it's very damaging to one's mental health essentially being in one place every day with the only activity available being watching TV. People request more games, arts and crafts, exercise programs, and ways to have community outings, Lack of Support, Grocery Stores, Community Resources Near Low-Income Housing - Many board and cares, ILFs, and SROs are located in areas where grocery stores, parks, and other positive community resources are not easily accessible. Particularly for the older adult population I work with, if the nearest bus stop is a mile away, it is unreachable given

limited mobility. In addition, many people with SMI struggle to use the bus and are at increased risk of victimization on public transportation. This leads to many of our members to lean on nearby liquor stores/smoke shops that deplete their already limited funds, are risks for triggering unhealthy coping skills like alcohol use, and usually result in less healthy options for food/drinks. It also leads to lack of community integration Trauma Inflicted by the System - I heard from many people in listening sessions, from members of my program, and have experienced personally trauma from the behavioral health system. This trauma largely relates to forced treatment, restraints, and seclusion. When a system that is meant to help people in crisis is responsible for trauma, it is extremely hard to rebuild trust and engage in a positive way with the system. It becomes an enormous barrier to recovery. I strongly encourage forced treatment, restraints, and seclusion being a truly last resort in situations that are immediate safety risks. This is not currently the case Lack of Clarity, Guidelines, Standardization - Many changes are coming or starting to take effect, and there's a lack of information around how they are meant to be/going to be implemented. For example, my program will be transitioning to a level 2 FSP in less than 3 months. My administrators are currently trying to design a program without specifics even as basic on what our staffing level will be and what positions we are able to have at the program (will we have a housing coordinator, intake specialist, etc). There is meant to be housing assistance available now through Medi-Cal, but in speaking with Medi-Cal representatives, we have largely been told they are unfamiliar with this program or don't know who to connect us to to obtain this support. Changes to MediCal and SNAP currently lack details on what will qualify a person for an exemption to things like work requirements and how this will be verified. This uncertainty is difficult for staff, but it is extremely challenging for our members living with SMI and has frequently led to exacerbated symptoms when access to housing and benefits are seemingly at risk, Lack of Options for People Losing Medi-Cal/SNAP - It appears there are few resources available for people living with SMI that may lose access to coverage through Medi-Cal. FQHCs, while extremely valuable, are not currently setup to treat SMI. How will people living with SMI that are, for instance, victims of human trafficking set to lose access to benefits, receive the support they need? Food banks are already having difficulty meeting demand, how will low-income people that lose access to SNAP consistently meet their basic needs? Thank you both for your time. I'm happy to provide additional detail on anything if it would be helpful, BHAB Member 3 Comments: - Accessibility of the document was horrible and a deterrent to actual feedback. - Disparities in Access to Care for both older adults and youth, particularly for non-English language. The solution described is to, “To address these gaps, SDCBHS is expanding crisis and diversionary services that reduce barriers to entry and improve linkage to ongoing care.” (pg. 24). While adding additional entry points, the outlined solutions do not address the need for services in different languages. - Why are the state measures starting on page 44 all “not applicable?” - Page 84- The plan notes collaboration with Healthy San Diego. Which date of HSD was BHSA and the IP presented for engagement versus simply a report out that it was happening? The direct collaboration between the county BHP and MCPs should happen before guidance from the state. - Page 88- care

continuum section is “marked complete” but has no information. Page 92- only 17% of county contracted providers have contracts with MCPs- this seems very low and could contribute to breakdowns in transitions of care. How are the programs benefiting from ECM and CS investments (pg. 189) if they aren’t contracted with MCPs? - Early Intervention Programs- Why are many operating without using EBPs? Why were there no additional opportunities identified for EI? - Page 192- good call out for what the community has been asking for. More of this and more specificity. “For the last three years, stakeholders have consistently identified the following areas as priorities for enhancement within San Diego County’s continuum of care: Accessibility; Care Coordination and Navigation; Community Outreach and Education; Crisis Response Services; Culturally Appropriate and Affirming Care; Support for People Experiencing Homelessness; Services for Youth and Transition Age Youth(TAY); and Workforce Capacity and Diversity.” - Page 192 has a comment about the importance of ACEs, but there was a recently terminated contract for ACEs? - In the community engagement summaries, there are really rich feedback reports, but I don’t see that feedback directly incorporated into the plan itself or informing future work as it’s currently outlined. Is there a way to include the voices of these stakeholders in a more meaningful way? - Where is the UCSD CPP report? - Page 310- the IHP feedback session has an inaccurate attendee list. - Page 486- missing data in the far right columns. - Can we see the breakdown in ages for adults/older adults instead of grouping them together? - Early intervention and focus on youth is disproportionate to spending. BHAB Member 4 Comments 3/30/26 Pg. 11, IP Section 34 - There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful. - 3/30/26, 10:22 AM, Engage SD: Pg. 11, IP Section 34 The poor quality of behavioral health services in the County jails has been documented by the Grand Jury, the State legislature audit, the League of Women Voters, and many other entities. Deaths have occurred in custody as a result of the SDSO policies and procedures and the county has paid out upwards of $100 million in lawsuits in a 10 year period. The State must consider the quality of services as the incarcerated person reenters the community as they likely will be more acute. It is THEREFORE, recommended that BHAB vote to approve the BHAB Recommendations to the Department Regarding the Draft BHSA Integrated Plan following the Public Hearing.

Voicemails
Total: 2

All Responses

- Caller has concerns about Parcel #444-110-2100 at 4307 3rd Avenue and the amount of traffic it will bring to 3rd Avenue. Caller is inquiring about the building layout and when it will commence. Caller is looking to get some litigation against the road conditions there because of the road conditions.
- Caller has concerns about Parcel #444-110-2100 at 4307 3rd Avenue and the amount of traffic it will bring to 3rd Avenue. Caller requests a return phone call.

Email Submissions
Total: 37

All Responses

- I have been suffering with a number of mental health issues. I think it's very important for mental health to be better served with employers because I had such a terrible experience of working at St Vincent de Paul with mental health where I ended up having an emotional mental and physical breakdown that led to a surgery and also a crisis house and psychiatric hospital. At the end because of my mental health I was forced to resign from St Vincent de Paul and therefore it left me without a job but education is important with an employer because I was always under impression that they hired me because they knew that I am a person who suffers with mental illness but yet they did the opposite of what my psychiatrist requested on paper for accommodations as an employee for St Vincent de Paul. Based on their lack of respecting someone with mental health or even understanding it with full compassion and empathy I was left without a job and it's very unfortunate because I am currently now struggling to find employment as a person with mental health and I hope in the near future that I can find an employer that understands people with mental health issues. Even though 6 months later I am medical managed with psychiatric medication St Vincent de Paul still will not consider rehiring me even though I have demonstrated through psychiatrist that work at St Vincent de Paul that I am fit to go back to work because my mental health is controlled with medical medication management and also ongoing trauma therapy and Psychiatric Services but it is very important for me that employers especially like St Vincent de Paul understand and respect individuals with mental health.
- I received this Email Address in a local news Article about Psychiatric Care Financial Funds regarding Prop 1. In 2011 I was Diagnosed with SMI. I have been on SSI and living in and out of Community Care Homes since then. I have 15 years of personal life experience living in the System. I hope to some how benefit from Prop 1 in regard to Service Options, Care, and Financially. For myself and others like me.
- I am writing to submit a public comment on the draft BHSA Integrated Plan in support of veteran permanent supportive housing as a priority use of the 30% housing intervention allocation.**About ESSH:**Elysian Shores Supportive Housing is a veteran-founded 501(c)(3) nonprofit (pending recognition) with a 21-property acquisition pipeline across

Southern California. We partner with Wakeland Housing Development Corporation and are actively pursuing Homekey+ funding through SDHC. Our founder, Marine Corps veteran Noble Woods III (9yr, Desert Shield/Storm), leads operations focused on cost-effective permanent supportive housing for veteran populations.**Our Recommendation:**We respectfully advocate for three critical provisions in the final BHSA Integrated Plan: (1) **Veteran PSH as Priority Use**: Designate permanent supportive housing for veterans as a priority category in BHSA housing intervention funding, given the 372 homeless veterans counted in San Diego's 2025 Point-in-Time survey. (1/5 parts)

- (2)**Capital Allocation for Hotel/Motel Conversion**: Reserve capital development funding for conversion projects (SRO/shared-amenity models). These yield 60-70% cost savings vs. new construction while serving identical populations. (2/5 parts)
- (3)**BHSA-CalAIM Coordination Language**: Enable PSH operators to stack BHSA capital grants with CalAIM operating revenue. This removes funding silos and reduces county match requirements for nonprofit operators. (3/5 parts)
- **Cost Efficiency Rationale:**Veteran-specific SRO/shared-amenity housing costs $75-120K per bed vs. $250K+ for new construction. At $90.9M annual allocation, PSH-first strategy serves 750-1,200 individuals while preserving capital for multiple annual cohorts. (4/5 parts)
- **Request for Engagement:**We welcome a meeting with BHS housing program staff to discuss ESSH's Ramada Suites conversion project and explore BHSA alignment. We are available at your convenience. Thank you for prioritizing veteran housing in the final plan. (5/5 parts)
- Just Whole Care writes in strong support of San Diego County Behavioral Health Services' (BHS) bold vision outlined in the 2026-2029 Behavioral Health Services Act (BHSA) Integrated Plan. The plan captures urgent community needs identified through a comprehensive Community Planning Process (CPP), while laying out practical, data-driven frameworks for expanding access, advancing equity, and implementing upstream interventions. We are especially encouraged by the robust focus on children, families, and youth throughout, including through CPP engagement and Youth Optimal Care Pathways (OCP) findings, the alignment of crisis services, trauma-informed care and collaboration with child welfare and education, and the robust cross-sector coordination and Next Move expansion planned for justice-involved youth. To ensure these ambitious goals translate into seamless operational reality for San Diego communities and the community-based organizations (CBOs) who serve them, we recommend the following specific language additions to the Integrated Plan. These precise edits will clearly link the county's strategic goals with necessary technical infrastructure and equitable Medi-Cal financing. Page 43: Untreated Behavioral Health Conditions: Cross-Measure Questions - Current Text: “SDCBHS also strengthened neighborhood-level engagement through Community Health Workers (CHWs)… and piloting targeted interventions including… BH-CONNECT Enhanced CHW services…naloxone distribution for harm reduction.” Recommended Addition (Insert immediately after): “To successfully scale these interventions and secure sustainable

agreements with Managed Care Plans, BHS will support CBOs in pursuing Medi-Cal certification, securing financial partnerships with California Children & Youth Behavioral Health Initiative (CYBHI) Fee Schedule schools, and designing impact measurement strategies and data dashboards tied to their CHW and neighborhood-level engagement programs, allowing community providers to showcase their value and impact." (1/5 parts)

- Page 93: Contracted BHSA Provider Locations - Current Text: "Coordinator will track the rates over time and identify and implement additional targeted and/or systemic interventions as needed based on the data." Recommended Addition (Insert immediately after): "To further scale MCP contracting, BHS will utilize its anticipated Medi-Cal Training and Technical Assistance for Community-Based Behavioral Health Providers program (RFP 12985) to deliver hands-on clinical, operational, and financial coaching. This will ensure CBOs can navigate PAVE registration, clearinghouse setup, and successfully contract with and bill Managed Care Plans and CYBHI schools, rapidly expanding San Diego's non-specialty behavioral health network in parallel with BHSA provider locations." (2/5 parts)
- Pages 105-109: Early Intervention (EI) Programs (ECS - Para Las Familias, Incredible Years, KidSTART & Incredible Families) - Current Text for Each Program: "Please describe intended outcomes of the program or service: decrease/prevent progression of mental health disorders." Recommended Addition (Insert immediately after for each program): "To advance the impact and long-term sustainability of this program, as well as maintain EI dollars for higher-risk children, youth and TAY, BHS will partner with Managed Care Plans and CYBHI Fee Schedule schools to develop technical assistance that helps early childhood-serving CBOs align their whole-family interventions with Medi-Cal's Non-Specialty Mental Health Dyadic Services and Family Therapy billing structures, allowing for seamlessly braided funding and coordinated care just upstream to EI." (3/5 parts)
- Page 156: Assertive Field-Based SUD Treatment Services - Current Text: "Use BHSA to reimburse targeted outreach and include data tracking and more deliberate outreach to areas in need. Add new positions into existing contracts." Recommended Addition (Insert immediately after): "To support small and minority-owned CBOs in safely managing the operational risk of this expansion, the county will offer providers scenario-based pro forma modeling to translate complex reimbursement structures into realistic revenue projections, allowing providers to determine sustainability thresholds before committing precious resources." (4/5 parts)
- Page 179: Build Workforce to Address Statewide Behavioral Health Goals - Current Text: "The County is also actively soliciting for a contractor who will provide Medi-Cal Training and Technical Assistance to prepare community-based behavioral health providers for compliance and operational readiness." Recommended Revision (Insert immediately after): "This technical assistance will ensure CBOs have the administrative infrastructure and clinical supervision protocols required to sustainably hire, retain, and bill for newly certified Peer Support Specialists, Community Health

Workers, and trainees deployed through the ELEVATE Behavioral Health Workforce Fund." (5/5 parts)

- Please ensure that the BHSA IP includes the following essential components: (1) Prioritizes the most vulnerable by reversing the BHS request to move funding away from full-service partnerships and housing interventions. (1/3 parts)
- (2) Funds full-service partnerships that enroll people with primary or standalone severe substance use disorder. (2/3 Parts)
- (3) Uses BHS administrative funds to appropriately transition stable individuals from BHSA-funded clinics to Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs). (3/3 parts)
- Dear Director Privara Brahms and the BHSA Planning Team. I am a San Diego County resident. I would like to highlight three ways the draft BHSA Integrated Plan could better prioritize residents with the most serious behavioral health needs. First, the County Behavioral Health Services should reverse the request to move funding away from full-service partnerships and housing interventions. The current plan would shift 7 percent from full-service partnerships and 3 percent from housing programs into broader behavioral health services. That moves resources away from the people who need the most help. Full-service partnerships support individuals who are too ill to regularly attend clinic appointments. These programs provide intensive, field-based care that helps keep people out of emergency rooms, hospitals, and jails. In the first year, the plan directs only the minimum required housing funding to people who are chronically homeless. Redirecting about $27 million away from these programs risks leaving the most vulnerable residents with fewer supports. I urge you to reverse this funding transfer request. (1/3 parts)
- Second, the County should fund full-service partnerships for people with primary or standalone severe substance use disorders. Recent state law allows individuals with severe substance use disorder to be detained for treatment, but many still have no access to the ongoing support of a full-service partnership. Without that support, people often return to crisis situations instead of receiving sustained care. (2/3 parts)
- Third, the County should use administrative funds to improve how the system works. One step would be helping stable patients transition from County clinics to community clinics. That would free up County specialists to focus on people with the most serious mental illness, homelessness, and justice involvement. These changes would help ensure that our behavioral health system prioritizes the residents who need the most care. Thank you for the opportunity to comment. (3/3 parts)
- Dear Ms. Evans Murray and the Engage BHS Team, I appreciate the scope and seriousness of this draft plan. It reflects genuine work across a complicated landscape of behavioral health needs, and I want to acknowledge that before getting into substance. I'm a Health Sciences Clinical Professor and Division Chief for Academic Affairs in the Division of Geriatrics, Gerontology & Palliative Care at UC San Diego Health. I'm board-certified in Hospice and Palliative Medicine and have spent over a decade caring for seriously ill adults in San Diego County. I submit these comments in my personal capacity as a community member whose clinical expertise is in the

behavioral health dimensions of serious illness and aging. My comments complement those submitted separately by Dr. Lindsey Yourman, a geriatrician colleague who has identified the plan's structural gap: older adults are named as a disparity population across multiple measure domains (SMHS, DMC-ODS, FUM, homelessness services) but receive no targeted intervention specificity, no disaggregated budgets, and no funded programs. I share her concern and will not repeat it here. Instead, I want to build on that foundation with recommendations specific to serious illness — a population within a population that this plan does not address at all. The plan contains no mention of palliative care, advance care planning, serious illness, goals-of-care communication, hospice, or bereavement services (outside of suicide loss). For a county with a large and growing older adult population, many of whom live with advanced heart failure, COPD, cancer, dementia, and end-stage renal disease, this is a meaningful omission. These individuals experience depression, anxiety, delirium, and substance use disorders at elevated rates, and they are among the highest utilizers of crisis and emergency behavioral health services. I offer six concrete recommendations: Embed a palliative care-trained behavioral health specialist in at least one Full Service Partnership (FSP) program serving older adults as a funded pilot during the plan period. The FSP older adult planning section (p.152-153) describes a thoughtful process but, as Dr. Yourman notes, specifies no services, dollars, or targets. A single-site pilot with defined outcomes — psychiatric symptom burden, ED utilization, housing stability — would produce the evidence base to scale during subsequent plan cycles. Address suicide risk in seriously ill older adults as a named priority. The plan supports the Suicide Prevention Council and related initiatives but does not identify older adults with serious medical illness as a high-risk subpopulation. Older white men with serious illness represent the highest-risk demographic for completed suicide in the United States. Expressed wishes to die in this population frequently reflect undertreated pain, poorly managed symptoms, or existential distress rather than primary psychiatric illness. Mobile Crisis Response Teams and crisis intervention staff need training to distinguish these presentations. Coordination with palliative care and oncology programs to screen for behavioral health needs at points of diagnosis and disease progression would be a concrete step. Connect ED follow-up for older adults to medical complexity. The plan documents that follow-up after ED visits for mental illness remains lowest among adults 65+, but the planned response does not name older adults as a targeted subgroup. Seriously ill older adults presenting to EDs with behavioral health crises frequently have delirium, medication-related psychiatric symptoms, or undertreated pain driving the presentation. Post-ED behavioral health follow-up for this population should include geriatric medicine or palliative care assessment — behavioral health follow-up alone will miss the underlying medical contributors. Fund bereavement and grief support as part of the social connection strategy. The plan appropriately identifies social isolation as a concern. Adults 18-59 in San Diego County report lower social connectedness than the state average. But the planned response — peer-delivered services, community outreach, public messaging — does not address grief and bereavement as a driver of isolation among older adults. Widowhood, progressive functional decline, and loss of social roles due to serious

illness are major contributors. The county has existing hospice bereavement programs that could extend grief support to Medi-Cal beneficiaries through partnership agreements. Complicated grief is a treatable condition with evidence-based interventions; it should appear in this plan. Prioritize seriously ill individuals in post-hospitalization and recuperative care housing. The plan identifies a "large gap" in short-term post-hospitalization housing and a "medium gap" in recuperative care. Seriously ill older adults discharged from hospitals with co-occurring behavioral health conditions are among the most vulnerable to cycling between homelessness, readmission, and death. Housing placements for this population should include access to palliative care and symptom management services, coordinated through Enhanced Care Management and Community Supports. Add palliative care competencies to behavioral health workforce development. The BH-CONNECT and ELEVATE workforce initiatives do not address the clinical skills that behavioral health providers serving older adults increasingly need: pain and symptom assessment, opioid safety, prognostic awareness, goals-of-care communication, and collaboration with medical teams managing serious illness. UCSD's Division of Geriatrics, Gerontology & Palliative Care and other local academic programs are available partners for cross-training. The caregiver burden expressed by community members throughout the engagement process (e.g., p.292-293) also warrants specific attention through a serious illness lens. Caregiving for someone with advanced illness produces depression, anticipatory grief, and complicated bereavement at rates that differ qualitatively from general caregiving stress. A funded caregiver behavioral health support initiative — not folded into general programming — would respond directly to what community members asked for. I recognize this plan was built on a standardized DHCS template and that the first cycle is necessarily foundational. These recommendations are offered in that spirit: concrete enough to act on during FY 2026-2029, with an eye toward what the evidence base and infrastructure should look like by the next plan cycle. I would welcome the opportunity to discuss any of these points further.

- Dear Engage BHS, Thank you for your work on San Diego County's Integrated Behavioral Health Plan. I am a practicing Geriatrics and Palliative Care physician who frequently treats older adults with complex behavioral health needs. As a former Geriatrician on the inpatient Senior Behavioral Health unit, and having completed my Internal Medicine and Geriatrics training in a similar inpatient unit dedicated to older adults in Los Angeles County, I know first-hand how impactful it is to have county based behavioral health services dedicated to older adults. Older adults have unique physical, neurocognitive, and social needs; older adults with serious mental illness are a vulnerable population who require specialized care and thus dedicated programming. Any loss of dedicated resources is deeply felt by these patients, their loved ones, and witnessed by their health care providers. For example, just yesterday I treated a patient in my palliative care clinic who has dementia with behavioral disturbance; her family is working hard to honor her wish to spend the remainder of her life at home with them. But she is experiencing behavioral disturbance that requires a higher level of care—because we no longer have an inpatient unit dedicated to patients like her, her family struggles to choose between available inpatient and outpatient options. They are trying to reconcile

her medical needs with the environment they know she will feel most comfortable and safe in. As you know, this story is not unique—caring for older adults with behavioral health needs is a challenge faced by many families across this country. I plead with Engage BHS to specify targeted interventions and programming for older adults with dedicated budget and enrollment goals. I am representing my own opinions as a citizen of San Diego County. Thank you for your consideration.

- As a practicing geriatrician, I can attest that older adults have unique health needs and mental health is no exception. Over my years in practice I have come to highly appreciate the mental health care given to my patients in both inpatient and ambulatory settings which has enabled them to live healthier and happier lives and also supported their caregivers and families. I therefore am strongly advocating for inclusion of interventions, services and programming for older adults. I am representing my own opinions as a resident of San Diego County. Thank you.
- Please find below public comment responses provided directly by the Breaking Down Barriers (BDB) Department and the Economic Mobility and Opportunity (EMO) Department of JFS. In addition, JFS at-large will be submitting separate public comment prior to the deadline that will address further key considerations. Breaking Down Barriers (BDB) (1) Early intervention New Definition of Early Intervention services include direct services for children and youth who are "at-risk" of a mental health condition but are not yet displaying symptoms (i.e. indicated n prevention) (WIC 5840) so when implementing we know that counties are not required to eliminate all programs they had previously categorized as prevention. There is space room and opportunity for flexibility within the new early intervention definition to translate many program models to incorporate the prevention efforts that have been shown effective. (2) Further Feedback: It is important to focus on community centered interventions based on community populations. Examples: (1) Having diverse providers who speak multiple languages (and regional dialects). (2) Loop in/identify additional supports/organizations that are culturally informed such as nonprofits, schools, community events, parent groups, community gardens, walking groups (adding physical movement to support with mental health). (3) You will miss queer communities if our comments aren't considered as it remains/becomes more dangerous to be identified through the government/programs for queer/trans identities under the threat of the current administration - while queer identities have disproportionately high instances of mental health symptoms, therefore the queer/trans youth are in categories of high risk before showing symptoms. (4) We should move beyond individual therapy as a default - like having community healing circles, group support. Though we are refocusing on direct services, some communities don't relate to some of the interventions / approaches to care. It is important that care is reflective of what communities want and pay them accordingly. Examples: (1) Working with cultural practitioners (2) Curanderisms (3) Spiritual/Faith leaders (4) Building up a diverse workforce and doing outreach, so communities know about scholarship opportunities. Examples for this include: A. Adding pathways in the mental health field. ie: San Diego City College Mental Health Work Certificate. But incentivizing it for people that speak other language. B. Increasing training (or even funds for non-licensed clinicians. We should

also build a broader culturally rooted workforce (i.e. community health workers, peer support/specialists) in order to expand who can give support. (5) More awareness and increased opportunities for interest free loans (Ex: SD Pay It Forward Loan Program & Indian Health Services Loan Repayment program). (6) Focus on supportive services to build trust with the youth (ex: before/after-school programs, (7) Expand language around housing interventions (consider early interventions and people at risk of being unhoused - for example, incorporate individuals who may be more transient living between homes, sleeping on couches, multi-generational homes due to housing costs such as invisible homelessness, those with SUD, LGBT homeless youth, those in DV/ IPV situations etc...) Economic Mobility and Opportunity (EMO) San Diego County is a place full of different communities with different contexts, life experiences, and needs. We'd like to elevate the consideration of direct cash as both a preventative and intervention tool for communities that will be served with this BHSA plan. Access to Care: Given the low access of mental health services that currently exist in the County, in addition to targeted expansion of crisis, residential, and substance use treatment services, there should be a focus on community engagement and education of the services that exist. This boasting of engagement and education can be done in collaboration and partnership with trusted partners such as educational institutions, community-based organizations, and community health partners. Trust and education are key to ensuring community members are aware of the resources that exist and are available for them. In addition, these services should be made available in the languages and with the needs of the community members they intend to serve in mind. Feedback from community members should be gathered throughout engagement and service connections to gauge what is working and what can be improved. Direct cash to community members should be considered as a further intervention tool that can be included in the ongoing care plan for individuals who access care. Direct cash meaning cash that is given to individuals seeking care with no strings attached that can be used by their discretion. Investments should be centered to train individuals who will be interacting with the variety of community members they will be coming across, focusing on trauma informed care, cultural competency, and strength based approaches. Homelessness: Given disparities of homelessness, intervention strategies can be designed to target these communities in mind. For example, direct cash assistance for transition age youth (18-24) can support individuals gain access to housing, their basic needs, and future investments such as education and certifications. Direct cash in addition to connections to concrete supports can be administered through community based organizations that already work with these populations and have the trust of individuals in the community. When considering the expansion of housing-centered interventions paired with behavioral health services, training should be a high level priority when preparing care providers in their engagement with those who they will be serving. Behavioral services should be accessible and available on site in these housing projects, in addition to resource service providers to ultimately benefit community members that are being housed. Care capacity should also be prioritized when considering per case load engagement in order to maximize engagement outcomes and limit burnout. Community based partners can be collaborators with these housing

centered projects, providing on-site workshops to relevant topics that will foster community members' growth, offer tools of independence and self-sufficiency. Justice Involvement: In addition to intensive community-based behavioral health treatment, care coordination, and housing supports, direct cash can be a tool for those being served to build their future and mitigate recidivism rates. The County of San Diego would greatly benefit from asking affected individuals and populations what they think they need to better build a support system, what barriers they may be facing, and what their goals are. Direct cash can be a tool for further engagement and a starting ground for many individuals who can work with care navigators and community-based organizations on how to best invest in their lives. Removal of Children from Home: Negligence is often associated to families experiencing poverty. Financial supports such as direct cash can be used at the County level as a mechanism of prevention for further child welfare involvement and can greatly reduce further family separation and strengthen families and communities. Poverty is a potent risk factor for child welfare involvement and child/family separation and should be a primary focus of prevention. Financial supports can: Decrease parental and familial stress and conflict, Increase family wellbeing, Increase family bond and strengthening, Increase opportunities to meet basic needs (food, housing, childcare, etc.), Research has shown that financial supports increase families' income and income stability and can reduce child welfare involvement.

- Hello, I have included my comments about programs listed and the listening sessions. For Programs listed, Incredible Families is listed as a BHSA funded program. In the last RFP, it was slated as a program that was going to be funded purely with Medi-Cal dollars. Due to this change, other programs would have bid on this program if it was known it would be covered with BHSA dollars. Hoping that this will be brought to Purchasing and Contracting. Regarding the Listening sessions: The questions were very narrow and seemed to focus on a certain narrative. For the Housing Listening session- my comments were not incorporated about the need for housing for families involved in CFWB, the importance of Recovery Residence funding, and the use of tiny homes/sleeping cabins. In the LWSD East Listening Session, I agree with the need to address housing instability and basic needs. Regarding the BHAB Pathways listening session- the questions were only geared to what is wrong in the SUD continuum of care. I strongly disagree that “SUD Treatment System is Fragmented and Lacks Coordination Between Providers Participants described the SUD system as fragmented, with limited coordination and inconsistent warm handoffs between detox, residential, outpatient, and Medication Assisted Treatment (MAT) services. Long wait times, insurance barriers, and disconnected systems further delay care and contribute to service gaps and relapse risks” (4/6 parts). The Alcohol and Drug Service Provider Association (ADSPA) works with 98% of County contracted SUD programs. We meet a few times a month to share best practices, networking and linkages. We work very well as a continuum of care. Of course no systems are without problems but we regularly work together to solve problems. I do agree with this statement though: “Housing Insecurity is a Barrier to Recovery Housing insecurity was identified as a critical barrier to recovery. Participants emphasized that treatment success and sustained recovery

depend on safe and stable housing. Attendees called for housing to be integrated as a fundamental part of the care continuum". Thank you for letting me make a comment.

- On behalf of the International Rescue Committee (IRC) - San Diego. The proposed goals demonstrate a strong foundation; however, we identified the following gaps: Section1: Behavioral Health Goals. Prioritizing Cultural Responsiveness: In its current draft, BHSA appropriately emphasizes service expansion through partnership with trusted community-based organizations to deliver culturally responsive care. As a deeply embedded and trusted presence across San Diego communities, BHSA would be well served by including the IRC as a formal partner. The IRC has delivered culturally responsive services for five decades (since 1975), with expertise grounded in serving diverse and often marginalized populations, including many BHSA-eligible populations. When it comes to addressing mental and behavioral health, the IRC brings deep experience and a trauma-informed approach that prioritizes meeting individuals where they are. Inclusion of Newcomers in the Target Population: Beyond language and culture barriers, many newcomers face undiagnosed mental health needs and significant challenges navigating U.S. systems, increasing their risk of compounding mental health crises. Many newcomers have also experienced displacement-related trauma that continues to remain unaddressed due to stigma, language barriers, and limited culturally responsive services. Although a substantial share of newcomers are BHSA-eligible, the absence of explicit recognition as a target population risks continued oversight of their distinct clinical needs. Compounding these challenges, many new San Diegans lack credit history or stable income, placing them at heightened risk of housing instability. Documentation Barriers: Documentation requirements should be assessed as a barrier influencing access to care. The draft does not set forth goals related to document requirement reform or navigation support, leaving many eligible residents unable to access care. The IRC is uniquely positioned to serve as a trusted intermediary and navigator, leveraging longstanding community relationships to help new San Diegans to access mental health services, complete enrollment, and successfully engage the behavioral health system. Prevention: The current BHSA draft does not articulate goals focused on prevention strategies or mental health education for BHSA-eligible populations who are not yet in crisis. Evidence indicates 80% of adult newcomers who have been forcibly displaced experience mental health conditions and up to 90% of young newcomers – many times unknowingly – underscoring the need for proactive approaches. Unaddressed trauma can increase the risk of developing more severe mental health disorders over time. Targeted programming that combines preventative intervention with education on coping strategies, healthy habit-building, and mental health literacy would help mitigate risk, prevent deterioration, and promote long-term wellbeing. A multi-layered prevention-focused approach is essential to achieving sustainable mental health outcomes. The Inclusion of Gender-Specific Mental Health Strategies & Household Structures: The BHSA should ensure that there is behavioral health and wellbeing programming that is targeted to each gender. For example, while BHSA correctly notes that men are overrepresented in the justice system, the draft does not adequately address the corresponding underrepresentation of men in mental and behavioral health programming. Newly displaced men, women,

and non-binary people experience traumas and stressors that are unique to each population, in addition to unique stigmatization that is faced by the different genders, and the distinct challenges that members of non-traditional household structures face. To ensure equitable and effective service delivery, BHSA would benefit from a multi-targeted approach that addresses individual mental health needs while also accounting for diverse household compositions, including single-parent households. Stakeholder Perspectives: The BHSA should explicitly incorporate stakeholder perspectives into program implementation language to ensure that stated goals reflect the operational realities of implementers and the lived experiences of target populations. For example, the Access to Care: Disparities Analysis notes that penetration rates for non-specialty mental health services are lower among several non-English-speaking populations, including Arabic, Cantonese, Farsi, Other Chinese, Russian, and Tagalog speakers. While numerous refugee and immigrant service organizations and ethnic community-based organizations are listed as stakeholders engaged in the BHSA planning process, none of the feedback from these organizations is meaningfully integrated into the BHSA to analyze barriers to accessing care or to inform implementation strategies that could reduce those barriers. Purposeful inclusion of stakeholder analysis within the BHSA would strengthen implementation planning, prioritize community and cultural responsiveness, and signal the importance of shared accountability, trust-building, and equity in achieving access goals. Section 2: Programs - Rebalancing Toward Primary Prevention and Upstream Mental Health Supports: While reactive and crisis-response programming is essential, the BHSA plan is heavily weighted toward addressing acute and ongoing mental health issues crises, with comparatively limited emphasis on proactive prevention. While significant resources are allocated to early intervention efforts, greater investment or reallocation of funds in primary prevention would strengthen the overall framework. Prevention-focused programming should include both education-based initiatives and solutions-oriented supports that address the underlying stressors that significantly impact mental health. Education-based programs may include interactive workshops for adults and children focused on stress management, coping strategies, value creation, healthy relationshipbuilding, and sustainable habit formation. Solution-oriented programming should assist with addressing stressors that greatly impact mental health, such as unemployment, financial instability, and housing security, through direct services including but not limited to employment assistance, financial coaching, and housing navigation. Such programs would be a step beyond only providing referrals and mental health-only support for people who are not yet in dire need, as the current BHSA focuses on. Existing programs – the kind of which the BHSA draft suggests providing linkages to – are often at full capacity, making referrals to those programs less effective. Therefore, funding should be provided for new programs that directly target the factors that negatively impact mental health specifically for BHSA-eligible populations, such as trauma-informed case management, financial coaching, employment navigation, and housing navigation, rather than simply providing linkages to such programs. The International Rescue Committee (IRC) has experience in providing culturally responsive, trauma-informed case management, financial coaching, employment

navigation, and housing navigation services to members of the community in San Diego County and is well positioned to support BHSA's prevention and early intervention goals. Cultural Responsiveness in Program Design and Implementation: Although the BHSA acknowledges the importance of cultural responsiveness in mental health services, as emphasized by stakeholder input, concrete provisions for culturally responsive programming are largely limited to a single initiative—the Native American PEI/Dreamweavers program. Communities across San Diego County have distinct behavioral health needs shaped by their cultural backgrounds, migration histories, and lived experiences. As such, the BHSA should include targeted provisions that enable community-based organizations to lead outreach and education efforts within diverse communities, with the goals of increasing understanding of mental health, reducing stigma, and improving access to care. The International Rescue Committee (IRC) has extensive experience conducting outreach to immigrant and refugee populations throughout San Diego County and has established trusted relationships across a wide range of communities. Additionally, the IRC has demonstrated capacity to develop and deliver culturally responsive, linguistically appropriate educational materials and programming. Given this track record, the IRC is well positioned to play a lead role in implementing mental health outreach and education activities that are responsive to community needs and aligned with BHSA equity goals. There is a need to include mental health and destigmatization programs specific to different genders in the BHSA, as each gender has unique mental health needs and faces unique challenges. The International Rescue Committee (IRC) supports the integration of Peer Support Specialists. Centering lived experience is vital for building trust and reducing stigma. However, providing external linkages to programs that assist with community integration and self-sufficiency is insufficient. The existing programs are usually at capacity and may not offer culturally competent, language-accessible, trauma-informed services. It is important to include in the BHSA plan the hiring and training of staff to work on programs that directly assist BHSA-eligible populations with practical needs that greatly contribute to their mental health needs, such as financial instability and housing instability. The workforce strategy should include the hiring of employment specialists, housing specialists, financial coaches, and case management staff to assist BHSA-eligible members of the community, in order to address significant stressors through practical solutions rather than solely relying on mental health staff to only address the direct mental consequences of those stress factors. These staff would assist BHSA-eligible populations with navigating employment challenges, guidance in finding appropriate housing, coaching to educate about finances and assist with financial planning, and assistance with other assessed stressors as determined on a case-by-case basis. The IRC has significant experience in assisting BHSA-eligible populations with language-accessible, trauma-informed case management, employment navigation, housing navigation, and financial coaching, addressing significant stressors for these populations and assisting them with sustainable, long-term solutions and strategies to address mental health needs. Workforce Education and Training (WET) activities should train providers to take into account the cultural and immigration backgrounds of the BHSA-eligible populations, and approach outreach and

discussions in a culturally responsive manner, rather than simply focus on technical training. WET activities should train community-facing staff in trauma-informed approaches and equip them with tools to work with newcomers and culturally diverse groups. IRC has expertise in training community members and providers on cultural responsiveness. Section 4: Budget - Funds should be allocated towards targeted programs that provide better community integration, financial stability, self-sufficiency, and autonomy tools in the long term, rather than relying on simple referrals. Programs designed to provide better integration and address major stressors help alleviate major contributors to mental health problems in a sustainable way. Community integration and self-sufficiency mean empowering individuals and families to be able to live independently, participate and engage fully in society and in their communities, and meet their own needs without relying on external systems. The programs proposed include case management, housing stability, financial coaching, and employment navigation assistance. This would be in conjunction with culturally responsive mental health-specific programming. For such programs to be successful, organizations that are experienced in assisting BHSA eligible populations with achieving self-sufficiency and better integration, like the International Rescue Committee (IRC), need to be included in the programs. A portion of funding should be earmarked for programming that specifically focuses on prevention strategies, as outlined above. **Following letters were received*.

- Dear Director Privara Brahms: Alvarado Parkway Institute (API) is pleased to submit formal public comment on San Diego County's draft Behavioral Health Services Act (BHSA) Integrated Plan for Fiscal Years 2026–2029. We appreciate the County's commitment to community engagement and the transparency with which this planning process has been conducted. API is a 66-bed licensed freestanding acute psychiatric hospital located at 7050 Parkway Drive in La Mesa, and we are the only freestanding acute psychiatric hospital serving East County's estimated 500,000 residents. With an average daily census of approximately 61 patients and over 22,000 patient days of care provided annually, API is a foundational component of San Diego County's behavioral health continuum. The majority of our patients are Medi-Cal beneficiaries with Serious Mental Illness (SMI), the population at the core of both BHSA and BH-CONNECT. We are also a confirmed Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, active since July 2025. Our comments are therefore offered not only as a community provider, but as an active partner in the County's behavioral health financing and delivery infrastructure. Our comments address five areas: (1) the critical role of acute inpatient capacity in the continuum; (2) the impact of AB 116 on provider financial sustainability; (3) BH-CONNECT FFP reinvestment and reimbursement rates; (4) care coordination and transition services; and (5) workforce development. We respectfully request that feedback in each area be incorporated into the final plan. Acute Inpatient Capacity: An Indispensable Tier of the Continuum - The BHSA Integrated Plan appropriately emphasizes investment in community-based services, housing, and crisis intervention. API fully supports these investments. We offer the following as essential context: community-based services and acute inpatient care are not competing priorities, they

are interdependent tiers of the same continuum. The effectiveness of the County's investment in lower levels of care depends on the availability and stability of acute inpatient capacity for those whose needs exceed what community-based settings can safely address. San Diego County Acute Psychiatric Bed Context API is the only freestanding acute psychiatric hospital in East County. The region has experienced repeated failures in attempts to add acute psychiatric inpatient capacity: Acadia/Scripps Eastlake: 120-bed acute psychiatric hospital proposal rejected in 2022; Palomar Health Behavioral Health Institute: BHCIP-funded 120-bed acute psychiatric hospital in Escondido, with completion not expected before 2029–2030. San Diego County faces a structural acute psychiatric bed shortage that will persist for at minimum eighteen months. API's 66 licensed beds represent a primary acute inpatient resource for a large and growing population. We respectfully request that the final Integrated Plan include explicit language recognizing freestanding acute psychiatric hospitals as a protected and essential tier of the behavioral health continuum, and that institutionalization reduction goals be framed around appropriate utilization rather than reduced utilization per se. Measuring success solely by fewer inpatient days risks perverse incentives that harm the most severely ill patients in our community. Recommended Plan Language (Section on Institutionalization Goals): Suggested language for the County's institutionalization section: "San Diego County recognizes that acute inpatient psychiatric care is a medically necessary and clinically appropriate service for individuals with Serious Mental Illness whose needs cannot be safely addressed in community-based or crisis residential settings. The County's institutionalization goals target the reduction of preventable or avoidable inpatient episodes through investment in upstream services, while preserving timely access to acute care for individuals who require it. The County will track both over-utilization and under-utilization of acute inpatient services as quality indicators, ensuring that access to medically necessary care is not constrained by utilization targets alone." AB 116 and Provider Financial Sustainability AB 116, California's new emergency nurse staffing ratio (1:6 licensed nurse-to-patient ratio), is expected to take effect June 1, 2026, the same month this Integrated Plan enters implementation. The financial impact on freestanding acute psychiatric hospitals is substantial and immediate. According to the California Hospital Association's March 2026 statewide survey, only 16% of affected psychiatric hospitals are likely to achieve full AB 116 compliance by June 1. API is making every effort to comply, including active RN recruitment, wage increase, and good-faith documentation for potential CDPH program flex consideration. However, the financial sustainability of this compliance depends on Medi-Cal reimbursement rates that reflect the mandated cost structure. The BHSA Integrated Plan is the foundational document governing how the County uses its behavioral health funding. We respectfully request that the plan include explicit recognition that AB 116 creates a structural cost gap for contracted acute inpatient providers and that the County commits to rate-setting and contract practices that reflect the true cost of mandated staffing levels. (please see chart in attachment). Recommended Plan Language (Provider Network and Contracting Section): "Effective July 1, 2026, California's AB 116 psychiatric emergency nurse staffing ratio law requires freestanding acute psychiatric

hospitals to maintain a 1:6 licensed nurse-to-patient ratio. San Diego County recognizes that this mandate substantially increases the cost of providing acute inpatient psychiatric services. The County commits to reviewing and, where appropriate, adjusting Specialty Mental Health Services reimbursement rates for contracted acute inpatient providers to ensure that rates reflect the actual cost of AB 116-mandated staffing. Rate adequacy reviews will occur at least annually during the FY 2026–2029 Integrated Plan period." BH-CONNECT FFP Reinvestment: Provider Rate Increases API is an active Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. Under this program, the County receives approximately 50% federal matching funds for Specialty Mental Health Services provided to qualifying Medi-Cal members (ages 21–64) during short-term stays at IMDs, including API. The BH-CONNECT Special Terms and Conditions (STCs) explicitly require that FFP reimbursement received for patient care services provided in IMDs be reinvested to support community-based behavioral health service provision, quality improvement, or capacity expansion — with allowable reinvestment modalities specifically including enhancement of provider payment rates to build capacity and expand workforce. BH-CONNECT FFP Reinvestment — API's Position. Since July 2025, San Diego County has been receiving substantial federal FFP generated by API's qualifying Medi-Cal IMD stays. Applying approximate figures: API's estimated Medi-Cal daily census: 27–34 patients (45–55% of 61 ADC), Estimated qualifying Medi-Cal IMD patient days (July 2025–March 2026): ~7,500–9,000 days, Approximate federal FFP generated for the County from API stays: significant six-figure amount. The BHSA Integrated Plan is the appropriate vehicle for the County to formalize its FFP reinvestment commitments. API respectfully requests that the plan include specific language on reinvestment of BH-CONNECT FFP savings into enhanced provider rates for qualifying IMDs. Recommended Plan Language (BH-CONNECT / Medi-Cal Financing Section): "San Diego County is an active participant in the BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. In accordance with BH-CONNECT Special Terms and Conditions, the County will reinvest FFP savings received for services provided in qualifying Institutions for Mental Diseases into community-based behavioral health services, workforce expansion, and/or enhanced provider payment rates. During the FY 2026–2029 Integrated Plan period, the County commits to conducting an annual review of SMHS rates for contracted acute inpatient providers that are active Participating Psychiatric Settings, with the explicit objective of ensuring that FFP reinvestment benefits flow to frontline providers whose patients generate those federal funds." Care Coordination, Transition Services, and Referral Pathways API strongly supports the County's investments in Assertive Community Treatment (ACT), Forensic ACT (FACT), Community Transition In-Reach Services, and the broader Full Service Partnership infrastructure. These programs serve our shared patient population and directly affect the quality of care transitions between acute inpatient settings and the community. We offer the following specific requests to strengthen care coordination language in the final plan: 4a. Community Transition In-Reach Services at API BH-CONNECT authorizes county-funded multidisciplinary teams to provide

Community Transition In-Reach Services inside IMDs for up to 180 days prior to discharge. This service is designed to support the precise patient population that API serves — high-acuity SMI individuals who require intensive community linkage before and after discharge. We formally request that the final plan include a commitment to implement Community Transition In-Reach Services at API during the FY 2026–2029 plan period, and that API be identified as a priority site for this service given our volume and patient acuity. 4b. ACT Team Referral Protocols As the County expands ACT and Forensic ACT capacity under BHSA and BH-CONNECT requirements, we request that the plan include explicit language establishing clear referral protocols between ACT teams and acute inpatient providers. Specifically: ACT teams should have defined pathways for referring clients in acute crisis to API, and API should have defined pathways for discharge to ACT teams. These bidirectional protocols reduce avoidable readmissions, improve patient outcomes, and support the County's BH-CONNECT performance metrics on readmission reduction. 4c. Post-Discharge Follow-Up (72-Hour Standard) BH-CONNECT requires either the county BHP or the IMD to contact Medi-Cal members within 72 hours of discharge. API is committed to meeting this standard. We request that the plan establish a shared data protocol between API and the County BHP for tracking 72-hour follow-up completion, a key quality measure that will support both the County's BH-CONNECT incentive program performance and API's accountability to our shared patients. 4d. SD County Behavioral Health Wellness Campus Integration. The County's $99.5 million BHCIP-funded Behavioral Health Wellness Campus (Crisis Stabilization Unit, MHRC, SRF, and outpatient services, completion projected May 2031) will create significant new lower-acuity capacity in San Diego. API views this as a positive development and a complement to our acute inpatient services. We request that the plan include language on how the Wellness Campus and acute inpatient providers like API will establish coordinated referral and transition protocols when the campus is operational, to ensure seamless movement of patients across levels of care. Behavioral Health Workforce Development - The BHSA Integrated Plan's workforce section is directly relevant to API's operational sustainability. We offer two specific requests: 5a. AB 116 Workforce Crisis Recognition - The California Hospital Association's statewide survey documented a need for 910 new licensed psychiatric nursing FTEs across California by June 1, 2026, with 222 of those in Southern California alone. San Diego County is a designated RN shortage area. We request that the plan explicitly identify the AB 116 psychiatric nursing mandate as a county-level workforce crisis and include strategies for addressing it — including coordination with HCAI on BH-CONNECT Workforce Initiative recruitment and retention bonus programs, and support for facilities in designated shortage areas. 5b. BH-CONNECT Workforce Program Access - BH-CONNECT's Workforce Initiative includes loan repayment programs, community-based provider training (up to $10,000 per participant), and recruitment and retention bonuses for organizations serving Medi-Cal members (threshold: approximately 40% Medi-Cal payer mix). API and other county-contracted acute providers meet this eligibility threshold. We request that the plan include outreach commitments to ensure that contracted providers, including acute inpatient hospitals, are fully informed of and supported in accessing these

workforce programs. Summary of Requested Plan Actions (please see chart in attachment) Closing Statement -API submits these comments as a committed partner in San Diego County's behavioral health system. We share the County's goals of expanding access, improving outcomes, reducing health disparities, and building a continuum of care that serves our region's most vulnerable residents. The requests we have made are not requests for special treatment, they are requests for a plan that accurately reflects the financial and operational realities of providing acute psychiatric care in 2026 and beyond, and that formalizes the partnership obligations that already exist under BH-CONNECT. We strongly support Director Privara Brahms's vision of a plan that supports access to care and addresses community needs. For the 22,000+ patient days of acute psychiatric care API provides annually, almost entirely to Medi-Cal members with Serious Mental Illness, access to care and community need are not abstractions. They are the daily work of our clinical team. We respectfully request an opportunity to present these comments in person at the May 7, 2026 public hearing before the Behavioral Health Advisory Board, and to schedule a follow-up meeting with your office to discuss implementation of the requested plan language. Thank you for the opportunity to contribute to this important process. We look forward to serving as an active partner as San Diego County implements the BHSA Integrated Plan beginning July 1, 2026. **Following letters were received.*

- Dear BHSA leadership, Thank you for the opportunity to provide feedback on San Diego County's draft 2026–2029 BHSA Integrated Plan. I am a long-time resident of San Diego and have worked in both the nonprofit and philanthropic communities. It is my honor to share my comments. I read your proposed plan with great interest. The amount of thought and research that went into it was impressive. Your listening sessions revealed critical information and suggestions for action, many of which were included in the plan. Community Engagement and Collaboration- I agree strongly with a statement from one of the focus groups (page 292). "No single agency or system can meet the layered needs of older adults and people with disabilities. Participants stressed that meaningful integration requires shared ownership, County-funded connector roles, and strong cross-sector collaboration. Community partners must be supported—not replaced—for integration to succeed." While I commend your use of partnerships, especially with San Diego County schools, I didn't see anything in the plan that points to coalition building or cross sector collaboration around older adults or any other group or issue. Lasting, impactful change usually comes through the deep work of broad collaboration. One group for potential collaboration would be philanthropic entities. Despite philanthropy investing heavily in behavioral health, I didn't see any references in the plan to leveraging community dollars, other than one mention of Price charities in the Workforce Partnership report. If community support thrives on the three-legged stool partnership between government, philanthropy and nonprofits, it would be useful to include ways to engage our active philanthropy community in your plan. A perfect opportunity to partner with community organizations is where you write "focus on expanding peer-delivered services, community-based outreach, and recovery-oriented supports that foster sustained social connection across the continuum of care." (page 50). Many organizations already offer such support, and the county could be a powerful

partner in that effort. Otherwise, the risk of duplication of services is much higher. In my opinion, there are two groups to whom government holds a special responsibility: foster youth and veterans. The youth because they have been in county care and veterans because of the sacrifices they have made for our county. One of your focus groups even mentioned foster youth as a special needs population (page 235), something that was not reflected through the rest of the plan. I don't remember seeing any references to support for veterans. The plan mentions the disparities surrounding transition age youth (page 28). You could add a phrase "particularly former foster youth" since they have the poorest outcomes of almost any other subpopulation. You could also identify homeless veterans as a distinct subset of homeless adults and extend special services to them. Notably absent from your listening sessions were organizations serving foster youth (e.g. Just in Time, Voices for Children, Promises 2 kids) and organizations serving veterans. In addition, two of our community's most expert groups on homelessness, The Regional Task Force on Homelessness and Funders Together to End Homelessness were also not on the list. Once again, philanthropy seems to be absent completely, despite their contributions to many of the areas you cover in your plan. Homelessness and Housing- BHSA has an opportunity to take a leading role in one of the most successful efforts regarding homelessness, homelessness prevention. While homelessness prevention has been identified as a key success marker in keeping families on solid footing, and is a priority for our own San Diego Housing Commission, it wasn't included in the plan. Research has shown much stronger outcomes if we can keep people off the streets altogether. It is also less expensive to help people stay in their homes than to find homes for them once they become homeless. You noted in your plan that the "County is unable to identify adults who are at risk of homelessness" (page 10.) Yes, the point in time count focuses on individuals/ families who are already homeless. However, in addition to the Housing Commission, there are nonprofits in our community that identify adults and youth who are at risk of homelessness and partner with philanthropy to provide services needed to keep the adults/families in their homes. The BHSA could work with these nonprofits to provide behavioral health support during these residents' challenging times. I'm glad that the need for landlord engagement programs was highlighted in one of your sessions and is reflected in your plan. Philanthropy, too, has been grappling with how to rehome people despite landlord bias against homeless individuals. Childcare- Childcare providers are among children's earliest teachers and are now being recognized as such. Your early intervention work in this arena could include training child care providers on which behaviors could be indicative or family destabilization or abuse and how to handle/report such situations. Or, perhaps, some of their family early intervention programs could be expanded to include child care providers. Closing- Thank you again for the opportunity to comment on the Draft BHSA Integrated Plan. I urge you to emphasize building partnerships and collaborations at every opportunity and look forward to seeing how the implementation of your plan will support the most vulnerable members of our community and enhance the community at large.

- JFS Comments on San Diego County's DRAFT 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan. Thank you for the opportunity to comment on San Diego

County's draft 2026–2029 BHSA Integrated Plan. We appreciate the significant effort the County has undertaken to align with the new BHSA framework, including providing engagement opportunities for agencies providing services to the community. The comments below are offered to strengthen the Plan's alignment with BHSA's intent and to support those we serve and create long-term system sustainability. Plan Organization & Language - While we recognize that the Plan follows a State required template, the document is difficult to navigate and relies heavily on technical language. This limits its accessibility and makes it challenging for readers to clearly understand the County's core strategies for improving access to behavioral health services and addressing community needs. (1/10 parts) Preserving the Balance Between Prevention, Early Intervention, and Crisis Response BHSA establishes Early Intervention (EI) as a core component of Behavioral Health Services and Supports, with the explicit goal of stopping mental health conditions and substance use disorders from becoming severe and disabling. The draft Plan demonstrates a strong commitment to crisis response, stabilization, and outpatient treatment services, all of which are essential elements of the behavioral health continuum. At the same time, the current Early Intervention portfolio appears heavily weighted toward crisis diversion and early treatment rather than upstream prevention and indicated prevention. While these services can reduce repeat hospitalization and acute utilization, they often engage individuals after acuity has already emerged. BHSA's updated definition of Early Intervention explicitly includes direct services for children and youth who are at risk of developing behavioral health conditions but are not yet displaying symptoms, often referred to as indicated prevention under WIC 5840. Counties are not required to eliminate programs previously categorized as prevention. This means that Counties have the ability to translate many prevention-oriented models into Early Intervention. Maintaining space for lower-acuity, prevention-oriented EI is critical. These services are typically less expensive, time-limited, and essential to preventing later reliance on higher-cost crisis, inpatient, and justice-involved systems. If preventive early intervention is limited, demand will shift toward more expensive downstream services, such as crisis response. We encourage the County to continue to find opportunities to create more balance by providing upstream early intervention with necessary crisis and treatment investments. (2/10 parts) Early Intervention for Children, Youth, and Young Adults- We recognize and support that there is a focus in the Draft on children, youth, and young adults, consistent with BHSA's requirement that a majority of Early Intervention funding be directed to individuals 25 and under. The Plan includes youth-focused programming, particularly through school-based and outpatient models. However, many of the youth Early Intervention programs described primarily serve children and young people who are already experiencing high levels of acuity, have been identified as seriously emotionally disturbed, or are already involved in child welfare, crisis stabilization, or hospitalization. The Draft has less programs clearly designed to engage children and youth earlier, before challenges escalate to severe mental illness, school failure, homelessness, justice involvement, or family separation. Early childhood represents a critical developmental window where timely intervention can alter long term trajectories and BHSA allows counties to serve all eligible children and youth, including

those who are not yet symptomatic but are at risk due to trauma, adversity, or environmental stressors, as outlined in WIC 5892. Children ages 0–5 are explicitly identified as a priority population and must be included in Early Intervention spending plans. This can include programming that gives parents the tools and resources to support their children. We ask the County to identify and create more opportunities for EI investments that will reach children, youth, and their parents/caregivers, earlier in the risk trajectory. Such services help reduce more severe outcomes later. (3/10 parts) School-Based Services and the Role of Medi-Cal- We saw that the Draft Plan and BHS's Youth Optimal Care Pathways (OCP) analysis both have a strong focus on schools as an access point for youth behavioral health services. We support this focus as an important strategy for early identification and engagement, particularly given the amount of time children and youth spend in school settings. However, it is important to recognize that not all children, youth, and families experience schools as a trusted or safe space for accessing services. This is especially true when services are structured as clinical treatment and request or at least are advertised as needing documentation. For some communities, including immigrant families, mixed-status households, and LGBTQ+ youth, requests for documentation can create barriers to enrollment. Additionally, some youth prefer to receive services outside of school settings due to stigma, privacy and scheduling needs. We encourage the County to continue partnership with trusted community-based organizations, cultural practitioners, and non-clinical providers. These partners are often better positioned to engage youth and families earlier, before conditions escalate, and to build trust outside of formal educational settings. (4/10 parts) We appreciate the Draft Plan's stated commitments to equity, cultural responsiveness, and community engagement. It is also important to provide Early Intervention services that reflect the ways communities define wellness and healing. Many communities may not relate to traditional clinical interventions. Expanding the use of community-defined practices, group-based supports, culturally rooted providers, and partnerships with schools, nonprofits, and other trusted community spaces would strengthen Early Intervention's reach and effectiveness. Recommended community centered interventions can include: Diverse providers speaking multiple languages, including regional dialects. Increased training of community members with the cultural competency, and trauma informed care. Working with cultural and religious practitioners, including spiritual faith leaders, curanderismo, and leaders of healing circles. Services provided by community health partners. Services provided by community-based organizations, including ones that partner with local community groups, parenting groups, etc. Services by trusted community partners, especially in the immigrant community and those with mixed status households. Non-traditional healing practices, such as community gardening, walking groups/incorporation of physical movement, community healing circles. (5/10 parts) Homelessness - We support the Plan's focus on housing centered interventions paired with behavioral health services and encourage the County to further strengthen these strategies by centering prevention for communities experiencing the greatest disparities. Direct cash assistance for transition age youth (ages 18–24), when paired with connections to concrete supports, can help young people stabilize housing, meet

basic needs, and invest in education or training. As the County expands housing centered initiatives, it will be important to prioritize training for care providers to support trauma-informed and culturally responsive engagement. Behavioral health and resource services should also be accessible on site, and staff should have balanced caseloads to increase engagement outcomes and reduce staff burnout. (6/10 parts). Justice Involvement- We support the Plan's emphasis on community based behavioral health treatment, care coordination, and housing for individuals impacted by the justice system. In addition to these supports, direct cash assistance can help individuals stabilize their lives, plan for the future, and reduce recidivism. When combined with care navigation and trusted community based partners, financial supports can serve as an engagement tool that helps individuals address immediate needs while working toward longer term goals for stability. (7/10 parts) County's Child and Family Well-Being department - We encourage the County to more explicitly incorporate poverty focused prevention strategies into its child welfare related investments. Neglect is often closely tied to family poverty, rather than intentional harm, and financial instability is a significant driver of child welfare involvement and family separation. Financial supports, including direct cash assistance, can function as effective prevention tools by reducing parental stress, strengthening family stability, and increasing families' ability to meet basic needs such as housing, food, and childcare. Research shows that improving income stability is associated with reduced child welfare involvement. Integrating financial supports as part of a broader approach that includes goal setting and case management would help reduce unnecessary family separations and better align with BHSA's prevention and equity goals. This is particularly important for former foster youth, who experience some of the poorest outcomes of any subpopulation, including disproportionately high rates of homelessness, behavioral health needs, justice involvement, and economic instability. While the Draft Plan references child welfare involved populations, former foster youth are not consistently elevated as a distinct priority subgroup. Explicitly naming former foster youth as a priority population and ensuring access to prevention oriented, stabilizing supports earlier would improve outcomes and further align the Plan with BHSA's goals. (8/10 parts) Parenting Education and Caregiver Support - After reviewing the Plan, we were concerned to see that parenting education is not explicitly included, particularly given the Plan's focus on youth justice involvement and the removal of children from the home. While there are some direct services, addressing youth behavioral health needs without also supporting parents and caregivers overlooks a critical part of what young people experience in their homes and caregiving environments. The roots of many adolescent mental health crises can be traced back to early childhood. Therefore, support for parents and caregivers it not just supplemental to treatment, but foundational. Parents and caregivers, especially those with limited resources, often lack access to education and support related to self regulation, stress management, and responding to challenging behaviors. Without these supports, families are left without tools that are proven to strengthen caregiver child relationships, reduce escalation within the home, and prevent both child welfare involvement and youth justice system contact. In conversations with community partners following recent program changes, we also

heard concerns from Head Start and Early Childhood Education providers. These sites have state requirements related to parenting education, and without dedicated parenting education programs, there is now a gap in available services to help them meet those requirements. This creates challenges for early learning providers and weakens prevention efforts during a critical developmental window. Childcare providers are increasingly recognized as children's earliest teachers rather than simply caregivers. The County should explore opportunities to train childcare providers on recognizing behaviors that may indicate family destabilization, trauma, or abuse, as well as understanding how to respond and report concerns appropriately. We encourage the County to consider parenting education and caregiver focused supports as core strategies that complement youth serving interventions and align with BHSA's goals around prevention, family stability, and reduced system involvement. (9/10 parts). Identification of Specific Priority Populations- We appreciate that the Plan recognizes disparities among transition age youth. Above we mentioned elevating former foster youth as a distinct priority population. We also see the importance in identifying homeless veterans as a specific subset of homeless adults. Calling these populations out directly in the Plan would support more targeted early intervention, housing, and transition age strategies and better align with the County's stated goals around equity, prevention, and accountability. Closing - We are grateful for the opportunity to comment on the Draft BHSA Integrated Plan. We encourage the County to further strengthen the Draft Plan by explicitly preserving meaningful space for preventive and indicated-prevention Early Intervention alongside crisis and treatment services. The right balance across the continuum of care is crucial to prevent higher-cost crises later. (10/10 parts). **Following letters were received.*

- To whom it may concern: I strongly support the recommendations outlined in this analysis. The data clearly shows a persistent and concerning imbalance in behavioral health funding, where children and youth—who represent a significant portion of those served and where most conditions begin—receive a disproportionately small share of resources. Investing in early intervention is not just the right thing to do—it is the most effective and fiscally responsible strategy. The current plan's emphasis on downstream, adult-focused services, combined with proposed reductions in youth funding, moves us in the wrong direction. Rebalancing investments toward children and youth, strengthening early intervention systems, and improving transparency and accountability will lead to better outcomes, reduced long-term costs, and a more equitable behavioral health system for San Diego County. I urge the County to align funding decisions with both the evidence and the intent of the Behavioral Health Services Act by prioritizing children and youth.
- 0n behalf of Mental Health Contractor's Association I am writing to express our appreciation for the Board's support of the Children and Youth Optimal Care Pathways (OCP) Framework. We are encouraged by the County's commitment to strengthening a more coordinated and responsive behavioral health system for children, youth, and families. Many of our organizations were engaged in the Strategic Behavioral Health Initiative (SBHI) process and contributed to the collective recommendations that were shared with your office. As implementation moves forward, we want to underscore the

importance of continued and meaningful stakeholder engagement. Ongoing partnership with providers, youth, families, and community-based organizations will be critical to ensuring the framework is implemented in a way that is effective, equitable, and responsive to real-world needs. In particular, we support the establishment of a permanent, multi-sector implementation oversight structure that includes representation from providers, families, youth, and community partners. Such a structure would help: Monitor implementation progress and data, Elevate both state-mandated and community-informed practices, Provide ongoing input to support continuous improvement and accountability. We remain committed to partnering with the County Behavioral Health Services department and the Board to support successful implementation of the OCP Framework. For reference, I have attached the SBHI recommendations document. Thank you for your leadership and continued support of children, youth, and families in our region. Respectfully. **Following letters were received*.

- Public Comment – San Diego Center for Children Honorable Chair and Members of the Board, As the President and CEO of San Diego Center for Children, an organization that has served youth with intensive behavioral health needs in this County for over a century, and as a representative to the SBHI Constituency Council, I am writing today in response to the BHSA Integrated Plan. We are deeply concerned that the proposed BHSA Integrated Plan does not adequately align funding with the needs of children and youth. Although young people make up more than one third of those served in the County's behavioral health system, they receive less than one fifth of total funding. Even more concerning, the plan proposes reductions to children and youth services over the next three years while adult services continue to grow. This runs counter to both the County's own Youth Optimal Care Pathway and the intent of the Behavioral Health Services Act, which emphasizes early intervention and prevention. We know that most behavioral health conditions begin in childhood and adolescence, and that timely intervention is both more effective and less costly than crisis driven care later in life. Reducing investment in children—especially in early intervention, school based services, and early childhood—will only increase reliance on emergency, inpatient, and adult systems in the future. While we appreciate the complexity of implementing the Behavioral Health Services Act and recognize the County's efforts to modernize and integrate the behavioral health system in alignment with State requirements, our review of the Integrated Plan indicates that children and youth will continue to be disproportionately underfunded relative to need. We respectfully urge the Board to pause and rebalance this plan by strengthening investment in children and youth, improving transparency around program level impacts, and ensuring that funding decisions truly reflect need and evidence. San Diego's children deserve a behavioral health system that invests in them early, equitably, and sustainably. Thank you for your consideration.
- A comprehensive review of the Integrated Plan, combined with SBHI stakeholder input, yields a consistent conclusion: children and youth behavioral health services remain underfunded relative to need, and current investment strategies risk reinforcing a reactive, adult-oriented system rather than advancing indicated prevention and early

intervention. Children and youth represent 37.7 percent of individuals served across the behavioral health continuum, yet receive only approximately 19% of total system spending, according to BHSA Integrated Plan Table 1 on page 486. At the same time, adult and older adult services receive approximately $1.05 billion annually compared to $257 million in year 1 for children and youth. However, when excluding SUD residential and housing services – given that there are no SUD residential programs serving under 18 in San Diego and housing services predominantly serve TAY and adults the adjusted funding more accurately reflecting services for children under age 18 is approximately $233,426,824 (17%) in Year 1 and $216,739,567 (16.7%) in Year 2. The proposed plan further exacerbates this imbalance by reducing children and youth funding by $17.2 million over the three-year period while increasing adult services funding by $10.1 million. Youth specialty mental health service penetration remains approximately 3.0 percent—below need and only marginally aligned with adult rates. These conditions exist despite overwhelming evidence that behavioral health conditions begin early in life and that early intervention is the most clinically effective and cost-efficient approach. As a result, there is a clear misalignment between documented need and investment, between evidence and system design, and between the policy intent of BHSA and its local implementation. For full text of public comment, please review attachment. **Following letters were received.*

- Introduction On behalf of the Strategic Behavioral Health Initiative (SBHI), we appreciate the opportunity to provide input on the County of San Diego's Behavioral Health Services Act (BHSA) Integrated Plan. SBHI is a cross-sector collaborative representing healthcare providers, schools, community-based organizations, workforce partners, and public agencies. Together, our partners engage with nearly all children and youth across San Diego County and bring direct insight into system demand, access barriers, and service gaps. We share the County's goal of implementing BHSA successfully. This feedback is offered to strengthen alignment between the Integrated Plan, the statutory intent of BHSA, and the documented needs of children, youth, and families. Below feedback is in line with the SBHI Youth OCP Recommendations submitted on March 24, 2026. Executive Summary. **Following letters were received.*
- Good day—below please find an additional comment from Jewish Family Service of San Diego, regarding the Draft BHSA Integrated Plan. Upon review we see no express reference to patient advocacy or patient's rights in the Draft BHSA Integrated Plan. Understanding that advocacy services are not currently funded by BHSA, we recommend that the County consider preserving the ability to do so in the future. As such, we ask that the County add in a reference to patient advocacy services in this draft plan. Thank you for the opportunity to provide comments and feedback.
- Greetings, Thank you in advance for your review of my feedback related to the FY26-27 Integrated Plan. Before providing my feedback on the Integrated Plan itself, I wanted to note that without detailed baseline data for current FY25-26 budgeting and programming (including detailed information for birth/prenatal to 5 years old), accurately evaluating the proposed three year plan for FY 26-29 budget and programming is extremely difficult if not impossible. Please make program level detail

for current and proposed budgets. Recommendations: Increase the proportion of total funding (across all sources) allocated to children and youth, moving toward alignment with both the spirit and intent of the 51% Behavioral Health Services and Supports Early Intervention expectation. The 51% is the bare minimum expectation. San Diego has always been a leader – it would be nice if we could lead in this area, too. Establish clear targets to increase youth specialty mental health services penetration rates to the statewide average at a minimum, with longer-term goals tied to population-level need. Rebalance investments toward early intervention, including: School-based behavioral health services, Pediatric primary care integration, Dyadic and family-based interventions, Community-based, culturally responsive services, Dedicated investment in early childhood (0–5). Please also find below several comments on the Integrated Plan: The County's Youth Optimal Care Pathway identified upstream interventions and mental health integration as essential to children and youth wellbeing. However, the BHSA Integrated plan does not reflect this priority in its investment decisions — creating a direct contradiction between the County's stated approach and its proposed resource allocation. Adult (3.2%) and youth (3.0%) penetration rates appear similar, but this does not reflect parity. Given higher prevalence and earlier onset of behavioral health conditions in youth and strong evidence that early intervention reduces long-term costs, equivalent penetration rates instead signal underinvestment in children relative to need. Despite serving a substantial population, child-serving systems are forced to operate with significantly fewer resources which limits their ability to expand access and intervene early. Early childhood (0–5) remains particularly under-resourced despite being the most critical developmental window for intervention. The Integrated Plan further compounds existing disparities by proposing a $17.2 million reduction in funding for children and youth over three years plan period, while adult services—already receiving 4.4 times the level of investment—are projected to increase by $10.1 million during the same period. Please note, disparities are most pronounced among children ages 0–11 and Hispanic and Asian/Pacific Islander youth, indicating systemic barriers to access services rather than lack of need for these services. Findings further indicate that San Diego infants, children, and youth are both underfunded and under-served, particularly in early childhood and traditionally marginalized communities. Thank you for your consideration.

- Hello, we are the parents of an adult son with a SMI in SD County. We have been dealing with getting him the help he needed over the past 18 years and it was not an easy process as his first break with reality happened after the age of 18. In looking through just the first 20 pages of the proposed plan, we came across the following acronyms and services we have never heard of (despite being trained facilitators of a NAMI San Diego Family Support Group): IPS Supported Employment Smart Care Electronic Health Record Connex and SD Health Connect Qualified Health Info Organization, The Bronzan-McCorquadale Act, FACT, Enhance Community Health Worker Services, CSC for FEP, Transition of Care Services. If indeed these services are already in place in SD County, we have no knowledge of them and how family members with loved ones living with a SMI can receive any of these services. There is a huge need for: Supported Employment - many of our loved ones are finally stabilized but still in

desperate need of finding and keeping a job Smart Care Electronic Health Record - currently there is no communication from one MH facility to the next so our loved ones often receive incorrect medications and there is no central MH record keeping track of how many 5150's have occurred, what meds are effective, how many hospitalizations, incarcerations or rehabilitation facilities have been tried. This would be a HUGE help for our loved ones to receive effective treatment in a timely manner! We do not know what: FACT, or ESC for FEP services are, Transition of Care Services - this is desperately needed as so often our loved ones are stabilized in a hospital setting, only to be discharged with no continuation of care, they return home, stop their meds and we are back to ground zero again. It is our suggestion that SD MH Services should be holding public information sessions to inform persons who are helping a loved one living with a SMI of all the programs and services that are supposedly happening in SD County. Don't just list things that are not available to all SMI persons in SD County. Make this available to all who need it! Currently, the agencies you have listed and their services are not mentioned by locked facilities in San Diego County to our SMI loved ones. Most of the time the locked or even walk-in facilities are not aware of the services listed in your report when they are released back onto the streets. As Facilitators with NAMI, this type of information mentioned in your report, would be critically important to provide the loved ones of SMI persons, yet, to date, it has yet to be provided. It would also be very helpful if we could know how these agencies are interconnected so that these loved ones of the SMI can be directed correctly. We are located in the San Diego area and it would be good to know if some of the agencies may provide more services than others.

