San Bernardino County
Behavioral Health Services Act (BHSA)
DRAFT Integrated Plan
Fiscal Years 2026/2027 – 2028/2029

Public Comment Period

February 27, 2026 – March 30, 2026

San Bernardino County invites community members, stakeholders, and partners to review and provide feedback on the Draft BHSA Integrated Plan.

We invite you to share your feedback by completing the survey linked below:

English
Spanish

For more information please visit:

Behavioral Health Services Act (BHSA) – DBH Internet Website

SAN BERNARDINO COUNTY

DRAFT INTEGRATED PLAN FY 2026/2027–2028/2029

TABLE OF CONTENTS

I. Executive & General Information

II. Statewide Behavioral Health Goals

III. Community Planning Process

IV. Behavioral Health Care Continuum

V. Behavioral Health Services Act (BHSA) Components

A. Behavioral Health Services and Supports (BHSS)

B. Full Service Partnership (FSP)

C. Assertive Field-Based Substance Use Disorder Services

D. Housing Interventions

VI. Innovative Behavioral Health Pilots

VII. Workforce Strategy

VIII. Budget and Prudent Reserve

IX. Plan Approval and Certifications

APPENDICES

2026 - 2029 Integrated Plan

San Bernardino 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 Bernardino County

Behavioral Health Agency Name
San Bernardino County Department of Behavioral Health

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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.

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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)	18876
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	360
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	242
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	124

DRAFT

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	<11*
Were chronically homeless or experiencing homelessness or at risk of homelessness	250
Were in the juvenile justice system	1141
Have reentered the community from a youth correctional facility	272
Were served by the Mental Health Plan and had an open child welfare case	4839
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	44

DRAFT

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	1538

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	2949
Received Medi-Cal SMHS	20721
Received DMC or DMC-ODS services	5208
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1164
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	1658

DRAFT

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	64
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	000
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	1141
Were incarcerated (including state prison and jail)	000
Reentered the community from state prison or county jail	272
Received acute psychiatric services	5136

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

Admitted or detained for 72-hour evaluation and treatment rate

13239

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Admitted for 14-day and 30-day periods of intensive treatment
3688

Admitted for 180-day post certification intensive treatment
000

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
000

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
000

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
The data provided was extracted from the Department of Behavioral Health's official system of record, the Electronic Health Record (EHR) platform, myAvatar, for Fiscal Year 2023–2024.

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

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

DRAFT

Please select which of the following EHRs the county uses
Netsmart

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

Please select which QHIO the county participates in
Manifest MedEx

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://wp.sbcounty.gov/dbh/medicalrecords/

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 .

DRAFT

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
Alcohol or Drug Treatment Services
Case Management Services
Community Mental Health Services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Outreach 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
Children's System of Care Set-Aside
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

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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
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Treat Opioid Use Disorder (OUD)

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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

DRAFT

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:
Assertive Community Treatment (ACT)
Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
Forensic Assertive Community Treatment (FACT)
Individual Placement and Support (IPS) Model of Supported Employment

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

DRAFT

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
CSC for FEP
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

DRAFT

services identified in the list below as of June 30, 2026?
Peer Support Services
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

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

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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

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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
Gender

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

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For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity
Spoken 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?
No Disparities Data Available

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
Below

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

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?
Below

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

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
Review of the California Department of Health Care Services (DHCS) Access to Care measures indicates disparities in timely access to behavioral health services across specific age, race, and ethnicity, and gender groups when stratified by demographic characteristics. Disparities were observed across multiple measures of service utilization and penetration, including Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS) penetration rates. For Specialty Mental Health Services (SMHS), San Bernardino County's penetration rates for both adults/older adults and children/youth were below statewide averages. Among adults, lower utilization was observed among individuals age 65 and older, females, and individuals identified as Hispanic, Asian, Pacific Islander, or other race. Among children and youth, disparities were observed among very young children (ages 0–2 and 3–5) and transition-age youth (ages 18–20), as well as among children identified as Hispanic, Asian, Pacific Islander, or Unknown/Other race. For Non-Specialty Mental Health Services (NSMHS), while overall county performance exceeded statewide averages, demographic variation persisted. Among adults, lower utilization was noted among individuals age 69 and older, males, and individuals identified as Asian or Pacific Islander. Among children and youth, variation in penetration rates was observed among children ages 6–11 and 18–20, and among children identified as African American, Asian or Pacific Islander, and American Indian or Alaska Native. For Drug Medi-Cal Organized Delivery System (DMC-ODS) services, penetration rates for both adults/older adults and children/youth were below statewide averages. Disparities were observed across racial and ethnic groups for both age categories, including individuals identified as African American, Hispanic/Latino, Asian/Pacific Islander, and Other race. While the supplemental measure for initiation of substance use disorder treatment (IET-INI) did not include stratified

DRAFT

disparity data, overall performance remained below the statewide rate. This analysis was informed by DHCS Phase I Access to Care measures, stratified by age, race and ethnicity, and gender. Phase I measures were used to identify baseline disparities and guide program planning, partnership prioritization, and resource alignment for the Integrated Plan. While these measures primarily establish current performance conditions, Phase II measures are expected to introduce additional outcome-focused metrics to support the development of more specific, measurable improvement targets tied to statewide priority goals. Although the data does not independently identify underlying causes, the observed variation across population groups highlights disparities in service penetration and timely access, underscoring the importance of targeted, equity-informed strategies to improve access to the right care at the right time across the behavioral health continuum.

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, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand multiple programs, services, and partnerships to improve access to care and address Access to Care measures where local performance is below the statewide average or median, as reflected in California Department of Health Care Services (DHCS) dashboards and locally stratified data. The County's current strategies are informed by Phase I statewide measures, which were used to identify disparities and guide program restructuring, collaboration priorities, and funding alignment under the Behavioral Health Services Act (BHSA). While Phase I measures establish baselines and identify populations with lower penetration or delayed access, Phase II measures are expected to provide additional outcome-focused metrics that will enable the County to set clearer, measurable improvement targets aligned with statewide priorities. In anticipation of Phase II implementation, DBH is actively working with Managed Care Plans, hospitals, schools, community-based organizations, housing and justice partners to identify and utilize relevant local operational, utilization, and timeliness data to strengthen monitoring capacity. The County is moving forward with a review of existing data points, such as referral-to-assessment timelines, outreach-to-engagement rates, and service initiation tracking, to support future, measurable goal-setting and performance improvement efforts. As part of implementing the Behavioral Health Services Act (BHSA), the County is advancing a more integrated behavioral health continuum by incorporating substance use disorder (SUD) services and housing-related supports into coordinated care delivery models for individuals with co-occurring needs. This effort directly addresses disparities in penetration rates among older adults,

DRAFT

transition-age youth, and select racial and ethnic populations by strengthening system navigation, warm handoffs, and culturally responsive engagement strategies. DBH is conducting a comprehensive review of its continuum of care using DHCS Access to Care measures, service utilization trends, and demographic stratification by age, race and ethnicity, geography, and gender. This review is guiding program restructuring and enhancement efforts to improve timely access, increase service penetration, and address access gaps among priority populations. Programs will be strengthened to align with evidence-based practices and local needs, with particular attention to sub-populations demonstrating lower utilization or delayed engagement compared to statewide benchmarks. To directly address barriers related to timeliness and entry into care, DBH will continue to strengthen its 24/7/365 mobile crisis response services, available in English and Spanish and serving all age groups. These teams provide same-day, field-based assessment, de-escalation, and linkage to appropriate outpatient, crisis, and follow-up services, supporting improved access in both urban and rural areas of the county. DBH will also continue to strengthen Urgent Care and Crisis Walk-In Centers as low-barrier access points, particularly for individuals who are uninsured or underinsured, or hesitant to use traditional clinic-based services. DBH's Clubhouse programs further support timely access to care through partnerships with city Community Oriented Active Support Teams (COAST) in Fontana, San Bernardino, and Ontario. These multidisciplinary teams engage individuals in the field and facilitate direct referrals to behavioral health services, including transportation to Clubhouse locations when appropriate. This collaboration supports diversion from emergency departments and justice involvement, reduces barriers to initial engagement, and improves timely entry into care for individuals experiencing behavioral health crises or unmet needs in community settings. In response to disparities observed in penetration rates and service utilization among specific racial, ethnic, and age groups, the County is leveraging its Office of Equity and Inclusion, Cultural Competency Advisory Committee, and cultural awareness subcommittees to co-design targeted outreach, engagement, and navigation strategies with communities most impacted by inequities. These efforts strengthen the connection between identified disparities and intervention design by ensuring community-informed service delivery approaches. The County is also strengthening cross-system partnerships with Managed Care Plans, including Inland Empire Health Plan (IEHP), Kaiser, Molina, the San Bernardino County Department of Public Health, schools, hospitals, and community-based organizations. Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) data are being used to identify high-need geographic areas and populations, including rural residents and youth, to expand community-based navigation, school-linked behavioral health services, and warm hand-offs from medical, justice, and housing systems into behavioral health care. Collectively, these strategies are intended to improve timely access, increase service penetration, and reduce disparities in Access to Care measures where San Bernardino County currently performs below statewide averages. As Phase II measures become available, DBH will establish measurable improvement targets tied to statewide benchmarks and integrate ongoing local data monitoring to support continuous quality improvement and accountability.

DRAFT

File Upload

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?

Above

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

Please describe other
Grade

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

DRAFT

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

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
A review of homelessness-related measures indicates variation across age, race and ethnicity, gender, and student status, based on analyses of Point-in-Time (PIT) count data, Continuum of Care (CoC) service utilization indicators, and California Department of Education (CDE) student homelessness measures. While San Bernardino County performs more favorably than the statewide average on overall PIT homelessness rates and on the prevalence of homelessness among individuals with serious mental illness or substance use disorders, disparities persist among specific sub-populations. PIT data show higher representation of adults ages 35–44 and adults 45 and older among individuals experiencing homelessness, with disproportionate representation among American Indian or Alaska Native, African American, Native Hawaiian or Other Pacific Islander, and Caucasian populations, as well as among males. CDE data indicate that the County performs below the statewide average for homeless student enrollment, with disparities observed among African American, American Indian or Alaska Native, Pacific Islander, and Hispanic or Latino students, particularly in grades 3–7 and grade 12, and among students identifying as non-binary. Supplemental CoC data further indicate variation in service access among individuals under age 18 and adults ages 35–44, as well as among select racial and ethnic populations. These data highlight patterns of housing instability and differential access to housing-linked services among populations with elevated behavioral health needs. This analysis was informed by DHCS-referenced Phase I measures, including PIT counts, CoC utilization data, and CDE student homelessness indicators. Phase I measures establish baseline prevalence and demographic variation and were used to guide prioritization of housing-linked behavioral health strategies within the Integrated Plan. While these measures identify populations disproportionately affected by homelessness and service access gaps, Phase II measures are anticipated to introduce additional outcome-focused metrics related to housing stability, successful placement, service engagement following housing entry, and sustained tenancy. Although Phase I data do not fully capture the longitudinal outcomes associated with housing interventions, the observed disparities underscore the importance of strengthening integrated housing and behavioral health strategies to reduce instability and improve equitable access to services.

