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.