- Comment: The Integrated Plan clearly identifies gaps in youth access but does not yet align funding with OCP findings or with the State's policy direction. Rebalancing investment toward children and youth is not only an issue of equity—it is a strategic and policy imperative. Behavioral health research is unequivocal: early intervention in children and youth yields the highest return on investment. Children are less costly to serve and more responsive to treatment, and timely intervention can alter life trajectories in ways that significantly reduce future system involvement.
- San Diego County BHSA Integrated Plan Draft for 2026–2029- Feedback on behalf of Alcohol and Drug Service Provider Association (ADSPA) On behalf of ADSPA and our numerous member organizations who provide substance use disorder services in partnership with the County of San Diego, we appreciate the opportunity to provide comments on the San Diego 2026–2029 Draft BHSA Integrated Plan. We commend the County's efforts to develop a comprehensive framework to guide behavioral health services; however, we have identified several areas that require clarification, reconciliation, and further development to ensure successful implementation. 1. Data Accuracy and Consistency - Across multiple sections of the Plan, there are notable discrepancies in reported data that warrant clarification. For example, the Plan indicates that over 1,000 individuals under age 21 received DMC-ODS services, which appears inconsistent with the Optimal Care Pathways presentation (791 individuals). Similarly, reported unsheltered homelessness figures (15,233) differ significantly from the Regional Task Force Point-in Time (PIT) count (approximately 10,000). These

inconsistencies raise concerns regarding data sources, methodology, and whether figures represent unduplicated individuals or service encounters. Given that these data inform program planning and funding decisions, reconciliation and transparency are critical. 2. Clarity on Service Settings and Scope - The Plan does not clearly define which service settings are included in utilization figures. It is unclear whether counts include services delivered across outpatient, school-based, justice-involved, or community-based settings. Greater specificity is needed to accurately interpret service capacity and system reach. 3. Target Population Definition and Older Adult Services- The Plan frequently references services for individuals over age 65; however, providers report significant barriers to serving this population due to Medi-Medi billing constraints. Clarification is needed regarding Behavioral Health Services' (BHS) definition of the target population and the scope of reimbursable services for older adults, particularly given that Medicare does not cover many of these services. Additionally, the Plan reports that 5,752 individuals over 65 are receiving services; it is unclear how these services are being delivered in light of current billing challenges and recent guidance to transition individuals from Medi-Medi to straight Medi-Cal. 4. Misalignment Between Reported Conditions and Provider Experience - In several instances, the Plan indicates that there are no implementation challenges; however, this does not align with provider experience. Significant challenges remain, including: Limited interoperability and ongoing delays in achieving meaningful data exchange across electronic health record systems - Barriers to effective care coordination, including implementation of Enhanced Care Management (ECM) and Individual Placement and Support (IPS) Challenges with MCP collaboration, data sharing, and MC3 file exchange Closure or transition of key programs, including population-specific ACT services and Clubhouse programs A more accurate representation of these challenges is necessary to ensure appropriate planning and resource allocation. 5. Implementation Feasibility and Operational Detail The Plan outlines several new initiatives but lacks sufficient operational detail regarding implementation. This includes: Assertive field-based SUD treatment services, Outreach reimbursement methodologies and data tracking mechanisms, Housing navigation processes and Coordinated Entry System requirements, Expectations for providers following July 1, 2026, Without clear guidance, providers may face difficulties operationalizing these initiatives. 6. Program Reductions and Funding Transitions The Plan indicates that several programs are being sunsetted or transitioned to Medi-Cal funding; however, it does not clearly identify which services will be discontinued or how service gaps will be addressed. For example, early intervention programs and certain community-based services appear to be reduced without a clear transition plan. This raises concerns about continuity of care and access to services.7. Workforce Development and Administrative Burden The Plan does not sufficiently address workforce capacity or administrative burden. The reduction in centralized training resources, particularly following the non-procurement of the RISE contract, has limited provider access to training. While Medi-Cal training and technical assistance are mentioned, it is unclear how these resources will support specialty behavioral health providers, particularly in the SUD system. Additionally, stakeholder-developed recommendations regarding

administrative relief are not reflected in the Plan. 8. Housing and Homelessness Strategy There are concerns regarding the accuracy of housing projections and the alignment with Coordinated Entry System processes. It is unclear how outpatient providers will be expected to verify homelessness status and whether current housing inventory estimates accurately reflect system capacity. Furthermore, there appears to be limited collaboration with major cities on housing solutions, representing a missed opportunity for system-level impact. 9. Alignment of Priorities and Investments The Plan identifies social connection as a key priority; however, providers note that more urgent issues—such as overdose prevention, suicide, and co-occurring physical health conditions—may warrant greater emphasis. Additionally, programs that directly address social isolation among older adults are being sunsetted, which appears inconsistent with the stated priority. Clarification is needed regarding how funding decisions align with identified community needs.10. Limited Engagement in New State Initiatives The Plan indicates that the County is opting out of several state-recommended initiatives. This raises concerns regarding missed opportunities for innovation, technical assistance, and cross-system collaboration. 11. Budget and Investment Trends The budget section raises questions regarding projected service levels and declining investment over time. For example, the projected number of adults served in housing programs appears low relative to need. Clarification is needed to ensure that funding levels align with population needs and system goals. Conclusion-While the Plan provides a broad framework for behavioral health service delivery, it would benefit from greater clarity, transparency, and alignment with provider experience. Addressing the issues outlined above will be critical to ensure that the Plan is both actionable and responsive to community needs. We appreciate your consideration of these comments and welcome the opportunity to engage further to support successful implementation. San Diego 2026-2029 BHSA Integrated Plan ADSPA Ad Hoc Detailed Meeting Notes The following feedback was collected during an Ad Hoc Meeting convened by ADSPA on April 2, 2026 for the purposes of the reviewing the 2026 - 2029 Integrated Plan. In addition to the comments collected from 42 participants, it also incorporates written feedback submitted by ADSPA member organizations that provide substance use disorder services in partnership with BHS. Page 6: County Behavioral Health System Overview and Population Served The plan indicates that over 1,000 individuals under the age of 21 received DMC-ODS services, which seems shockingly high and actually contradicts the Optimal Care Pathways presentation data (791 individuals). In what other settings is the County referring to services that will be provided? Page 8 The County references services for individuals over 65 years old throughout the document. However, providers find it discouraging to serve this population due to Medi-Medi billing issues. Providers need policy clarification regarding BHS's definition of the target population and what can be provided to clients over the age of 65, even given that Medicare never covers services. How are these 5,752 individuals receiving services, given the issues with Medi-Medi and the latest instructions to transition these individuals from Medi-Medi to straight Medi-Cal? Page 9-10 Homeless statistics need clarification. Unsheltered homeless data does not align with the Regional Task Force point-in-time (PIT) count (BHSA reports 15,233 vs. >

10,000 in PIT). The unsheltered data is very different as well. Relevant because programs will be built based on those statistics. Maybe everyone on the PIT count did not receive services? Page 12: County Behavioral Health Technical Infrastructure - The County reports having no implementation challenges or concerns around inoperability. That seems curious based on the delays. BHS recently reported that they are working toward participating in the HIE and that they are years away from meaningful interoperability with other EHRs. Page 17 - The County reports experiencing no implementation challenges regarding the requirements under the DMC-ODS program. Currently, there are challenges, including population-specific ACT, Clubhouses programs closing, and operationalization and enforcement of care coordination concepts (i.e., Enhanced Care Management (ECM) services, Individual Placement & Support). MCP collaboration and data exchange: Inaccurate representation. Challenges also remain with MC3 file sharing post-SC implementation. ADSPA Ad HOC Detailed Meeting Notes 2 | Page 20: Population-Level Behavioral Health Measures - Overall, the plan appears to address lower-hanging issues, and there may be missed opportunities for population needs assessment and collaborating with other cities for innovative housing interventions. Currently, there is minimal collaboration with the five most populous cities on housing. Does not Adequately fund contracts to ensure that non-county contracted providers are resourced to achieve the behavioral health goals outlined in their contract for the purposes of meeting statewide metrics. The County may be overstating the status of critical opportunities (i.e., assertive field-based interventions, same-day access to MAT). Answering "no" to questions about implementation challenges, missed opportunities for community engagement, real problem-solving, TA from the state, and collaboration to resolve challenges. Page 44-49 The State is asking the County to commit to new bodies of work. The county is opting out of most of them. Page 50: Statewide Population Behavioral Health Goals Providers are surprised that the County reported that social connection consistently emerged as a top priority for community members at the community engagement listening sessions. Providers believe there are other priority areas to address, such as suicide, overdose, co-occurring physical health conditions over social connection. The County is highlighting social connection to address depression and social isolation of home-bound seniors; However, the County is sunsetting programs that support these issues, such as UPAC's Elder Multicultural Access and Support Services (EMASS). It appears that the County's priority of social connection is in direct contradiction to sunsetting these programs. What programs has the County already removed that actually address these goals? Why are these programs being sunsetted? Page 84: Medi-Cal Managed Care Plan (MCP) Community Reinvestment There may be a meaningful opportunity for the joint advocacy between the County and providers regarding how the Medi-Cal Managed Care Plan (MCP) Community reinvestment dollars will be redeployed in the San Diego community. Page 95: Behavioral Health Services and Supports (BHSS) – Specific Services Selected. Children's System of Care (non-Full Service Partnership) (FSP), Outreach and Engagement (O&E), Workforce Education and Training (WET), Adult and Older Adult System of Care (non-FSP), Early Intervention Programs (EIP) What has the County not included in the Integrated Plan? ADSPA Ad HOC Detailed

Meeting Notes 3 | Page The County is sunsetting quite a few programs or transitioning them to Medi-Cal funding. For instance, on page 122, the Incredible Families program is included; however, the RFP has been switched to Medi-Cal funding. If the funding were covered under BHSA, Vista Hill would have bid on that. Page 99: Full-Service Partnerships There is no mention of planning any specific work surrounding the primary SUD population. Page 101: Early Intervention (EI) Programs The Integrated Plan fails to mention what will no longer be funded and how these gaps will be picked up by remaining programs. For instance, early intervention programs are sunsetting, so how will these services be provided? There seems to be more mental health services mentioned than SUD services. Page 138-139: Workforce Education and Training (WET) It appears the County is not moving to restore any centralized training resources. Since the nonprocurement of the RISE (Academy for Professional Excellence) contract provider training opportunities have decreased significantly. There is mention of the board- directed Medi-Cal training and technical assistance to community-based organizations, which ADSPA has strongly advocated; however, it's concerning that these resources will be directed to the mild to moderate behavioral health supports and non-specialty systems. These resources should be directed toward specialty services (i.e., SUD) to maximize revenue and support sustainability. Toward the end of the document, the County's goals include an increase in the percentage of people who receive at least one peer support service. How will providers meet the County's goals if the TA assistance is not available? Will this be measured in the QAPR? Page 148: Full-Service Partnership Program ACT and FACT practitioners will also be responsible for providing FSP intensive case management, even though the current procurements are completely divorcing these services. Mental health providers have historically relied on co-location for efficiencies, but now BHSA is requiring that there be separate programs. The plan mentions SmartCare's wonderful capabilities in improving data consistency, billing accuracy, and outcome tracking. However, there are no outcome tracking reports available in SmartCare. Currently, providers must track outcomes internally, which is increasing the administrative burden. There needs to be CalOMS and other outcome reports in SmartCare. ADSPA Ad HOC Detailed Meeting Notes 4 | Page 149 It appears the County is not making any investment in additional engagement and/or outreach services. Page 155: New Programs for Assertive Field-Based SUD Treatment Services The County reports that BHSA will reimburse targeted outreach and include data tracking. How do they plan to do this? Currently, there is no explanation regarding how this will be accomplished. How do they plan on achieving this? Is it being addressed through the Assertive field-based intervention? Page 156 The plan speaks to the importance of targeted work to address disparities and population-specific interventions. However, it appears that services are moving toward a more generalized population. Population-specific interventions are being chipped away at despite BHSA goals to focus on disparities and these types of interventions (i.e., LGBTQ, justice-involved, seniors, ACT). Page 160: Housing Interventions – System Gap Has the County used all the definitions available to them from the State? Outpatient providers will be verifying homeless status through the coordinated entry system. Will this be a requirement for outpatient providers? How will this roll out? Does the COC inventory

count match the County's answers? ADSPA is concerned that the County is reporting more housing availability than we actually have. Page 162 The plan does not acknowledge the method to assess the homelessness (risk) status via the Coordinated Entry System. Page 174 "To support the Transitional Rent referral process, individuals will need to have a Housing Support Plan in place, which will be developed by a Housing Transition Navigation Services (HTNS) Community Support provider. The HTNS provider will confirm BHSA eligibility and, if not already in place, work with the individual's program to refer to housing-related Community Supports. If an individual is not connected to a BHS-funded program, they will need to be referred to an outpatient clinic for assessment and program referral." Is this the expectation after July 1, 2026? ADSPA Ad HOC Detailed Meeting Notes Page 425: Behavioral Workforce Retention The plan talks about pursuing administrative relief opportunities. How are we going to reduce the administrative burden? ADSPA convened a few stakeholders and representatives and spearheaded Figure A5 regarding administrative relief and provided the County with 29 specific recommendations. Figure A5 is missing from the plan and should be added for state visibility. Microsoft Word - FINAL - SD Behavioral Health Workforce Report .docx. Page 486: BHSA Budget Template - Housing (Mental Health & SUD) The budget reports that 575 Adult/Older Adults are projected to be served annually. The number seems incredibly low. Was this figure accidentally swapped with the number of youth (5,500)? The budget reflects a decrease in investment over time. Why are the amounts of investment decreasing in many of these areas over time? In the back of the document, the BHAB Pathways to Continuum of Care listening sessions report that the SUD treatment system is fragmented and lacks coordination between providers. As an organization, ADSPA feels that we do an excellent job of coordinating across providers and working well together. **Following letters were received.*

***The following pages include letters of public comment submitted by organizations through email.**

April 20, 2026

San Diego County Behavioral Health Services
Attn: Liberty Donnelly, BHSA Coordinator
3255 Camino del Rio South
San Diego, CA 92108

Re: Public Comment – San Diego County 2026–2029 Behavioral Health Services Act Integrated Plan

Dear Ms. Donnelly and the San Diego County Behavioral Health Services Department,

The San Diego Housing Commission (SDHC) supports the County of San Diego's 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan. SDHC commends San Diego County Behavioral Health Services (SDCBHS) for the depth and thoughtfulness of this Integrated Plan and the inclusive planning process through which it was developed.

SDHC appreciates the SDCBHS engaging with us as a stakeholder partner throughout the development of this plan. The recognition of SDHC's role as a Public Housing Agency (PHA) partner, co-developer of the Homekey+ property, and key participant in the County's housing and homelessness response system reflects the strong and productive working relationship our organizations have built over many years. We appreciate that the plan explicitly acknowledges the partnership between SDHC and SDCBHS as foundational to expanding permanent supportive housing and housing-linked services for individuals experiencing homelessness with behavioral health conditions.

SDHC notes the plan's Housing Interventions component, including the development of the Flexible Housing Pool (FHP) Pilot, the continued investment in Homekey developments, and the plan's commitment to aligning BHSA funding with CalAIM Community Supports and other federal and state resources. The County's commitment to building a continuum of housing options for BHSA-eligible individuals — from transitional rent and interim housing to permanent supportive housing — is consistent with SDHC's purpose — to provide stable, quality housing solutions so the community can thrive.

We look forward to continuing our collaborative work with SDCBHS as this plan is implemented, and to learning more about the allocation of these critical services, the associated allocation methodologies, system coordination and integration activities, and workforce development initiatives necessary to ensure the County maintains the personnel to fulfill the programmatic objectives outlined in the Integrated Plan. SDHC remains committed to serving as a housing resource and implementation partner, including through our current Homekey+ co-development effort and our broader work across the Continuum of Care. We are eager to see the strategies outlined in this plan translate into real, measurable outcomes for the individuals and families our organizations serve within the City of San Diego.

Thank you again for your partnership and for the opportunity to participate in this important planning process.

Respectfully,

Lisa Jones
President & CEO
San Diego Housing Commission

Response to the County of San Diego
Behavioral Health Services Act (BHSA) Integrated Plan
April 15, 2026

Introduction

On behalf of the Strategic Behavioral Health Initiative (SBHI), we appreciate the opportunity to provide input on the County of San Diego's Behavioral Health Services Act (BHSA) Integrated Plan.

SBHI is a cross-sector collaborative representing healthcare providers, schools, community-based organizations, workforce partners, and public agencies. Together, our partners engage with nearly all children and youth across San Diego County and bring direct insight into system demand, access barriers, and service gaps.

We share the County's goal of implementing BHSA successfully. This feedback is offered to strengthen alignment between the Integrated Plan, the statutory intent of BHSA, and the documented needs of children, youth, and families.

Below feedback is in line with the SBHI Youth OCP Recommendations submitted on March 24, 2026.

Executive Summary

A comprehensive review of the Integrated Plan, combined with SBHI stakeholder input, yields a consistent conclusion: children and youth behavioral health services remain underfunded relative to need, and current investment strategies risk reinforcing a reactive, adult-oriented system rather than advancing indicated prevention and early intervention.

Children and youth represent 37.7 percent of individuals served across the behavioral health continuum, yet receive only approximately 19% of total system spending, according to BHSA Integrated Plan Table 1 on page 486. At the same time, adult and older adult services receive approximately $1.05 billion annually compared to $257 million in year 1 for children and youth. However, when excluding SUD residential and housing services – given that there are no SUD residential programs serving under 18 in San Diego and housing services predominantly serve TAY and adults the adjusted funding more accurately reflecting services for children under age 18 is approximately $233,426,824 (17%) in Year 1 and $216,739,567 (16.7%) in Year 2.

The proposed plan further exacerbates this imbalance by reducing children and youth funding by $17.2 million over the three-year period while increasing adult services funding by $10.1 million. Youth specialty mental health service penetration remains approximately 3.0 percent—below need and only marginally aligned with adult rates.

These conditions exist despite overwhelming evidence that behavioral health conditions begin early in life and that early intervention is the most clinically effective and cost-efficient approach. As a result, there is a clear misalignment between documented need and investment, between evidence and system design, and between the policy intent of BHSA and its local implementation.

BHSA and Implications for Children and Youth

The Behavioral Health Services Act represents a significant restructuring of California's behavioral health system, introducing changes that shift both funding structures and programmatic priorities. While BHSA requires that 51 percent of Behavioral Health Services and Supports (BHSS) Early Intervention funding be directed toward individuals ages 0–25, Early Intervention represents only a small portion of the overall funding framework. The remaining categories—particularly housing and Full Service Partnerships—are largely oriented toward adult-serving systems. The 51% was intentionally set as a "minimum" threshold, not a cap. The rationale for this requirement was clear in Proposition 1:

- To correct longstanding underinvestment in youth services
- To align funding with the fact that most behavioral health conditions begin before age 18
- To prioritize early identification and intervention, which yield the greatest clinical and fiscal impact
- To reduce long-term reliance on high-cost adult and crisis systems

Furthermore, a significant portion of programs that make up the 51% requirement for the Early Intervention category have utilization data showing that only individuals 18 and older are being served -- meaning the actual investment reaching younger children is even lower than the minimum.

Key Findings:

Structural Imbalance in Funding

Current spending patterns reflect a substantial and persistent imbalance in how resources are allocated across age groups. While children and youth account for more than one-third of individuals served, they receive less than one-fifth of total behavioral health spending. Adult and older adult services receive more than four times the level of investment, despite comparable levels of system utilization.

Importantly, total behavioral health expenditures exceed $1.58 billion annually, indicating that this imbalance is not the result of insufficient resources but rather a function of allocation priorities. The proposed plan further widens this gap by reducing funding for children and youth while increasing investments in adult services, reinforcing a system that prioritizes downstream care over early intervention.

Youth Are Underserved Relative to Need

The Youth Optimal Care Pathway identifies a goal of reaching the statewide penetration rate, which would require serving approximately 5,000 additional youth annually. However, available estimates suggest that up to 67,000 youth in San Diego County may require specialty mental health services.

This indicates that the current system is reaching only a fraction of those in need. Even achieving the statewide average would leave a substantial proportion of youth without access to care. Disparities are particularly pronounced among younger children, especially those ages 0–11, and among Hispanic and Asian/Pacific Islander youth. These patterns reflect systemic barriers to access rather than a lack of demand for services.

Misleading Signals from Penetration Rates

At first glance, youth and adult penetration rates appear similar, at approximately 3.0 percent and 3.2 percent respectively. However, this comparison does not reflect true parity. Given that behavioral health conditions emerge earlier in life, that children are more responsive to intervention, and that untreated conditions lead to significantly higher long-term costs, equivalent penetration rates actually indicate underinvestment in youth relative to need.

Rather than signaling equity, these figures suggest that the system is not reaching children early enough, when intervention is most effective and least costly.

System Design Remains Downstream and Crisis-Oriented

The current investment strategy continues to emphasize crisis stabilization, residential and inpatient care, and expansion of adult-serving systems. For children and youth, the plan highlights limited capacity, including a 16-bed crisis residential program, while offering relatively little investment in upstream access points such as schools, pediatric primary care, and community-based services.

This approach increases reliance on high-cost interventions, limits opportunities for early identification and treatment, and contradicts the County's own Youth Optimal Care Pathway, which emphasizes prevention and early intervention as central strategies.

Early Intervention Is at Risk of Narrow Interpretation

There is growing concern among stakeholders that BHSA is being implemented in a way that restricts the scope of Early Intervention services, reducing investment in prevention and limiting eligibility to individuals with diagnosable conditions.

However, state statute and guidance from the Department of Health Care Services clearly allow Early Intervention funding to support individuals at risk of developing behavioral health conditions, including indicated prevention services that do not require a formal diagnosis. A narrow interpretation of risks excluding younger children, delaying access to care, and shifting demand toward crisis services—ultimately undermining the intent of BHSA.

Early Childhood (Ages 0–5) Remains Underprioritized

Children ages 0–5 are explicitly identified as a priority population under BHSA and represent a critical developmental window for intervention. Yet, current investments in early childhood behavioral health remain limited, and many effective interventions—particularly those delivered through pediatric, early learning, and community-based settings—are underrepresented in the plan.

This represents a missed opportunity to invest in interventions with the highest return on investment, both in terms of improved outcomes and long-term cost savings.

Lack of Transparency Limits Accountability

The Integrated Plan does not provide sufficient detail to fully assess how funding decisions will impact children and youth services. There is no clear baseline comparison to current funding levels, limited visibility into program-level allocations, and insufficient information to determine how funding shifts will affect specific services over time.

In some cases, existing programs appear to have been reclassified within Early Intervention categories, making it difficult to determine whether investments are expanding or simply being redistributed. For example, SchooLink, the largest children and youth program in BHS has been moved from FSP to BHSS EI; and several other existing children and youth programs not funded through MHSA, such as Polinsky Children's Center, FFAST and Kid Start Clinic, are now bundled in the BHSS EI category. This lack of transparency limits meaningful stakeholder engagement, constrains system alignment, and reduces public accountability.

System-Level Implications

The County's Youth Optimal Care Pathway (OCP) identifies closing the Specialty Mental Health Services penetration gap to reach the statewide average of 3 percent as a priority, which is estimated to require serving approximately 5,000 additional youth annually. At the same time, the OCP suggests that up to 67,000 youth in San Diego County may require specialty mental health services, indicating that achieving the statewide average would still leave a substantial proportion of need unmet.

Given this context, it is unclear how the County intends to meet even this modest benchmark of 3 percent penetration and expand capacity to serve an additional 5,000 youth, particularly as funding for children and youth services appears to be declining.

If current divestment patterns persist, the County is likely to experience continued low access rates for youth, persistent gaps between need and capacity, and increasing reliance on high-cost emergency and

inpatient services. These dynamics will contribute to higher long-term costs across behavioral health, child welfare, and justice systems, while missing critical opportunities to intervene during key developmental periods.

In effect, the system will continue to absorb higher downstream costs as a direct result of insufficient upstream investment.

Recommendations

To better align the Integrated Plan with both the evidence base and the intent of BHSA, SBHI recommends a strategic rebalancing of investments across the full behavioral health system. This includes increasing the proportion of total funding (across all funding sources) allocated to children and youth and aligning more closely with the policy expectation that Early Intervention resources meaningfully support individuals ages 0–25.

The County should establish clear and measurable targets to increase youth access to specialty mental health services, including reaching beyond the statewide penetration rate and developing longer-term goals tied to population-level need. Achieving these targets will require a sustained commitment to expanding capacity and addressing structural barriers to access.

Investment strategies should prioritize upstream models of care, including school-based behavioral health services, integration within pediatric primary care, early childhood interventions, and family-centered, community-based models. These approaches are essential to improving outcomes and reducing long-term system costs and are in alignment with the County's Youth Optimal Care Pathway.

In addition, the County should strengthen cross-system coordination by developing clear access pathways that ensure children and families can enter care through multiple points of contact. A "no wrong door" approach, supported by coordinated referral and transition protocols, will improve navigation and continuity of care across systems.

Finally, the County should enhance transparency and accountability by publicly reporting key metrics, including funding by age group (including a breakdown of children and youth), number of individuals served, cost per beneficiary, and access timelines and outcomes. Providing program-level budget detail will be essential to enabling meaningful oversight and stakeholder engagement.

Partnership Opportunity

SBHI offers to partner with the County to support successful implementation of the BHSA Integrated Plan. As a cross-sector collaborative with deep community reach and system-level perspective, SBHI is well-positioned to support alignment, implementation, and continuous improvement.

To that end, we recommend establishing a standing Children and Youth Behavioral Health Workgroup, jointly convened by Behavioral Health Services and SBHI stakeholders. This workgroup would provide a structured forum to monitor implementation, track investments and outcomes for children and youth, and inform ongoing development of the Youth Optimal Care Pathway.

This approach would strengthen transparency, support continuous improvement, and ensure that implementation efforts remain aligned with community needs and policy goals.

Conclusion

The Integrated Plan identifies important gaps in youth access to behavioral health services, but current investment decisions do not yet align with the scale of need, the evidence base for early intervention, or the intent of BHSA.

Children and youth represent more than one-third of those served in the system yet receive less than one-fifth of total funding. This imbalance is not only an issue of equity—it is a strategic and fiscal concern. Early intervention improves outcomes, reduces long-term costs, and strengthens the sustainability of the behavioral health system as a whole.

A system that invests more heavily in adults than in children is, by definition, responding too late.

We offer this input to strengthen the Integrated Plan and look forward to continued partnership with the County to build a behavioral health system that is proactive, equitable, and effective for children, youth, and families.

Specific Questions

<u>Housing Services:</u>

Table 1 on page 486 presents projected funding and individuals served across mental health, substance use disorder, and housing services within the behavioral health continuum, inclusive of all funding streams. Within the housing services category, approximately 5,500 youth (under 21 years) and 575 adults will be served.

However, Table 5 on page 493, which details BHSA Housing Interventions programs and services, projects that 740 youth and 17,989 adults will be served. As the latter table appears to represent a subset of the broader continuum outlined in Table 1, the significantly lower adult count in Table 1 is difficult to reconcile.

Additionally, the projection of 5,500 youth served within housing services in Table 1 is unexpected, as this figure appears substantially higher than typical utilization for youth within housing-focused programs.

We would appreciate clarification on the source of this discrepancy between the two tables, including how populations are being categorized and which specific programs are included in the estimate of 5,500 youth served within the housing services category.

Early Intervention:

Based on Table 1 on page 486, total funding for mental health and SUD early intervention and prevention services for children ages 0–21 appears to be approximately $34.8 million.

In contrast, Table 7 on page 495, which outlines Behavioral Health Services and Supports (BHSS), indicates total Early Intervention funding for children and youth 0-25 totals $51.43 million.

Can it be assumed that the difference between these two figures is attributable to the broader age range reflected in Table 7? Specifically, does this imply that approximately $16.63 million of Early Intervention funding is allocated to transition-age youth (ages 22–25), with the remaining $34.8 million supporting children and youth under age 21?

We would appreciate clarification on how funding is distributed across age groups in these tables to ensure accurate interpretation.

SUD Residential Services:

Table 1 on page 486 indicates that 475 children and youth (0-21) are projected to be served annually through SUD residential services, with total funding of $10,849,866 across all funding streams.

Can you clarify whether SUD residential providers in San Diego County currently have the capacity to serve children under age 18? If not, should this category be understood as primarily serving individuals age 18 and older?

Early Intervention reductions:

Based on Table 1 on page 486, Mental Health Early Intervention funding for children and youth appears to decrease from approximately $27.7 million in Year 1 to $13.5 million in Year 2. This loss is not made up in any other category or year.

Can you provide clarification on the cause of this significant reduction? Specifically, which funding stream(s) account for this change, and which programs or services are anticipated to be reduced, eliminated, or otherwise impacted?

Rationale for 0-21 age investment:

Based on Table 1 on page 486, total funding across all funding streams—including housing services—for children and youth ages 0–21 is approximately $257,238,307 in Year 1 and $238,803,843 in Year 2.

However, when excluding SUD residential and housing services – given that there are no SUD residential programs serving under 18 in San Diego and housing services predominantly serve TAY and adults —the adjusted funding more accurately reflecting services for children under age 18 is approximately $233,426,824 (17%) in Year 1 and $216,739,567 (16.7%) in Year 2.

This adjustment suggests that the proportion of funding directly supporting children may be lower than initially reflected in the total figures. We would appreciate confirmation of this interpretation, including whether SUD residential and housing investments are appropriately attributed to the children and youth category in Table 1.

Sincerely,

Strategic Behavioral Health Initiative (SBHI)

Facilitators of SBHI Contact information:

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POLICY & INNOVATION CENTER

MHCA
MENTAL HEALTH CONTRACTORS ASSOCIATION OF SAN DIEGO COUNTY

On behalf of Mental Health Contractor's Association I am writing to express our appreciation for the Board's support of the Children and Youth Optimal Care Pathways (OCP) Framework.

We are encouraged by the County's commitment to strengthening a more coordinated and responsive behavioral health system for children, youth, and families. Many of our organizations were engaged in the Strategic Behavioral Health Initiative (SBHI) process and contributed to the collective recommendations that were shared with your office.

As implementation moves forward, we want to underscore the importance of continued and meaningful stakeholder engagement. Ongoing partnership with providers, youth, families, and community-based organizations will be critical to ensuring the framework is implemented in a way that is effective, equitable, and responsive to real-world needs.

In particular, we support the establishment of a permanent, multi-sector implementation oversight structure that includes representation from providers, families, youth, and community partners. Such a structure would help:

- Monitor implementation progress and data
- Elevate both state-mandated and community-informed practices
- Provide ongoing input to support continuous improvement and accountability

We remain committed to partnering with the County Behavioral Health Services department and the Board to support successful implementation of the OCP Framework.

For reference, I have attached the SBHI recommendations document.

Thank you for your leadership and continued support of children, youth, and families in our region.

Respectfully,

Laura Beadles Laura Beadles, MHCA President Date: 4/16/26

Aisha Pope, LCSW Aisha Pope, Children's At-Large Representative Date: 4/15/2026

Behavioral Health Services Act Public Comment

April 14th, 2026, International Rescue Committee in San Diego

Section 1: Behavioral Health Goals

On behalf of the International Rescue Committee (IRC) - San Diego. The proposed goals demonstrate a strong foundation; however, we identified the following gaps:

Prioritizing Cultural Responsiveness: In its current draft, BHSA appropriately emphasizes service expansion through partnership with trusted community-based organizations to deliver culturally responsive care. As a deeply embedded and trusted presence across San Diego communities, BHSA would be well served by including the IRC as a formal partner. The IRC has delivered culturally responsive services for five decades (since 1975), with expertise grounded in serving diverse and often marginalized populations, including many BHSA-eligible populations. When it comes to addressing mental and behavioral health, the IRC brings deep experience and a trauma-informed approach that prioritizes meeting individuals where they are.

Inclusion of Newcomers in the Target Population: Beyond language and culture barriers, many newcomers face undiagnosed mental health needs and significant challenges navigating U.S. systems, increasing their risk of compounding mental health crises. Many newcomers have also experienced displacement-related trauma that continues to remain unaddressed due to stigma, language barriers, and limited culturally responsive services. Although a substantial share of newcomers are BHSA-eligible, the absence of explicit recognition as a target population risks continued oversight of their distinct clinical needs. Compounding these challenges, many new San Diegans lack credit history or stable income, placing them at heightened risk of housing instability.

Documentation Barriers: Documentation requirements should be assessed as a barrier influencing access to care. The draft does not set forth goals related to document requirement reform or navigation support, leaving many eligible residents unable to access care. The IRC is uniquely positioned to serve as a trusted intermediary and navigator, leveraging longstanding community relationships to help new San Diegans to access mental health services, complete enrollment, and successfully engage the behavioral health system.

Prevention: The current BHSA draft does not articulate goals focused on prevention strategies or mental health education for BHSA-eligible populations who are not yet in crisis. Evidence indicates 80% of adult newcomers who have been forcibly displaced experience mental health conditions and up to 90% of young newcomers – many times unknowingly – underscoring the

need for proactive approaches. Unaddressed trauma can increase the risk of developing more severe mental health disorders over time. Targeted programming that combines preventative intervention with education on coping strategies, healthy habit-building, and mental health literacy would help mitigate risk, prevent deterioration, and promote long-term wellbeing. A multi-layered prevention-focused approach is essential to achieving sustainable mental health outcomes.

The Inclusion of Gender-Specific Mental Health Strategies & Household Structures: The BHSA should ensure that there is behavioral health and wellbeing programming that is targeted to each gender. For example, while BHSA correctly notes that men are overrepresented in the justice system, the draft does not adequately address the corresponding underrepresentation of men in mental and behavioral health programming. Newly displaced men, women, and non-binary people experience traumas and stressors that are unique to each population, in addition to unique stigmatization that is faced by the different genders, and the distinct challenges that members of non-traditional household structures face. To ensure equitable and effective service delivery, BHSA would benefit from a multi-targeted approach that addresses individual mental health needs while also accounting for diverse household compositions, including single-parent households.

Stakeholder Perspectives: The BHSA should explicitly incorporate stakeholder perspectives into program implementation language to ensure that stated goals reflect the operational realities of implementers and the lived experiences of target populations. For example, the Access to Care: Disparities Analysis notes that penetration rates for non-specialty mental health services are lower among several non-English-speaking populations, including Arabic, Cantonese, Farsi, Other Chinese, Russian, and Tagalog speakers. While numerous refugee and immigrant service organizations and ethnic community-based organizations are listed as stakeholders engaged in the BHSA planning process, none of the feedback from these organizations is meaningfully integrated into the BHSA to analyze barriers to accessing care or to inform implementation strategies that could reduce those barriers. Purposeful inclusion of stakeholder analysis within the BHSA would strengthen implementation planning, prioritize community and cultural responsiveness, and signal the importance of shared accountability, trust-building, and equity in achieving access goals.

Section 2: Programs

Rebalancing Toward Primary Prevention and Upstream Mental Health Supports: While reactive and crisis-response programming is essential, the BHSA plan is heavily weighted toward addressing acute and ongoing mental health issues crises, with comparatively limited emphasis on proactive prevention. While significant resources are allocated to early intervention efforts, greater investment or reallocation of funds in primary prevention would strengthen the overall

framework. Prevention-focused programming should include both education-based initiatives and solutions-oriented supports that address the underlying stressors that significantly impact mental health. Education-based programs may include interactive workshops for adults and children focused on stress management, coping strategies, value creation, healthy relationship-building, and sustainable habit formation. Solution-oriented programming should assist with addressing stressors that greatly impact mental health, such as unemployment, financial instability, and housing security, through direct services including but not limited to employment assistance, financial coaching, and housing navigation. Such programs would be a step beyond only providing referrals and mental health-only support for people who are not yet in dire need, as the current BHSA focuses on. Existing programs – the kind of which the BHSA draft suggests providing linkages to – are often at full capacity, making referrals to those programs less effective. Therefore, funding should be provided for new programs that directly target the factors that negatively impact mental health specifically for BHSA-eligible populations, such as trauma-informed case management, financial coaching, employment navigation, and housing navigation, rather than simply providing linkages to such programs. The International Rescue Committee (IRC) has experience in providing culturally responsive, trauma-informed case management, financial coaching, employment navigation, and housing navigation services to members of the community in San Diego County and is well positioned to support BHSA's prevention and early intervention goals.

Cultural Responsiveness in Program Design and Implementation: Although the BHSA acknowledges the importance of cultural responsiveness in mental health services, as emphasized by stakeholder input, concrete provisions for culturally responsive programming are largely limited to a single initiative—the Native American PEI/Dreamweavers program. Communities across San Diego County have distinct behavioral health needs shaped by their cultural backgrounds, migration histories, and lived experiences. As such, the BHSA should include targeted provisions that enable community-based organizations to lead outreach and education efforts within diverse communities, with the goals of increasing understanding of mental health, reducing stigma, and improving access to care. The International Rescue Committee (IRC) has extensive experience conducting outreach to immigrant and refugee populations throughout San Diego County and has established trusted relationships across a wide range of communities. Additionally, the IRC has demonstrated capacity to develop and deliver culturally responsive, linguistically appropriate educational materials and programming. Given this track record, the IRC is well positioned to play a lead role in implementing mental health outreach and education activities that are responsive to community needs and aligned with BHSA equity goals. There is a need to include mental health and destigmatization programs specific to different genders in the BHSA, as each gender has unique mental health needs and faces unique challenges.

Section 3: Workforce Strategy

The International Rescue Committee (IRC) supports the integration of Peer Support Specialists. Centering lived experience is vital for building trust and reducing stigma. However, providing external linkages to programs that assist with community integration and self-sufficiency is insufficient. The existing programs are usually at capacity and may not offer culturally-competent, language-accessible, trauma-informed services. It is important to include in the BHSA plan the hiring and training of staff to work on programs that directly assist BHSA-eligible populations with practical needs that greatly contribute to their mental health needs, such as financial instability and housing instability. The workforce strategy should include the hiring of employment specialists, housing specialists, financial coaches, and case management staff to assist BHSA-eligible members of the community, in order to address significant stressors through practical solutions rather than solely relying on mental health staff to only address the direct mental consequences of those stress factors. These staff would assist BHSA-eligible populations with navigating employment challenges, guidance in finding appropriate housing, coaching to educate about finances and assist with financial planning, and assistance with other assessed stressors as determined on a case-by-case basis. The IRC has significant experience in assisting BHSA-eligible populations with language-accessible, trauma-informed case management, employment navigation, housing navigation, and financial coaching, addressing significant stressors for these populations and assisting them with sustainable, long-term solutions and strategies to address mental health needs.

Workforce Education and Training (WET) activities should train providers to take into account the cultural and immigration backgrounds of the BHSA-eligible populations, and approach outreach and discussions in a culturally responsive manner, rather than simply focus on technical training. WET activities should train community-facing staff in trauma-informed approaches and equip them with tools to work with newcomers and culturally diverse groups. IRC has expertise in training community members and providers on cultural responsiveness.

Section 4: Budget

Funds should be allocated towards targeted programs that provide better community integration, financial stability, self-sufficiency, and autonomy tools in the long term, rather than relying on simple referrals. Programs designed to provide better integration and address major stressors help alleviate major contributors to mental health problems in a sustainable way. Community integration and self-sufficiency mean empowering individuals and families to be able to live independently, participate and engage fully in society and in their communities, and meet their own needs without relying on external systems. The programs proposed include case management, housing stability, financial coaching, and employment navigation assistance.

This would be in conjunction with culturally responsive mental health-specific programming. For such programs to be successful, organizations that are experienced in assisting BHSA-eligible populations with achieving self-sufficiency and better integration, like the International Rescue Committee (IRC), need to be included in the programs.

A portion of funding should be earmarked for programming that specifically focuses on prevention strategies, as outlined above.

April 14, 2026

Nadia Privara Brahms, Director
County of San Diego Behavioral Health Services
3255 Camino del Rio South
San Diego, California 92108

Submitted via email: Engage.BHS@sdcounty.ca.gov

RE: Formal Public Comment — Draft BHSA Integrated Plan for Fiscal Years 2026–2029

Dear Director Privara Brahms:

Alvarado Parkway Institute (API) is pleased to submit formal public comment on San Diego County's draft Behavioral Health Services Act (BHSA) Integrated Plan for Fiscal Years 2026–2029. We appreciate the County's commitment to community engagement and the transparency with which this planning process has been conducted.

API is a 66-bed licensed freestanding acute psychiatric hospital located at 7050 Parkway Drive in La Mesa, and we are the only freestanding acute psychiatric hospital serving East County's estimated 500,000 residents. With an average daily census of approximately 61 patients and over 22,000 patient days of care provided annually, API is a foundational component of San Diego County's behavioral health continuum. The majority of our patients are Medi-Cal beneficiaries with Serious Mental Illness (SMI), the population at the core of both BHSA and BH-CONNECT.

We are also a confirmed Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, active since July 2025. Our comments are therefore offered not only as a community provider, but as an active partner in the County's behavioral health financing and delivery infrastructure.

Our comments address five areas: (1) the critical role of acute inpatient capacity in the continuum; (2) the impact of AB 116 on provider financial sustainability; (3) BH-CONNECT FFP reinvestment and reimbursement rates; (4) care coordination and transition services; and (5) workforce development. We respectfully request that feedback in each area be incorporated into the final plan.

1. Acute Inpatient Capacity: An Indispensable Tier of the Continuum

The BHSA Integrated Plan appropriately emphasizes investment in community-based services, housing, and crisis intervention. API fully supports these investments. We offer the following as essential context: community-based services and acute inpatient care are not competing priorities, they are interdependent tiers of the same continuum. The effectiveness of the County's investment in lower levels of care depends on the availability and stability of acute inpatient capacity for those whose needs exceed what community-based settings can safely address.

San Diego County Acute Psychiatric Bed Context

API is the only freestanding acute psychiatric hospital in East County. The region has experienced repeated failures in attempts to add acute psychiatric inpatient capacity:

- Acadia/Scripps Eastlake: 120-bed acute psychiatric hospital proposal rejected in 2022

- Palomar Health Behavioral Health Institute: BHCIP-funded 120-bed acute psychiatric hospital in Escondido, with completion not expected before 2029–2030

San Diego County faces a structural acute psychiatric bed shortage that will persist for at minimum eighteen months.

API's 66 licensed beds represent a primary acute inpatient resource for a large and growing population.

We respectfully request that the final Integrated Plan include explicit language recognizing freestanding acute psychiatric hospitals as a protected and essential tier of the behavioral health continuum, and that institutionalization reduction goals be framed around appropriate utilization rather than reduced utilization per se. Measuring success solely by fewer inpatient days risks perverse incentives that harm the most severely ill patients in our community.

Recommended Plan Language (Section on Institutionalization Goals):

Suggested language for the County's institutionalization section:

"San Diego County recognizes that acute inpatient psychiatric care is a medically necessary and clinically appropriate service for individuals with Serious Mental Illness whose needs cannot be safely addressed in community-based or crisis residential settings. The County's institutionalization goals target the reduction of preventable or avoidable inpatient episodes through investment in upstream services, while preserving timely access to acute care for individuals who require it. The County will track both over-utilization and under-utilization of acute inpatient services as quality indicators, ensuring that access to medically necessary care is not constrained by utilization targets alone."

2. AB 116 and Provider Financial Sustainability

AB 116, California's new emergency nurse staffing ratio (1:6 licensed nurse-to-patient ratio), is expected to take effect June 1, 2026, the same month this Integrated Plan enters implementation. The financial impact on freestanding acute psychiatric hospitals is substantial and immediate.

AB 116 Impact Factor	API Estimate
Annual incremental staffing cost	$2.5 million (Nursing Targets compliance model)
Additional Registered Nurses required	23 FTEs by June 1, 2026
Statewide RN shortage context	San Diego County is a designated RN shortage area; API competes with 8 other San Diego County hospitals for the same nursing workforce
Non-compliance fine exposure	$15,000–$30,000 per day per CDPH enforcement action
Current Medi-Cal rate adequacy	Existing SMHS rates do not reflect AB 116 mandated cost increases; a structural funding gap will exist from July 1, 2026 forward

According to the California Hospital Association's March 2026 statewide survey, only 16% of affected psychiatric hospitals are likely to achieve full AB 116 compliance by June 1. API is making every effort to comply, including active RN recruitment, wage increase, and good-faith documentation for potential CDPH program flex consideration. However, the financial sustainability of this compliance depends on Medi-Cal reimbursement rates that reflect the mandated cost structure.

The BHSA Integrated Plan is the foundational document governing how the County uses its behavioral health funding. We respectfully request that the plan include explicit recognition that AB 116 creates a structural cost gap

for contracted acute inpatient providers and that the County commits to rate-setting and contract practices that reflect the true cost of mandated staffing levels.

Recommended Plan Language (Provider Network and Contracting Section):

> "Effective July 1, 2026, California's AB 116 psychiatric emergency nurse staffing ratio law requires freestanding acute psychiatric hospitals to maintain a 1:6 licensed nurse-to-patient ratio. San Diego County recognizes that this mandate substantially increases the cost of providing acute inpatient psychiatric services. The County commits to reviewing and, where appropriate, adjusting Specialty Mental Health Services reimbursement rates for contracted acute inpatient providers to ensure that rates reflect the actual cost of AB 116-mandated staffing. Rate adequacy reviews will occur at least annually during the FY 2026–2029 Integrated Plan period."

3. BH-CONNECT FFP Reinvestment: Provider Rate Increases

API is an active Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. Under this program, the County receives approximately 50% federal matching funds for Specialty Mental Health Services provided to qualifying Medi-Cal members (ages 21–64) during short-term stays at IMDs, including API.

The BH-CONNECT Special Terms and Conditions (STCs) explicitly require that FFP reimbursement received for patient care services provided in IMDs be reinvested to support community-based behavioral health service provision, quality improvement, or capacity expansion — with allowable reinvestment modalities specifically including enhancement of provider payment rates to build capacity and expand workforce.

BH-CONNECT FFP Reinvestment — API's Position

Since July 2025, San Diego County has been receiving substantial federal FFP generated by API's qualifying Medi-Cal IMD stays. Applying approximate figures:

- API's estimated Medi-Cal daily census: 27–34 patients (45–55% of 61 ADC)
- Estimated qualifying Medi-Cal IMD patient days (July 2025–March 2026): ~7,500–9,000 days
- Approximate federal FFP generated for the County from API stays: significant six-figure amount

The BHSA Integrated Plan is the appropriate vehicle for the County to formalize its FFP reinvestment commitments. API respectfully requests that the plan include specific language on reinvestment of BH-CONNECT FFP savings into enhanced provider rates for qualifying IMDs.

Recommended Plan Language (BH-CONNECT / Medi-Cal Financing Section):

> "San Diego County is an active participant in the BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. In accordance with BH-CONNECT Special Terms and Conditions, the County will reinvest FFP savings received for services provided in qualifying Institutions for Mental Diseases into community-based behavioral health services, workforce expansion, and/or enhanced provider payment rates. During the FY 2026–2029 Integrated Plan period, the County commits to conducting an annual review of SMHS rates for contracted acute inpatient providers that are active Participating Psychiatric Settings, with the explicit objective of ensuring that FFP reinvestment benefits flow to frontline providers whose patients generate those federal funds."

4. Care Coordination, Transition Services, and Referral Pathways

API strongly supports the County's investments in Assertive Community Treatment (ACT), Forensic ACT (FACT), Community Transition In-Reach Services, and the broader Full Service Partnership infrastructure. These

programs serve our shared patient population and directly affect the quality of care transitions between acute inpatient settings and the community.

We offer the following specific requests to strengthen care coordination language in the final plan:

4a. Community Transition In-Reach Services at API

BH-CONNECT authorizes county-funded multidisciplinary teams to provide Community Transition In-Reach Services inside IMDs for up to 180 days prior to discharge. This service is designed to support the precise patient population that API serves — high-acuity SMI individuals who require intensive community linkage before and after discharge. We formally request that the final plan include a commitment to implement Community Transition In-Reach Services at API during the FY 2026–2029 plan period, and that API be identified as a priority site for this service given our volume and patient acuity.

4b. ACT Team Referral Protocols

As the County expands ACT and Forensic ACT capacity under BHSA and BH-CONNECT requirements, we request that the plan include explicit language establishing clear referral protocols between ACT teams and acute inpatient providers. Specifically: ACT teams should have defined pathways for referring clients in acute crisis to API, and API should have defined pathways for discharge to ACT teams. These bidirectional protocols reduce avoidable readmissions, improve patient outcomes, and support the County's BH-CONNECT performance metrics on readmission reduction.

4c. Post-Discharge Follow-Up (72-Hour Standard)

BH-CONNECT requires either the county BHP or the IMD to contact Medi-Cal members within 72 hours of discharge. API is committed to meeting this standard. We request that the plan establish a shared data protocol between API and the County BHP for tracking 72-hour follow-up completion, a key quality measure that will support both the County's BH-CONNECT incentive program performance and API's accountability to our shared patients.

4d. SD County Behavioral Health Wellness Campus Integration

The County's $99.5 million BHCIP-funded Behavioral Health Wellness Campus (Crisis Stabilization Unit, MHRC, SRF, and outpatient services, completion projected May 2031) will create significant new lower-acuity capacity in San Diego. API views this as a positive development and a complement to our acute inpatient services. We request that the plan include language on how the Wellness Campus and acute inpatient providers like API will establish coordinated referral and transition protocols when the campus is operational, to ensure seamless movement of patients across levels of care.

5. Behavioral Health Workforce Development

The BHSA Integrated Plan's workforce section is directly relevant to API's operational sustainability. We offer two specific requests:

5a. AB 116 Workforce Crisis Recognition

The California Hospital Association's statewide survey documented a need for 910 new licensed psychiatric nursing FTEs across California by June 1, 2026, with 222 of those in Southern California alone. San Diego County is a designated RN shortage area. We request that the plan explicitly identify the AB 116 psychiatric nursing mandate as a county-level workforce crisis and include strategies for addressing it — including coordination with HCAI on BH-CONNECT Workforce Initiative recruitment and retention bonus programs, and support for facilities in designated shortage areas.

5b. BH-CONNECT Workforce Program Access

BH-CONNECT's Workforce Initiative includes loan repayment programs, community-based provider training (up to $10,000 per participant), and recruitment and retention bonuses for organizations serving Medi-Cal members (threshold: approximately 40% Medi-Cal payer mix). API and other county-contracted acute providers meet this

eligibility threshold. We request that the plan include outreach commitments to ensure that contracted providers, including acute inpatient hospitals, are fully informed of and supported in accessing these workforce programs.

6. Summary of Requested Plan Actions

#	Requested Action	Plan Section	Priority
1	Add language distinguishing appropriate from avoidable institutionalization in goals section	Statewide BH Goals / Institutionalization	**Critical**
2	Include explicit commitment to review SMHS rates to reflect AB 116 mandated staffing costs, beginning July 1, 2026	Provider Network / Contracting	**Critical**
3	Formalize BH-CONNECT FFP reinvestment commitment to include annual rate review for qualifying IMD Participating Psychiatric Settings	BH-CONNECT / Medi-Cal Financing	**Critical**
4	Commit to implementing Community Transition In-Reach Services at API as a priority site during FY 2026–2029	BH-CONNECT / Care Transitions	**High**
5	Establish formal bidirectional ACT/FACT referral protocols with acute inpatient providers	Full Service Partnerships / ACT	**High**
6	Designate shared 72-hour post-discharge data protocol for IMD Participating Psychiatric Settings	BH-CONNECT / Quality Measures	**High**
7	Include transition/referral protocols between the SD County BH Wellness Campus and acute inpatient providers when the campus opens	Care Continuum / Capital Projects	**Moderate**
8	Recognize AB 116 psychiatric nurse mandate as a county workforce crisis and include HCAI BH-CONNECT bonus program outreach in workforce strategy	Workforce Strategy	**High**

Closing Statement

API submits these comments as a committed partner in San Diego County's behavioral health system. We share the County's goals of expanding access, improving outcomes, reducing health disparities, and building a continuum of care that serves our region's most vulnerable residents. The requests we have made are not requests for special treatment, they are requests for a plan that accurately reflects the financial and operational realities of providing acute psychiatric care in 2026 and beyond, and that formalizes the partnership obligations that already exist under BH-CONNECT.

We strongly support Director Privara Brahms's vision of a plan that "supports access to care and addresses community needs." For the 22,000+ patient days of acute psychiatric care API provides annually, almost entirely to Medi-Cal members with Serious Mental Illness, access to care and community need are not abstractions. They are the daily work of our clinical team.

We respectfully request an opportunity to present these comments in person at the May 7, 2026 public hearing before the Behavioral Health Advisory Board, and to schedule a follow-up meeting with your office to discuss implementation of the requested plan language.

Thank you for the opportunity to contribute to this important process. We look forward to serving as an active partner as San Diego County implements the BHSA Integrated Plan beginning July 1, 2026.

Respectfully submitted,

Patrick Ziemer
Chief Executive Officer
pziemer@apibhs.com | (619) 667-6031

San Diego County BHSA Integrated Plan Draft for 2026–2029
Feedback on behalf of Alcohol and Drug Service Provider Association (ADSPA)

On behalf of ADSPA and our numerous member organizations who provide substance use disorder services in partnership with the County of San Diego, we appreciate the opportunity to provide comments on the San Diego 2026–2029 Draft BHSA Integrated Plan. We commend the County's efforts to develop a comprehensive framework to guide behavioral health services; however, we have identified several areas that require clarification, reconciliation, and further development to ensure successful implementation.

1. **Data Accuracy and Consistency**
   Across multiple sections of the Plan, there are notable discrepancies in reported data that warrant clarification. For example, the Plan indicates that over 1,000 individuals under age 21 received DMC-ODS services, which appears inconsistent with the Optimal Care Pathways presentation (791 individuals). Similarly, reported unsheltered homelessness figures (15,233) differ significantly from the Regional Task Force Point-in-Time (PIT) count (approximately 10,000). These inconsistencies raise concerns regarding data sources, methodology, and whether figures represent unduplicated individuals or service encounters. Given that these data inform program planning and funding decisions, reconciliation and transparency are critical.

2. **Clarity on Service Settings and Scope**
   The Plan does not clearly define which service settings are included in utilization figures. It is unclear whether counts include services delivered across outpatient, school-based, justice-involved, or community-based settings. Greater specificity is needed to accurately interpret service capacity and system reach.

3. **Target Population Definition and Older Adult Services**
   The Plan frequently references services for individuals over age 65; however, providers report significant barriers to serving this population due to Medi-Medi billing constraints. Clarification is needed regarding Behavioral Health Services' (BHS) definition of the target population and the scope of reimbursable services for older adults, particularly given that Medicare does not cover many of these services. Additionally, the Plan reports that 5,752 individuals over 65 are receiving services; it is unclear how these services are being delivered in light of current billing challenges and recent guidance to transition individuals from Medi-Medi to straight Medi-Cal.

4. **Misalignment Between Reported Conditions and Provider Experience**
   In several instances, the Plan indicates that there are no implementation challenges; however, this does not align with provider experience. Significant challenges remain, including:

- Limited interoperability and ongoing delays in achieving meaningful data exchange across electronic health record systems
- Barriers to effective care coordination, including implementation of Enhanced Care Management (ECM) and Individual Placement and Support (IPS)
- Challenges with MCP collaboration, data sharing, and MC3 file exchange
- Closure or transition of key programs, including population-specific ACT services and Clubhouse programs

A more accurate representation of these challenges is necessary to ensure appropriate planning and resource allocation.

5. **Implementation Feasibility and Operational Detail**

   The Plan outlines several new initiatives but lacks sufficient operational detail regarding implementation. This includes:

   - Assertive field-based SUD treatment services
   - Outreach reimbursement methodologies and data tracking mechanisms
   - Housing navigation processes and Coordinated Entry System requirements
   - Expectations for providers following July 1, 2026

   Without clear guidance, providers may face difficulties operationalizing these initiatives.

6. **Program Reductions and Funding Transitions**

   The Plan indicates that several programs are being sunsetted or transitioned to Medi-Cal funding; however, it does not clearly identify which services will be discontinued or how service gaps will be addressed. For example, early intervention programs and certain community-based services appear to be reduced without a clear transition plan. This raises concerns about continuity of care and access to services.

7. **Workforce Development and Administrative Burden**

   The Plan does not sufficiently address workforce capacity or administrative burden. The reduction in centralized training resources, particularly following the non-procurement of the RISE contract, has limited provider access to training. While Medi-Cal training and technical assistance are mentioned, it is unclear how these resources will support specialty behavioral health providers, particularly in the SUD system. Additionally, stakeholder-developed recommendations regarding administrative relief are not reflected in the Plan.

8. **Housing and Homelessness Strategy**

   There are concerns regarding the accuracy of housing projections and the alignment with Coordinated Entry System processes. It is unclear how outpatient providers will be expected to verify homelessness status and whether current housing inventory estimates accurately reflect system capacity. Furthermore, there appears to be limited collaboration with major cities on housing solutions, representing a missed opportunity for system-level impact.

9. **Alignment of Priorities and Investments**
   The Plan identifies social connection as a key priority; however, providers note that more urgent issues—such as overdose prevention, suicide, and co-occurring physical health conditions—may warrant greater emphasis. Additionally, programs that directly address social isolation among older adults are being sunsetted, which appears inconsistent with the stated priority. Clarification is needed regarding how funding decisions align with identified community needs.

10. **Limited Engagement in New State Initiatives**
    The Plan indicates that the County is opting out of several state-recommended initiatives. This raises concerns regarding missed opportunities for innovation, technical assistance, and cross-system collaboration.

11. **Budget and Investment Trends**
    The budget section raises questions regarding projected service levels and declining investment over time. For example, the projected number of adults served in housing programs appears low relative to need. Clarification is needed to ensure that funding levels align with population needs and system goals.

Conclusion

While the Plan provides a broad framework for behavioral health service delivery, it would benefit from greater clarity, transparency, and alignment with provider experience. Addressing the issues outlined above will be critical to ensure that the Plan is both actionable and responsive to community needs.

We appreciate your consideration of these comments and welcome the opportunity to engage further to support successful implementation.

Sincerely,

Marisa Varond, Chair
ADSPA

Enclosure: 2026-2029 Integrated Plan – ADSPA Ad Hoc Detailed Meeting Notes

San Diego 2026-2029 BHSA Integrated Plan

ADSPA Ad Hoc Detailed Meeting Notes

The following feedback was collected during an Ad Hoc Meeting convened by ADSPA on April 2, 2026 for the purposes of the reviewing the 2026 - 2029 Integrated Plan. In addition to the comments collected from 42 participants, it also incorporates written feedback submitted by ADSPA member organizations that provide substance use disorder services in partnership with BHS.

Page 6: County Behavioral Health System Overview and Population Served

The plan indicates that over 1,000 individuals under the age of 21 received DMC-ODS services, which seems shockingly high and actually contradicts the Optimal Care Pathways presentation data (791 individuals). In what other settings is the County referring to services that will be provided?

Page 8

The County references services for individuals over 65 years old throughout the document. However, providers find it discouraging to serve this population due to Medi-Medi billing issues. Providers need policy clarification regarding BHS's definition of the target population and what can be provided to clients over the age of 65, even given that Medicare never covers services. How are these 5,752 individuals receiving services, given the issues with Medi-Medi and the latest instructions to transition these individuals from Medi-Medi to straight Medi-Cal?

Page 9-10

Homeless statistics need clarification. Unsheltered homeless data does not align with the Regional Task Force point-in-time (PIT) count (BHSA reports 15,233 vs. > 10,000 in PIT). The unsheltered data is very different as well. Relevant because programs will be built based on those statistics. Maybe everyone on the PIT count did not receive services?

Page 12: County Behavioral Health Technical Infrastructure

The County reports having no implementation challenges or concerns around inoperability. That seems curious based on the delays. BHS recently reported that they are working toward participating in the HIE and that they are years away from meaningful interoperability with other EHRs.

Page 17

The County reports experiencing no implementation challenges regarding the requirements under the DMC-ODS program. Currently, there are challenges, including population-specific ACT, Clubhouses programs closing, and operationalization and enforcement of care coordination concepts (i.e., Enhanced Care Management (ECM) services, Individual Placement & Support). MCP collaboration and data exchange: Inaccurate representation. Challenges also remain with MC3 file sharing post-SC implementation.

Page 20: Population-Level Behavioral Health Measures

Overall, the plan appears to address lower-hanging issues, and there may be missed opportunities for population needs assessment and collaborating with other cities for innovative housing interventions. Currently, there is minimal collaboration with the five most populous cities on housing. Does not "Adequately fund contracts to ensure that non-county contracted providers are resourced to achieve the behavioral health goals outlined in their contract for the purposes of meeting statewide metrics."

The County may be overstating the status of critical opportunities (i.e., assertive field-based interventions, same-day access to MAT). Answering "no" to questions about implementation challenges, missed opportunities for community engagement, real problem-solving, TA from the state, and collaboration to resolve challenges.

Page 44-49

The State is asking the County to commit to new bodies of work. The county is opting out of most of them.

Page 50: Statewide Population Behavioral Health Goals

Providers are surprised that the County reported that social connection consistently emerged as a top priority for community members at the community engagement listening sessions. Providers believe there are other priority areas to address, such as suicide, overdose, co-occurring physical health conditions over social connection. The County is highlighting social connection to address depression and social isolation of home-bound seniors; However, the County is sunsetting programs that support these issues, such as UPAC's Elder Multicultural Access and Support Services (EMASS). It appears that the County's priority of social connection is in direct contradiction to sunsetting these programs. What programs has the County already removed that actually address these goals? Why are these programs being sunsetted?

Page 84: Medi-Cal Managed Care Plan (MCP) Community Reinvestment

There may be a meaningful opportunity for the joint advocacy between the County and providers regarding how the Medi-Cal Managed Care Plan (MCP) Community reinvestment dollars will be redeployed in the San Diego community.

Page 95: Behavioral Health Services and Supports (BHSS) – Specific Services Selected.

- Children's System of Care (non-Full Service Partnership) (FSP)
- Outreach and Engagement (O&E)
- Workforce Education and Training (WET)
- Adult and Older Adult System of Care (non-FSP)
- Early Intervention Programs (EIP)

What has the County not included in the Integrated Plan?

The County is sunsetting quite a few programs or transitioning them to Medi-Cal funding. For instance, on page 122, the Incredible Families program is included; however, the RFP has been switched to Medi-Cal funding. If the funding were covered under BHSA, Vista Hill would have bid on that.

Page 99: Full-Service Partnerships

There is no mention of planning any specific work surrounding the primary SUD population.

Page 101: Early Intervention (EI) Programs

The Integrated Plan fails to mention what will no longer be funded and how these gaps will be picked up by remaining programs. For instance, early intervention programs are sunsetting, so how will these services be provided? There seems to be more mental health services mentioned than SUD services.

Page 138-139: Workforce Education and Training (WET)

It appears the County is not moving to restore any centralized training resources. Since the non-procurement of the RISE (Academy for Professional Excellence) contract provider training opportunities have decreased significantly. There is mention of the board- directed Medi-Cal training and technical assistance to community-based organizations, which ADSPA has strongly advocated; however, it's concerning that these resources will be directed to the mild to moderate behavioral health supports and non-specialty systems. These resources should be directed toward specialty services (i.e., SUD) to maximize revenue and support sustainability.

Toward the end of the document, the County's goals include an increase in the percentage of people who receive at least one peer support service. How will providers meet the County's goals if the TA assistance is not available? Will this be measured in the QAPR?

Page 148: Full-Service Partnership Program

ACT and FACT practitioners will also be responsible for providing FSP intensive case management, even though the current procurements are completely divorcing these services. Mental health providers have historically relied on co-location for efficiencies, but now BHSA is requiring that there be separate programs.

The plan mentions SmartCare's wonderful capabilities in improving data consistency, billing accuracy, and outcome tracking. However, there are no outcome tracking reports available in SmartCare. Currently, providers must track outcomes internally, which is increasing the administrative burden. There needs to be CalOMS and other outcome reports in SmartCare.

Page 149

It appears the County is not making any investment in additional engagement and/or outreach services.

Page 155: New Programs for Assertive Field-Based SUD Treatment Services

The County reports that BHSA will reimburse targeted outreach and include data tracking. How do they plan to do this? Currently, there is no explanation regarding how this will be accomplished. How do they plan on achieving this? Is it being addressed through the Assertive field-based intervention?

Page 156

The plan speaks to the importance of targeted work to address disparities and population-specific interventions. However, it appears that services are moving toward a more generalized population. Population-specific interventions are being chipped away at despite BHSA goals to focus on disparities and these types of interventions (i.e., LGBTQ, justice-involved, seniors, ACT).

Page 160: Housing Interventions – System Gap

Has the County used all the definitions available to them from the State?

Outpatient providers will be verifying homeless status through the coordinated entry system. Will this be a requirement for outpatient providers? How will this roll out?

Does the COC inventory count match the County's answers? ADSPA is concerned that the County is reporting more housing availability than we actually have.

Page 162

The plan does not acknowledge the method to assess the homelessness (risk) status via the Coordinated Entry System.

Page 174

"To support the Transitional Rent referral process, individuals will need to have a Housing Support Plan in place, which will be developed by a Housing Transition Navigation Services (HTNS) Community Support provider. The HTNS provider will confirm BHSA eligibility and, if not already in place, work with the individual's program to refer to housing-related Community Supports. If an individual is not connected to a BHS-funded program, they will need to be referred to an outpatient clinic for assessment and program referral."

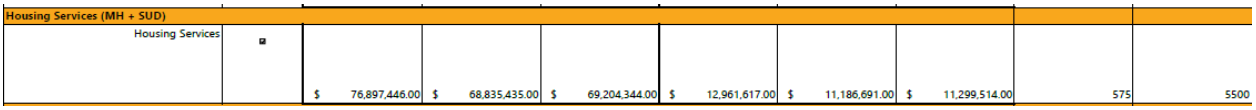
Is this the expectation after July 1, 2026?

Page 425: Behavioral Workforce Retention

The plan talks about pursuing administrative relief opportunities. How are we going to reduce the administrative burden? ADSPA convened a few stakeholders and representatives and spearheaded Figure A5 regarding administrative relief and provided the County with 29 specific recommendations. Figure A5 is missing from the plan and should be added for state visibility. Microsoft Word - FINAL - SD Behavioral Health Workforce Report .docx

Page 486: BHSA Budget Template - Housing (Mental Health & SUD)

The budget reports that 575 Adult/Older Adults are projected to be served annually. The number seems incredibly low. Was this figure accidentally swapped with the number of youth (5,500)?



Housing Services (MH + SUD)									
Housing Services		$ 76,897,446.00	$ 68,835,435.00	$ 69,204,344.00	$ 12,961,617.00	$ 11,186,691.00	$ 11,299,514.00	575	5500

The budget reflects a decrease in investment over time. Why are the amounts of investment decreasing in many of these areas over time?

In the back of the document, the BHAB Pathways to Continuum of Care listening sessions report that the SUD treatment system is fragmented and lacks coordination between providers. As an organization, ADSPA feels that we do an excellent job of coordinating across providers and working well together.

JFS Comments on San Diego County's DRAFT 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan

Thank you for the opportunity to comment on San Diego County's draft 2026–2029 BHSA Integrated Plan. We appreciate the significant effort the County has undertaken to align with the new BHSA framework, including providing engagement opportunities for agencies providing services to the community. The comments below are offered to strengthen the Plan's alignment with BHSA's intent and to support those we serve and create long-term system sustainability.

Plan Organization & Language

While we recognize that the Plan follows a State required template, the document is difficult to navigate and relies heavily on technical language. This limits its accessibility and makes it challenging for readers to clearly understand the County's core strategies for improving access to behavioral health services and addressing community needs.

Preserving the Balance Between Prevention, Early Intervention, and Crisis Response

BHSA establishes Early Intervention (EI) as a core component of Behavioral Health Services and Supports, with the explicit goal of stopping mental health conditions and substance use disorders from becoming severe and disabling. The draft Plan demonstrates a strong commitment to crisis response, stabilization, and outpatient treatment services, all of which are essential elements of the behavioral health continuum.

At the same time, the current Early Intervention portfolio appears heavily weighted toward crisis diversion and early treatment rather than upstream prevention and indicated prevention. While these services can reduce repeat hospitalization and acute utilization, they often engage individuals after acuity has already emerged.

BHSA's updated definition of Early Intervention explicitly includes direct services for children and youth who are at risk of developing behavioral health conditions but are not yet displaying symptoms, often referred to as indicated prevention under WIC 5840. Counties are not required to eliminate programs previously categorized as prevention. This means that Counties have the ability to translate many prevention-oriented models into Early Intervention.

Maintaining space for lower-acuity, prevention-oriented EI is critical. These services are typically less expensive, time-limited, and essential to preventing later reliance on higher-cost crisis, inpatient, and justice-involved systems. If preventive early intervention is limited, demand will shift toward more expensive downstream services, such as crisis response.

We encourage the County to continue to find opportunities to create more balance by providing upstream early intervention with necessary crisis and treatment investments.

Early Intervention for Children, Youth, and Young Adults

We recognize and support that there is a focus in the Draft on children, youth, and young adults, consistent with BHSA's requirement that a majority of Early Intervention funding be directed to individuals 25 and under. The Plan includes youth-focused programming, particularly through school-based and outpatient models.

However, many of the youth Early Intervention programs described primarily serve children and young people who are already experiencing high levels of acuity, have been identified as seriously emotionally disturbed, or are already involved in child welfare, crisis stabilization, or hospitalization. The Draft has less programs clearly designed to engage children and youth earlier, before challenges escalate to severe mental illness, school failure, homelessness, justice involvement, or family separation.

Early childhood represents a critical developmental window where timely intervention can alter long term trajectories and BHSA allows counties to serve all eligible children and youth, including those who are not yet symptomatic but are at risk due to trauma, adversity, or environmental stressors, as outlined in WIC 5892. Children ages 0–5 are explicitly identified as a priority population and must be included in Early Intervention spending plans. This can include programming that gives parents the tools and resources to support their children.

We ask the County to identify and create more opportunities for EI investments that will reach children, youth, and their parents/caregivers, earlier in the risk trajectory. Such services help reduce more severe outcomes later.

School-Based Services and the Role of Medi-Cal

We saw that the Draft Plan and BHS's Youth Optimal Care Pathways (OCP) analysis both have a strong focus on schools as an access point for youth behavioral health services. We support this focus as an important strategy for early identification and engagement, particularly given the amount of time children and youth spend in school settings.

However, it is important to recognize that not all children, youth, and families experience schools as a trusted or safe space for accessing services. This is especially true when services are structured as clinical treatment and request or at least are advertised as needing documentation. For some communities, including immigrant families, mixed-status households, and LGBTQ+ youth, requests

for documentation can create barriers to enrollment. Additionally, some youth prefer to receive services outside of school settings due to stigma, privacy and scheduling needs.

We encourage the County to continue partnership with trusted community-based organizations, cultural practitioners, and non-clinical providers. These partners are often better positioned to engage youth and families earlier, before conditions escalate, and to build trust outside of formal educational settings.

Community-Centered and Culturally Responsive Approaches

We appreciate the Draft Plan's stated commitments to equity, cultural responsiveness, and community engagement. It is also important to provide Early Intervention services that reflect the ways communities define wellness and healing. Many communities may not relate to traditional clinical interventions. Expanding the use of community-defined practices, group-based supports, culturally rooted providers, and partnerships with schools, nonprofits, and other trusted community spaces would strengthen Early Intervention's reach and effectiveness.

Recommended community centered interventions can include:

- Diverse providers speaking multiple languages, including regional dialects.
- Increased training of community members with the cultural competency, and trauma informed care.
- Working with cultural and religious practitioners, including spiritual faith leaders, curanderismo, and leaders of healing circles.
- Services provided by community health partners.
- Services provided by community-based organizations, including ones that partner with local community groups, parenting groups, etc.
- Services by trusted community partners, especially in the immigrant community and those with mixed status households.
- Non-traditional healing practices, such as community gardening, walking groups/incorporation of physical movement, community healing circles

Homelessness

We support the Plan's focus on housing centered interventions paired with behavioral health services and encourage the County to further strengthen these strategies by centering prevention for communities experiencing the greatest disparities. Direct cash assistance for transition age youth (ages 18–24), when paired with connections to concrete supports, can help young people stabilize housing, meet basic needs, and invest in education or training.

As the County expands housing centered initiatives, it will be important to prioritize training for care providers to support trauma-informed and culturally responsive engagement. Behavioral health and resource services should also be accessible on site, and staff should have balanced caseloads to increase engagement outcomes and reduce staff burnout.

Justice Involvement

We support the Plan's emphasis on community-based behavioral health treatment, care coordination, and housing for individuals impacted by the justice system. In addition to these supports, direct cash assistance can help individuals stabilize their lives, plan for the future, and reduce recidivism. When combined with care navigation and trusted community-based partners, financial supports can serve as an engagement tool that helps individuals address immediate needs while working toward longer-term goals for stability.

County's Child and Family Well-Being department

We encourage the County to more explicitly incorporate poverty-focused prevention strategies into its child welfare-related investments. Neglect is often closely tied to family poverty, rather than intentional harm, and financial instability is a significant driver of child welfare involvement and family separation.

Financial supports, including direct cash assistance, can function as effective prevention tools by reducing parental stress, strengthening family stability, and increasing families' ability to meet basic needs such as housing, food, and childcare. Research shows that improving income stability is associated with reduced child welfare involvement. Integrating financial supports as part of a broader approach that includes goal setting and case management would help reduce unnecessary family separations and better align with BHSA's prevention and equity goals.

This is particularly important for former foster youth, who experience some of the poorest outcomes of any subpopulation, including disproportionately high rates of homelessness, behavioral health needs, justice involvement, and economic instability. While the Draft Plan references child-welfare-involved populations, former foster youth are not consistently elevated as a distinct priority subgroup.

Explicitly naming former foster youth as a priority population and ensuring access to prevention-oriented, stabilizing supports earlier would improve outcomes and further align the Plan with BHSA's goals.

Parenting Education and Caregiver Support

After reviewing the Plan, we were concerned to see that parenting education is not explicitly included, particularly given the Plan's focus on youth justice involvement and the removal of children from the home. While there are some direct services, addressing youth behavioral health needs without also supporting parents and caregivers overlooks a critical part of what young people

experience in their homes and caregiving environments. The roots of many adolescent mental health crises can be traced back to early childhood. Therefore, support for parents and caregivers it not just supplemental to treatment, but foundational.

Parents and caregivers, especially those with limited resources, often lack access to education and support related to self-regulation, stress management, and responding to challenging behaviors. Without these supports, families are left without tools that are proven to strengthen caregiver-child relationships, reduce escalation within the home, and prevent both child welfare involvement and youth justice system contact.

In conversations with community partners following recent program changes, we also heard concerns from Head Start and Early Childhood Education providers. These sites have state requirements related to parenting education, and without dedicated parenting education programs, there is now a gap in available services to help them meet those requirements. This creates challenges for early learning providers and weakens prevention efforts during a critical developmental window.

Childcare providers are increasingly recognized as children's earliest teachers rather than simply caregivers. The County should explore opportunities to train childcare providers on recognizing behaviors that may indicate family destabilization, trauma, or abuse, as well as understanding how to respond and report concerns appropriately.

We encourage the County to consider parenting education and caregiver-focused supports as core strategies that complement youth-serving interventions and align with BHSA's goals around prevention, family stability, and reduced system involvement.

Identification of Specific Priority Populations

We appreciate that the Plan recognizes disparities among transition-age youth. Above we mentioned elevating former foster youth as a distinct priority population. We also see the importance in identifying homeless veterans as a specific subset of homeless adults. Calling these populations out directly in the Plan would support more targeted early intervention, housing, and transition-age strategies and better align with the County's stated goals around equity, prevention, and accountability.

Cross-Sector Collaboration, Philanthropy

The Draft plan acknowledges that the needs of those served by the behavioral health system are complex and require layers of cross-sector collaboration. While the Plan references partners, particularly schools, it does not describe the deeper coalition building, coordination and partnership needed to create meaningful change. This also includes partnership with private philanthropy and the role they play in the local behavioral health ecosystem.

The Draft references the inability to identify some data points related to youth and also adults at risk of homelessness. There are non-profit community partners who work to identify and provide cash,

support, rental subsidies, and other services as part of homelessness diversion programs. This is a prime opportunity for providing behavioral health support to County residents during these challenging times.

We request the County consider ways for further collaboration with private philanthropy and community-based organizations to better serve the community and help bridge gaps in data and funding.

Closing

We are grateful for the opportunity to comment on the Draft BHSA Integrated Plan. We encourage the County to further strengthen the Draft Plan by explicitly preserving meaningful space for preventive and indicated-prevention Early Intervention alongside crisis and treatment services. The right balance across the continuum of care is crucial to prevent higher-cost crises later.