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

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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, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand strategies to reduce homelessness and improve access to behavioral health services for individuals and families experiencing housing instability. These efforts respond to Phase I data identifying disparities among adults ages 35–44 and older adults, students experiencing homelessness, and racial and ethnic populations disproportionately represented in homelessness-related measures. The County's housing strategies are grounded in Phase I homelessness measures, which were used to identify demographic variation in housing instability and guide alignment of Behavioral Health Services Act (BHSA) Housing Interventions funding, outreach priorities, and cross-system coordination efforts. While Phase I measures primarily establish baseline prevalence and access disparities, Phase II measures are anticipated to introduce additional outcome-oriented indicators related to housing retention, reduced returns to homelessness, and improved behavioral health engagement following placement. In anticipation of Phase II implementation, DBH is strengthening collaborative data review processes with the Office of Homeless Services, Community Development and Housing, housing authorities, Managed Care Plans, and community-based providers to enhance tracking of housing referrals, placement timelines, and service engagement following housing entry. Local operational indicators, including supportive housing placement rates, tenancy retention tracking, housing-linked treatment engagement, and referral-to-placement timelines, are being reviewed to build infrastructure for measurable target setting once statewide Phase II metrics are finalized. As part of BHSA implementation, DBH will continue integrating housing-related supports into the behavioral health continuum for individuals with mental health and substance use needs. This includes strengthening linkages among outreach, engagement, and treatment services and expanding access to supportive housing and tenancy-sustaining services. Data indicating elevated housing instability among adults ages 35–44 and older adults are guiding prioritization of individuals with complex behavioral health and housing needs. DBH is actively participating in a Housing Interventions and Homelessness Strategic Planning workgroup led by the County Administrative Office. This cross-department collaboration includes the Office of Homeless Services and Community Development and Housing and is focused on streamlining housing access pathways, designing a Transitional Rent Program, aligning BHSA Housing Interventions funding with permanent supportive housing strategies, and reducing system fragmentation. These coordinated efforts are intended to improve the timeliness of placement and reduce barriers that contribute to prolonged homelessness. DBH will also implement innovative housing models, including the Peer Housing Project approved by the State Commission for Behavioral Health. This recovery-oriented housing model serves adults experiencing homelessness who are engaged in DBH-operated Clubhouse programs and provides peer-led operations, in-home peer support, and coordinated linkage to behavioral health and supportive services. Lessons learned from this project will inform future housing strategies and

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performance benchmarks related to housing stability and recovery outcomes. To address disparities among children and youth experiencing homelessness, DBH will continue collaborating with Public Health, local education agencies, schools, and community-based organizations to strengthen school-linked behavioral health services and referral pathways. CDE data identifying elevated homelessness rates among specific grade levels and racial and ethnic populations are guiding targeted outreach, coordination with McKinney-Vento liaisons, and expansion of trauma-informed supports. DBH will further strengthen partnerships with the Continuum of Care, housing authorities, Managed Care Plans, and other County departments to improve warm hand-offs from outreach and housing systems into behavioral health treatment. Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) data will continue to inform geographic prioritization and community-based service expansion. Collectively, these strategies are intended to maintain progress where the County performs favorably relative to statewide benchmarks while reducing disparities in housing instability and service access among disproportionately impacted populations. As Phase II measures become operationalized, DBH will establish measurable improvement targets aligned with statewide housing and behavioral health priorities and integrate ongoing local monitoring processes to support sustained housing stability and continuous quality improvement.

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

BHSA Housing Interventions

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

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Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Above

For children/youth
Not Applicable

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

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
Above

30-day involuntary detention rates per 10,000
Not Applicable

180-day post-certification involuntary detention rates per 10,000
Same

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

Conservatorships, FY 2021 - 2022

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

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Temporary Conservatorships
Below

Permanent Conservatorships
Above

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

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
Above

For children/youth
Above

Crisis Stabilization

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For adults/older adults
Below

For children/youth
Below

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

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
Review of California Department of Health Care Services (DHCS) Institutionalization measures indicates disparities in the utilization of inpatient and crisis-based services among select demographic groups, particularly when examining indicators associated with extended lengths of stay and reliance on higher levels of care. According to the DHCS Adult MHS AB470 reporting framework, San Bernardino County's institutionalization rate for adults and older adults is 48.4%, compared to the statewide rate of 25.6%. This higher rate indicates elevated institutional utilization among adults and older adults relative to statewide performance. Demographic stratification of available data shows variation across age, race, ethnicity, and gender. Higher utilization of inpatient administrative days was observed among adult females, while elevated use of crisis residential services was identified among adults ages 33–44, males, and individuals identified as Asian or Pacific Islander. Supplemental crisis service utilization measures also show differences in service patterns by age and race. Disparity data for children and youth remain limited across several indicators, and within the AB470 dashboard framework. This analysis was informed by DHCS Phase I Specialty Mental Health Services (SMHS) utilization measures, including inpatient administrative days per beneficiary, crisis residential treatment days, and crisis-related service indicators. Phase I measures were designed to establish statewide baseline conditions and identify populations experiencing higher reliance on institutional settings or prolonged stays. In alignment with that planning intent, San Bernardino County is using these baseline comparisons to inform targeted system improvement efforts rather than as fixed performance targets. While these measures highlight utilization disparities and system flow pressures, Phase II measures are anticipated to introduce additional outcome-focused metrics related to reduced length of stay, improved step-down transitions, sustained community placement, and strengthened diversion effectiveness. Although the data does not independently capture all clinical or structural drivers of institutionalization, the observed variation and elevated overall utilization underscore the importance of strengthening community-based alternatives, improving care coordination across levels of care, enhancing discharge planning, and addressing systemic barriers that contribute to extended institutional stays.

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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)

San Bernardino County does not maintain a single comprehensive local dataset that independently captures institutionalization across all settings beyond the California Department of Health Care Services (DHCS) reported measures. However, the Department of Behavioral Health (DBH) routinely monitors multiple local operational indicators to understand institutional utilization patterns and system flow. The County's institutionalization strategies are grounded in Phase I measures, including inpatient administrative days per beneficiary and crisis residential utilization rates, which were used to identify baseline performance gaps and demographic variation. These measures informed prioritization of diversion initiatives, enhanced discharge coordination, and expansion of community-based services. While Phase I establishes comparative utilization patterns, Phase II measures are expected to introduce additional outcome-based indicators that will support the establishment of measurable improvement targets tied to reduced administrative days, shorter crisis residential stays where clinically appropriate, and improved transition to lower levels of care. In anticipation of Phase II implementation, DBH is strengthening structured review of local operational data, including inpatient discharge delay tracking, crisis stabilization length-of-stay monitoring, placement coordination timelines for Mental Health Rehabilitation Centers (MHRCs) and Skilled Nursing Facility–Special Treatment Programs (SNF-STPs), and diversion program utilization. These data are reviewed collaboratively with hospitals, long-term care providers, courts, housing partners, and Managed Care Plans to identify barriers to timely step-down and to build infrastructure for measurable performance improvement once Phase II benchmarks are finalized. These operational monitoring processes provide real-time insight into system pressures and support proactive identification of placement bottlenecks, service capacity gaps, and coordination barriers that contribute to prolonged institutional stays.

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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)

Beginning July 1, 2026, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand strategies aimed at reducing institutionalization by improving diversion from inpatient settings,

decreasing lengths of stay where clinically appropriate, and increasing access to timely, community-based services and housing-linked supports. These efforts directly respond to California Department of Health Care Services (DHCS) measures indicating higher-than-statewide utilization of inpatient administrative days and crisis residential treatment services among specific adult populations. The County's strategies are informed by Phase I utilization data, which identified demographic variation among adults ages 33–44, females, males, and select racial and ethnic populations experiencing elevated reliance on institutional levels of care. While Phase I measures provide baseline utilization patterns, Phase II measures are anticipated to support more clearly defined, outcome-focused improvement targets related to length-of-stay reduction, successful diversion, and sustained community integration. To reduce reliance on inpatient hospitalization and extended institutional stays, DBH will continue enhancing its crisis continuum, including 24/7/365 mobile crisis response services, Crisis Walk-In Centers, Crisis Stabilization Units, and Crisis Residential Treatment programs as clinically appropriate alternatives to inpatient admission. Data indicating elevated crisis residential utilization among specific adult populations are guiding efforts to strengthen discharge planning, improve coordination with outpatient providers, and expand step-down pathways into community-based care. To address prolonged inpatient administrative days, DBH will focus on improving transitions from acute care to less restrictive settings by strengthening coordination with hospitals, long-term care providers, housing partners, and Managed Care Plans. Efforts include improving placement pathways to MHRCs, SNF-STPs, and community-based residential options, as well as expanding supportive housing and intensive outpatient services for individuals with complex needs. These strategies directly align with Phase I data showing delays related to placement availability and service linkage. DBH will also continue implementing and expanding diversion-focused programs designed to reduce involuntary detention, conservatorship, and justice-related pathways into institutional care. Programs such as CARE Act implementation, Recovery-Based Engagement Support Teams (RBEST), Mental Health Court, and Forensic Assertive Community Treatment (FACT) provide intensive, community-based engagement and treatment to individuals with serious mental illness who might otherwise experience repeated hospitalization or custodial placement. In preparation for Phase II measurable targets, DBH is reviewing local indicators such as discharge-to-community timelines, diversion program enrollment rates, crisis stabilization outcomes, and placement transition tracking. These structured reviews, conducted in collaboration with cross-system partners, will support the establishment of quantifiable benchmarks once statewide Phase II metrics are operationalized. Workforce development, culturally responsive service delivery, and strengthened cross-system collaboration with hospitals, courts, long-term care providers, housing systems, and Managed Care Plans will further support timely transitions and sustained community placement. Collectively, these strategies are intended to reduce reliance on institutional settings, shorten lengths of stay where clinically appropriate, and improve equitable access to community-based alternatives. As Phase II measures become available, DBH will formalize measurable improvement targets aligned with statewide benchmarks and integrate ongoing local monitoring processes to support continuous quality improvement and accountability.

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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

Above

For juveniles

Below

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

Age
Gender
Race or Ethnicity

Justice-Involvement: Supplemental Measures

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

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

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

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
Review of California Department of Health Care Services (DHCS) justice involvement measures indicates disparities across age, race, ethnicity, and gender, based on analysis of adult arrest rates, adult recidivism conviction rates, youth arrest indicators, and Incompetent to Stand Trial (IST) measures. According to the DHCS justice involvement reporting framework, San Bernardino County's adult arrest rates and adult recidivism conviction rates are higher than the statewide median, indicating comparatively elevated levels of justice system contact among adults relative to statewide performance. In contrast, youth arrest indicators and IST measures perform more favorably when compared to statewide benchmarks. Demographic stratification of arrest and recidivism data shows higher rates of justice involvement among adults ages 18–39, particularly males, with disproportionate representation among African American, Hispanic/Latino, and Caucasian populations. Supplemental recidivism conviction data indicate elevated rates among adults ages 20–39, with Latino males particularly impacted. While disparity data are limited for certain youth measures, available information suggests that adult populations, especially young to middle-aged adults, experience higher rates of justice contact and repeat involvement. This analysis was

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informed by DHCS-referenced Phase I justice involvement measures, including arrest and recidivism indicators. Phase I measures were designed to establish statewide baseline conditions and identify patterns of justice system contact among individuals with behavioral health needs. In alignment with the planning intent of Phase I reporting, these baseline comparisons were used to identify demographic disparities and inform prioritization of diversion, treatment, and reentry-focused system improvement strategies within the Integrated Plan.

