**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

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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

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**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.

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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

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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

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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.

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- 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.

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