MAY 7, 2026
BEHAVIORAL HEALTH ADVISORY BOARD (BHAB) ACTION ITEM
APPROVE BHAB RECOMMENDATIONS TO THE DEPARTMENT REGARDING THE DRAFT BHSA INTEGRATED PLAN FOLLOWING THE PUBLIC HEARING

To: San Diego County Behavioral Health Services (BHS) and Board of Supervisors (BOS)
From: Behavioral Health Advisory Board (BHAB)
Date: May 7, 2026
Subject: BHAB Feedback on the Draft 2026–2029 BHSA Integrated Plan

This memo provides BHAB's high-level feedback on the draft 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan (IP). It is meant to accompany the detailed comments submitted by Board members and community stakeholders and to highlight the key issues that should be addressed before adoption.

The IP reflects significant work and includes several important investments. At the same time, it was difficult for both Board members and the community to fully engage with the document. Parts of the Plan are hard to follow, the page numbers were not visible, and some sections are marked "not applicable" without explanation, and it is not always clear what is actually changing as a result of this Plan. While stakeholder feedback is summarized, the connection between the feedback and the proposed solutions is unclear.

More importantly, the IP does not yet show how the system will work differently for the people who rely on it the most, especially those who move between crisis services, homelessness, and the justice system.

Across stakeholder input, the same concerns came up repeatedly. People described weak follow-through as they move between programs and systems, a lack of accountability for whether services are actually helping, and a disconnect between the problems identified in the Plan and the solutions that are proposed. There is also a lack of clarity around how major changes, including Enhanced Care Management (ECM) and BHSA, will work in practice.
Taken together, these concerns point to a larger issue: there is no clear way to understand whether people are doing better over time. The Plan does not explain how outcomes will be tracked across crisis services, custody, housing, and ongoing care. This makes it difficult to know whether the system is improving or just continuing to operate as it does today.

The Plan does a strong job identifying disparities across age, race and ethnicity, and language. However, the responses to those disparities are often general and not clearly tied back to what

was identified. There needs to be a more direct connection between the disparities described and the actions the County plans to take, including specific approaches to language access and culturally appropriate care.

The IP also does not fully address behavioral health care in custody or what happens when people leave jail and return to the community. This includes both the quality of care provided while in custody and the lack of clear transitions back into community-based treatment. Without stronger connections between these parts of the system, people will continue to cycle through the same patterns the Plan is trying to change.

Care coordination is another area that needs more clarity. The Plan relies heavily on models like ECM, but feedback from providers and community members suggests that these services are inconsistent and often not enough for people with serious mental illness. It is not clear what level of support individuals can expect or how coordination will work between County services and managed care.

Early intervention is mentioned but not clearly developed as a strategy. Recent changes to contracts and programs raise questions about whether the system has lost capacity in areas that were previously supported through grants. The Plan should more clearly describe how individuals who are not currently engaged in care will be identified and supported earlier. This includes expanding field-based outreach and engagement, particularly for individuals experiencing homelessness with serious mental illness or substance use disorders. The Plan should also consider how voluntary, field-based treatment can be used more consistently, and where appropriate, how existing authorities can support earlier intervention before individuals cycle into crisis, hospitalization, or the justice system.

Finally, while the IP includes summaries of stakeholder input, it does not clearly show how that input changed the Plan. There should be a more direct connection between what was heard from the community and what is being proposed, as well as a clear plan for continuing to gather and use feedback during implementation.

The IP sets a direction, but it does not yet provide enough clarity on how outcomes will improve for the people most affected by the system. These issues should be addressed before adoption or clearly incorporated into implementation moving forward.

Addressing the comments summarized above and in their raw form below will make the Plan more practical and increase the likelihood that these investments lead to real improvements in access, continuity, and outcomes. BHAB will continue to stay engaged as implementation moves forward.

Thank you,

San Diego County Behavioral Health Advisory Board

BHAB Member 1 Comments:

The following comments have estimated page numbers, however since the draft IP does not contain page numbers these numbers may be approximal rather than specific.

These comments were generated after 60 hours of exposure to and personal interviews of dozens of stakeholders including practitioners, family members, crisis team members and first responders whose lives are devoted to helping the targeted care population specified in Prop 1 and BHSA, including my own personal study of Prop 1, BHSA and studying the entire 500 page draft IP, and my involvement in our Ad Hoc BHSA Subcommittee composed of 4 BHAB members, 4 staff members and 4 community members. It is my belief that these comments, if included in the BHS IP will serve as a written guide to BHS in our common pursuit of reaching these specified unreached or under reached people suffering with SMI and/or SUDs for the next three years. Robert Alm.

Please add these comments:

Into pages 29, 43,164 and 176: The county will study the homeless population to determine the percentage experiencing an SMI or SUD. The county will consider the use of outpatient field teams to treat this population, voluntarily, in the field.

Into page 30: The county will pursue outpatient conservatorships when the level of care allows.

Into page 34: Utilize electronic medical record sharing to facilitate voluntary and involuntary administration of medication as soon as possible in the hold sequences.

Into page 34: The county will support and encourage the crisis response teams of the cities within the county. The county will grant authority to these crisis response teams to initiate 5150 holds.

Into page 37: Look for and implement field-based programs to identify gravely disabled or SUD people and pursue voluntary administration of medication in the field, and possibly involuntary administration of medication in the field within the guidance of the law and ethical medical practices. Our goal is to identify and treat the gravely disabled homeless people before they are arrested thus reducing all upstream numbers of justice involved individuals.

Into pages 101-130 as is appropriate under Early Intervention (EI): Early intervention strategies will include efforts to identify gravely disabled people who are experiencing homelessness, pursue voluntary field treatment, or involuntary treatment if necessary. This would reduce all upstream numbers of justice involved, experiencing or at risk of experiencing homelessness, non-competent to stand trial people sent to a state mental hospital, and in justice involved reentry numbers.

Into page 43: Broaden the use of the term “Any Person” under WIC 5201 to allow more and easier access to help through mandated Evaluations of people suffering with a mental disorder.

BHAB Member 2 Comments:
Below is feedback regarding the IP. For context, this information has been gathered through a combination of two listening sessions hosted by the county for people with lived experience as consumers of San Diego county behavioral health services, conversation with colleagues and my own experiences working in strengths-based behavioral case management for low income older adults living with SMI, conversations with administrators at my program, and my own lived experience as a consumer and family member. I appreciate you both taking the time to review and consolidate information on behalf of the board.

- Intensive Out-Patient Programs (IOP) - IOPs are an incredible resource for people living with SMI, particularly after hospitalization while transitioning back into the community. Some San Deigo county examples include Sharp Mesa-Vista, Alvardo Parkway Institute, and Sharp Grossmont. However, Medi-Cal does not currently cover these programs (at least as it relates to mental health, there may be SUD IOP programs Medi-Cal covers). I heard from many community members the value IOP had for them and also heard about the difficulty accessing these services. I've seen older adults in my program benefit tremendously from these programs when they've been able to access them through Medicare, but there are not options for these services for our members that are not yet eligible for Medicare. I can also speak from personal experience for the value of these programs in providing support and reducing re-hospitalization having been a part of an IOP program as a consumer

- Enhanced Care Management (ECM) - The county has been increasingly been encouraging the use of ECMs. While the concept of ECM is wonderful, in practice, it is currently not meeting the needs of many people living with SMI. ECMs, in my experience, largely are able to schedule appointments and help setup transportation, but they do not attend or go into appointments with their clients. This leads to people living with SMI not ever making it to appointments/feeling intimidated or unsure of what to do inside of appointments/leaving appointments without important information on next steps. Most ECMs have been very difficult to reach with any consistency, even during moments of urgency, both for the client and for other professionals trying to coordinate. And many ECMs do not have extensive experience working with/knowledge around SMI. My program has been repeatedly encouraged to use ECMs for our members' physical health needs, but attempts to do so have been largely ineffective

- Desire For More Support to be Successful in the Community - Many people expressed feeling as though they were left to fend for themselves after hospitalization. Being told to schedule follow-up appointments, but essentially feeling left alone. People described the value of "having a hand to hold" as they navigate returning to the community. This could be field based FSPs, peer support, or an area where IOP would be valuable. Peer

involvement at each step of the recovery process was requested. I believe this also aligns with what ECM would look like if it were functioning ideally

- Lack of Board and Cares for Low-Income Individuals, Lack of Support at ILFs - My program supports members at many board and cares and ILFs. The lack of board and cares for low-income people is a consistent issue to providing safety when members leave the hospital. Many board and cares cost upwards of $3,000 a month for a shared room, something completely outside the means of members of our program/people on Medi-Cal as a whole (Medi-Cal's income limit is generally around $1,900 per month). Most of the members of my program live on Supplemental Security Insurance (SSI), which is generally about $1,200 per month. A person on SSI cannot have more than $2,000 of total assets to receive these benefits. Some board and cares have an "SSI rate" where they will charge roughly $1,300 a month for a shared room. SSI adjusts the total SSI received by such a person to roughly $1,400 per month, leaving about $100 total per month for a person living in a board and care after their rent in covered. Most board and cares do not have this type of accommodation. This leads to our members often being discharged unsafely to an ILF after hospitalization due to lack of supportive housing options, despite advocacy from my program that a member needs a higher level of care. ILFs, as they are currently, have very little (if any) support for people living with SMI, and in many situations can be a trigger. The biggest issue is only board and cares and levels of care higher than that can assist people with medications

- Lack of Engagement Activities at Board and Cares - Most board and cares have few, if any, activities for residents. Most people living in board and cares have limited ability to leave the facility, and it's very damaging to one's mental health essentially being in one place every day with the only activity available being watching TV. People request more games, arts and crafts, exercise programs, and ways to have community outings

- Lack of Support, Grocery Stores, Community Resources Near Low-Income Housing - Many board and cares, ILFs, and SROs are located in areas where grocery stores, parks, and other positive community resources are not easily accessible. Particularly for the older adult population I work with, if the nearest bus stop is a mile away, it is unreachable given limited mobility. In addition, many people with SMI struggle to use the bus and are at increased risk of victimization on public transportation. This leads to many of our members to lean on nearby liquor stores/smoke shops that deplete their already limited funds, are risks for triggering unhealthy coping skills like alcohol use, and usually result in less healthy options for food/drinks. It also leads to lack of community integration

- Trauma Inflicted by the System - I heard from many people in listening sessions, from members of my program, and have experienced personally trauma from the behavioral health system. This trauma largely relates to forced treatment, restraints, and seclusion. When a system that is meant to help people in crisis is responsible for trauma, it is extremely hard to rebuild trust and engage in a positive way with the system. It becomes

an enormous barrier to recovery. I strongly encourage forced treatment, restraints, and seclusion being a truly last resort in situations that are immediate safety risks. This is not currently the case

- Lack of Clarity, Guidelines, Standardization - Many changes are coming or starting to take effect, and there's a lack of information around how they are meant to be/going to be implemented. For example, my program will be transitioning to a level 2 FSP in less than 3 months. My administrators are currently trying to design a program without specifics even as basic on what our staffing level will be and what positions we are able to have at the program (will we have a housing coordinator, intake specialist, etc). There is meant to be housing assistance available now through Medi-Cal, but in speaking with Medi-Cal representatives, we have largely been told they are unfamiliar with this program or don't know who to connect us to to obtain this support. Changes to Medi-Cal and SNAP currently lack details on what will qualify a person for an exemption to things like work requirements and how this will be verified. This uncertainty is difficult for staff, but it is extremely challenging for our members living with SMI and has frequently led to exacerbated symptoms when access to housing and benefits are seemingly at risk

- Lack of Options for People Losing Medi-Cal/SNAP - It appears there are few resources available for people living with SMI that may lose access to coverage through Medi-Cal. FQHCs, while extremely valuable, are not currently setup to treat SMI. How will people living with SMI that are, for instance, victims of human trafficking set to lose access to benefits, receive the support they need? Food banks are already having difficulty meeting demand, how will low-income people that lose access to SNAP consistently meet their basic needs?

Thank you both for your time. I'm happy to provide additional detail on anything if it would be helpful,

BHAB Member 3 Comments:

- Accessibility of the document was horrible and a deterrent to actual feedback.
- Disparities in Access to Care for both older adults and youth, particularly for non-English language. The solution described is to, “To address these gaps, SDCBHS is expanding crisis and diversionary services that reduce barriers to entry and improve linkage to ongoing care.” (pg. 24). While adding additional entry points, the outlined solutions do not address the need for services in different languages.
- Why are the state measures starting on page 44 all “not applicable?”
- Page 84- The plan notes collaboration with Healthy San Diego. Which date of HSD was BHSA and the IP presented for engagement versus simply a report out that it was happening? The direct collaboration between the county BHP and MCPs should happen before guidance from the state.
- Page 88- care continuum section is “marked complete” but has no information.

- Page 92- only 17% of county contracted providers have contracts with MCPs- this seems very low and could contribute to breakdowns in transitions of care. How are the programs benefiting from ECM and CS investments (pg. 189) if they aren't contracted with MCPs?
- Early Intervention Programs- Why are many operating without using EBPs? Why were there no additional opportunities identified for EI?
- Page 192- good call out for what the community has been asking for. More of this and more specificity. "For the last three years, stakeholders have consistently identified the following areas as priorities for enhancement within San Diego County's continuum of care: Accessibility; Care Coordination and Navigation; Community Outreach and Education; Crisis Response Services; Culturally Appropriate and Affirming Care; Support for People Experiencing Homelessness; Services for Youth and Transition Age Youth(TAY); and Workforce Capacity and Diversity."
- Page 192 has a comment about the importance of ACEs, but there was a recently terminated contract for ACEs?
- In the community engagement summaries, there are really rich feedback reports, but I don't see that feedback directly incorporated into the plan itself or informing future work as it's currently outlined. Is there a way to include the voices of these stakeholders in a more meaningful way?
- Where is the UCSD CPP report?
- Page 310- the IHP feedback session has an inaccurate attendee list.
- Page 486- missing data in the far right columns.
- Can we see the breakdown in ages for adults/older adults instead of grouping them together?
- Early intervention and focus on youth is disproportionate to spending.

BHAB Member 4 Comments 3/30/26

Pg. 11, IP Section 34

- There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful.
- 3/30/26, 10:22 AM, Engage SD:

Pg. 11, IP Section 34

- The poor quality of behavioral health services in the County jails has been documented by the Grand Jury, the State legislature audit, the League of Women Voters, and many other entities. Deaths have occurred in custody as a result of the SDSO policies and procedures and the county has paid out upwards of $100 million in lawsuits in a 10 year period. The State must consider the quality of services as the incarcerated person re-enters the community as they likely will be more acute.

April 20, 2026

San Diego County Behavioral Health Services
Attn: Liberty Donnelly, BHSA Coordinator
3255 Camino del Rio South
San Diego, CA 92108

Re: Public Comment – San Diego County 2026–2029 Behavioral Health Services Act Integrated Plan

Dear Ms. Donnelly and the San Diego County Behavioral Health Services Department,

The San Diego Housing Commission (SDHC) supports the County of San Diego's 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan. SDHC commends San Diego County Behavioral Health Services (SDCBHS) for the depth and thoughtfulness of this Integrated Plan and the inclusive planning process through which it was developed.

SDHC appreciates the SDCBHS engaging with us as a stakeholder partner throughout the development of this plan. The recognition of SDHC's role as a Public Housing Agency (PHA) partner, co-developer of the Homekey+ property, and key participant in the County's housing and homelessness response system reflects the strong and productive working relationship our organizations have built over many years. We appreciate that the plan explicitly acknowledges the partnership between SDHC and SDCBHS as foundational to expanding permanent supportive housing and housing-linked services for individuals experiencing homelessness with behavioral health conditions.

SDHC notes the plan's Housing Interventions component, including the development of the Flexible Housing Pool (FHP) Pilot, the continued investment in Homekey developments, and the plan's commitment to aligning BHSA funding with CalAIM Community Supports and other federal and state resources. The County's commitment to building a continuum of housing options for BHSA-eligible individuals — from transitional rent and interim housing to permanent supportive housing — is consistent with SDHC's purpose — to provide stable, quality housing solutions so the community can thrive.

We look forward to continuing our collaborative work with SDCBHS as this plan is implemented, and to learning more about the allocation of these critical services, the associated allocation methodologies, system coordination and integration activities, and workforce development initiatives necessary to ensure the County maintains the personnel to fulfill the programmatic objectives outlined in the Integrated Plan. SDHC remains committed to serving as a housing resource and implementation partner, including through our current Homekey+ co-development effort and our broader work across the Continuum of Care. We are eager to see the strategies outlined in this plan translate into real, measurable outcomes for the individuals and families our organizations serve within the City of San Diego.

Thank you again for your partnership and for the opportunity to participate in this important planning process.

Respectfully,

Lisa Jones
President & CEO
San Diego Housing Commission

Response to the County of San Diego
Behavioral Health Services Act (BHSA) Integrated Plan
April 15, 2026

Introduction

On behalf of the Strategic Behavioral Health Initiative (SBHI), we appreciate the opportunity to provide input on the County of San Diego's Behavioral Health Services Act (BHSA) Integrated Plan.

SBHI is a cross-sector collaborative representing healthcare providers, schools, community-based organizations, workforce partners, and public agencies. Together, our partners engage with nearly all children and youth across San Diego County and bring direct insight into system demand, access barriers, and service gaps.

We share the County's goal of implementing BHSA successfully. This feedback is offered to strengthen alignment between the Integrated Plan, the statutory intent of BHSA, and the documented needs of children, youth, and families.

Below feedback is in line with the SBHI Youth OCP Recommendations submitted on March 24, 2026.

Executive Summary

A comprehensive review of the Integrated Plan, combined with SBHI stakeholder input, yields a consistent conclusion: children and youth behavioral health services remain underfunded relative to need, and current investment strategies risk reinforcing a reactive, adult-oriented system rather than advancing indicated prevention and early intervention.

Children and youth represent 37.7 percent of individuals served across the behavioral health continuum, yet receive only approximately 19% of total system spending, according to BHSA Integrated Plan Table 1 on page 486. At the same time, adult and older adult services receive approximately $1.05 billion annually compared to $257 million in year 1 for children and youth. However, when excluding SUD residential and housing services – given that there are no SUD residential programs serving under 18 in San Diego and housing services predominantly serve TAY and adults the adjusted funding more accurately reflecting services for children under age 18 is approximately $233,426,824 (17%) in Year 1 and $216,739,567 (16.7%) in Year 2.

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The proposed plan further exacerbates this imbalance by reducing children and youth funding by $17.2 million over the three-year period while increasing adult services funding by $10.1 million. Youth specialty mental health service penetration remains approximately 3.0 percent—below need and only marginally aligned with adult rates.

These conditions exist despite overwhelming evidence that behavioral health conditions begin early in life and that early intervention is the most clinically effective and cost-efficient approach. As a result, there is a clear misalignment between documented need and investment, between evidence and system design, and between the policy intent of BHSA and its local implementation.

BHSA and Implications for Children and Youth

The Behavioral Health Services Act represents a significant restructuring of California's behavioral health system, introducing changes that shift both funding structures and programmatic priorities. While BHSA requires that 51 percent of Behavioral Health Services and Supports (BHSS) Early Intervention funding be directed toward individuals ages 0–25, Early Intervention represents only a small portion of the overall funding framework. The remaining categories—particularly housing and Full Service Partnerships—are largely oriented toward adult-serving systems. The 51% was intentionally set as a "minimum" threshold, not a cap. The rationale for this requirement was clear in Proposition 1:

- To correct longstanding underinvestment in youth services
- To align funding with the fact that most behavioral health conditions begin before age 18
- To prioritize early identification and intervention, which yield the greatest clinical and fiscal impact
- To reduce long-term reliance on high-cost adult and crisis systems

Furthermore, a significant portion of programs that make up the 51% requirement for the Early Intervention category have utilization data showing that only individuals 18 and older are being served -- meaning the actual investment reaching younger children is even lower than the minimum.

Key Findings:

Structural Imbalance in Funding

Current spending patterns reflect a substantial and persistent imbalance in how resources are allocated across age groups. While children and youth account for more than one-third of individuals served, they receive less than one-fifth of total behavioral health spending. Adult and older adult services receive more than four times the level of investment, despite comparable levels of system utilization.

Importantly, total behavioral health expenditures exceed $1.58 billion annually, indicating that this imbalance is not the result of insufficient resources but rather a function of allocation priorities. The proposed plan further widens this gap by reducing funding for children and youth while increasing investments in adult services, reinforcing a system that prioritizes downstream care over early intervention.

Youth Are Underserved Relative to Need

The Youth Optimal Care Pathway identifies a goal of reaching the statewide penetration rate, which would require serving approximately 5,000 additional youth annually. However, available estimates suggest that up to 67,000 youth in San Diego County may require specialty mental health services.

This indicates that the current system is reaching only a fraction of those in need. Even achieving the statewide average would leave a substantial proportion of youth without access to care. Disparities are particularly pronounced among younger children, especially those ages 0–11, and among Hispanic and Asian/Pacific Islander youth. These patterns reflect systemic barriers to access rather than a lack of demand for services.

Misleading Signals from Penetration Rates

At first glance, youth and adult penetration rates appear similar, at approximately 3.0 percent and 3.2 percent respectively. However, this comparison does not reflect true parity. Given that behavioral health conditions emerge earlier in life, that children are more responsive to intervention, and that untreated conditions lead to significantly higher long-term costs, equivalent penetration rates actually indicate underinvestment in youth relative to need.

Rather than signaling equity, these figures suggest that the system is not reaching children early enough, when intervention is most effective and least costly.

System Design Remains Downstream and Crisis-Oriented

The current investment strategy continues to emphasize crisis stabilization, residential and inpatient care, and expansion of adult-serving systems. For children and youth, the plan highlights limited capacity, including a 16-bed crisis residential program, while offering relatively little investment in upstream access points such as schools, pediatric primary care, and community-based services.

This approach increases reliance on high-cost interventions, limits opportunities for early identification and treatment, and contradicts the County's own Youth Optimal Care Pathway, which emphasizes prevention and early intervention as central strategies.

Early Intervention Is at Risk of Narrow Interpretation

There is growing concern among stakeholders that BHSA is being implemented in a way that restricts the scope of Early Intervention services, reducing investment in prevention and limiting eligibility to individuals with diagnosable conditions.

However, state statute and guidance from the Department of Health Care Services clearly allow Early Intervention funding to support individuals at risk of developing behavioral health conditions, including indicated prevention services that do not require a formal diagnosis. A narrow interpretation of risks excluding younger children, delaying access to care, and shifting demand toward crisis services—ultimately undermining the intent of BHSA.

Early Childhood (Ages 0–5) Remains Underprioritized

Children ages 0–5 are explicitly identified as a priority population under BHSA and represent a critical developmental window for intervention. Yet, current investments in early childhood behavioral health remain limited, and many effective interventions—particularly those delivered through pediatric, early learning, and community-based settings—are underrepresented in the plan.

This represents a missed opportunity to invest in interventions with the highest return on investment, both in terms of improved outcomes and long-term cost savings.

Lack of Transparency Limits Accountability

The Integrated Plan does not provide sufficient detail to fully assess how funding decisions will impact children and youth services. There is no clear baseline comparison to current funding levels, limited visibility into program-level allocations, and insufficient information to determine how funding shifts will affect specific services over time.

In some cases, existing programs appear to have been reclassified within Early Intervention categories, making it difficult to determine whether investments are expanding or simply being redistributed. For example, SchooLink, the largest children and youth program in BHS has been moved from FSP to BHSS EI; and several other existing children and youth programs not funded through MHSA, such as Polinsky Children's Center, FFAST and Kid Start Clinic, are now bundled in the BHSS EI category. This lack of transparency limits meaningful stakeholder engagement, constrains system alignment, and reduces public accountability.

System-Level Implications

The County's Youth Optimal Care Pathway (OCP) identifies closing the Specialty Mental Health Services penetration gap to reach the statewide average of 3 percent as a priority, which is estimated to require serving approximately 5,000 additional youth annually. At the same time, the OCP suggests that up to 67,000 youth in San Diego County may require specialty mental health services, indicating that achieving the statewide average would still leave a substantial proportion of need unmet.

Given this context, it is unclear how the County intends to meet even this modest benchmark of 3 percent penetration and expand capacity to serve an additional 5,000 youth, particularly as funding for children and youth services appears to be declining.

If current divestment patterns persist, the County is likely to experience continued low access rates for youth, persistent gaps between need and capacity, and increasing reliance on high-cost emergency and

inpatient services. These dynamics will contribute to higher long-term costs across behavioral health, child welfare, and justice systems, while missing critical opportunities to intervene during key developmental periods.

In effect, the system will continue to absorb higher downstream costs as a direct result of insufficient upstream investment.

Recommendations

To better align the Integrated Plan with both the evidence base and the intent of BHSA, SBHI recommends a strategic rebalancing of investments across the full behavioral health system. This includes increasing the proportion of total funding (across all funding sources) allocated to children and youth and aligning more closely with the policy expectation that Early Intervention resources meaningfully support individuals ages 0–25.

The County should establish clear and measurable targets to increase youth access to specialty mental health services, including reaching beyond the statewide penetration rate and developing longer-term goals tied to population-level need. Achieving these targets will require a sustained commitment to expanding capacity and addressing structural barriers to access.

Investment strategies should prioritize upstream models of care, including school-based behavioral health services, integration within pediatric primary care, early childhood interventions, and family-centered, community-based models. These approaches are essential to improving outcomes and reducing long-term system costs and are in alignment with the County's Youth Optimal Care Pathway.

In addition, the County should strengthen cross-system coordination by developing clear access pathways that ensure children and families can enter care through multiple points of contact. A "no wrong door" approach, supported by coordinated referral and transition protocols, will improve navigation and continuity of care across systems.

Finally, the County should enhance transparency and accountability by publicly reporting key metrics, including funding by age group (including a breakdown of children and youth), number of individuals served, cost per beneficiary, and access timelines and outcomes. Providing program-level budget detail will be essential to enabling meaningful oversight and stakeholder engagement.

Partnership Opportunity

SBHI offers to partner with the County to support successful implementation of the BHSA Integrated Plan. As a cross-sector collaborative with deep community reach and system-level perspective, SBHI is well-positioned to support alignment, implementation, and continuous improvement.

To that end, we recommend establishing a standing Children and Youth Behavioral Health Workgroup, jointly convened by Behavioral Health Services and SBHI stakeholders. This workgroup would provide a structured forum to monitor implementation, track investments and outcomes for children and youth, and inform ongoing development of the Youth Optimal Care Pathway.

This approach would strengthen transparency, support continuous improvement, and ensure that implementation efforts remain aligned with community needs and policy goals.

Conclusion

The Integrated Plan identifies important gaps in youth access to behavioral health services, but current investment decisions do not yet align with the scale of need, the evidence base for early intervention, or the intent of BHSA.

Children and youth represent more than one-third of those served in the system yet receive less than one-fifth of total funding. This imbalance is not only an issue of equity—it is a strategic and fiscal concern. Early intervention improves outcomes, reduces long-term costs, and strengthens the sustainability of the behavioral health system as a whole.

A system that invests more heavily in adults than in children is, by definition, responding too late.

We offer this input to strengthen the Integrated Plan and look forward to continued partnership with the County to build a behavioral health system that is proactive, equitable, and effective for children, youth, and families.

Specific Questions

<u>Housing Services:</u>

Table 1 on page 486 presents projected funding and individuals served across mental health, substance use disorder, and housing services within the behavioral health continuum, inclusive of all funding streams. Within the housing services category, approximately 5,500 youth (under 21 years) and 575 adults will be served.

However, Table 5 on page 493, which details BHSA Housing Interventions programs and services, projects that 740 youth and 17,989 adults will be served. As the latter table appears to represent a subset of the broader continuum outlined in Table 1, the significantly lower adult count in Table 1 is difficult to reconcile.

Additionally, the projection of 5,500 youth served within housing services in Table 1 is unexpected, as this figure appears substantially higher than typical utilization for youth within housing-focused programs.

We would appreciate clarification on the source of this discrepancy between the two tables, including how populations are being categorized and which specific programs are included in the estimate of 5,500 youth served within the housing services category.

Early Intervention:

Based on Table 1 on page 486, total funding for mental health and SUD early intervention and prevention services for children ages 0–21 appears to be approximately $34.8 million.

In contrast, Table 7 on page 495, which outlines Behavioral Health Services and Supports (BHSS), indicates total Early Intervention funding for children and youth 0-25 totals $51.43 million.

Can it be assumed that the difference between these two figures is attributable to the broader age range reflected in Table 7? Specifically, does this imply that approximately $16.63 million of Early Intervention funding is allocated to transition-age youth (ages 22–25), with the remaining $34.8 million supporting children and youth under age 21?

We would appreciate clarification on how funding is distributed across age groups in these tables to ensure accurate interpretation.

SUD Residential Services:

Table 1 on page 486 indicates that 475 children and youth (0-21) are projected to be served annually through SUD residential services, with total funding of $10,849,866 across all funding streams.

Can you clarify whether SUD residential providers in San Diego County currently have the capacity to serve children under age 18? If not, should this category be understood as primarily serving individuals age 18 and older?

Early Intervention reductions:

Based on Table 1 on page 486, Mental Health Early Intervention funding for children and youth appears to decrease from approximately $27.7 million in Year 1 to $13.5 million in Year 2. This loss is not made up in any other category or year.

Can you provide clarification on the cause of this significant reduction? Specifically, which funding stream(s) account for this change, and which programs or services are anticipated to be reduced, eliminated, or otherwise impacted?

Rationale for 0-21 age investment:

Based on Table 1 on page 486, total funding across all funding streams—including housing services—for children and youth ages 0–21 is approximately $257,238,307 in Year 1 and $238,803,843 in Year 2.

However, when excluding SUD residential and housing services – given that there are no SUD residential programs serving under 18 in San Diego and housing services predominantly serve TAY and adults —the adjusted funding more accurately reflecting services for children under age 18 is approximately $233,426,824 (17%) in Year 1 and $216,739,567 (16.7%) in Year 2.

This adjustment suggests that the proportion of funding directly supporting children may be lower than initially reflected in the total figures. We would appreciate confirmation of this interpretation, including whether SUD residential and housing investments are appropriately attributed to the children and youth category in Table 1.

Sincerely,

Strategic Behavioral Health Initiative (SBHI)

Facilitators of SBHI Contact information:

Stephanie Gioia Beckman
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POLICY & INNOVATION CENTER

MHCA
MENTAL HEALTH CONTRACTORS ASSOCIATION OF SAN DIEGO COUNTY

On behalf of Mental Health Contractor's Association I am writing to express our appreciation for the Board's support of the Children and Youth Optimal Care Pathways (OCP) Framework.

We are encouraged by the County's commitment to strengthening a more coordinated and responsive behavioral health system for children, youth, and families. Many of our organizations were engaged in the Strategic Behavioral Health Initiative (SBHI) process and contributed to the collective recommendations that were shared with your office.

As implementation moves forward, we want to underscore the importance of continued and meaningful stakeholder engagement. Ongoing partnership with providers, youth, families, and community-based organizations will be critical to ensuring the framework is implemented in a way that is effective, equitable, and responsive to real-world needs.

In particular, we support the establishment of a permanent, multi-sector implementation oversight structure that includes representation from providers, families, youth, and community partners. Such a structure would help:

- Monitor implementation progress and data
- Elevate both state-mandated and community-informed practices
- Provide ongoing input to support continuous improvement and accountability

We remain committed to partnering with the County Behavioral Health Services department and the Board to support successful implementation of the OCP Framework.

For reference, I have attached the SBHI recommendations document.

Thank you for your leadership and continued support of children, youth, and families in our region.

Respectfully,

Laura Beadles Laura Beadles, MHCA President Date: 4/16/26

Aisha Pope, LCSW Aisha Pope, Children's At-Large Representative Date: 4/15/2026

Behavioral Health Services Act Public Comment

April 14th, 2026, International Rescue Committee in San Diego

Section 1: Behavioral Health Goals

On behalf of the International Rescue Committee (IRC) - San Diego. The proposed goals demonstrate a strong foundation; however, we identified the following gaps:

Prioritizing Cultural Responsiveness: In its current draft, BHSA appropriately emphasizes service expansion through partnership with trusted community-based organizations to deliver culturally responsive care. As a deeply embedded and trusted presence across San Diego communities, BHSA would be well served by including the IRC as a formal partner. The IRC has delivered culturally responsive services for five decades (since 1975), with expertise grounded in serving diverse and often marginalized populations, including many BHSA-eligible populations. When it comes to addressing mental and behavioral health, the IRC brings deep experience and a trauma-informed approach that prioritizes meeting individuals where they are.

Inclusion of Newcomers in the Target Population: Beyond language and culture barriers, many newcomers face undiagnosed mental health needs and significant challenges navigating U.S. systems, increasing their risk of compounding mental health crises. Many newcomers have also experienced displacement-related trauma that continues to remain unaddressed due to stigma, language barriers, and limited culturally responsive services. Although a substantial share of newcomers are BHSA-eligible, the absence of explicit recognition as a target population risks continued oversight of their distinct clinical needs. Compounding these challenges, many new San Diegans lack credit history or stable income, placing them at heightened risk of housing instability.

Documentation Barriers: Documentation requirements should be assessed as a barrier influencing access to care. The draft does not set forth goals related to document requirement reform or navigation support, leaving many eligible residents unable to access care. The IRC is uniquely positioned to serve as a trusted intermediary and navigator, leveraging longstanding community relationships to help new San Diegans to access mental health services, complete enrollment, and successfully engage the behavioral health system.

Prevention: The current BHSA draft does not articulate goals focused on prevention strategies or mental health education for BHSA-eligible populations who are not yet in crisis. Evidence indicates 80% of adult newcomers who have been forcibly displaced experience mental health conditions and up to 90% of young newcomers – many times unknowingly – underscoring the

need for proactive approaches. Unaddressed trauma can increase the risk of developing more severe mental health disorders over time. Targeted programming that combines preventative intervention with education on coping strategies, healthy habit-building, and mental health literacy would help mitigate risk, prevent deterioration, and promote long-term wellbeing. A multi-layered prevention-focused approach is essential to achieving sustainable mental health outcomes.

The Inclusion of Gender-Specific Mental Health Strategies & Household Structures: The BHSA should ensure that there is behavioral health and wellbeing programming that is targeted to each gender. For example, while BHSA correctly notes that men are overrepresented in the justice system, the draft does not adequately address the corresponding underrepresentation of men in mental and behavioral health programming. Newly displaced men, women, and non-binary people experience traumas and stressors that are unique to each population, in addition to unique stigmatization that is faced by the different genders, and the distinct challenges that members of non-traditional household structures face. To ensure equitable and effective service delivery, BHSA would benefit from a multi-targeted approach that addresses individual mental health needs while also accounting for diverse household compositions, including single-parent households.

Stakeholder Perspectives: The BHSA should explicitly incorporate stakeholder perspectives into program implementation language to ensure that stated goals reflect the operational realities of implementers and the lived experiences of target populations. For example, the Access to Care: Disparities Analysis notes that penetration rates for non-specialty mental health services are lower among several non-English-speaking populations, including Arabic, Cantonese, Farsi, Other Chinese, Russian, and Tagalog speakers. While numerous refugee and immigrant service organizations and ethnic community-based organizations are listed as stakeholders engaged in the BHSA planning process, none of the feedback from these organizations is meaningfully integrated into the BHSA to analyze barriers to accessing care or to inform implementation strategies that could reduce those barriers. Purposeful inclusion of stakeholder analysis within the BHSA would strengthen implementation planning, prioritize community and cultural responsiveness, and signal the importance of shared accountability, trust-building, and equity in achieving access goals.

Section 2: Programs

Rebalancing Toward Primary Prevention and Upstream Mental Health Supports: While reactive and crisis-response programming is essential, the BHSA plan is heavily weighted toward addressing acute and ongoing mental health issues crises, with comparatively limited emphasis on proactive prevention. While significant resources are allocated to early intervention efforts, greater investment or reallocation of funds in primary prevention would strengthen the overall

framework. Prevention-focused programming should include both education-based initiatives and solutions-oriented supports that address the underlying stressors that significantly impact mental health. Education-based programs may include interactive workshops for adults and children focused on stress management, coping strategies, value creation, healthy relationship-building, and sustainable habit formation. Solution-oriented programming should assist with addressing stressors that greatly impact mental health, such as unemployment, financial instability, and housing security, through direct services including but not limited to employment assistance, financial coaching, and housing navigation. Such programs would be a step beyond only providing referrals and mental health-only support for people who are not yet in dire need, as the current BHSA focuses on. Existing programs – the kind of which the BHSA draft suggests providing linkages to – are often at full capacity, making referrals to those programs less effective. Therefore, funding should be provided for new programs that directly target the factors that negatively impact mental health specifically for BHSA-eligible populations, such as trauma-informed case management, financial coaching, employment navigation, and housing navigation, rather than simply providing linkages to such programs. The International Rescue Committee (IRC) has experience in providing culturally responsive, trauma-informed case management, financial coaching, employment navigation, and housing navigation services to members of the community in San Diego County and is well positioned to support BHSA's prevention and early intervention goals.

Cultural Responsiveness in Program Design and Implementation: Although the BHSA acknowledges the importance of cultural responsiveness in mental health services, as emphasized by stakeholder input, concrete provisions for culturally responsive programming are largely limited to a single initiative—the Native American PEI/Dreamweavers program. Communities across San Diego County have distinct behavioral health needs shaped by their cultural backgrounds, migration histories, and lived experiences. As such, the BHSA should include targeted provisions that enable community-based organizations to lead outreach and education efforts within diverse communities, with the goals of increasing understanding of mental health, reducing stigma, and improving access to care. The International Rescue Committee (IRC) has extensive experience conducting outreach to immigrant and refugee populations throughout San Diego County and has established trusted relationships across a wide range of communities. Additionally, the IRC has demonstrated capacity to develop and deliver culturally responsive, linguistically appropriate educational materials and programming. Given this track record, the IRC is well positioned to play a lead role in implementing mental health outreach and education activities that are responsive to community needs and aligned with BHSA equity goals. There is a need to include mental health and destigmatization programs specific to different genders in the BHSA, as each gender has unique mental health needs and faces unique challenges.

Section 3: Workforce Strategy

The International Rescue Committee (IRC) supports the integration of Peer Support Specialists. Centering lived experience is vital for building trust and reducing stigma. However, providing external linkages to programs that assist with community integration and self-sufficiency is insufficient. The existing programs are usually at capacity and may not offer culturally-competent, language-accessible, trauma-informed services. It is important to include in the BHSA plan the hiring and training of staff to work on programs that directly assist BHSA-eligible populations with practical needs that greatly contribute to their mental health needs, such as financial instability and housing instability. The workforce strategy should include the hiring of employment specialists, housing specialists, financial coaches, and case management staff to assist BHSA-eligible members of the community, in order to address significant stressors through practical solutions rather than solely relying on mental health staff to only address the direct mental consequences of those stress factors. These staff would assist BHSA-eligible populations with navigating employment challenges, guidance in finding appropriate housing, coaching to educate about finances and assist with financial planning, and assistance with other assessed stressors as determined on a case-by-case basis. The IRC has significant experience in assisting BHSA-eligible populations with language-accessible, trauma-informed case management, employment navigation, housing navigation, and financial coaching, addressing significant stressors for these populations and assisting them with sustainable, long-term solutions and strategies to address mental health needs.

Workforce Education and Training (WET) activities should train providers to take into account the cultural and immigration backgrounds of the BHSA-eligible populations, and approach outreach and discussions in a culturally responsive manner, rather than simply focus on technical training. WET activities should train community-facing staff in trauma-informed approaches and equip them with tools to work with newcomers and culturally diverse groups. IRC has expertise in training community members and providers on cultural responsiveness.

Section 4: Budget

Funds should be allocated towards targeted programs that provide better community integration, financial stability, self-sufficiency, and autonomy tools in the long term, rather than relying on simple referrals. Programs designed to provide better integration and address major stressors help alleviate major contributors to mental health problems in a sustainable way. Community integration and self-sufficiency mean empowering individuals and families to be able to live independently, participate and engage fully in society and in their communities, and meet their own needs without relying on external systems. The programs proposed include case management, housing stability, financial coaching, and employment navigation assistance.

This would be in conjunction with culturally responsive mental health-specific programming. For such programs to be successful, organizations that are experienced in assisting BHSA-eligible populations with achieving self-sufficiency and better integration, like the International Rescue Committee (IRC), need to be included in the programs.

A portion of funding should be earmarked for programming that specifically focuses on prevention strategies, as outlined above.

April 14, 2026

Nadia Privara Brahms, Director
County of San Diego Behavioral Health Services
3255 Camino del Rio South
San Diego, California 92108

Submitted via email: Engage.BHS@sdcounty.ca.gov

RE: Formal Public Comment — Draft BHSA Integrated Plan for Fiscal Years 2026–2029

Dear Director Privara Brahms:

Alvarado Parkway Institute (API) is pleased to submit formal public comment on San Diego County's draft Behavioral Health Services Act (BHSA) Integrated Plan for Fiscal Years 2026–2029. We appreciate the County's commitment to community engagement and the transparency with which this planning process has been conducted.

API is a 66-bed licensed freestanding acute psychiatric hospital located at 7050 Parkway Drive in La Mesa, and we are the only freestanding acute psychiatric hospital serving East County's estimated 500,000 residents. With an average daily census of approximately 61 patients and over 22,000 patient days of care provided annually, API is a foundational component of San Diego County's behavioral health continuum. The majority of our patients are Medi-Cal beneficiaries with Serious Mental Illness (SMI), the population at the core of both BHSA and BH-CONNECT.

We are also a confirmed Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, active since July 2025. Our comments are therefore offered not only as a community provider, but as an active partner in the County's behavioral health financing and delivery infrastructure.

Our comments address five areas: (1) the critical role of acute inpatient capacity in the continuum; (2) the impact of AB 116 on provider financial sustainability; (3) BH-CONNECT FFP reinvestment and reimbursement rates; (4) care coordination and transition services; and (5) workforce development. We respectfully request that feedback in each area be incorporated into the final plan.

1. Acute Inpatient Capacity: An Indispensable Tier of the Continuum

The BHSA Integrated Plan appropriately emphasizes investment in community-based services, housing, and crisis intervention. API fully supports these investments. We offer the following as essential context: community-based services and acute inpatient care are not competing priorities, they are interdependent tiers of the same continuum. The effectiveness of the County's investment in lower levels of care depends on the availability and stability of acute inpatient capacity for those whose needs exceed what community-based settings can safely address.

San Diego County Acute Psychiatric Bed Context

API is the only freestanding acute psychiatric hospital in East County. The region has experienced repeated failures in attempts to add acute psychiatric inpatient capacity:

- Acadia/Scripps Eastlake: 120-bed acute psychiatric hospital proposal rejected in 2022

- Palomar Health Behavioral Health Institute: BHCIP-funded 120-bed acute psychiatric hospital in Escondido, with completion not expected before 2029–2030

San Diego County faces a structural acute psychiatric bed shortage that will persist for at minimum eighteen months.

API's 66 licensed beds represent a primary acute inpatient resource for a large and growing population.

We respectfully request that the final Integrated Plan include explicit language recognizing freestanding acute psychiatric hospitals as a protected and essential tier of the behavioral health continuum, and that institutionalization reduction goals be framed around appropriate utilization rather than reduced utilization per se. Measuring success solely by fewer inpatient days risks perverse incentives that harm the most severely ill patients in our community.

Recommended Plan Language (Section on Institutionalization Goals):

Suggested language for the County's institutionalization section:

"San Diego County recognizes that acute inpatient psychiatric care is a medically necessary and clinically appropriate service for individuals with Serious Mental Illness whose needs cannot be safely addressed in community-based or crisis residential settings. The County's institutionalization goals target the reduction of preventable or avoidable inpatient episodes through investment in upstream services, while preserving timely access to acute care for individuals who require it. The County will track both over-utilization and under-utilization of acute inpatient services as quality indicators, ensuring that access to medically necessary care is not constrained by utilization targets alone."

2. AB 116 and Provider Financial Sustainability

AB 116, California's new emergency nurse staffing ratio (1:6 licensed nurse-to-patient ratio), is expected to take effect June 1, 2026, the same month this Integrated Plan enters implementation. The financial impact on freestanding acute psychiatric hospitals is substantial and immediate.

AB 116 Impact Factor	API Estimate
Annual incremental staffing cost	$2.5 million (Nursing Targets compliance model)
Additional Registered Nurses required	23 FTEs by June 1, 2026
Statewide RN shortage context	San Diego County is a designated RN shortage area; API competes with 8 other San Diego County hospitals for the same nursing workforce
Non-compliance fine exposure	$15,000–$30,000 per day per CDPH enforcement action
Current Medi-Cal rate adequacy	Existing SMHS rates do not reflect AB 116 mandated cost increases; a structural funding gap will exist from July 1, 2026 forward

According to the California Hospital Association's March 2026 statewide survey, only 16% of affected psychiatric hospitals are likely to achieve full AB 116 compliance by June 1. API is making every effort to comply, including active RN recruitment, wage increase, and good-faith documentation for potential CDPH program flex consideration. However, the financial sustainability of this compliance depends on Medi-Cal reimbursement rates that reflect the mandated cost structure.

The BHSA Integrated Plan is the foundational document governing how the County uses its behavioral health funding. We respectfully request that the plan include explicit recognition that AB 116 creates a structural cost gap

for contracted acute inpatient providers and that the County commits to rate-setting and contract practices that reflect the true cost of mandated staffing levels.

Recommended Plan Language (Provider Network and Contracting Section):

> "Effective July 1, 2026, California's AB 116 psychiatric emergency nurse staffing ratio law requires freestanding acute psychiatric hospitals to maintain a 1:6 licensed nurse-to-patient ratio. San Diego County recognizes that this mandate substantially increases the cost of providing acute inpatient psychiatric services. The County commits to reviewing and, where appropriate, adjusting Specialty Mental Health Services reimbursement rates for contracted acute inpatient providers to ensure that rates reflect the actual cost of AB 116-mandated staffing. Rate adequacy reviews will occur at least annually during the FY 2026–2029 Integrated Plan period."

3. BH-CONNECT FFP Reinvestment: Provider Rate Increases

API is an active Participating Psychiatric Setting under San Diego County's BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. Under this program, the County receives approximately 50% federal matching funds for Specialty Mental Health Services provided to qualifying Medi-Cal members (ages 21–64) during short-term stays at IMDs, including API.

The BH-CONNECT Special Terms and Conditions (STCs) explicitly require that FFP reimbursement received for patient care services provided in IMDs be reinvested to support community-based behavioral health service provision, quality improvement, or capacity expansion — with allowable reinvestment modalities specifically including enhancement of provider payment rates to build capacity and expand workforce.

BH-CONNECT FFP Reinvestment — API's Position

Since July 2025, San Diego County has been receiving substantial federal FFP generated by API's qualifying Medi-Cal IMD stays. Applying approximate figures:

- API's estimated Medi-Cal daily census: 27–34 patients (45–55% of 61 ADC)
- Estimated qualifying Medi-Cal IMD patient days (July 2025–March 2026): ~7,500–9,000 days
- Approximate federal FFP generated for the County from API stays: significant six-figure amount

The BHSA Integrated Plan is the appropriate vehicle for the County to formalize its FFP reinvestment commitments. API respectfully requests that the plan include specific language on reinvestment of BH-CONNECT FFP savings into enhanced provider rates for qualifying IMDs.

Recommended Plan Language (BH-CONNECT / Medi-Cal Financing Section):

> "San Diego County is an active participant in the BH-CONNECT IMD Federal Financial Participation (FFP) Program, effective July 2025. In accordance with BH-CONNECT Special Terms and Conditions, the County will reinvest FFP savings received for services provided in qualifying Institutions for Mental Diseases into community-based behavioral health services, workforce expansion, and/or enhanced provider payment rates. During the FY 2026–2029 Integrated Plan period, the County commits to conducting an annual review of SMHS rates for contracted acute inpatient providers that are active Participating Psychiatric Settings, with the explicit objective of ensuring that FFP reinvestment benefits flow to frontline providers whose patients generate those federal funds."

4. Care Coordination, Transition Services, and Referral Pathways

API strongly supports the County's investments in Assertive Community Treatment (ACT), Forensic ACT (FACT), Community Transition In-Reach Services, and the broader Full Service Partnership infrastructure. These

programs serve our shared patient population and directly affect the quality of care transitions between acute inpatient settings and the community.

We offer the following specific requests to strengthen care coordination language in the final plan:

4a. Community Transition In-Reach Services at API

BH-CONNECT authorizes county-funded multidisciplinary teams to provide Community Transition In-Reach Services inside IMDs for up to 180 days prior to discharge. This service is designed to support the precise patient population that API serves — high-acuity SMI individuals who require intensive community linkage before and after discharge. We formally request that the final plan include a commitment to implement Community Transition In-Reach Services at API during the FY 2026–2029 plan period, and that API be identified as a priority site for this service given our volume and patient acuity.

4b. ACT Team Referral Protocols

As the County expands ACT and Forensic ACT capacity under BHSA and BH-CONNECT requirements, we request that the plan include explicit language establishing clear referral protocols between ACT teams and acute inpatient providers. Specifically: ACT teams should have defined pathways for referring clients in acute crisis to API, and API should have defined pathways for discharge to ACT teams. These bidirectional protocols reduce avoidable readmissions, improve patient outcomes, and support the County's BH-CONNECT performance metrics on readmission reduction.

4c. Post-Discharge Follow-Up (72-Hour Standard)

BH-CONNECT requires either the county BHP or the IMD to contact Medi-Cal members within 72 hours of discharge. API is committed to meeting this standard. We request that the plan establish a shared data protocol between API and the County BHP for tracking 72-hour follow-up completion, a key quality measure that will support both the County's BH-CONNECT incentive program performance and API's accountability to our shared patients.

4d. SD County Behavioral Health Wellness Campus Integration

The County's $99.5 million BHCIP-funded Behavioral Health Wellness Campus (Crisis Stabilization Unit, MHRC, SRF, and outpatient services, completion projected May 2031) will create significant new lower-acuity capacity in San Diego. API views this as a positive development and a complement to our acute inpatient services. We request that the plan include language on how the Wellness Campus and acute inpatient providers like API will establish coordinated referral and transition protocols when the campus is operational, to ensure seamless movement of patients across levels of care.

5. Behavioral Health Workforce Development

The BHSA Integrated Plan's workforce section is directly relevant to API's operational sustainability. We offer two specific requests:

5a. AB 116 Workforce Crisis Recognition

The California Hospital Association's statewide survey documented a need for 910 new licensed psychiatric nursing FTEs across California by June 1, 2026, with 222 of those in Southern California alone. San Diego County is a designated RN shortage area. We request that the plan explicitly identify the AB 116 psychiatric nursing mandate as a county-level workforce crisis and include strategies for addressing it — including coordination with HCAI on BH-CONNECT Workforce Initiative recruitment and retention bonus programs, and support for facilities in designated shortage areas.

5b. BH-CONNECT Workforce Program Access

BH-CONNECT's Workforce Initiative includes loan repayment programs, community-based provider training (up to $10,000 per participant), and recruitment and retention bonuses for organizations serving Medi-Cal members (threshold: approximately 40% Medi-Cal payer mix). API and other county-contracted acute providers meet this

eligibility threshold. We request that the plan include outreach commitments to ensure that contracted providers, including acute inpatient hospitals, are fully informed of and supported in accessing these workforce programs.

6. Summary of Requested Plan Actions

#	Requested Action	Plan Section	Priority
1	Add language distinguishing appropriate from avoidable institutionalization in goals section	Statewide BH Goals / Institutionalization	**Critical**
2	Include explicit commitment to review SMHS rates to reflect AB 116 mandated staffing costs, beginning July 1, 2026	Provider Network / Contracting	**Critical**
3	Formalize BH-CONNECT FFP reinvestment commitment to include annual rate review for qualifying IMD Participating Psychiatric Settings	BH-CONNECT / Medi-Cal Financing	**Critical**
4	Commit to implementing Community Transition In-Reach Services at API as a priority site during FY 2026–2029	BH-CONNECT / Care Transitions	**High**
5	Establish formal bidirectional ACT/FACT referral protocols with acute inpatient providers	Full Service Partnerships / ACT	**High**
6	Designate shared 72-hour post-discharge data protocol for IMD Participating Psychiatric Settings	BH-CONNECT / Quality Measures	**High**
7	Include transition/referral protocols between the SD County BH Wellness Campus and acute inpatient providers when the campus opens	Care Continuum / Capital Projects	**Moderate**
8	Recognize AB 116 psychiatric nurse mandate as a county workforce crisis and include HCAI BH-CONNECT bonus program outreach in workforce strategy	Workforce Strategy	**High**

Closing Statement

API submits these comments as a committed partner in San Diego County's behavioral health system. We share the County's goals of expanding access, improving outcomes, reducing health disparities, and building a continuum of care that serves our region's most vulnerable residents. The requests we have made are not requests for special treatment, they are requests for a plan that accurately reflects the financial and operational realities of providing acute psychiatric care in 2026 and beyond, and that formalizes the partnership obligations that already exist under BH-CONNECT.

We strongly support Director Privara Brahms's vision of a plan that "supports access to care and addresses community needs." For the 22,000+ patient days of acute psychiatric care API provides annually, almost entirely to Medi-Cal members with Serious Mental Illness, access to care and community need are not abstractions. They are the daily work of our clinical team.

We respectfully request an opportunity to present these comments in person at the May 7, 2026 public hearing before the Behavioral Health Advisory Board, and to schedule a follow-up meeting with your office to discuss implementation of the requested plan language.

Thank you for the opportunity to contribute to this important process. We look forward to serving as an active partner as San Diego County implements the BHSA Integrated Plan beginning July 1, 2026.

Respectfully submitted,

Patrick Ziemer
Chief Executive Officer
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San Diego County BHSA Integrated Plan Draft for 2026–2029
Feedback on behalf of Alcohol and Drug Service Provider Association (ADSPA)

On behalf of ADSPA and our numerous member organizations who provide substance use disorder services in partnership with the County of San Diego, we appreciate the opportunity to provide comments on the San Diego 2026–2029 Draft BHSA Integrated Plan. We commend the County's efforts to develop a comprehensive framework to guide behavioral health services; however, we have identified several areas that require clarification, reconciliation, and further development to ensure successful implementation.

1. **Data Accuracy and Consistency**
   Across multiple sections of the Plan, there are notable discrepancies in reported data that warrant clarification. For example, the Plan indicates that over 1,000 individuals under age 21 received DMC-ODS services, which appears inconsistent with the Optimal Care Pathways presentation (791 individuals). Similarly, reported unsheltered homelessness figures (15,233) differ significantly from the Regional Task Force Point-in-Time (PIT) count (approximately 10,000). These inconsistencies raise concerns regarding data sources, methodology, and whether figures represent unduplicated individuals or service encounters. Given that these data inform program planning and funding decisions, reconciliation and transparency are critical.

2. **Clarity on Service Settings and Scope**
   The Plan does not clearly define which service settings are included in utilization figures. It is unclear whether counts include services delivered across outpatient, school-based, justice-involved, or community-based settings. Greater specificity is needed to accurately interpret service capacity and system reach.

3. **Target Population Definition and Older Adult Services**
   The Plan frequently references services for individuals over age 65; however, providers report significant barriers to serving this population due to Medi-Medi billing constraints. Clarification is needed regarding Behavioral Health Services' (BHS) definition of the target population and the scope of reimbursable services for older adults, particularly given that Medicare does not cover many of these services. Additionally, the Plan reports that 5,752 individuals over 65 are receiving services; it is unclear how these services are being delivered in light of current billing challenges and recent guidance to transition individuals from Medi-Medi to straight Medi-Cal.

4. **Misalignment Between Reported Conditions and Provider Experience**
   In several instances, the Plan indicates that there are no implementation challenges; however, this does not align with provider experience. Significant challenges remain, including:

- Limited interoperability and ongoing delays in achieving meaningful data exchange across electronic health record systems
- Barriers to effective care coordination, including implementation of Enhanced Care Management (ECM) and Individual Placement and Support (IPS)
- Challenges with MCP collaboration, data sharing, and MC3 file exchange
- Closure or transition of key programs, including population-specific ACT services and Clubhouse programs

A more accurate representation of these challenges is necessary to ensure appropriate planning and resource allocation.

5. **Implementation Feasibility and Operational Detail**

   The Plan outlines several new initiatives but lacks sufficient operational detail regarding implementation. This includes:

   - Assertive field-based SUD treatment services
   - Outreach reimbursement methodologies and data tracking mechanisms
   - Housing navigation processes and Coordinated Entry System requirements
   - Expectations for providers following July 1, 2026

   Without clear guidance, providers may face difficulties operationalizing these initiatives.

6. **Program Reductions and Funding Transitions**

   The Plan indicates that several programs are being sunsetted or transitioned to Medi-Cal funding; however, it does not clearly identify which services will be discontinued or how service gaps will be addressed. For example, early intervention programs and certain community-based services appear to be reduced without a clear transition plan. This raises concerns about continuity of care and access to services.

7. **Workforce Development and Administrative Burden**

   The Plan does not sufficiently address workforce capacity or administrative burden. The reduction in centralized training resources, particularly following the non-procurement of the RISE contract, has limited provider access to training. While Medi-Cal training and technical assistance are mentioned, it is unclear how these resources will support specialty behavioral health providers, particularly in the SUD system. Additionally, stakeholder-developed recommendations regarding administrative relief are not reflected in the Plan.

8. **Housing and Homelessness Strategy**

   There are concerns regarding the accuracy of housing projections and the alignment with Coordinated Entry System processes. It is unclear how outpatient providers will be expected to verify homelessness status and whether current housing inventory estimates accurately reflect system capacity. Furthermore, there appears to be limited collaboration with major cities on housing solutions, representing a missed opportunity for system-level impact.

9. **Alignment of Priorities and Investments**
   The Plan identifies social connection as a key priority; however, providers note that more urgent issues—such as overdose prevention, suicide, and co-occurring physical health conditions—may warrant greater emphasis. Additionally, programs that directly address social isolation among older adults are being sunsetted, which appears inconsistent with the stated priority. Clarification is needed regarding how funding decisions align with identified community needs.

10. **Limited Engagement in New State Initiatives**
    The Plan indicates that the County is opting out of several state-recommended initiatives. This raises concerns regarding missed opportunities for innovation, technical assistance, and cross-system collaboration.

11. **Budget and Investment Trends**
    The budget section raises questions regarding projected service levels and declining investment over time. For example, the projected number of adults served in housing programs appears low relative to need. Clarification is needed to ensure that funding levels align with population needs and system goals.

Conclusion

While the Plan provides a broad framework for behavioral health service delivery, it would benefit from greater clarity, transparency, and alignment with provider experience. Addressing the issues outlined above will be critical to ensure that the Plan is both actionable and responsive to community needs.

We appreciate your consideration of these comments and welcome the opportunity to engage further to support successful implementation.

Sincerely,

Marisa Varond, Chair
ADSPA

Enclosure: 2026-2029 Integrated Plan – ADSPA Ad Hoc Detailed Meeting Notes

San Diego 2026-2029 BHSA Integrated Plan

ADSPA Ad Hoc Detailed Meeting Notes

The following feedback was collected during an Ad Hoc Meeting convened by ADSPA on April 2, 2026 for the purposes of the reviewing the 2026 - 2029 Integrated Plan. In addition to the comments collected from 42 participants, it also incorporates written feedback submitted by ADSPA member organizations that provide substance use disorder services in partnership with BHS.

Page 6: County Behavioral Health System Overview and Population Served

The plan indicates that over 1,000 individuals under the age of 21 received DMC-ODS services, which seems shockingly high and actually contradicts the Optimal Care Pathways presentation data (791 individuals). In what other settings is the County referring to services that will be provided?

Page 8

The County references services for individuals over 65 years old throughout the document. However, providers find it discouraging to serve this population due to Medi-Medi billing issues. Providers need policy clarification regarding BHS's definition of the target population and what can be provided to clients over the age of 65, even given that Medicare never covers services. How are these 5,752 individuals receiving services, given the issues with Medi-Medi and the latest instructions to transition these individuals from Medi-Medi to straight Medi-Cal?

Page 9-10

Homeless statistics need clarification. Unsheltered homeless data does not align with the Regional Task Force point-in-time (PIT) count (BHSA reports 15,233 vs. > 10,000 in PIT). The unsheltered data is very different as well. Relevant because programs will be built based on those statistics. Maybe everyone on the PIT count did not receive services?

Page 12: County Behavioral Health Technical Infrastructure

The County reports having no implementation challenges or concerns around inoperability. That seems curious based on the delays. BHS recently reported that they are working toward participating in the HIE and that they are years away from meaningful interoperability with other EHRs.

Page 17

The County reports experiencing no implementation challenges regarding the requirements under the DMC-ODS program. Currently, there are challenges, including population-specific ACT, Clubhouses programs closing, and operationalization and enforcement of care coordination concepts (i.e., Enhanced Care Management (ECM) services, Individual Placement & Support). MCP collaboration and data exchange: Inaccurate representation. Challenges also remain with MC3 file sharing post-SC implementation.

Page 20: Population-Level Behavioral Health Measures

Overall, the plan appears to address lower-hanging issues, and there may be missed opportunities for population needs assessment and collaborating with other cities for innovative housing interventions. Currently, there is minimal collaboration with the five most populous cities on housing. Does not "Adequately fund contracts to ensure that non-county contracted providers are resourced to achieve the behavioral health goals outlined in their contract for the purposes of meeting statewide metrics."

The County may be overstating the status of critical opportunities (i.e., assertive field-based interventions, same-day access to MAT). Answering "no" to questions about implementation challenges, missed opportunities for community engagement, real problem-solving, TA from the state, and collaboration to resolve challenges.

Page 44-49

The State is asking the County to commit to new bodies of work. The county is opting out of most of them.

Page 50: Statewide Population Behavioral Health Goals

Providers are surprised that the County reported that social connection consistently emerged as a top priority for community members at the community engagement listening sessions. Providers believe there are other priority areas to address, such as suicide, overdose, co-occurring physical health conditions over social connection. The County is highlighting social connection to address depression and social isolation of home-bound seniors; However, the County is sunsetting programs that support these issues, such as UPAC's Elder Multicultural Access and Support Services (EMASS). It appears that the County's priority of social connection is in direct contradiction to sunsetting these programs. What programs has the County already removed that actually address these goals? Why are these programs being sunsetted?

Page 84: Medi-Cal Managed Care Plan (MCP) Community Reinvestment

There may be a meaningful opportunity for the joint advocacy between the County and providers regarding how the Medi-Cal Managed Care Plan (MCP) Community reinvestment dollars will be redeployed in the San Diego community.

Page 95: Behavioral Health Services and Supports (BHSS) – Specific Services Selected.

- Children's System of Care (non-Full Service Partnership) (FSP)
- Outreach and Engagement (O&E)
- Workforce Education and Training (WET)
- Adult and Older Adult System of Care (non-FSP)
- Early Intervention Programs (EIP)

What has the County not included in the Integrated Plan?

The County is sunsetting quite a few programs or transitioning them to Medi-Cal funding. For instance, on page 122, the Incredible Families program is included; however, the RFP has been switched to Medi-Cal funding. If the funding were covered under BHSA, Vista Hill would have bid on that.

Page 99: Full-Service Partnerships

There is no mention of planning any specific work surrounding the primary SUD population.

Page 101: Early Intervention (EI) Programs

The Integrated Plan fails to mention what will no longer be funded and how these gaps will be picked up by remaining programs. For instance, early intervention programs are sunsetting, so how will these services be provided? There seems to be more mental health services mentioned than SUD services.

Page 138-139: Workforce Education and Training (WET)

It appears the County is not moving to restore any centralized training resources. Since the non-procurement of the RISE (Academy for Professional Excellence) contract provider training opportunities have decreased significantly. There is mention of the board- directed Medi-Cal training and technical assistance to community-based organizations, which ADSPA has strongly advocated; however, it's concerning that these resources will be directed to the mild to moderate behavioral health supports and non-specialty systems. These resources should be directed toward specialty services (i.e., SUD) to maximize revenue and support sustainability.

Toward the end of the document, the County's goals include an increase in the percentage of people who receive at least one peer support service. How will providers meet the County's goals if the TA assistance is not available? Will this be measured in the QAPR?

Page 148: Full-Service Partnership Program

ACT and FACT practitioners will also be responsible for providing FSP intensive case management, even though the current procurements are completely divorcing these services. Mental health providers have historically relied on co-location for efficiencies, but now BHSA is requiring that there be separate programs.

The plan mentions SmartCare's wonderful capabilities in improving data consistency, billing accuracy, and outcome tracking. However, there are no outcome tracking reports available in SmartCare. Currently, providers must track outcomes internally, which is increasing the administrative burden. There needs to be CalOMS and other outcome reports in SmartCare.

Page 149

It appears the County is not making any investment in additional engagement and/or outreach services.

Page 155: New Programs for Assertive Field-Based SUD Treatment Services

The County reports that BHSA will reimburse targeted outreach and include data tracking. How do they plan to do this? Currently, there is no explanation regarding how this will be accomplished. How do they plan on achieving this? Is it being addressed through the Assertive field-based intervention?

Page 156

The plan speaks to the importance of targeted work to address disparities and population-specific interventions. However, it appears that services are moving toward a more generalized population. Population-specific interventions are being chipped away at despite BHSA goals to focus on disparities and these types of interventions (i.e., LGBTQ, justice-involved, seniors, ACT).

Page 160: Housing Interventions – System Gap

Has the County used all the definitions available to them from the State?

Outpatient providers will be verifying homeless status through the coordinated entry system. Will this be a requirement for outpatient providers? How will this roll out?

Does the COC inventory count match the County's answers? ADSPA is concerned that the County is reporting more housing availability than we actually have.

Page 162

The plan does not acknowledge the method to assess the homelessness (risk) status via the Coordinated Entry System.

Page 174

"To support the Transitional Rent referral process, individuals will need to have a Housing Support Plan in place, which will be developed by a Housing Transition Navigation Services (HTNS) Community Support provider. The HTNS provider will confirm BHSA eligibility and, if not already in place, work with the individual's program to refer to housing-related Community Supports. If an individual is not connected to a BHS-funded program, they will need to be referred to an outpatient clinic for assessment and program referral."

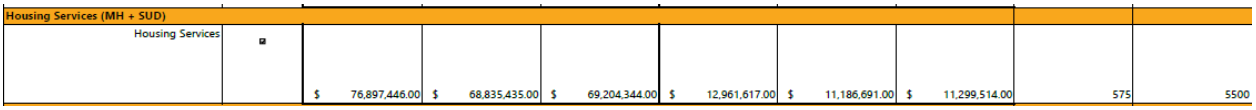
Is this the expectation after July 1, 2026?

Page 425: Behavioral Workforce Retention

The plan talks about pursuing administrative relief opportunities. How are we going to reduce the administrative burden? ADSPA convened a few stakeholders and representatives and spearheaded Figure A5 regarding administrative relief and provided the County with 29 specific recommendations. Figure A5 is missing from the plan and should be added for state visibility. Microsoft Word - FINAL - SD Behavioral Health Workforce Report .docx

Page 486: BHSA Budget Template - Housing (Mental Health & SUD)

The budget reports that 575 Adult/Older Adults are projected to be served annually. The number seems incredibly low. Was this figure accidentally swapped with the number of youth (5,500)?



Housing Services (MH + SUD)									
Housing Services		$ 76,897,446.00	$ 68,835,435.00	$ 69,204,344.00	$ 12,961,617.00	$ 11,186,691.00	$ 11,299,514.00	575	5500

The budget reflects a decrease in investment over time. Why are the amounts of investment decreasing in many of these areas over time?

In the back of the document, the BHAB Pathways to Continuum of Care listening sessions report that the SUD treatment system is fragmented and lacks coordination between providers. As an organization, ADSPA feels that we do an excellent job of coordinating across providers and working well together.

JFS Comments on San Diego County's DRAFT 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan

Thank you for the opportunity to comment on San Diego County's draft 2026–2029 BHSA Integrated Plan. We appreciate the significant effort the County has undertaken to align with the new BHSA framework, including providing engagement opportunities for agencies providing services to the community. The comments below are offered to strengthen the Plan's alignment with BHSA's intent and to support those we serve and create long-term system sustainability.

Plan Organization & Language

While we recognize that the Plan follows a State required template, the document is difficult to navigate and relies heavily on technical language. This limits its accessibility and makes it challenging for readers to clearly understand the County's core strategies for improving access to behavioral health services and addressing community needs.

Preserving the Balance Between Prevention, Early Intervention, and Crisis Response

BHSA establishes Early Intervention (EI) as a core component of Behavioral Health Services and Supports, with the explicit goal of stopping mental health conditions and substance use disorders from becoming severe and disabling. The draft Plan demonstrates a strong commitment to crisis response, stabilization, and outpatient treatment services, all of which are essential elements of the behavioral health continuum.

At the same time, the current Early Intervention portfolio appears heavily weighted toward crisis diversion and early treatment rather than upstream prevention and indicated prevention. While these services can reduce repeat hospitalization and acute utilization, they often engage individuals after acuity has already emerged.

BHSA's updated definition of Early Intervention explicitly includes direct services for children and youth who are at risk of developing behavioral health conditions but are not yet displaying symptoms, often referred to as indicated prevention under WIC 5840. Counties are not required to eliminate programs previously categorized as prevention. This means that Counties have the ability to translate many prevention-oriented models into Early Intervention.

Maintaining space for lower-acuity, prevention-oriented EI is critical. These services are typically less expensive, time-limited, and essential to preventing later reliance on higher-cost crisis, inpatient, and justice-involved systems. If preventive early intervention is limited, demand will shift toward more expensive downstream services, such as crisis response.

We encourage the County to continue to find opportunities to create more balance by providing upstream early intervention with necessary crisis and treatment investments.

Early Intervention for Children, Youth, and Young Adults

We recognize and support that there is a focus in the Draft on children, youth, and young adults, consistent with BHSA's requirement that a majority of Early Intervention funding be directed to individuals 25 and under. The Plan includes youth-focused programming, particularly through school-based and outpatient models.

However, many of the youth Early Intervention programs described primarily serve children and young people who are already experiencing high levels of acuity, have been identified as seriously emotionally disturbed, or are already involved in child welfare, crisis stabilization, or hospitalization. The Draft has less programs clearly designed to engage children and youth earlier, before challenges escalate to severe mental illness, school failure, homelessness, justice involvement, or family separation.

Early childhood represents a critical developmental window where timely intervention can alter long term trajectories and BHSA allows counties to serve all eligible children and youth, including those who are not yet symptomatic but are at risk due to trauma, adversity, or environmental stressors, as outlined in WIC 5892. Children ages 0–5 are explicitly identified as a priority population and must be included in Early Intervention spending plans. This can include programming that gives parents the tools and resources to support their children.

We ask the County to identify and create more opportunities for EI investments that will reach children, youth, and their parents/caregivers, earlier in the risk trajectory. Such services help reduce more severe outcomes later.

School-Based Services and the Role of Medi-Cal

We saw that the Draft Plan and BHS's Youth Optimal Care Pathways (OCP) analysis both have a strong focus on schools as an access point for youth behavioral health services. We support this focus as an important strategy for early identification and engagement, particularly given the amount of time children and youth spend in school settings.

However, it is important to recognize that not all children, youth, and families experience schools as a trusted or safe space for accessing services. This is especially true when services are structured as clinical treatment and request or at least are advertised as needing documentation. For some communities, including immigrant families, mixed-status households, and LGBTQ+ youth, requests

for documentation can create barriers to enrollment. Additionally, some youth prefer to receive services outside of school settings due to stigma, privacy and scheduling needs.

We encourage the County to continue partnership with trusted community-based organizations, cultural practitioners, and non-clinical providers. These partners are often better positioned to engage youth and families earlier, before conditions escalate, and to build trust outside of formal educational settings.

Community-Centered and Culturally Responsive Approaches

We appreciate the Draft Plan's stated commitments to equity, cultural responsiveness, and community engagement. It is also important to provide Early Intervention services that reflect the ways communities define wellness and healing. Many communities may not relate to traditional clinical interventions. Expanding the use of community-defined practices, group-based supports, culturally rooted providers, and partnerships with schools, nonprofits, and other trusted community spaces would strengthen Early Intervention's reach and effectiveness.

Recommended community centered interventions can include:

- Diverse providers speaking multiple languages, including regional dialects.
- Increased training of community members with the cultural competency, and trauma informed care.
- Working with cultural and religious practitioners, including spiritual faith leaders, curanderismo, and leaders of healing circles.
- Services provided by community health partners.
- Services provided by community-based organizations, including ones that partner with local community groups, parenting groups, etc.
- Services by trusted community partners, especially in the immigrant community and those with mixed status households.
- Non-traditional healing practices, such as community gardening, walking groups/incorporation of physical movement, community healing circles

Homelessness

We support the Plan's focus on housing centered interventions paired with behavioral health services and encourage the County to further strengthen these strategies by centering prevention for communities experiencing the greatest disparities. Direct cash assistance for transition age youth (ages 18–24), when paired with connections to concrete supports, can help young people stabilize housing, meet basic needs, and invest in education or training.

As the County expands housing centered initiatives, it will be important to prioritize training for care providers to support trauma-informed and culturally responsive engagement. Behavioral health and resource services should also be accessible on site, and staff should have balanced caseloads to increase engagement outcomes and reduce staff burnout.

Justice Involvement

We support the Plan's emphasis on community-based behavioral health treatment, care coordination, and housing for individuals impacted by the justice system. In addition to these supports, direct cash assistance can help individuals stabilize their lives, plan for the future, and reduce recidivism. When combined with care navigation and trusted community-based partners, financial supports can serve as an engagement tool that helps individuals address immediate needs while working toward longer-term goals for stability.

County's Child and Family Well-Being department

We encourage the County to more explicitly incorporate poverty-focused prevention strategies into its child welfare-related investments. Neglect is often closely tied to family poverty, rather than intentional harm, and financial instability is a significant driver of child welfare involvement and family separation.

Financial supports, including direct cash assistance, can function as effective prevention tools by reducing parental stress, strengthening family stability, and increasing families' ability to meet basic needs such as housing, food, and childcare. Research shows that improving income stability is associated with reduced child welfare involvement. Integrating financial supports as part of a broader approach that includes goal setting and case management would help reduce unnecessary family separations and better align with BHSA's prevention and equity goals.