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)

Beginning July 1, 2026, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand justice-involved behavioral health strategies aimed at reducing arrests, lowering recidivism, and decreasing reliance on custodial settings for individuals with mental health and substance use needs. These efforts respond directly to Phase I data showing adult arrest and recidivism rates above statewide averages and demographic patterns indicating disproportionate justice involvement among young and middle-aged adults, particularly males and select racial and ethnic populations. The County's approach is grounded in Phase I justice involvement measures, which were used to identify baseline disparities and guide the expansion of diversion programming, forensic behavioral health services, and reentry coordination efforts. While Phase I establishes comparative performance gaps, Phase II measures are expected to introduce additional outcome-focused metrics that will support the establishment of measurable improvement targets related to reduced justice contact, improved treatment engagement during supervision, and sustained behavioral health stability following reentry. In anticipation of Phase II implementation, DBH is strengthening structured data review and cross-system collaboration with the Sheriff's Department, Probation, the Superior Court, Managed Care Plans, and community-based organizations. Local operational indicators, including diversion program enrollment, treatment engagement during probation, court compliance support utilization, reentry linkage timelines, and retention in community-based services, are being reviewed collaboratively to build infrastructure for measurable target setting once statewide Phase II benchmarks are finalized. DBH will continue to enhance diversion-focused and forensic behavioral health services that provide treatment-centered alternatives to incarceration. Programs such as Adult Forensic Services, Mental Health Court, and Forensic Assertive Community Treatment (FACT) deliver coordinated treatment, case management, and court-based support

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for adults with serious mental illness who are on probation or participating in specialty court programs. These services are designed to address underlying behavioral health needs identified through Phase I arrest and recidivism data and to reduce repeat justice contact. DBH's Clubhouse programs further support justice-involved individuals by providing recovery-oriented engagement in partnership with Probation and community organizations. Through collaboration on initiatives such as shelter court sessions, community wellness events, and the Multidimensional Anti-Recidivism Partnership (MAP), Clubhouses support compliance, vocational development, and connection to social services. Transportation assistance, peer support, and on-site probation check-ins reduce logistical barriers that can contribute to technical violations and support sustained engagement in behavioral health care. For youth, DBH will continue collaboration with juvenile justice partners through programs such as the Forensic Adolescent Services Team (FAST) and Integrated New Family Opportunities (INFO), which provide therapy, supervision, and family-centered supports for detained and recently released youth. Although youth arrest rates perform more favorably compared to statewide benchmarks, these services support early intervention and prevention of deeper justice system involvement. Additionally, DBH will expand coordination with Community Assistance, Recovery, and Empowerment Act (CARE) Act implementation and Recovery-Based Engagement Support Teams (RBEST) to provide voluntary engagement and civil pathways for individuals with untreated serious mental illness who are at risk of justice system involvement. These programs strengthen early identification and diversion before behavioral health crises escalate into arrest or incarceration. Collectively, these strategies are intended to reduce arrests, decrease recidivism, and improve treatment continuity for justice-involved individuals, particularly among populations disproportionately represented in Phase I data. As Phase II measures become operationalized, DBH will establish measurable improvement targets aligned with statewide justice and behavioral health priorities and integrate ongoing cross-system monitoring to support sustained performance improvement and accountability.

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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?
Not Applicable

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

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?
Above

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

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

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Review of child welfare and behavioral health measures indicates disparities in the removal of children from the home across age, race and ethnicity, gender, and developmental stage. This analysis is based on data from the California Child Welfare Indicators Project (CCWIP) and California Department of Health Care Services (DHCS) Specialty Mental Health Services (SMHS) penetration measures. San Bernardino County shows higher rates of children in foster care across multiple age groups, with disproportionate representation among African American, Latino, Native American, and Caucasian children. CCWIP indicators demonstrate elevated rates of foster care entry among infants and young children under age five, as well as among school-aged children and transition-age youth. Supplemental maltreatment substantiation data indicate higher incidence rates among infants and toddlers, particularly among African American and Native American children, with females disproportionately represented in substantiated cases. Behavioral health–specific data further show variation in SMHS penetration rates among children and youth with open child welfare cases, particularly among children ages 6–17 and among African American and Caucasian populations. These findings suggest that behavioral health needs among children and caregivers may not always be identified or addressed early enough to prevent escalation to child welfare involvement or placement instability. This analysis was informed by DHCS-referenced Phase I measures, including CCWIP indicators related to entry into foster care, placement type, length of stay, and maltreatment substantiations, as well as SMHS penetration data for children with child welfare involvement. Phase I measures establish baseline disparity patterns and were used to guide prioritization of prevention, early intervention, and cross-system coordination strategies within the Integrated Plan. While Phase I data identifies demographic variation and service access gaps, Phase II measures are anticipated to introduce additional outcome-focused indicators related to prevention effectiveness, timely service engagement, placement stability, and successful reunification. Although DBH does not determine child removal decisions, the observed disparities underscore the importance of strengthening behavioral health prevention, caregiver engagement, and coordinated service delivery to reduce risk factors associated with removal and improve family stability outcomes.

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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

Beginning July 1, 2026, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and align behavioral health strategies that support child and family stability and reduce behavioral health–related risk factors associated with removal from the home. These efforts directly respond to Phase I

data identifying disparities in foster care entry, maltreatment substantiation, and behavioral health service engagement among infants, young children, and racial and ethnic populations disproportionately represented in child welfare involvement. The County's approach is grounded in Phase I child welfare and behavioral health measures, which were used to identify baseline disparities and inform the expansion of prevention and early intervention strategies, caregiver-focused treatment pathways, and cross-system coordination with Children and Family Services (CFS). While Phase I measures establish patterns of foster care entry and behavioral health penetration, Phase II measures are expected to introduce additional outcome-based metrics to support the development of measurable improvement targets for timely service access, prevention effectiveness, placement stability, and reunification support. In anticipation of Phase II implementation, DBH is strengthening structured data-sharing and case coordination processes with CFS, Managed Care Plans, Public Health, and educational partners to monitor referral-to-service timelines, caregiver engagement rates, and behavioral health penetration among families at risk of removal. Local operational indicators, including early intervention referrals, parent participation in behavioral health treatment, coordinated care planning activities, and service continuity during placement, are being reviewed collaboratively to build infrastructure for measurable goal-setting once statewide Phase II benchmarks are finalized. DBH will focus on expanding prevention and early intervention services for children, youth, and caregivers, particularly during the prenatal period and early childhood, when Phase I data indicate elevated risk of maltreatment and removal. Through collaboration with CFS and community-based organizations, DBH will strengthen referral pathways for mental health and substance use services for parents and caregivers involved with or at risk of child welfare involvement. These efforts prioritize timely access to treatment addressing parental behavioral health conditions, parenting stress, trauma exposure, and substance use disorders—factors that contribute to removal risk. To address disparities among school-aged children and youth with open child welfare cases, DBH will continue strengthening access to Specialty Mental Health Services through school-linked services, outpatient treatment, and coordinated care planning with CFS and educational partners. Targeted engagement strategies will focus on improving continuity of care and culturally responsive service delivery for families disproportionately represented in Phase I foster care and substantiation data. DBH will also enhance cross-system coordination to support placement stability and timely reunification when removal occurs. This includes improved information sharing and collaborative case planning with CFS, Probation, Managed Care Plans, and community providers to ensure children and caregivers receive appropriate behavioral health supports during investigation, placement, and reunification phases. Partnerships with Tribal programs and Native American–serving organizations will be strengthened to address disparities among Native American children and families and to support culturally responsive prevention and engagement strategies. Collectively, these strategies are intended to reduce behavioral health–related risk factors associated with child removal, improve timely access to prevention and treatment services, and strengthen family stability outcomes. As Phase II measures become operationalized, DBH will establish measurable improvement targets aligned with statewide child welfare and behavioral health priorities and integrate ongoing cross-system monitoring processes to support sustained performance improvement and accountability.

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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

Below

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

No Disparities Data Available

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

Above

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

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
Above

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

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
Review of California Department of Health Care Services (DHCS) Untreated Behavioral Health Conditions measures identified disparities across select age, race, and ethnicity, and gender groups, based on demographic stratification of service utilization and outcome data. While Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) exceeded the statewide rate, San Bernardino County performed below the statewide average for Follow-Up After Emergency Department Visit for Substance Use (FUA-30) and for the supplemental measure capturing adults who reported needing help for emotional or mental health conditions or substance use but had no related visits in the past year. Stratified data for the supplemental unmet-need measure showed higher rates of untreated behavioral health conditions among adults aged 65 and older, young adults aged 18–24, Asian and Latino populations, and females. These findings suggest variation in engagement and continuity of care following identification of a behavioral health need, particularly outside emergency or acute settings. This analysis was informed by DHCS Phase I measures, including FUA-30, FUM-30, and the unmet-need indicator, which establish baseline conditions and identify demographic disparities in follow-up and service engagement. Phase I measures were used to guide prioritization of outreach, engagement, and follow-up strategies within the Integrated Plan. While these measures highlight current performance gaps, Phase II measures are anticipated to introduce additional outcome-focused metrics to support the development of more specific, measurable

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improvement targets for timely follow-up, treatment initiation, and reduction of untreated behavioral health conditions across priority populations. Although the data does not independently identify underlying drivers of unmet need, the observed variation across age, race, ethnicity, and gender underscores the importance of strengthening continuity of care, proactive outreach, and culturally responsive engagement strategies to reduce untreated conditions and improve timely access to services.

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)

Beginning July 1, 2026, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand strategies aimed at reducing untreated behavioral health conditions by improving engagement following crisis encounters, increasing continuity of care after emergency department visits, and expanding prevention-oriented and community-based service pathways for populations with higher unmet needs. These efforts directly respond to DHCS measures where the County performs below the statewide average, including Follow-Up After Emergency Department Visit for Substance Use (FUA-30) and population-level indicators of untreated mental health and substance use conditions. The County's approach is grounded in Phase I measures, which were used to identify disparities in follow-up engagement and unmet need among older adults, young adults, and select racial and ethnic populations. While Phase I establishes baseline performance and highlights areas of disparity, Phase II measures are expected to introduce additional outcome-based metrics that will enable the County to establish clearer, measurable improvement targets linked to follow-up timeliness, treatment initiation, and the reduction of untreated behavioral health conditions. In anticipation of Phase II implementation, DBH is strengthening structured data-sharing and monitoring processes with Managed Care Plans, including Inland Empire Health Plan (IEHP), and hospital partners to track near-real-time follow-up after emergency department visits. Through participation in the Behavioral Health Collaborative led by the Institute for Healthcare Improvement in partnership with the California Department of Health Care Services, DBH is working to improve performance on both FUA-30 and FUM-30 measures. Staff within the Substance Use Disorder and Recovery Services (SUDRS) Access Line and the Screening, Assessment, and Referral Center (SARC) receive near-real-time data identifying individuals who experienced a substance use–related emergency department visit, enabling timely outreach and proactive linkage to treatment. To support measurable performance improvement, DBH is reviewing local operational indicators, including outreach completion rates, referral-to-assessment timelines, treatment initiation tracking, and engagement retention following emergency department visits.

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These local data points are being reviewed collaboratively with Managed Care Plans and service providers to build infrastructure for measurable goal-setting once Phase II benchmarks are finalized. To address capacity-related barriers contributing to untreated substance use conditions, DBH will expand the SUDRS network of care over the three-year Integrated Plan period, including increased adult and adolescent outpatient and residential treatment capacity to reduce delays in access to Drug Medi-Cal Organized Delivery System (DMC-ODS) services. These strategies directly align with disparities identified through FUA-30 and unmet-need measures by improving timely entry into treatment following identification of substance use conditions. DBH will also increase outreach and engagement for populations experiencing higher levels of untreated behavioral health conditions, including individuals in rural and geographically isolated areas of the county. Targeted outreach campaigns, deployment of the Mobile Outreach vehicle, and telehealth services, where clinically appropriate, will reduce geographic and transportation barriers to care. Additionally, DBH will expand the scope of work for its Promotores de Salud/Community Health Workers Program to include targeted outreach to individuals identified through data as experiencing higher unmet need. Promotores and Community Health Workers will provide culturally responsive education, navigation, and linkage support for populations demonstrating lower follow-up engagement or reduced access to care. Complementing these efforts, the County's Office of Suicide Prevention and population-based behavioral health initiatives will continue to promote early identification, reduce stigma, and increase community awareness of available treatment pathways before conditions escalate into crisis or prolonged untreated states. Collectively, these strategies are intended to improve follow-up after emergency department visits, reduce unmet need, and strengthen continuity of care across the behavioral health continuum. As Phase II measures become operationalized, DBH will establish measurable improvement targets aligned with statewide benchmarks and integrate ongoing local data monitoring to support sustained performance improvement and accountability.

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File Upload

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
Above

For children/youth
Below

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

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

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For adults/older adults
Above

For children/youth
Below

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?
Same

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?
Not Applicable

Student Chronic Absenteeism Rate (Data Quest), 2022

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

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

DRAFT

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?
Above

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
Not Applicable

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

DRAFT

For children/youth
Not Applicable

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)
Above

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)
Below

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

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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
Above

For adults/older adults
Above

For children/youth
Above

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
Not Applicable

DRAFT

For adults/older adults
Same

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?
Not Applicable

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
Below

For adults/older adults
Not Applicable

DRAFT

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.
Suicides
Overdoses

Overdoses

Please describe why this goal was selected
San Bernardino County selected overdose reduction as an additional priority goal based on local and statewide overdose trends, demographic disparities, and stakeholder input gathered through the Integrated Plan development process. Phase I data indicate that the County's rate of all drug-related overdose deaths (26.9 per 100,000) is slightly below the statewide rate of 28.8 per 100,000. Similarly, the County's rate of overdose-related emergency department (ED) visits (127.3 per 100,000) performs more favorably compared to the statewide rate of 143.8 per 100,000. While these comparative rates reflect performance below the statewide average, demographic stratification reveals concentrated disparities among specific populations that warrant focused intervention. Age-specific data demonstrate elevated overdose mortality among adults ages 25–69, with particular concentration among individuals ages 30–59. Racial and ethnic disparities are evident, with African American and Caucasian populations disproportionately represented. Males are consistently overrepresented in both overdose deaths and ED visits. Although overall county rates are comparatively favorable, the presence of concentrated disparities, particularly among adult males ages 25–69 in select racial and ethnic groups, supports the County's decision to prioritize overdose prevention within the Integrated Plan. Phase II measures are anticipated to introduce additional outcome-focused indicators related to treatment initiation following overdose, continuity of medication-assisted treatment (MAT), and reduction of repeat overdose events, which will further guide measurable improvement targets.

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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

Analysis of overdose-related measures identified disparities across age, race and ethnicity, gender, and geography. For all drug-related overdose deaths, elevated rates were observed among adults ages 25–69, particularly within the 30–59 age range. African American and Caucasian populations were disproportionately represented, and males experienced significantly higher mortality rates compared to females. For overdose-related emergency department (ED) visits, elevated rates were observed among young adults and middle-aged adults, including ages 15–44, with notable variation among males and among Caucasian and African American populations. ED visit patterns suggest ongoing risk among both youth and working-age adults, highlighting the need for both prevention and post-overdose engagement strategies. Geographic analysis conducted in partnership with the San Bernardino County Department of Public Health identified clusters of elevated overdose activity within rural desert and mountain regions. Data derived from Reddinet infrastructure and reviewed through the Inland Empire Opioid Crisis Coalition (IEOCC) revealed that communities with limited access to emergency services and treatment providers experienced higher overdose burden relative to surrounding areas. These findings underscore the role of geographic isolation, transportation barriers, and limited healthcare access as structural contributors to overdose risk. Phase I data establish baseline mortality and ED utilization patterns and identify demographic and geographic disparities. While these measures reflect outcome trends, Phase II metrics are anticipated to introduce additional indicators related to follow-up care after overdose events, initiation and retention in medication-assisted treatment, and repeat overdose reduction.

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 Overdoses 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, the San Bernardino County Department of Behavioral Health (DBH) will strengthen and expand a comprehensive overdose prevention and response strategy focused on harm reduction, targeted outreach, treatment expansion, and cross-system coordination. These efforts directly respond to Phase I data identifying elevated overdose risk among adult males ages 25–69, African American and Caucasian populations, and residents of rural desert and mountain communities. The County's approach is grounded in Phase I overdose mortality and emergency department (ED) visit measures, which were used to identify demographic and geographic disparities and guide prioritization of targeted interventions. While Phase I establishes baseline patterns, Phase II measures are expected to support measurable improvement targets related to post-overdose follow-up, medication-assisted treatment (MAT) initiation and retention, and reduction of repeat overdose events. To address disparities among adult males ages 25–69, DBH will implement a targeted outreach and media campaign focused on opioid overdose risk awareness, stigma reduction, and connection to treatment and harm reduction resources. Messaging will be tailored to

DRAFT

populations disproportionately represented in mortality data and will leverage partnerships with recovery communities, faith-based organizations, and local cities. To address geographic disparities in rural desert and mountain communities, DBH has procured high-dose (8 mg) intranasal naloxone in addition to the standard 4 mg dose distributed through the Naloxone Distribution Project. Distribution prioritizes communities with delayed emergency response times or limited access to acute medical services. Naloxone distribution will be paired with education, overdose recognition training, and linkage-to-treatment materials. DBH is currently recruiting for a Behavioral Health Physician II to provide direct field-based services aboard the Mobile Wellness Outreach Unit. This expansion of medical capacity will strengthen medication-assisted treatment access, provide low-barrier buprenorphine initiation in the field, and improve linkage for unhoused individuals and rural residents with opioid use disorder. This strategy directly responds to the geographic clustering of overdose events identified through Inland Empire Opioid Crisis Coalition (IEOCC) and Public Health data review. DBH will continue expanding access to medication-assisted treatment and opioid treatment programs (OTPs), increasing enrollment capacity and strengthening retention supports for individuals with opioid use disorder. Local operational indicators, including medication-assisted treatment (MAT) initiation rates, referral-to-treatment timelines following overdose events, and engagement retention, will be monitored collaboratively with Managed Care Plans and providers in preparation for Phase II measurable benchmarks. Partnerships remain central to the County's overdose strategy. DBH collaborates closely with the Department of Public Health in the development of the Overdose Prevention Dashboard (ODASH), which supports real-time monitoring of overdose trends. The Inland Empire Opioid Crisis Coalition, comprised of over 100 community-based organizations, supports cross-sector coordination and data review. Additional partners include the San Bernardino County Sheriff's Department, the Inland Counties Emergency Medical Agency (ICEMA), contracted treatment providers, and emergency response agencies. To strengthen data-to-field alignment, DBH will support inclusion of field-based service providers within the IEOCC Data Committee to enhance real-time coordination between overdose trend analysis and outreach deployment. Strengthened engagement with faith-based organizations, recovery communities, and local municipalities will further enhance prevention reach. Collectively, these strategies are intended to reduce overdose mortality, decrease overdose-related ED visits, improve equitable access to treatment, and address geographic and demographic disparities identified in Phase I data. As Phase II measures are operationalized, DBH will establish measurable improvement targets aligned with statewide overdose-reduction priorities and integrate ongoing local monitoring processes to support sustained performance improvement and accountability.

DRAFT

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

2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe other
Opioid Settlement Funding

Suicides

Please describe why this goal was selected
San Bernardino County selected suicide as an additional priority goal due to its significant public health impact, local data trends, and input gathered through a structured internal and external community program planning process. As part of Integrated Plan development, the County engaged internal behavioral health partners and community stakeholders to review statewide behavioral health goals, examine local and statewide data, and identify priority areas for focused improvement. Participants were provided with an overview of statewide goals, Phase I baseline measures, and locally stratified suicide-related data. Through this process, suicide emerged as the top additional priority based on both quantitative indicators and stakeholder concern regarding suicide mortality and non-fatal self-harm trends within the County. Phase I data from the California Comprehensive Death File indicate that San Bernardino County's suicide death rate of 11.2 per 100,000 slightly exceeds the statewide rate of 11.0 per 100,000. Emergency department data further demonstrate elevated rates of non-fatal self-harm among youth and young adults. These measures establish baseline performance and demographic variation and informed the County's decision to prioritize suicide prevention strategies within the Integrated Plan. While Phase I measures provide comparative baseline rates of suicide mortality and self-harm, Phase II measures are anticipated to introduce additional outcome-focused metrics related to follow-up after crisis encounters, treatment engagement following self-harm events, and reduction of repeat attempts. The County's selection of suicide as a priority goal reflects both current performance patterns and a commitment to strengthening measurable prevention and follow-up outcomes as Phase II metrics become operationalized.

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
Analysis of suicide-related measures identified disparities across age, race and ethnicity, and gender, based on review of suicide deaths and non-fatal emergency department (ED) visits due to self-harm. Suicide death rates were highest among individuals ages 25–44, 45–64, and 65–84, with Caucasian males disproportionately represented across these age groups. These findings indicate elevated risk for suicide mortality among middle-aged and older adult males. In contrast, non-fatal ED visits for self-harm were most prevalent among youth and young adults ages 10–14, 15–19, 20–24, and 25–44. Within these age groups, females were disproportionately represented, with higher rates observed among Caucasian and African American populations. This divergence between suicide deaths and self-harm injuries highlights differing risk profiles across demographic groups and underscores the importance of age- and

DRAFT

gender-responsive prevention and intervention strategies. This analysis was informed by DHCS-referenced Phase I measures, including suicide mortality data from the California Comprehensive Death File and ED visit data for non-fatal self-harm. Phase I measures establish baseline patterns of mortality and injury and were used to guide prioritization of targeted prevention, outreach, crisis response, and follow-up strategies within the Integrated Plan. While Phase I data identify elevated-risk populations and comparative performance relative to statewide benchmarks, Phase II measures are anticipated to introduce additional outcome-oriented indicators related to follow-up timeliness, linkage to ongoing care after self-harm events, and reduction of repeat crisis episodes. Although the measures reflect different points along the suicide prevention continuum, together they provide a comprehensive baseline for identifying disparities and strengthening coordinated prevention, early intervention, and post-crisis engagement efforts.