This is particularly important for former foster youth, who experience some of the poorest outcomes of any subpopulation, including disproportionately high rates of homelessness, behavioral health needs, justice involvement, and economic instability. While the Draft Plan references child-welfare-involved populations, former foster youth are not consistently elevated as a distinct priority subgroup.

Explicitly naming former foster youth as a priority population and ensuring access to prevention-oriented, stabilizing supports earlier would improve outcomes and further align the Plan with BHSA's goals.

Parenting Education and Caregiver Support

After reviewing the Plan, we were concerned to see that parenting education is not explicitly included, particularly given the Plan's focus on youth justice involvement and the removal of children from the home. While there are some direct services, addressing youth behavioral health needs without also supporting parents and caregivers overlooks a critical part of what young people

experience in their homes and caregiving environments. The roots of many adolescent mental health crises can be traced back to early childhood. Therefore, support for parents and caregivers it not just supplemental to treatment, but foundational.

Parents and caregivers, especially those with limited resources, often lack access to education and support related to self-regulation, stress management, and responding to challenging behaviors. Without these supports, families are left without tools that are proven to strengthen caregiver-child relationships, reduce escalation within the home, and prevent both child welfare involvement and youth justice system contact.

In conversations with community partners following recent program changes, we also heard concerns from Head Start and Early Childhood Education providers. These sites have state requirements related to parenting education, and without dedicated parenting education programs, there is now a gap in available services to help them meet those requirements. This creates challenges for early learning providers and weakens prevention efforts during a critical developmental window.

Childcare providers are increasingly recognized as children's earliest teachers rather than simply caregivers. The County should explore opportunities to train childcare providers on recognizing behaviors that may indicate family destabilization, trauma, or abuse, as well as understanding how to respond and report concerns appropriately.

We encourage the County to consider parenting education and caregiver-focused supports as core strategies that complement youth-serving interventions and align with BHSA's goals around prevention, family stability, and reduced system involvement.

Identification of Specific Priority Populations

We appreciate that the Plan recognizes disparities among transition-age youth. Above we mentioned elevating former foster youth as a distinct priority population. We also see the importance in identifying homeless veterans as a specific subset of homeless adults. Calling these populations out directly in the Plan would support more targeted early intervention, housing, and transition-age strategies and better align with the County's stated goals around equity, prevention, and accountability.

Cross-Sector Collaboration, Philanthropy

The Draft plan acknowledges that the needs of those served by the behavioral health system are complex and require layers of cross-sector collaboration. While the Plan references partners, particularly schools, it does not describe the deeper coalition building, coordination and partnership needed to create meaningful change. This also includes partnership with private philanthropy and the role they play in the local behavioral health ecosystem.

The Draft references the inability to identify some data points related to youth and also adults at risk of homelessness. There are non-profit community partners who work to identify and provide cash,

support, rental subsidies, and other services as part of homelessness diversion programs. This is a prime opportunity for providing behavioral health support to County residents during these challenging times.

We request the County consider ways for further collaboration with private philanthropy and community-based organizations to better serve the community and help bridge gaps in data and funding.

Closing

We are grateful for the opportunity to comment on the Draft BHSA Integrated Plan. We encourage the County to further strengthen the Draft Plan by explicitly preserving meaningful space for preventive and indicated-prevention Early Intervention alongside crisis and treatment services. The right balance across the continuum of care is crucial to prevent higher-cost crises later.

MAY 7, 2026
BEHAVIORAL HEALTH ADVISORY BOARD (BHAB) ACTION ITEM
APPROVE BHAB RECOMMENDATIONS TO THE DEPARTMENT REGARDING THE DRAFT BHSA INTEGRATED PLAN FOLLOWING THE PUBLIC HEARING

To: San Diego County Behavioral Health Services (BHS) and Board of Supervisors (BOS)
From: Behavioral Health Advisory Board (BHAB)
Date: May 7, 2026
Subject: BHAB Feedback on the Draft 2026–2029 BHSA Integrated Plan

This memo provides BHAB's high-level feedback on the draft 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan (IP). It is meant to accompany the detailed comments submitted by Board members and community stakeholders and to highlight the key issues that should be addressed before adoption.

The IP reflects significant work and includes several important investments. At the same time, it was difficult for both Board members and the community to fully engage with the document. Parts of the Plan are hard to follow, the page numbers were not visible, and some sections are marked "not applicable" without explanation, and it is not always clear what is actually changing as a result of this Plan. While stakeholder feedback is summarized, the connection between the feedback and the proposed solutions is unclear.

More importantly, the IP does not yet show how the system will work differently for the people who rely on it the most, especially those who move between crisis services, homelessness, and the justice system.

Across stakeholder input, the same concerns came up repeatedly. People described weak follow-through as they move between programs and systems, a lack of accountability for whether services are actually helping, and a disconnect between the problems identified in the Plan and the solutions that are proposed. There is also a lack of clarity around how major changes, including Enhanced Care Management (ECM) and BHSA, will work in practice.
Taken together, these concerns point to a larger issue: there is no clear way to understand whether people are doing better over time. The Plan does not explain how outcomes will be tracked across crisis services, custody, housing, and ongoing care. This makes it difficult to know whether the system is improving or just continuing to operate as it does today.

The Plan does a strong job identifying disparities across age, race and ethnicity, and language. However, the responses to those disparities are often general and not clearly tied back to what

was identified. There needs to be a more direct connection between the disparities described and the actions the County plans to take, including specific approaches to language access and culturally appropriate care.

The IP also does not fully address behavioral health care in custody or what happens when people leave jail and return to the community. This includes both the quality of care provided while in custody and the lack of clear transitions back into community-based treatment. Without stronger connections between these parts of the system, people will continue to cycle through the same patterns the Plan is trying to change.

Care coordination is another area that needs more clarity. The Plan relies heavily on models like ECM, but feedback from providers and community members suggests that these services are inconsistent and often not enough for people with serious mental illness. It is not clear what level of support individuals can expect or how coordination will work between County services and managed care.

Early intervention is mentioned but not clearly developed as a strategy. Recent changes to contracts and programs raise questions about whether the system has lost capacity in areas that were previously supported through grants. The Plan should more clearly describe how individuals who are not currently engaged in care will be identified and supported earlier. This includes expanding field-based outreach and engagement, particularly for individuals experiencing homelessness with serious mental illness or substance use disorders. The Plan should also consider how voluntary, field-based treatment can be used more consistently, and where appropriate, how existing authorities can support earlier intervention before individuals cycle into crisis, hospitalization, or the justice system.

Finally, while the IP includes summaries of stakeholder input, it does not clearly show how that input changed the Plan. There should be a more direct connection between what was heard from the community and what is being proposed, as well as a clear plan for continuing to gather and use feedback during implementation.

The IP sets a direction, but it does not yet provide enough clarity on how outcomes will improve for the people most affected by the system. These issues should be addressed before adoption or clearly incorporated into implementation moving forward.

Addressing the comments summarized above and in their raw form below will make the Plan more practical and increase the likelihood that these investments lead to real improvements in access, continuity, and outcomes. BHAB will continue to stay engaged as implementation moves forward.

Thank you,

San Diego County Behavioral Health Advisory Board

BHAB Member 1 Comments:

The following comments have estimated page numbers, however since the draft IP does not contain page numbers these numbers may be approximal rather than specific.

These comments were generated after 60 hours of exposure to and personal interviews of dozens of stakeholders including practitioners, family members, crisis team members and first responders whose lives are devoted to helping the targeted care population specified in Prop 1 and BHSA, including my own personal study of Prop 1, BHSA and studying the entire 500 page draft IP, and my involvement in our Ad Hoc BHSA Subcommittee composed of 4 BHAB members, 4 staff members and 4 community members. It is my belief that these comments, if included in the BHS IP will serve as a written guide to BHS in our common pursuit of reaching these specified unreached or under reached people suffering with SMI and/or SUDs for the next three years. Robert Alm.

Please add these comments:

Into pages 29, 43,164 and 176: The county will study the homeless population to determine the percentage experiencing an SMI or SUD. The county will consider the use of outpatient field teams to treat this population, voluntarily, in the field.

Into page 30: The county will pursue outpatient conservatorships when the level of care allows.

Into page 34: Utilize electronic medical record sharing to facilitate voluntary and involuntary administration of medication as soon as possible in the hold sequences.

Into page 34: The county will support and encourage the crisis response teams of the cities within the county. The county will grant authority to these crisis response teams to initiate 5150 holds.

Into page 37: Look for and implement field-based programs to identify gravely disabled or SUD people and pursue voluntary administration of medication in the field, and possibly involuntary administration of medication in the field within the guidance of the law and ethical medical practices. Our goal is to identify and treat the gravely disabled homeless people before they are arrested thus reducing all upstream numbers of justice involved individuals.

Into pages 101-130 as is appropriate under Early Intervention (EI): Early intervention strategies will include efforts to identify gravely disabled people who are experiencing homelessness, pursue voluntary field treatment, or involuntary treatment if necessary. This would reduce all upstream numbers of justice involved, experiencing or at risk of experiencing homelessness, non-competent to stand trial people sent to a state mental hospital, and in justice involved reentry numbers.

Into page 43: Broaden the use of the term “Any Person” under WIC 5201 to allow more and easier access to help through mandated Evaluations of people suffering with a mental disorder.

BHAB Member 2 Comments:
Below is feedback regarding the IP. For context, this information has been gathered through a combination of two listening sessions hosted by the county for people with lived experience as consumers of San Diego county behavioral health services, conversation with colleagues and my own experiences working in strengths-based behavioral case management for low income older adults living with SMI, conversations with administrators at my program, and my own lived experience as a consumer and family member. I appreciate you both taking the time to review and consolidate information on behalf of the board.

- Intensive Out-Patient Programs (IOP) - IOPs are an incredible resource for people living with SMI, particularly after hospitalization while transitioning back into the community. Some San Deigo county examples include Sharp Mesa-Vista, Alvardo Parkway Institute, and Sharp Grossmont. However, Medi-Cal does not currently cover these programs (at least as it relates to mental health, there may be SUD IOP programs Medi-Cal covers). I heard from many community members the value IOP had for them and also heard about the difficulty accessing these services. I've seen older adults in my program benefit tremendously from these programs when they've been able to access them through Medicare, but there are not options for these services for our members that are not yet eligible for Medicare. I can also speak from personal experience for the value of these programs in providing support and reducing re-hospitalization having been a part of an IOP program as a consumer

- Enhanced Care Management (ECM) - The county has been increasingly been encouraging the use of ECMs. While the concept of ECM is wonderful, in practice, it is currently not meeting the needs of many people living with SMI. ECMs, in my experience, largely are able to schedule appointments and help setup transportation, but they do not attend or go into appointments with their clients. This leads to people living with SMI not ever making it to appointments/feeling intimidated or unsure of what to do inside of appointments/leaving appointments without important information on next steps. Most ECMs have been very difficult to reach with any consistency, even during moments of urgency, both for the client and for other professionals trying to coordinate. And many ECMs do not have extensive experience working with/knowledge around SMI. My program has been repeatedly encouraged to use ECMs for our members' physical health needs, but attempts to do so have been largely ineffective

- Desire For More Support to be Successful in the Community - Many people expressed feeling as though they were left to fend for themselves after hospitalization. Being told to schedule follow-up appointments, but essentially feeling left alone. People described the value of "having a hand to hold" as they navigate returning to the community. This could be field based FSPs, peer support, or an area where IOP would be valuable. Peer

involvement at each step of the recovery process was requested. I believe this also aligns with what ECM would look like if it were functioning ideally

- Lack of Board and Cares for Low-Income Individuals, Lack of Support at ILFs - My program supports members at many board and cares and ILFs. The lack of board and cares for low-income people is a consistent issue to providing safety when members leave the hospital. Many board and cares cost upwards of $3,000 a month for a shared room, something completely outside the means of members of our program/people on Medi-Cal as a whole (Medi-Cal's income limit is generally around $1,900 per month). Most of the members of my program live on Supplemental Security Insurance (SSI), which is generally about $1,200 per month. A person on SSI cannot have more than $2,000 of total assets to receive these benefits. Some board and cares have an "SSI rate" where they will charge roughly $1,300 a month for a shared room. SSI adjusts the total SSI received by such a person to roughly $1,400 per month, leaving about $100 total per month for a person living in a board and care after their rent in covered. Most board and cares do not have this type of accommodation. This leads to our members often being discharged unsafely to an ILF after hospitalization due to lack of supportive housing options, despite advocacy from my program that a member needs a higher level of care. ILFs, as they are currently, have very little (if any) support for people living with SMI, and in many situations can be a trigger. The biggest issue is only board and cares and levels of care higher than that can assist people with medications

- Lack of Engagement Activities at Board and Cares - Most board and cares have few, if any, activities for residents. Most people living in board and cares have limited ability to leave the facility, and it's very damaging to one's mental health essentially being in one place every day with the only activity available being watching TV. People request more games, arts and crafts, exercise programs, and ways to have community outings

- Lack of Support, Grocery Stores, Community Resources Near Low-Income Housing - Many board and cares, ILFs, and SROs are located in areas where grocery stores, parks, and other positive community resources are not easily accessible. Particularly for the older adult population I work with, if the nearest bus stop is a mile away, it is unreachable given limited mobility. In addition, many people with SMI struggle to use the bus and are at increased risk of victimization on public transportation. This leads to many of our members to lean on nearby liquor stores/smoke shops that deplete their already limited funds, are risks for triggering unhealthy coping skills like alcohol use, and usually result in less healthy options for food/drinks. It also leads to lack of community integration

- Trauma Inflicted by the System - I heard from many people in listening sessions, from members of my program, and have experienced personally trauma from the behavioral health system. This trauma largely relates to forced treatment, restraints, and seclusion. When a system that is meant to help people in crisis is responsible for trauma, it is extremely hard to rebuild trust and engage in a positive way with the system. It becomes

an enormous barrier to recovery. I strongly encourage forced treatment, restraints, and seclusion being a truly last resort in situations that are immediate safety risks. This is not currently the case

- Lack of Clarity, Guidelines, Standardization - Many changes are coming or starting to take effect, and there's a lack of information around how they are meant to be/going to be implemented. For example, my program will be transitioning to a level 2 FSP in less than 3 months. My administrators are currently trying to design a program without specifics even as basic on what our staffing level will be and what positions we are able to have at the program (will we have a housing coordinator, intake specialist, etc). There is meant to be housing assistance available now through Medi-Cal, but in speaking with Medi-Cal representatives, we have largely been told they are unfamiliar with this program or don't know who to connect us to to obtain this support. Changes to Medi-Cal and SNAP currently lack details on what will qualify a person for an exemption to things like work requirements and how this will be verified. This uncertainty is difficult for staff, but it is extremely challenging for our members living with SMI and has frequently led to exacerbated symptoms when access to housing and benefits are seemingly at risk

- Lack of Options for People Losing Medi-Cal/SNAP - It appears there are few resources available for people living with SMI that may lose access to coverage through Medi-Cal. FQHCs, while extremely valuable, are not currently setup to treat SMI. How will people living with SMI that are, for instance, victims of human trafficking set to lose access to benefits, receive the support they need? Food banks are already having difficulty meeting demand, how will low-income people that lose access to SNAP consistently meet their basic needs?

Thank you both for your time. I'm happy to provide additional detail on anything if it would be helpful,

BHAB Member 3 Comments:

- Accessibility of the document was horrible and a deterrent to actual feedback.
- Disparities in Access to Care for both older adults and youth, particularly for non-English language. The solution described is to, “To address these gaps, SDCBHS is expanding crisis and diversionary services that reduce barriers to entry and improve linkage to ongoing care.” (pg. 24). While adding additional entry points, the outlined solutions do not address the need for services in different languages.
- Why are the state measures starting on page 44 all “not applicable?”
- Page 84- The plan notes collaboration with Healthy San Diego. Which date of HSD was BHSA and the IP presented for engagement versus simply a report out that it was happening? The direct collaboration between the county BHP and MCPs should happen before guidance from the state.
- Page 88- care continuum section is “marked complete” but has no information.

- Page 92- only 17% of county contracted providers have contracts with MCPs- this seems very low and could contribute to breakdowns in transitions of care. How are the programs benefiting from ECM and CS investments (pg. 189) if they aren't contracted with MCPs?
- Early Intervention Programs- Why are many operating without using EBPs? Why were there no additional opportunities identified for EI?
- Page 192- good call out for what the community has been asking for. More of this and more specificity. "For the last three years, stakeholders have consistently identified the following areas as priorities for enhancement within San Diego County's continuum of care: Accessibility; Care Coordination and Navigation; Community Outreach and Education; Crisis Response Services; Culturally Appropriate and Affirming Care; Support for People Experiencing Homelessness; Services for Youth and Transition Age Youth(TAY); and Workforce Capacity and Diversity."
- Page 192 has a comment about the importance of ACEs, but there was a recently terminated contract for ACEs?
- In the community engagement summaries, there are really rich feedback reports, but I don't see that feedback directly incorporated into the plan itself or informing future work as it's currently outlined. Is there a way to include the voices of these stakeholders in a more meaningful way?
- Where is the UCSD CPP report?
- Page 310- the IHP feedback session has an inaccurate attendee list.
- Page 486- missing data in the far right columns.
- Can we see the breakdown in ages for adults/older adults instead of grouping them together?
- Early intervention and focus on youth is disproportionate to spending.

BHAB Member 4 Comments 3/30/26

Pg. 11, IP Section 34

- There is a great need in this county to track individuals throughout the continuum of care, especially those individuals cycling in and out of county jails and juvenile detention. There currently is no way to clearly know if any interventions have been successful.
- 3/30/26, 10:22 AM, Engage SD:

Pg. 11, IP Section 34

- The poor quality of behavioral health services in the County jails has been documented by the Grand Jury, the State legislature audit, the League of Women Voters, and many other entities. Deaths have occurred in custody as a result of the SDSO policies and procedures and the county has paid out upwards of $100 million in lawsuits in a 10 year period. The State must consider the quality of services as the incarcerated person re-enters the community as they likely will be more acute.

APPENDIX E

Quality Improvement Work Plan
FY25-27

County of San Diego

Behavioral Health Services

FY 2025-27

Quality Improvement Program & Work Plan

LIVE WELL SAN DIEGO

Table of Contents

INTRODUCTION

In accordance with the California Department of Health Care Services (DHCS) requirements outlined in Title 9, Section 1810.440, San Diego County Behavioral Health Services (SDCBHS) has a Quality Improvement (QI) Program and corresponding Annual Quality Improvement Work Plan (QIWP).

The goals of the SDCBHS QI are based on targeted healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: "Crossing the Quality Chasm." All health care services are to be *safe, client centered, effective, timely, efficient,* and *equitable*. The QI and QIWP are guided by the IOM aims, the SDCBHS' mission statement, and these guiding principles.

SDCBHS Guiding Principles:

- To foster continuous improvement to maximize efficiency and effectiveness of services.
- To support activities designed to reduce stigma and raise awareness surrounding mental health and substance use disorder.
- To maintain fiscal integrity.
- To ensure services are:
    - Outcome driven
    - Culturally competent
    - Recovery and client/family centered
    - Innovative and creative
    - Trauma-informed
- To assist County employees to reach their full potential.

County of San Diego Behavioral Health Services Mission Statement:

To help ensure safe, mentally healthy, addiction-free communities.

In partnership with our communities, work to make people's lives safe, healthy, and self-sufficient by providing quality behavioral health services.

QUALITY IMPROVEMENT (QI)

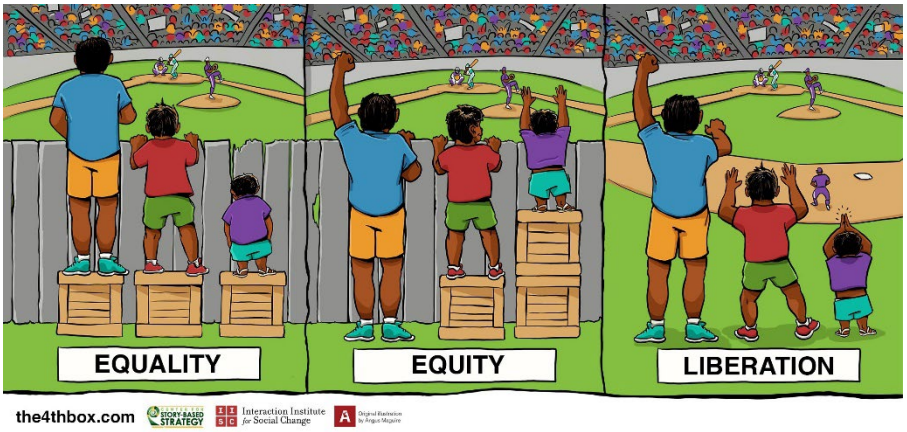
QI Purpose

The purpose of the SDCBHS QI is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

QI delineates the structures and processes that are used to monitor and evaluate the quality of mental health and substance use disorder services provided to members. QI encompasses the efforts of persons with lived experience, behavioral health advocates, family members of members served, mental health clinicians, substance use treatment providers, quality improvement personnel, and other stakeholders.

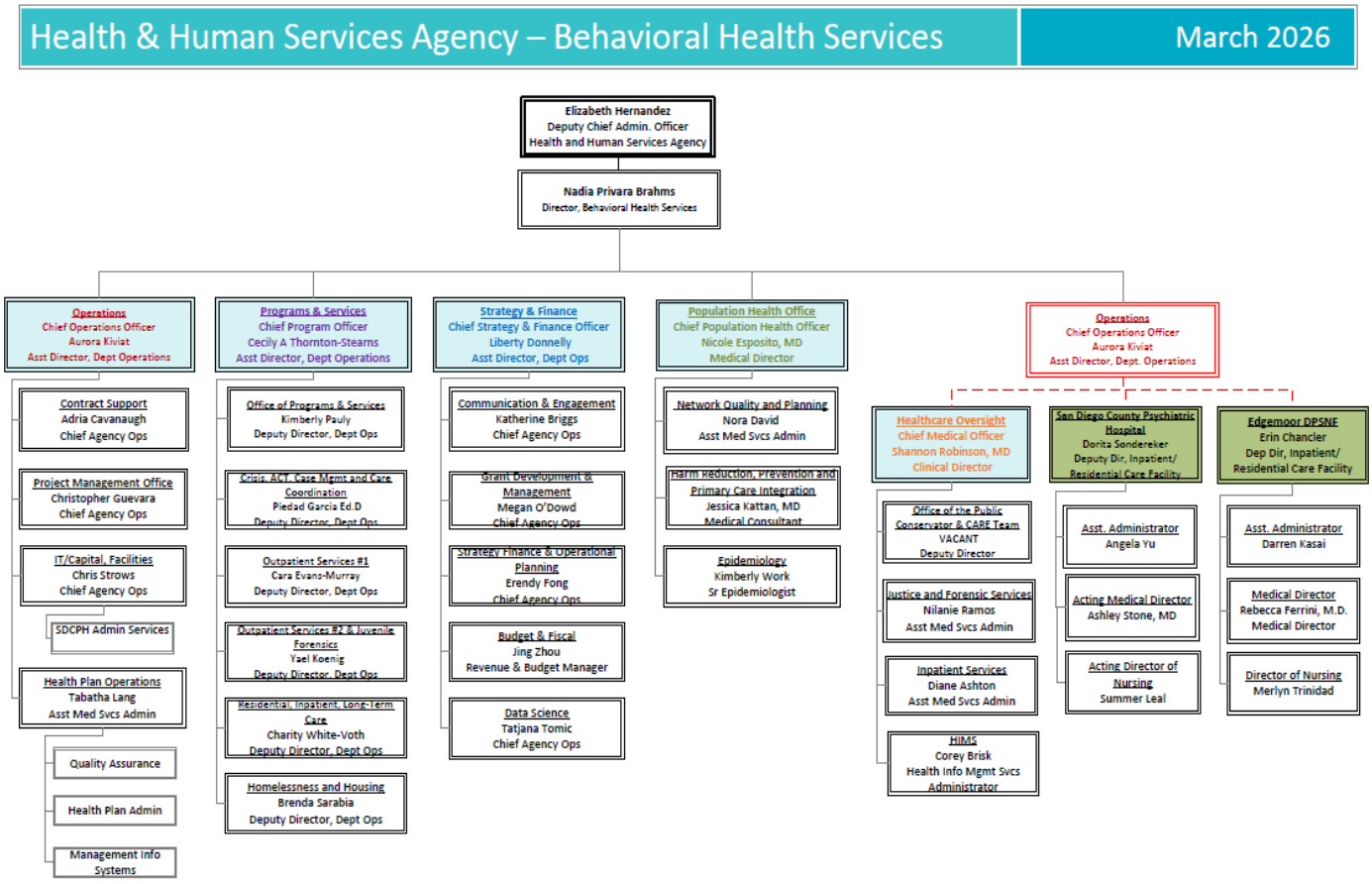
QI and the Quality Improvement Work Plan (QIWP) are based on the following values:

- Collaboration with persons with lived experience and stakeholders when developing QI and QIWP objectives.
- Member feedback is an essential component and incorporated into the QI and QIWP.
- QI and QIWP are mindful of those whom data represent and, therefore, integrate an equity framework to improve systems and services.



Quality Improvement Program

Over the past few years, SDCBHS has undergone additional reorganization. Part of the reorganization was the restructuring of the QI Program. To ensure a more comprehensive approach, multiple teams now have responsibility for enhancing quality improvement. The new structure consists of collaboration from the following departments:



Recent state-level behavioral health policy changes have driven efforts to enhance service delivery by streamlining and integrating care across the continuum for vulnerable populations. These efforts are informed by population needs and emphasize equity and cultural responsiveness.

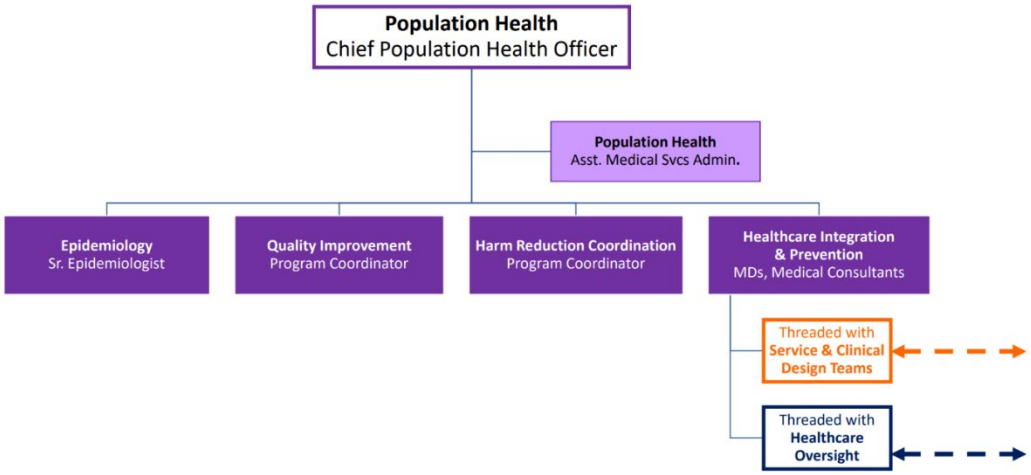
Proposition 1 significantly amends MHSA and renames the law as the Behavioral Health Services Act (BHSA). BHSA structurally reforms MHSA and reconfigures funding for local services and state initiatives to increase behavioral health care capacity for vulnerable populations, including individuals with substance use disorder (SUD). In addition to the allowance of treatment for SUD, BHSA invests resources for housing interventions to address chronic homelessness, support for the behavioral health workforce, and expands prevention and early intervention efforts, such as pilot programs for diverse populations. Lastly, BHSA revises local county processes for Community Program Planning (CPP) and reporting for improved accountability and transparency.

The Centers for Medicare & Medicaid Services (CMS) approved the BH-CONNECT demonstration which establishes a robust continuum of evidence-based community services for people with significant behavioral health needs. By expanding community-based services and

integrating evidence-based practices (EBPs), BH-CONNECT aims to reduce costly emergency department visits, hospitalizations, and institutional stays, including within carceral settings. This initiative will help Medi-Cal members with significant behavioral health needs, including children and youth involved in child welfare, individuals and families experiencing or at risk of homelessness, and people involved in the justice system. BH-CONNECT also includes incentives for Counties which includes a $1.9 billion Access, Reform, and Outcomes Incentive Program to reward county behavioral health plans for improving access, reducing disparities, and strengthening behavioral health quality improvement. These new changes are impacting quality improvement work within SDCBHS.

QI Program Structure

Population Health: The Population Health Unit under the leadership of the Chief Population Health Officer Dr. Nicole Esposito implements a population health approach to support access to behavioral health care by ensuring those in need have access to services, working to identify and eliminate health disparities, driving excellent health outcomes and supporting continuous improvement with the goal of addressing meaningful clinical issues affecting beneficiaries system-wide.



Data Science: A centralized data hub to support rapid-response evidence-based decision making and inform program, clinical, and operations strategies; provide oversight in relation to key Data Governance components. Data Science consists of the following units:

- **Data Acquisition** - Support Data Integration by acquiring data from internal and external partners and maintaining data glossary
- **Data Integration** - Combine data from multiple sources to extract additional value and leverage data as an enterprise asset
- **Management Reporting & Analysis** - Responsible for all SDCBHS reporting & analysis to support decision making

- **Training & User Engagement** - Provide internal and external training to promote user engagement and adoption

Quality Assurance (QA): The QA team is another component of the QI program and is comprised of Utilization Review Quality Improvement Specialists—licensed clinicians—who conduct Medi-Cal site certifications, grievance, appeal and state fair hearings oversite, medical record reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs. The team includes analyst support to develop reports used to track data trends with a focus on quality improvement activities. Through monitoring conducted by the QA team, appropriate and timely intervention of occurrences that raise quality of care concerns are implemented. Appropriate follow-up action steps are taken when these quality concerns arise and the results of the interventions taken are evaluated annually at a minimum.

Management Information Systems (MIS): This team provides data management and systems support to SDCBHS consumer management information system users, including but not limited to service providers, administrative and support staff, and SDCBHS staff. MIS manages the administrative functions of San Diego Web Infrastructure for Treatment Services (SanWITS) and Cerner Community Behavioral Health (CCBH), including system development activities and promotions testing.

Health Plan Administration: As part of the reorganization SDCBHS created the Health Plan Administration (HPA) team as part of the SDCBHS Operations division. The HPA team is tasked with both existing and emerging bodies of work related to the Specialty Mental Health Plan and Drug Medi-Cal Organized Delivery System. This includes planning, developing, organizing, and coordinating various SDCBHS tactical policies, processes, and controls to comply with federal and state regulations, mandates, and guidance.

Program and Services: The largest unit in SDCBHS, comprised of nearly 450 staff who provide oversight to 300 programs and services in 400 locations. The key activities of this unit include program planning and development, clinical leadership, services coordination, contract administration, and direct service. During the most recent phase 5 of the reorganization, the program and services unit focused on centralizing oversight under teams led by deputy directors refining contract officer representatives (COR) expertise on specific areas and improving oversight for better behavioral health program development and delivery.

While the responsibility is now shared among these various teams, the collective purpose of the SDCBHS QI Program is to ensure that all members and their families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The following are essential elements of the QI structure:

- **Executive Quality Improvement Team (EQIT)**
  The EQIT is responsible for implementing the QI, responding to recommendations from the Quality Review Committee (QRC), and identifying and initiating quality improvement activities. The EQIT consists of the SDCBHS senior leadership including the Director, Clinical Director, Assistant Directors, Deputy Directors, Chief Population Health Officer, and QI Assistant Medical Services Administrator.

- **Outcomes and Metrics Committee (OMC)**
  The Outcomes and Metrics Committee (OMC), established in 2022, evaluates the effectiveness of programs and services within San Diego County Behavioral Health Services (SDCBHS). One of the OMC's primary objectives is to establish performance indicators that assess the quality of services provided within the mental health (MH) and substance use disorder (SUD) systems of care. By identifying and selecting key performance indicators at each level of care, the committee aims to spotlight areas for increased efficiency and quality improvement.

OMC Completed/Current Phases:
In Phase 1: *Initial Assessment*, a comprehensive review was conducted for each level of care (LOC) within both the MH and SUD systems. Subject Matter Experts (SMEs) were engaged to gather valuable insights and feedback. This phase ensured the continuity of services across the MH and SUD programs.
In Phase 2: *Development of Performance Indicators*, key performance indicators were established to measure the quality and effectiveness of services. The focus was on metrics that highlighted areas for potential efficiency improvements. During this phase, the BH Connect initiative was launched as a statewide incentive opportunity. BH Connect was designed to enhance access to care for individuals with complex needs, aligning with OMC's intention to improve care coordination and communication across behavioral health services. Thus, many of the BH Connect indicators were incorporated into the development of performance indicators selected by OMC. Evidence-based research outcomes and SME feedback also guided the selection of these indicators. Baseline data for all selected indicators was obtained, and approval from EQIT is currently in progress.

OMC Future Phases
In Phase 3: Implementation and Monitoring, the identified indicators will be implemented across the systems of care. Processes will be developed for ongoing monitoring and evaluation of performance data, with regular reviews to assess progress and adjust as needed.
Moving to Phase 4: Continuous Improvement, the collected data will be analyzed to identify trends and areas requiring enhancement. Stakeholders will be engaged to discuss the findings and collaborate on strategies for improvements. Additionally, efforts will be made to foster a culture of continuous improvement within SDCBHS.

Quality Review Committee (QRC)
The Population Health Network Quality and Planning (NQP) team organizes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and substance use disorder systems, and the QIWP. The QRC meets quarterly, and the members are persons with lived experience and family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides recommendations and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including members in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

Quality Review Committee (QRC) Focus

QRC has identified the following topics of focus for FY 2025-27:

- Review reports and identify areas for improvement
- Examine EQRO, BHSA, and BH Connect metric requirements and consider strategies to address areas with the highest level of impact
- Continue to conduct root cause analysis and propose interventions for quality improvement activities

Performance Improvement Projects

To be responsive and transformative, the SDCBHS is working on four Performance Improvement Projects (PIPs):

PIP #1:	
TOPIC:	**MH Non-clinical PIP: Improve timely access from first contact from any referral source to first offered appointment for any specialty mental health service (SMHS)**
AIM STATEMENT:	This project aims to increase the timeliness to first non-urgent mental health service to a minimum of 80%.
INTERVENTION/PLANS:	Established access workgroups for both Child/Youth programs and Adult programs. Currently examining data of programs with high access times to establish intervention. Planned PDSA with CY high access time program as pilot.
LEARNINGS:	TBD

PIP #2:	
TOPIC:	**MH Clinical PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM)**
AIM STATEMENT:	This project aims to increase by 5% the percent of adult, Medi-Cal-eligible clients from pilot EDs receiving navigation support services within 30 days after an ED visit.
INTERVENTION/PLANS:	Reviewing data, discussing data sharing with HPs, SD Relay for involuntary MH holds, review previous interventions from BHQIPs (NAMI Peers)
LEARNINGS:	TBD

PIP #3:	
TOPIC:	**SUD Non-clinical PIP: Peer Increase the percentage of members who receive at least one Peer Support Service**
AIM STATEMENT:	This project aims to increase by 5% the percentage of members who receive at least one Peer Support service.
INTERVENTION/PLANS:	Reviewing data on number of Peers in SUD programs by LOC, expansion of peers in programs (SD Relay, Drug Checking, OTPs)
LEARNINGS:	TBD

PIP #4:	
TOPIC:	**SUD Clinical PIP: Follow-Up After Emergency Department Visit for Substance Use (FUA)**
AIM STATEMENT:	This project aims to increase by 5% the percent of adult, Medi-Cal-eligible clients from pilot EDs receiving navigation support services within 30 days after an ED visit.
INTERVENTION/PLANS:	Reviewing data, discussing data sharing with HPs, establishing SD Relay for primary intervention, presentation at February's Hospital Partner's meeting on SD Relay
LEARNINGS:	TBD

QI Committee and Workgroup Diagram

The following radial diagram depicts the committees and workgroups that the QI Program collaborates with to ensure high quality of care:

QI Process

SDCBHS has adopted a continuous quality improvement process that threads multiple levels of coordination through an iterative Plan-Do-Study-Act (PDSA) problem-solving model. The PDSA cycle is ongoing, with different levels of the organization becoming more efficient as the model is intuitively adopted into program planning.

This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service, and administrative functions. The overall objective of the quality improvement process is to ensure that quality is built, measured consistently, interpreted, and articulated into the performance of the SDCBHS functions. The quality improvement process is incorporated internally into all service areas of SDCBHS. It is applied when examining the care and services delivered by the SDCBHS network of providers, programs, facilities, and the Administrative Service Organization.

Member and Family Involvement in QI

Consistent with our goals of involving members and family members in the quality improvement process, many of the QI activities are based on direct consumer feedback.

Members, persons with lived experience and family members, providers, and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Behavioral Health Advisory Board, community coalitions, planning councils, community engagement forums, consumer and family focus groups, member and family-contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups (PAGs), consumer satisfaction surveys, behavioral health advocacy programs, complaints, grievances, and the County Behavioral Health website.

Member Grievance and Appeals

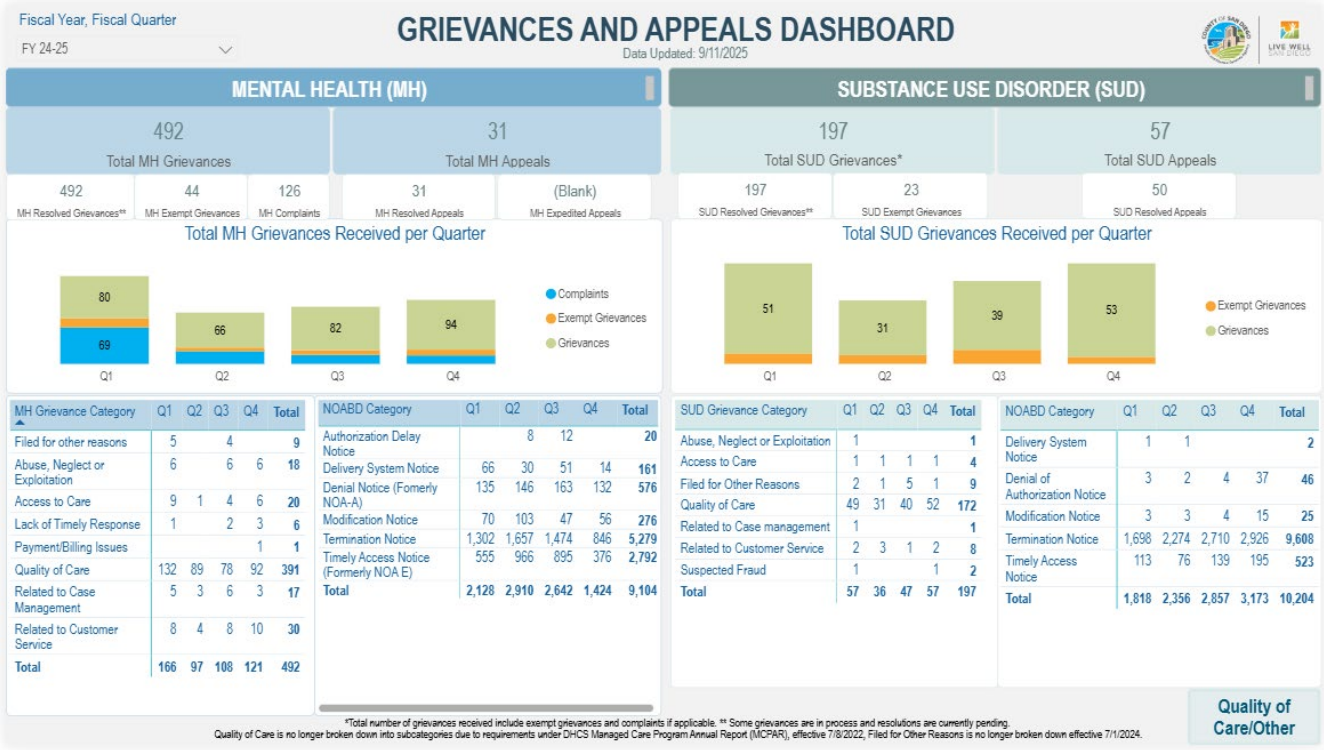
San Diego County Behavioral Health Services is committed to honoring the rights of every member to have access to a fair, impartial, effective process through which the member can seek resolution of a grievance or adverse benefit determination by the MHP. All county operated and contracted providers are required to participate fully in the Member and Appeal Process. The MHP has delegated the roles and responsibilities of managing the grievance and appeal resolution process for members to contracted advocacy organizations. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider will cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

At all times, Grievance and Appeal information must be readily available for members to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and stamped, self-addressed envelopes available to members. These materials shall be displayed in a prominent public place. Members

shall not be subject to any discrimination, penalty, sanction, or restriction for filing a grievance/appeal.

Monitoring the Member Grievance and Appeal Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and experience of members, will monitor feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the SDCBHS System of Care and stakeholder through system-wide meetings and councils. Below is an example of the Grievance and Appeals Dashboard data for FY 2024-25.



State Fair Hearing (SFH)

Members must exhaust the BHP's appeal process prior to requesting a State Hearing. A member has the right to request a State Hearing only after receiving notice that the Plan is upholding an Adverse Benefit Determination. If the Plan fails to adhere to the notice and timing requirements in 42 CFR§438.408, including the BHP's failure to provide a NOABD or a NAR the member is deemed to have exhausted the Plan's appeals process. The member may then initiate a State Hearing. Members may request a State Hearing within 120 calendar days from the date of the NAR which informs the member the Adverse Benefit Decision has been upheld by the Plan.

For Standard Hearings, the BHP shall notify members that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing.

- For Expedited Hearings, the BHP shall notify members that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing.
- For Overturned Decisions, the BHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the Plan's adverse benefits determination.

Services for Dual Diagnosis Members (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult & Older Adult Behavioral Health, Children, Youth and Families Services and Substance Use Disorders, recognize that clients with a dual diagnosis, a combination of mental illness and substance use, may appear in all parts of the system. These conditions are associated with poor outcomes and higher costs for care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

Upon intake to a behavioral health program, the presence of substance use by clients shall be assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention.

To support the implementation of the Dual Diagnosis Initiative, Behavioral Health Services recommends the development of Dual Diagnosis Capable programs. Programs shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- COMPASS completion
- Action Plan development
- Program Policies
    - Welcoming Policy/Statement
    - BHS Co-occurring Disorders Policy
- Training and supervision of staff in Integrated Treatment Practice Model
- Integrated Screening
- Integrated Clinical Assessment
- Integrated Psychiatric Assessment
- Implementing Stage of Change Interventions
- Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)

- QA Baseline Monitoring Tool compliance

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use No. BHS 01-02-205 and the HHSA, Dual Diagnosis Strategic Plan, 2005.

Cultural and Linguistic Competence at SDCBHS

SDCBHS is committed to enhancing service delivery to meet cultural and linguistic competence requirements. San Diego County is the second most populous of California's 58 counties and the fifth largest county in the United States. For county residents under 18, 30.1% are Latinx, and approximately 27.1 of the county's population are immigrants, including refugees, and speak 68 languages *(Cultural Competency Plan FY 2024-25)*.The rich diversity in San Diego County requires consistent efforts to augment service delivery based on community needs. The Organizational Providers Operation Handbook (OPOH) and Substance Use Disorder Provider Operation Handbook (SUDPOH) are service delivery operational manuals that include guidance on providing *Culturally and Linguistically Appropriate Services (CLAS)* Standards, 15 action steps developed by the Health and Human Services Office of Minority Health, intended to inform, and facilitate efforts towards becoming culturally and linguistically sensitive across all levels of a healthcare continuum. All SDCBHS provider's Statements of Work include specific language on the requirements to implement the CLAS Standards. Countywide, staff are required to complete 4 hours of cultural competency training per fiscal year. In FY 2023-24, the program transitioned to the name Cultural Responsiveness Academy. The new training model takes the form of individual day trainings, as the County's current workforce shortages has not allowed for the foundational series model.

In an effort to continuously monitor the county's progress towards reducing disparities SDCBHS in partnership with UCSD, developed the *Community Experience Partnership (CEP)*, a set of interactive dashboards that help to track and monitor gaps in services, an ongoing project with components for further development with stakeholder engagement.

San Diego Access and Crisis Line

The San Diego Access and Crisis Line (ACL) is confidential, free of charge, 24 hours a day, 7 days a week resource designed to connect individuals who may require behavioral health information or intervention to appropriate programs, providers, and resources.

The ACL offers behavioral health resources countywide on mental health and substance use from experienced counselors, all trained in crisis intervention, including but not limited to: mental health referrals, suicide prevention, crisis intervention, mobile crisis response services, community resources, and alcohol and substance use support services. Language interpreter

services enable the ACL to assist in over 200 languages within seconds. Staff evaluates the degree of immediate danger and determines the most appropriate intervention.

The ACL provides access to crisis intervention and response services for those actively experiencing a behavioral health crisis. SDCBHS receives the Optum Access and Crisis Line Summary Statistics Report monthly where services are regularly monitored. In FY 2023-2024, a total of 93,316 Mental Health and DMC-ODS (SUD) calls were received by the ACL, with the average responsive time ranging between 14-19 seconds.

Ensuring Access to Behavioral Health Services

SDCBHS is committed to ensuring access to services in a timely manner consistent with the Department of Health Care Services standards. When a consumer contacts a Mental Health and/or Substance Use Disorder program, providers are required to log every inquiry for services they receive. This tracking mechanism is in place to ensure members receive services within state required standards. SDCBHS monitors monthly access times to first appointment and has set up data infrastructure through PowerBI dashboards (internal) to aid in this QI process.

Targeted Aspects of Care Monitored by the QI Program

Appropriateness of Services

- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes
- Utilization Management
- Crisis Stabilization Services

Utilization of Services

- Retention Rate
- Completion Rate
- Readmission Rate
- Patterns of Utilization
- Average Length of Stay (ALOS) for Hospitals

Access to Routine, Urgent and Emergency Services

- Crisis Stabilization Services
- Access Times for Assessments
- Access to Inpatient Hospital Beds
- Access to Crisis Residential Services
- Access to Residential Treatment Services
- Call Volume for the Access and Crisis Line (ACL)

Safety of Services

- Serious Incidents
- Medication Monitoring
- On- Site Review of Safety

Client Satisfaction

- Grievances
- Satisfaction Surveys
- Trauma-Informed
- Staff Cultural Competence
- Analysis of Gaps in Services
- Provider Language Capacity
- Penetration Rate of Populations
- Training Provided and Evaluated for Feedback

Client Rights

- LPS Facility Reviews
- Patient Advocate Findings
- Quarterly Grievance and Appeals Reports
- Conservatorship Trend Reports

Effectiveness of Managed Care Practices

- Provider Satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

Coordination with Physical Health and Other Community Services

- MOAs with Healthy San Diego
- Integration with Physical Health Providers
- Integration with Mental Health and/or Substance Use Disorder Providers
- Outcomes Resulting from Improved Integration

QUALITY IMPROVEMENT WORK PLAN (QIWP) DEVELOPMENT

QIWP Goals

The purpose of the SDCBHS QIWP is to establish the framework for evaluating how QI has contributed to meaningful improvement in trauma-informed care and administrative services. SDCBHS priorities have shifted under the new guidance of DHCS and HSAG. Priorities of the QIWP align with the new guidance with areas of focus as Performance Validation Measures (PMV), Network Adequacy Validation Measures (NAV), and Performance Improvement Projects (PIPs).

The QIWP goals define targeted measures by which SDCBHS can objectively evaluate the quality of services, provided to members and families. It defines the specific areas of quality of services, both clinical and administrative, that SDCBHS will evaluate for FY 2025-26, with consideration for continuation in FY 2026-27.

The QIWP will be monitored and revised throughout the year in a continuous quality improvement process. It will be reviewed and approved by the Quality Review Committee (QRC), and a formal evaluation will be completed annually.

Goals established on the QIWP can be process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

1) Consumer and family feedback on areas that need improvement
2) Systemwide enhancement identified through data and analysis

DEVELOPING THE QIWP

The QIWP defines the goals, indicators and/or measures, and planned activities for quality improvement within the domains of Performance Measure Validation (PMV), Network Adequacy Validation (NAV), and Performance Improvement Projects (PIP).

Areas of focus within these domains include:

1. *ACCESS* -Ensuring that members have ready access to all necessary services within the MHP: this includes access to culturally relevant services to address the unserved, underserved and inappropriately served communities.

2. *TIMELINESS*- Ensure timely access to high quality, culturally sensitive services for individuals and their families.

3. *QUALITY/EFFECTIVENESS OF CARE*- Analyzing and supporting continual improvement of MHP clinical and administrative processes in order to achieve the highest standard of care, with care processes that are recovery oriented, evidence-based and culturally sensitive.

4. *CONSUMER REPORTED OUTCOMES*- Ensure the accountability, quality and impact of the services provided to clients through research, evaluation, and performance outcomes.

Annual Evaluation of the QIWP

SDCBHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

Target Objectives for the QIWP

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations. It ensures high-quality, trauma-informed systems and services are being engaged by consumers and family members in San Diego County. San Diego County SDCBHS identifies and prioritizes opportunities for improvement driven by the results of the QIWP. SDCBHS also utilizes qualitative and quantitative data gathered through various means including the results of the Consumer Satisfaction Surveys; grievance and appeal data and reports; discussions in community forums; regional meetings attended including the Mental Health Contractors Association (MHCA) and Alcohol and Drug Services Provider Association (ADSPA); and councils such as the Quality Review Committee (QRC), the Cultural Competence Resource Team (CCRT) and the Behavioral Health Advisory Board (BHAB). The significant issues identified by these various means are considered when implementing efforts around opportunities for improvement, including the manner and extent to which the opportunity affects care and services.

Mental Health Services Goals

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Performance Measure Validation (PMV)	1	FUM: Follow-Up After Emergency Department Visit for Mental Illness: Meet the minimum state required MPL or if previously met, increase by 5% the emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days.	Percent of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days. **MY 2024 Baseline:** 61.79% MY 2024 Benchmark MPL: 53.82%	BHS will join the IHI collaborative project with Blue Shield and Kaiser Permanente to improve population health outcomes for FUM/FUA. BHS will continue collaborating with Managed Care Plans through the Healthy San Diego Behavioral Health Quality Improvement workgroup, prioritizing developing data infrastructure and care coordination for FUA and FUM.	Population Health Network Quality & Planning (NQP)
	2	FUH: Follow-Up After Hospitalization for Mental Illness: Meet the minimum state required MPL or if previously met, increase by 5% the discharges for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.	Percent of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge. **30 Day MY 2024 Baseline**: 44.48%	Complete the A3 Lean Process template to identify processes for measure rating improvement. Work with hospital leadership to review patient follow-up protocols to identify potential areas of enhancement.	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
			7 Day MY 2024 Baseline: 20.12% MY 2024 Benchmark MPL: 59.85%		
	3	APP: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics: Meet the minimum state required MPL or if previously met, increase by 5% the children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Percent of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. **MY 2024 Baseline:** 76.72% MY 2024 Benchmark MPL: 60.22%	BHS will develop a care framework that incorporates evidence-based psychosocial interventions as the first-line treatment for applicable conditions. BHS will develop a report that tracks children and adolescent clients who receive medication services with no other concurrent services to monitor that antipsychotic medication is part of a comprehensive and coordinated treatment plan.	Population Health Network Quality & Planning (NQP)
	4	SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia: Meet the minimum state required MPL or if previously met, increase by 5% the members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Percent of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. **MY 2024 Baseline:** 60.98% MY 2024 Benchmark MPL: 62.56%	Conduct research on the social determinants of health and special populations impacted by schizophrenia and present recommendations to leadership/ stakeholders aimed at enhancing adherence to antipsychotic medications for individuals with schizophrenia. Complete the A3 Lean Process template to identify processes for measure rating improvement.	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Network Adequacy Validation (NAV)	5	First Non-Urgent Appointment Offered: The average for first offered non-urgent appointment for all SDCBHS services will be within 10 business days of request for service.	Offered an appointment within 10 business days of request for service. **FY 2023-24 Baseline:** 11 days	Collaborate with Data Science to review Timely Access Data Tool (TADT) Reports in SmartCare to monitor status and assess if meeting standards. Review methodology used to measure the TADT and identify programs with high un-met standards, work with CORs; establish workgroups as needed.	Population Health Network Quality & Planning (NQP)
	6	First Non-Urgent Psychiatry Appointment Offered: The average for first offered non-urgent psychiatry appointment for SDCBHS will be within 15 business days of request for service.	Offered an appointment within 15 business days of request for service. **FY 2023-24 Baseline:** 4.8 days	Collaborate with Data Science to review Timely Access Data Tool (TADT) Reports in SmartCare to monitor status and assess if meeting standards. Review methodology used to measure the TADT and identify programs with high un-met standards, work with CORs; establish workgroups as needed.	Population Health Network Quality & Planning (NQP)
	7	Urgent Services Offered (Including all Outpatient Services): The average for first offered urgent appointment for all SDCBHS services will be within 48 hours without prior authorization and 96 hours with prior authorization of request for service.	48 hours without prior authorization 96 hours with prior authorization **FY 2023-24 Baseline:** 5.7 hours	Collaborate with Data Science to review Timely Access Data Tool (TADT) Reports in SmartCare to monitor status and assess if meeting standards. Review methodology used to measure the TADT and identify programs with high un-met standards, work with CORs; establish workgroups as needed.	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Performance Improvement Project (PIP)	8	San Diego County BHS will conduct two mental health PIPs per EQRO regulations.	a. FUM: Follow-Up After Emergency Department Visit for Mental Illness **[PMV Goal]** **MY 2024 Baseline:** 61.79% MY 2024 Benchmark MPL: 53.82% b. Improve timely access from first contact from any referral source to first offered appointments for any specialty mental health services (SMHS) **CY 2024 Baseline:** 75.9%	a. In collaboration with two of our local health plans, Kaiser and Blue Shield, BHS will participate in the second cycle of the Medi-Cal Behavioral Health Collaborative, which will include Learning Sessions Action Periods with educational webinars, Coaching and Measurement. BHS will identify interventions for the implementation stage prior to 1/1. b. In collaboration with UCSD, BHS will support and approve interventions, which are to begin 1/1/26. BHS will conduct data analysis to measure progress.	Population Health Network Quality & Planning (NQP)
Consumer Reported Outcomes	9	In FY 2025-26, BHS will demonstrate an improvement in client-perceived quality of life, as measured by Question #16 on the Recovery Markers Questionnaire (RMQ) ("I have a decent quality of life"), for newly enrolled clients in behavioral health services.	Increase the mean of 3.66 from FY 2024-25 with a target mean score of ≥ 3.96 in FY 2025–26 for RMQ #16 for newly enrolled clients.	Conduct a crosswalk analysis of quality of life indicators across the RMQ, CANS, and PSCs. Identify correlations and gaps in quality of life data elements that align with BH Connect incentive requirements. Partner with UCSD analysts and researchers to conduct a deeper evaluation of RMQ Question #16 responses. Analyze trends by demographic characteristics, service	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
				types, and length of engagement to identify key drivers of improvement.	

Substance Use Services Goals

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Performance Measure Validation (PMV)	1	Follow-up after emergency department visit for substance use (FUA): Meet the minimum state required MPL or if previously met, increase by 5% the emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days.	Percent of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days. **30 day MY 2024 Baseline:** 53.28% MY 2024 Benchmark MPL: 36.18%	BHS will join the IHI collaborative project with Blue Shield and Kaiser Permanente to improve population health outcomes for FUM/FUA. BHS will continue collaborating with Managed Care Plans through the Healthy San Diego Behavioral Health Quality Improvement workgroup, prioritizing developing data infrastructure and care coordination for FUA.	Population Health Network Quality & Planning (NQP)
	2	Pharmacotherapy for Opioid Use Disorder (POD): Meet the minimum state required MPL or if previously met, increase by 5% the opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.	Percent of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. **MY 2024 Baseline:** 20.51% MY 2024 Benchmark MPL: 25.28%	Complete the A3 Lean Process template to identify processes for measure rating improvement. Enhance contract requirements to increase access to medication-assisted treatment (MAT) services. Address negative attitudes and stigma surrounding individuals with OUD through public awareness campaigns and educational initiatives.	Population Health Network Quality & Planning (NQP)
	3	Use of Pharmacotherapy for	Percent of adults age 18 years and older with pharmacotherapy for opioid	Enhance contract requirements to increase access to	Population Health Network Quality &

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
		Opioid Use Disorder (OUD): Meet the minimum state required MPL or if previously met, increase by 5% the adults age 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	use disorder (OUD) who have at least 180 days of continuous treatment. **MY 2024 Baseline:** 80.66% MY 2024 Benchmark MPL: 60.20%	medication-assisted treatment (MAT) services. Address negative attitudes and stigma surrounding MAT and individuals with OUD through public awareness campaigns and educational initiatives.	Planning (NQP)
	4	Increase the timely initiation of SUD treatment following a new diagnosis (IET): Meet the minimum state required MPL or if previously met, increase by 5% the new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.	Percent of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. **MY 2024 Baseline**: 48.59% MY 2024 Benchmark MPL: 44.51%	Conduct a root cause analysis and review program policies and procedures to Identify and address potential barriers to care and areas for enhancements.	Population Health Network Quality & Planning (NQP)
	5	Increase sustained engagement in SUD treatment following initiation (IET): Meet the minimum state required MPL or if previously met, increase by 5% the new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Percent of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. **MY 2024 Baseline**: 25.32% MY 2024 Benchmark MPL: 14.39%	Conduct a root cause analysis and review program policies and procedures to Identify and address potential barriers to care and areas for enhancements.	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Network Adequacy Validation (NAV)	6	First Non-Urgent Appointment Offered: The average for first offered non-urgent OP/Residential appointment for all SDCBHS services will be within 10 business days of request for service.	% of contacts that met the state required (10 business days for OP/Residential) for non-urgent appointment. **FY 2023-24 Baseline**: 4.2 days	BHS will conduct data analysis of first non-urgent appointment offered by reviewing the TADT in SmartCare. BHS will identify any outliers and share with CORs.	Population Health Network Quality & Planning (NQP)
	7	Opioid Treatment Program: The average for first offered Opioid Treatment appointment for all SDCBHS services will be within 3 business days of request for service.	Offered an appointment within 3 business days of request for services **FY 2023-24 Baseline**: 0.2 days	BHS will conduct data analysis of first offered appointments in SmartCare by reviewing the TADT. BHS to share any findings of outliers with CORs.	Population Health Network Quality & Planning (NQP)
Performance Improvement Project (PIP)	8	San Diego County BHS will conduct two substance use PIPs per EQRO regulations.	a. Follow-up after emergency department visit for substance use (FUA) **[PMV Goal]** **Pre-PIP Baseline**: 53.28% MY 2024 Benchmark MPL: 36.18 b. Increase the percentage of members who receive at least one peer support service **Pre-PIP Baseline: 23.1%**	a. BHS will join the IHI collaborative project with Blue Shield and Kaiser Permanente to improve population health outcomes for FUM/FUA. BHS will continue collaborating with Managed Care Plans through the Healthy San Diego Behavioral Health Quality Improvement workgroup, prioritizing developing data infrastructure and care coordination for FUA and FUM. BHS will collaborate with UCSD to inform the PIP. BHS will Implement SD Relay, a peer led	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
				program that works directly with members in the EDs to connect them with follow-up services. b. Establish a collaboration involving biweekly to monthly meetings. Ensure that interventions are finalized and submitted on time for the 1/1/26 deadline. Connect with San Diego County's Peer Council to review and analyze both past and current initiatives.	
Consumer Reported Outcomes	9	In FY 2025-26, BHS will improve youth perception of the effectiveness of services, as measured by Question #16 on the Treatment Perception Survey (TPS) (*As a direct result of the services I am receiving, I am better able to do things I want to do),* by 5 percentage points.	Increase the response rate from the current baseline of 72.8% to the target rate of 77.8% in FY 2025–26 for question #16 on the TPS for youth responding.	Identify programs or providers with downward trends in TPS Question #16 outcomes. Enhance regular feedback loops with CORs to communicate and collaboratively interpret data trends. Provide program-level summaries and comparative benchmarks to support performance discussions. Support CORs with talking points and recommended follow-up actions to discuss with providers.	Population Health Network Quality & Planning (NQP)

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
				Collaborate with UCSD to utilize available post-handout intervention tools or guidance tailored for youth.	

Quality Data Infrastructure Services Goals

Domain	#	Goal	Indicators	Planned Activities	Lead for Coordination
Quality Data Infrastructure (QDI)	1	In FY 2025-26, Behavioral Health Services will work together with Managed Care Plans to establish an interim data sharing solution aimed at identifying patients who had a mental health/substance use related emergency department (ED) visit while establishing real-time data sharing solution.	Process established for data sharing to identify clients utilizing the ED.	Establish workgroup to discuss data sharing. Current Healthy San Diego (HSD) Quality Improvement Subcommittee will address this as a priority. Workgroup consists of SDCBHS staff and representatives from each of the Managed Care Plans.	Population Health NQP in collaboration with Epidemiology, HPA, and Data Science
	2	In FY 2025-26, the Behavioral Health Services Data Science team will work to establish data sharing with San Diego Health Connect to enable the County to receive ED encounter data via San Diego Health Connect.	SDCBHS will establish data sharing for receiving ADT data.	Data Science will collaborate with San Diego Health Information Exchange, in partnership with Pop Health (EPI). Population Health to inform what data fields are necessary for QI (e.g., FUM/FUA metrics).	Data Science with Pop Health to inform data fields needed
	3	In FY 2025-26, the County will work together with Managed Care Plans to create a data process for reporting on eligible and active members of the Enhanced Care Management program.	Process established for data sharing and enhanced communication for ECM clients. Establish data exchange process for ECM clients.	Established workgroup to discuss data infrastructure and data sharing. Current Healthy San Diego (HSD) Quality Improvement Subcommittee will address this as a priority. Workgroup consists of SDCBHS staff and representatives from each of the Managed Care Plans.	Population Health NQP, Epidemiology and Data Science staff

APPENDIX F

HR Report for Assessing Workforce Gaps
October 2025

Location Name	Union Code	FTE	Eff Date	Action	Reason	Modified Job	Job Code	Job Code Title
Edgemoor Skilled Nursing Fac	UM	1.000000	6/27/2025	PAY	ADJ	N	000340	Medical Director
Edgemoor Skilled Nursing Fac	UM	1.000000	6/27/2025	PAY	ADJ	N	000927	Chief, Departmental Operations
Edgemoor Skilled Nursing Fac	EM	1.000000	6/27/2025	PAY	ADJ	N	002156	Dep Dir, Inpat/Resid Care Fac
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Edgemoor Skilled Nursing Fac	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Edgemoor Skilled Nursing Fac	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Edgemoor Skilled Nursing Fac	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Edgemoor Skilled Nursing Fac	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	002387	Quality Assurance Specialist
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	002387	Quality Assurance Specialist
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002430	Cashier
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002521	Account Clerk Specialist
Edgemoor Skilled Nursing Fac	AE	1.000000	6/27/2025	PAY	ATB	N	002650	Stock Clerk
Edgemoor Skilled Nursing Fac	AE	1.000000	6/27/2025	PAY	ATB	N	002650	Stock Clerk
Edgemoor Skilled Nursing Fac	AE	1.000000	6/27/2025	PAY	ATB	N	002660	Storekeeper
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	002730	Sr Office Assistant
Edgemoor Skilled Nursing Fac	CL	1.000000	9/18/2025	PLA	FMC	N	002757	Admin Secretary II
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Edgemoor Skilled Nursing Fac	MA	1.000000	7/11/2025	PAY	MCP	N	003042	Manager, Health Info Mgmt Svcs
Edgemoor Skilled Nursing Fac	CL	1.000000						
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	7/25/2025	PRO	PRO	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	CL	1.000000	6/27/2025	PAY	ATB	N	003046	Health Info Mgmt Clerk
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	003049	Health Info Mgmt Tech
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	003055	Sr Health Info Mgmt Tech
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004162	Medical Consultant
Edgemoor Skilled Nursing Fac	PR	1.000000	8/22/2025	HIR	REG	N	004162	Medical Consultant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004406	Recreation Therapy Aide
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004406	Recreation Therapy Aide
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004406	Recreation Therapy Aide
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004406	Recreation Therapy Aide
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Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004407	Recreational Therapist
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004407	Recreational Therapist
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	004408	Recreation Therapy Supervisor
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004421	Occupational/Phy Therapst
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004421	Occupational/Phy Therapst
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	004423	Supv Occupational/Phy Therapst
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	004423	Supv Occupational/Phy Therapst
Edgemoor Skilled Nursing Fac	PR	1.000000						
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004465	Nutritionist
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004465	Nutritionist
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	004497	Asst Dir of Nursing
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	004497	Asst Dir of Nursing
Edgemoor Skilled Nursing Fac	MA	1.000000	6/27/2025	PAY	ATB	N	004506	Dir of Nursing
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004533	Inservice Education Coord
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004533	Inservice Education Coord
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse

Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
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Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
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Edgemoor Skilled Nursing Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	9/20/2025	LOA	FMC	N	004538	Staff Nurse
Edgemoor Skilled Nursing Fac	RN	1.000000	9/24/2025	DTA	XRD	N	004538	Staff Nurse
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Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
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Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
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Edgemoor Skilled Nursing Fac	HS	1.000000						
Edgemoor Skilled Nursing Fac	HS	1.000000						
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Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant

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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/5/2025	PAY	SPG	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	10/9/2025	DTA	XRD	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
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Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant

Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/25/2025	HIR	REG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/26/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	8/12/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/11/2025	HIR	REG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/11/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/11/2025	HIR	REG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/16/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/16/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	DTA	XRD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/16/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	8/16/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/3/2025	DTA	XRD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/5/2025	PAY	SPG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/5/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/19/2025	HIR	REG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/11/2025	PAY	SPG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/2/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant

Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	8/26/2025	PLA	FMC	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/25/2025	RFL	RFL	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	9/5/2025	HIR	REG	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	7/16/2025	POS	UPD	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
Edgemoor Skilled Nursing Fac	HS	1.000000						
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	7/1/2025	RFL	RFL	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
Edgemoor Skilled Nursing Fac	MA	1.000000						
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Edgemoor Skilled Nursing Fac	SW	1.000000	8/22/2025	PAY	SPG	N	004911	Social Services Aide
Edgemoor Skilled Nursing Fac	SW	1.000000	6/27/2025	PAY	ATB	N	004911	Social Services Aide
Edgemoor Skilled Nursing Fac	SW	1.000000	6/27/2025	PAY	ATB	N	004911	Social Services Aide
Edgemoor Skilled Nursing Fac	PR	1.000000	6/27/2025	PAY	ATB	Y	005045	Clinical Psychologist
Edgemoor Skilled Nursing Fac	SW	1.000000	8/22/2025	PAY	SPG	N	005265	Social Worker II
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	006405	Food Services Supervisor
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	006405	Food Services Supervisor
Edgemoor Skilled Nursing Fac	MM	1.000000	10/3/2025	PAY	SPG	N	006405	Food Services Supervisor
Edgemoor Skilled Nursing Fac	MM	1.000000	6/27/2025	PAY	ATB	N	006405	Food Services Supervisor
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006410	Sr Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006411	Cook
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006411	Cook
Edgemoor Skilled Nursing Fac	FS	1.000000						
Edgemoor Skilled Nursing Fac	FS	1.000000						
Edgemoor Skilled Nursing Fac	FS	1.000000						
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	10/9/2025	DTA	XRD	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker

Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	8/29/2025	DTA	XRD	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	9/26/2025	LOA	FMC	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	FS	1.000000	6/27/2025	PAY	ATB	N	006415	Food Services Worker
Edgemoor Skilled Nursing Fac	CM	1.000000						
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	Y	006865	Healthcare Agency Housekpr AL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	Y	006829	Healthcare Agency Housekpr BL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	RFL	RFL	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	10/2/2025	DTA	XRD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
Edgemoor Skilled Nursing Fac	CM	1.000000	9/24/2025	POS	UPD	N	007035	Healthcare Agency Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000						
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007036	Sr Healthcare Agency Housekpr
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	N	007036	Sr Healthcare Agency Housekpr
Edgemoor Skilled Nursing Fac	MM	1.000000	7/2/2025	LOA	OTH	N	007045	Exec Housekeeper
Edgemoor Skilled Nursing Fac	CM	1.000000	9/5/2025	PAY	ATB	Y	006901	Shuttle Bus Driver BG
Mental Health Admin	EM	1.000000	9/19/2025	HIR	REG	N	000335	Clinic Dir, Behavioral Hth Svc
SD County Psyc Hospital	UM	1.000000						
SD County Psyc Hospital	UM	1.000000	9/5/2025	PAY	ADJ	N	000927	Chief, Departmental Operations
SD County Psyc Hospital	EM	1.000000	9/15/2025	RFL	MIL	N	002156	Dep Dir, Inpat/Resid Care Fac
SD County Psyc Hospital	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
SD County Psyc Hospital	CEM	1.000000	8/8/2025	PAY	SPG	N	002303	Admin Analyst II
SD County Psyc Hospital	CEM	1.000000	8/27/2025	POS	UPD	Y	002304	Admin Analyst I
SD County Psyc Hospital	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
SD County Psyc Hospital	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
SD County Psyc Hospital	CEM	1.000000	10/3/2025	PAY	SPG	N	002303	Admin Analyst II
SD County Psyc Hospital	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
SD County Psyc Hospital	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
SD County Psyc Hospital	RN	1.000000						
SD County Psyc Hospital	RN	1.000000	8/8/2025	PAY	SPG	N	002387	Quality Assurance Specialist
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	SPG	N	002387	Quality Assurance Specialist

SD County Psyc Hospital	AE	1.000000						
SD County Psyc Hospital	CL	1.000000	9/19/2025	PAY	SPG	N	002700	Office Assistant
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	9/19/2025	PAY	SPG	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	9/5/2025	PAY	SPG	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	7/15/2025	RFL	RFL	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	9/19/2025	HIR	REG	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	7/11/2025	PAY	SPG	N	002706	Admissions Clerk
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002707	Sr Admissions Clerk
SD County Psyc Hospital	CL	1.000000	8/8/2025	PAY	SPG	N	002707	Sr Admissions Clerk
SD County Psyc Hospital	CL	1.000000						
SD County Psyc Hospital	CL	1.000000						
SD County Psyc Hospital	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
SD County Psyc Hospital	CL	1.000000	8/27/2025	POS	UPD	N	002729	Office Support Specialist
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	002745	Supv Office Assistant
SD County Psyc Hospital	CL	1.000000	8/22/2025	DTA	TIM	N	002757	Admin Secretary II
SD County Psyc Hospital	CL	1.000000	8/22/2025	PRO	PRO	N	002757	Admin Secretary II
SD County Psyc Hospital	CL	1.000000	8/27/2025	POS	UPD	N	002757	Admin Secretary II
SD County Psyc Hospital	MA	1.000000						
SD County Psyc Hospital	MA	1.000000	7/25/2025	PAY	SPG	N	004102	Asst Medical Services Admin
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
SD County Psyc Hospital	HS	1.000000						
SD County Psyc Hospital	HS	1.000000	8/13/2025	POS	UPD	N	004406	Recreation Therapy Aide
SD County Psyc Hospital	HS	1.000000	8/13/2025	POS	UPD	N	004406	Recreation Therapy Aide
SD County Psyc Hospital	PR	1.000000						
SD County Psyc Hospital	PR	1.000000						
SD County Psyc Hospital	PR	1.000000	8/13/2025	POS	UPD	N	004407	Recreational Therapist
SD County Psyc Hospital	PR	1.000000	8/13/2025	POS	UPD	N	004407	Recreational Therapist
SD County Psyc Hospital	PR	1.000000	8/13/2025	POS	UPD	N	004407	Recreational Therapist
SD County Psyc Hospital	MA	1.000000	6/27/2025	PAY	ATB	N	004497	Asst Dir of Nursing
SD County Psyc Hospital	MA	1.000000	8/13/2025	POS	UPD	N	004497	Asst Dir of Nursing
SD County Psyc Hospital	MA	1.000000	6/27/2025	PAY	ATB	N	004506	Dir of Nursing
SD County Psyc Hospital	RN	1.000000						
SD County Psyc Hospital	RN	1.000000						
SD County Psyc Hospital	RN	1.000000						
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/1/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/26/2025	PLA	PDL	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/19/2025	DTA	TIM	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/5/2025	HIR	REG	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/5/2025	HIR	REG	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	DTA	XRD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/30/2025	DTA	XRD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/27/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse

SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/27/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/1/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/16/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/1/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/21/2025	DTA	XRD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/27/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	10/8/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	10/6/2025	DTA	BEU	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/3/2025	PLA	FMC	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/8/2025	HIR	REG	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/27/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/1/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/5/2025	RFL	RFL	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/5/2025	HIR	REG	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/4/2025	DTA	XRD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	7/1/2025	POS	UPD	N	004525	Psychiatric Nurse

SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	8/14/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/17/2025	LOA	FMC	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	9/24/2025	POS	UPD	N	004525	Psychiatric Nurse
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004533	Inservice Education Coord
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004533	Inservice Education Coord
SD County Psyc Hospital	RN	1.000000	6/27/2025	PAY	ATB	N	004533	Inservice Education Coord
SD County Psyc Hospital	MM	1.000000						
SD County Psyc Hospital	MM	1.000000						
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	8/27/2025	POS	UPD	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	9/19/2025	PRO	PRO	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	8/27/2025	POS	UPD	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	9/19/2025	PAY	ADJ	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	8/27/2025	POS	UPD	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	8/21/2025	DTA	XRD	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	8/27/2025	POS	UPD	N	004544	Supv Nurse
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	004544	Supv Nurse
SD County Psyc Hospital	HS	1.000000	9/14/2025	RFL	RFL	N	004615	Certified Nurse Assistant
SD County Psyc Hospital	HS	1.000000	7/1/2025	POS	UPD	N	004615	Certified Nurse Assistant
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004615	Certified Nurse Assistant
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004615	Certified Nurse Assistant
SD County Psyc Hospital	HS	1.000000						
SD County Psyc Hospital	HS	1.000000						
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004625	Licensed Vocational Nurse
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004625	Licensed Vocational Nurse
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004625	Licensed Vocational Nurse
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	10/1/2025	LOA	OTH	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/8/2025	HIR	REG	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/5/2025	HIR	REG	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	6/27/2025	PAY	ATB	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	7/1/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/19/2025	PAY	SPG	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/19/2025	PAY	SPG	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/14/2025	POS	UPD	N	004839	Mntl Hlth Aide