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 Suicides 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, the San Bernardino County Department of Behavioral Health (DBH) will continue to strengthen a comprehensive, data-informed suicide prevention strategy that addresses both suicide mortality and non-fatal self-harm. These efforts are coordinated through the County's Office of Suicide Prevention (OSP) and directly respond to Phase I data showing elevated suicide mortality among middle-aged and older adult males and higher rates of self-harm among youth and young adult females. The County's suicide prevention approach is grounded in Phase I measures, which were used to identify demographic disparities and guide prioritization of community training, targeted outreach, crisis response coordination, and follow-up engagement strategies. While Phase I measures establish baseline mortality and injury rates, Phase II measures are expected to introduce additional outcome-based metrics that will support the establishment of measurable improvement targets related to follow-up continuity, linkage to outpatient services after crisis encounters, and reduction of repeat self-harm events. In anticipation of Phase II implementation, DBH is strengthening structured data-sharing and monitoring processes with emergency departments and Managed Care Plans, including Inland Empire Health Plan. Through timely notification of non-fatal self-harm emergency department (ED) visits, DBH supports rapid outreach, care coordination, and linkage to ongoing treatment services. Local operational indicators, including outreach completion rates following ED visits, referral-to-treatment timelines, engagement retention in outpatient services, and geographic distribution of training deployment, are being reviewed collaboratively to build infrastructure for measurable target setting once statewide Phase II benchmarks are finalized. DBH will expand population-based prevention strategies through OSP, including countywide public awareness campaigns, community training initiatives, and data monitoring. Free safeTALK and applied suicide intervention skills training (ASIST) trainings will continue to be offered to schools, law enforcement, faith-based organizations, healthcare providers, and community partners, with deployment prioritized in geographic areas and populations identified through Phase I suicide and self-harm data. These strategies aim to increase early identification of suicide risk, strengthen community response capacity, and reduce

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stigma associated with help-seeking. To address disparities among youth and young adults, DBH will continue strengthening school-linked behavioral health services, trauma-informed supports, and referral pathways in collaboration with local education agencies and youth-serving organizations. For older adults and middle-aged males, targeted outreach will emphasize social connection, culturally responsive engagement, screening, and timely access to behavioral health care. Suicide prevention strategies will also be integrated into broader behavioral health initiatives addressing untreated conditions, substance use, and crisis response. Cross-system collaboration with Public Health, hospitals, Managed Care Plans, and community-based organizations will support coordinated prevention, postvention, and referral efforts across the continuum of care. Collectively, these strategies are intended to reduce suicide mortality, decrease non-fatal self-harm injuries, and address demographic disparities identified through Phase I data. As Phase II measures become operationalized, DBH will establish measurable improvement targets aligned with statewide suicide prevention priorities and integrate ongoing local data monitoring to support sustained performance improvement and accountability.

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

BHSA BHSS

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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
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
1/6/2026

Type of engagement
Focus group discussions

DRAFT

Date
1/27/2026

Type of engagement
Focus group discussions

Date
1/28/2026

Type of engagement
Focus group discussions

Date
2/11/2026

Type of engagement
Focus group discussions

Date
2/19/2026

Type of engagement
Focus group discussions

Date
2/25/2026

Type of engagement
Key informant interviews with subject matter experts

Date
6/6/2025

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Type of engagement
Meeting(s) with county

Date
1/9/2025

Type of engagement
Meeting(s) with county

Date
1/13/2025

Type of engagement
Meeting(s) with county

Date
1/14/2025

Type of engagement
Meeting(s) with county

Date
1/15/2025

Type of engagement
Meeting(s) with county

Date
1/16/2025

Type of engagement
Meeting(s) with county

DRAFT

Date
1/19/2025

Type of engagement
Meeting(s) with county

Date
1/21/2025

Type of engagement
Meeting(s) with county

Date
1/22/2025

Type of engagement
Meeting(s) with county

Date
1/24/2025

Type of engagement
Meeting(s) with county

Date
1/28/2025

Type of engagement
Meeting(s) with county

Date
1/29/2025

DRAFT

Type of engagement
Meeting(s) with county

Date
1/30/2025

Type of engagement
Meeting(s) with county

Date
2/6/2025

Type of engagement
Meeting(s) with county

Date
2/12/2025

Type of engagement
Meeting(s) with county

Date
2/20/2025

Type of engagement
Meeting(s) with county

Date
4/2/2025

Type of engagement
Meeting(s) with county

DRAFT

Date
4/17/2025

Type of engagement
Meeting(s) with county

Date
5/7/2025

Type of engagement
Meeting(s) with county

Date
5/15/2025

Type of engagement
Meeting(s) with county

Date
6/4/2025

Type of engagement
Meeting(s) with county

Date
7/2/2025

Type of engagement
Meeting(s) with county

Date
7/17/2025

DRAFT

Type of engagement
Meeting(s) with county

Date
8/6/2025

Type of engagement
Meeting(s) with county

Date
8/21/2025

Type of engagement
Meeting(s) with county

Date
9/3/2025

Type of engagement
Meeting(s) with county

Date
10/23/2025

Type of engagement
Meeting(s) with county

Date
11/19/2025

Type of engagement
Meeting(s) with county

DRAFT

Date
12/2/2025

Type of engagement
Meeting(s) with county

Date
12/11/2025

Type of engagement
Meeting(s) with county

Date
12/13/2025

Type of engagement
Meeting(s) with county

Date
1/17/2026

Type of engagement
Meeting(s) with county

Date
1/20/2026

Type of engagement
Meeting(s) with county

Date
1/22/2026

DRAFT

Type of engagement
Meeting(s) with county

Date
1/26/2026

Type of engagement
Provided data to county

Date
1/16/2025

Type of engagement
Provided data to county

Date
2/20/2025

Type of engagement
Provided data to county

Date
4/2/2025

Type of engagement
Provided data to county

Date
4/17/2025

Type of engagement
Provided data to county

DRAFT

Date
5/7/2025

Type of engagement
Provided data to county

Date
5/15/2025

Type of engagement
Provided data to county

Date
6/4/2025

Type of engagement
Provided data to county

Date
7/17/2025

Type of engagement
Provided data to county

Date
8/21/2025

Type of engagement
Provided data to county

Date
9/18/2025

DRAFT

Type of engagement
Provided data to county

Date
10/16/2025

Type of engagement
Provided data to county

Date
10/23/2025

Type of engagement
Provided data to county

Date
11/20/2025

Type of engagement
Meeting(s) with county

Date
12/18/2025

Type of engagement
Meeting(s) with county

Date
1/15/2026

Type of engagement
Public e-mail inbox submission

DRAFT

Date
3/26/2025

Type of engagement
Public e-mail inbox submission

Date
4/30/2025

Type of engagement
Public e-mail inbox submission

Date
7/30/2025

Type of engagement
Public e-mail inbox submission

Date
9/10/2025

Type of engagement
Public e-mail inbox submission

Date
10/6/2025

Type of engagement
Public e-mail inbox submission

Date
10/14/2025

DRAFT

Type of engagement
Public e-mail inbox submission

Date
10/23/2025

Type of engagement
Survey participation

Date
4/17/2025

Type of engagement
Survey participation

Date
7/17/2025

Type of engagement
Survey participation

Date
9/18/2025

Type of engagement
Survey participation

Date
11/20/2025

Type of engagement
Survey participation

DRAFT

Date
12/18/2025

Type of engagement
Training, education, and outreach related to community planning

Date
1/16/2025

Type of engagement
Training, education, and outreach related to community planning

Date
2/20/2025

Type of engagement
Training, education, and outreach related to community planning

Date
3/6/2025

Type of engagement
Training, education, and outreach related to community planning

Date
4/2/2025

Type of engagement
Training, education, and outreach related to community planning

Date
4/9/2025

DRAFT

Type of engagement
Training, education, and outreach related to community planning

Date
4/17/2025

Type of engagement
Training, education, and outreach related to community planning

Date
5/15/2025

Type of engagement
Training, education, and outreach related to community planning

Date
6/18/2025

Type of engagement
Training, education, and outreach related to community planning

Date
7/2/2025

Type of engagement
Training, education, and outreach related to community planning

Date
7/17/2025

Type of engagement
Training, education, and outreach related to community planning

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Date
7/25/2025

Type of engagement
Training, education, and outreach related to community planning

Date
8/6/2025

Type of engagement
Training, education, and outreach related to community planning

Date
8/21/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/18/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/16/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

DRAFT

Type of engagement
Workgroups and committee meetings

Date
10/6/2025

Type of engagement
Workgroups and committee meetings

Date
10/9/2025

Type of engagement
Workgroups and committee meetings

Date
10/15/2025

Type of engagement
Workgroups and committee meetings

Date
10/28/2025

Type of engagement
Workgroups and committee meetings

Date
11/12/2025

Type of engagement
Workgroups and committee meetings

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Date
11/20/2025

Type of engagement
Workgroups and committee meetings

Date
1/12/2026

Type of engagement
Workgroups and committee meetings

Date
1/13/2026

Type of engagement
Workgroups and committee meetings

Date
1/14/2026

Type of engagement
Workgroups and committee meetings

Date
1/15/2026

Type of engagement
Workgroups and committee meetings

Date
1/20/2026

DRAFT

Type of engagement
Workgroups and committee meetings

Date
1/21/2026

Type of engagement
Workgroups and committee meetings

Date
1/22/2026

Type of engagement
Workgroups and committee meetings

Date
1/26/2026

Type of engagement
Workgroups and committee meetings

Date
1/27/2026

Type of engagement
Workgroups and committee meetings

Date
1/28/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Stakeholder groups/organizations that we have engaged includes but is not limited to: Foster Care Advisory Council, San Bernardino County (SBC) Department of Behavioral Health (DBH) Consumer and Family Awareness Committee, SBC DBH Native American Subcommittee, SBC DBH Older Adults Awareness Subcommittee, SBC DBH African American Awareness Subcommittee, SBC DBH Women's Awareness Subcommittee, Pinnacle Treatment Center (Drug Rehab), Morongo Band of Indians, various San Bernardino

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County Department of Behavioral Health Substance Use Disorder and Recovery Services (SUDRS) contracted providers, San Bernardino County Department of Public Health (DPH), Inland Empire Health Plan (IEHP), Molina Health Plan, San Bernardino Valley College Veterans Resource Center and Office of Student Life, San Bernardino Behavioral Health Commission (All Districts Countywide), San Bernardino County Probation, San Bernardino County Children and Family Services, San Bernardino County Transitional Assistance Department, San Bernardino County Department of Aging and Adult Services, San Bernardino County Office of Homeless Services, San Bernardino Unified School District, Ontario-Montclair Unified School District Health & Wellness Services, Teamsters Local 1932, Arrowhead Regional Medical Center (ARMC), Sedgwick-Disability Insurer, Young Visionaries Youth Leadership Academy, Kiwanis Club-Redlands, Kiwanis Club-Victorville, Inland Christian Home – Ontario, Morongo Basin Health District, Children Resource Center (CCRC), VA Loma Linda Health Care, Diocese of San Bernardino-Office of Community Services and Outreach program, Patria Church Rancho Cucamonga, African American Health Coalition – Champion Mzazi (Parents) – Effective Black Parenting Program, Fontana Foundation of Hope, Planned Parenthood of Orange and San Bernardino, The Mom and Dad Project, West End Family Counseling Services, Rim Family Services, Inc., Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), Inland Behavioral and Health Services, Inc. (IBHS), Autism Society-Inland Empire, Inland Regional Center, SBC Sheriff's Department

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
1	San Bernardino
2	Fontana
3	Ontario
4	Rancho Cucamonga
5	Victorville

Were you able to engage all required stakeholders/groups in the planning process?
No

DRAFT

If not, which required stakeholder/groups were you unable to engage in the planning process?