SD County Psyc Hospital	HS	1.000000	9/30/2025	RFL	RFL	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	9/24/2025	POS	UPD	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	HS	1.000000	8/22/2025	PAY	SPG	N	004839	Mntl Hlth Aide
SD County Psyc Hospital	PR	1.000000						
SD County Psyc Hospital	PR	1.000000						
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	7/30/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	9/13/2025	LOA	PDL	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
SD County Psyc Hospital	CM	1.000000						
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/24/2025	DTA	XRD	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	Y	006865	Healthcare Agency Housekpr AL
SD County Psyc Hospital	CM	1.000000	9/19/2025	HIR	REG	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/19/2025	RFL	RFL	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	N	007035	Healthcare Agency Housekeeper
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	Y	006864	Sr Healthcare Agency Hsekpr AL
SD County Psyc Hospital	CM	1.000000	9/5/2025	PAY	ATB	Y	006864	Sr Healthcare Agency Hsekpr AL
SD County Psyc Hospital	MM	1.000000	6/27/2025	PAY	ATB	N	007045	Exec Housekeeper
SD County Psyc Hospital	EM	1.000000	6/27/2025	PAY	ADJ	N	000335	Clinic Dir, Behavioral Hth Svc
Mental Health Admin	EM	1.000000						
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002239	Dir, Behavioral Health Service
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002297	Asst Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002297	Asst Dir, Departmental Ops
Mental Health Admin	EM	1.000000	6/27/2025	PAY	ADJ	N	002297	Asst Dir, Departmental Ops
Mental Health Admin	EM	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	8/22/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	10/3/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/5/2025	PAY	TMP	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III

Mental Health Admin	MA	1.000000	7/25/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	8/13/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	7/11/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/5/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	8/22/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	7/25/2025	PRO	PRO	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/24/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/19/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	7/11/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	8/4/2025	RFL	RFL	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	8/22/2025	PAY	SPG	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	7/25/2025	PRO	PRO	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/8/2025	PLA	OTH	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II

Mental Health Admin	CEM	1.000000	6/27/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	10/3/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	9/19/2025	XFR	INT	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/1/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/8/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	LOA	FMC	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/30/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/25/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/3/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
North Coastal Live Well Center	CEM	1.000000	10/8/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	8/8/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	9/15/2025	PLA	FMC	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/1/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/1/2025	POS	UPD	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	TMP	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/2/2025	POS	UPD	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	7/25/2025	PAY	SPG	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	8/13/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II

Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	HIR	REG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/1/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/25/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/2/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/30/2025	PLA	FMC	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/8/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/27/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/3/2025	XFR	INT	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	LOA	PDL	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	7/25/2025	XFR	INT	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/11/2025	POS	UPD	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	7/11/2025	XFR	INT	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	7/25/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/3/2025	DTA	TIM	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	8/13/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	N	002303	Admin Analyst II

Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	8/8/2025	PRO	PRO	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	9/2/2025	PLA	PDL	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002367	Principal Admin Analyst
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	8/8/2025	DTA	TIM	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	8/13/2025	POS	UPD	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	7/9/2025	POS	UPD	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002517	Principal Accountant
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002521	Account Clerk Specialist
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002537	Departmental Budget Manager
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002537	Departmental Budget Manager
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002543	Sr Data and Research Analyst
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002543	Sr Data and Research Analyst
Mental Health Admin	CEM	1.000000	8/22/2025	PAY	ADJ	N	002543	Sr Data and Research Analyst
Mental Health Admin	CEM	1.000000						
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002580	Information Technology Spec

Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002580	Information Technology Spec
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002581	Information Technology Analyst
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002581	Information Technology Analyst
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002581	Information Technology Analyst
Mental Health Admin	MA	1.000000	7/25/2025	PAY	ADJ	N	002582	Information Technology Princpl
Mental Health Admin	CL	1.000000						
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Mental Health Admin	CL	1.000000	7/16/2025	POS	UPD	N	002700	Office Assistant
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002729	Office Support Specialist
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	002745	Supv Office Assistant
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	9/25/2025	DTA	XRD	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	7/31/2025	POS	UPD	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	SPG	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002757	Admin Secretary II
Mental Health Admin	CE	1.000000						
Mental Health Admin	CE	1.000000	6/27/2025	PAY	ATB	N	002758	Admin Secretary III
Mental Health Admin	CE	1.000000	6/27/2025	PAY	ATB	N	002758	Admin Secretary III
Mental Health Admin	CE	1.000000	6/27/2025	PAY	ATB	N	002759	Admin Secretary IV
Mental Health Admin	HS	1.000000	6/27/2025	PAY	ATB	N	003055	Sr Health Info Mgmt Tech
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	7/1/2025	POS	UPD	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	9/19/2025	PAY	SPG	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	9/18/2025	RFL	RFL	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004102	Asst Medical Services Admin
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004107	Health Planning & Prog Spec
Mental Health Admin	MA	1.000000	9/24/2025	POS	UPD	N	004107	Health Planning & Prog Spec
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004117	Chief, Child & Adolescent Svcs
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	9/19/2025	PAY	SPG	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	9/19/2025	PAY	SPG	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	9/16/2025	LOA	FMC	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	7/29/2025	RFL	RFL	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	7/16/2025	POS	UPD	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	9/5/2025	PAY	SPG	N	004140	Chief, Agency Operations
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004140	Chief, Agency Operations
Mental Health Admin	PR	1.000000	7/16/2025	POS	UPD	N	004162	Medical Consultant
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004173	Epidemiologist II
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004173	Epidemiologist II
Mental Health Admin	PR	1.000000	7/1/2025	POS	UPD	N	004173	Epidemiologist II
Mental Health Admin	PR	1.000000	10/3/2025	PAY	SPG	Y	004172	Epidemiologist I
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004174	Sr Epidemiologist
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004174	Sr Epidemiologist
Mental Health Admin	MM	1.000000						
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	PR	1.000000	7/1/2025	POS	UPD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	7/1/2025	POS	UPD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	9/24/2025	DTA	XRD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	7/1/2025	POS	UPD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	7/1/2025	POS	UPD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	MA	1.000000						

Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	8/8/2025	PRO	PRO	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	8/22/2025	PAY	SPG	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	7/16/2025	POS	UPD	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Morena Central Clinic	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Mental Health Admin	MA	1.000000	8/13/2025	POS	UPD	N	004780	Agency Program & Ops Manager
Mental Health Admin	PR	1.000000	8/27/2025	POS	UPD	N	004816	Health Information Spec II
Mental Health Admin	HS	1.000000	8/22/2025	XFR	INT	N	004846	Community Health Worker
North Coastal Live Well Center	HS	1.000000	8/22/2025	XFR	INT	N	004846	Community Health Worker
Mental Health Admin	HS	1.000000	8/22/2025	POS	XFR	N	004846	Community Health Worker
Mental Health Admin	HS	1.000000	8/22/2025	POS	XFR	N	004846	Community Health Worker
Mental Health Admin	HS	1.000000	8/22/2025	XFR	INT	N	004846	Community Health Worker
Mental Health Admin	HS	1.000000	8/22/2025	POS	XFR	N	004846	Community Health Worker
Mental Health Admin	HS	1.000000	8/22/2025	XFR	INT	N	004846	Community Health Worker
S. Region LWC - Chula Vista	HS	1.000000	8/22/2025	XFR	INT	N	004846	Community Health Worker
Mental Health Admin	PR	1.000000						
Mental Health Admin	PR	1.000000						
Mental Health Admin	PR	1.000000						
Mental Health Admin	MA	1.000000	10/8/2025	POS	UPD	N	005244	Program Specialist II
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/3/2025	PAY	SPG	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	8/8/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/19/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/3/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	10/8/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	7/16/2025	POS	UPD	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	7/7/2025	RFL	RFL	N	003041	Health Info Mgmt Svcs Admin
Hlth Svcs Complex	MA	1.000000						
Mental Health Admin	HS	1.000000						
Mental Health Admin	HS	1.000000	7/16/2025	POS	UPD	N	003049	Health Info Mgmt Tech
Mental Health Admin	HS	1.000000	10/3/2025	PAY	SPG	N	003049	Health Info Mgmt Tech
Mental Health Admin	HS	1.000000	7/16/2025	POS	UPD	N	003049	Health Info Mgmt Tech
Mental Health Admin	HS	1.000000	7/16/2025	POS	UPD	N	003049	Health Info Mgmt Tech
Mental Health Admin	HS	1.000000	7/16/2025	POS	UPD	N	003049	Health Info Mgmt Tech
Mental Health Admin	HS	1.000000	7/16/2025	POS	UPD	N	003049	Health Info Mgmt Tech
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004140	Chief, Agency Operations
Youth Development Center	MA	1.000000	6/27/2025	PAY	ATB	N	004195	Supv Psychiatrist
Mental Health Admin	MM	1.000000	7/1/2025	POS	UPD	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	MM	1.000000	7/1/2025	POS	UPD	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	MM	1.000000	7/1/2025	POS	UPD	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec

Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	9/2/2025	LOA	PDL	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004780	Agency Program & Ops Manager
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	CL	1.000000	7/11/2025	HIR	REG	N	002700	Office Assistant
East County Mental Health	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	MM	1.000000						
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	003049	Health Info Mgmt Tech
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
East County Mental Health	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Southeastern Live Well Center	RN	1.000000						
East County Mental Health	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
East County Mental Health	HS	1.000000						
Morena Central Clinic	HS	1.000000						
Morena Central Clinic	HS	1.000000						
Mental Health Admin	HS	1.000000	6/27/2025	PAY	ATB	N	004833	Mntl Hlth Case Mgmt Asst
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004833	Mntl Hlth Case Mgmt Asst
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004833	Mntl Hlth Case Mgmt Asst
East County Mental Health	HS	1.000000	8/26/2025	RFL	RFL	N	004833	Mntl Hlth Case Mgmt Asst
Southeastern Live Well Center	PR	1.000000						
Morena Central Clinic	PR	1.000000						
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	8/27/2025	POS	UPD	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	9/25/2025	DTA	XRD	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist

East County Mental Health	HS	1.000000						
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004914	Peer Support Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004914	Peer Support Specialist
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	CL	1.000000	10/3/2025	DTA	TIM	N	002700	Office Assistant
Southeastern Live Well Center	CL	1.000000	7/10/2025	RFL	RFL	N	002700	Office Assistant
Southeastern Live Well Center	MM	1.000000	8/8/2025	PAY	SPG	N	002730	Sr Office Assistant
Southeastern Live Well Center	HS	1.000000	6/27/2025	PAY	ATB	N	003049	Health Info Mgmt Tech
Southeastern Live Well Center	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Southeastern Live Well Center	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Southeastern Live Well Center	RN	1.000000						
Southeastern Live Well Center	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Southeastern Live Well Center	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	9/5/2025	HIR	REG	N	004914	Peer Support Specialist
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
East County Mental Health	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
East County Mental Health	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
East County Mental Health	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
East County Mental Health	MM	1.000000	6/27/2025	PAY	ATB	N	002730	Sr Office Assistant
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	003049	Health Info Mgmt Tech
East County Mental Health	MM	1.000000						
East County Mental Health	MM	1.000000						
East County Mental Health	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
East County Mental Health	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
East County Mental Health	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
East County Mental Health	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
East County Mental Health	PR	1.000000						
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	SPG	N	004914	Peer Support Specialist
East County Mental Health	HS	1.000000	7/25/2025	REH	REG	N	004914	Peer Support Specialist
East County Mental Health	PR	1.000000						
East County Mental Health	PR	1.000000						
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
East County Mental Health	PR	1.000000	7/25/2025	XFR	INT	N	005102	Licensed Mntl Hlth Clinician
East County Mental Health	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician
Hall of Justice	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Hall of Justice	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II
Hall of Justice	CL	1.000000	6/27/2025	PAY	ATB	N	002784	Legal Support Assistant III
Hall of Justice	PR	1.000000	6/27/2025	PAY	SPG	N	005087	Sr Clinical Psychologist
Hall of Justice	PR	0.500000	6/27/2025	PAY	SPG	N	005087	Sr Clinical Psychologist
Morena Central Clinic	CL	1.000000						
Morena Central Clinic	CL	1.000000						
Morena Central Clinic	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	MM	1.000000	8/8/2025	PAY	SPG	N	002730	Sr Office Assistant
Morena Central Clinic	HS	1.000000						
East County Mental Health	HS	1.000000	10/8/2025	DTA	XRD	N	003049	Health Info Mgmt Tech
Morena Central Clinic	MM	1.000000						
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004196	Psychiatrist

Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004196	Psychiatrist
Morena Central Clinic	RN	1.000000	10/8/2025	POS	UPD	N	004525	Psychiatric Nurse
Morena Central Clinic	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Morena Central Clinic	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Morena Central Clinic	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	9/12/2025	RFL	RFL	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004836	Mntl Hlth Specialist
Morena Central Clinic	HS	1.000000						
Morena Central Clinic	HS	1.000000	8/22/2025	HIR	REG	N	004914	Peer Support Specialist
Morena Central Clinic	HS	1.000000	6/27/2025	PAY	ATB	N	004914	Peer Support Specialist
Morena Central Clinic	PR	0.500000	6/27/2025	PAY	SPG	N	005087	Sr Clinical Psychologist
Morena Central Clinic	PR	1.000000						
East County Mental Health	PR	0.500000						
Morena Central Clinic	PR	1.000000	9/8/2025	RFL	RFL	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	10/3/2025	HIR	REG	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	9/11/2025	LOA	FMC	N	005102	Licensed Mntl Hlth Clinician
Morena Central Clinic	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Youth Development Center	MA	1.000000	9/10/2025	POS	UPD	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Youth Development Center	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Morena Central Clinic	CL	1.000000						
Youth Development Center	CL	1.000000	7/11/2025	PRO	PRO	N	002729	Office Support Specialist
Youth Development Center	HS	1.000000	6/27/2025	PAY	ATB	N	003049	Health Info Mgmt Tech
Youth Development Center	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
North Coastal Live Well Center	MM	1.000000	9/24/2025	POS	UPD	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	004195	Supv Psychiatrist
Youth Development Center	PR	1.000000						
Youth Development Center	PR	1.000000						
Girls Rehabilitation Facility	PR	1.000000						
Youth Development Center	PR	1.000000						
Youth Development Center	PR	1.000000						
North Coastal Live Well Center	PR	1.000000	9/11/2025	DTA	HRS	N	004199	Psychiatrist - Specialist
Youth Development Center	PR	1.000000	9/11/2025	DTA	HRS	N	004199	Psychiatrist - Specialist
Girls Rehabilitation Facility	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
KM Juv Det Fac	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
Youth Development Center	RN	1.000000	6/27/2025	PAY	ATB	N	004525	Psychiatric Nurse
EM Juvenile Detention Facility	PR	1.000000						
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Youth Development Center	PR	1.000000						
Youth Development Center	PR	1.000000						
Youth Development Center	PR	1.000000						
KM Juv Det Fac	PR	1.000000						
KM Juv Det Fac	PR	1.000000						
Youth Development Center	PR	1.000000						
Youth Development Center	PR	1.000000	7/25/2025	PAY	SPG	Y	005045	Clinical Psychologist
Girls Rehabilitation Facility	PR	1.000000	6/27/2025	PAY	SPG	N	005087	Sr Clinical Psychologist
North Coastal Live Well Center	PR	1.000000	9/24/2025	POS	UPD	N	005087	Sr Clinical Psychologist
Youth Development Center	PR	1.000000	6/27/2025	PAY	SPG	N	005087	Sr Clinical Psychologist
Youth Development Center	PR	1.000000						
Girls Rehabilitation Facility	PR	1.000000						
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Girls Rehabilitation Facility	PR	1.000000	7/11/2025	PAY	ADJ	N	005102	Licensed Mntl Hlth Clinician
North Coastal Live Well Center	PR	1.000000	9/24/2025	POS	UPD	Y	004835	Mntl Hlth Case Mgmt Clinician
Youth Development Center	PR	1.000000	9/22/2025	LOA	OTH	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
North Coastal Live Well Center	PR	1.000000	9/24/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician

Youth Development Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Youth Development Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Girls Rehabilitation Facility	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Girls Rehabilitation Facility	PR	1.000000	7/9/2025	RFL	RFL	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	9/24/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Youth Development Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Youth Development Center	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	9/24/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002302	Admin Analyst III
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002302	Admin Analyst III
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	9/5/2025	PAY	SPG	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	Y	002304	Admin Analyst I
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	MA	1.000000						
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	6/27/2025	PAY	ATB	N	002437	Program Coordinator
Mental Health Admin	MM	1.000000	8/13/2025	POS	UPD	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	MM	1.000000	8/13/2025	POS	UPD	N	004304	Utilization Rev Qlty Imp Supv
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	9/15/2025	DTA	XRD	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Services Annex	PR	1.000000	6/27/2025	PAY	ATB	N	004314	Utilization Rev Qlty Imp Spec
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Southeastern Live Well Center	MM	1.000000	6/27/2025	PAY	ATB	N	002730	Sr Office Assistant
Southeastern Live Well Center	MM	1.000000	9/19/2025	PAY	ADJ	N	004108	Behavioral Hlth Program Mgr
Southeastern Live Well Center	RN	1.000000						
Mental Health Admin	RN	1.000000						
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	PR	1.000000	6/27/2025	PAY	ATB	N	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	PR	1.000000	8/22/2025	DTA	ARI	N	004835	Mntl Hlth Case Mgmt Clinician
Southeastern Live Well Center	HS	1.000000	9/5/2025	PAY	SPG	N	004914	Peer Support Specialist
Southeastern Live Well Center	PR	1.000000						
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	EM	1.000000	7/30/2025	POS	UPD	N	002296	Dep Dir, Departmental Ops
Mental Health Admin	CEM	1.000000	10/3/2025	PAY	SPG	N	002303	Admin Analyst II
Mental Health Admin	MA	1.000000	9/11/2025	POS	UPD	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	CL	1.000000	9/5/2025	PAY	SPG	N	002700	Office Assistant
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	002730	Sr Office Assistant
COC Bldg 202	CL	1.000000	8/8/2025	DTA	WDN	N	002783	Legal Support Assistant II
Mental Health Admin	CL	1.000000	8/4/2025	RFL	RFL	N	002783	Legal Support Assistant II
COC Bldg 202	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II
COC Bldg 202	CL	1.000000	10/3/2025	PAY	SPG	N	002783	Legal Support Assistant II
COC Bldg 202	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II

COC Bldg 202	CL	1.000000	6/27/2025	PAY	ATB	N	002784	Legal Support Assistant III
COC Bldg 202	CL	1.000000	6/27/2025	PAY	ATB	N	002784	Legal Support Assistant III
COC Bldg 202	MM	1.000000	6/27/2025	PAY	ATB	N	002785	Legal Support Supervisor I
COC Bldg 202	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
COC Bldg 202	HS	1.000000	7/11/2025	PAY	SPG	N	004833	Mntl Hlth Case Mgmt Asst
Mental Health Admin	PR	1.000000						
Mental Health Admin	PR	1.000000						
COC Bldg 202	PR	1.000000	9/11/2025	POS	UPD	N	005087	Sr Clinical Psychologist
COC Bldg 202	PR	1.000000	8/8/2025	DTA	WDN	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	8/8/2025	DTA	WDN	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	8/8/2025	DTA	WDN	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	8/8/2025	PAY	ADJ	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	8/8/2025	DTA	WDN	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	8/8/2025	DTA	WDN	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	9/30/2025	DTA	XRD	N	005102	Licensed Mntl Hlth Clinician
COC Bldg 202	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	MA	1.000000	9/5/2025	PRO	PRO	N	002302	Admin Analyst III
Mental Health Admin	CEM	1.000000	9/11/2025	POS	UPD	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	CEM	1.000000	6/27/2025	PAY	ATB	N	002303	Admin Analyst II
Mental Health Admin	MA	1.000000	8/8/2025	PAY	TMP	N	002355	Behavioral Hlth Program Coord
Mental Health Admin	MA	1.000000	9/19/2025	PAY	SPG	N	002367	Principal Admin Analyst
Mental Health Admin	CL	1.000000						
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002700	Office Assistant
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	002730	Sr Office Assistant
Mental Health Admin	CL	1.000000	7/25/2025	PAY	SPG	N	002757	Admin Secretary II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II
Mental Health Admin	CL	1.000000	6/27/2025	PAY	ATB	N	002783	Legal Support Assistant II
Mental Health Admin	CL	1.000000	9/19/2025	PAY	ADJ	N	002783	Legal Support Assistant II
Mental Health Admin	CL	1.000000	9/5/2025	PAY	SPG	N	002783	Legal Support Assistant II
Mental Health Admin	MM	1.000000	9/11/2025	POS	UPD	N	002785	Legal Support Supervisor I
Mental Health Admin	MA	1.000000	7/1/2025	POS	UPD	N	004102	Asst Medical Services Admin
Mental Health Admin	MM	1.000000						
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	MM	1.000000	6/27/2025	PAY	ATB	N	004108	Behavioral Hlth Program Mgr
Mental Health Admin	HS	1.000000	6/27/2025	PAY	ATB	N	004833	Mntl Hlth Case Mgmt Asst
Mental Health Admin	HS	1.000000	8/8/2025	PRO	PRO	N	004833	Mntl Hlth Case Mgmt Asst
Mental Health Admin	HS	1.000000	7/14/2025	RFL	RFL	N	004833	Mntl Hlth Case Mgmt Asst
Mental Health Admin	HS	1.000000	9/19/2025	PAY	SPG	N	004914	Peer Support Specialist
Mental Health Admin	HS	1.000000	8/22/2025	HIR	REG	N	004914	Peer Support Specialist
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	Y	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	SPG	N	005045	Clinical Psychologist
Mental Health Admin	PR	1.000000						
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	9/11/2025	POS	UPD	Y	004835	Mntl Hlth Case Mgmt Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	N	005102	Licensed Mntl Hlth Clinician
Mental Health Admin	PR	1.000000	6/27/2025	PAY	ATB	Y	004835	Mntl Hlth Case Mgmt Clinician

APPENDIX G

San Diego Behavioral Health Worker Shortage
August 2022

San Diego Workforce Partnership

Addressing San Diego's Behavioral Health Worker Shortage

A needs assessment and vision to attract and retain essential behavioral health professionals

AUGUST 2022

LIVE WELL SAN DIEGO

ALLIANCE HEALTHCARE FOUNDATION
ADVANCING HEALTH AND WELLNESS FOR THOSE IN NEED

NATHAN FLETCHER

CHAIR

San Diego County Board of Supervisors

August 2022

Dear San Diegans:

As Chair of the San Diego County Board of Supervisors, my single highest policy priority since taking office in 2019 has been behavioral health – the intersection of mental health and addiction treatment.

I have witnessed the difficulties in hiring behavioral health workers as we took action to build a better way to deliver services and transform our behavioral health system. As part of my 2021 State of the County Address, I called on our County government to work with entities across San Diego County to develop a strategy to tackle the shortage of trained behavioral health workers in our region.

This report provides a deeper understanding of the worker shortage and outlines existing talent attraction and retention challenges in the behavioral health industry. It also brings new solutions to expand the size and diversity of mental health and addiction treatment professionals in San Diego over the long term.

To develop this transformative strategy, it took many partners. I want to extend my appreciation to the 1,600 San Diego Behavioral Health workers and students who provided input; the members of the San Diego Behavioral Health Workforce Steering Committee and the San Diego Workforce Partnership for leading this effort, and the County of San Diego Health and Human Services Agency and Alliance Healthcare Foundation for investing in this work.

With this roadmap, it is imperative we act with urgency to recruit, train and retain more mental health and addiction treatment professionals to work in San Diego County. Let's get to work!

Sincerely,

Chair Nathan Fletcher
Supervisor, Fourth District
County of San Diego

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To the **1,600 San Diego Behavioral Health workers and students** who shared their experiences despite being busier than ever. No workforce strategy is complete without hearing directly from workers. Thank you.

To the members of the San Diego Behavioral Health Workforce steering committee who generously volunteered hundreds of hours to help guide our understanding of the Behavioral Health system. Thank you for your efforts to help us understand some (not all) of the complexity, disseminate the survey to allow us to hear directly from workers and your overall enthusiasm and vision to work on this regional challenge together.

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This report was completed by the **San Diego Workforce Partnership** with financial support from the **County of San Diego Health and Human Services Agency** and the **Alliance Healthcare Foundation**. Thank you for investing in this important work.

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Section 1: Executive Summary

San Diego County is facing a significant behavioral health (BH) worker shortage. This report estimates 17,000 BH professionals were employed in 11 key occupations in 2022. This is 8,000 workers short of the 25,000 needed.

This worker shortage is not unique to San Diego. According to the Steinberg Institute, the state's BH workforce can only serve about a quarter of its need[1]. In 2018, researchers from the University of California San Francisco (UCSF) estimated growing shortages over the next 10 years. UCSF estimated California will have 41% fewer psychiatrists and 11% fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors and licensed clinical social workers than needed by 2028[2].

These statewide projected shortages were all before the outbreak of the COVID-19 global pandemic. Since 2020, community need for behavioral health services, workforce shortages and wage competition from other industries have intensified, intensifying the long-standing workforce shortage to crisis levels.

At the same time, public investment in behavioral health services at the federal, state, and local level continue to increase. Services for crisis care, homelessness prevention, substance use prevention and treatment services, expanded services in public schools and healthcare integration are all driving more demand for BH workers. Demographic trends are not helping; each year more San Diego workers retire than the year before as the "baby-boom" generation ages. In 2018 for example, about half of California's psychiatrists are over 60 years of age (UCSF).

The convergence of these demographic trends, the global pandemic, growing mental health and substance use crises and historic public spending focused on expanding BH services raises a fundamental question:

Is our regional Behavioral Health Workforce equipped to meet the need?

This report sets out to address this question with responses to the following four related lines of inquiry. Below are our key findings and recommendations:

1. How many additional behavioral health professionals in each key occupation does the region need to meet the demand for services today and in the future?

[1] Steinberg Institute, "What is the behavioral health workforce shortage?" Behavioral Health Workforce Strategy Group
[2] UCSF Health Force, "California's Current and Future Behavioral Health Workforce" (2018)

- San Diego's regional behavioral health system currently employs approximately 17,000 professionals in 11 high priority occupations.
- This is approximately 8,000 workers short of the estimated 25,000 professionals needed to meet the population's need for services.
- By 2027, the San Diego region needs an estimated 27,600 to continue meeting unmet need while keeping pace with population growth.
- Based on current trends, an estimated 7,800 BH workers are expected to leave their professions by 2027.
- Starting from the nearly 17,000 workers in the field today, the San Diego region needs to educate, train, attract, employ, and retain 18,500 professionals between 2022 and 2027.

2. What do 1,600 San Diego BH professionals and students say are the principal factors influencing their career decisions?

   - Overall, BH workers reported high levels of satisfaction with their job security (84%), physical safety at work (82%), relationships with coworkers (91%), their boss (84%), the population they serve (93%) and that they are contributing to a purpose they care about (84%). These job quality features are attracting and retaining professionals to the field.
   - 39% of respondents reported varying levels of burnout. This is a relatively low burnout rate. National post-COVID studies find healthcare burnout rates around 50%.
   - 44% of BH respondents reported being somewhat likely (25%) or extremely likely (19%) to search for a job in the next 12 months. This is relatively high compared to national data ranging between 18-37% for various healthcare and behavioral health professionals.
   - Top push factors influencing worker burnout and intent to leave were dissatisfaction with pay (55%), stress on the job (44%), and documentation requirements (39%). In focus groups, stress on the job often related to staffing shortages, high caseload sizes and challenges accessing additional support services and treatment for their clients.

3. What could a long-term regional vision look like to develop, attract, and retain the most resilient, representative, skilled and qualified workforce in the United States?

    - Invest in competitive compensation: San Diego professionals across occupations are paid less than their counterparts in most California counties. Other recommendations described in this report will have limited effect if relative pay gaps for BH jobs continue to increase against other industries, non-BH settings and private practice.

    - Pursue administrative relief opportunities: Streamlining documentation requirements for current frontline professionals was one of the top three push factors. This report includes 12 issue areas and 29 actions to reduce administrative requirements for BH workers aimed at increasing retention and reducing intent to leave the field.

    - Establish regional training centers of excellence (COEs): Multi-partner sites that serve the public and develop core competencies in training and supervision programs are needed to expand the region's BH workforce infrastructure. These COEs would also provide technical assistance and operational support to other community-based organizations to establish their own training programs, and provide applied research opportunities for innovations in service delivery, training efficacy and workforce optimization

    - Build a regional BH workforce training fund: This report estimates a $425M investment is needed to expand the regions BH talent recruitment, training, and education systems for the additional 18,500 workers needed over the next five years. This report provides a financial framework for an initial $128M down payment to train 4,250 professionals.

        - $98M for scholarships, stipends, in-school support, loan forgiveness, expanding programs and other incentives for public service.

        - $30M of philanthropy and flexible public dollars to capitalize a first-in-the nation, regional BH revolving training fund that provides 0% interest loans to students entering specific programs and upfront financing for organizations to establish supervision programs.

    - Continue to listen to workers: This report should be a starting point for regional BH workforce development applied research focused on improving job quality and talent strategies for current and future public sector BH professionals.

4. What are specific projects and initiatives that can accelerate this vision on the ground?

The report includes nine occupational profiles with a description of initial projects for the $128M down payment that would train 4,250 professionals over 10 years. The projects are focused on regional investments to expand the size, diversity and capacity of San Diego's training, education, and clinical supervision system. Selected highlights include:

- $6M to recruit, place, certify and provide on-the-job-training for 600 certified peer support specialists.
- $3M for a regional apprenticeship program to train 600 community health workers.
- $8.5M in scholarships and 0% interest loans to recruit, train, place and certify 1,150 substance use disorder counselors.
- $1.3M to establish a psychiatric technician program with regional community colleges.
- $7.8M for stipends for 260 master of social work students to complete paid internships in BH settings.
- $7M to create 280 new supervision slots for associate social workers to accrue the 3,000 hours required for LCSW licensure. Learn and adapt model for registered nurses, marriage and family therapists, and psychologists in BH settings.
- $64M to train 84 community psychiatrists and 200 psychiatric mental health nurse practitioners to work in integrated teams in community settings, serving as a statewide model to address California's designation as a Health Professional Shortage Area (HPSA) related to a psychiatrist shortage statewide.
- Targeted loan forgiveness and mortgage down-payment assistance in exchange for public service for diverse professionals to build wealth, live and work in San Diego.

Where possible and appropriate, this report targets interventions that have demonstrated evidence attracting and retaining professionals to work in public behavioral health settings defined as follows:

> **Public Behavioral Health Professionals:**
> The full range of providers that serve the Behavioral Health needs of people who may be eligible for publicly-funded health insurance based on economic need. This includes County employees, contracted service providers, FQHCs, hospitals, providers in education settings, and private organizations that serve people eligible for publicly-funded health insurance.

This report lays out a vision to make San Diego home to the most resilient, representative, skilled and qualified BH workforce in the United States. As a result, the system of care will have the workforce needed to provide the highest quality of care possible for all San Diego residents, regardless of economic means or ability to pay.

HOW MANY MORE BEHAVIORAL HEALTH PROFESSIONALS DOES SAN DIEGO NEED?

18,500 more workers needed by 2027

17,000 behavioral health professionals in the current workforce

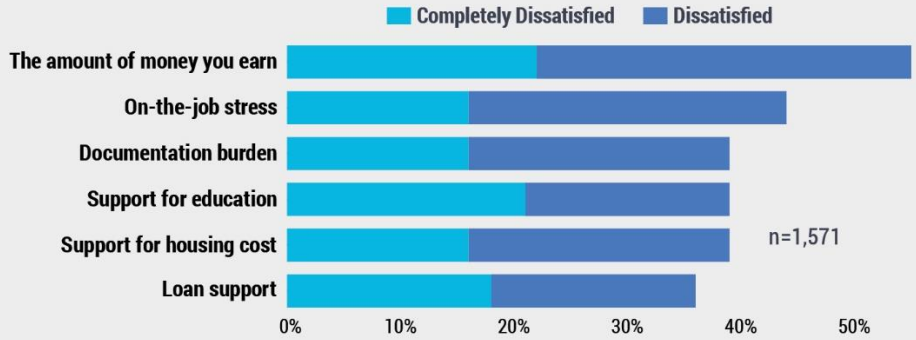
8,100 more workers needed to meet **today's** demand

7,800 to replace those leaving in next 5 years

2,600 to meet growth in demand by 2027

	2022 Workers	2022 Needed	2027 Needed	# Leaving Profession	Additional Needed 2022-2027
Community Health Worker & Social Service Assistant, including Peer Support Specialist	4,644	6,930	7,588	2,783	5,727
Marriage and Family Therapist	4,443	6,637	7,101	2,111	4,770
Substance Abuse and Behavioral Disorder Counselor	2,566	3,631	4,248	1,270	2,952
Mental Health and Substance Abuse Social Worker	1,283	1,913	2,142	616	1,476
Psychologist (Clinical, Counseling, and School)	1,603	2,401	2,522	533	1,451
Psychiatric Technician	789	1,181	1,334	292	837
Registered Nurse working in BH settings	1,040	1,548	1,641	56	656
Psychiatric Aide	129	192	248	89	208
Psychiatrist	265	396	431	37	204
Psychiatric Mental Health Nurse Practitioner	159	238	297	46	184
Physician's Assistant working in BH settings	28	42	48	8	28
Totals	**16,949**	**25,109**	**27,600**	**7,841**	**18,493**

WHY DO BEHAVIORAL HEALTH WORKERS LEAVE JOBS?



44% likely to search for a job in the next 12 months, vs 18-37% nationally

45% turnover for San Diego behavioral health workers, vs. 42% in the rest of California.

WHAT CAN BE DONE TO ADDRESS THIS SHORTAGE?

Invest in Competitive Compensation

San Diego BH professionals are paid less than other CA counties. **55% of workers surveyed were dissatisfied with pay**.

Pursue Administrative Relief

Streamlining documentation is a top concern for BH professionals. Explore **12 issue areas and 29 opportunities** to reduce administrative requirements.

Build Regional Workforce Training Fund

This report provides a financial framework for a **$128M** down payment to train **4,250** more professionals.

Establish Regional Training Centers of Excellence

Sites would **deliver services**, **expand training and supervision** opportunities, and provide **research** opportunities focused on integrated care, workforce optimization, and training best practices.

Continue Listening to Workers

Input from **1,600 San Diego workers and students** informed this report. Levels of job satisfaction, burnout, intent to leave, and other factors driving career decisions should be surveyed annually to inform implementation and measure progress.

$98M for scholarships, stipends, loan forgiveness, and expanding programs.

$30M first-in-the nation renewable training fund providing 0% interest loans to students and financing to establish training and supervision programs.

Sample projects for $128M Fund

- **$6M** to recruit, place, certify and provide on-the-job-training for **600 certified peer support specialists**.
- **$3M** for a regional apprenticeship program to train **600 community health workers**.
- **$8.5M** in scholarships and 0% interest loans to recruit, train, place and certify **1,150 substance use disorder counselors**.
- **$1.3M** to establish a **psychiatric technician** program with regional community colleges.
- **$7.8M** for stipends for **260 master of social work student**s to complete paid internships in BH settings.
- **$7M** to create **280 new supervision slots** for associate social workers to accrue the 3,000 hours for LCSW licensure.
- **$64M** to train **84 psychiatrists** and **200 psychiatric mental health nurse practitioners** to work in integrated teams in community settings.
- **Loan forgiveness** and **down-payment assistance** in exchange for public service for diverse professionals to build wealth, live and work in San Diego long term.

WHAT ARE WORKERS SAYING?

> **I have had to take out personal loans to cover my groceries. Rent is a whole paycheck. I've thought about going to grad school, but is it worth it to go thousands in debt for two more dollars an hour? I want to do this for the rest of my life, I love it. It makes me sad, but I don't think I will be able to.**
>
> – SUD Counselor, Female

> **I just I want to help people. But being extremely short-staffed—feeling the pressure, it's brutal. I'm really burned out and I'm white knuckling it. Being hyper-vigilant in that way is not conducive to being a good clinician. It's pretty maddening to be honest. I'm disillusioned.**
>
> – Pre-Licensed Counselor, Female

Section 2: Understanding San Diego's Behavioral Health Worker Shortage

Today, there are approximately 17,000 professionals working in a BH setting across 12 key occupations. By 2027, the San Diego region needs to produce, attract, or retain an additional 18,500 behavioral health professionals to meet the need for services from San Diego residents, replace existing workers that will leave the industry and keep up with population growth. This section provides a detailed methodology for these estimates for 12 key occupations, listed in Figure 1.

Figure 1: Occupations included in the workforce needs assessment

SOC Code(s)	Description[3]	2022 Professionals in San Diego
21-1094	**Community Health Workers:** Promote health within a community by assisting individuals to adopt healthy behaviors and advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare and social service agencies.	4644
21-1093	**Social and Human Services Assistants (includes Peer Support Specialists[4]):** Assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.	
31-1133	**Psychiatric Aides:** Assist mentally impaired or emotionally disturbed patients, working under direction of nursing and medical staff. May assist with daily living activities, lead patients in educational and recreational activities, or accompany patients to and from examinations and treatments. Includes psychiatric orderlies.	129
21-1011	**Substance Abuse and Behavioral Disorder (SUD) Counselors:** Counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. May counsel individuals, families, or groups or engage in prevention programs.	2566
29-2053	**Psychiatric Technicians (multiple related job titles):** Care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. Monitor patients' physical and emotional well-being and report to medical staff. May participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.	789
21-1013	**Marriage and Family Therapists / Professional Counselor:** Diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.	4443
21-1023	**Mental Health and Substance Abuse Social Workers:** Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.	1283

[3] Descriptions were based on standard O*NET occupational descriptions and may not reflect every aspect of the professional's job.
[4] While peer support specialists do not have specific Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) code, their job titles are commonly found in the broader Social and Human Service Assistants category.

SOC Code(s)	Description[3]	2022 Professionals in San Diego
19-3033 19-3034	**Psychologists (Clinical and Counseling and School):** Assess, diagnose, and treat mental and emotional disorders of individuals through observation, interview, and psychological tests. Help individuals with distress or maladjustment understand their problems through their knowledge of case history, interviews with patients, and theory. Provide individual or group counseling services to assist individuals in achieving more effective personal, social, educational, and vocational development and adjustment.	1603
29-1141 29-1141 (02)	**Registered Nurses working in BH settings**: Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. This report used national estimates that 4% of all RN's work in BH settings.	1040
29-1171	**Psychiatric Mental Health Nurse Practitioner:** Diagnose and treat acute, episodic, or chronic illness, independently or as part of a healthcare team. May focus on health promotion and disease prevention. May order, perform, or interpret diagnostic tests such as lab work and x rays. May prescribe medication. Must be registered nurses who have specialized graduate education.	159
29-1071	**Physician's Assistant working in BH settings:** Provide BH services typically performed by a physician, under the supervision of a physician. Conduct complete physicals, provide treatment, and counsel patients. May, in some cases, prescribe medication.	28
29-1223	**Psychiatrists:** Diagnose, treat, provide medication management, and help prevent mental disorders	265
Total		16,949

To estimate the need for behavioral health workers across occupations in 2022, we used staffing level estimates and estimates of unmet need in San Diego for BH professionals. For future years (2027 and 2032), we used estimates of growth and rates of workers leaving the profession (referred to hereafter as "replacement") to project numbers of jobs and the number of new providers needed to fill those jobs. This section will review the sources and methods for each of these estimates.

Step 1 – Calculating unmet need: We started by finding estimates of unmet need for behavioral health and substance use disorder. The most recent available substate estimates of mental disorders by The National Survey on Drug Use and Health (NSDUH) at the time of analysis were 2016-2018[5]. They indicate that 18.36% of adults had a mental illness, but only 12.28% received care, leaving an unmet need for mental health services for 6.08% of San Diego's population. Given that 12.28% of the population is receiving care with our current number of service providers, we would need 49.51% additional service providers to reach the 6.08% of San Diego's population who needs but does not receive mental health treatment.

We determined the unmet need for substance use disorder in collaboration with subject matter experts, who noted that a small percentage of people determined to need substance use treatment as measured by the NSDUH ever sought treatment. According to the 2019 NSDUH national data[6], we would need to increase substance use providers by 411% to have enough providers available for

[5] Substate Estimates of Substance Use and Mental Illness from the 2016-2018 NSDUH: Results and Detailed Tables | CBHSQ Data. (n.d.). Retrieved June 14, 2022, from https://www.samhsa.gov/data/nsduh/2016-2018-substate-reports

[6] Sub-state estimates of the NSDUH report unmet need for SUD directly without including number of people who receive treatment; we used the most recent available national numbers that do include the number of people currently receiving treatment to estimate the needed increase of providers.

every person who needs substance use disorder treatment. However, NSDUH reports that 97.5% of respondents classified as having a substance use disorder in 2020 did not feel they needed treatment[7]. Recognizing San Diego County initiatives to expand the reach of substance use disorder treatment[8] and in conversation with epidemiologists engaged with this question, we decided to aim for an increase of 10% of the unmet need for substance use disorder treatment, resulting in a shortage of 41.19% of providers that treat substance use disorder exclusively.

For professions that treat both mental health and substance use disorders, we set our goal to increase service provision by the larger amount (49.51%).

To account for the outdated unmet need estimates, we started with the number of jobs in each occupation in 2017 using labor market information from the Bureau of Labor Statistics (BLS), supplemented by data from State of California licensing boards. Where possible, we used BLS employment numbers because they are consistently measured year over year. However, BLS numbers are collected by Standard Occupational Classification Codes, some of which are broad enough to include workers outside of behavioral health (e.g., registered nurses). In those cases, we used methods modeled by the HealthForce Center at UC San Francisco from their "California's Current and Future Behavioral Health Workforce" report to estimate the number of professionals in the occupation working in behavioral health settings in San Diego[9].

We then applied unmet need for 2017 to the number of jobs in 2017, assuming that our current workforce is serving our current *met* need we would need a proportionate increase in the workforce to meet unmet need. The resulting values represent the number of workers needed in 2017.

Step 2-Estimating BH employment numbers in 2022, 2027 and 2032 to meet unmet need: To understand what that workforce would look like in 2022, we applied the growth rate for each occupation from 2017 to 2022. This gives us an estimate of the workforce required to meet local needs in 2022, if the need during that period grew linearly, proportionately to the occupation growth. This assumption can be evaluated when the NSDUH releases more recent substate estimates.
To estimate the number of jobs and new professionals needed for future years (2027 and 2032), we used growth projections based on Bureau of Labor Statistics[10] to predict the change in the number of jobs in the county for each occupation.

Step 3-Accounting for separations and retirements: To mitigate the shortage from steps 1 and 2, recruiting and retaining the difference between the current workforce and the future workforce over that time would be insufficient. We also need to account for outflows from each profession due to

[7] Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. (2020). 156.
[8] Alcohol and Drug Services (ADS). (n.d.). Retrieved June 14, 2022, from https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/alcohol_drug_services/prevention_services.html
[9] Particularly, registered nurses (RNs) and nurse practitioners SOC codes include nurses across specialties. Further complicating this issue, Advance Practice Psychiatric Nurses are counted under the Registered Nurses parent code, rather than with the rest of Nurse Practitioners. For registered nurses, we used the estimate from the 2018 report that 4% of registered nurses are RNs working in behavioral health settings. For Nurse Practitioners, we multiplied the number of actively licensed professionals statewide by 8.4%, the most recent available ratio of San Diego County's population to California's (2020 San Diego Population 3.324 million: 2020 California population 39.35 million). Where needed, we adjusted data from these professions using estimates from the 2018 report of the proportion of Nurse Practitioners (6.9%) and Registered Nurses (4%) working in behavioral health. For both of these professions, we used Emsi growth and replacement estimates for the closest available professions (Registered Nurses and Nurse Practitioners).
[10] provided by Emsi Burning Glass, 2022

people leaving the occupation (e.g., to retire or leaving the industry) or moving out of the region. We used the occupational replacement rate–this includes people leaving the profession entirely. Workers leaving their job for another in the same occupation (e.g., a SUD Counselor leaving one employer for another) are not included in this analysis because that move does not reduce the number of workers in the occupation. Each occupation has a different replacement rate and demographic distribution, and so some professions will need to hire faster to replace workers leaving the profession than others. This method gives us the following estimates of interest for each occupation:

- The number of workers needed to meet the existing demand in 2022.
- The total number of jobs needed in 2027 and 2032 (considering growth and unmet need).
- The number of workers who need to enter the profession in 2027 and 2032 (to meet growth, unmet need, and to replace workers leaving the profession).

Figure 2 estimates the San Diego regional behavioral health worker shortage is 8,160 professionals, assuming existing staffing patterns and caseload sizes. Note that the following results include everyone in these occupations working in San Diego BH settings, regardless of whether they work in private practice or the public behavioral health system.

Figure 2: 2022 Professionals Needed

Occupation	2022 BH Professionals	Total Professionals Needed	2022 Worker Shortage
Community Health Workers & Social Service Assistants, including Peer Support Specialists	4644	6930	2286
Psychiatric Aides	129	192	63
Substance Abuse and Behavioral Disorder (SUD) Counselors	2566	3631	1065
Psychiatric Technicians	789	1181	392
Marriage and Family Therapists	4443	6637	2194
Mental Health and Substance Abuse Social Workers	1283	1913	630
Psychologists (Clinical, Counseling, and School)	1603	2401	798
Registered Nurses working in BH settings	1040	1548	508
Psychiatric Mental Health Nurse Practitioner	159	238	79
Physician Assistant	28	42	14
Psychiatrists	265	396	131
Totals	**16,949**	**25,109**	**8,160**

We then take the "total professionals needed" number and add 5-year occupational growth rates and replacement rates to get a sense of the total number of professionals the region needs to attract and/or retain (below benchmark replacement rates). This analysis shows an additional 10,333 professionals are needed between 2022-2027 to continue to meet existing and unmet need (figure 3).

Figure 3: Replacement and occupational growth rates from 2022-2027

Occupation	Prof. Needed (2022)	Growth Rate 2022- 2027	Prof. needed (2027)	Replacement rate[2]	Replace-ments	New Prof. Needed 2022-2027
Community Health Workers & Social Service Assistants, including Peer Support Specialists	6930	9%	7588	11.3%	2783	3441
Psychiatric Aides	192	29%	248	12.1%	89	145
Substance Abuse and Behavioral Disorder Counselors	3631	17%	4248	9.2%	1270	1887
Psychiatric Technicians	1181	13%	1334	7%	292	445
Marriage and Family Therapists	6637	7%	7101	9.2%	2111	2576
Mental Health and Substance Abuse Social Workers	1913	12%	2142	9.2%	616	846
Psychologists (Clinical, Counseling, and School)	2401	5%	2522	6.5%	533	653
Registered Nurses working in BH settings	1548	6%	1641	5.2%	56	148
Psychiatric Mental Health Nurse Practitioner	238	25%	297	5.2%	46	105
Physician's Assistant	42	13%	48	5.5%	8	14
Psychiatrists	396	9%	431	2.7%	37	73
Totals	25,109		27,600		7,841	10,333

The final step in estimating the total number of BH professionals needed in San Diego over the next 5 years combines the total number of workers to meet unmet need and the 5-year projected growth and replacement rates to give the total number of workers that need to be trained, attracted, placed, and retained at levels below estimated replacement rates (figure 4).

Figure 4: Total number of additional professionals needed in San Diego (2022-2027)

Occupation	2022 BH Prof.	Prof. Needed (2022)	Prof. Needed (2027)	2022 Shortage	New Prof. Needed 2022-2027	Total Additional Needed (2022-2027)
Community Health Workers & Social Assistants, including Peer Support Specialists	4644	6930	7588	2286	3441	5727
Psychiatric Aides	129	192	248	63	145	208
Substance Abuse and Behavioral Disorder Counselors	2566	3631	4248	1065	1887	2952
Psychiatric Technicians	789	1181	1334	392	445	837
Marriage and Family Therapists	4443	6637	7101	2194	2576	4770
Mental Health and Substance Abuse Social Workers	1283	1913	2142	630	846	1476
Psychologists (Clinical, Counseling, and School	1603	2401	2522	798	653	1451
Registered Nurses working in BH settings	1040	1548	1641	508	148	656
Psychiatric Mental Health Nurse Practitioner	159	238	297	79	105	184
Physician's Assistant	28	42	48	14	14	28
Psychiatrists	265	396	431	131	73	204
Totals	16,949	25,109	27,600	8,160	10,333	18,493

Limitations

Because of limitations on available data, this analysis has some weaknesses.

First, BLS Standard Occupation Classifications (SOC) are broad and do not change often. Several occupations in our analysis (for example, registered nurses, nurse practitioners, and physician's assistants) are employed throughout the health system; behavioral health is only one of several specialties or work settings. To include them in our analysis, we used statewide estimates, as explained above. The validity of those estimates rests on several assumptions: 1) that San Diego has a similar proportion of each of these professions working in behavioral health as California at large and 2) that key features, like turnover and replacement rates, are similar across specialties within professions. Additionally, a handful of high-priority occupations for San Diego BH leaders, such as peer support specialists, do not have a designated SOC code and their job titles are included in the SOC code for social and human service assistants and community health workers, making it difficult to estimate how many peer support specialists are needed.

Second, our analysis rests primarily (and necessarily) on historical data, but recent and anticipated changes impact the reliability of our estimates. First, coming changes to the statewide public behavioral health system through CalAIM will extend and change Medi-Cal eligibility and service provision over the course of the next 10 years. Second, the COVID-19 pandemic has changed the demand and supply for behavioral health services. We cannot predict what long term impacts these changes will have.

Third, this analysis does not consider opportunities to use telehealth providers that do not live in San Diego. Further inquiry is needed to see how telehealth operational capacity, policy changes, and technology advancements can allow for professionals living outside San Diego County to meet local needs.

Finally, our analysis does not include workforce optimization modeling. Currently, federal, state and county policies constrain the scope of practice for professions and in many cases dictate staffing models by regional BH employers. These scopes are changing. For example, nurse practitioners will be able to practice independently in California by 2023[11] and peer support specialists will soon be certified and their services eligible for Medi-Cal coverage[12].

[11] AB-890 Nurse practitioners: Scope of practice: Practice without standardized procedures. (n.d.). Retrieved May 20, 2022, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890

[12] California Mental Health Services Authority | Peer Certification. (n.d.). Retrieved May 20, 2022, from https://www.calmhsa.org/peer-certification/

Section 3: Frontline Perspectives

> "If I could stay, I would – I love my job so much. But I got to this point where I felt like I could not possibly stay."
>
> – Former Peer Support Specialist, currently re-training for a technology career

The previous section highlighted an existing worker shortage of more than 8,000 professionals across 11 key occupations and the need to attract or retain an additional 18,500 professionals between 2022–2027. Of those 18,500 new professionals needed, 7,800 of them will leave the profession by 2027.

A combination of both new talent development and attraction and existing talent retention strategies and investments will be necessary to meet the region's goals. Strategies to do this should be informed by the voices, perspectives and experiences of current and future workers themselves.

This section highlights what we heard from over 1,600 San Diego BH workers about their career goals, burnout out, intent to leave and job satisfaction between February and May 2022 through focus groups and direct surveys.

Methodology

We took a two-phase approach to understanding the experiences of behavioral health workers, their perspectives on job quality and job satisfaction, and the drivers of burnout, intent to leave and turnover.

First, we conducted semi-structured focus groups and interviews with 30 workers. Discussions were conducted over video calls in February 2022. The moderator referred to a script written in advance to ensure that privacy disclosures were consistent among participants and to focus the conversation on topics of interest. Among participants who provided job information were eight licensed clinicians, nine certified workers, six licensed prescribers, three people who described themselves as site supervisors or program managers, and one psychologist[13], all working in San Diego County. Focus groups and interviews were automatically transcribed, then labelled with qualitative codes. Codes included concepts from the literature review, topics of interest and topics that emerged after analysis of the qualitative data.

Second, we conducted a survey of behavioral health workers in San Diego County. We developed a survey based on our findings in focus groups, our past surveys and findings in workforce development and a review of relevant literature. The survey was distributed through the following partners in San Diego County:

[13] Certified workers included 1 case manager, 1 gambling and alcohol addiction counselor, 1 peer support worker, and 6 substance use disorder counselors. Prescribing participants included 1 Nurse Practitioner and 5 Psychiatrists. Licensed clinicians included Licensed Clinical Social Workers, Marriage and Family Therapists, and Licensed Clinical Counselors. These can't be split out because we asked them about their job, not licensure, and some employers hire all of the above under the title "social worker." We spoke to at least four pre-licensed workers for these occupations as well.

- The Alcohol and Drug Service Providers Association (ADSPA)
- The San Diego County Mental Health Contractors Association (MHCA)
- The Hospital Association of San Diego & Imperial Counties (HASDIC)
- Health Center Partners (HCP)
- The San Diego Imperial County Community Colleges (SDICCC)
- Deans, department chairs, and executives with the region's universities
- The San Diego Psychiatric Society (SDPS)
- The 13-member steering committee that advised on this project.

The survey used a branching design to collect relevant data from students, workers and those who are both students and workers. In April and May of 2022, our survey collected 1,571 responses. The median response time was 13 minutes and 2 seconds.

Figure 5: Survey respondents' occupations, gender identity, and race/ethnicity

Occupations (select all that apply)		Gender Identity		
	N		%	N
Administrator	192	Women	55%	871
Case Manager	176	Men	16.7%	262
Certified SUD Counselor	125	Non-Binary	0.8%	13
Licensed Clinical Social Worker	114	A Gender not listed	.06%	1
Associate Social Worker	122	Unspecified or Prefer not to say	27.0%	424
Licensed Marriage and Family Therapist	118	**Total**		**1571**
Peer Support	113			
Registered SUD Counselor	94	**Race/Ethnicity**	**%**	**N**
Associate MFT	81	White	29.2%	458
Community Health Worker	66	Hispanic or Latino/a/x	22.4%	352
Psychologist	46	Multi Racial	5.9%	93
Psychiatrist	39	Asian	5.2%	82
Associate PCC	36	Black or African American	4.8%	76
Registered Nurses	35	Middle Eastern or North African[14]	1.0%	16
Outreach worker	24	Pacific Islander	0.7%	11
Nurse Practitioner	19	American Indian or Alaska Native	0.4%	7
Licensed Professional Clinical Counselor	13	Other	1.0%	16
Psychiatric Aide	9	Unspecified or Decline to State	29.3%	460
Nurse Practitioner Trainee	2	**Total**		**1571**
Interpreter	3			
Psychiatric Technician	1			
Physician's Assistant	1			
Other Non-certified Professional	79			
Other Certified Professional	14			
Other Occupation	102			
Students only	20			

[14] In the census, Middle Eastern and North African are considered part of the category "White," but that may obscure valuable information and fails to reflect this community's contemporary self-identification, so we include it (Maghbouleh et al., 2022). In this report, where we compare to Census data, we collapse this category with "White" to maximize comparability.

Our focus group highlighted industry, occupational and local factors driving workers to and away from their jobs in behavioral health. The survey allowed us to ask workers about their burnout, intent to leave and satisfaction with each of the aspects of work revealed in the focus groups, along with other features of work generally that the literature has shown to push workers away from their jobs or make those jobs more appealing. This section will review our findings about burnout, intent to leave, factors that push workers away from working in behavioral health and factors that attract workers to behavioral health using insights from focus groups, our survey and context from other studies and industries.

Burnout

Burnout is conceptualized as "prolonged response to chronic interpersonal stressors on the job" including exhaustion, cynicism, detachment and lack of accomplishment or ineffectiveness at work[15]. Burnout has long been a concern in behavioral health, prompting several studies to understand[16] and reduce[17] burnout among behavioral health providers. COVID-19 may be exacerbating burnout among public sector employees,[18] health care workers[19] and behavioral health care providers[20]. Burnout has been associated with intent to leave among mental health providers[21]. We elected to include burnout alongside intent to leave for two reasons. First, research suggests that burnout is one of many factors contributing to workers leaving their jobs, including pay and lack of advancement[22]. Second, burnout may be associated with worsening quality of care among healthcare providers[23].

In our survey, 39% of respondents reported some burnout, with 25% reporting some symptoms, 9% reporting persistent burnout, and 5% indicating, "I feel completely burned out and often wonder if I can go on." Sadly, this is a relatively low burnout number across healthcare, with post-COVID studies

[15] Maslach, C., & Leiter, M. P. (2017). Understanding burnout: New models. In The handbook of stress and health: A guide to research and practice (pp. 36–56). Wiley Blackwell. https://doi.org/10.1002/9781118993811.ch3

[16] Paris, M., & Hoge, M. A. (2010). Burnout in the Mental Health Workforce: A Review. The Journal of Behavioral Health Services & Research, 37(4), 519–528. https://doi.org/10.1007/s11414-009-9202-2

[17] Rollins, A. L., Kukla, M., Morse, G., Davis, L., Leiter, M., Monroe-DeVita, M., Flanagan, M. E., Russ, A., Wasmuth, S., Eliacin, J., Collins, L., & Salyers, M. P. (2016). Comparative Effectiveness of a Burnout Reduction Intervention for Behavioral Health Providers. Psychiatric Services, 67(8), 920–923. https://doi.org/10.1176/appi.ps.201500220

[18] Liss-Levinson, R. (2022). Survey Results: Continued Impact of COVID-19 on Public Sector Employee Job and Financial Satisfaction, and Retention. https://slge.org/wp-content/uploads/2022/03/public-workforce-and-covid-march2022.pdf

[19] Amanullah, S., & Ramesh Shankar, R. (2020). The Impact of COVID-19 on Physician Burnout Globally: A Review. Healthcare, 8(4), 421. https://doi.org/10.3390/healthcare8040421

[20] Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. Asian Journal of Psychiatry, 54, 102300. https://doi.org/10.1016/j.ajp.2020.102300

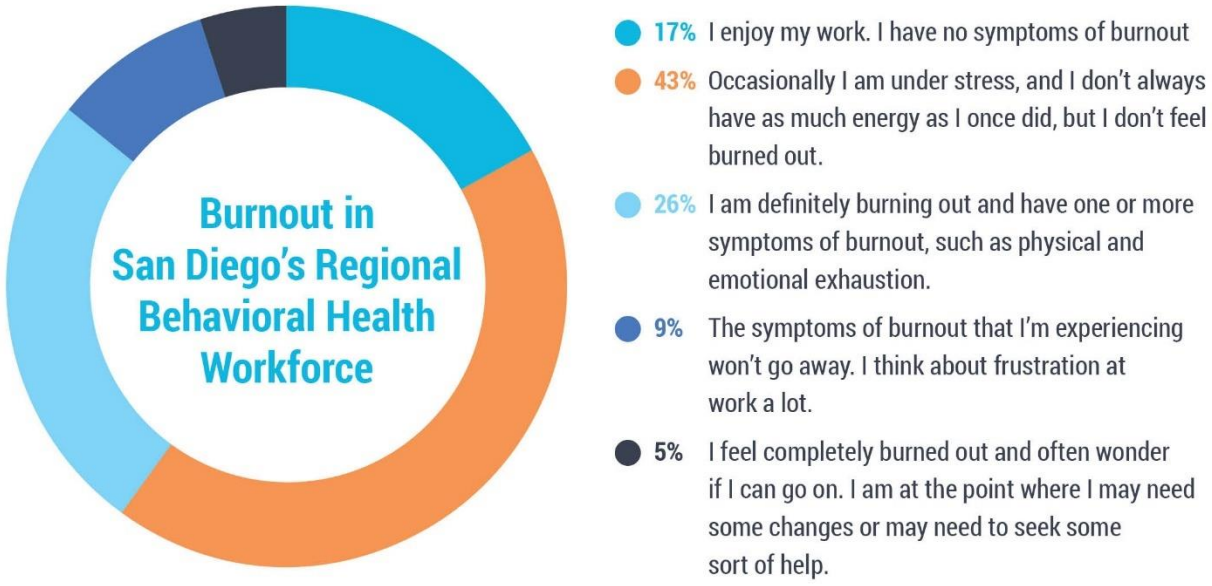
[21] Sklar, M., Ehrhart, M. G., & Aarons, G. A. (2021). COVID-related work changes, burnout, and turnover intentions in mental health providers: A moderated mediation analysis. Psychiatric Rehabilitation Journal, 44(3), 219–228. https://doi.org/10.1037/prj0000480

[22] Parker, K., & Horowitz, J. M. (2022, March 9). Majority of workers who quit a job in 2021 cite low pay, no opportunities for advancement, feeling disrespected. Pew Research Center. https://www.pewresearch.org/fact-tank/2022/03/09/majority-of-workers-who-quit-a-job-in-2021-cite-low-pay-no-opportunities-for-advancement-feeling-disrespected/

[23] Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence Relating Health Care Provider Burnout and Quality of Care. Annals of Internal Medicine, 171(8), 555–567. https://doi.org/10.7326/M19-1152

finding burnout rates around 50%[24]. Nevertheless, burnout drives turnover, occupational replacement rates, and may hurt quality of care [25].

Figure 6: Burnout among San Diego behavioral health professionals



In the survey data burnout was best predicted by stress on the job. Other than stress, burnout was correlated by satisfaction with respondents' relationship with their boss, caseload, pay, licensure cost and documentation. The strong relationship between burnout and relationships with supervisors is not surprising, but it is encouraging. Many workers in our focus groups mentioned relationships with their supervisors as a strength of San Diego's behavioral health system.

Stress builds up over time to cause burn out. Stress is a serious problem among our focus group respondents. Behavioral health workers across occupational groups face vicarious trauma from their patients, a pattern especially salient among SUD counselors.

Participants in focus groups noted that caseloads, pay and documentation were primary contributors to their stress. They also mentioned several mitigating factors for stress: supportive management, cooperative culture among peers, small breaks in their schedule for a walk or conferring with a colleague, pay and paid time off (PTO).

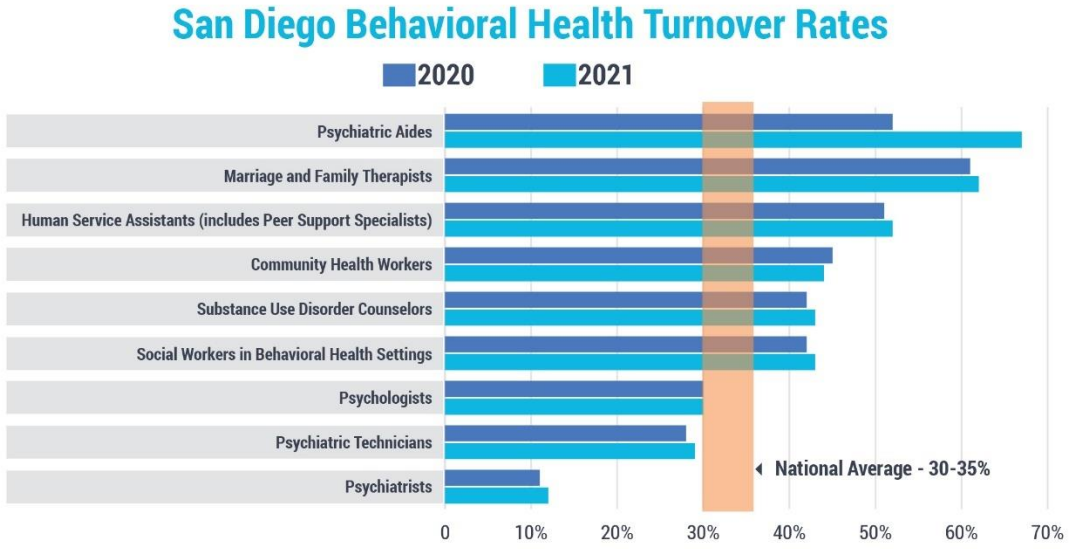
[24] Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., Barbouche, M., & Sinsky, C. A. (2021). Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. EClinicalMedicine, 35. https://doi.org/10.1016/j.eclinm.2021.100879
Linzer, M., Smith, C. D., Hingle, S., Poplau, S., Miranda, R., Freese, R., & Palamara, K. (2020). Evaluation of Work Satisfaction, Stress, and Burnout Among US Internal Medicine Physicians and Trainees. JAMA Network Open, 3(10), e2018758. https://doi.org/10.1001/jamanetworkopen.2020.18758
[25] Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence Relating Health Care Provider Burnout and Quality of Care. Annals of Internal Medicine, 171(8), 555–567. https://doi.org/10.7326/M19-1152

Turnover and intent to leave

In our survey, 44% of respondents indicated that they were somewhat likely (25%) or extremely likely (19%) to search for a job in the next 12 months. This is high compared to historical measures of intent to leave in the field (for example, 18%-25% in substance abuse disorder treatment[26], 22-33% in public health[27]). Data after the onset of the pandemic started is harder to find, but one study found 37% intent to leave among psychiatric nurses.[28]

Turnover is a substantial problem around the country: national annual turnover in behavioral health is between 30% and 35%[29]. In San Diego, many behavioral health occupations meet or exceed that average, and eight San Diego behavioral health occupations saw increases in turnover in 2020. Turnover includes workers leaving their employer for any reason, including to retire, leave the profession, or move to another employer within the same profession. Figure 9 shows 11 behavioral health occupations and their turnover rates in 2019 and 2020 compared to national behavioral health turnover rates.

Figure 7: San Diego behavioral health turnover rates

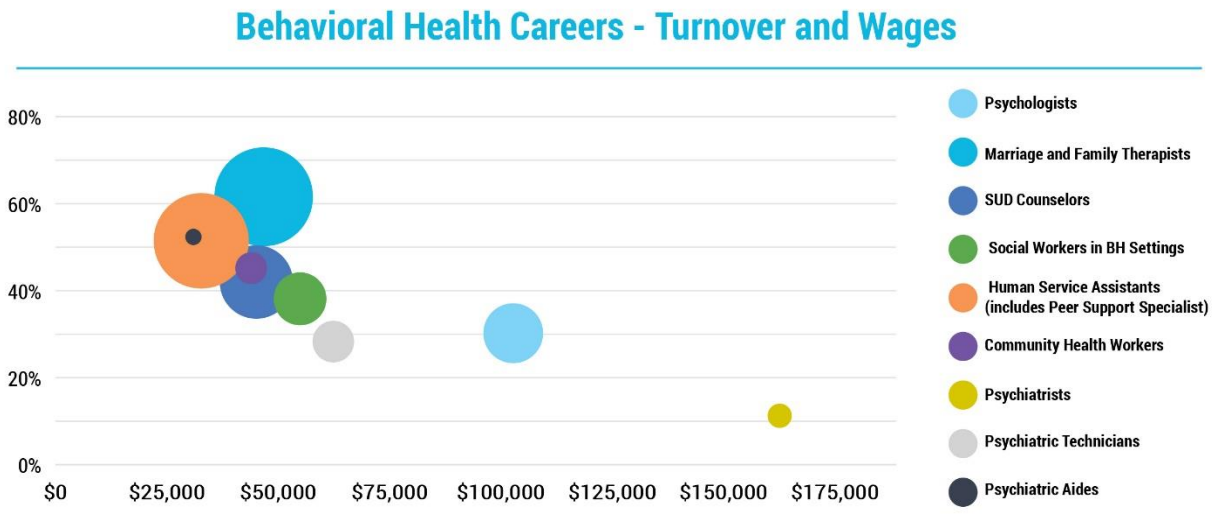


Pay appears to be negatively associated with turnover. The higher the pay, the less likely an individual is to leave their job. Figure 10 shows the pay and turnover rates of 11 behavioral health occupations in San Diego County, with the size of each bubble reflecting the number of workers.

[26] Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. Journal of Substance Abuse Treatment, 40(1), 67–76. https://doi.org/10.1016/j.jsat.2010.08.008
[27] Leider, J. P., Sellers, K., Owens-Young, J., Guerrero-Ramirez, G., Bogaert, K., Gendelman, M., & Castrucci, B. C. (2021). Determinants of workplace perceptions among federal, state, and local public health staff in the US, 2014 to 2017. BMC Public Health, 21(1), 1654. https://doi.org/10.1186/s12889-021-11703-x
[28] de Cordova, P. B., Johansen, M. L., Grafova, I. B., Crincoli, S., Prado, J., & Pogorzelska-Maziarz, M. (n.d.). Burnout and intent to leave during COVID-19: A cross-sectional study of New Jersey hospital nurses. Journal of Nursing Management, n/a(n/a). https://doi.org/10.1111/jonm.13647
[29] Johnson-Kwochka, A., Wu, W., Luther, L., Fischer, M. W., Salyers, M. P., & Rollins, A. L. (2020). The Relationship Between Clinician Turnover and Client Outcomes in Community Behavioral Health Settings. Psychiatric Services, 71(1), 28–34. https://doi.org/10.1176/appi.ps.201900169

Research has noted many factors associated with intent to leave jobs in other industries, including job satisfaction, supervisor support, structural & contextual factors of the work setting or employer[30]. Because several studies identified contextual factors of work as drivers of turnover intent, we used focus groups to surface contextual factors that may be particular to behavioral health, the San Diego region, or the behavioral health system in San Diego.

Figure 8: San Diego behavioral health turnover and wages



It's important to note that turnover intent does not perfectly predict turnover: many who want to leave may not be able to find another job that meets their needs, and many who leave do so unexpectedly, for example leaving for family related reasons. However, turnover intent is correlated with turnover and can be measured by survey[31].

We asked about respondents' intent to leave their jobs and intent to move out of San Diego County. 11% of survey respondents indicated that they were likely to move away from San Diego in the next 12 months. Most of those who are likely to move selected "Switching to a similar job in a location with higher pay or lower cost of living as their reason for an anticipated move" (67% of those likely to move, 9.5% of all respondents).

The relatively low burnout paired with high intent to leave suggests that, although burnout may drive a large portion of turnover intent among behavioral health workers in San Diego, there are other job quality factors at work that may contribute to San Diego behavioral health workers intent to leave.

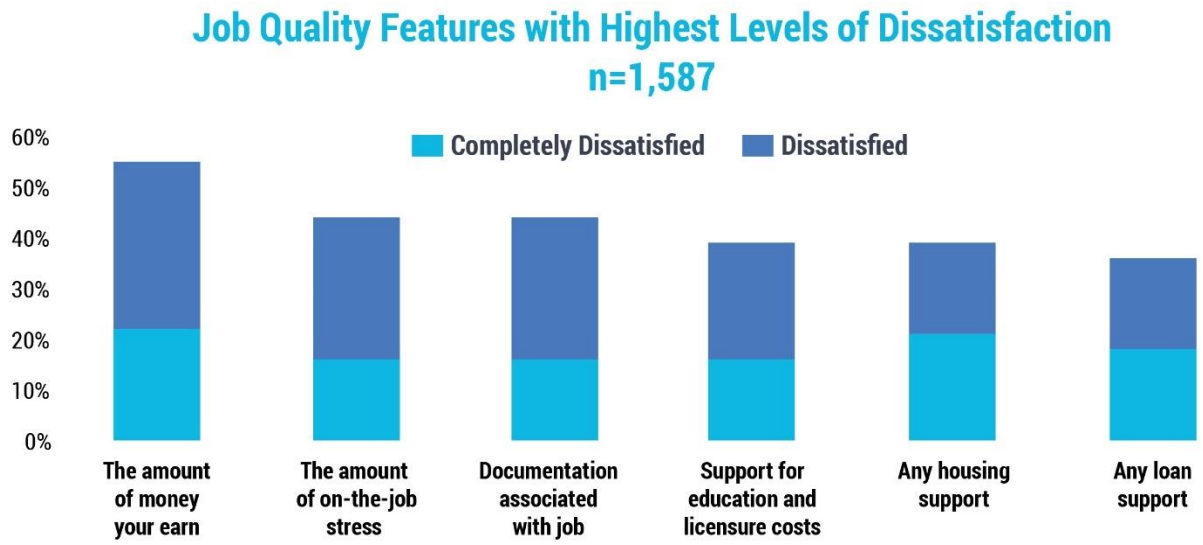
[30] Hellman, C. M. (1997). Job Satisfaction and Intent to Leave. The Journal of Social Psychology, 137(6), 677–689. https://doi.org/10.1080/00224549709595491
Cho, S., Johanson, M. M., & Guchait, P. (2009). Employees intent to leave: A comparison of determinants of intent to leave versus intent to stay. International Journal of Hospitality Management, 28(3), 374–381. https://doi.org/10.1016/j.ijhm.2008.10.007
Coomber, B., & Louise Barriball, K. (2007). Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. International Journal of Nursing Studies, 44(2), 297–314. https://doi.org/10.1016/j.ijnurstu.2006.02.004
[31] Fukui, S., Wu, W., & Salyers, M. P. (2019). Impact of Supervisory Support on Turnover Intention: The Mediating Role of Burnout and Job Satisfaction in a Longitudinal Study. Administration and Policy in Mental Health and Mental Health Services Research, 46(4), 488–497. https://doi.org/10.1007/s10488-019-00927-0

Job quality features making talent attraction and retention difficult (push factors)

To better understand worker intent to leave, we asked about workers relative levels of satisfaction against 35 different job quality features related to economic stability and security, economic mobility and wealth building opportunities, meaningful work, schedules, vacation, rest and relationship with coworkers.

In exploratory data analysis, intent to leave was best predicted by dissatisfaction with pay, workers relationship with their boss, job security, licensure cost, stress and documentation. Pay was by far the strongest predictor and contributed to intent to leave more than it contributed to burnout. This suggests that although focusing intervention on manager's relationships with their workers may mitigate burnout, pay increases are the best strategy for reducing intent to leave.

Figure 9: Job quality features with highest levels of dissatisfaction



- Participants across the board assess pay to be too low. In our survey, 55% respondents were dissatisfied with their pay, with 23% reporting they were "completely dissatisfied." This compares unfavorably with US workers overall: in 2021, a Gallup survey asking a similar question found that 24% were dissatisfied with their pay and 75% were somewhat or completely satisfied with their pay[32]. Pay dissatisfaction cut across all occupations surveyed; no occupation had 50% or more workers answering "completely" and "somewhat" satisfied.