Emergency medical services

Emergency medical services

Attempted but did not receive a response

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

The San Bernardino County Department of Behavioral Health (DBH) incorporates diverse stakeholder viewpoints into the development of its Integrated Plan through a comprehensive engagement process led by the Behavioral Health Services Act (BHSA) Administration team. This process ensures that community-identified strengths, needs, and priorities are reflected in planning and decision-making. DBH actively participates in state-led meetings, conferences, and trainings to remain informed about Proposition 1 and the Behavioral Health Transformation (BHT). This information is translated into customized trainings and presentations designed to educate stakeholders and invite meaningful feedback, which directly informs program development and service improvements. The cornerstone of this engagement is the Community Policy Advisory Committee (CPAC), coordinated by BHSA Administration and held monthly on the third Thursday. CPAC serves as an open community forum, drawing diverse participants including individuals with lived experience, family members, community-based organizations, cultural and linguistic groups, and county agencies. Outreach to encourage participation targets these groups through emails, phone calls, community events, the DBH website, departmental announcements, and social media. During 2025, DBH hosted 10 CPAC meetings with a total of 762 attendees and collected 347 completed surveys. CPAC meetings provide education on the Mental Health Services Act (MHSA) Annual Plan and Update, the Community Program Planning (CPP) process, and Behavioral Health Transformation. Additionally, CPAC meetings include BHSA education and discussions on changes in program identification and service delivery, ensuring stakeholders understand evolving priorities and have opportunities to provide input. Real-time and written feedback is collected through live polling and online or paper surveys, which are essential to the CPP process. Including CPAC, DBH conducted a total of 132 meetings to ensure broad and inclusive engagement. These meetings included focus groups, key informant interviews, county meetings, work groups and committee meetings, training and outreach sessions, public email inbox submissions, and survey participation. The CPP process was shared across a variety of stakeholder groups, including LGBTQ+ individuals, older adults, Transitional Age Youth (TAY), families, and community members with lived experience, ensuring that diverse perspectives were incorporated into planning. Through these efforts, DBH identified three priority themes from stakeholder engagement: Housing and Homelessness Integration; Access to Services and Infrastructure; and Outreach, Education, and Engagement. These priorities were analyzed and incorporated into the Integrated Plan through targeted strategies and program adjustments, ensuring stakeholder perspectives directly influence service

DRAFT

delivery improvements. Documentation supporting these activities, including CPAC meeting minutes, survey summaries, outreach records, and notes from focus groups and key informant interviews, is attached and available for review. As of January 2026, DBH continues to expand its community planning efforts using a variety of engagement strategies to ensure inclusive and meaningful participation. Engagement activities will occur through April 2026 and are designed to gather input on local needs, priorities, and opportunities across the behavioral health continuum. Stakeholders will be provided with multiple opportunities to participate and share feedback on the Integrated Plan. Input collected during this period will be analyzed and incorporated into the final BHSA Integrated Plan, to be submitted in June 2026. It will also inform ongoing and future community planning efforts. The required 30-day public comment period and public hearing will be completed before June 2026. The public hearing is tentatively scheduled for April 2.

Upload File
CPAC 2025 Data.pdf

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
The County of San Bernardino collaborated closely with the Local Health Jurisdiction (LHJ) through the Community Vital Signs Initiative, a long-standing, cross-departmental framework jointly led by the Department of Public Health and supported by the Department of Behavioral Health (DBH) and other County departments. This structure provided shared governance, regular coordination, and aligned decision-making throughout the development of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), known as the Community Transformation Plan. DBH has

DRAFT

actively participated in Community Vital Signs since 2011 as a steering committee member and continues to play a key role in both steering and implementation committees. DBH contributed subject-matter expertise in behavioral health, injury and violence prevention, and chronic disease priorities, and worked alongside LHJ to align assessment findings with Countywide strategic priorities. DBH promotes broad stakeholder engagement by sharing participation opportunities with over 800 stakeholders via distribution lists, including MHSA stakeholders, Cultural Competency Advisory Committee members, and DBH clubhouses. Behavioral health consumers were supported through paper surveys and staff assistance at DBH's five clubhouses. In 2023, DBH stakeholders, including consumers and advisory committee members—attended a planning-for-action community engagement meeting to ensure community voices were central to the process, and DBH executive staff also participated. The 2023 assessment identified three health priorities: Behavioral Health, Injury and Violence Prevention, and Chronic Disease, which will guide efforts over the next five years. DBH continues to support implementation by sharing service data, chairing the Behavioral Health implementation group, and aligning efforts with BHSA Integrated Plan requirements. In 2025, LHJ established the MCP/San Bernardino County CHIP Collaboration Meeting to support MCPs (Inland Empire Health Plan, Kaiser, and Molina) in meeting DHCS Population Health Management Policy Guide requirements. DBH's involvement ensures alignment with BHSA goals, strengthens MCP collaboration, and advances behavioral health priorities within the Transformation Plan.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
No

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
Overdoses
Prevention of Co-Occurring Physical Health Conditions
Quality of Life

DRAFT

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
Homelessness
Justice Involvement

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.
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
Other
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.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

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Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP

The County Department of Behavioral Health, in collaboration with Public Health, has actively aligned Integrated Plan (IP) development with broader community health planning efforts. The County coordinated stakeholder activities for IP development with awareness of the Local Health Jurisdiction's (LHJ) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) engagement processes, incorporating relevant findings and stakeholder input where appropriate. As part of this process, the County participated in and reviewed input collected through CHA and CHIP activities, including community surveys, data-sharing initiatives, and planning discussions. This information was considered in establishing behavioral health priorities for the IP. Additionally, the County engaged in planning discussions with the LHJ and Medi-Cal Managed Care Plans to review CHA and CHIP findings and identify areas of intersection with Statewide Behavioral Health Goals. These collaborative efforts supported a shared understanding of priority focus areas and informed ongoing coordination across community health planning and Behavioral Health Services Act IP development. Looking ahead, the County Departments of Behavioral Health and Public Health will co-host a Community Health Forum. This event will guide community-wide and organizational health improvement planning for the CHIP and future IPs, further strengthening alignment and collaboration across health initiatives.

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

The County is aligning its planning efforts with the behavioral health priority area and goals outlined in the Transformation Plan to enhance access to substance use disorder (SUD) services. As part of the Access to Health and Wellness strategy, the County is expanding initiatives to address SUD and opioid use disorders by increasing the availability of Medication-Assisted Treatment (MAT) and implementing harm reduction approaches throughout San Bernardino County.

DRAFT

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

The County engaged with all three Medi-Cal Managed Care Plans (MCPs) operating within the County to support coordination related to community reinvestment planning and decision-making processes. Of the three MCPs, one (Molina) met the income threshold established by the Department of Health Care Services (DHCS) requiring submission of a Community Reinvestment Plan, with the first plan due in early Q3 of calendar year 2026. That MCP is currently in the community reinvestment planning phase and has invited the County Department of Behavioral Health (DBH) to serve as an active participant in the planning process to support alignment of priorities. As planning moves forward, the County and the MCP will work collaboratively to collect and share relevant data and stakeholder input regarding community needs, with the goal of informing future community reinvestment strategies and investment opportunities. The County will continue to coordinate, as appropriate, with all MCPs to support alignment with community planning efforts and the Behavioral Health Services Act Integrated Plan.

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?

At the time of Integrated Plan development, Medi-Cal Managed Care Plan (MCP) Community Reinvestment Plans are in the planning phase and have not yet been finalized or submitted. As such, specific reinvestment activities addressing identified needs are still under development. However, activities anticipated to be included in future MCP Community Reinvestment Plan submissions are being informed by needs identified through the Behavioral Health Services Act (BHSA) community planning process, including priorities and disparities identified through the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and stakeholder engagement supporting the County's Integrated Plan. The County Department of Behavioral Health (DBH) has been invited to participate as an active partner in the MCP's community reinvestment planning process to support alignment of priorities. Through this collaboration, the County and MCP are working to collect and share relevant data and stakeholder input on community behavioral health needs. This coordinated planning approach is intended to inform future community reinvestment activities once MCP plans are finalized and submitted.

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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 .

Date the draft Integrated Plan (IP) was released for stakeholder comment
2/27/2026

Date the stakeholder comment period closed
3/31/2026

Date of behavioral health board public hearing on draft IP
4/2/2026

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
to be added

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
to be added

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File Upload

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

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
to be added

Summarize the substantive revisions recommended this stakeholder during the comment period
to be added

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
to be added

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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.

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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

San Bernardino QI Work Plan 2025.pdf

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

San Bernardino QI Work Plan 2025 (1).pdf

Contracted BHSA Provider Locations

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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	32
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

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	175
DMC/DMC-ODS only	41
Both SMHS and DMC/DMC-ODS systems	8

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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?

23

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

San Bernardino County Department of Behavioral Health (DBH) is implementing a comprehensive strategy to address workforce gaps beyond those funded under the Behavioral Health Services Act (BHSA) Workforce, Education, and Training component. A key effort includes the planned release of a Request for Proposal (RFP) in Fiscal Year 2026–2027 for newly designed early intervention services funded by BHSA. These services will be provided by contractors who are currently not certified to bill Medi-Cal. Selected providers will receive training on Medi-Cal certification requirements during the RFP bidder's conference and will be required to obtain certification upon Board approval. DBH will provide technical assistance throughout the certification process, which includes site certification, compliance with Medi-Cal standards, and ongoing chart reviews. Certification must be renewed every three years, accompanied by on-site reviews and triennial audits conducted by DBH Quality Management and the Office of Compliance to ensure billing accuracy and prevent fraud. To support providers after contract execution, DBH will offer technical assistance through designated program staff and administrative services. Billing compliance will be monitored regularly through invoice validation against electronic health records before reimbursement. DBH has also enhanced engagement and education efforts through recurring meetings and forums with community-based organizations, compliance sessions, and revenue cycle office hours. These forums address topics such as Medi-Cal site certification standards, documentation requirements, chart review preparation, Managed Care Plan referral processes, and claims submission support. Additional trainings are planned for Fiscal Year 2026–2027 to address billing activities, denials, and Medi-Cal eligibility verification. Beginning July 1, 2027, DBH will focus on strategies to increase Medi-Cal Managed Care Plan contracting among BHSA-funded providers through the Program Improvements for Valued Outpatient Treatment (PIVOT) project. This initiative aims to strengthen provider capacity, promote culturally responsive care, and integrate Community-Defined Evidence Practices to better serve diverse communities. DBH will collaborate with community-based organizations to explore eligibility for Medi-Cal and Drug Medi-Cal contracting,

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guide credentialing and compliance, and facilitate communication between Managed Care Plans and providers to address barriers to network participation. These efforts are designed to help providers navigate Medi-Cal systems, improve sustainability, and align with state priorities for behavioral health transformation.

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

DRAFT

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

Yes

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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))
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)

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

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Please describe the specific services provided

Crisis Stabilization Units provide voluntary mental health urgent care services in a community-based setting for individuals who require immediate stabilization due to a mental health crisis. These programs operate twenty-four hours a day, seven days a week, and services are designed to last less than twenty-four hours. Two units offer twenty spaces each, and two units offer twelve spaces each for crisis stabilization services. Each facility includes separate areas for adults, defined as individuals aged eighteen and older, and for children and adolescents, defined as individuals aged seventeen and younger. Crisis Stabilization Unit facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages who are experiencing a mental health crisis. The units provide a comprehensive range of services, including crisis intervention and stabilization, psychiatric evaluation and medication, when necessary, voluntary peer-to-peer engagement and support, screening for substance use disorders, assessment, referral, and linkage to appropriate resources, and therapeutic interventions.

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	752
FY 2027 – 2028	752
FY 2028 – 2029	752

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Program reviewed trends across three (3) complete Fiscal Years and calculated average growth percentages to determine projections.

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 .