  Participants used several additional factors to assess whether they felt their pay is fair: they noted their level of education and training, loans (especially student loans), experience, average pay in San Diego, supervisory responsibilities, how stressful their job is, their skills and competencies, known pay in other careers, known wages of others in their workplace

[32] https://news.gallup.com/poll/1720/work-work-place.aspx Both dissatisfaction numbers were found by adding the proportion of respondents who answered "somewhat dissatisfied" and "completely dissatisfied."

and the ability of their pay to support the future they want (e.g. can they afford to have kids, own a home, or retire). One SUD Counselor put it like this:

> "Two of my clients died of overdoses in the last year . . . you go through a lot emotionally. And then on top of it, I have to know the documentation. . . you have certain competencies that are hard to develop. And it's just weird to me that that doesn't equate to an average [living] wage. I don't understand."
> – SUD Counselor, Male

- Required documentation was one of the focus group participants' biggest sources of frustration and concern. This sentiment was validated in the survey. 39% of respondents were dissatisfied with documentation requirements, the third highest job feature behind only pay and stress on the job. 23% of respondents were dissatisfied and 16% were completely dissatisfied with the documentation requirements of their jobs. Respondents reportedly understood why some paperwork is necessary for compliance, but point to the effort and time required, frequency of changes, redundancy, priorities reflected in enforcement, inconsistency in enforcement by different auditors year to year, consequences of errors and disconnection of documentation requirements from the reality of care as major points of frustration. Participants referred to the documentation as "impossible," "unsustainable," and the audit process as "merciless," "pathological," "demoralizing" and "brutal."

  While this sentiment is not unique to San Diego and is common across publicly funded health and human service programs, section 4.2 addresses specific opportunities to streamline documentation requirements in San Diego County and to advocate for statewide opportunities for administrative relief.

- Licensed and prescribing focus group participants frequently mentioned access to additional treatment and wraparound services for clients as a high priority that is often not met, especially for clients experiencing homelessness. Participants cited long wait times, lack of case management, lack of walk-in or appointment services, difficult to navigate networks of resources and absence specific referral services as limitations. In addition to long wait lists for affordable housing, participants mentioned the lack of credit recovery options for high school students, a shortage of inpatient psychiatric beds and a desire to expand assertive community treatment teams as examples. In these conversations, participants cited the importance of other workers on their teams, including administrators, case managers, and peer support workers, and the benefits of co-occurring programs with many services in-house. In our survey psychologists, psychiatrists, RNs, and LMFTs expressed their dissatisfaction with access to continuum of care and wraparound services.

While it is out of scope of this report to evaluate the feasibility, policy, or service implications of the frustrations described above, we highlight it here because issues related to their ability to provide effective care were consistently mentioned by licensed professionals (psychiatrists,

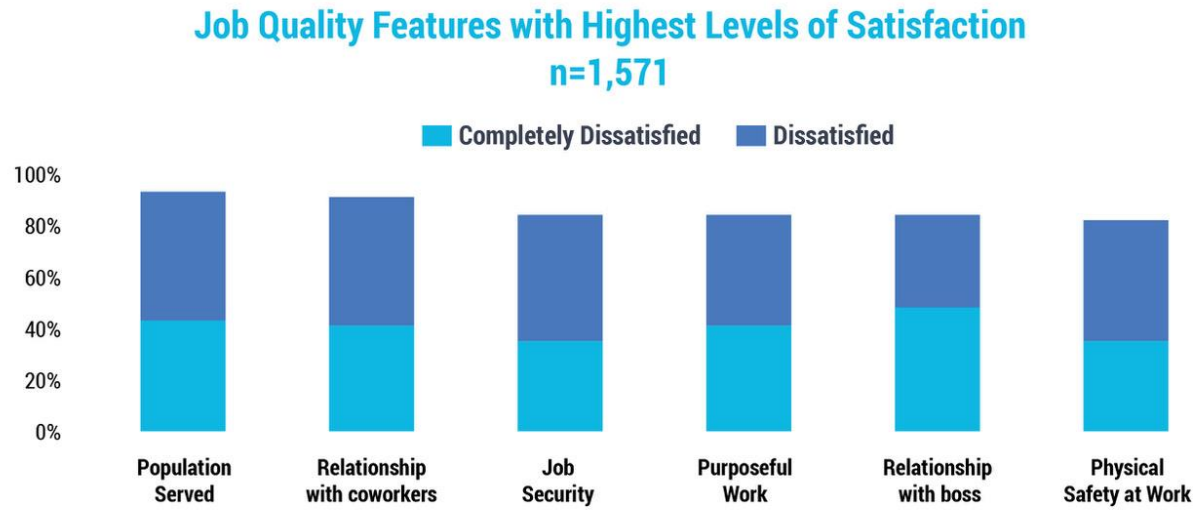
psychiatric mental health nurse practitioners, LCSWs, phycologists, LMFTs) that have options to work in private practice or non-public BH settings as a reason to leave their jobs.

No occupation reported more than 50% satisfaction with staffing (in their own roles, support roles, or management roles), their caseload, pay, retirement plans, stress at work, or recognition for their work. Workers were largely unsatisfied with support for education and licensure (39%) costs, learning and development opportunities, and access to external and internal wraparound services.

Job quality features driving talent attraction and retention (pull factors)

We also wanted to understand what features attract and retain workers to BH professions in San Diego. Top job quality features were job security, physical safety conditions in the workplace, purposeful work, connection to the population served and relationships with supervisors and coworkers (figure 12).

Figure 10: Job quality features with high levels of satisfaction



- Meaningful and purposeful work appears to be the number one factors helping attract and retain BH professionals: 93% of survey respondents felt strongly connected to the populations they serve and 84% reported either they were completely satisfied (41%) or satisfied (43%) with the way in which their jobs contribute to a purpose they care about. Workers connect the challenges of a given population to their professional identity, purpose and personal dreams or lived experience, and that connection can extend to pride for working in the public behavioral health system.

> "Helping people who have been saddled with decades of institutional neglect is something I find personally rewarding."
> – Psychiatrist, Male

> I did a little private practice on the side for a while. I was paid four times as much there and we had a full caseload, but I love working with low income, diverse families.
>
> – Psychologist, Female

- Positive relationships with coworkers and supervisors were also a consistent "pull factor" across survey and focus group participants. 84% of survey respondents were completely satisfied (48%) or satisfied (36%) with their relationships with their managers and 91% were completely satisfied (41%) or satisfied (50%) with relations with coworkers.

Supportive management as described in focus groups included taking time to check in on workers, helping to manage the workers' caseloads and stress, helping make decisions and manage crises, evaluating workers not solely on productivity metrics, supporting workers' career growth within and outside their current employer, verbal affirmations and listening to and valuing workers' concerns and ideas.

> It's a very beautiful place to work. My employer allows a lot of autonomy, I feel very supported. If I have an idea, I feel heard, and they will try to carry out some sort of programming that's related to that idea.
>
> – SUD Site Supervisor

Participants mentioned relationships with coworkers and the diversity in race, gender, culture, disciplinary backgrounds, ethnicity, and language proficiency as important in staffing. They made special note of needing more Black workers and more male workers, and where language services were lacking their absence was noted. When language services for clients were present, they were cited as a point of pride in the workers' employer.

> I've worked for multiple organizations where I was the only bilingual person. They would put me in with anyone who didn't speak English, thinking I guess that because I spoke Spanish, it would be easier for me to figure out how to translate in a third language. One of the things that drew me to my current employer is that they offer services in over 30 languages.
>
> – SUD Counselor

- Participants desire autonomy over their treatment approach. Licensed clinicians and prescribing participants wanted to be able to use their expertise to decide whether telehealth or in-person visits are better for a patient, how many visits the client needs, and what treatment modality they should use (e.g., cognitive behavioral therapy or eye movement desensitization and reprocessing). In our survey, 86% of workers were satisfied with their autonomy at work.

- Where loan forgiveness is offered and participants believe they have hope of receiving it, it is a substantial draw for focus group participants. Participants appreciated the support

their employers offered for continuing education and license renewal, but consistently redirected questions about tuition assistance to student loan assistance. Licensed focus group participants generally did not anticipate returning for a PhD but did want student loan forgiveness. Some participants mentioned the federal government's student loan assistance program, either because they were planning on using it, or because they felt they had no hope of getting it. Among workers who did not select "not applicable" for loan support, workers reported dissatisfaction with the loan support available to them. This reflects longstanding issues with the Public Service Loan Forgiveness program that many behavioral health workers qualify for and reflects the frustration some of our focus group participants have faced trying and failing to receive the loan forgiveness.

> "I had a bad experience dealing with public loan forgiveness. It was so much work. Its almost like having a second job. To get it, I would have to start over and do another 10 years. At this point, making more money is a better solution for me."
>
> – Nurse Practitioner Female

In addition to the themes that emerged in the focus groups, respondents to our survey working in most occupations reported satisfaction with their relationships with coworkers, the physical safety of their workplace, the security of their job, the mastery they feel they can get over their work tasks and their sense of work contributing to an important purpose. Students across occupations expect that they will feel they are helping those who need it, they will have opportunities to advance, they will be able to master the skills and tasks required of them and their work will be contributing to a purpose they care about. Students in no occupations expected good pay or autonomy, although they rated those features of work to be highly important to them.

Overall, the process of asking, listening and responding to the job quality features most important to workers in each BH occupation will be critical to refining and measuring the effectiveness of a regional BH workforce strategy. Insights from the focus groups and surveys described in this section informed the recommendations in sections 4 and 5 of this report. Occupation by occupation survey response data are available in section 5 and the project research team will be doing deeper analysis, including multi-variate regression analysis, to draw deeper insights from the survey data.

Addressing the job features pushing people out of the industry like pay, documentation requirements and on-the-job stress will be critical in attracting new workers to the field and retaining some of the 7,800 workers expected to leave the profession in the next five years. Finally, and as described in section 4.5, the goal of this initial survey is to be a starting point in using the voices and perspectives of workers to center the region's BH workforce strategy and serve as a benchmark for future surveys to understand trends and progress.

Section 4: Recommendations

This report outlines five recommendations that together make up a regional strategy designed to attract and retain the most resilient, representative, skilled and qualified behavioral health workforce in the United States.

1. Invest in competitive compensation
2. Pursue administrative relief opportunities
3. Establish regional training hubs
4. Build a regional workforce training fund
5. Continue listening to workers

While these recommendations are presented in separate subsections, they are parts of a single vision. If implemented in isolation, they will have less than desired results.

4.1: Invest in Competitive Compensation

> "I look at coworkers who have more experience and I'm getting the message. There's not a future in this. And I'm still young – I'm in my early 30s and my life really got sidetracked when I was younger but I'm on track now. Saving for retirement and growing a family seems totally unworkable in this job."
>
> – Peer Support Specialist, Male

Focus groups, survey data and labor market data analysis highlight pay as a significant problem in attracting and retaining behavioral health workers in San Diego. Among workers responding to our survey, 55% were dissatisfied with their pay more than all other 34 job quality features we asked about. This compares unfavorably with US workers overall: in 2021, a Gallup survey found 24% were dissatisfied with their pay and 75% were somewhat or completely satisfied with their pay[33]. Pay dissatisfaction cut across all San Diego BH occupations surveyed; no occupation had 50% or more workers answering "completely" and "somewhat" satisfied.

To contextualize the widespread dissatisfaction with pay, we used labor market information, focus group data, and reported pay from employers and survey respondents to understand how pay in San Diego's BH system compares to workers' other options.

[33] https://news.gallup.com/poll/1720/work-work-place.aspx Both dissatisfaction numbers were found by adding the proportion of respondents who answered "somewhat dissatisfied" and "completely dissatisfied."

> First, we found workers in San Diego's public behavioral health system are paid poorly compared to workers in behavioral health in other California counties. We also found that workers compare their pay unfavorably to local workers in other industries, workers in other healthcare and social service settings, and workers in private practice.

Comparing San Diego compensation to other California counties

To compare wages across California Metropolitan Statistical Areas (MSAs), we took the following steps:

1. Compiled a list of relevant Standard Occupational Classification (SOC) Codes

To identify relevant occupations, we used the definition of "behavioral health" from the "About Behavioral Health Services" section of the County BHS website: "provision of mental health and substance use disorder services." We reviewed the descriptions of Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) codes and identified those that include treating either or both of substance use disorder and mental health. To confirm our target SOC codes, a steering committee of 13 behavioral health experts were surveyed to rank highest occupations of concern. Figure 13 reflects the SOC codes selected.

2. Gathered wage data for those occupations from San Diego and 33 other California MSAs

The research team used the economic data aggregation tool EMSI to compile average 2021 compensation data from the Bureau of Labor Statistics Quarterly Census of Employment and Wages (QCEW) for each SOC code for each of the 33 MSAs.

3. Adjusted wages for all occupations and locations by cost of living

For each MSA we identified the cost-of-living (COL) index,[34] a value that reflects the cost of living in a region as a percentage of the average cost of living in the US. We then calculate COL-adjusted wages for each MSA by adjusting the nominal wage by the COL. For example, the San Diego COL index is 142.2, meaning that the expense of living in San Diego is 42.2% higher than the national average. More information about the cost-of-living adjustment is available here.

4. Ranked San Diego by COL-adjusted wages among comparison MSAs for each occupation

At this stage, for each occupation, we had a list of median wages in each of 33 MSAs. We then identified the top and 75th percentile of each occupation's list. We used the cost-of-living adjustment and inflation data to determine how much a worker in San Diego would have to earn to meet the 75th percentile and top COL-adjusted pay for each occupation. We reported San Diego's percentile rank as well—for each occupation and among 33 other California MSAs, how do San Diego's COL-adjusted wages compare? Zero would mean that we are the worst paying among the set of comparison MSAs

[34] The Cost of Living Index is produced by the Council for Community and Economic Research.

for that occupation (e.g., peer support specialists); our best rank is 48: we pay our psychiatric technicians better than 48% of the MSAs on our list. A full listing of all nominal and COL adjusted wages for each MSA by occupation can be found in the Appendix (Figure A.6).

5. Calculated 2021 wages that would meet the top wage (and 75th percentile wage) in the comparison set, adjusted for cost of living and inflation.

6. Adjusted the 2021 wages identified in Step 5 for inflation between 2021 and 2022

Results

In Figure 11 we report the percentile, the current (unadjusted) wages in San Diego, what we would have to pay (unadjusted) to meet the 75th percentile and top pay considering cost of living differences and inflation.

> **Behavioral health workers in San Diego County are significantly underpaid compared to their peers in other California MSAs. In all 10 occupations, wages in San Diego County are lower than those in the median MSA (adjusted for cost of living). In 6 of the 10, wages are in the bottom 20%.**

Social and human services assistants, which includes peer support specialists, is one of the largest occupations of interest and San Diego pays the lowest wages of all comparison MSAs. Pay for psychiatrists is also surprisingly low, but a plurality of local psychiatrists (34%) work in independent offices where wages may be influenced by factors outside the labor market (e.g., other costs associated with the practice may be high, or a clinician may prefer to work part time).

Figure 11: Wage recommendations for 10 BH professionals

SOC Code	Occupation	San Diego Percentile rank of 34 CA MSAs	Average 2021 San Diego Wage	Match median wage in highest-paying MSA	Match median wage in 75th percentile MSA
21-1093	Social and Human Services Assistants (Includes Peer Support Specialists)	1%	$32,620	$73,340	$51,067
29-1223	Psychiatrists	4%	$165,386	$383,773	$329,385
31-1133	Psychiatric Aides	11%	$31,176	$66,957	$42,956
21-1094	Community Health Workers	12%	$43,892	$73,882	$55,669
21-1013	Marriage & Family Therapists	12%	$46,944	$98,632	$69,319
21-1023	Mental Health and Substance Use Disorder Social Workers	17%	$56,216	$119,113	$93,362
19-3033	Clinical, Counseling, and School Psychologists	45%	$103,811	$153,474	$140,097
21-1014	SUD Counselors	27%	$45,590	$85,947	$63,837

SOC Code	Occupation	San Diego Percentile rank of 34 CA MSAs	Average 2021 San Diego Wage	Match median wage in highest-paying MSA	Match median wage in 75th percentile MSA
29-1141	Registered Nurses[35]	33%	$112,222	$175,701	$138,380
29-2053	Psychiatric Technicians	48%	$62,656	$96,016	$80,543

San Diego professionals across all 10 occupations looked at in the compensation analysis need significantly higher salaries to have the same purchasing power of their colleagues in other parts of the state. A full listing of all competitor MSAs actual and COL adjusted salaries by occupation can be found in the appendix (Figure A.4).

While dramatic increases are needed to get San Diego professionals up to the same levels as these peers, it is important to understand not only that our workforce was significantly underpaid in 2021, but also that San Diego County experienced 8.2% inflation over the past year—one of the highest rates in the country, in a year when the national rate was the highest in 40 years. In other words, anything less than an 8.2% raise would constitute a reduction in the purchasing power of behavioral health workers.

Additional perspectives on compensation

While the above analysis uses IRS payroll tax record data as reported by the BLS and is an "apples to apples" comparison with other MSAs, there are several difficulties with labor market information for use in compensation studies for behavioral health. The remaining portion of this section attempts to reconcile these difficulties and provide additional data points and perspectives on how workers consider pay when making career decisions.

The Bureau of Labor Statistics uses SOC codes to categorize reported wages. Some of these SOC codes are not closely scoped to the jobs we are interested in, collapse nuances within professions that are essential to understanding pay and fail to reflect job structures that influence pay. These nuances are discussed in further detail below:

- Settings and Scope of Practice: SOC codes don't reflect settings of employment for some professions. Notably, nurses are grouped together across specialties or departments. Because there is a lot of diversity between, for example, neonatal intensive care, home health care and nurses working in behavioral health, information about how behavioral health nurses are paid is obscured in BLS data by aggregating all nurses together. Further confusing the issue is BLS classifying psychiatric nurse practitioners not under the nurse practitioner classification, but under registered nurses. BH nurses in our survey reported pay on the lower end of the spectrum for nurses overall; if these self-reported wages are accurate, nurses in training deciding how to specialize may perceive behavioral health to be

[35] Note: we ran this analysis for Registered Nurses because, confusingly, Advanced Practice Psychiatric Nurses are included under that SOC Code. However, the analysis should be interpreted with caution: we cannot distinguish our population of interest from the larger group of Nurses in this SOC code and we do expect their wages to vary.

an unattractive option. This difference across settings was validated by expert interviews for nurses, as well as social workers, psychiatric mental health nurse practitioners and physician's assistants.

Figure 12: San Diego BH nurses in survey make less than non-BH settings

Occupation Name	SOC Code	Wages by SOC (25^{th} – 75^{th} Percentile)	Employer Reports (Public)	San Diego BH Survey Respondents Median
Registered Nurses	29-1141	$90,730 to $134, 805	$98,400	$90,000
Nurse Practitioners	29-1171	$133,266 to $232, 452	Insufficient Data	$125,000

- Collapsed distinctions in education and training: Even within occupations that are well described by the scope of their SOC codes, the wage estimates collapse distinctions with the occupation that influence pay. For example, the mental health and substance abuse social worker classification will include fully licensed social workers and associate social workers. Our survey gives us a view into that distinction: there is a $19,000 difference between registered and certified SUD counselors in our survey and more than $27,000 between the associate and licensed social workers who responded to our survey.

- Part time vs full time: Two professions show average reported wages outside the 25^{th}-75^{th} percentile band of wages reported by BLS. Because the reported wages of psychiatric aides were not only below the 25^{th} percentile wage (which is annualized) and below the minimum wage, we suspect that a substantial contingent of our survey respondents work part-time or worked part of the year[36]. Employers reported hourly rates for psychiatrists that would, if annualized, vastly exceed the self-reported wages from the survey, indicating either that psychiatrist working for these employers were not well-represented in the survey or that psychiatrists are not working 40 hours per week at those wages. BLS data, which is annualized, for this profession better aligns with the self-reported wages. This could indicate that many psychiatrists in the county are working for themselves, working part-time, or have other work arrangements that make their annualized salary lower than expected. To better understand how psychiatrists are being compensated, we would need a focused study that includes contextual information like job structure.

Figure 13: Wage nuance likely caused by job structure

Occupation Name	SOC Code	Wages by SOC (25^{th} – 75^{th})	Employer Reports (Public)	San Diego BH Survey Respondents Median
Psychiatric Aides	31-1133	$29,295 to $36,801	Insufficient Data	$21,014
Psychiatrists	29-1223	$133,265 to 232,452	*$170-220 per hour ($349,400 to $457,600 annually)*	$237,299

[36] To solicit grounded wage data rather than speculated wages for the current year, following survey best practices, we asked respondents "What was your approximate individual income from your primary job last year?" The BLS, on the other hand, annualizes wages of part-time or part-year workers based on detailed tax information for comparability in aggregate.

- Private vs public sector: The lengthier and costlier the education pathway for a given profession, the more likely they are to be "locked in" to the occupation and think about pay and career moves by type of employer (e.g., private, or public sector). The most common comparison that licensed and prescribing focus group participants made when discussing their wages were to workers in their same occupation that were working in private practice. The BLS data used does not distinguish between these two settings, and secondary data was not sufficient to make estimates across these two settings but focus group discussions confirmed this pay gap was top of mind for these professionals.

> "Increasing the pay—it's a big deal. We have a mental health therapist position that has been open for a year. It's just really hard to compete. Compared with private practice, or even for-profits, it's hard to keep up."
>
> – Program Manager

- Across locations: In focus groups and in our survey, among those who planned or considered moving from San Diego to do behavioral health work in another location, most expressed considering alternate locations within California unless they had family connections in other states. We can make direct comparison between pay in San Diego and other MSAs in California. Although BLS data has evident problems classifying workers as described, we would expect the direction and scale of comparisons among counties to be similar. Therefore, this analysis contributes a high-level view of how behavioral health pay in San Diego County compares to pay in other California MSAs.

- Across industries: It's worth noting that, for prospective workers who may be considering a career in behavioral health, some workers are comparing their wages across industries. This is particularly true in lower-paid occupations with shorter educational requirements and lower barriers to entry including community health workers, peer support specialists, and SUD counselors.

Figure 14: BH occupations competing on wage with entry level jobs in other industries

Occupation Name	SOC Code	Wages by SOC (25th – 75th percentile)	Employer Reports (public)	San Diego BH Survey Respondents Median
Community Health Workers	21-1093	$36,670 to $68,764	Insufficient Data	$44,045
Peer Support Specialists	21-1093 (Social and Human Service Assistants)	$29,141 to $45,156	$36,000 to $47,000	$36,784
Substance Abuse Counselors	21-1018	$36,379 to $57,491	$31,200 to $62,400	$52,223

For comparison, Target recently announced a minimum wage of up to $24 (over $50,000 a year) in markets like San Diego where the cost of living is high. In focus groups, San Diego behavioral health workers described how demoralizing it was to discover that they earned less than the starting salary at many fast-food chains, and they described wanting to continue working in their fields but feeling forced out because they could not afford the cost of living on a behavioral health salary.

One interviewee, who had worked as a substance use disorder counselor and a peer support specialist, discussed how he thought about wages:

> "At Panda Express they were hiring someone at the exact same wage. And like here I was: I completed a two-year certificate, I had done hundreds of hours of an unpaid internship, and I had years of experience. I've been trained on medical documentation. I helped the interns in my program, I was training. I helped with the entry level staff, right? And it really felt demeaning."
>
> – SUD Counselor & Peer Support, Male

- Retention and upskilling decisions: Multiple professionals in lower wage BH occupation described their internal dialogue about the tradeoffs between upskilling, career growth and retention in the BH field. In many cases, their outlook on career growth within the industry was more negative the longer they had worked in the field. Less experienced professionals in these lower paid occupations looked at the wage growth opportunities for more experienced and education colleagues to help inform their decisions.

> "There is a counselor who had 10 years' experience and he spoke a foreign language and English. He's the only counselor in the county fluent in this language. No one else was both credentialed and bilingual. And they pay him $18.50. They wouldn't even pay him 20 bucks an hour with 10 years' experience. And that was what got me to go back to school to change professions."
>
> – SUD Counselor, Male

- Professionals newly entering the field in the lower wage BH occupations tend to be the most optimistic about their wage and career advancement prospects.

  When we asked current students, 43% (108 respondents) expressed their intention to "to pursue further clinical education in behavioral health (for example, a higher level of certification or licensure)" compared to 33% (84 respondents) who intend to pursue the career until they retire, 17% (42 respondents) who want to advance into administration, 4% (9 respondents) who plan to leave behavioral health for another type of job, and 4% (9 respondents) who intend to work for a period of time and then become a full-time parent or caregiver.

While this report does not examine the reasons behind low compensation in San Diego, it is important to note that BH services delivered in the public system are largely funded by federal, state, and local dollars that have complex requirements and rate-setting structures. In addition, most (but not all) of San Diego's public BH services are delivered through contracted providers. Efforts to address compensation must consider this context.

4.2: Pursue Administrative Relief Opportunities

> 39% of San Diego Behavioral Health workers surveyed were either dissatisfied of completely dissatisfied with the documentation, paperwork, and administrative requirements in their jobs. Of the 34 job quality features asked about, this ranked third behind pay (55%) and stress on the job (44%).

Qualitative data from focus groups with frontline staff working in public behavioral health settings described documentation as "impossible," and "unsustainable," and monitoring as "merciless," "brutal," and "incredibly demoralizing."

In response, this report recommends establishing a task force with sufficient expertise, resources, and decision-making authority to prioritize and pursue solutions to reduce administrative burdens for frontline workers as much as possible. The task force would develop an administrative relief workplan and lead implementation against specific, measurable, attainable, relevant, time-based (SMART) goals and report back to County leadership at regular intervals. The task force administrative relief recommendations should focus on:

- Advancing CalAIM reform efforts to reduce or streamline documentation
- Conducting a comparative analysis of documentation practices across other counties, care settings, payors, and regulatory entities
- Reviewing County of San Diego contracting and monitoring policies and practices
- Supporting electronic health record integration and technology solutions that reduce redundancies

To help advance this recommendation, *Appendix A.5: Administrative Relief Issue Areas and Opportunities* includes 12 issue areas and 29 opportunities that should be reviewed and prioritized for action. This report acknowledges the issues related to administrative requirements are complex, systemic, and historical. Pursuing meaningful action on the below items will require thoughtful, collaborative, and ongoing efforts from leaders at the County of San Diego, provider organizations, state agencies, elected leaders, and – critically – behavioral health care workers, as well as significant project and change management expertise and resources.

Reducing administrative burden (combined with the recommendation in *section 4.1: Invest in Competitive Compensation*) represent an opportunity to address current workers' top areas of dissatisfaction, increasing retention and reducing the number of professionals leaving public service, leaving BH in favor of other healthcare settings, or leaving their occupations all together.

4.3: Establish Regional Behavioral Health Training Centers of Excellence

> "I just want to help people. Dealing with all this big systemic stuff, being extremely short staffed and feeling the pressure, it's brutal. I'm really burned out; I'm white knuckling it (and still just getting supervision hours). Its not conducive to being a good clinician."
>
> – Pre-Licensed Clinician, Female

While competitive compensation and administrative relief is the most direct (and important, according to workers) retention strategies, the behavioral health training and education pipeline must also expand to meet the region's needs. Licensing requirements add complexity to these investments. Many of the occupations profiled in this report require thousands of hours of internships, residencies, and other forms of on-the-job, supervised clinical experience in addition to education to sit for licensure with the Board of Behavioral Sciences (BBS) or other licensure organizations.

Behavioral health training and education programs have identified the lack of quality training sites as one of the primary obstacles to increasing the number of students and graduates in their programs. A shortage of structured, paid, quality internship and supervision slots are limiting the region's ability the produce the number and diversity of professionals the region needs.

This need, coupled with the current unmet demand for access to behavioral health services, provides an opportunity to envision and develop a regional solution that more effectively addresses access to services and training. In addition, educational institutions recognize the inherent value of providing interprofessional training opportunities for students that are more reflective of the experiences they will have on interprofessional teams in their careers.

This report recommends the County of San Diego establish a partnership with educational institutions (mental health undergraduate and graduate programs including through community colleges), community based organizations delivering behavioral health services (CBOs), health systems, community colleges, and the San Diego Workforce Partnership, to develop multi-agency partnerships at existing service sites that develop core competencies in integrated training and supervision program design, operations, BH training financing and public sector retention, all while providing much needed services to the public.

Specifically, this recommendation is to establish a working group with sufficient expertise, decision making authority, and conduct further diligence on this concept, with a focus on:

- Further diligence on potential sites, locations, and priority specialty areas to establish COEs

- Develop a draft MOU template for core partners interested in establishing a COE
- Creating a competitive grant program to establish COEs
- Establishing key performance indicators for COEs
- Developing a financial model to sustain CEO activities
- Opportunities of alignment of the COE concept with existing initiatives and investments.

Figure 15: Vision for regional training centers of excellence (COEs)

As presently envisioned, the COEs will be where community resources and partnership come together to deliver on four primary functions:

- Provide behavioral health services to the public: COEs would be established within existing service programs providing a range of behavioral health services to be delivered by a multidisciplinary team of certified peer support professionals, non-certified behavioral health professionals, practicum students, associates/interns and prescribing professionals under supervision. COEs would target primarily underserved populations and individuals covered by Medi-Cal. The range of services provided could include screenings and assessments, preventative supports focused on promotion of psycho-social strengths, social-emotional health wellness screenings, as well as a full range of outpatient services, crisis response, intensive clinical services and other elements of the continuum of care as needed by the population to be served.

- Develop and host training programs: COEs will expand on and develop shared core competency in designing, administering, and financing BH training and clinical supervision

programs. Trainees will develop the skills necessary to effectively deliver high quality and evidence-informed behavioral health services in public mental health settings, with CBOs, FQHCs and other clinical and educational sites. In addition, trainees will receive the training and supervision necessary to successfully complete all the requirements for certification and/or licensure. The COEs will be designed to provide an interdisciplinary experience to trainees by including the following disciplines:

- Non-certified/non-licensed professionals
- Certified peer support and substance use disorder counselors
- Practicum students (MSW, MFT, PCC, psychology)
- Interns and associates (MSW, MFT, PCC, psychology)
- Psychology post-doctoral fellows
- Nursing, medical assistants and nurse practitioners
- Community psychiatry
- Speech language pathologists and occupational therapists

This could also include job shadows, externships, and other career exposure events for K-12 students to help them learn about BH career paths in partnership with public school systems.

- Technical assistance: The core competencies in designing, executing, and financing behavioral health training and supervision programs will be available as a resource to support and provide technical assistance to other community-based organizations (CBOs) interested in developing or expanding behavioral health training programs. CBOs in underserved communities could be identified to explore the possibility of starting training programs that could serve as satellite behavioral health sites in partnership with the COE in the given region (e.g., HHSA South, Central, North, or East) or specialty or target population (pediatric, unhoused, immigrant and refugee, geriatric). COEs would also help with clinical supervision and will provide professional development to ensure quality supervision is available in the community for university and community college students and graduates.

  To enhance the quality of training and better understand and respond to community needs, regional convenings of CBOs and faculty will be sponsored by the COE to identify and share best practices and respond to challenges or unmet needs. The site could also provide shared services for specific elements related to training and supervision that a smaller organization may not be able to provide, such as stipend disbursement, navigation of student loan forgiveness programs, didactic curriculum, supervision staff and other back-office support.

- Research: In collaboration with faculty from academic institutions placing students and graduates, research can be done to bridge the gap between educational programs and practice, training and supervision best practices, and services outcomes. The COEs could also provide opportunities to evaluate strategies for workforce optimization and integrated staffing patterns to maximize the case load size of prescribing professionals such as

psychiatrists and the role non-licensed professionals may play along the continuum of mental health services.

The COEs will also develop expertise in funding strategies that promote diversity, inclusion, accessibility, earn and learn opportunities, and affordability for trainees. Ongoing operating revenue would come from:

- Federal and state workforce investments: the San Diego Workforce Partnership would dedicate existing resources for wage subsidies and cohort training programs to support ongoing training programs. This could including exploring registered apprenticeships that would provide federal and state supplemental instruction (SI) revenues for various roles as well as a portion of its $35M-$40M annual allocation from funding streams like the Workforce Innovation and Opportunity Act (WIOA) funds, State of California Employment Training Panel (ETP) funds, Temporary Assistance for Needy Families (TANF) subsidized employment funds, CalFresh Employment and Training (CFET) reimbursements, competitive philanthropic and government grants.

- Ongoing federal and state (HRSA, WIOA, MHSA, ETP, HCAI) competitive grants and funding opportunities.

- Medi-Cal reimbursement from patient encounters, including CA's implementation of SB 855 that will allow associates under supervision to be credentialed and bill Managed Care Medi-Cal (as they can in specialty mental health programs),

- Medi-Cal reimbursement through County Specialty Mental Health contracts.

The BH regional training COEs will be critical beachheads in the regions effort to expand the capacity of the region's talent development system. The infrastructure described in this section will be anchors in effectively deploying the recommend capital in section 4.3: Regional Behavioral Health Workforce Fund.

4.4: Build a Regional Behavioral Health Workforce Training Fund

> "I have had to take out personal loans to cover my groceries. Rent is a whole paycheck. I've thought about going to grad school, but is it worth it to go thousands in debt for two more dollars an hour? I want to do this for the rest of my life, I love it. It makes me sad, but I don't think I will be able to."
>
> – SUD Counselor, Female

While investing in competitive compensation will help attract and retain more behavioral health professionals and the training COEs will provide additional delivery and partnership infrastructure, strategic cash investments along the education, training, job placement and retention pipeline is also needed to produce the additional 18,500 BH professionals needed over the next five years.

This report estimates approximately $425M in additional investments in the training and education pipeline is needed to meet the workforce needs. This estimate came from cost estimates with specific vetted programs and initiatives listed in section 5 and the workforce needs assessment in section 2.

Figure 16: Investments in the training and education system to meet 2027 worker shortage

Occupation / Job Title	Estimated Additional Cost Per Person Trained	Additional Workers Needed (2022-2027)	Total Investment Needed ($)
Community Health Workers & Certified Peer Support Specialists	$7,561	5727	$43,301,707
Certified Substance Use Disorder Counselors	$7,391	2952	$21,819,130
Psychiatric Technicians	$6,397	837	$5,353,914
Licensed Clinicians (LCSW / LMFT/ LPCC)	$31,905	6246	$152,185,714
Psychologists (Clinical, Counseling and School)	$41,125	1451	$59,672,375
Registered Nurses in Behavioral Health Settings & Psychiatric Mental Health Registered Nurses	$31,603	656	$20,731,282
Psychiatric Mental Health Nurse Practitioners & PAs	$99,000	212	$20,988,000
Psychiatrists**	$493,810	204	$100,737,143
Total		18,285*	**$424,789,266**

*These numbers do not include the 208 psychiatric aides including in the regional needs assessment in section 2.
**Across four-years of post-graduate residency training per person.

However, this report does not recommend an initial investment of this full amount; programs cannot scale overnight. The recruitment, education, training, supervision and placement needed, and public service incentive system infrastructure (such as the COEs described in section 4.3) are not yet in place to effectively manage this size of investment. Curriculum needs to be approved and validated.

Policies and procedures need to be worked out for public service incentives. Based on discussions with universities, community colleges, employers and workforce agencies, this report recommends an initial $128 million "down payment" in this regional training strategy to establish key infrastructure and processes. Once established, a larger investment to meet the full need can be considered.

Getting Started: A framework for an initial $128 million down payment

This $128 million fund would expand the regional BH education and training pipeline by approximately 4,250 individuals over the next 5-10 years.

- $98 million would braid together new and existing public and private/philanthropic funding sources in the region to support scholarships, stipends, in-school support, expanding and creating evidenced-based programs, loan forgiveness, tuition reimbursement, relocation and other incentives for public service.

- $30 million of philanthropy and flexible public dollars would capitalize a first-in-the nation, regional BH revolving training fund the provides 0% interest loans to students entering specific programs and upfront financing for organizations providing clinical supervision hours.

All investments of the fund would expand regional education and training capacity for the long term and be done with partners and programs with demonstrated track-records of outcomes, diversity, inclusion, accessibility and affordability. Initial investments will focus on programs with clear paths to financial sustainability from existing federal and state revenue streams for healthcare, behavioral health, education and job training programs to address financial barriers at three key pain points:

- Improving access to education and training. Some potential behavioral health workers cannot afford to enter training programs; they lack the financial resources to pay tuition, are ineligible for further grants or financial aid and can't access reasonable financing to cover costs. This limits the pipeline of trainees, especially among communities of color.

- Helping improve persistence and completion. For those learners who do enter training and education, graduation is far from assured. School often means lower earnings, which can strain household finances; even small financial shocks – car repairs, childcare gaps – can disrupt progress.

- Retention in public service. After graduating and finding a job in behavioral health, employees may feel pressure to transition to higher-paid roles in the private sector, leave the region for areas with higher salaries and/or lower costs of living to keep up with debt obligations, and to position themselves for career advancement opportunities.

Funding tools

- Scholarships, living stipends and in-school support. Grants – to cover tuition, fees, materials, transportation, childcare, living stipends and other critical needs – can help open the door for people with limited assets to enter training and education for in-demand behavioral health jobs. These are especially important for people preparing for lower-wage occupations, which wouldn't allow them to afford to take on further debt burdens or quit their current jobs to further their education or training.

- Loan forgiveness, down payment assistance, tuition reimbursement and relocation allowance: These incentives would be used to keep behavioral health workers to public settings.

  While federal and state loan forgiveness programs currently exist for behavioral health workers in the public workforce, many eligible workers never receive loan forgiveness as (a) forgiveness programs are underfunded relative to the need, and (b) often require stringent and difficult to achieve eligibility requirements, such as substantial years of service. For example, 98% of workers (164,000 of 168,000 applicants) had their loan forgiveness applications rejected from the Public Service Loan Forgiveness (PSLF) program between November 2020 and April 2021[37].

- Outcomes-based financing: For occupations that place students into higher-paying jobs, innovative student financing mechanisms can help increase access, affordability and completion for students. Outcomes-based tools require students to pay little or nothing upfront to attend a program and to repay the cost of tuition only if they land a job paying above a certain income (e.g., over $50,000 per year). The model is most applicable to occupations with 1) scalable, short-term training programs and more commensurate starting salaries and career advancement opportunities; and 2) higher paying occupations that require longer and more expensive education, with subsequently larger student debt burdens[38]. Examples of workforce funds leveraging outcomes-based financing to expand access to good-paying jobs include the Workforce Partnership's Renewable Training Fund, the Google Career Certificates Fund, and Pay it Forward Funds (PIFFs). As students find good-paying jobs and pay back into the fund, those payments can be used to support others.

The below chart outlines a funding allocation for this $128 million investment. Recommended allocations are based on number of additional workers needed in the region (section 2) and expert input on priorities in San Diego.

[37] "If You Are Denied Student Loan Forgiveness, Do This," Forbes, September 2021
[38] Such as psychiatric registered nurses and nurse practitioners, psychologists, and licensed professionals. In combination with in-school support, the Fund would provide financing to students as a "completion play" in their last or second to last year of an undergraduate or graduate degree program and to replace higher interest rate student debt.

Figure 17: A financial framework for a $128 million BH education and training investment

Occupation / Job Title	Public Service Attraction & Retention Investments	Outcomes-Based Loans and Supervision Fund (OBF)	Total ($)	Total Served	Additional Needed Next 5 Years	% of Additional Workers Needed
Certificated Community Health Workers & Certified Peer Support Specialists	$9,000,000	$300,000	$9,300,000	1,230	5,727	21%
Certified Substance Use Disorder Counselors	$7,000,000	$1,500,000	$8,500,000	1150	2952	39%
Psychiatric Technicians	$1,455,000	$400,000	$1,855,000	290	837	35%
Licensed Clinicians (LCSW / LMFT/ LPCC)	$12,800,000	$14,000,000	$26,800,000	840	6,246	13%
Psychologists (Clinical, Counseling and School Psychologists)	$5,000,000	$4,870,000	$9,870,000	240	1,451	17%
Registered Nurses in Behavioral Health Settings & Psychiatric Mental Health Registered Nurses	$5,395,000	$2,000,000	$7,395,000	234	656	36%
Psychiatric Mental Health Nurse Practitioners & PAs	$12,000,000	$7,800,000	$19,800,000	200	212	94%
Psychiatrists	$44,480,000		$44,480,000	84	204	41%
Total	**$97,130,000**	**$30,870,000**	**$128,000,000**	**4,268**	**18,285**	**23%**

The $128M fund is broken down into two funding buckets:

- Public service attraction and retention ($97,130,000): Most of the fund would be used for scholarships, stipends, loan forgiveness, fellowships, and launching and expanding education and residency programs that have demonstrated, or promising, outcomes to attract, support, and retain diverse workers to the public sector and to the San Diego region. Some of these interventions are designed to partially offset the need to leave the behavioral health workforce or enter the private sector for higher wages. Post-education support should be viewed as a worker benefit in addition to compensation increases. An initial list of "shovel-ready" investments can be found in section 5.

- Outcomes-based financing ($30,870,000): These funds will establish the first national revolving financing fund exclusively designed for BH professionals. Products offered by the fund will provide student-friendly financing options to help fill talent gaps within the workforce and upfront financing for community-based organizations to begin or expand supervision programs. These funds are designed to recycle capital. Though the rate of repayment varies significantly based on design decisions, we envision recouping ~60% of each initial investment, increasing the number of students the fund will reach for each dollar investment. Financing options would focus on higher-paying non-certified, non-licensed professionals' occupations, licensed and certified counselors, nurses and psychologists. Trainings for these roles typically require significant tuition costs and fees, which lower-

income students can't afford. Available financing alternatives overburden such students with higher debt to income ratios.

For these roles, we would propose a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training if students make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.[39]

The fund will also finance "last mile" educational needs as a "completion" play. This might include providing financing for the fourth year of a bachelor's program or the final years of a master's after a student has exhausted federally subsidized student loan products and grants, which is often when students drop out due to financial hardship because lack of a co-signer on a Parent Plus loan and/or other unfavorable and expensive options (Source: Better Future Forward, 2022). We envision the following payment terms:

- Minimum income threshold of $50,000 per year (i.e., workers only repay if earning above $50,000)
- A flat monthly payment indexed to a sustainable debt to income ratio
- Five-year payment term without extensions
- 0% interest rate applied to the principal amount
- Loan forgiveness at the end of five years for any unpaid principal, if the worker remains in the public sector workforce
- Borrowing amount will vary by occupation (details in section 5)

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. As an example, Social Finance's Career Impact Bond (CIB) for diesel technicians – an industry facing similar workforce shortages – has structured outcomes–based financing whereby employers repay the employee's monthly cost of training if they remain with the organization.

In this model, a $128 million fund with a $30 million outcomes-based financing allocation and conservative education and employment assumptions over a five-year enrollment period[40], will recycle a projected $20 million[41] in capital over 10 years through student repayment. The $20 million can be retained within the fund to support future students and workers or be directed towards other behavioral health workforce initiatives.

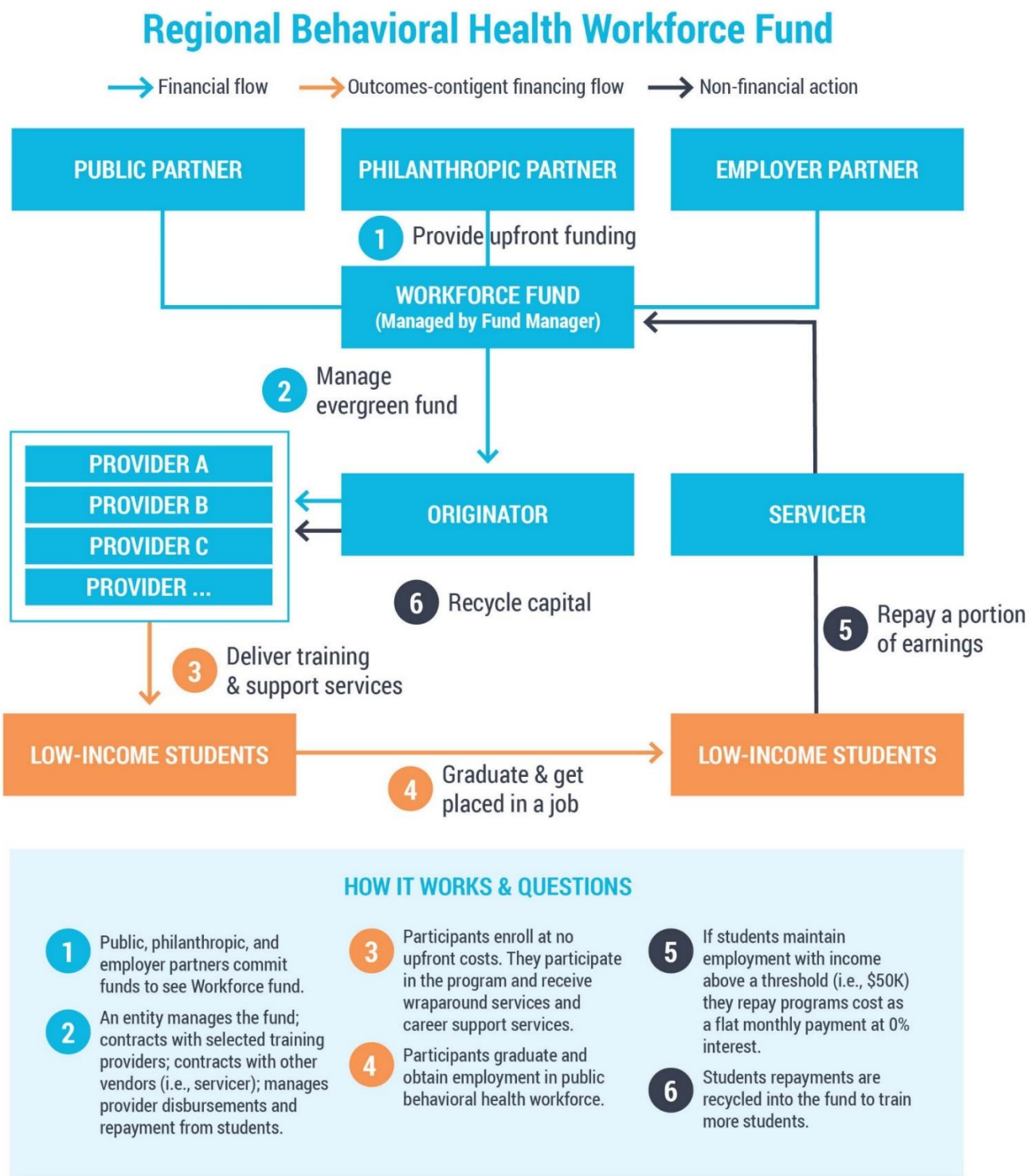
Implementation considerations

[39] Additional payment terms may include a 3-month grace period, a tuition refund guarantee, a 1.0x maximum payment cap, and no extensions
[40] Current, non-exhaustive, assumptions include education outcomes (95% graduation rates, 90% placement rates), student repayment terms (flat monthly repayment, 0% interest rate and 1.0x payment cap, $50,000 minimum income thresholds), and student repayment (90% payment compliance).
[41] Assuming placement rates of 90%. Phase 2 of this work will include further work on fund design and implementation with more detailed projections on fund recyclability, through detailed conversations with education institutions and employers.

Specific projects in these three categories for each occupation group can be found in section 5. As regional leaders evaluate the viability, scale and scope of the Behavioral Health Workforce Fund, the following is a non-exhaustive list of key considerations to move from concept to launch.

- Eligibility criteria: Occupation and population eligibility and priority for funding and financing (e.g., non-certified, non-licensed professionals and certified scholarships focused on the County's underemployed, unemployed, dislocated workers, opportunity youth, people of color, women, and those without college degrees).
- Outcomes-based fund sustainability & timeline; The duration of the fund and expected return profile (e.g., 10-year fund earning 50 cents back for future workforce initiatives for every $1 spent through the fund on outcomes-based financing)
- Fund structure & manager: The structure of the fund (e.g., County administered, an LLC, Trust, etc.) and the organization(s) responsible for fund management (e.g., braiding capital, legal entity, disbursing funds, conducting diligence of prospective partners, etc.)
- Fund governance, reporting, and active performance management (APM): The organization(s) responsible for general oversight of the fund, in addition to the fund manager, identifying the key performance indicators to track, and the data collection and reporting procedures (e.g., reporting on equity and disparate impact, education outcomes and public sector retention outcomes).The APM process of (1) analyzing data and education, employment and retention outcomes to evaluate the fund's impact, (2) reallocating funding and financing as needed, and (3) course correcting in real time to address underperformance
- Loan forgiveness & tuition reimbursement: Designing and administering the process for behavioral health workers to apply for loan forgiveness and tuition reimbursement (e.g., eligible occupations, tenure requirements, maximum funding per worker, etc.).
- Outcomes-based financing mechanism, student repayment terms, & payment structure: The fund's underlying outcome-based financing mechanism (e.g., outcomes-based loan, income share agreement, etc.), the student repayment terms (e.g., minimum income threshold for repayment at $50,000 per year, 5 year payment terms, maximum loan amount, 0% interest rate, no extensions, etc.), and the payment structure to prospective training provider partners to financially incentivize completion and employment outcomes (e.g., 50% at enrollment, 30% at graduation, 20% at placement)
- Origination & servicing: Outcomes-based financing will require an originator to create and countersign the OBF contracts with students and a servicer to manage student repayment.
- Education and outreach: To ensure San Diegans and current behavioral health workers have equitable and inclusive access to capital, the fund manager will need to partner with community leaders to raise awareness and help counsel workers to navigate their career and funding options.
- Timeline to launch: Developing and launching the fund will likely require nine to twelve months.

Figure 18: Operational and governance model for a regional behavioral health workforce fund



4.5: Continue Listening to Workers

> Thank you for asking about all this. These are conversations we need to be having more of.
>
> – Peer Support Specialist, Male

Through this project the San Diego region has established a network, local expertise, and regional infrastructure to center BH workforce initiatives on the experiences and perspectives of workers themselves. This report should be a starting point in establishing San Diego as national leader in BH workforce development applied research and frontline worker survey work focused on improving the quality of jobs for current and future public sector BH professionals. To do this, the region should regularly survey workers, improve on methods, track trends and progress toward goals, and regularly report back to the local community of practice on findings and insights that can inform job quality investments for BH workers at all levels.

Existing survey and research data is either focused on a specific occupation, often led by an industry or professional association, or is led by a university or research institution using state-wide licensure and certification data. While these national and state level research efforts are important, the on-the-ground solutions to workforce challenges often happen regionally with local partners from government, education and community-based organizations. This initial effort brought together these local partners who are now all connected and well-prepared for local action. Partnerships and assets developed in this project that can be built upon to continue to center workforce voice in local BH workforce strategies include:

- Elected and executive leadership support to champion the cause and communicate a regional vision to address BH workforce challenges and solutions.
- Baseline survey data with year 1 high response rates (1571) from Spring of 2022 with replicable, field-tested survey instrument. Established network of survey dissemination partners.
- The San Diego Workforce Partnership, a public regional agency, can subsidize intermediary and research work with core funding aligned with its mission.
- Engaged advisory committee of key education, healthcare, BH professionals and BH service provider executives committed to supporting these activities.

- Ability to translate research into specific local projects with local partners in ways that national and state level research centers and survey providers cannot.

Continued focus and investment in the research, goal setting and measurement, listening to worker perspectives and regional network management is a critical step in advancing the recommendations above.

Addressing the job features pushing people out of the industry like pay, documentation requirements and on-the-job stress will be critical in attracting new workers to the field and retaining some of the 7,800 workers expected to leave the profession in the next five years. Finally, and as described in section 3, the goal of this initial survey fielded in 2022 is to inform the initial vision and serve as a benchmark for future surveys to understand trends and progress

Section 5: Occupational Profiles and Initial Workforce Development Projects

This section provides a deeper dive into the projected shortages, survey responses, proposed workforce training fund allocations and justifications, and the initial set of workforce development projects and interventions the training fund would finance to help expand the size, diversity and skills of the San Diego BH professionals, all with a focus on retention in public service. Below are a few important considerations when reviewing this section:

- Cost and person served estimates for projects are based on subject matter expertise, the project team's field experience, internet searches and feedback from local education leaders. Please consider these high-level estimates as an initial starting point. Funders and partners interested in advancing these programs should conduct their own detailed budgeting and due diligence to develop the most accurate and up to date information related to program design, persons served and costs.

- In cases where partners are identified in general terms (e.g., local universities and community colleges) the project team assessed there are multiple organizations capable of providing the programming described and further assessment, competition and/or due diligence is needed to select the right partner(s).

- In some cases, the project team identified a partner as uniquely positioned to provide the education or training program or service (e.g., UCSD is the only medical school in San Diego). This report names those organizations for clarity purposes only. To the best of our knowledge, the project team could not find another program or partner positioned to provide similar education or training services. However, if other entities capable of providing similar services exist, these examples should not influence or preclude named or unnamed organizations from related procurements. Funders should follow their procedures related to competitive procurements, single-source awards, and other purchasing requirements.

5.1: Community Health Workers and Certified Peer Support Specialists

Community health workers (CHWs) promote health within a community by assisting individuals adopt healthy behaviors, serve as an advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare providers or social service agencies and act as liaison or advocate and implement programs that promote, maintain and improve individual and overall community health.

Note: Effective July 1, 2022, the Medi-Cal program launched a new benefit that includes services provided by Medi-Cal Managed Care Plans. This will further drive demand for community health workers in all healthcare settings.

Social and human service assistants assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. They may assist clients in identifying and obtaining available benefits and social and community services and social workers with developing, organizing and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.

Certified peer support specialists do not have specific Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) code, their job titles are commonly found in the broader community health worker and social and human service assistants' categories. Senate Bill 803 (SB 803), the "Mental Health Services: Peer Support Specialist Certification Program Act of 2020," sets a standard of 17 core competencies that every peer support specialist is required to know to be certified as a practitioner. In California, this creates a new provider and service type eligible for Medi-Cal reimbursement through the county mental health and behavioral health plans, making it a key occupation of focus in this report.

Figure 19: Community health workers & social and human services assistants' occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
4644	6.87%	6930	7588	51%	11.3%	5727

** Common job titles include Care Coordinators, Outreach Worker, and Peer Support Specialist*

Of the 66 community health workers and 113 peer support specialists in our survey:

- Representation

Peer support worker respondents (64% women, 31% men, 3% non-binary, 2% unspecified) were more often women than men, but had a higher proportion of men than community health worker respondents (74% women, 18% men, 4% non-binary, and 5% unspecified).

Figure 20: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[42]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	5.9%	10.8%	12%	7%
Black	4.8%	9.6%	5%	5%
Hispanic	22.4%	32.4%	31%	39%
Native American	0.4%	.6%	.4%	.4%

[42] These proportions are based on the 5-year 2020 American Community Survey respondents who indicated they worked in the occupation "Social and Human Service Assistants," the parent category that includes Peer Support Workers. Community Health Workers were not counted in the 2020 American Community Survey

White	30.2%	34.5%	45%	18%
Multi-racial	5.9%	12.2%	7%	
Other	1%		.2%	
Not Reported	29.3%			30%

- Salaries: Respondents reported a median salary of $36,784 (peer support) and $50,000 (community health workers). Peer support workers do not have their own classification from BLS, but reported salaries are somewhat below the salaries for the comparison category we use in this report: the median salary among social and human service assistants is $32,573. Reported salaries among community health workers are higher than the median salary of $43,908 for community health workers ($53,248 mean) from the BLS.

- Student loans: community health workers reported a much higher debt load ($63,000 median initial balance (n=7), $55,500 median remaining balance (n=6)). The median monthly payment was $400. Peer support workers had more workers who reported zero loans (20 with zero initial loan balance). Among the rest, however, the median initial loan balance was $25,000 (n=25). Among those who had a remaining balance, the median was $30,000 (n=25). 25 peer support workers reported a monthly payment of zero and the median payment among those who had one (n=15) was $200.

- Burnout: 39% of community health workers respondents and 28% of peer support workers reported some level of burnout. Persistent burnout was reported by 5.5% of peer support workers and 5.1% of community health workers, with 4.6% of peer support workers and 8.5% of community health workers reporting complete burnout. This is similar to the 39% burnout among all 1,572 survey respondents and lower than the 50% of all mental health professionals reporting burnout.

- Intent to leave: 51% of community health workers and 42% of peer support specialists reported they were either somewhat likely (22.7% community health workers; 18.6% of peer support specialists) or extremely likely (28.8% community health workers; 23% of peer support specialists) to leave their job in the next 12 months. Community health workers are more likely to report some intent to leave (51%) than the 44% of all 1572 survey respondents and much more likely than the 18%-37% reported among mental health workers. Community health workers and peer support workers reported similar likelihood of leaving San Diego: 10.6%, compared to 11% in our survey overall.

- Job quality and job satisfaction: Non-certified professionals were overall satisfied with their managers, relationships with co-workers, the population they work with and the sense of autonomy and purpose they have at work. They were dissatisfied with pay, support staffing and loan support (where it exists).

Figure 21: Regional training fund project recommendations

Program		Avg. Amount Per Worker	Est. # Served	Funding Total
1	Establish Community Health Worker Apprenticeship Program	$5,000	600	**$3,000,000**
2	On-the-Job Training, Support, & Certification of Peer Support Specialists	$10,000	600	**$6,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$10,000	30	**$300,000**
Totals			**1230**	**$9,300,000**

Program 1: Establish a regional community health worker apprenticeship program

This recommendation would expand the regions CHW output by 600 workers over the next 10 years. With an initial investment of $3,000,000 with a community-based non-profit and a partnering local education agency (LEA), the program lead would work with employer partners to validate curriculum, get the program registered with the California Division of Apprenticeship Standards (DAS), establish MOUs with hiring partners and begin recruiting and operating the program. The $3,000,000 would cover start-up and operating costs for the first five years, serving at least 300 CHWs. After that, ongoing revenues from DAS, ETP, WIOA and education partner enrollment revenues can sustain the program to serve an additional 300 over the next five years.

Establishing a CHW registered apprenticeship program (RAP) with a BH emphasis would provide regional standards, a curriculum and competency advisory structure and a structured pathway for professionals to become CHWs while earning wages at each step of the process. The recommendation would also position the region for long-term training revenue through Related Supplemental Instruction (RSI) and Employment Training Panel (ETP) funds, and competitive grants from multiple federal and state agencies focused on expanding "earn & learn" opportunities.

Expanding and funding healthcare RAPs has been a big priority for the US Department of Labor. The Urban Institute and the US DOL published this report to help local jurisdictions set up CHW apprenticeship programs in 2018. In Riverside County, local employers have partnered with community colleges to offer a 12-month registered apprenticeship program that starts workers at $17.00 per hour with step-raises after specific training milestones are completed. San Francisco City College offers a 16-month CHW program in partnership with the Homeless Pre-Natal Program (HPP). During the apprenticeship, participants receive a minimum of 250 hours of education and receive customized related instruction to fit their roles at HPP as they advance through their training. The apprenticeship combines classroom instruction with on-the-job training working with clients, reception skills, performing client intakes, use of the HPP database and other computer applications, learning about local resources, skills for outreach and other client-centered professional skills. Establishing a RAP would also create the formal structure for partner employers that hire CHW apprentices to review and update curriculum, which may be particularly important as the CalAIM rollout may impact job functions over the next 10 years.

Program 2: On-the-job training subsidy for certified peer support specialists ($6,000,000)

$6,000,000 would establish a regional system that provides outreach, case management, job placement, supportive services (e.g., transportation, childcare assistance), on-the-job training subsidies and certification exam fees to recruit, train, place, and certify 600 peer support specialists

over a 10-year period. This system would leverage existing workforce development infrastructure and funds, including those provided by WIOA and Temporary Assistance for Needy Families (TANF) Expanded Subsidized Employment (ESE) funds. In San Diego County, these funds are administered by the San Diego Workforce Partnership who have committed $3,000,000 of the $6,000,000 recommended over the next 10 years to stand up and operate this regional program.

Certified peer support specialist programs are currently offered for zero cost and are likely to remain low cost. Individual career coaches based in the region's American Job Centers (AJCs) would be available to support individuals qualified and interested in becoming a certified peer support specialist through job-readiness training, coaching and financial assistance to arrange child care, transportation, help getting laptops/internet and a job placement with partner employers.

Employers that hire from this regional system and support peer supports specialists through the certification process, would get 50% of the employees' wages reimbursed by the San Diego Workforce Partnership for the first six months of employment though the On-the-Job Training (OJT) program ($8,000 – $12,000) in cases where the individual is enrolled in the Temporary Assistance for Needy Families program (TANF), the employer subsidy may be more generous through the Expanded Subsidized Employment (ESE) program.

This recommendation would allow organizations to continue hiring peers that are not certified, train and pay them on the job, and receive reimbursement for the time required to support the individuals in the certification process. Effectively, this recommendation bridges a financial gap between date of hire until the individual begins generating Medi-Cal reimbursements post-certification and helps participating employer partners establish and scale peer training and onboarding programs aligned to CalMHSA core competencies.

Program 3: Outcomes-based financing ($300,000)

This program will set aside $300,000 to provide 0% interest loans to peer support specialists interested in upskilling. This dollar amount is relatively small and will be used as an innovation pilot to see if a larger investment would be beneficial.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven. This product would finance peer specialists to pursue education to become SUD Counselors, psychiatric technicians, and licensed clinician roles that require four-year and advanced degrees.

Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives. $300,000 in 0% outcomes loans would serve an estimated 30 students over the first five years, with cashflows from these first 30 students serving another 10-15

students after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.4.

5.2: Certified Substance Use Disorder Counselors (SUD Counselors)

SUD counselors: These professionals counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. They may counsel individuals, families, or groups or engage in prevention programs.

SUD counselors must complete minimum education requirements, plus register as a SUD counselor with one of three state accrediting bodies and pass a certification exam after education plus 2,000 hours of supervised work experience. Navigating this system, covering all course fees and tuition, and successfully completing all requirements can be challenging. Considering that well over 50% of SUD counselors are in active recovery, investing in infrastructure to help these individuals enter and advance in BH careers will expand the number of professionals with lived experience.

Figure 22: Substance use disorder (SUD) counselor occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
2566	7.66%	3631	4248	43%	9.2%	2952

Of the 121 substance abuse counselors in our survey:

- Representation: 60% were women, 36% were men, and 4% declined to state.

Figure 23: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[43]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	2.3%	11.6%	12%	7%
Black	9.4%	9.7%	5%	5%
Hispanic	22.7%	22.9%	31%	39%
Native American	3.9%	.07%	.4%	.4%
White	39%	41.2%	45%	18%
Multi-racial	8.6%	14.5%	7%	
Other	.8%		.2%	
Not Reported	13.3%			30%

- Salaries: Respondents to our survey reported a median salary of $47,500. These reported salaries are similar to the median salary of $44,470 ($50,876 mean) for all SUD Counselors in San Diego.

[43] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Substance Use, Behavioral Health, and Mental Health Counselors."

- Student loans: 17 SUD counselors reported zero debt loads and 22 reported some loan information. The median initial balance among all SUD counselors who reported taking out loans was $39,000 (n=20) the median remaining balance was $32,500 (n=22), and the median monthly payment was $275.

- Burnout: 27% of respondents reported some level of burnout, with 7% reporting persistent burnout and 4% reporting complete burnout. This is below the 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- Intent to leave: 31% reported they were either somewhat likely (22%) or extremely likely (9%) to leave their job in the next 12 months. This is below the 44% of all 1,572 survey respondents and slightly above the 18%-25% among substance abuse disorder treatment workers in the United States. 6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: SUD counselors were satisfied with their relationships with coworkers, population and managers. They were dissatisfied with pay, documentation requirements, support staffing levels and loan support (where it exists).

Figure 24: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Regional SUD Recruitment, Case Management, and Scholarship Program	$6,000	500	**$3,000,000**
2	Establish the State of California's first SUD Registered Apprenticeship Program	$10,000	400	**$4,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$6,000	250	**$1,500,000**
Totals			**1150**	**$8,500,000**

Program 1: Regional SUD recruitment, case management, and scholarship program ($3,000,000)

This recommendation would train, certify and place an estimated 500 SUD counselors over a 10-year period. This system would leverage existing infrastructure and funds, including those provided by the Workforce Innovation and Opportunity Act (WIOA), administered by the San Diego Workforce Partnership who have committed $3,000,000 over the next 10 years to stand up and operate this regional program.

This recommendation would establish a regional system that provides scholarships, case management, course fees, supportive services (e.g., transportation, childcare assistance) and job placement and mentorship support to local jobseekers interested in becoming SUD counselors.

The first step requires getting high-quality, affordable substance use disorder training programs with demonstrated completion and placement outcomes onto the San Diego Workforce Partnership's Eligible Training Provider List (ETPL). Initial partner programs include San Diego City College,

Palomar Community College, and UCSD Extension. Once these programs are on the ETPL, WIOA eligible jobseekers and students would be enrolled in the American Job Center network, assigned a career coach that specializes in supporting the SUD counselor career path, and provided with a full scholarship (including fees and books) to their preferred program on the ETPL.

Individual career coaches would be available to support them through their program, provide coaching and financial assistance to arrange childcare, transportation, help getting laptops/internet and anything else the individual needs to successfully complete their education in partnership with the training provider.

After graduation, the American Job Center staff would work with the individual to place them in a job and provide 180 days of post-placement retention and supportive services (coaching on work-place dynamics, fees for taking certification exams, checking in on supportive service needs, etc.).

Programs and training providers would be added to the ETPL based on their eligibility and accreditation, ability to report outcomes (completion, placement, wage at placement, ideally disaggregated by key demographics such as race/ethnicity and gender), and curriculum validation by key employers from San Diego's Alcohol and Drug Service Provider Association (ADSPA), which includes over 15 agencies that employ the majority of SUD counselors in the region.

Within this system there is an opportunity to contract with community-based organizations (CBOs) to provide recruitment, outreach, case management and career support, paid work experience and other career navigation in lieu of and/or in addition to the American Job Center. For example, the San Diego Refugee Communities Coalition (SDRCC) recently received a 3-year, $400,000 grant from the CA Department of Health Care Services (DHCS) through the Sierra Health Foundation to provide scholarships and wages to 10 employees of SDRCC member organizations to participate in SUD counselor certification programs. Partnership with these equity-based CBOs will help ensure there is sufficient diversity, cultural, and language competency in the SUD training pipeline.

Program 2: Establish SUD registered apprenticeship program ($4,000,000)

This recommendation would create one of the first SUD counselor registered apprenticeship program (RAP) in the United States and train an additional 400 trained professionals over the next 10 years. With an initial investment of $4,000,000 and a regional lead and local education agency (LEA) identified, partners can validate curriculum, get the program registered with the California Division of Apprenticeship Standards (DAS), establish MOUs with hiring partners, and begin recruiting and operating the program for the first five years, serving at least 200 SUD counselors. At which point, ongoing revenues from DAS, ETP, WIOA and education partner enrollment revenues can sustain the program to serve an additional 200 participants over the next five years.

The apprenticeship would combine classroom instruction (6-12 months) with 2,000 hours of supervised and paid on-the-job training required for certification. At the completion of the 18–24-month apprenticeship, SUD counselors will get a registered apprenticeship certification, a two-year associate degree from the partner community college, and state SUD certification, all with $0 out of pocket cost and earning wages all along the way.

Establishing a RAP would also create the formal structure for partner employers to review and validate curriculum from education partners. In addition to the structured learning and support from the education partner and the employer sponsor(s), apprentices would also get individual career coaches from the American Job Centers to support them through their program, provide coaching and financial assistance to arrange childcare, transportation, help getting laptops/internet, and anything else the individual needs to successfully complete their education in partnership with the training provider. Many peer support specialists have an interest in becoming certified SUD counselors; this apprenticeship program could tailor recruitment and outreach efforts to peers, creating a clear pathway in the BH system.

Program 3: Outcomes-based financing ($1,500,000)

Some individuals interested in pursuing a SUD counselor career may not qualify for WIOA Adult or Dislocated Funds because they may be currently working and/or their household income is too high, but they do not have money out of pocket and/or want to take out private loans.

This program will set aside $1,500,000 to provide 0% interest loans to those individuals to pursue the vetted programs on the Eligible Training Provider List (ETPL) listed above. The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan would be forgiven.

Loan repayments will support future students and workers towards other behavioral health workforce initiatives. $1,500,000 in 0% outcomes loans would serve an estimated 250 students over the first five years, with cashflows from these first 250 students serving another 60-75 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

5.3: Psychiatric Technician

Psychiatric technicians: These professionals care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. They monitor patients' physical and emotional well-being and report to medical staff and may participate in rehabilitation and treatment programs, help with personal hygiene and administer oral or injectable medications.

While there are several psychiatric technician training programs across Southern California, the project team did not identify any active programs in San Diego.

Figure 25: Psychiatric technician occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
789	6.08%	1181	1334	29%	7%	837

There were insufficient responses from psychiatric technicians to make inferences. This report recommends making a concerted effort to increase psychiatric technician's survey participation in future years.

Figure 26: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Establish local Psychiatric Technician Program	$9,550	200	**$955,000**
2	Relocation Payment	$10,000	50	**$500,000**
3	0% Outcomes Based Loan (OBL) Fund	$10,000	40	**$400,000**
Totals			**290**	**$1,855,000**

Program 1: Establish local psychiatric technician program ($955,000)

San Diego County does not have a psychiatric technician training program in the region. According to the California department of consumer affairs, there are 13 psychiatric technician training programs across California that prepare students for licensure as a psychiatric technician. Southern California programs include San Bernardino Valley College and Cypress College.

San Diego's cost of living is making it increasingly difficult to attract psychiatric technicians from out of the region.

With multiple planned and active health system infrastructure projects that will increase the number of beds for in-patient psychiatric patients, establishing at least one local program for San Diego residents from the community to get trained, licensed and placed in in-patient settings is the highest priority investment for this occupation.

A one-time grant of $955,000 delivered through a regional RFP process could identify the institution best positioned to establish this program for the region. The selection criteria could be focused on domain expertise, demonstrated partnerships with psychiatric hospitals (the primary employer of psychiatric technicians), track record of diversity, equity, inclusion, and accessibility, program affordability, demonstrated outcomes with like programs and a model for financial sustainability.

Funds would be used to develop curriculum, hire faculty, get approval from the state, and begin outreach and recruitment activities. The investment would generate at least 200 psychiatric technicians regionally over the next ten years.

Program 2: Hiring and retention bonuses ($500,000)

In the short term while the local program described above is being established, this report recommends $500,000 for hiring and retention bonuses and relocation incentives local employers of psychiatric technicians can use to attract graduates from the 13 other California programs. Employees receiving these funds would make three-year commitments to their employers. In the

event these funds are not spent on hiring or retention bonuses in the short term, funds could be reallocated to either program #1 or program #3 in this section.

Program 3: Outcomes-based financing ($400,000)

High-performing psychiatric technicians' programs are good candidates to outcomes-based financing because they are relatively short-term, low-cost, and salaries at placement are well above the $50,000 minimum income threshold that triggers repayment. In short, the economics of these programs are well suited for the loan product we have described in this report.

The loan fund would set aside $400,000 to provide 0% interest loans to those individuals to pursue the local psychiatric training program once established. This tool would help the new program generate enrollments, reduce student acquisition costs, and potentially be a source of early revenue while the program is getting off the ground.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives. $400,000 in 0% outcomes loans would serve an estimated 40 students over the first five years, with cashflows from these first 40 students serving another 15-25 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.4.

5.4: Licensed Clinicians (LCSWs, LMFTs, LPCCs)

Licensed clinical social workers assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs through individual and group therapy, crisis intervention, case management, client advocacy, prevention and education.

Figure 27: Licensed clinical social workers working in behavioral health settings occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1283	6.87%	1913	2142	39%	9.2%	1476

Licensed marriage and family therapists: These professionals diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems and apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

Figure 28: Licensed marriage and family therapist (LMFT) / licensed professional clinical counselor (LPCC) occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
4443	6.87%	6637	7101	62%	9.2%	4770

Of the 248 Licensed Clinicians in our survey:

- **Representation:** 80% were women, 18% were men, and 3% declined to state.

Figure 29: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[44]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	5.6%	14.4%	12%	7%
Black	2.8%	8.1%	5%	5%
Hispanic	25.8%	20.8%	31%	39%
Native American	.04%	.06%	.4%	.4%
White	48%	44.2%	45%	18%
Multi-racial	6.9%	12.0%	7%	
Other	0%	.3%	.2%	
Not Reported	10.5%			30%

- **Salaries:** Respondents reported a median salary of $75,000. These reported salaries are higher than the median salaries of $55,099 for mental health and substance abuse social workers and $46,779 for marriage and family therapists from the BLS. We expect this is because trainees seeking licensure hours and sole proprietors are included in the BLS data.

- **Student loans:** 24 licensed clinicians who reported loan data took out no student loans. The median initial loan amount reported was $82,000 (n=148) and among those who reported a remaining balance, the median was $80,000. Among the 110 students who reported a payment, the median monthly payment was $400 (32 reported $0 payments).

- **Burnout:** 42% of respondents reported some level of burnout, with 11% reporting persistent burnout and 3% reporting complete burnout. This is above the 39% of all 1,572 survey respondents and 50% of all mental health professionals

- **Intent to leave:** 40% reported they were either somewhat likely (27%) or extremely likely (13%) to leave their job in the next 12 months. This is 44% of all 1,572 survey respondents and higher than the 18%-37% among mental health workers in the United States. 8.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- **Job quality and job satisfaction**: Workers in these occupations were most satisfied with their autonomy, relationships with coworkers and the populations they work with. They were

[44] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Mental Health and Substance Abuse Social Workers and Marriage and Family Therapists."

dissatisfied with pay, support staffing, documentation and (where it exists) loan support. LCSWs were satisfied with more aspects of their jobs than other Licensed clinicians.