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Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

The Centralized Children's Intensive Case Management Program provides clinical services in three primary areas: direct care services, coordination of services for youth placed outside the county, and assessments for youth admitted to residential placement. Clinical staff within this program deliver intensive case management, therapeutic services, and ongoing care to children and youth experiencing severe challenges, such as involvement with Children and Family Services or Probation, substance use issues, Commercial Sexual Exploitation of Children, frequent psychiatric hospitalizations, or episodes of being absent without leave. Staff also assist with coordinating linkage to mental health services and medication support services. Within the Centralized Children's Intensive Case Management Assembly Bill 1299 program, staff manage the placement of foster children outside the county and ensure that youth from San Bernardino County who are placed out of county, as well as youth from other counties placed within San Bernardino County, receive clinical treatment to address their individual needs. Additionally, within the Centralized Children's Intensive Case Management Qualified Individual program, staff conduct the required Qualified Individual assessments for residential placement. These assessments involve comprehensive evaluations to determine the most appropriate level of care for each youth and include treatment recommendations aimed at supporting the youth's overall success.

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	3448
FY 2027 – 2028	3792
FY 2028 – 2029	4171

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

There were two thousand eight hundred seventy-four (2874) children and youth who qualified in this category during a twelve-month period. Due to the increase in children and youth placed in both in-county and out-of-county placements who require Qualified Individual assessments, referral and linkage through the Assembly Bill 1299 process, and/or intensive mental health services, it is estimated that the number of

children and youth served in Fiscal Year (FY) 2026–2027 will increase by twenty percent compared to FY 2025–2026. FY 2027–2028 is projected to reflect an additional ten percent increase compared to FY 2026–2027, and FY 2028–2029 is expected to represent a further ten percent increase compared to FY 2027–2028.

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
Supportive services

Please describe the specific services provided

The Children's Residential Intensive Services (ChRIS) Program is a structured initiative designed to provide Specialty Mental Health Services to children and youth placed in Short-Term Residential Therapeutic Programs by Children and Family Services and Probation. The primary goal of the Children's Residential Intensive Services Program is to deliver short-term, specialized, and intensive treatment to serve specific target populations requiring residential care. This program is intended to provide a high level of therapeutic services to children and youth who experience severe emotional and behavioral disorders, supporting their recovery and helping them achieve socially acceptable levels of functioning while simultaneously building permanency options and facilitating transitions to lower levels of care. The expectation is that the Children's Residential Intensive Services Program will operate within the framework of the Integrated Core Practice Model, as required by the Department of Health Care Services, and utilize Clinical Decision Support Systems to guide treatment planning and decision-making.

DRAFT

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	634
FY 2027 – 2028	760
FY 2028 – 2029	912

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

The number of clients served is expected to increase with the expansion of the Children's Residential Intensive Services (ChRIS) contract and the implementation of Assembly Bill 1051, effective July 1, 2024. Specifically, there has been a notable increase in the number of youth who will be served through the Children's Residential Intensive Services program. Based on recent annual data, which reflects four hundred eighty-eight youth served, it is estimated that the number of youth served in Fiscal Year 2026–2027 will increase by thirty percent. Each subsequent year is projected to experience an additional twenty percent (20%) increase in the number of youth served.

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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
Supportive services

Please describe the specific services provided

The Children's Assessment Center (CAC) provides comprehensive clinical assessments conducted by licensed clinicians. These clinicians collaborate closely with medical staff from Loma Linda University Medical Center, who are co-located at the center and perform forensic interviews and evidentiary medical examinations. This collaborative approach assists in the evaluation of child abuse allegations and ensures that appropriate referrals and linkages to mental health services are provided for children and youth in need of care.

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	24
FY 2027 – 2028	25
FY 2028 – 2029	26

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

There were twenty-three (23) children who qualified in this category during a twelve-month period. The number of clients served is projected to increase by five percent (5%) in Fiscal Year (FY) 2026–2027 as a result of additional assessments generated through collaboration with Child Welfare Services and Loma Linda University Medical Center. FY 2027–2028 is anticipated to reflect an additional five percent (5%) increase compared to FY 2026–2027, and FY 2028–2029 is expected to represent a further five percent increase compared to FY 2027–2028.

DRAFT

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

The Integrated New Family Opportunities (INFO) program is a collaborative effort between the Department of Behavioral Health and Probation staff to serve justice-involved youth. The program is designed to increase family stabilization, reduce problematic behaviors, and improve the overall functioning of both the youth and their families. In addition to monitoring by Probation, the program provides three evidence-based practices: Functional Family Therapy, Moral Reconation Therapy, and Intensive Care Coordination for youth diagnosed with a mental health disorder.

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	100
FY 2027 – 2028	100
FY 2028 – 2029	100

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Due to evidence-based practice staff-to-client ratios, there can be no increase in the number of clients served unless additional clinicians are added to this program and trained in Functional Family Therapy (FFT). Without these staffing and training enhancements, it is anticipated that there will be no growth in this program over the next three (3) years.

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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
Supportive services

Please describe the specific services provided

Juvenile Court Behavioral Health Services (JCBHS) Program provides comprehensive assessments, mental health and psychiatric referrals, and linkages to address the complex needs of children and youth, six years of age and older, who are involved in the Child Welfare System. Within JCBHS, the Healthy Homes clinical unit consists of clinicians who are co-located at Child Welfare offices. Healthy Homes conducts assessments for individuals involved in Child Welfare and facilitates the delivery of specialty mental health services. This includes performing comprehensive assessments at the request of the Family Court to provide consultation regarding psychotropic medication.

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	738
FY 2027 – 2028	1477
FY 2028 – 2029	2238

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

There were four hundred thirty-nine (439) children and youth who qualified in this category during a twelve-month period. All County Letter 25-10 will require the Juvenile Collaborative Behavioral Health Services program to assess all children and youth, six (6) years of age and older, who are initially detained, as well as children already in Child Welfare care who are not currently receiving mental health services and require a mental health assessment. It is estimated that the number of children and youth served in Fiscal Year (FY) 2026–2027 will increase by two hundred ninety-nine (299) compared to FY 2025–2026. FY 2027–2028 is projected to reflect an increase of one thousand thirty-eight (1038) compared to FY 2025–2026, and FY 2028–2029 is expected to represent an increase of one thousand seven hundred ninety-nine (1799) compared to FY 2025–2026.

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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
Supportive services

Please describe the specific services provided

The Screening, Assessment, Referral, and Treatment (SART) Program ensures that specialty mental health services are provided to foster children and other eligible children in the community between birth and five years of age who are experiencing social, physical, cognitive, behavioral, developmental, or psychological challenges. The Screening, Assessment, Referral, and Treatment (SART) program adheres to the values and principles of the Integrated Core Practice Model. It delivers comprehensive specialty mental health services, including Parent-Child Interactive Therapy (PCIT), which is one of the required evidence-based practices (EBPs) under BH-Connect.

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	3576
FY 2027 – 2028	3755
FY 2028 – 2029	3943

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

There were two thousand forty-four (2,044) children who qualified in this category during a twelve-month period. It is estimated that All County Letter (ACL) 25-10 will require the Screening, Assessment, Referral, and Treatment (SART) program to conduct two thousand two hundred eighty-seven (2,287) additional

initial assessments. Of these initial assessments, approximately sixty-six percent (66%), or one thousand five hundred thirty-two (1,532), are expected to continue in ongoing care and qualify to be counted as Children's System of Care (CSOC). Therefore, Fiscal Year (FY) 2026–2027 is projected to serve a total of three thousand five hundred seventy-six (3,576) children and youth, which includes the original two thousand forty-four (2,044) plus one thousand five hundred thirty-two (1,532). Fiscal Year 2027–2028 represents a five percent (5%) increase from FY 2026–2027, and Fiscal Year 2028–2029 represents an additional five percent (5%) increase from FY 2027–2028.

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
Supportive services

Please describe the specific services provided

The Early Identification and Intervention Services (EIIS) program provides services to children up to nine years of age who may or may not have experienced abuse or trauma but are at risk of developing emotional and behavioral disorders or significant developmental delays without the provision of attachment enrichment activities. The EIIS program adheres to the values and principles of the Integrated Core Practice Model (ICPM). It delivers comprehensive specialty mental health services, including Parent-Child Interactive Therapy (PCIT), which is one of the required evidence-based practices (EBP) under BH-Connect.

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1557
FY 2027 – 2028	1635
FY 2028 – 2029	1717

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

There were one thousand two hundred fifty-one (1,251) children who qualified in this category during a twelve-month period. It is estimated that All County Letter (ACL) 25-10 will require the Screening, Assessment, Referral, and Treatment (SART) program to conduct two thousand two hundred eighty-seven (2,287) additional initial assessments. Of these assessments, approximately twenty percent (20%), or four hundred fifty-seven (457), will require an assessment from the Early Identification and Intervention Services (EIIS) program. Of these additional initial assessments, approximately sixty-six percent (66%), or three hundred six (306), are expected to continue in ongoing care and qualify to be counted as Children's System of Care (CSOC). Therefore, Fiscal Year (FY) 2026–2027 is projected to serve a total of one thousand five hundred fifty-seven (1,557) children and youth, which includes the original one thousand two hundred fifty-one (1,251) plus three hundred six (306). Fiscal Year 2027–2028 represents a five percent (5%) increase from FY 2026–2027, and Fiscal Year 2028–2029 represents an additional five percent (5%) increase from FY 2027–2028.

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
Supportive services

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Please describe the specific services provided

One Stop Transitional Age Youth (TAY) Center Early Intervention Services provides group sessions and rehabilitation activities focused on activities of daily living (ADL), such as laundry, meal preparation, showers, and opportunities for socialization and recreation.

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	15
FY 2027 – 2028	15
FY 2028 – 2029	15

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

In Fiscal Year (FY) 2023–2024, the System Development (SD) program served an unduplicated total of one hundred five (105) clients, as reported in the Exhibit Six Annual Report. Since FY 2023–2024, the program has restructured its intake process to more quickly enroll clients into the Full Service Partnership (FSP), thereby reducing the number of non-FSP (system development) clients receiving services. However, we anticipate a small number of non-FSP but FSP-eligible clients, approximately fifteen (15) annually who may wish to receive support services such as group sessions and shower or laundry services without agreeing to individual therapy. These youth would receive Early Intervention services to keep them engaged until they fully commit to the FSP program.

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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

Crisis Stabilization Units (CSUs) provide voluntary mental health urgent care services in a community-based setting for individuals who require immediate crisis stabilization as a result of a mental health crisis. These programs operate twenty-four (24) hours a day, seven (7) days a week, and services are designed to last for less than twenty-four (24) hours. Two CSUs offer twenty (20) spaces each, and two CSUs offer twelve (12) spaces each for crisis stabilization services. Each facility includes separate areas for adults, defined as individuals aged eighteen (18) and older, and for children and adolescents, defined as individuals aged seventeen (17) and younger. CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis. CSUs provide a comprehensive range of services, including crisis intervention and stabilization; psychiatric evaluation and medication, when necessary; voluntary peer-to-peer enriched engagement and support; screening for substance use disorders; assessment and referral or linkage to appropriate resources; and therapeutic interventions.

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	5594
FY 2027 – 2028	5594
FY 2028 – 2029	5594

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

The program reviewed trends across three (3) complete Fiscal Years and calculated average growth percentages to determine projections.