Figure 30: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	BH MSW Stipend Program	$30,000	260	**$7,800,000**
2	Upskilling Scholarships for Public BH Workers	$50,000	100	**$5,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$35,000	200	**$7,000,000**
4	Renewable Supervision Fund	$25,000	280	**$7,000,000**
Totals			**840**	**$26,800,000**

Program 1: BH Master of Social Work stipend program ($7,800,000)

This intervention is modeled after the discontinued Mental Health Services Act Stipend Program for MSW Students. The UC Berkeley California Social Worker Education Center (CALSWEC) recently completed a retrospective study of the program that demonstrated positive outcomes related to program completion, fulfillment of public service, retention in behavioral health professions, and high levels of diversity, lived experience, and cultural and linguistic competency among program completers.

Under this program, MSW students from Cal State University San Marcos (CSUSM) and San Diego State University (SDSU) will be provided stipends of $15,000 if enrolled part-time and $30,000 if enrolled full-time. These funds can be used for living expenses (gas, rent, food) at the student's discretion. Trainees will be required to complete advanced-year field training at public behavioral health sites, advanced-year clinical courses focused on applying the recovery model and other MHSA principles in clinical practice and specialized symposia, capstone projects and other consumer-focused learning experiences designed by their MSW programs. After graduation, all trainees will be required to complete 24 months of full-time paid work (or equivalent part time service) in a public behavioral health setting in San Diego County. Graduates who fail to complete this service obligation and who are not entitled to a waived repayment will repay stipend funding, prorated to reflect any service fulfilled.

A $7.8 million investment would provide an estimated 200 full-time students with $30,000 stipends, 60 part-time students with $15,000 stipends and have $900,000 available for SDSU and CSUSM for coordination, matching and placement activities, community-based organizations internship supervision costs, wrap around career coaching/supportive services, and stipend origination, disbursement and servicing fees.

Program 2: Upskilling scholarships for public BH workers ($5,000,000)

This program would provide full-tuition scholarships for CSU San Marcos and SDSU's Bachelor of Social Work (BSW) and/or Master of Social Work programs for incumbent-behavioral health workers in San Diego. The program could specifically target unlicensed professionals that have worked for the County of San Diego, and/or a County of San Diego Behavioral Health Services (BHS) contracted provider, and/or an FQHC for 5 or more years. Applicants not meeting those criteria could be evaluated on a case-by-case basis to provide flexibility while still ensuring the spirit of the program is

achieved (for example, a peer-support specialist working on a philanthropic or city funded program to reduce homelessness may be eligible, but an administrative support professional at a cash-only psychiatry practice would not be).

Applicants would include case workers, eligibility workers, outreach workers, certified SUD counselors, certified peer support specialists, and other unlicensed professionals working in the public system that are looking for an opportunity to advance their education and training but may not have the disposable income, ability to finance education, and/or willingness to take on additional student debt loads. The program could prioritize individuals with lived experience and cultural and linguistic competencies.

Long term, the scholarship program could focus on advanced standing and/or accelerated programs and will work with the CSUSM, SDSU, and the San Diego Imperial County Community College Association (SDICCA) colleges to expand opportunities for accelerated programs and consideration of work-experience for entry into advanced standing programs.

After graduation, all trainees could be required to complete between 3-5 years (depending on scholarship amount) of full-time paid (or equivalent part time service) in public behavioral health settings in San Diego County. Graduates who fail to complete this service obligation and who are not entitled to a waived repayment would repay scholarship funding in cash, prorated to reflect any service fulfilled.

If funded, a $5M investment would provide an estimated 100 full time students with $40,000 scholarships. There would also be $1M set aside for colleges to expand faculty and administrative support to expand slots. The program application, fund distribution, reporting, and repayment servicing for recipients that do not fulfil their public service obligation can be handled centrally by a regional organization to reduce administrative burden for participating employers. Once launched, the program could also be expanded to programs training LMFTs and LPCCs.

Program 3: 0% Outcomes based loan (OBL) fund ($7,000,000)

To expand education access, outcomes-based financing would cover the upfront cost of master's degree or gap financing for the fourth year of a bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion and work toward licensure as an LCSW, LMFT, or LPCC.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available for students' pursuing careers in the public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $7,000,000 in 0% outcomes loans averaged at $35,000 each would serve an estimated 200 students over the first five years, with cashflows from these first 200 students serving another 75-100 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

Program 4: Renewable supervision fund ($7,000,000)

This recommendation would provide upfront financing for FQHCs and CBOs to provide structured supervision to professionals that need to accrue hours to sit for LCSW, LMFT, and LPCC licensure exams with the Board of Behavioral Sciences. The funding would cover the following costs:

- Setting up/expanding supervision infrastructure
- 3,000 hours of supervision over a minimum of 104 weeks
- Application fees, test preparation and test fees
- Incidentals/support for all other CA Board of Behavioral Sciences (BBS) requirements

Below is how the fund could work, with example financing terms for demonstration purposes only:

- Step 1: The fund provides $200,000 - $300,000 to a qualified FQHC or community-based organization over a two-to-three-year period. The FQHC/CBO provides supervision to 8-12 ASWs, AMFTs, or APCCs and helps them prepare for and complete their licensure exams.

- Step 2: Each quarter post licensure (minimum of two years after step 1 begins) the participant remains in good standing with employer, the employer sponsor pays back the fund.

Figure 31: Example Payment Terms with Employer Sponsor

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Trainee 1	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 2	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 3	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 4	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 5	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 6	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 7	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 8	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
	$40,000	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	$320,000

If a student does not complete licensure, the employer sponsor is not responsible for payment. If a trainee is separated from employment from the employer sponsor for any reason before eight full quarters (two years) of post-training program retention commitment, the employer sponsor no

longer makes payments back to the fund. If the trainee leaves the employ of the client mid-quarter, the quarterly invoices for that trainee will be pro-rated based on the percentage of the quarter trainee remained in employ of employer sponsors.

The aim of the fund is to create a renewable supervision fund that reaches financial self-sufficiency. Returns over and above break-even will be used to support either the expansion of program to serve additional individuals, employers, or occupations.

Figure 32: Potential new billable revenue for employer sponsor generated by graduates (LCSW)

Assumption = $80 per hour through the Prospective Payment System (PPS) @ 30 billable hours per week (13 weeks per quarter)

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Trainee 1	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 2	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 3	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 4	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 5	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 6	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 7	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 8	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
	$249,600	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$1,996,800**

Note: $1,996,800 also represents local economic impact of new billable funding brought into San Diego local economy for health care services for vulnerable populations from federal government.

- Step 3: Outcomes based repayment agreement

If, and only if, the trainee leaves the employ of the employer sponsor during the program or before the two-year post licensure employment commitment is complete, the trainee will be required to repay the fund. This is an important retention tool to encourage continued employment with the FQHC or community-based organization. The repayment agreement will include a $50,000 minimum income threshold to protect trainees who may become un/underemployed as well as a flat, affordable monthly payment plan similar to the outcomes-based loan outlined above. These terms would be disclosed to the trainee prior to initiating the program.

A note on the licensed clinician pathway: careful attention and discussion is required with the CSU Schools of Social Work, community colleges and participating CBOs about ensuring sufficient resources for faculty, coordination, project management and intermediary support, and administrative costs are provided to support each proposal. Additionally, clinicians servings as supervisors must be compensated accordingly for additional scope and requirements.

In proposals #1 and #2, a total of $1.9 million is recommended for this activity but should be validated at the project level to avoid pushing more students through the pipeline without expanding the number of slots available at each step of the career pathway. Proposals #3 and #4 include these costs generally but do not itemize a specific amount.

If faculty and administrative support is not sufficiently resourced, the result of these investments would be longer waitlists for students, not more throughput in the regional education system for licensed clinicians.

5.5: Psychologist

Clinical and counseling psychologist: These professionals assess, diagnose, and treat mental and emotional disorders of individuals through observation, interview and psychological tests. They help individuals with distress or maladjustment understand their problems through their knowledge of case history, interviews with patients and theory. They provide individual or group counseling services to assist individuals in achieving more effective personal, social, educational, and vocational development and adjustment and may design behavior modification programs and consult with medical personnel regarding the best treatment for patients.

School psychologists: These professionals diagnose and implement individual or schoolwide interventions or strategies to address educational, behavioral, or developmental issues that adversely impact educational functioning in a school. They may address student learning and behavioral problems and counsel students or families. These professionals are required to get a doctoral degree from an approved or accredited program in clinical or counseling psychology and complete 3,000 hours (two years) of supervised clinical experience.

Figure 33: Clinical, counseling and school psychologists occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1603	6.08%	2401	2522	30%	6.5%	1451

Of the 47 psychologists in our survey:

- Representation: 77%% were women, 19% were men, and 5% declined to state.

Figure 34: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[45]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	4.3%	7.4%	12%	7%
Black	0%		5%	5%
Hispanic	8.5%	11.9%	31%	39%
Native American	0%		.4%	.4%
White	48.9%	76.9%	45%	18%
Multi-racial	12.8%	1.6%	7%	
Other	2.1%	2.1%	.2%	
Not Reported	23.4%			30%

[45] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Clinical, Counseling, and School Psychologists."

- Salaries: Respondents reported a median salary of $100,000. These reported salaries are similar to the median salary of $102,502 ($121,493 mean) from the BLS for clinical, counseling, and school psychologists.

- Student loans: 19 psychologists reported the median initial student loan balance of $195,000 and median remaining balance of $180,000. The median monthly payment was $800 per month among those with a payment.

- Burnout: 58% of respondents reported some level of burnout, with 18% reporting persistent burnout and 7% reporting complete burnout. This is above 39% of all 1,572 survey respondents and above the approximately 50% of all mental health professionals experiencing burnout reported in the survey.

- Intent to leave: 26% reported they were either somewhat likely (6.5%) or extremely likely (19.6%) to leave their job in the next 12 months. This is below 44% of all 1,572 survey respondents and similar to other mental health workers in the United States. Psychologists are the only profession with respondents answering "somewhat" less than "extremely." One of our focus group participants mentioned that she had one foot out the door of public behavioral health but was trying to see if she could bring her staff with her. Having almost 20% of the psychologist workforce "extremely likely" to leave their jobs is highly concerning. Psychologist do not appear to be planning to leave the County: 4.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: Psychologists in our survey were most satisfied with their relationships with and emotional support among co-workers, their managers, their sense of purpose at work and perceived job security. They were most dissatisfied with their pay, licensure costs, documentation requirements and on-the-job stress.

Figure 35: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Loan Forgiveness for Public Service	$50,000	80	**$4,000,000**
2	Homeownership Incentive Fund	$40,000	25*	**$1,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$40,000	60	**$2,370,000**
4	Renewable Supervision Fund	$25,000	100	**$2,500,000**
Totals			**240**	**$9,870,000**

*Individuals served would be in one of the other programs.

Program 1: Loan forgiveness for service in public behavioral health settings ($3,000,000)

Psychologists have many options post licensure, including working in research settings and private practice. To attract these professionals to public service in behavioral health settings, this program will provide additional short term loan forgiveness incentives to help bridge the pay gap and connect

recent graduates and licensure recipients to organizations serving the behavioral health needs of the community.

Based on focus group and survey feedback, existing federal loan forgiveness programs are very difficult to navigate, reflecting larger national challenges. While federal and state loan forgiveness programs currently exist for behavioral health workers in the public workforce, many eligible workers never receive loan forgiveness as (a) forgiveness programs are underfunded relative to the need, and (b) often require stringent and difficult to achieve eligibility requirements, such as substantial years of service. For example, 98% of workers (164,000 of 168,000 applicants) had their loan forgiveness applications rejected from the Public Service Loan Forgiveness (PSLF) program between November 2020 and April 2021.[46]

Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula. The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Program 2: Home ownership incentives for public service ($2,000,000)

While psychologists make starting salaries of at or near $100,000 per year could service home loans, they typically graduate with significant negative net worth. Psychologists that reported student debt in our survey had a median balance of $180,000 and struggle to make down-payments on homes in expensive markets (like San Diego) for their first 5-10 years practicing.

To address this, we also recommend offering beneficiaries that complete or are near completion of the programs listed in this section and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership.

A portion of funds could be combined with homeownership programs like Landed for down-payment assistance to incent living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a psychologist committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students

[46] "If You Are Denied Student Loan Forgiveness, Do This," Forbes, September 2021

and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 36: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual
$800,000	$160,000	$80,000	$40,000	$40,000

Program 3: 0% Outcomes based loan (OBL) fund ($2,370,000)

To expand education access, outcomes-based financing would cover the upfront cost of a doctoral degree or gap financing for the final year of a master's/bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are moving toward licensure and community practice in San Diego. Programs with high pass rates with focus on clinical and community service in San Diego include Alliant University and programs at San Diego State University.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available for students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $2,370,000 in 0% outcomes loans averaged at $40,000 each would serve an estimated 60 students over the first five years, with cashflows from these first 60 students serving another 20-30 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

Program 4: Renewable supervision fund ($2,500,000)

Similar to the model described for licensed clinicians, this fund would provide upfront financing for community focused clinics such as SDSUs Psychology Clinic, FQHCs and CBOs to provide structured supervision to professionals that need to accrue the 3,000 hours needed to sit for licensure. The hosting site, such as an established regional training hub, would provide best-in-class supervision training and the fund would be repaid over time by the employer sponsor each quarter the licensed psychologist retains employment with their sponsor. This $2,500,000 investment would create an additional 100 additional community-focused psychology supervision slots over a ten-year period.

5.6: Registered Nurses Working in BH Settings

Registered nurses in behavioral health settings (RNs): This occupation group refers to registered nurses that do not possess advanced degrees but may work across various behavioral health settings. These professionals assess patient health problems and needs, develop and implement nursing care plans, and administer nursing care to ill, injured, convalescent, or disabled patients. An estimated 4% of all RN's in California work in Behavioral health settings.

Psychiatric mental health registered nurses (Psych RNs): This occupation group refers to advanced practice registered nurses listed with the California Board of Registered Nursing as a psychiatric mental health registered nurse. To be eligible for this listing, registered nurses must possess a master's degree in psychiatric/mental health nursing and complete two years of supervised clinical experience.

Figure 37: Registered nursed working in BH settings occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1040	6.87%	1548	1641	21%	5.2%	656

Of the 36 registered nurses in our survey:

- **Representation:** 61% were women, 29% were men, and 10% declined to state.

Figure 38: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[47]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	30.6%	27.9%	12%	7%
Black	2.8%	3.3%	5%	5%
Hispanic	2.8%	10.7%	31%	39%
Native American	0%	0%	.4%	.4%
White	30.6%	51.6%	45%	18%
Multi-racial	2.8%	6.3%	7%	
Other	0%	0.2%	0.2%	
Not Reported	30.6%			30%

- **Salaries:** Respondents reported a median salary of $90,000. These reported salaries are lower than the median salary of $112,507 ($111,613 mean) from the BLS for all RNs, potentially reflecting lower pay for RNs working in Behavioral Health settings.

[47] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as Registered Nurses across specialties and departments

- Student loans: Among RNs who responded to student loan questions, two reported 0 initial balance, and the median among those who reported taking out loans was $52,500 initial balance (n=10), a $48,000 remaining balance (n=9), and $600 monthly payment (n=8).

- Burnout: 32% of respondents reported some level of burnout, with 13% reporting persistent burnout and 0% reporting complete burnout. This is below 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- Intent to leave: 43% reported they were either somewhat likely (26%) or extremely likely (17%) to leave their job in the next 12 months. This is similar to the 44% of all 1,572 survey respondents and slightly above the 18%-37% across mental health workers in the United States. 3% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: RNs we surveyed were most satisfied with their relationships with co-workers, the population they work with and their mastery over job tasks. They were most dissatisfied with self-care opportunities at work and support staffing. RNs were the most dissatisfied with their caseloads out of all professions we surveyed.

Figure 39: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Scholarships for RNs committing to public BH settings	$30,000	67	**$2,000,000**
2	Expanding BH clinical site slots for RN students	$33,950	100	**$3,395,000**
3	0% Outcomes Based Loan (OBL) Fund	$30,000	67	**$2,000,000**
Totals			**234**	**$7,395,000**

Program 1: Scholarships for RNs committing to public BH settings ($2,000,000)

This recommendation would provide $30,000 scholarships to 67 RNs to pursue their master's degree and get their license and be listed as a psychiatric mental health registered nurses through local programs such as Cal State San Marcos, San Diego State University and the University of San Diego.

The Board of Registered Nursing maintains a list of registered nurses who are eligible for direct reimbursement by some health care plans for providing psychiatric/mental health services to insured persons. To be eligible for the listing, the California Registered Nurse must possess a master's degree in psychiatric/mental health nursing and complete two years of supervised clinical experience in providing psychiatric/mental health counseling services. The master's degree in nursing must be directly related to mental health, such as psychiatric/mental health nursing or community mental health nursing.

Scholarships will come with five-year commitments to serve in public behavioral health settings post-graduation in San Diego County. This investment will help increase the number of RNs with specialized skills working in behavioral health settings and be used by employers as both a retention and upskilling strategy.

Program 2: Expanding BH clinical site slots for RN students ($3,395,000)

This intervention will be modeled after the Mental Health Services Act Stipend Program for MSW Students. The UC Berkeley California Social Worker Education Center (CALSWEC) recently completed a retrospective study of the discontinued program that demonstrated positive outcomes related to program completion, fulfillment of public service, retention in behavioral health professions, and high levels of diversity, lived experience, and cultural and linguistic competency among program completers.

Under this program, RN students from Cal State University San Marcos (CSUSM), University of San Diego (USD), Point Loma Nazarene University and San Diego State University (SDSU) will be provided stipends of $15,000 if enrolled part-time and $30,000 if enrolled full-time. These funds can be used for living expenses (gas, rent, food) at the student's discretion. Trainees will be required to complete their 800 hours of advanced-year field training at public behavioral health sites[48], advanced-year clinical courses in behavioral health specialties and specialized symposia, capstone projects, and other consumer-focused learning experiences designed by their RN programs. After graduation, all trainees will be required to complete either six or 12 months (depending on stipend amount) of full-time paid (or equivalent part time service) in public behavioral health settings in San Diego County. Graduates who fail to complete this service obligation and who are not entitled to a waived repayment will repay stipend funding in cash, prorated to reflect any service fulfilled.

A $3,395,000 investment would provide an estimated 50 full time students with $30,000 stipends, 50 part-time students with $15,000 stipends and have $1,145,000 available for coordination, matching, and placement activities, community-based organizations internship supervision costs, wrap around career coaching/supportive services, and stipend origination, disbursement and servicing fees.

Program 3: 0% Outcomes based loan (OBL) ($2,000,000)

To expand education access, outcomes-based financing would cover the upfront cost of master's degree or gap financing for the fourth year of a bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion of their graduate or undergraduate coursework.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available to students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

[48]The full range of providers that serve the Behavioral Health needs of people who may be eligible for public health insurance based on economic need. This includes County employees, contractors, FQHCs, hospitals, providers in education settings, and private organizations that serve people who may be eligible for public health insurance.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus. Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $2,000,000 in 0% outcomes loans averaged at $30,000 each would serve an estimated 67 students over the first five years, with cashflows from these first 67 students serving another 25-35 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

5.7: Psychiatric Mental Health Nurse Practitioner (PMHNNPs)

Psychiatric mental health nurse practitioner (PMHNPs): These professionals are master's level RNs who also possess a nurse practitioner certification and are therefore able to prescribe medication. While a master's degree is currently required to become a nurse practitioner, by 2025 a Doctor of Nursing practice (DNP) may be required.

Many healthcare leaders believe increasing the number of advanced practice nurses is the only realistic way to mitigate the physician shortage. Typically, advanced practice nurses are trained in a narrow clinical area and work in partnership with a supervising physician. The advanced practice nurse manages more routine, stable cases while the physician focuses on more complex, challenging cases. Ultimately, this partnership model expands the practice's total patient capacity.

Assembly Bill 890 allows NPs to work to the full extent of their license, including seeing mental health patients, without a physicians' supervision. This report recommends a strategic investment to expand the pipeline for PMHNPs to take advantage of these changes and position San Diego County to be a national leader PHMHNPs and psychiatrist integrated team to expand community psychiatry capacity.

Figure 40: Occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
159	6.87%	238	297	22%	5.2%	184

Of the 20 nurse practitioners in our survey:

- Representation: 95% were women, 0% were men, and 5% declined to state.

Figure 41: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[49]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022[50])
Asian / Pacific Islander	20%	5.5%	12%	7%
Black	5%	4.7%	5%	5%
Hispanic	5%	5.3%	31%	39%
Native American	0%		.4%	.4%
White	40%	75.8%	45%	18%
Multi-racial	5%	8.7%	7%	
Other	5%		.2%	
Not Reported	20%			30%

- Salaries: Respondents reported a median salary of $115,500. These reported salaries slightly below the median salary of $124,612 ($126,110 mean) from the BLS.

- Student loans: Two respondents reported not taking out student loans. Among those who reported taking out loans, the median initial loan amount was $100,000 (n=9), the median remaining balance was $90,000 (n=8). Three respondents reported $0 student loan payments, and the median payment among those who reported paying was $1000 (n=7).

- Burnout: 45% of respondents reported some level of burnout, with 6% reporting persistent burnout and 22% reporting complete burnout. This is above 39% of all 1,572 survey respondents and 50% of all mental health professionals. Nurse practitioners in our survey had one of the highest rates of complete burnout.

- Intent to leave: 32% reported they were either somewhat likely (26%) or extremely likely (5%) to leave their job in the next 12 months. This is less than the 44% of all 1,572 survey respondents similar to the 18%-37% among behavioral health workers in the United States[51]. 5.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: These professionals were most satisfied with the autonomy they have at work, their relationships with their managers and coworkers and the emotional support they get from their peers. They were least satisfied with support staffing and (when applicable) loan support available to them.

Figure 42: Regional training fund project recommendations

[49] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as Nurse Practitioners across specialties and departments

[50] California Health and Human Services Open Data Portal (link) showed 991,503 Medi-Cal eligibles for the April 2022.

[51] Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. Journal of Substance Abuse Treatment, 40(1), 67–76. https://doi.org/10.1016/j.jsat.2010.08.008
Leider, J. P., Sellers, K., Owens-Young, J., Guerrero-Ramirez, G., Bogaert, K., Gendelman, M., & Castrucci, B. C. (2021). Determinants of workplace perceptions among federal, state, and local public health staff in the US, 2014 to 2017. BMC Public Health, 21(1), 1654. https://doi.org/10.1186/s12889-021-11703-x

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Expanding UCSD's School of Medicine Community Psychiatry Programs for Nurse Practitioner Students and Graduates	$140,000	50	**$7,000,000**
2	Establish a Doctor of Nursing Practice PMHNP Program at San Diego State University	$60,000	50	**$3,000,000**
3	Home Ownership and Loan Forgiveness Incentives for Public Service	$40,000	50*	**$2,000,000**
4	0% Outcomes Based Loan (OBL) Fund	$65,000	100	**$7,800,000**
Totals			**200**	**$19,800,000**

*Individuals served would be in one of the other programs.

Program 1: Expanding UCSD's School of Medicine Community Psychiatry Programs for nurse practitioner students and graduates ($7,000,000)

This investment would expand two of the UCSD School of Medicine's Community Psychiatry Program (CPP) innovative nurse practitioner training programs that are demonstrating both capacity to scale and promising results in attracting nurse practitioners to San Diego and to public service in behavioral health settings.

The Nurse Practitioner Student Rotation program takes students from local psychiatric mental health nurse practitioner (PMHNP) programs including San Diego State University, Cal State University San Marcos and the University of San Diego as well as UCSF students and provides clinical training and rotations at Federally Qualified Health Centers (FQHCs) (such as Family Health Centers of San Diego and San Ysidro Health), County-supported Behavioral Health clinics and programs such as the Jane Westin Center and South Bay Guidance Center, and specialty programs with County of San Diego contractors, such as Survivors of Torture International.

The program began in 2014 and takes eight students per year from a pool of over 40+ qualified applicants. Cohorts are 18 months long with new cohorts starting each January. The students rotate through a variety of community sites focusing on underserved populations with Serious Mental Illness (SMI). Students receive didactics through their primary nursing programs/schools. Since 2014 when NP students first started there have been 30 graduates and an estimated >90% accepted community/public sector jobs as their first positions post-graduation.

The primary barrier to scaling this program is faculty supervisor salaries, administrative costs and clinical placement coordination. A $2 million, five-year investment would provide an estimated 10 additional slots for this program per year (50-75 total). These funds would go to faculty supervisor salaries, and administration and supervision site coordination.

Additionally, there is an opportunity to scale the PMHNP New Graduate Fellowship program. UCSD's School of Medicine currently offers the only post-graduate fellowship program in California for nurse practitioners to gain experience in community psychiatric settings working with SMI populations. The 12-month program runs from November to October every year and currently offers a pediatric specialization serving children/adolescents (generously supported by Price Philanthropies) and one specializing in adult services (funded through a time-limited HRSA grant). Both funding streams are

designed to gradually decrease, with Price Philanthropies funding slated to end in Summer of 2024 and HRSA funding slated to end in August 2023. Both tracks provide placements in community settings in many of the same FQHCs and County BHS contractors and community-based partners as the residency program.

The program is currently on its third cohort of pediatric fellows and second cohort of adult fellows. The program has nine graduates so far and 100% accepted community/public sector positions as their first jobs post-graduation.

The primary barrier to scaling this program is faculty salaries, PMHNP salaries and clinical placement coordination. A $5 million, five-year investment would provide an estimated four additional slots for this program per year (20 overall). These funds would go to resident salaries (est. $120,000 + benefits per year), faculty salaries and administration and supervision site coordination.

The services provided by fellows would be billable to Medi-Cal and recoverable by the FQHC and/or County provider, which could be reinvested into the program to create long-term financial sustainability after the initial $5M investment.

Program 2: Establish a Doctorof Nursing practice PMHNP program at San Diego State University ($3,000,000)

San Diego State University's School of Nursing has received approval to begin conferring Doctor of Nursing Practice (DNP) degrees and could stand up the program with a specialty in psychiatric mental health by the Fall of 2024. The program would begin with an initial 10 students and would increase enrollment annually, hitting 15-20 students per year by 2030. This program would create additional nurse practitioner slots in the San Diego community and position San Diego's regional education system to be responsive to a potential new requirement for nurse practitioners to have doctorate degrees. Public investments in this program would be explicitly focused on producing PMHNPs that will be patient-seeing practitioners, as opposed to PMHNP's pursuing research or other careers in academia.

Starting this program would require a one-time investment of $100,000 to write and submit the curriculum by October 2023 (per CSU guidelines), $2,600,000 to hire four program instructors/faculty for the initial five years while the program gets off the ground and an additional $300,000 for administration and set-up costs (coordinating clinical sites, etc.).

After this initial five-year investment, the program would reach 20-25 enrolled students and be financially self-sufficient through standard tuition costs, including through outcomes loan fund. SDSU would enroll students from San Diego as well as Imperial County residents, where 96% of students in current nursing programs identify as Hispanic, while most of those individuals being bi-lingual in Spanish and English. This new SDSU program will partner with UCSD to ensure clinical placement sites with UCSD clinical faculty members.

Program 3: Home ownership and loan forgiveness incentives for public service ($2,000,000)

While PMHNP/DNPs make starting salaries of $110,000 - $150,000 per year and could potentially service home loans, they typically graduate with significant negative net worth. PHMNPs in our survey had a median student debt load of approximately $100,000.

To address this, we also recommend offering beneficiaries that complete or are near completion of the programs listed above and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership. A portion of funds could be combined with homeownership programs for down-payment assistance to incentivize living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a PMHNP committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 43: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual
$800,000	$160,000	$80,000	$40,000	$40,000

Additionally, these funds could be used for loan forgiveness for public service. Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula. The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Program 4: 0% Outcomes based loan (OBL) fund ($7,800,000)

To expand education access, outcomes-based financing would cover the upfront cost of tuition for the last 1-2 years of future DNP programs in San Diego, master's degree costs, or gap financing for the fourth year of an RN bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion and work toward PNP/DNP degrees and licensure.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available for students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus and/or annual retention strategy.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $7,800,000 in 0% outcomes loans averaged at $65,000 each would serve an estimated 100 students over the first five years, with cashflows from these first 100 students serving another 40-50 after that. An additional 1.3 million in this category set aside for additional clinical supervision slots.
More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

5.8: *Psychiatrist*

Psychiatrist: Diagnose, treat, and help prevent mental disorders.

Figure 44: Psychiatrist occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
265	6.08%	396	431	11%	2.7%	204

Of the 42 psychiatrists in our survey:

- Representation: 50% were women, 44% were men, and 6% declined to state.

Figure 45: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	16.7%	12.9%	12%	7%
Black	2.4%	1.9%	5%	5%
Hispanic	4.8%	2.8%	31%	39%
Native American	0%	0.6%	.4%	.4%
White	33.4%	68.1%	45%	18%
Multi-racial	7.1%		7%	
Other	4.8%		.2%	

Not Reported	30.9%	12.6%		30%

- Salaries: Respondents reported a median salary of $250,000. These reported salaries are higher than the median salary of $162,718 ($191,880 mean) from the BLS. We believe this difference is a sampling difference: we did not actively recruit sole proprietors, whom we expect to make less take home pay due to overhead costs and part time hours.

- Student loans: 14 psychiatrists reported loan amounts. Four reported not taking out loans; the median initial balance among those who reported taking out loans was $232,500 (n=10). Seven reported having no student loan balance remaining; among those with a remaining balance, the median was $280,000 (n=7). Five reported no monthly payment; among those who had a payment reported a median of $1,700 per month (n=8).

- Burnout: 36% of respondents reported some level of burnout, with 14% reporting persistent burnout and 4% reporting complete burnout. This is below 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- Intent to leave: 43% reported they were either somewhat likely (22.5%) or extremely likely (20%) to leave their job in the next 12 months. This is near the 44% of all 1,572 survey respondents and slightly above the 18%-37% among behavioral health workers in the United States. 6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: These professionals were most satisfied with their autonomy at work, relationships with coworkers and flexibility in treatment modality. They were least satisfied with their on-the-job stress and lack of access to continuum of care and wraparound services for their patients.

Figure 46: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Make strategic investments in Community Psychiatry Program Residency Programs	$493,809*	84	**$41,480,000**
2	Home Ownership and Loan Forgiveness Incentives for Public Service	$40,000	75**	**$3,000,000**
Totals			**84**	**$44,480,000**

*Cost includes four year of residency salary, benefits, and faculty and administration costs, on average across the two programs described in 1a and 1b below.
**Individuals served would be in one of the other programs.

Program 1a: Expand the community psychiatry program residency track at UCSD School of Medicine
UCSD's School of Medicine Community Psychiatry Program (CPP) Residency Track, within the General Psychiatry Residency, was developed in partnership with the County of San Diego's Health and Human Services Agency. This specialized track trains providers to address the mental health needs of the community working in public behavioral health settings at rotation sites that treat underserved communities. This allows residents to develop an understanding of the public

mental health system and the skills necessary to provide quality patient care to each unique population.

In addition to clinical rotations within the UCSD Medical Center, residents rotate through community-based organizations (CBOs) for training sites including San Ysidro Health , Family Health Centers of San Diego, San Diego Youth Services, Survivors of Torture International, Deaf Community Services, Community Research Foundation, San Diego Center for Children and Vista Hill.

The pediatrics residency track is hosted by Rady Children's Hospital and provides residents with best-in-class pediatric care facilities and supervising psychiatrists.

CPP Residents also have a special didactic seminar series in their third and fourth year, every Thursday afternoon, focused on learning about population health, advocacy, healthcare leadership, program design, finance, budgeting, collaborative care and outcomes-based research.

The CPP track is a four-year program and opens two slots per year (eight total residents). In 2021, the program had nearly 500 applicants from top medical schools across the United States. This program has demonstrated evidence of attracting psychiatrists to public sector settings. Of the 25+ graduates dating back to 2012-13, 100% have taken jobs in community/public sector or academic positions as their first job out of residency or fellowship.

Increasing from two slots to four slots per year would provide an additional 20 psychiatrists and psychiatrist resident students trained and connected to San Diego's public behavioral health system over a 10-year period, increasing the services provided in the community through residents and maximizing faculty placements. The cost of expanding to two additional slots is estimated to be $3 million in the first three years, and $1.74 million for each year after that (15 million over 10 years). Primary expense categories include faculty placements, administration and coordination with clinical sites, and supervision and resident salaries and fringe.

After the initial expansion, the program will be funded by ongoing revenues generated through patient and third-party encounters.

Program 1b: Support the launch of a new 8x4 community psychiatry residency program at a San Diego FQHC

The proposed psychiatry residency program would address the growing need in San Diego County for accredited community-based primary care residency programs in psychiatry, to address the physician workforce shortages and challenges faced by rural and underserved communities in San Diego County. The program would include a four-year psychiatry residency for adult and pediatric psychiatric residents that includes community clinic-based experience, inpatient rotation at a new, state-of-the-art psychiatry hospital, robust experience treating underserved patient populations and didactic sessions including interprofessional training and care of special populations.

The program would train eight psychiatry residents each project year and will host 32 psychiatry residents in total, once the program reaches a four-year maturity (eight slots per year for four years). The program would track residents' career outcomes for a minimum of five years post-graduation

from the residency program, including retention in San Diego County and with underserved areas and equity populations.

Financial support against the $26,480,000 estimated cost of launching the program would create eight additional four-year residency slots per year (32 residents when the program is at year four). Over a 10-year period, this would create 64 new psychiatrist graduates connected to and experience and training working in the San Diego community health system.

Residents will serve the medically underserved populations presenting for care in San Diego County's Health and Human Services Central, East, North and South Regions. Residents also will complete clinical experiences at FQHC clinics located in underserved communities and Mental Health HPSAs across San Diego County. The proposed psychiatry residency program will help meet a critical need for training programs in our region, as there is currently only one other psychiatry residency program accepting non-military applicants.

The FQHC would need well-developed partnerships with academic institutions and clinical training sites to provide community-based clinical experiences and didactic education to psychiatry residents and psychiatric mental health nurse practitioners fellows. This experience can be leveraged alongside integrated and interprofessional care delivery and the tremendous and diverse needs of FQHC patients to develop a new Accreditation Council for Graduate Medical Education (ACGME)-accredited psychiatry residency program that leads to successful board certification and readiness for clinical practice.

Medical and executive leadership from the FQHC and psychiatric hospital partners would establish mutually agreed upon rotation schedule, identified board-certified faculty and subject matter experts to contribute toward curriculum development in all sub-specialties and/or to provide administration and supervision, and have agreed upon the clinical training sites. The FQHC and its partners would also need to determine adequate patient care volumes and interprofessional care teams across training sites and identified the high-need special populations in the region, including patients who are uninsured, undocumented, non-English speaking, living with HIV/Hep C, experiencing homelessness, lesbian, gay, bisexual, and/or transgender (LGBT), veterans, refugee/asylees, people who inject drugs, and experiencing substance use disorder, for whom residents will build relationships and provide longitudinal management and follow-up for during year three continuity clinic.

One example of an FQHC that has made significant progress toward expanding the psychiatry training pipeline is Family Health Centers of San Diego (FHCSD). FHCSD has a planned 25,000 square foot multi-cultural mental health complex in the City Heights neighborhood in the City of San Diego. The project has broken ground and is under-construction and consists of a parking garage, mental health clinic and 170 units of housing for formerly unsheltered people. FHCSD and its partners are currently developing the program curriculum and infrastructure in order to achieve ACGME accreditation by November 30, 2023, with resident matriculation planned for July 1, 2024.

FHCSD is one of the nation's ten largest Federally Qualified Health Centers (FQHC) and is the largest health center system serving low-income and uninsured San Diegans. In 2020, FHCSD provided primary health care services to 160,902 unduplicated patients through 995,125 visits at 25 community-based health center sites situated in Health Professional Shortage Areas (HPSA) across San Diego County, California. FHCSD currently operates a Family Medicine Residency in which five of six graduates have stayed working in community health in San Diego (above national average).

After initial launch, and once the program is functioning at a four-year level of maturity, the program will be funded by ongoing revenues generated through patient and third-party encounters. The program will then be able to tap into federal and state residency funding to support on-going operations.

Program 2: Home ownership and loan forgiveness incentives for public service ($3,000,000)

While psychiatrists make high-starting salaries of $250,000 - $350,000 per year and could potentially service home loans, they typically graduate with significant negative net worth. Of the 18 physiatrists that took our survey, their average reported debt at graduation was $350,000 and focus group participants reported challenges making down-payments on homes in expensive markets (like San Diego) for their first 5-10 years practicing. Focus groups with psychiatry chairs/directors charged with recruiting and retaining psychiatrists have indicated that getting a professional connected in the local community is critical in the first 1-3 years post residency to keep them living and working in San Diego.

To address this, we also recommend offering beneficiaries who complete the residency programs listed above and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership.

A portion of funds could be combined with homeownership programs like Landed for down-payment assistance to incentivize living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a psychiatrist committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 47: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual
$800,000	$160,000	$80,000	$40,000	$40,000

Additionally, these funds could be used for loan forgiveness for public service. Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula. The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Section 6: Moving Forward

This report provides a deeper understanding of San Diego's behavioral health worker shortage and provides concrete recommendations - informed by the perspectives and experiences of workers – to address it. With a regional vision and framework for action, the people, organizations, systems, and policies that drive the behavioral health system will determine if and how that vision is carried out in San Diego. Below are four considerations focused on implementation:

- Invest in the project management and technical resources necessary to execute

Designing and executing against the regional vision outlined in this report will require significant project management and technical resources. The time and expertise needed cannot be undervalued and will require a senior leader with budget authority and a team of managers and subject matter experts with clear lines of accountability and significant time dedicated to these efforts will be required to make meaningful progress.

- Establish a California legislative agenda

The recommendations in this report require both local and state action. Members of the steering committee and other key stakeholders should develop a San Diego County policy brief to compliment this report, providing local elected officials, advocacy groups, employers, and professional associations with a clear, concise platform to engage California policy makers and administrators.

- Build a broad coalition and provide regular updates on progress

Executing on the recommendations outlined in this report will require partnerships with colleges, universities, healthcare providers, workforce development and nonprofit organizations, foundations, state and local government, health plans, elected officials, professional associations, and workers themselves. Hosting an annual symposium to introduce this vision and providing regular updates to communicate progress will help grow the size and strength of this coalition.

- Set metrics and provide regular updates on progress

This report outlines significant public and private investment to address a regional problem. The implementation team should work with key stakeholders to establish key metrics for workforce retention, talent attraction, diversity, equity, and inclusion, and ultimately, how the investments impact quality and availability of care to San Diego residents.

Understanding the worker shortage, hearing from frontline professionals, and detailing regional recommendations is an important step in San Diego's efforts to address the Behavioral Health staffing shortage. The considerations above will help facilitate the next steps toward implementing the vision of the most resilient, representative, and skilled and qualified BH workforce in the United States.

Appendix

Figure A.1: Replacement and occupational growth rates from 2022-2032

Occupation	Prof. Needed (2022)	Growth Rate (%) 2022- 2032	Prof. needed (2032)	Annual Replacement rate	Replace-ments 2022-2032	New Prof. Needed 2022-2032
Community Health Workers & Social and Human Service Assistants, including Peer Support Specialists	6930	17%	8087	11.3%	5854	7011
Psychiatric Aides	192	48%	284	12.1%	196	288
Substance Abuse and Behavioral Disorder Counselors	3631	30%	4720	9.2%	2716	3805
Psychiatric Technicians	1181	21%	1429	7%	613	861
Marriage and Family Therapists	6637	12%	7433	9.2%	4339	5135
Mental Health and Substance Abuse Social Workers	1913	21%	2315	9.2%	1292	1694
Psychologists (Clinical, Counseling, and School	2401	9%	2618	6.5%	1088	1304
Registered Nurses working in BH settings (4% of all RNs)	1548	10%	1702	5.2%	570	724
Psychiatric and Mental Health Nurse Practitioner	238	44%	342	5.2%	100	205
Physician's Assistants	42	24%	52	5.5%	17.352	27
Psychiatrists	396	14%	451	2.7%	77	132
Totals	**25,109**		**29,433**		**16,862**	**21,186**

Figure A.2: Total number of behavioral health professionals needed in San Diego by 2032

Occupation	2022 BH Prof.	Prof. Needed (2022)	Prof. Needed (2032)	2022 Regional BH Worker Shortage	New Prof. Needed 2022-2032	Total Additional Workers Needed (2022-2032)
Community Health Workers & Social and Human Service Assistants, including Peer Support Specialists	4644	6930	8087	2286	7011	9297
Psychiatric Aides	129	192	284	63	288	351
Substance Abuse and Behavioral Disorder Counselors	2566	3631	4720	1065	3805	4870
Psychiatric Technicians	789	1181	1429	392	861	1253
Marriage and Family Therapists	4443	6637	7433	2194	5135	7329
Mental Health and Substance Abuse Social Workers	1283	1913	2315	630	1694	2324
Psychologists (Clinical, Counseling, and School	1603	2401	2618	798	1304	2102
Registered Nurses working in BH settings (4% of all RNs)	1040	1548	1702	508	724	1232
Psychiatric and Mental Health Nurse Practitioner	159	238	342	79	205	284
Physician's Assistants	28	42	52	14	27	41
Psychiatrists	265	396	451	131	132	263
Totals	**16,949**	**25,109**	**29,433**	**8,160**	**21,186**	**29,346**

Figure A.3 San Diego BH professionals' satisfaction with job quality features

Green Text = Top Talent Attraction and Retention Feature (Pull Factor)
Red Text: Top Driver of Intent to Leave (Push Factor)

	n	Completely Satisfied	Satisfied	Dis-satisfied	Completely Dissatisfied	No Opinion
Economic Stability & Security						
The amount of money you earn	1238	11%	32%	33%	22%	2%
Your job security	1238	35%	49%	10%	3%	4%
The paid sick leave available to you	1238	28%	40%	18%	9%	6%
The physical safety conditions of your workplace	1198	35%	47%	11%	4%	3%
The retirement plan your employer offers	1238	22%	44%	15%	8%	11%
Economic Mobility & Wealth Building						
Learning and development opportunities provided by your employer	1198	25%	46%	18%	6%	5%
The frequency of feedback on your job performance	1238	27%	47%	16%	6%	3%
Support for education or licensure costs	1198	15%	29%	23%	16%	17%
Support for continuing education	1198	22%	42%	15%	10%	11%
The mastery you have over the skills and tasks required of at work	1198	35%	54%	7%	2%	2%
The recognition you receive at work for your work accomplishments	1198	25%	43%	20%	8%	3%
Any loan support available to you (e.g., student loan assistance or forgiveness)	1198	9%	19%	18%	18%	36%
Any housing support available to you (e.g., rent or mortgage assistance)	1198	5%	12%	18%	21%	44%
Meaningful Work						
The ways in which your job contributes to a purpose you care about	1198	41%	43%	9%	3%	3%
The sense that your work is valued	1238	34%	39%	18%	6%	2%
The population you work with	1198	43%	50%	4%	1%	2%
The autonomy you have at work	1198	36%	50%	8%	3%	4%
Mandates and regulations that you must follow in the course of your work	1198	19%	53%	17%	8%	4%
The documentation associated with your job	1238	17%	40%	16%	23%	2%
In-house wraparound services or resources for clients	1198	16%	40%	20%	7%	16%
Support for warm handoffs to external wraparound services or resources for clients	1198	17%	42%	22%	7%	13%
Your caseload	1238	19%	45%	16%	7%	12%
Schedules, Vacation, and Rest						
The amount of on-the-job stress in your job	1198	11%	41%	28%	16%	3%
The paid vacation days available to you	1198	27%	41%	17%	8%	7%
The flexibility of your hours	1198	30%	47%	15%	5%	3%
Support for working caretakers (e.g., parental leave, schedule flexibility, childcare)	1238	21%	39%	15%	6%	19%
Available modality options (i.e., flexibility to see clients in person or telehealth)	1238	30%	44%	8%	5%	13%
The self-care time available at work (e.g., time between clients, team meetings)	1238	19%	37%	26%	14%	4%
Self-care resources available from your employer	1238	18%	41%	26%	10%	5%
Relationship with Coworkers						
Your boss or immediate supervisor	1198	48%	36%	9%	4%	3%
Your relations with coworkers	1198	41%	50%	6%	2%	2%
The social and emotional support provided by your peers	1238	37%	46%	11%	4%	3%
The social and emotional support provided by your manager or immediate supervisor	1238	39%	37%	15%	7%	3%
The number of people working in positions similar to yours	1238	20%	43%	21%	10%	7%
The number of staff working in support roles	1238	20%	40%	27%	9%	4%
The number of staff working in management roles	1238	27%	47%	16%	6%	3%

Figure A.4: Compensation analysis using California Metropolitan Statistical Areas (MSAs)

For each MSA we identified the cost-of-living (COL) index,[52] a value that reflects the cost of living in a region as a percentage of the average cost of living in the US. We then calculate COL-adjusted wages for each MSA by adjusting the nominal wage by the COL. For example, the San Diego COL index is 142.2, meaning that the expense of living in San Diego is 42.2% higher than the national average. More information about the cost-of-living adjustment is available here.

	Cost of Living Adjustment	Social Services Assistants (includes Peer Support)		Psychiatrists		Psychiatric Aides	
California MSA		**2021 Avg Wage**	**COL Adj. Avg**	**2021 Avg Wage**	**COL Adj. Avg**	**2021 Avg Wage**	**COL Adj. Avg**
Bakersfield	119.1	$ 38,966	$ 32,717	$ 241,967	$ 203,163	$ 32,032	$ 26,895
Chico	128.2	$ 39,591	$ 30,882	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Clearlake	130.3	$ 34,342	$ 26,356	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Crescent City	126.9	$ 33,824	$ 26,654	Insf. Data	Insf. Data	Insf. Data	Insf. Data
El Centro	103.5	$ 45,115	$ 43,590	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Eureka-Arcata	130.1	$ 37,454	$ 28,789	$ 290,816	$ 223,533	$ 29,940	$ 23,013
Fresno	122.5	$ 36,252	$ 29,593	$ 199,263	$ 162,664	$ 38,846	$ 31,711
Hanford-Corcoran	122.2	$ 36,861	$ 30,164	$ 188,103	$ 153,931	$ 30,001	$ 24,551
LA-Long Beach-Anaheim	157.6	$ 39,807	$ 25,258	$ 274,289	$ 174,042	$ 33,390	$ 21,186
Madera	124.1	$ 37,843	$ 30,494	$ 276,609	$ 222,892	Insf. Data	Insf. Data
Merced	121.0	$ 52,230	$ 43,165	$ 187,058	$ 154,593	Insf. Data	Insf. Data
Modesto	124.8	$ 39,556	$ 31,696	$ 182,630	$ 146,338	$ 29,941	$ 23,992
Napa	144.3	$ 39,346	$ 27,266	$ 259,429	$ 179,785	Insf. Data	Insf. Data
Oxnard-Thousand Oaks-Ventura	135.3	$ 44,595	$ 32,960	$ 275,000	$ 203,252	$ 30,956	$ 22,879
Red Bluff	125.9	$ 50,859	$ 40,397	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Redding	128.2	$ 37,605	$ 29,333	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Riverside-San Bernardino-Ontario	127.9	$ 38,608	$ 30,186	$ 319,020	$ 249,429	$ 55,659	$ 43,518
Sacramento-Roseville-Folsom	136.0	$ 46,654	$ 34,304	$ 181,603	$ 133,532	$ 32,941	$ 24,221
Salinas	132.2	$ 39,719	$ 30,044	$ 263,067	$ 198,992	$ 34,517	$ 26,109
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 32,620**	**$ 22,940**	**$ 165,386**	**$ 116,305**	**$ 31,176**	**$ 21,924**
San Francisco-Oakland-Berkeley	164.8	$ 45,260	$ 27,464	$ 280,534	$ 170,227	$ 36,774	$ 22,314
San Jose-Sunnyvale-Santa Clara	145.3	$ 55,886	$ 38,463	$ 288,709	$ 198,699	$ 36,866	$ 25,372
San Luis Obispo-Paso Robles	134.3	$ 36,297	$ 27,027	$ 278,186	$ 207,138	$ 37,735	$ 28,097
Santa Cruz-Watsonville	137.8	$ 41,523	$ 30,133	$ 195,393	$ 141,795	$ 36,056	$ 26,165
Santa Maria-Santa Barbara	134.6	$ 41,773	$ 31,035	$ 290,661	$ 215,944	$ 37,569	$ 27,912
Santa Rosa-Petaluma	138.7	$ 40,289	$ 29,048	$ 294,736	$ 212,499	$ 30,101	$ 21,702
Sonora	132.7	$ 42,654	$ 32,143	$ 185,378	$ 139,697	Insf. Data	Insf. Data

[52] The Cost of Living Index is produced by the Council for Community and Economic Research.

	Cost of Living Adjustment	Social Services Assistants (includes Peer Support)		Psychiatrists		Psychiatric Aides	
Stockton	125.7	$ 41,817	$ 33,267	$ 248,276	$ 197,515	$ 37,244	$ 29,629
Susanville	129.8	$ 50,202	$ 38,677	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	$ 56,735	$ 41,534	$ 120,369	$ 88,118	Insf. Data	Insf. Data
Ukiah	131.1	$ 38,386	$ 29,280	$ 282,733	$ 215,662	Insf. Data	Insf. Data
Vallejo	131.8	$ 36,758	$ 27,889	$ 294,283	$ 223,280	$ 36,823	$ 27,939
Visalia	118.2	$ 38,720	$ 32,758	$ 263,854	$ 223,227	$ 29,945	$ 25,334
Yuba City	126.2	$ 60,155	$ 47,667	$ 189,203	$ 149,923	Insf. Data	Insf. Data

	Cost of Living Adjustment	Community Health Workers		Marriage and Family Therapists		Social Workers (in BH Settings)	
California MSA		2021 Avg Wage	2021 Avg Wage	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg
Bakersfield	119.1	$ 57,190	$ 48,019	$ 49,111	$ 41,235	$ 54,663	$ 45,897
Chico	128.2	$ 30,519	$ 23,806	$ 47,213	$ 36,828	$ 39,876	$ 31,104
Clearlake	130.3	$ 41,320	$ 31,711	$ 52,115	$ 39,996	$ 49,793	$ 38,214
Crescent City	126.9	Insf. Data	Insf. Data	$ 51,301	$ 40,426	Insf. Data	Insf. Data
El Centro	103.5	Insf. Data	Insf. Data	$ 42,516	$ 41,079	$ 30,795	$ 29,754
Eureka-Arcata	130.1	$ 43,404	$ 33,362	$ 52,955	$ 40,704	$ 52,719	$ 40,522
Fresno	122.5	$ 40,878	$ 33,370	$ 40,302	$ 32,900	$ 49,145	$ 40,119
Hanford-Corcoran	122.2	$ 43,392	$ 35,509	$ 62,907	$ 51,478	$ 91,854	$ 75,167
LA-Long Beach-Anaheim	157.6	$ 46,811	$ 29,702	$ 46,789	$ 29,689	$ 71,160	$ 45,152
Madera	124.1	$ 43,396	$ 34,968	$ 58,340	$ 47,011	$ 95,941	$ 77,310
Merced	121.0	$ 43,885	$ 36,269	$ 42,406	$ 35,047	$ 59,567	$ 49,229
Modesto	124.8	$ 45,778	$ 36,681	$ 36,009	$ 28,854	$ 64,594	$ 51,758
Napa	144.3	$ 47,889	$ 33,187	$ 40,519	$ 28,080	$ 93,285	$ 64,646
Oxnard-Thousand Oaks-Ventura	135.3	$ 48,294	$ 35,694	$ 57,042	$ 42,160	$ 87,540	$ 64,701
Red Bluff	125.9	Insf. Data	Insf. Data	$ 59,726	$ 47,439	Insf. Data	Insf. Data
Redding	128.2	$ 46,273	$ 36,095	$ 64,728	$ 50,490	$ 57,055	$ 44,504
Riverside-San Bernardino-Ontario	127.9	$ 49,069	$ 38,365	$ 51,801	$ 40,501	$ 65,350	$ 51,094
Sacramento-Roseville-Folsom	136.0	$ 59,762	$ 43,942	$ 51,268	$ 37,697	$ 62,699	$ 46,102
Salinas	132.2	$ 39,155	$ 29,618	$ 58,192	$ 44,018	$ 74,974	$ 56,712
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 43,892**	**$ 30,867**	**$ 46,944**	**$ 33,013**	**$ 56,216**	**$ 39,533**
San Francisco-Oakland-Berkeley	164.8	$ 55,999	$ 33,980	$ 65,187	$ 39,555	$ 86,641	$ 52,573
San Jose-Sunnyvale-Santa Clara	145.3	$ 60,881	$ 41,900	$ 57,560	$ 39,614	$ 61,276	$ 42,172
San Luis Obispo-Paso Robles	134.3	$ 43,461	$ 32,361	$ 59,752	$ 44,491	$ 91,744	$ 68,313

	Cost of Living Adjustment	Community Health Workers		Marriage and Family Therapists		Social Workers (in BH Settings)	
Santa Cruz-Watsonville	137.8	$ 47,892	$ 34,755	$ 64,807	$ 47,030	$ 50,124	$ 36,375
Santa Maria-Santa Barbara	134.6	$ 43,796	$ 32,538	$ 48,021	$ 35,677	$ 88,207	$ 65,533
Santa Rosa-Petaluma	138.7	$ 54,665	$ 39,413	$ 52,479	$ 37,836	$ 105,280	$ 75,905
Sonora	132.7	Insf. Data	Insf. Data	$ 48,974	$ 36,906	$ 57,388	$ 43,247
Stockton	125.7	$ 44,169	$ 35,139	$ 43,212	$ 34,377	$ 59,044	$ 46,972
Susanville	129.8	Insf. Data	Insf. Data	$ 58,184	$ 44,826	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	Insf. Data	Insf. Data	$ 60,229	$ 44,091	$ 63,386	$ 46,403
Ukiah	131.1	$ 44,179	$ 33,699	$ 59,314	$ 45,243	$ 56,046	$ 42,751
Vallejo	131.8	$ 43,657	$ 33,124	$ 83,940	$ 63,687	$ 102,035	$ 77,416
Visalia	118.2	$ 40,447	$ 34,219	$ 53,342	$ 45,129	$ 66,459	$ 56,226
Yuba City	126.2	Insf. Data	Insf. Data	$ 80,900	$ 64,105	$ 36,489	$ 28,914

	Cost of Living Adjustment*	**Psychologists**		**SUD Counselors**		**Registered Nurses**		**Psychiatric Technicians**	
California MSA		2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg
Bakersfield	119.1	$ 106,987	$ 89,829	$ 51,362	$ 43,125	$ 95,640	$ 80,302	$ 74,324	$ 62,405
Chico	128.2	$ 91,867	$ 71,659	$ 51,451	$ 40,133	$ 87,287	$ 68,087	$ 49,543	$ 38,645
Clearlake	130.3	$ 104,765	$ 80,403	$ 40,493	$ 31,077	$ 94,645	$ 72,636	Insf. Data	Insf. Data
Crescent City	126.9	Insf. Data	Insf. Data	$ 40,390	$ 31,828	$ 92,326	$ 72,755	Insf. Data	Insf. Data
El Centro	103.5	$ 98,924	$ 95,579	$ 57,815	$ 55,860	$ 84,757	$ 81,891	Insf. Data	Insf. Data
Eureka-Arcata	130.1	$ 95,433	$ 73,353	$ 42,749	$ 32,859	$ 88,909	$ 68,339	$ 54,351	$ 41,776
Fresno	122.5	$ 117,238	$ 95,705	$ 49,463	$ 40,378	$ 97,134	$ 79,293	$ 63,522	$ 51,855
Hanford-Corcoran	122.2	$ 114,839	$ 93,976	$ 62,376	$ 51,044	$ 112,038	$ 91,684	$ 49,100	$ 40,180
LA-Long Beach-Anaheim	157.6	$ 106,714	$ 67,712	$ 48,769	$ 30,945	$ 113,004	$ 71,703	$ 43,833	$ 27,813
Madera	124.1	$ 120,443	$ 97,053	$ 53,377	$ 43,012	$ 62,117	$ 50,054	$ 46,879	$ 37,775
Merced	121.0	$ 102,574	$ 84,772	$ 53,498	$ 44,213	$ 103,542	$ 85,572	$ 49,430	$ 40,851
Modesto	124.8	$ 114,668	$ 91,882	$ 54,528	$ 43,692	$ 110,049	$ 88,180	$ 48,602	$ 38,944
Napa	144.3	$ 123,537	$ 85,611	$ 49,781	$ 34,498	$ 116,147	$ 80,490	$ 55,853	$ 38,706
Oxnard-Thousand Oaks-Ventura	135.3	$ 103,081	$ 76,187	$ 40,795	$ 30,152	$ 105,220	$ 77,768	$ 71,731	$ 53,016
Red Bluff	125.9	$ 96,315	$ 76,502	$ 37,467	$ 29,760	$ 102,911	$ 81,740	Insf. Data	Insf. Data
Redding	128.2	$ 70,607	$ 55,075	$ 44,197	$ 34,475	$ 115,731	$ 90,274	$ 51,615	$ 40,261
Riverside-San Bernardino-Ontario	127.9	$ 103,811	$ 81,166	$ 53,537	$ 41,858	$ 109,068	$ 85,276	$ 62,925	$ 49,199
Sacramento-Roseville-Folsom	136.0	$ 111,561	$ 82,030	$ 53,114	$ 39,055	$ 136,697	$ 100,513	$ 46,677	$ 34,321
Salinas	132.2	$ 103,845	$ 78,551	$ 47,968	$ 36,285	$ 132,385	$ 100,140	$ 73,354	$ 55,487
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 102,185**	**$ 71,860**	**$ 45,590**	**$ 32,060**	**$ 112,222**	**$ 78,919**	**$ 62,656**	**$ 44,062**
San Francisco-Oakland-Berkeley	164.8	$ 101,234	$ 61,428	$ 57,764	$ 35,051	$ 154,193	$ 93,564	$ 58,049	$ 35,224

	Cost of Living Adjustment*	Psychologists		SUD Counselors		Registered Nurses		Psychiatric Technicians	
San Jose-Sunnyvale-Santa Clara	145.3	$ 111,222	$ 76,546	$ 62,218	$ 42,821	$ 155,576	$ 107,072	$ 68,341	$ 47,034
San Luis Obispo-Paso Robles	134.3	$ 124,436	$ 92,655	$ 64,494	$ 48,022	$ 105,091	$ 78,251	$ 63,460	$ 47,252
Santa Cruz-Watsonville	137.8	$ 78,692	$ 57,106	$ 40,223	$ 29,190	$ 131,385	$ 95,344	$ 51,235	$ 37,180
Santa Maria-Santa Barbara	134.6	$ 116,765	$ 86,749	$ 54,360	$ 40,386	$ 110,027	$ 81,744	$ 71,392	$ 53,040
Santa Rosa-Petaluma	138.7	$ 128,913	$ 92,943	$ 41,261	$ 29,748	$ 119,188	$ 85,932	$ 65,274	$ 47,062
Sonora	132.7	$ 114,629	$ 86,382	$ 46,644	$ 35,150	$ 93,182	$ 70,220	$ 70,919	$ 53,443
Stockton	125.7	$ 107,310	$ 85,370	$ 43,502	$ 34,607	$ 114,898	$ 91,407	$ 73,919	$ 58,806
Susanville	129.8	Insf. Data	Insf. Data	$ 38,465	$ 29,634	$ 110,898	$ 85,438	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	$ 100,081	$ 73,266	$ 42,241	$ 30,923	$ 116,032	$ 84,943	Insf. Data	Insf. Data
Ukiah	131.1	$ 108,884	$ 83,054	$ 46,893	$ 35,769	$ 83,672	$ 63,823	Insf. Data	Insf. Data
Vallejo	131.8	$ 119,646	$ 90,779	$ 42,321	$ 32,110	$ 150,509	$ 114,195	$ 69,125	$ 52,447
Visalia	118.2	$ 117,903	$ 99,749	$ 38,425	$ 32,508	$ 84,170	$ 71,210	$ 61,524	$ 52,050
Yuba City	126.2	$ 81,873	$ 64,876	$ 45,535	$ 36,081	$ 112,232	$ 88,932	Insf. Data	Insf. Data

Figure A5: Administrative Relief Issue Areas and Opportunities

Issue Area	Opportunities
A. According to local focus group data from individuals working in behavioral health positions funded by the County of San Diego, documentation burden is the primary driver of dissatisfaction and staff turnover. Respondents cited: • Effort and time required • Frequency of changes • Redundancy • Priorities reflected in enforcement • Inconsistency in enforcement by different auditors • Consequences of errors • Disconnection of documentation requirements from the reality of care	1. Advance CalAIM documentation reform. a. Work with County leadership to champion a culture change that accepts some risk in order to prioritize the triple aim of improving clinical care, promoting better outcomes, and reducing costs. Even when there is a lack of clarity or State guidance, embrace the opportunity presented by CalAIM and maximize all opportunities to reduce documentation. b. Limit disallowances to instances where there is fraud, waste, or abuse. c. Work with California Department of Healthcare Services (DHCS) to clearly define "fraud, waste, and abuse," advocating for a high threshold that focuses on patterns of fraud, waste, and abuse and ensures issues such as incorrect billing codes, missed timelines, or minor human errors do not result in recoupment. 2. Resolve competing sets of requirements (e.g., Drug Medi-Cal and Substance Abuse Prevention and Treatment Block Grant) and require consensus among regulatory agencies prior to enforcement. a. Where necessary, seek legislative reform to align requirements. b. Standardize forms at the state level to simplify chart review, reduce administrative burden, and ensure consistency. 3. Simplify clinical and administrative documentation. a. Identify areas where standardized language would be allowable (e.g., utilizing drop-down menus to select criteria) so that staff can focus on individualizing relevant components of documentation. b. Reduce the information required for progress notes, eliminating the need to repeat components when there has been no change. c. Eliminate requirements to document how every note and intervention ties to a treatment plan and medical necessity. d. Reduce the number of data fields that must be repeated across forms. e. Remove client signature requirements on problem lists and/or treatment plans. f. Eliminate documentation redundancy such as completing Discharge Summary and Discharge Progress Note. g. Reduce admission paperwork and leverage the ability to bill prior to establishing a diagnosis to create a low barrier intake process that better reflects the realities of care, which prioritizes access, and that improves the client experience. h. Add flexibility to deadlines where justified. i. Eliminate change of provider letters. j. Reduce documentation associated with credit cards and mileage.
B. In addition to state requirements, county programs can add additional requirements for behavioral health professionals.	4. Retain a professional consultant to evaluate San Diego County's documentation and monitoring practices. a. Align County requirements with minimum State standards b. Conduct a comparative analysis of documentation requirements in other counties and other specialty mental health plans, other payors, and other settings (including FQHCs). c. Identify and seek to replicate reform efforts that have been successful in other states. d. Advocate for parity across settings and regulatory entities, aligning to minimum requirements accepted for physical health providers such as FQHCs and Managed Care Plans.
C. The County has two separate electronic health records (EHRs) for specialty mental health and	5. Explore the current EHR structure with contracted providers.

Issue Area	Opportunities
substance use disorder services. Providers are required to submit clinical and billing information into each respective system; however, the two systems are not able to share data. This leads to challenges with care coordination, duplicative disclosures for clients who are served in both systems, and duplicative data entry for clinicians working across both systems. Moreover, because these EHRs lack interoperability, programs with their own EHR must enter the exact same data twice.	a. If the County continues to build its own electronic health record(s), identify resources to increase the internal capacity of BHS for data management and systems architecture. 6. Reduce redundant data entry by prioritizing interoperability with other systems and only utilize the County's systems where necessary.
D. Clinical staff who entered the field to provide direct care are increasingly required to do administrative functions that take away time from direct care/services. • The County's Organizational Provider Operations Handbook states that "the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost." This policy exacerbates the negative impacts of staffing shortages, such that administrative staff cannot be hired to support programs when there are vacancies in direct service positions. As a result, even when there is money in the contract budget to hire administrative support, already-overwhelmed clinicians are forced to take on duties that could be performed by non-clinical staff. • In Drug Medi-CAL (DMC) programs, licensed and license-eligible clinicians (known as Licensed Practitioners of the Healing Arts) are required to review and sign off on documentation done by SUD counselors. This review usually does not involve the client and is not considered clinical care, nor does it contribute to integrated service delivery. Instead, this administrative function makes these positions less attractive to license-eligible individuals who need 3,000 hours of clinical experience. In the short-term, this creates shortages of individuals to fill these positions. In the long-term, this negatively impacts the pipeline of individuals who will gain the hours needed to achieve licensure.	7. Retain a consultant to conduct a formal analysis of what documentation and monitoring contributes to improved clinical outcomes and advocate to the State and CMS to align requirements to support the triple aim. 8. Re-evaluate current ratios that limit contractors' admin-to-clinical staff allowances. 9. Work with DHCS to limit documentation that must be reviewed and signed by LPHAs in SUD programs. Where LPHAs must still review and sign documentation, extend the timelines for acquiring such signature(s).
E. Focus groups conducted by SDWP show that frontline workers feel demoralized and overwhelmed by the level of scrutiny, describing audits as "merciless," "self-defeating," "unfair," "brutal," and "catastrophic," citing examples such as using the verbiage "client will provide physical exam results" rather than "client will obtain physical exam" on a DMC treatment plan and having *all* subsequent services associated with that treatment plan disallowed. While the prospect of recoupment does inform monitoring priorities, it is important to note that frontline staff report clinically insignificant documentation contributes to feelings of reduced dignity and respect in the workplace.	10. In addition to the documentation reforms mentioned above, simplify chart review processes. 11. Defer to contractors to internally monitor compliance issues. a. Eliminate "double jeopardy" wherein providers are required to self-audit and self-disallow, only to be re-audited by the County and have their self-disallowances count towards disallowance rates. 12. Implement a simple process that allows for corrections to minor compliance issues at the program level, ensuring that monitoring prioritizes clinical care and that corrective action plans do not place a significant burden on staff. 13. Establish a Tier System for medical record reviews and compliance monitoring based on contract performance (i.e., reduce the frequency of reviews for programs that demonstrate strong compliance and/or internal capacity for monitoring). Form an ad hoc workgroup to

Issue Area	Opportunities
	determine details regarding timelines, items monitored, sample sizes, continuous improvement plans and ongoing monitoring requirements.
F. County-contracted providers are required to submit duplicative, time-consuming information, frequently requiring the same information to be sent multiple times, to multiple people, in multiple formats. • *Example*: A Contractor that offers services at five school sites under a single contract may be asked to complete the exact same Site Visit Tool for all five locations as part of the annual contract monitoring process. This can require sending the same contract monitor identical information such as policies and procedures five times. Any requests for clarification or revisions must then be done and resubmitted five times. • *Example*: The same or similar staffing information may be required to be reported and regularly updated/corrected on: o Annual budgets and subsequent AARs o Monthly invoices / labor distributions o Monthly Staffing Status Reports (SSR) o Credentialing o System of care (SOC) application o SanWITS/CCBH registration o DHCS audits o Medi-Cal provider enrollment (PAVE) o Site visit reports G. In addition to duplicating work, such processes reveal the significant discrepancies in County review practices and inconsistent expectations across the system. *Example*: The County recently implemented a legal entity-level review tool for Article 14 compliance; however, it is reviewed each year by multiple BHS divisions (i.e., CYF and AOA) such that the exact same policy may be deemed compliant by one contract monitoring team and non-compliant by another.	14. Implement provider audits at the legal entity-level where possible and identify a streamline review process across County departments/divisions. 15. Identify opportunities for reporting efficiencies and/or technology solutions to share data across reports. a. Consider creating a portal for contractors to submit and upload required documents to a single place, in a single format. This could also include applicable policies and procedures, cost allocation plans, attestations, etc. b. Utilize data from the SOC application to auto-populate other reports that require staffing information. 16. Allow exceptions to requirements for obtaining a minimum of three bids for certain purchases when it may unnecessarily result in having to seek duplicative bids or where it may defeat organizational efficiencies. 17. Use existing structures and agencies for oversight and monitoring where possible (i.e., defer to licensing boards to monitor annual CEU requirements) and encourage the State to do so as well. 18. Consider the benefits of a statewide credentialing process and advocate accordingly.
H. The State has three distinct contracts with the County for behavioral health services, each of which entails extensive monitoring that can result in corrective actions for inconsequential findings. Many such findings are subject to interpretation of the reviewing entity and may vary from year-to-year or from auditor to auditor. Importantly, most audits do not focus on direct services and client records; rather, they are audits of County BHS as the pass-through entity. In turn, findings must be passed down to Contractors and monitored, even if they have no bearing on clinical care.	19. Advocate for simplified, reduced oversight of the County at Federal and State levels which will, in turn, be passed on to contractors and direct service staff. a. Limit pass-through auditing to focus on those items expressly required by CMS and Mega Regs. b. Similar to Specialty Mental Health Services, request a clear list of reasons for recoupment for services billed to Drug Medi-Cal. c. Eliminate scrutiny over word choice and phrasing to ensure documentation can reflect and elevate the client voice. d. Only disallow billing directly attributable to fraud, waste, and abuse, ensuring that subsequent services appropriately rendered and documented are reimbursable. e. Reduce the frequency of changes and consider limiting such changes to a predictable schedule (i.e., at the beginning of the fiscal year) and eliminate retroactive compliance with changes. 20. Advance CalAIM efforts towards administrative behavioral health integration. 21. Advocate for consistent understanding and application of regulations at the State level.

Issue Area	Opportunities
	22. Establish a structure that allows the County and contractor representatives to directly and collaboratively problem solve with the State.
I. County BHS and, by extension, BHS contracts are funded by multiple, complex funding sources such as Medi-Cal, SABG, MHSA, Realignment, etc., and each may have its own set of restrictive and sometimes even conflicting requirements. *Example*: Even as Medi-Cal payment reform looks to implement simplified CPT codes, other primary sources of BHS funding like SABG and MHSA continue to require competing cost reimbursement requirements.	23. Evaluate and consider opportunities to simplify and/or "unbraid" funding and/or seek legislative reform to align requirements across funding streams and regulatory entities. 24. Participate in statewide efforts to integrate MH and SUD administrative functions.
J. BHS contractors are required to submit time-consuming administrative authorization requests (AARs) for nearly every change to their budgets. Despite ongoing efforts to create thresholds for "materiality," contractors still must submit and resubmit AARs (which often requires resubmitting revised budgets and invoice templates) numerous times throughout the fiscal year.	25. In place of the current AAR process, implement a quarterly or semi-annual process to submit budget changes, with a final true-up at the end of the fiscal year.
K. The administrative burdens placed on clinical and accounting staff when administering Flex Funds reduces client access.	26. While some level of tracking is important to reduce fraud and waste, revise requirements and approvals depending on amount of spending.
L. Most BHS contracts are awarded for one (1) year with four (4) one-year option terms. In addition, this usually includes the option to extend the term in one or more increments for a total of no less than one (1) and no more than six (6) calendar months with at least fifteen (15) calendar days' notice. Especially in the wake of COVID, numerous BHS contracts have been renewed beyond their intended terms – often multiple times, in small increments, with little notice, and at the same funding level, contributing to: • High levels of staff anxiety about job security and difficulty retaining valuable staff • Vacant positions that cannot be filled due to uncertainty about future employment • Budget stagnation that does not allow for competitive compensation • Unrealistic timelines for staffing programs and other start-up activities that contribute to lapses in care when a contract transitions to a new provider • Contracting practices that do not account for operational realities such as lease terms	27. Require a minimum of 60 days' notice to exercise extension options. 28. Require contract extensions to occur in a minimum of one-year increments. 29. As a standard procurement practice, include a transition period of at least 30 days when there is a change in provider for a direct service contract to prevent any lapse in services and workforce transition.

San Diego
Workforce
Partnership

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APPENDIX H

BHSA Budget Template

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 5,034,519.00	$ 4,984,058.00	$ 4,873,024.00	$ 3,356,501.00	$ 3,361,754.00	$ 3,364,807.00	0.00	0.00
Early Intervention Services	☑	$ 54,239.00	$ 54,324.00	$ 54,374.00	$ 29,206.00	$ 29,252.00	$ 29,278.00	220	120.00
Outpatient Services	☑	$ 96,374,209.00	$ 98,268,390.00	$ 99,698,553.00	$ 25,529,795.00	$ 25,573,095.00	$ 25,599,851.00	5800	700.00
Intensive Outpatient Services	☑	$ 64,249,473.00	$ 65,512,260.00	$ 66,465,702.00	$ 17,019,863.00	$ 17,048,730.00	$ 17,066,576.00	1300	100.00
Crisis and Field-Based Services	☑	$ 3,062,175.00	$ 3,066,967.00	$ 3,069,750.00	$ -	$ -	$ -	700	0.00
Residential Treatment Services	☑	$ 86,482,073.00	$ 86,714,063.00	$ 86,895,558.00	$ 10,849,866.00	$ 10,877,585.00	$ 10,898,879.00	6060	140.00
Inpatient Services	☑	$ 10,788,956.00	$ 10,805,841.00	$ 10,815,655.00	$ -	$ -	$ -	1288	0.00
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 9,793,761.00	$ 9,152,769.00	$ 9,161,082.00	$ 3,689,708.00	$ 2,711,002.00	$ 2,713,464.00	1096	3227
Early Intervention Services	☑	$ 52,116,952.00	$ 51,153,385.00	$ 51,444,480.00	$ 27,711,511.00	$ 27,963,318.00	$ 28,802,218.00	5150	2850
Outpatient and Intensive Outpatient Services	☑	$ 259,245,269.00	$ 258,175,537.00	$ 261,746,794.00	$ 128,388,918.00	$ 126,344,502.00	$ 126,758,271.00	18340	9800
Crisis Services	☑	$ 68,858,463.00	$ 72,313,193.00	$ 76,454,185.00	$ 18,643,588.00	$ 19,044,650.00	$ 19,514,759.00	10000	2675
Residential Treatment Services	☑	$ 31,762,241.00	$ 31,912,965.00	$ 32,046,195.00	$ 67,438.00	$ 69,808.00	$ 72,421.00	2100	100
Hospital and Acute Services	☑	$ 119,112,228.00	$ 121,106,897.00	$ 121,375,852.00	$ 8,601,618.00	$ 8,626,203.00	$ 8,646,003.00	3050	600
Subacute and Long-Term Care Services	☑	$ 169,794,917.00	$ 170,138,935.00	$ 170,386,125.00	$ 388,678.00	$ 395,420.00	$ 395,779.00	680	100
Housing Services (MH + SUD)									
Housing Services	☑	$ 76,897,446.00	$ 68,835,435.00	$ 69,204,344.00	$ 12,961,617.00	$ 11,186,691.00	$ 11,299,514.00	575	5500
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 1,053,626,921.00	$ 1,052,195,019.00	$ 1,063,691,673.00	$ 257,238,307.00	$ 253,232,010.00	$ 255,161,820.00	56359	25912

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures

Other Expenditures	Total Projected Expenditures (Year One)	Total Projected Expenditures (Year Two)	Total Projected Expenditures (Year Three)
Capital Infrastructure Activities	$ 35,319,035.00	$ 2,383,177.00	$ 2,383,177.00
Workforce Investment Activities	$ 33,511,486.00	$ 23,948,016.00	$ 19,237,846.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 188,497,242.00	$ 195,282,941.00	$ 195,329,458.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 13,752,240.00	$ 13,752,240.00	$ 13,752,240.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 271,080,003.00	$ 235,366,374.00	$ 230,702,721.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 329,492,633.00	$ 350,434,032.00	$ 350,842,877.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 44,341,216.00	$ 44,341,216.00	$ 44,341,216.00
2011 Realignment (Public Safety Realignment)	$ 231,514,298.00	$ 197,931,541.00	$ 176,014,595.00
State General Fund	$ 96,236,468.00	$ 71,633,022.00	$ 74,452,261.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 723,691,644.00	$ 762,435,851.00	$ 789,594,358.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 811,265.00	$ 811,265.00	$ 811,265.00
Community Mental Health Block Grant (MHBG)	$ 3,404,540.00	$ 3,404,540.00	$ 3,404,540.00
Substance Use Block Grant (SUBG)	$ 21,795,572.00	$ 21,795,572.00	$ 21,795,572.00
Commercial Insurance	$ 1,093,233.00	$ 1,093,233.00	$ 1,093,233.00
County General Fund	$ 32,578,466.00	$ 32,578,466.00	$ 32,578,466.00
Opioid Settlement Funds	$ 7,303,151.00	$ 7,303,151.00	$ 7,303,151.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 463,771.00	$ 463,771.00	$ 463,771.00
Other state funding (including DSH funding)	$ 38,612,157.00	$ 20,735,926.00	$ 21,029,092.00
Other county mental health or SUD funding	$ 44,808,177.00	$ 20,033,177.00	$ 20,033,177.00
Other foundation funding	$ 5,798,640.00	$ 5,798,640.00	$ 5,798,640.00
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 1,581,945,231.00	$ 1,540,793,403.00	$ 1,549,556,214.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 1,310,865,228.00	$ 1,305,427,029.00	$ 1,318,853,493.00
Auto-validation: Table 2: Other County Expenditures	$ 271,080,003.00	$ 235,366,374.00	$ 230,702,721.00

Instructions
Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**
Rows 38-40: input your county's base BHSA funding allocation by component and year.
Rows 43-54: this section will be auto-populated from the sections below it.
Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.
Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.
Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.
Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.
Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.
Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.
Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.
Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.
Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.
Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.
Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.
Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."
Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."
Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."
Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.
Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."
Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.
Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.
Row 133: enter the dollar amount of prior year prudent reserve ending balance
Row 134: enter the prudent reserve maximum for your county.
Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**
Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.
Row 139: the total transferred excess prudent reserve is auto-populated.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers

	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 82,382,692.42	$ 96,113,141.16	$ 96,113,141.16	$ 274,608,974.74
Year Two Component Allocation (dollars)	$ 81,352,877.99	$ 94,911,690.99	$ 94,911,690.99	$ 271,176,259.97
Year Three Component Allocation (dollars)	$ 80,810,656.30	$ 94,279,099.02	$ 94,279,099.02	$ 269,368,854.35

BHSA Transfers
Year One Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	27%	28%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 74,144,423.18	$ 76,890,512.93	$ 123,574,038.63	$ 274,608,974.74
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ -	$ 180,930,868.29	$ 180,930,868.29
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers
Year Two Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	27%	28%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 73,217,590.19	$ 75,929,352.79	$ 122,029,316.99	$ 271,176,259.97

BHSA Transfers
Year Three Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	27%	28%	45%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 72,729,590.67	$ 75,423,279.22	$ 121,215,984.46	$ 269,368,854.35

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)

Base Component (Year One)	Housing Intervention Percentage (Year One)	Housing Intervention Funds (Year One)
Base Percentage and Funding	30%	$ 82,382,692.42
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 82,382,692.42
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 96,113,141.16
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 96,113,141.16
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 96,113,141.16
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 96,113,141.16

Funding Transfers (Year One)

	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-3%	-7%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	10%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	27%	28%	45%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)

Base Component (Year Two)	Housing Intervention Percentage (Year Two)	Housing Intervention Funds (Year Two)
Base Percentage and Funding	30%	$ 81,352,877.99
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 81,352,877.99
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 94,911,690.99
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 94,911,690.99
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 94,911,690.99
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 94,911,690.99

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-3%	-7%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-10%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	27%	28%	45%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)

Base Component	Housing Intervention Percentage (Year Three)	Housing Intervention Funds (Year Three)
Base Percentage and Funding	30%	$ 80,810,656.30
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 80,810,656.30
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 94,279,099.02
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 94,279,099.02
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 94,279,099.02
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 94,279,099.02

Funding Transfers (Year Three)

	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-3%	-7%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-10%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	27%	28%	45%	Row Equals 100%

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 44,791,324.34	$ -	$ -	$ 44,791,324.34
PEI	$ 74,012,179.58	$ -	$ -	$ 74,012,179.58
Encumbered INN	$ 52,953,103.32	$ -	$ -	$ 52,953,103.32
Unencumbered INN	$ 4,295,128.00	$ -	$ -	$ 4,295,128.00
WET	$ 4,879,133.06			$ 4,879,133.06
CFTN	$ -			$ -
Total (auto-populated)	$ 180,930,868.29	$ -	$ -	$ 180,930,868.29

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 33,478,186.00
Local Prudent Reserve Maximum (2)	$ 51,032,375.28
Excess Prudent Reserve Funding that must be transferred	**$ (17,554,189.28)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated**.**

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 74,144,423.00	$ 73,217,590.00	$ 72,729,590.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 74,144,423.00	$ 73,217,590.00	$ 72,729,590.00

Housing Interventions Category

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 26,536,774.20	$ 36,268,010.48	$ 36,386,362.55	$ 15,426,589.65	$ -	$ -
Operating Subsidies	$ 1,142,173.00	$ 1,142,173.00	$ 1,142,173.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 23,578,362.42	$ 31,867,934.08	$ 31,968,752.51	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 51,257,309.62	$ 69,278,117.56	$ 69,497,288.06	$ 15,426,589.65	$ -	$ -
Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**			

Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 7,688,596.44	$ 10,391,717.63	$ 10,424,593.21
Total Housing Interventions Expenditures (auto-populated)	$ 58,945,906.06	$ 79,669,835.19	$ 79,921,881.26
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 37,559,816.60	$ 55,215,340.38	$ 55,423,552.35
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 15,659,297.90	$ 15,659,297.90	$ 15,659,297.90
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.7%	75.4%	76.2%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	740	762	778
Eligible Adults/Older Adults	17989	18529	18918
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.

3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.

4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.

5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).

6. W&I Code § 5892, subdivision (b)(2).

7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.

8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions
Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.
Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.
Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.
Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.
Rows 31-40: input the projected expenditures for each FSP service category or program for each year.
Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.
Row 39: input expenditures for BHSA-funded innovation pilots or projects.
Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.
Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.
Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.
Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.
Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 76,890,512.00	$ 75,929,352.00	$ 75,423,279.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 76,890,512.00	$ 75,929,352.00	$ 75,423,279.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 30,605,056.23	$ 31,923,186.37	$ 32,372,672.77	$ 70,654,952.42	$ 66,988,233.22	$ 67,726,162.33	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 2,243,777.97	$ 2,243,777.97	$ 2,243,777.97	$ 6,527,670.60	$ 6,527,670.60	$ 6,527,670.60	$ -	$ -	$ -
FSP Intensive Case Management	$ 19,065,269.81	$ 19,761,164.85	$ 20,252,277.64	$ 14,909,721.80	$ 14,959,506.04	$ 15,237,111.85	$ -	$ -	$ -
High Fidelity Wraparound	$ 5,838,249.11	$ 5,838,249.11	$ 5,838,249.11	$ 5,728,040.58	$ 5,728,040.58	$ 5,728,040.58	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 2,522,506.89	$ 2,450,231.31	$ 2,504,053.73	$ 2,681,859.16	$ 2,901,178.80	$ 2,998,955.70	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 1,620,602.00	$ 1,620,602.00	$ 1,620,602.00	$ 1,493,500.00	$ 1,493,500.00	$ 1,493,500.00	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define: Club House and Administrative Services Organization	$ 3,555,446.95	$ 1,644,768.67	$ 2,642,371.08	$ 12,333,841.68	$ 16,130,121.17	$ 17,112,400.03	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 65,450,908.96	$ 65,481,980.29	$ 67,474,004.30	$ 114,329,586.24	$ 114,728,250.42	$ 116,823,841.09	$ -	$ -	$ -
FSP Transfer Information	**Year One**	**Year Two**	**Year Three**						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**						
FSP Component Admin Expenses	$ 9,817,636.34	$ 9,822,297.04	$ 10,121,100.65						
Total Full Service Partnership Expenditures (auto-populated)	$ 75,268,545.30	$ 75,304,277.33	$ 77,595,104.95						
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**						
Eligible Children/TAY (25 years and younger)	1255	1295	1320						
Eligible Adults/Older Adults	6325	6515	6650						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**						
MHSA "Encumbered" INN	$ -	$ -	$ -						

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions
Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.
Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.
Row 45: input expenditures for BHSA-funded innovation pilots or projects.
Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 123,574,038.00	$ 122,029,316.00	$ 121,215,984.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 60,310,289.43	$ 60,310,289.43	$ 60,310,289.43
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 183,884,327.00	$ 182,339,605.00	$ 181,526,273.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 3,290,245.81	$ 3,417,103.08	$ 3,547,879.70	$ 4,458,039.21	$ 4,688,495.41	$ 4,926,071.71	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 24,085,318.19	$ 24,334,603.14	$ 24,724,158.52	$ 33,480,638.77	$ 34,295,711.38	$ 35,003,400.02	$ -	$ -	$ -
Early Intervention Expenditures	$ 99,303,379.38	$ 100,168,608.98	$ 101,774,322.35	$ 94,236,727.42	$ 97,404,864.59	$ 100,321,895.59	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 1,382,489.52	$ 1,382,489.52	$ 1,382,489.52	$ 1,277,443.54	$ 1,277,443.54	$ 1,277,443.54	$ -	$ -	$ -
All Other EI Expenditures	$ 97,920,889.87	$ 98,786,119.46	$ 100,391,832.83	$ 92,959,283.87	$ 96,127,421.05	$ 99,044,452.05	$ -	$ -	$ -
Outreach and Engagement	$ 6,549,139.25	$ 6,765,127.79	$ 6,941,424.26	$ 168,843.98	$ 149,364.34	$ 175,473.41	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 4,567,349.60	$ 4,567,349.60	$ 4,567,349.60	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ 4,255,566.14	$ 4,567,349.60	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 4,567,349.60	$ 311,783.46	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 16,145,426.96	$ 16,998,274.78	$ 12,902,475.06	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 153,940,859.18	$ 156,251,067.37	$ 154,457,609.49	$ 132,344,249.38	$ 136,538,435.73	$ 140,426,840.74	$ -	$ -	$ -

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 23,091,128.88	$ 23,437,660.11	$ 23,168,641.42
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 177,031,988.06	$ 179,688,727.48	$ 177,626,250.91
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 51,430,656.45	$ 51,597,451.40	$ 51,968,150.54
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	78.8%	69.0%	62.9%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.8%	51.5%	51.1%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	13362	14196	14906
Eligible Adults/Older Adults	12636	13764	14704
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ -	$ 4,245,595.74	$ 4,562,364.40
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 4,879,133.06	$ 311,783.46	$ -
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ 52,953,103.32	$ 36,807,676.36	$ 19,809,401.58

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 5,857,103.00	$ 5,738,949.00	$ 5,701,369.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 12,389,091.00	$ 10,032,243.00	$ 9,998,270.00
New and Ongoing Administrative Costs	$ -	$ -	$ -
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 292,855,167.00	$ 286,947,450.00	$ 285,068,492.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2.0%	2.0%	2.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	4.2%	3.5%	3.5%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 33,478,186.00
Local Prudent Reserve Maximum (1)	$ 51,032,375.28
Excess Prudent Reserve Funds (auto-populated)	$ (17,554,189.28)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	27%	28%	45%	100%
Component Allocations	$ 74,144,423.00	$ 76,890,512.00	$ 123,574,038.00	$ 274,608,973.00
Year Two				
Allocation Percentage, with Transfers	27%	28%	45%	100%
Component Allocations	$ 73,217,590.00	$ 75,929,352.00	$ 122,029,316.00	$ 271,176,258.00
Year Three				
Allocation Percentage, with Transfers	27%	28%	45%	100%
Component Allocations	$ 72,729,590.00	$ 75,423,279.00	$ 121,215,984.00	$ 269,368,853.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	**Full Service Partnerships (Year One)**	**Behavioral Health Services and Supports (Year One)**	**Year One Totals**
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 74,144,423.00	$ 76,890,512.00	$ 123,574,038.00	$ 274,608,973.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ -	$ 60,310,289.43	$ 60,310,289.43
Estimated Total Available Funding for Year One	$ 74,144,423.00	$ 76,890,512.00	$ 183,884,327.43	$ 334,919,262.43
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 58,945,906.06	$ 75,268,545.30	$ 177,031,988.06	$ 311,246,439.42

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	**Full Service Partnerships (Year Two)**	**Behavioral Health Services and Supports (Year Two)**	**Year Two Totals**
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 73,217,590.00	$ 75,929,352.00	$ 122,029,316.00	$ 271,176,258.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 15,198,516.94	$ 1,621,966.70	$ 67,162,628.80	$ 83,983,112.44
Estimated Total Available Funding for Year Two	$ 88,416,106.94	$ 77,551,318.70	$ 189,191,944.80	$ 355,159,370.44
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 79,669,835.19	$ 75,304,277.33	$ 179,688,727.48	$ 334,662,840.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	**Full Service Partnerships (Year Three)**	**Behavioral Health Services and Supports (Year Three)**	**Year Three Totals**
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 72,729,590.00	$ 75,423,279.00	$ 121,215,984.00	$ 269,368,853.00

Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 8,746,271.75	$ 2,247,041.37	$ 69,813,506.75	$ 80,806,819.87
Estimated Total Available Funding for Year Three	$ 81,475,861.75	$ 77,670,320.37	$ 191,029,490.75	$ 350,175,672.87
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 79,921,881.26	$ 77,595,104.95	$ 177,626,250.91	$ 335,143,237.12

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 5,857,103.00	$ 5,738,949.00	$ 5,701,369.00	$ 17,297,421.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 12,389,091.00	$ 10,032,243.00	$ 9,998,270.00	$ 32,419,604.00
Total Projected New and Ongoing Administrative Expenditures	$ -	$ -	$ -	$ -

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA "Encumbered" INN Funds and unspent MHSA "Unencumbered" INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for "Improvement and Monitoring" (2% or 4%) and "Planning" (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to "No Excess" or "Reduce Excess"	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

APPENDIX I

Funding Transfer Request Supporting Data
(From MHSA FY ’25-’26)

Table of Contents

Overview

The Mental Health Services Act (MHSA) **Community Program Planning (CPP)** process is statutorily required to ensure local stakeholders have the opportunity to provide input regarding investments, priorities, and the array of behavioral health services funded through the MHSA. This report summarizes MHSA stakeholder engagement activities conducted by the department to inform its **Fiscal Year (FY) 2025-26 MHSA Annual Update** (MHSA Annual Update) and outlines input and feedback from stakeholders collected through CPP activities. It also includes strategies around ongoing efforts to refine and broaden engagement.

Pursuant to *California Welfare and Institutions Code (WIC) Section 5848(a)*, the CPP process requires counties to administer an inclusive community engagement and feedback process to gather input about the experiences of community members and stakeholders within MHSA-funded programs. The CPP process includes an array of local stakeholders, including adults and seniors with serious mental illness (SMI), families, service providers, justice partners, education partners, health care organizations, community members with interest in the local behavioral health services, and other communities with shared characteristics based on ethnicity, religion, disability, age, or other social identity factors. The CPP process facilitates opportunities for community members to provide feedback, identify unmet needs, recommend improvements, and make recommendations about MHSA investments.

The MHSA CPP process aligns with the County of San Diego enterprise-wide goal of ensuring communities have opportunities to participate in meaningful discussions and decision-making about local behavioral health services to ensure programs are reflective of the needs and voices of the community. Over the last year, the County of San Diego Behavioral Health Services (BHS) department has continued to enhance community engagement efforts. Additionally, significant new State policies and County initiatives have further emphasized the importance of stakeholder participation. The passage of Proposition 1 by California voters in March 2024 and the Behavioral Health Services Act (BHSA) will require further enhancements to the CPP process.

San Diego County At-A-Glance

San Diego County, located in Southern California along the Pacific Coast, shares a border with Mexico and features a diverse landscape that includes beaches, mountains, and deserts. San Diego County consists of 18 cities, 37 unincorporated communities, and 18 federally recognized Indian reservations. According to the United States (U.S.) Census Bureau, as of 2022 San Diego County has an estimated population of about 3.3 million people, making it the second most populous county in California. The population is diverse across various demographics:

- Approximately 54% are adults aged 25 to 64, 17.7% of residents are children under 14 years old, 14.7% are older adults aged 65 and over, and 13.7% are transition age youth (TAY) aged 15-24.

- In terms of ethnicity, 43.6% identify as White, 34.5% as Hispanic, 12.2% as Asian American or Pacific Islander (AAPI), and 4.5% as Black or African American, with smaller numbers identifying as Native American or other groups.
- The gender distribution is nearly equal, with 50.7% male and 49.3% female residents.

Engaging Local Stakeholders

To inform the FY 2025-26 MHSA Annual Update, a series of listening sessions, focus groups, and interviews were facilitated, in concert with the University of California, San Diego Health Partnership (UCSD Health Partnership), to gather stakeholder input from residents with unique perspectives across San Diego County. An online input form was also developed allowing stakeholders to submit feedback and ideas throughout the year.

Descriptions of featured and host organizations are outlined in Appendix D.

Stakeholder Participation Activities

The following information outlines stakeholder participation activities specifically conducted as part of the MHSA CPP process. The information collected was reviewed by BHS and UCSD Health Partnership to identify community and regional behavioral health needs and priorities to help inform the investment of MHSA funds.

Each activity was completed to discuss the following key questions with stakeholders:

1. What are the most pressing issues related to mental health and substance use in your community?
2. What are some of the biggest challenges to accessing resources for mental health and substance use?
3. What are some ideas that might help address priority mental health and substance use needs?

Cumulative demographic information for participants across all completed activities may be found in the **Participant Demographics** section of this report.

Community Listening Sessions

Nine listening sessions were held in collaboration with local partners, including behavioral health providers and/or other social services support for people in San Diego County. Partners informed the structure and guided sessions that were held across multiple regions. Sessions were held in-person, lasted one to two hours, and featured opportunities for partners to share information about their organization, upcoming initiatives, and how their program supports the health and wellness of the local community. Accommodations were also made to support people with interpretation or translation needs.

Partners Featured in Listening Sessions Include:

- Better Cuts Mental Health Alliance
- Diverse Research Now, Inc.
- Fallbrook Regional Health District
- Grama Blue's House
- Healthy San Diego Justice-Involved Workgroup
- Mental Health Ministry Network
- National Alliance on Mental Illness (NAMI)
- San Diego City College
- SBCS *(formerly South Bay Community Services)*

A sample of the presentation provided during listening sessions may be found in **Appendix A** of this report. Additionally, a list of sessions conducted, including corresponding dates and locations can be found in **Appendix C**. For additional information on each listed partner, please see **Appendix D/Figure D1** of this report.

Focus Groups

Eight focus groups were held to identify specific strengths and resources currently available to each participating population, as well as the needs and challenges communities are experiencing in accessing behavioral health resources. The focus groups were offered virtually and in-person at locations individuals and community members gather.

Host Partners Include:

- Jewish Family Service of San Diego-*Breaking Down Barriers* Outreach Team
- Jewish Family Service of San Diego-Patient Advocacy Team
- Peer Professionals of California
- Rady Children's Hospital Clinic
- San Diego Rescue Mission
- Somali Family Services
- Telecare-AgeWise
- Telecare-Mobile Crisis Response Team

Refer to **Appendix C** of this report for a list of the focus groups conducted, including corresponding dates and locations. For additional information on each listed partner, please see **Appendix D/Figure D2** of this report.

Interviews

A total of 10 individual interviews were completed with people who have lived experience and/or expertise. Discussions provided an opportunity to gain insight from residents affiliated with local organizations who self-identified as part of an unserved, underserved, or hard-to-reach population.

Affiliated Organizations of Interviewees Include:

- Disabled in Higher Education
- Disabled LGBTQIA+ Coalition
- Gooden Center
- Grow Lead Motivate (GLM) House
- HEAL Network
- Homelessness Hub
- Interfaith Community Services
- Inspired Mind
- Recovery International
- Unhoused Collective

Refer to **Appendix C** of this report for a list of the interviews conducted, including corresponding dates and locations.

Online Input Form

An input form tool was utilized through Qualtrics to gather data from people interested in providing input on mental health and substance use. Individuals were encouraged to indicate which engagement forums were of interest, inclusive of listening sessions, focus groups, and interviews. Respondents were also prompted to provide feedback on behavioral health in San Diego County. The form was promoted in different ways across the region including:

- During listening sessions, focus groups, and interviews, participants were informed about the form and encouraged to share it with their networks.
- With partner organizations and their clients.
- Through outreach and engagement events via a QR code on the UCSD Health Partnership banner, flyers, and other resource booth materials, including a summary document that included past learnings from previous years.

Existing Networks

In addition to these CPP process activities, the department continued to learn from the insights of its local behavioral health Board/Commission and other established BHS councils and collaboratives. These longstanding groups are designed to generate feedback and inform the delivery of behavioral health services for specific populations. Descriptions of these departmental groups are noted below.

BHS Councils and Collaboratives

The Behavioral Health Advisory Board (BHAB) and BHS' System of Care (SoC) Councils work directly with BHS and other system partners to examine disparities in care and collaboratively identify recommendations. Membership includes participation from over 200 individuals representing a variety of disciplines and community sectors. Participants contribute their time and

expertise to collaboratively discuss opportunities and solutions to behavioral health challenges via monthly and ad-hoc general meetings, as well as separate subcommittee convenings.

- **BHAB:** Serves as San Diego County's local Board/Commission for behavioral health and reviews and evaluates the community's behavioral health needs, services, programs, facilities, and procedures used to ensure citizen and professional involvement in the planning process. Monthly Brown Act meetings facilitated by BHAB Executive Officers ensure community involvement in identifying, assessing, and addressing challenges within the County behavioral health system. Additionally, BHAB holds subcommittee meetings where community stakeholders can discuss specific and pressing behavioral health issues and provide recommendations to BHAB. General BHAB meetings can be attended in-person or virtually on the first Thursday of every month.
- **Adult SoC Council:** Examines and informs planning/programming for the public adult system of care for San Diego County and provides recommendations to the department.
- **Older Adult SoC Council:** Examines and informs planning/programming for the public older adult system of care for San Diego County and provides recommendations to the department.
- **Children, Youth, and Families SoC Council:** Examines and informs planning/programming for services for children, youth, and families and provides recommendations to the department; advances systems and services to ensure these populations are healthy, safe, lawful, successful in school, and in their transition to adulthood.
- **Transition Aged Youth (TAY) SoC Council:** Examines and informs planning/programming for services for TAY (ages 16 to 25 years) and provides recommendations to the department.
- **Cultural Competence Resource Team (CCRT):** Collaborates with SoC Councils and other BHS collaboratives to examine and address health care disparities and social determinants of health in unserved and underserved communities, particularly around access to care and workforce goals.
- **Housing Collaborative:** Facilitates design, implementation, and evaluation of housing interventions to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity.

Community-Based Convenings

BHS and the UCSD Health Partnership also attended existing community-based convenings to learn about behavioral health needs and enlist new and diverse stakeholders. Descriptions of these existing community convenings are noted below.

- ***Live Well San Diego* Community Regional Leadership Team (CLT) Meetings:** Five separate regional CLTs convene across San Diego County, hosting both general and

supplementary Work Group/Subcommittee meetings. Meetings are held on a hybrid, monthly basis, and participants include community partners, agencies, and advocates that work together to identify the priorities of their respective region, including behavioral health needs.

- **NAMI Peer Council Meetings:** NAMI peer leaders with lived experience host meetings monthly. Meetings bring together peers, community members, service providers, organizations, and County representatives to discuss effective ways to improve the BHS system of care.
- **Partners in Equity Coalition Meetings:** Monthly, hybrid, community-based meetings, facilitated by the YMCA of San Diego County, focused on addressing and combating structural racism and inequities within the child welfare system. These meetings leverage the expertise of community members and families with lived experience to formulate ideas for change in the child welfare system.
- **Spring Valley Collaborative Meetings:** Monthly meetings hosted and facilitated by the Spring Valley Collaborative, a coalition of over 50 local organizations. These gatherings convene non-profit organizations, local government, healthcare providers, educational institutions, and community leaders, offering a platform for open dialogue, resource sharing, and collaborative efforts to improve conditions for Spring Valley residents.
- **Re-Entry Roundtable Meetings:** Monthly workgroup meetings hosted by the San Diego Re-Entry Roundtable focus on supporting individuals transitioning from incarceration back into the community. This collaborative forum includes diverse stakeholders such as representatives from correctional institutions, law enforcement agencies, faith-based organizations, community-based organizations, and individuals with lived experience in the criminal justice system to participate in meaningful dialogue to enhance re-entry efforts.

Community Outreach

Community outreach was conducted to inform stakeholders about opportunities to provide feedback and participate in the CPP process. Outreach was facilitated by UCSD Health Partnership through their network of community partners and included people with an understanding of MHSA populations who supported recruitment of other community members to increase CPP process participation. Outreach materials were translated into Spanish and included information about requesting interpreter services. Sample flyers promoting stakeholder participation activities can be found in **Appendix B/Figure B2** of this report.

To foster trust and encourage CPP process participation, efforts were conducted alongside community organizations and leaders with trusted relationships within their communities. Population-specific outreach and recruitment was also supported by community leaders and organizations to ensure diversity and relevance and to support engagement of people who may not otherwise participate in the CPP process. Outreach focused on connecting with communities often

identified as being underserved, unserved, or having limited participation in engagement activities, including:

- People with serious mental illness (SMI)
- People with disabilities
- People with lived experience
- People experiencing homelessness
- People with justice-involvement
- Faith-based communities
- Older adults
- Refugee communities
- Transition aged youth (TAY)
- Black and African Americans
- Asian American and Pacific Islanders (AAPI)
- Hispanic and Latinos
- LGBTQIA+ populations

Social Media Promotion

In March 2024, the UCSD Health Partnership launched an Instagram account (**@ucsd.hp**) to enhance promotional efforts and promote upcoming CPP input opportunities and community meetings/events, connect with community partners, build relationships, and share resources. Sample social media posts promoting stakeholder participation activities may be found in **Appendix B/Figure B1 of this report**.

Resource Booths and Community Events

The UCSD Health Partnership hosted resource booths at multiple local community events to share information on CPP process engagement opportunities, including listening sessions and upcoming community events. These networking activities supported connection with a diverse range of community members, advocates, and behavioral health workers. Information on health and wellness resources, mental health support, and available community services was also provided.

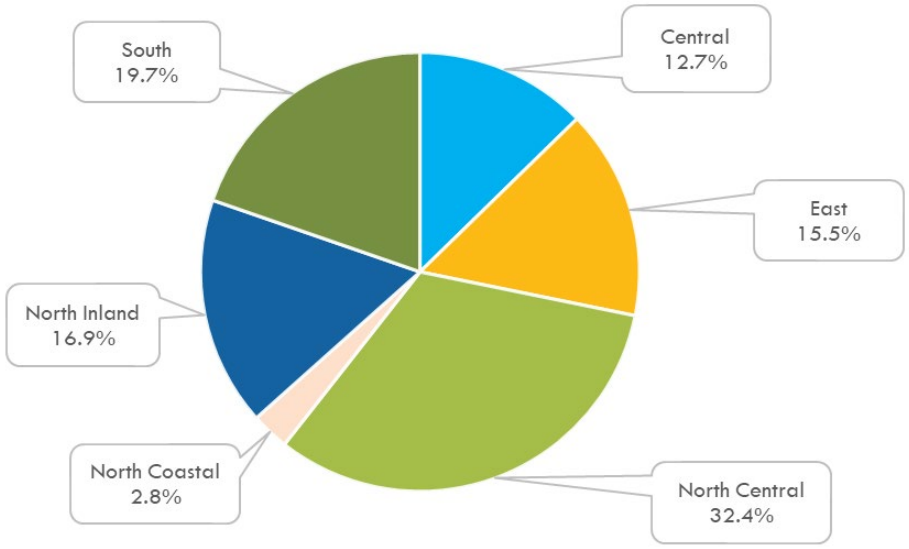
For more information on resource booth events, including corresponding dates and locations, refer to **Appendix C: Activities for Stakeholder Input - Resource Booths**.

Participant Demographics

Participants at CPP process activities varied in age, gender, ethnicity, and geographic location, providing a diverse representation of people residing in San Diego County. Participants were encouraged to complete a questionnaire via Qualtrics, or a written form, to allow for demographic information to be collected for this report.

Approximately 44% of participants completed the questionnaire following a CPP activity.

- *Age*
  - 58.6% were between 26-59 years of age
  - 32.4% were aged 60 years and over
- *Race/Ethnicity*
  - 51.9% identified as Hispanic/Latino/a
  - 18.5% identified as White
  - 13% identified as Black or African American
- *Primary Language*
  - 58.2% reported English
  - 38.2% reported Spanish
- *Veteran Status*
  - 6% of participants indicated their Veteran status
- *Living with a Disability*
  - Over 36% of respondents indicated they were living with at least one type of disability, including physical impairments, mental health conditions, difficulty seeing or hearing, learning disabilities, developmental disabilities, and others. Participants also had the option to indicate other specific conditions.
- *Geographic Location*
  - Respondents' region (by County of San Diego HHSA Service Region):

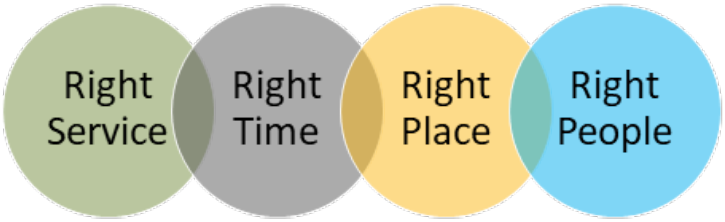


The characteristics representing the people who participated in one of the CPP input activities and completed the questionnaire may be found in **Appendix E** of this report.

Community Recommendations and Recent Efforts

Overwhelming feedback received from the community through recent CPP process activities reinforced a continued need for individuals and families to have access to behavioral health care that meets their unique circumstances -- ***"the right service, at the right time, in the right place, and by the right people."***

Community Vision for Behavioral Health Services



- ***"Right Services"*** to ensure people receive effective, high quality, tailored services within the level of care they need.
- ***"Right Time"*** to ensure people have timely access to the care they need when they need it, including flexible hours of service and no waitlists.
- ***"Right Place"*** to ensure barriers around access to care are reduced or eliminated, including services that are close to transportation and language accessibility.
- ***"Right People"*** to ensure services are provided by culturally competent practitioners who reflect the diversity of the communities being served.

Stakeholders expressed the need for enhanced community outreach efforts to reduce behavioral health stigma, raise awareness of services, and improve health literacy of community members related to behavioral health resources. They also highlighted challenges in navigating the complexities around behavioral health care and the need for more seamless care coordination.

Opportunities to Improve Care

In FY 2024–25, BHS continued to accelerate transformation of the behavioral health continuum of care by enhancing, expanding, and innovating the array of services available. This includes enhancements to services and infrastructure with a focus on integrated and preventative care that improves outcomes over time and is tailored to reduce health disparities. BHS continued to enhance care by making significant investments across the continuum of care through MHSA and other funding sources; however, opportunities remain to continue to improve care across the continuum.

Eight priority areas were elevated by participants through CPP process activities as areas for enhancement within the continuum of care. These include:

1. Accessibility
2. Care Coordination and Navigation
3. Community Outreach and Education

4. Crisis Response Services
5. Culturally Appropriate and Affirming Care
6. Support for People Experiencing Homelessness
7. Services for Youth and Transition Age Youth (TAY)
8. Workforce Capacity and Diversity

These areas remain consistent with learnings from the last two years of the current three-year MHSA cycle and highlight complex and longstanding systemic challenges. The following section provides a general overview of each area and the community's recommendations, as well as related departmental updates from FY 2024-25, and anticipated opportunities to improve care within the local public behavioral health system. The department looks forward to ongoing collaboration with BHAB, SoC Councils, and other existing stakeholder groups to continue efforts to identify and improve behavioral health care in San Diego County.

Area 1: Accessibility

Participants identified significant barriers to care, including extensive wait times, insurance limitations, funding disparities, and geographic disparities. Participants with behavioral health needs who are eligible for Medi-Cal reported experiencing delays in accessing care and noted that providers often wouldn't accept their insurance because of the low reimbursement rates. Participants shared that the lack of access, waitlists, and/or the need for out-of-pocket expenses often resulted in a crisis escalation or a higher demand for emergency care. These likely would have been prevented through more upstream preventative or outpatient care.

Additionally, community providers identified the lack of dedicated, ongoing funding for behavioral health care as a primary barrier to providing accessible, continuous, and effective mental health and substance use services. Insufficient funding was identified as a factor leading to shorter program lifespans, inconsistencies with providing effective healthcare, and subsequently resulting in waitlists and instability for clients. Smaller organizations that are trusted by stakeholders to provide community-based supports, identified challenges in being equipped to compete with larger entities when new funding opportunities were available.

Many stakeholders also identified geographic disparities as significantly impacting access to care, which are most pronounced in suburban or rural areas, where the nearest facilities to receive care may require driving or taking transportation for long periods of time.

Community Recommendations

To ensure behavioral health care is provided in locations and ways that are easier and more convenient for the community to access, stakeholders provided the following recommendations:

- Provide more services at local community spaces (e.g., libraries or places of worships) and implement activities such as mobile behavioral health clinics and community-based naloxone distribution events, where the applicable resource is brought to the community.

- Expand telehealth and remote care options, particularly for low-income and rural communities.
- Explore investments to help make transportation options available for people in need of care.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve access to care:

- The **Tri-City Psychiatric Health Facility (PHF)** in Oceanside is a 16-bed, 13,600-square-foot facility that provides access to care for adults experiencing a behavioral health crisis.
- The **Sharp Chula Vista CSU**, located adjacent to the emergency department, provides behavioral health care to adults who are Medi-Cal eligible and experiencing a behavioral health crisis.
- Construction of the new 14,300-square-foot **East Region Crisis Stabilization Unit (CSU)** is underway in the City of El Cajon to provide care to adults who are Medi-Cal eligible and experiencing a behavioral health crisis.

Area 2: Care Coordination and Navigation

Participants identified care coordination and navigation as a critical area of need. Individuals described the challenges related to accessing integrated and comprehensive healthcare services, with specific barriers for people who have a dual diagnosis and/or co-occurring mental health and substance use conditions. This often requires people to choose one type of care over another, resulting in fragmented care that did not fully address their needs. The complexity of cases was described by representatives from some programs as overwhelming and without an easy long-term solution. Stakeholders also expressed a desire for investments in more dynamic resources that help people access information about available services "in one place," significantly improving the experience of those navigating County-specific resources.

Community Recommendations

To improve care coordination across the behavioral health system, stakeholders provided the following recommendations:

- Increase the availability of integrative treatment models and programs that target both mental health and substance use challenges. These models are essential for providing comprehensive care to individuals with co-occurring disorders.
- Enhance communication across behavioral health silos to foster smooth transitions for clients, enabling warm hand-offs that ensure continuity of care.
- Establish clear protocols for seamless collaboration among crisis teams, law enforcement, and providers as a mechanism to improve responses to mental health crises and ensure that individuals receive the support they need in a timely and coordinated manner.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to support care coordination and navigation:

- Starting in 2025, a new program, **San Diego Relay (SD Relay),** is leveraging Peer Support Specialists to provide care coordination and engagement within several Hospital Emergency Departments (EDs). Peer Support Specialists connect with people while they are in EDs following a nonfatal opioid overdose or a behavioral health-related involuntary hold and help to provide "warm hand-offs" to other local providers and services. Services may include medication-assisted treatment, medical care, harm reduction tools, and community-based services.
- **System flow mapping** for suicide reporting and crisis response, particularly for youth and young adults, is underway through a pilot program with the California Department of Public Health through June 2025. This exercise will assist with identifying gaps related to local reporting and crisis response systems and bolsters connections across various community sectors.
- In Summer 2025, a **new public messaging campaign** will be released to enhance promotion of the San Diego Access & Crisis Line (ACL). Now accessible through the national three-digit dialing code 9-8-8, the ACL serves as the local crisis call center for the region and is a recommended "first stop" for those seeking guidance and support with behavioral health services. The ACL offers support in various crises and helps to facilitate connections to local resources, including adult and children outpatient services, deployment of mobile response teams (e.g., MCRT or PERT) if appropriate, and referrals to community and hospital-based CSUs.

Area 3: Community Outreach and Education

Participants identified the need to enhance and increase community outreach and education efforts around behavioral health resources to help keep people informed and feel empowered to seek care. The complexity and lack of understanding was noted as a significant gap, often delaying a person's ability to receive care. Stakeholders emphasized the need to develop comprehensive public health messaging and utilize various communication channels to connect with broader audiences. This would help reduce stigma, promote mental wellness, increase community education, support suicide prevention, and empower people to prevent substance misuse.

Community Recommendations

To improve community outreach and education, stakeholders provided the following recommendations:

- Develop more comprehensive education and outreach strategies.
- Increase ongoing public messaging via social media platforms.
- Increase additional print and digital advertising.
- Increase in-person engagement opportunities.

In addition to existing stigma reduction and suicide prevention efforts, participants indicated a desire for broader health education and health promotion programming to increase awareness and learning of strategies and skills to support mental wellness and combat substance misuse. This includes more overdose prevention workshops to continue to inform the public about the latest wave of the opioid epidemic, the dangers of illicit fentanyl, and to train stakeholders on the availability and administration of life-saving naloxone.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve community outreach and engagement. These include

- The **Breaking Down Barriers (BDB)** program was enhanced to provide increased outreach, education, and community engagement, including new community engagement activities required under the Behavioral Health Services Act.
- The ***It's Up to Us*** public messaging program was enhanced to provide increased support for outreach and public messaging efforts.
- The **BHS Communication & Engagement** team enhanced health promotion activities to increase stakeholder feedback and support program planning, including:
    - Data and public messaging workshops conducted with the BHS Population Health Unit and other County teams, where regional population health data on self-harm, suicide, fatal and non-fatal overdoses were presented to community convenings.
    - A *"30-Day Mental Wellness Practice"* initiative provided community members with a fun, free, accessible way to identify and engage in self-care activities to support their mental health.
    - Community dialogues with stakeholders through *It's Up to Us "Let's Talk About…"* events resulting in the identification of key areas of focus to help guide health promotion programming in the coming year. These topics include:
        - Bolstering socio-emotional competence and wellness
        - Promoting behavioral health literacy
        - Preventing social isolation and deaths by suicide
        - Substance use and overdose prevention
- BHS also continues to emphasize the importance and benefits of tailoring engagement opportunities to the unique experiences of groups of shared social identity.

Area 4: Crisis Response Services

Participants consistently emphasized the importance of shifting away from models with law enforcement as the primary responder for behavioral health crises. They advocated for peers and behavioral health professionals to respond, when appropriate, with an emphasis on delivering recovery-focused care, to de-escalate situations where individuals are experiencing emotional distress. While community perception of the County Mobile Crisis Response Team (MCRT) program appears to be positive as people experience its impact firsthand, some stakeholders noted challenges in communication, coordination, and accessibility. Systemic shortages, such as the low availability of behavioral health professionals to staff MCRTs, were noted. Participants also

identified the need for enhanced law enforcement training around behavioral health conditions and highlighted the importance of addressing racial disparities, particularly for the Black, Indigenous, and people of color (BIPOC) population who experience heighted control measures or are perceived to be dangerous by law enforcement.

Community Recommendations

To improve behavioral health crisis response, stakeholders provided the following recommendations:

- Expand the Psychiatric Emergency Response Teams (PERTs) and Mobile Crisis Response Teams (MCRTs). PERT and MCRT programs include personnel with specific training in behavioral health. They improve collaboration between the behavioral health and law enforcement systems to de-escalate situations and connect individuals to the care that they need.
- Ensure more immediate service access to 24/7 Drop-in Centers and CSUs to support individuals in crisis.
- Expand harm reduction services.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve crisis response services:

- More than **40 MCRTs are available countywide** with response times generally less than an hour and teams operational 24 hours a day, 7 days a week.
- As of November 2024, **MCRTs are responding to schools**, including charter, adult, and public-school districts in San Diego County (grades K-12) and school personnel may contact MCRT directly.
- Community-based **crisis response panel presentations** are being coordinated on an ad-hoc basis to promote availability of services and to explain to community members how different crisis response services interact and complement each other.

Area 5: Culturally Appropriate and Affirming Care

Participants identified the need for culturally appropriate and affirming community-based services and supports. Cultural competency was raised as a critical factor in ensuring behavioral health services can effectively meet the diverse needs of people within the community. Community members emphasized a desire for programs to be tailored to respect cultural practices, chosen families, and community connections to build rapport, enhance relevancy, and increase accessibility to care. Stakeholders highlighted the importance of family-oriented behavioral health care and community support systems.

Faith-based communities were also identified as critical in helping address gaps across behavioral health care, particularly for populations where stigma remains a significant barrier to individuals seeking care. They highlighted the need to explore strategies to integrate community-led initiatives into formal systems to create more inclusive, person-centered care.

Lastly, informal peer relationships and community engagement events were deemed important contributors to behavioral health support. Behavioral health fairs and similar events offer opportunities for community members to connect, collaborate, and learn about available resources.

Community Recommendations

To improve culturally appropriate and affirming care, stakeholders provided the following recommendations:

- Enhance culturally appropriate services to better serve diverse populations.
- Offer cultural humility training for behavioral health practitioners to foster understanding and respect for the diverse communities they serve.
- Hire more bilingual staff, including translators and ASL interpreters, to better meet the needs of people receiving care.
- Utilize cultural liaisons to build rapport and understanding with communities.
- Increase support for immigrant and refugee communities.
- Increase support to parents and other adults in parenting and caregiving roles.
- Collaborate with community-based and faith-based organizations to create programming.
- Expand resources and services available in multiple languages to enhance accessibility.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 related to culturally appropriate and affirming care. These include:

- An **Emotional Wellness & Self-Care educational program** was piloted to deliver culturally sensitive and responsive interventions to refugee children and families transitioning to the region. The program provided emotional support and helped to prevent acute and chronic negative mental health outcomes following an individuals' transition to the region. The program was delivered by community Afghan leaders, health educators/navigators and/or cultural brokers in Pashto, Farsi and Dari.
- Afghan cultural brokers and community leaders involved with BDB outreach and education efforts also led **peer support groups and workshops** with refugee communities. These efforts started gathering feedback from community listening sessions and engagement with local groups, including El Cajon Collaborative, International Rescue Committee, and Afghan Family Services. Embedding community leadership into service delivery in this way has helped to expand behavioral health access**.**
- **BHS community health workers (CHWs)** were hired for the first time to conduct outreach and education activities and share information on behavioral health topics and services. These include suicide prevention and mental wellness, crisis services such as San Diego Access & Crisis Line, MCRTs, PERTs, and CSUs, and education for youth, their parents and caregivers, and other education sectors. CHWs also disseminated **information about behavioral health programs**, including the Community Assistance, Recovery, and Empowerment (CARE) Act Program, County-operated outpatient behavioral health centers, and naloxone administration.

Area 6: Support for People Experiencing Homelessness

Participants identified the need for additional housing and support for people experiencing homelessness who have behavioral health conditions. Unhoused populations face unique challenges in engaging in treatment, and for many who face a daily struggle to secure food and shelter, attending healthcare appointments or following through with care plans is not the priority. This can result in people deprioritizing their care needs, experiencing difficulty in taking consistent medications, and conditions rapidly worsening. Overall, recommendations aimed to improve quality of live and housing stability for people experiencing homelessness.

Community Recommendations

To improve access to behavioral health care and housing for people experiencing homelessness, stakeholders provided the following recommendations:

- Increase availability of services to support basic needs, including food, shelter, and clothing.
- Expand job and workforce opportunities to help people gain employment and financial stability.
- Increase supportive housing options and utilizing single-point housing navigators to secure housing.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve access to care and housing for people experiencing homelessness:

- To improve service delivery, BHS established the **Housing & Homelessness Services unit**, which provides oversight of County-funded programs that provide behavioral health care and housing to people experiencing homelessness.
- Planning is underway within BHS to integrate the new **BHSA Housing component** that will be established under the BHSA. This will allocate 30% of County BHSA funding for housing interventions to support people with behavioral health needs who are homeless or at risk of homelessness.

Area 7: Services for Youth and Transition Age Youth (TAY)

Participants identified services for youth and transition age youth (TAY) as an urgent priority. A need for more comprehensive support and education on mental health and substance use, including enhanced behavioral health education in schools, is needed. As mental health challenges continue to rise among young people, expanded mental health and substance use educational efforts are important to raise awareness at an early age. This includes prevention education on topics such as vaping and marijuana use to reduce these behaviors among youth.

Participants highlighted that the disconnect between education and employment often places youth in vulnerable situations that can lead to poor outcomes later in adulthood. They also noted challenges for TAY in navigating and accessing care within the local system where services may be

categorized within children and adult cohorts, creating a gray area for TAY who may not fall into either.

Community Recommendations

To improve access to behavioral health care for youth and TAY, stakeholders provided the following recommendations:

- Ensure children, youth, and family constituents who are accessing services have opportunities to engage in spaces that are accessible and comfortable for them and consider their needs and preferences.
- Increase awareness and promotion of available services for youth and TAY populations to encourage help-seeking, self-sufficiency, and well-being.
- Bolster workforce development efforts, including those focused on service provision for children ages 0-5 to address infant and early child mental health.
- Enhance mental health services within schools by adding more counselors and therapists, bolstering mental health curriculum, and promoting opportunities for parents and caregivers of students to become involved.
- Review community-based programs at the regional and state level and explore strategies to implement and scale-up evidence-based programs with positive outcomes.
- Develop a resource directory tailored for TAY to support them in accessing the care that they need.
- Increase workshops and other educational opportunities for youth and their families to learn about behavioral health concerns, healthy coping strategies, and available resources to address them.
- Expand efforts to reduce vaping and marijuana use among youth.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve the access to care for youth and TAY. These include:

- ***Own Your Mindset*** (www.OwnYourMindset.org) is a new youth public messaging brand, informed and developed in collaboration with local youth, youth-led, and youth-serving organizations, to help reduce stigma and promote open discussions among youth around their mental health. Released in the last year, brand content focuses on elevating simple, tangible tips and tools for teens to help them explore their feelings and encourage agency and ownership of their emotional well-being. Activities promote the importance of mental health "check-ins" and resources to help youth identify common signs that may indicate they could benefit from mental health support, whether from a trusted individual in their social circle or a trained behavioral health expert.
- Additional **local youth-oriented public messaging for suicide prevention** is forthcoming to complement *Never A Bother* resources released by the California Department of Public Health earlier this year.
- **Enhancements to health education and health promotion**, including workshops for youth, TAY, and their parents and caregivers is also anticipated in 2025. Programming will

include new *It's Up to Us "Let's Talk About…"* community events to continue to encourage people to talk openly about behavioral health topics, challenges, and needs, promote local organizations and available resources to support wellness, and reduce stigma through community dialogues.

- ***"What I Wish My Parents Knew"* forums** will be held in collaboration with various community-based partners that emphasize youth training, conflict communication and resolution, and encourage youth to openly discuss issues that may be causing them anxiety or distress.
- Enhancements to existing **youth-directed mental health resources,** such as the Organized Support Companion in an Emergency Room Junior (oscER, Jr.) mobile app, are also planned. Designed for youth, oscER, Jr. provides emergency guidance and help resources to children who are relatives or friends of an individual suffering from a mental illness.
- **Screening to Care (S2C)** efforts continue, in collaboration with the San Diego County Office of Education, with regional contractors providing support in all service regions of the county. S2C provides universal screenings for middle school students to determine socioemotional needs and provides therapeutic interventions.
- In the coming year, BHS will also develop a **Children, Youth, and Transition Age Youth Behavioral Health Continuum Framework** for those across the 0 to 25 age continuum, consistent with previous work performed on the BHS adult-focused Optimal Care Pathways (OCP) Model. The framework leverages available data to help quantify optimal service levels and inform a comprehensive long-term plan to address identified gaps in services. Efforts will be in collaboration with other HHSA departments and integrate community input and feedback.

Area 8: Workforce Capacity and Diversity

Participants identified workforce capacity and diversity as a major ongoing priority within the local public behavioral health system. Stakeholders highlighted opportunities for better cultural representation across mental health and substance use service providers, ensuring staff are reflective of the communities they serve. Some participants expressed that providers may lack experience to serve diverse communities effectively and in a culturally responsive manner. Increased representation is pivotal to building trust and fostering inclusivity in service delivery.

Participants also noted the importance of a workforce that includes individuals with lived experience who are uniquely positioned to provide support to clients who are navigating the behavioral health system of care. Peer support models hold immense value in that they foster connection, reduce stigma, and enrich care models.

The public behavioral health system of care has continued to experience high turnover rates, staff burnout, lack of competitive pay, inadequate staffing ratios, and limited resources to support workforce training, many of which were highlighted in the *Addressing San Diego's Behavioral Health*

Worker Shortage report published in August 2022. This workforce shortage continues to remain a challenge in supporting continuity of care and coordination between services for stakeholders.

Community Recommendations

To improve workforce capacity and diversity efforts within the local public behavioral health system, stakeholders provided the following recommendations:

- Utilize peers and other community experts with lived experience, such as CHWs and Promotores in Spanish-speaking communities.
- Hire a more diverse array of behavioral health practitioners.
- Maximize partnerships with community-based organizations who provide mild-to-moderate mental health and/or other social service supports.
- Maintain more community-based dissemination points and co-locating resources in locations where community members congregate.
- Train and compensate community experts who are culturally representative and self-identify with particular communities to educate those communities, provide tailored outreach and education, and address language barriers.
- Integrate more effectively into community services to improve outcomes for clients navigating behavioral health and justice systems.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve the public behavioral health workforce. These include:

- Onboarding the administrator for the **MHSA Public Behavioral Health Workforce Development and Retention Program Innovation Program** in October 2024, which will establish an outcomes-based renewable training and tuition fund and an upskilling program to support people in the public behavioral health in advancing their career path.
- A new **Medi-Cal Training and Technical Assistance Program** to engage and equip small and minority-owned community-based organizations to deliver Medi-Cal funded mild-to-moderate mental health and substance use care to improve health outcomes for the BIPOC population. Focus groups and other community engagement events will occur in 2025.

Looking Ahead

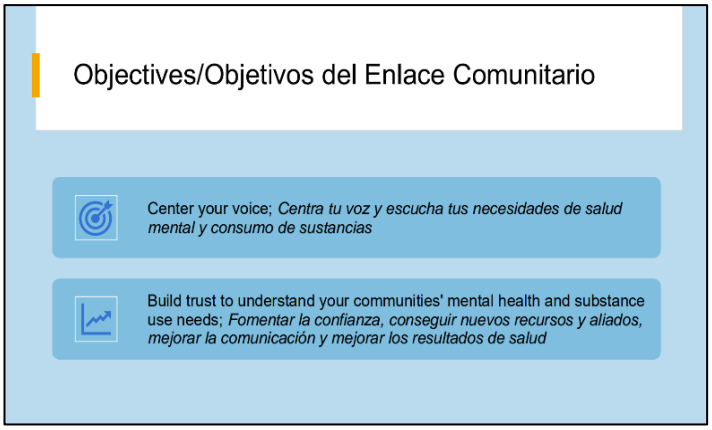
Although great strides have been made in enhancing community engagement and participation to ensure services meet the needs of the diverse local community, there are still opportunities to expand within existing places that facilitate participation and representation of underserved, unserved, and hard-to-reach communities. BHS continues to prioritize innovative community engagement approaches to facilitate stakeholder collaboration, education, involvement, and feedback in order to meet the unique needs of the community. This includes tailored outreach to communities of shared identity to uplift their voices.

In response to significant State and federal policy changes, changes across HHSA and the broader County enterprise, and feedback from the community, BHS continues to streamline and optimize community engagement activities. While the new BHSA will require changes to funding allocations, service requirements, and the CPP process, it also presents an opportunity to re-evaluate stakeholder engagement activities to support more cohesive and inclusive community collaboration. Over the next several months, BHS will be working closely with department councils and collaboratives, community-based organizations, contractors, and other stakeholders to design and refine opportunities focused on continuing to address the recommendations in this report and improving community engagement strategies.

APPENDICES

Appendix Guide

Appendix A: Listening Session Presentation

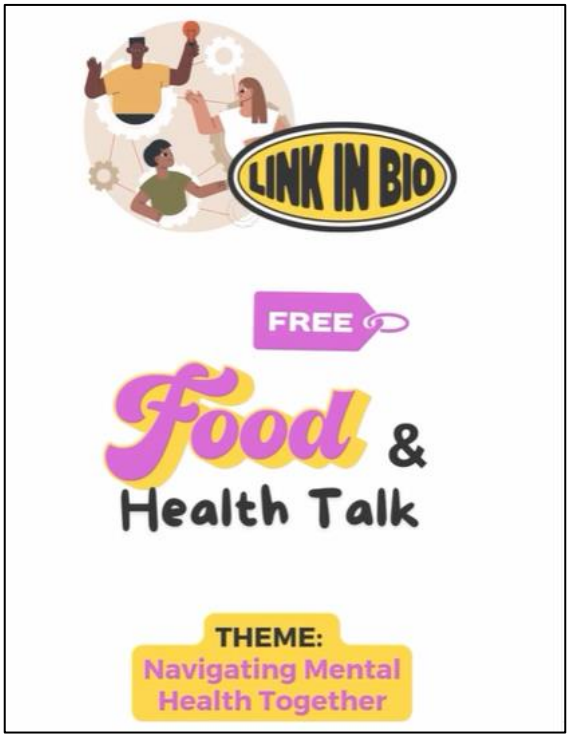


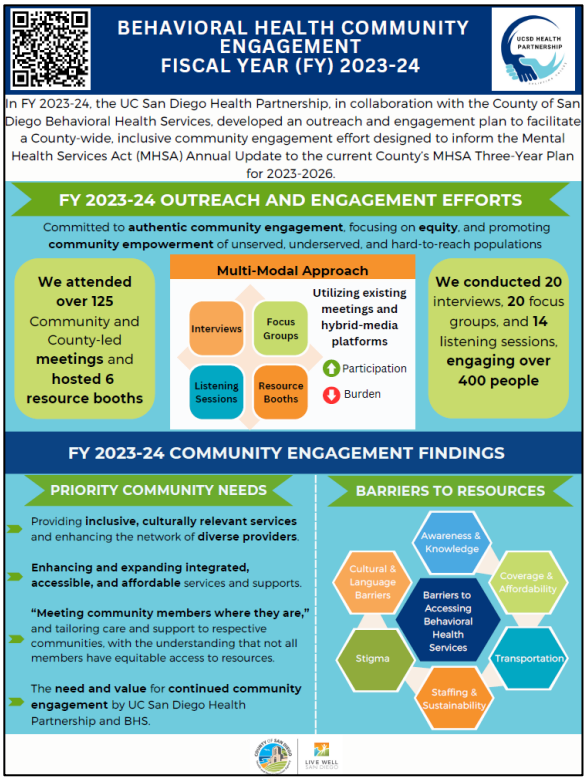
Appendix A: Listening Session Presentation *(continued)*

Appendix A: Listening Session Presentation *(continued)*

Appendix B: Social Media Posts/Promotional Outreach

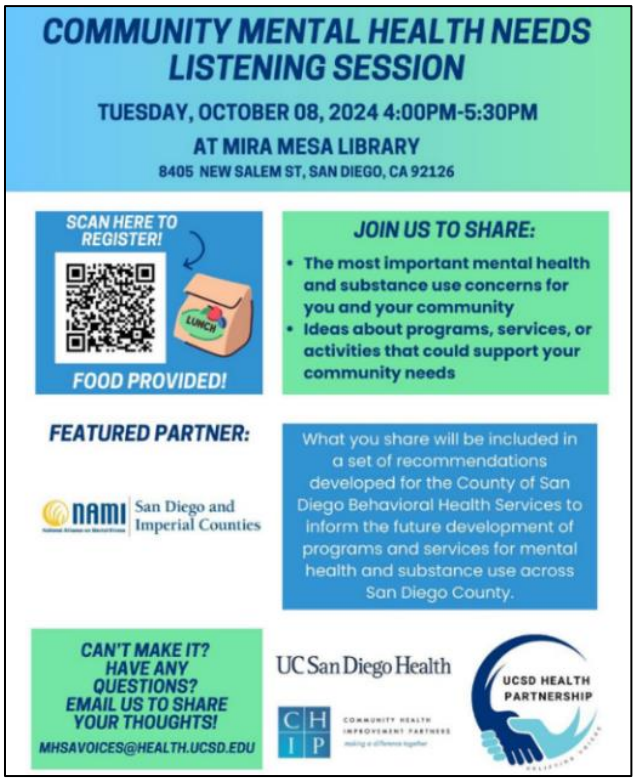
Figure B1. Promotional Instagram Posts (Instagram: @ucsd.hp)

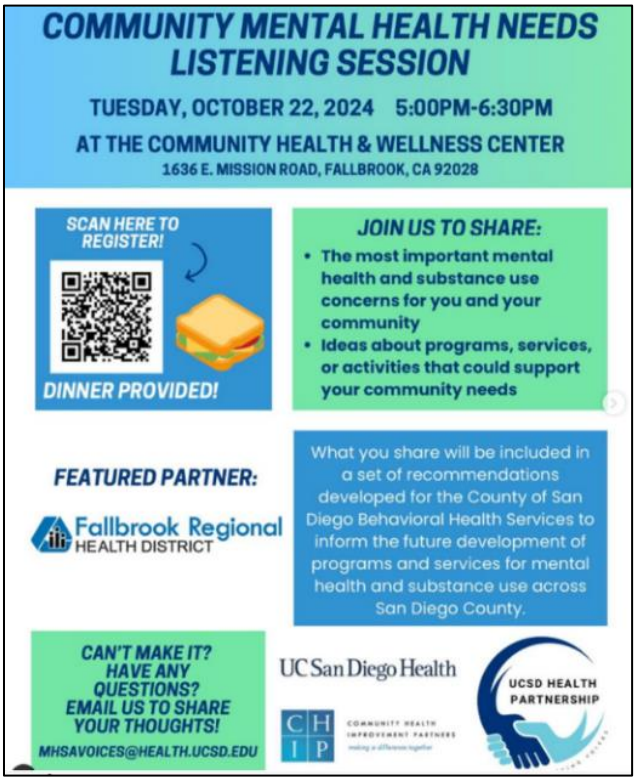




Appendix B: Social Media Posts/ Promotional Outreach *(continued)*

Figure B2. Promotional Flyers/Instagram Posts (Instagram: @ucsd.hp)






COMMUNITY MENTAL HEALTH NEEDS LISTENING SESSION
TUESDAY, NOVEMBER 5, 2024 11:00 AM-1:00 PM
AT LAUDERBACH CENTER
333 OXFORD ST CHULA VISTA, CA 91911
SCAN HERE TO REGISTER!
FOOD PROVIDED!
JOIN US TO SHARE:
• The most important mental health and substance use concerns for you and your community
• Ideas about programs, services, or activities that could support your community needs
• Session will be held in Spanish*
FEATURED PARTNER:
STRENGTHENING SBCS COMMUNITIES
What you share will be included in a set of recommendations developed for the County of San Diego Behavioral Health Services to inform the future development of programs and services for mental health and substance use across San Diego County.
CAN'T MAKE IT? HAVE ANY QUESTIONS? EMAIL US TO SHARE YOUR THOUGHTS!
MHSAVOICES@HEALTH.UCSD.EDU
UC San Diego
SCHOOL OF MEDICINE
CHIP
UCSD HEALTH PARTNERSHIP


NECESIDADES DE SALUD MENTAL DE LA COMUNIDAD: UNA SESIÓN DE ESCUCHA
MARTES, 5 DE NOVIEMBRE DE 2024 11:00 AM -1:00 PM
EN EL CENTRO LAUDERBACH
333 OXFORD ST CHULA VISTA, CA 91911
¡ESCANEA AQUÍ PARA REGISTRARSE!
¡COMIDA PROPORCIONADA!
ÚNETE CON NOSOTROS PARA COMPARTIR:
• Las preocupaciones más importantes sobre la salud mental y el consumo de sustancias para usted y su comunidad
• Ideas sobre programas, servicios o actividades que podrían apoyar las necesidades de su comunidad
SOCIO DESTACADO:
STRENGTHENING SBCS COMMUNITIES
Lo que usted comparte se incluirá en un conjunto de recomendaciones desarrolladas para los Servicios de Salud Conductual del Condado de San Diego para informar el desarrollo futuro de programas y servicios para la salud mental y el uso de sustancias en todo el Condado de San Diego.
¿NO PUEDES VENIR? ¿TIENES ALGUNA PREGUNTA? ¡ENVÍANOS UN CORREO ELECTRÓNICO PARA COMPARTIR TUS PENSAMIENTOS!
MHSAVOICES@HEALTH.UCSD.EDU
UC San Diego
SCHOOL OF MEDICINE
CHIP
UCSD HEALTH PARTNERSHIP

Appendix C: Activities for Stakeholder Input

Interviews		
Description	**Date**	**Engagement Site/ City**
Staff Member from Grow Lead Motivate (GLM) House	08/06/2024	Lemon Grove Café *HHSA East Region*
Staff Member from The Gooden Center	08/07/2024	Virtual *HHSA North, East, & Central Regions*
Staff Member from Disabled in Higher Education	08/08/2024	Virtual *HHSA South Region*
Staff Member from Interfaith Community Services	08/09/2024	Kensington Café *HHSA All Regions*
Staff Member from Continuum of Care/Homelessness Hub	08/15/2024	Virtual *HHSA North & Central Regions*
Staff Member from Inspired Mind	08/19/2024	Virtual *HHSA North & Central Regions*
Staff Member from Homeless-experienced Advocacy and Leadership (HEAL) Network	08/29/2024	Virtual *HHSA Central Region*
Staff Member from San Diego Unhoused Collective	08/30/2024	House of Black Coffee Company *HHSA North Inland Region*
Staff Member from the Disabled LGBTQ+ Coalition	09/11/2024	Virtual *HHSA North Central Region*
Interview with Staff Member from Recovery International	10/24/2024	San Diego *HHSA Central Region*
Focus Groups		
Description	**Date**	**Engagement Site/ City**
Peer Specialists of California	08/13/2024	San Diego *HHSA All Regions*
Rady Children's Hospital Staff	08/27/2024	Virtual *HHSA North Coastal Region*
Telecare Service Providers to Older Adults with Serious Mental Illness	09/18/2024	Virtual *HHSA All Regions*
Telecare – Mobile Crisis Resource Team (MCRT) Staff	09/25/2024	San Diego *HHSA Central Region*
Somali Family Services (SFS)	10/03/2024	SFS of San Diego *HHSA East Region*
San Diego Rescue Mission	10/09/2024	Virtual *HHSA Central Region*
Focus Group with Jewish Family Service – Patients	10/28/2024	Jewish Family Service of San Diego *HHSA North Central Region*
Focus Group with Jewish Family Service – Administration & Outreach Staff	10/28/2024	Jewish Family Service of San Diego *HHSA North Central Region*

Appendix C: Activities for Stakeholder Input *(continued)*

Listening Sessions		
Description	**Date**	**Engagement Site/ City**
Central Region Listening Session with Grama Blue's House Inc.	09/28/2024	City Heights/Weingart Library *HHSA Central Region*
San Diego Community College Listening Session	10/03/2024	Classroom at San Diego City College *HHSA Central Region*
North Central Listening Session with National Alliance on Mental Illness (NAMI) Next Steps	10/08/2024	San Diego *HHSA North Central Region*
Justice Involved Listening Session with Health SD Justice Involved Meeting	10/16/2024	Virtual *HHSA All Regions*
North Region Listening Session with Spotlight Partner: Fallbrook Regional Health District	10/22/2024	Community Health and Wellness Center *HHSA North Inland Region*
Listening Session with Diverse Research Now	10/24/2024	Church of Nazarene *HHSA Central Region*
South Region Listening Session with SBCS Promise Neighborhoods	11/05/2024	Lauderbach Center *HHSA South Region*
Mental Health Ministries Listening Session	11/19/2024	Good Shepard Catholic Church *HHSA North Central Region*
Better Cuts Therapy Listening Session	11/21/2024	Southeastern Live Well Center *HHSA Central Region*
Resource Booths		
Description	**Date**	**Engagement Site/ City**
Community Health and Resource Fair	09/04/2024	Jackie Robinson Family YMCA *HHSA Central Region*
Annual Walk in Remembrance with Hope	09/08/2024	Balboa Park *HHSA Central Region*
Mental Health America Meeting of the Minds Behavioral Health Conference	10/10/2024	Marina Village Conference Center *HHSA North Central Region*
Out of the Darkness San Diego Walk	10/19/2024	Naval Training Center Park *HHSA Coastal Region*
Live Well Advance Conference & School Conference	11/21/2024	San Diego Convention Center *HHSA Central Region*

Appendix D: Partner Organizations for Input Activities

Figure D1. Partners Featured During Listening Sessions

Better Cuts Mental Health Alliance - By integrating mental health advocacy into the barbershop experience, this organization aims to break down barriers and provide essential resources through safe spaces created by trauma-informed barbers within Black and Brown communities. In November, a listening session was held in collaboration with Better Cuts Mental Health Alliance.

Diverse Research Now Inc. - Nonprofit organization aims to empower historically underrepresented communities by bridging the gap in clinical research diversity and ensuring that these communities have a voice in advancing medical discoveries. In November, a listening session was held in partnership with Diverse Research Now Inc.

Fallbrook Regional Health District - A single-function, non-enterprise, independent government agency serving the evolving health and wellness needs of the community with a Community Health & Wellness Center serving as a hub for District Health & Wellbeing Programs. In October, a bilingual listening session was held in collaboration with Fallbrook Regional Health District.

Grama Blue's House - Nonprofit organization created to provide support, counseling, resources, and a place of healing to women with co-occurring disorders and substance misuse. UC San Diego Health Partnership collaborated with Grama Blue's House to host a listening session in the Central region of San Diego in September.

Healthy San Diego Justice-Involved Workgroup - A workgroup dedicated to addressing issues raised by the criminal justice sector and justice-involved population. In October, a listening session was held during a monthly meeting to engage the justice-involved stakeholders in attendance.

Mental Health Ministry Network - A network of active ministries with mental health leaders who supply prayer, accompaniment, and human connections to supplement the treatment of mental illness. In November, a bilingual listening session was held in one of the active parishes.

NAMI Next Steps - Working in partnership with San Diego County Psychiatric Hospital and BHS, NAMI Next Steps is a recovery-oriented peer and family support program that provides outreach and engagement to help access behavioral health services as needed. In October, UC San Diego Health Partnership collaborated with NAMI Next Steps to host a listening session in the North Central region of San Diego.

San Diego City College - A community college located in Downtown San Diego. In October, the UC San Diego Health Partnership held a listening session in a classroom at San Diego City College with college students training to work in the behavioral health sector.

SBCS (formerly South Bay Community Services) - A community-based nonprofit organization that transforms communities to support the well-being and prosperity of children, youth, and families throughout San Diego County. UC San Diego Health Partnership collaborated with SBCS to host a Spanish-led listening session in the South region of San Diego.

Figure D2. Partners Featured During Focus Groups

- **Jewish Family Service (JFS)** - is currently considered one of San Diego's most impactful nonprofit human services agencies, providing compassionate care and supportive services to more than 70,000 people every year. The services provided by JFS range from patient advocacy to running safe parking lots.
- **Peer Professionals of California** - is a 501(c)(3) nonprofit community-based organization that provides services to communities in need. Their services address the justice-involved, peer support, and community health needs throughout San Diego County.
- **Mobile Crisis Response Team (MCRT)** - is a 24/7 county-wide alternative to law enforcement response with teams comprised of behavioral health experts who are trained to respond in the community and de-escalate crises related to alcohol, drugs, or mental health conditions.
- **Rady Children's Hospital Clinic** – is located in Escondido and provides services to the communities in the North County, from Poway, San Marcos, and Julian to Borrego Springs, and also Pauma Valley. The clinic provides urgent care services along with psychiatric care.
- **San Diego Rescue Mission** – provides meals, shelter, clothing, education, and job-skills training for men, women, and single parents with children experiencing homelessness. The services provided by San Diego Rescue Mission vary from emergency shelters, to services for children, to mobile shower trailers.
- **Somali Family Services (SFS)** – is a community-based social service organization that provides culturally and linguistically appropriate programs and services to refugee and immigrant communities of San Diego. SFS provides services in English, Somali, Swahili, Arabic, and Farsi.
- **Telecare AgeWise** – is an older adult case management services program that collaborates with primary care physicians and coordinates with home health agencies, senior centers, and other community resources for older adults to ensure they get the most comprehensive care possible.

Appendix E: Stakeholder Data & Demographics

Table E1. Characteristics of Persons Participating in Input Activities

Age Group	**N=111**	**%**
16-25 years old	3	2.7%
26-59 years old	65	58.6%
60 years old and over	36	32.4%
Prefer not to answer	7	6.3%
Race/Ethnicity[1]	**N=108**	**%**
Another Hispanic, Latino/a, or Spanish origin	2	1.9%
Black or African American	14	13.0%
Filipino	8	7.4%
Filipino, Native Hawaiian	1	0.9%
Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano	56	51.9%
Native or Indigenous American	1	0.9%
Samoan	1	0.9%
Vietnamese	1	0.9%
White	20	18.5%
Race or ethnic identity not captured above	1	0.9%
Prefer not to answer	3	2.8%
Primary Language	**N=110**	**%**
English	64	58.2%
Farsi	1	0.9%
Spanish	42	38.2%
Tagalog	2	1.8%
Vietnamese	1	0.9%
Veteran Status	**N=106**	**%**
Yes	6	5.7%
No	96	90.6%
Other	2	1.9%
Prefer not to answer	2	1.9%
Sex Assigned at Birth	**N=107**	**%**
Female	85	79.4%
Male	22	20.6%

Table E1. Characteristics of Persons Participating in Input Activities *(continued)*

Gender	**N=110**	**%**
Female	87	79.1%
Male	21	19.1%
Genderqueer/gender non-conforming	2	1.8%
Sexual Orientation	**N=95**	**%**
Bisexual/pansexual/sexually fluid	2	2.1%
Gay or Lesbian	2	2.1%
Queer	2	2.1%
Heterosexual or straight	81	85.3%
Prefer not to answer	8	8.4%
Disability[1]	**N=108**	**%**
Has some form of disability	39	36.1%
Does not have a disability	64	59.3%
Prefer not to answer	5	4.6%
Additional Groups with Whom Participants Identify	**N=92**	**%**
African	3	3.3%
Homeless	1	1.1%
Immigrant	33	35.9%
LGBTQIA+	4	4.3%
Refugee/Newcomer	1	1.1%
Veterans/Military	5	5.4%
Other groups not mentioned above	4	4.3%
Do not identify as any of these additional groups	33	35.9%
Prefer not to answer	8	8.7%

[1] *Participants could select more than one response so values may total to more than 100%.*

APPENDIX J

Behavioral Health Director Certification

Behavioral Health Director Certification

Certification

1. I hereby certify that San Diego County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ☑ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ☑ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ☑ The IP was submitted to the local behavioral health board

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

County of San Diego

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update

5. County Behavioral Health Agency Director name

Nadia Privara

6. County Behavioral Health Agency Director phone number

619-563-2700

7. County Behavioral Health Agency Director email

Nadia.Privara@sdcounty.ca.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

N/A

9. Title

N/A

10. Phone

N/A

11. Email

N/A

County Behavioral Health Agency Director signature

12. Print name

Nadia Privara

13. Title

Director, Behavioral Health Services

14. Date

3/10/26

15. Signature

Nadia Privara Digitally signed by Nadia Privara
Date: 2026.03.10 15:21:30 -07'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

N/A

17. Title

N/A

18. Date

N/A

19. Signature

APPENDIX K

County Administrator or Designee Certification

DHCS | County Portal

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ✔ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ✔ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ✔ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

Signature

3. Print name
   Ebony N. Shelton
4. Date
   3/26/2026
5. Signature

Contact information

6. County Name
   County of San Diego

7. Certification for
   - (•) Three-Year Integrated Plan
   - ( ) Annual Update

8. County Chief Administration Officer Name
   Ebony N. Shelton
9. County Chief Administration Officer Phone number
   (619) 531-5880
10. County Chief Administration Officer Email
    CAOEbony.Shelton@sdcounty.ca.gov

APPENDIX L

Board of Supervisors Certification

{forthcoming}