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

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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
Supportive services

Please describe the specific services provided

Triage Transitional Services (TTS) were designed to assess clients who voluntarily present to the Arrowhead Regional Medical Center – Behavioral Health Unit (ARMC-BHU). As part of a collaborative team, TTS works alongside Arrowhead Regional Medical Center Behavioral Health Unit (ARMC-BHU) staff to determine whether the client meets medical necessity criteria for psychiatric inpatient treatment or if their needs can be met in other, less restrictive settings outside of an emergency department or psychiatric inpatient unit. TTS staff are co-located with ARMC-BHU and provide a comprehensive range of services, including crisis assessment and intervention; case management; collateral contacts; linkage to transportation assistance; linkage to housing assistance; linkage to outpatient resources and providers; referrals to medical and social service agencies; family and caretaker education; and consumer advocacy.

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	350
FY 2027 – 2028	350
FY 2028 – 2029	350

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

The projected number of individuals to be served was determined through an analysis of walk-in assessments completed by Triage Transitional Services (TTS) staff for Fiscal Year (FY) 2024–2025. There are two (2) TTS staff members on site, who provided these services to approximately thirty (30) individuals each month.

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
Supportive services

Please describe the specific services provided

The Placement After Stabilization (PAS) program provides discharge planning and serves as a liaison to facilitate appropriate placement upon discharge for each of the five (5) contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County, located in the following areas: San Bernardino (two (2) sites), Joshua Tree, Victorville, and Fontana. PAS staff work collaboratively with CRT staff to provide services intended to divert and reduce psychiatric inpatient hospitalization, assist clients in maintaining self-sufficiency, increase housing stability, and support successful reintegration into the community. PAS Clinical Therapists support each CRT facility and are assigned to provide the following services to adults aged eighteen (18) and older: screening for discharge services; conducting clinical assessments; coordinating discharge planning; assisting with placement options; and facilitating transportation arrangements.

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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	300

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	300
FY 2028 – 2029	300

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

The projected number of individuals to be served was determined through an analysis of current caseloads and a review of the recent reduction in services provided.

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

Community Crisis Response Teams (CCRT) include the Crisis Contact Center and community-based mobile crisis response services. These teams provide immediate, community-based intervention for children and adults experiencing a psychiatric emergency. The CCRT model ensures rapid response and stabilization in the least restrictive environment possible, reducing the need for emergency department visits or inpatient psychiatric hospitalization.

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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	7117
FY 2027 – 2028	7687
FY 2028 – 2029	8301

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

There has been a historical average increase of eight percent (8%), resulting from expanded outreach efforts, increased response to schools, additional staffing, and the implementation of Mobile Crisis services operating twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.

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

Valley Star Crisis Mobile Response Team provides overnight mobile crisis response services to individuals experiencing a mental health emergency, ensuring timely intervention and support in the community.

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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	7117
FY 2027 – 2028	7687
FY 2028 – 2029	8301

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

There has been a historical average increase of eight percent (8%), resulting from expanded outreach efforts, increased response to schools, additional staffing, and the implementation of Mobile Crisis services operating twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.

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
Supportive services

Please describe the specific services provided

The Homeless Outreach Support Team (HOST) and San Bernardino Department of Mental Health (SBDMH) Homeless – Projects for Assistance in Transition from Homelessness (PATH) program provide recovery-focused assistance with the housing application process and housing readiness, including support in successfully maintaining responsibilities in bridge housing settings, as applicable. PATH funding covers HOST staff and requires a three-to-one (3:1) match from other funds, which is currently met through

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Mental Health Services Administration (MHSA) funds.

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	200
FY 2027 – 2028	200
FY 2028 – 2029	200

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

Approximately seventy-five (75) clients were referred to the Homeless Outreach and Support Team (HOST) for assistance in preparing clients for Permanent Supportive Housing (PSH) units. Additionally, about one hundred twenty-five (125) clients were referred through community partners.

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

Clients engaged through Outreach and Engagement who express interest in behavioral health services may receive support through Innovation Remote Onsite Assistance Delivery (InnROADs) in the field while being connected to ongoing care. This approach ensures immediate access to services and a seamless transition to long-term behavioral health resources.

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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	100
FY 2027 – 2028	100
FY 2028 – 2029	100

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
Clients with an Avatar service during the fiscal year (FY) may also be entered into the Homeless Management Information System (HMIS).

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
Transitional Age Youth Crisis Residential Treatment (TAY CRT), a specialized crisis residential treatment program for Transitional Age Youth (TAY) and commonly referred to as "The STAY," is a short-term, voluntary residential treatment center. The STAY serves individuals ages eighteen (18) to twenty-five (25) who are experiencing a mental health crisis. Participants may remain for up to ninety (90) days and receive services in a home-like environment that fosters recovery, wellness, and resiliency within the community. The STAY enhances access to appropriate mental health services for TAY in crisis. Co-located with the Department of Behavioral Health (DBH) One-Stop TAY Center in San Bernardino, this unique program offers comprehensive and collaborative services tailored to young adults, supporting maximum recovery

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outcomes. Services provided through The STAY include comprehensive clinical assessments and therapy, therapeutic and psychoeducational groups, activities and training focused on daily living skills, behavioral intervention and modification training, individual and group counseling, crisis intervention, psychiatric and medication support, substance use disorder counseling and referrals, recreational therapy, educational assistance, and pre-release and discharge preparation and planning.

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	93
FY 2027 – 2028	93
FY 2028 – 2029	93

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

Program reviewed trends across three (3) complete Fiscal Years and calculated average growth percentages to determine projections.

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

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Please describe the specific services provided

The Adult Crisis Residential Treatment (CRT) program offers short-term, voluntary crisis residential treatment options for San Bernardino County residents ages eighteen (18) to fifty-nine (59). Individuals may remain for up to ninety (90) days to receive services in a home-like environment that promotes recovery, wellness, and resiliency within the community. Services are designed for individuals experiencing an acute psychiatric episode or mental health crisis who require short-term residential treatment to prevent acute psychiatric hospitalization. CRT programs operate twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. The program provides comprehensive clinical assessments and therapy, crisis intervention, psychiatric and medication support, life skills coaching, peer and family support networks, coping techniques, recovery education, substance use education, and community resource linkages.

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	428
FY 2027 – 2028	428
FY 2028 – 2029	428

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

Program reviewed trends across three (3) complete Fiscal Years and calculated average growth percentages to determine projections.

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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
Diversion Services through Triage Engagement and Supports Teams (TEST) provide crisis response, engagement, outreach, referrals, and linkage to appropriate resources. These services are designed to address immediate needs while connecting individuals to ongoing care and support systems.

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	6393
FY 2027 – 2028	6840
FY 2028 – 2029	7318

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
There has been an approximate seven percent (7%) increase in persons served since fiscal year (FY) 2023–2024, which has been impacted by the expansion of co-located sites, improved staff retention, and an increase in referrals.

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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
Supportive services

Please describe the specific services provided
Clubhouse and Community Connections provides peer support services for adults eighteen (18) years of age or older who are experiencing mental health and substance use challenges. Services include access to showers, laundry facilities, meal support, peer-run groups, resources, linkages, community integration excursions, housing navigation, volunteer opportunities, job skills development, life skills training, system navigation assistance, and a clothing closet. These services are designed to promote recovery, wellness, and community engagement for participants.

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	3000
FY 2027 – 2028	3500
FY 2028 – 2029	4000

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
The Internal Data Tracking System estimates that approximately eighty percent (80%) of individuals would fall under outreach and engagement, while about twenty percent (20%) would be system linked. This distribution reflects the program's emphasis on proactive engagement and connection to supportive services.

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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
Integrated New Family Opportunities (INFO)

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

Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Juvenile Involved Youth

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

The intended outcome is to provide behavioral health (BH) services to individuals within thirty (30) days post-discharge.

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

Yes

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

Additional priority name	Description
Functional Family Therapy (FFT)	designed to improve family dynamics and address behavioral issues in youth aged 11 to 18.

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	100
FY 2027 – 2028	100
FY 2028 – 2029	100

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

For youth ages thirteen (13) to seventeen (17) who are involved with the juvenile justice system, program goals include increasing family stabilization, strengthening connections to community support, and preventing ongoing involvement with the justice system while promoting recovery, wellness, and resiliency.

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

Juvenile Court Behavioral Health Services

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

Outreach
Access and Linkage: Assessments
Access and Linkage: Referrals
Access and Linkage: Other
Treatment Services and Supports: Other

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Please specify "other" type of Access and Linkage
Provide "other" types of access and linkage to various mental health and psychiatric providers to ensure individuals receive appropriate care and support.

Please specify "other" type of Treatment Services and Supports
Juvenile Court Behavioral Health Services (JCBHS) focuses on the early identification, assessment, and treatment of the mental health needs of children in out-of-home care.

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
The Juvenile Court Behavioral Health Services (JCBHS) program provides comprehensive assessments, mental health and psychiatric referrals, and linkages to address the complex needs of children and youth ages six (6) years and older who are involved in the Child Welfare System. Through coordinated access and linkage to appropriate mental health services, JCBHS expands outreach to underserved and marginalized communities and actively works to reduce stigma and discrimination associated with mental health diagnoses, conditions, and help-seeking behaviors.

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	2830
FY 2027 – 2028	4456

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Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	6132

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

There were one thousand two hundred three (1,203) children and youth who qualified in this category during a twelve (12)-month period. It is estimated that All County Letter (ACL) 25-10 will require Juvenile Court Behavioral Health Services (JCBHS) to conduct four thousand nine hundred twenty-nine (4,929) additional initial assessments per year, which qualify as early intervention. It is expected that not all of these cases will be referred to JCBHS in fiscal year (FY) 2026–2027; therefore, only thirty-three percent (33%) of the additional cases—approximately one thousand six hundred twenty-seven (1,627)—will be added in FY 2026–2027. As a result, FY 2026–2027 will serve two thousand eight hundred thirty (2,830) individuals, which includes the original one thousand two hundred three (1,203) plus the additional one thousand six hundred twenty-seven (1,627). FY 2027–2028 represents sixty-six percent (66%) of the expected increased referrals, totaling approximately three thousand two hundred fifty-three (3,253). FY 2028–2029 reflects one hundred percent (100%) of the projected annual increase, totaling four thousand nine hundred twenty-nine (4,929) assessments.

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

Screening, Assessment, Referral and Treatment (SART)

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

Outreach
Access and Linkage: Assessments
Access and Linkage: Referrals
Access and Linkage: Other

DRAFT

Treatment Services and Supports: Other

Please specify "other" type of Access and Linkage
Provide "other" types of access and linkage to various mental health to ensure individuals receive appropriate care and support.

Please specify "other" type of Treatment Services and Supports
Parent Child Interactive Therapy (PCIT), Occupational Therapy, Speech and Language Therapy, Medication Support Services

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
The program ensures that Specialty Mental Health Services are provided to foster children and other eligible children in the community between the ages of zero (0) and five (5) years who are experiencing social, physical, cognitive, behavioral, developmental, and/or psychological challenges. The Screening, Assessment, Referral, and Treatment (SART) program delivers comprehensive mental health clinical assessments, which minimally include direct interactions with the child, observation of interactions with caregivers, formal interviews with caregivers, and review of all available records. In addition, SART provides linkage to community resources, psychoeducation regarding trauma and development, and strategies to support children in achieving their mental health goals.

DRAFT

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	4870
FY 2027 – 2028	5114
FY 2028 – 2029	5369

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

It is estimated that All County Letter (ACL) 25-10 will require the Screening, Assessment, Referral, and Treatment (SART) program to conduct two thousand two hundred eighty-seven (2,287) additional initial assessments, which qualify as early intervention. Therefore, fiscal year (FY) 2026–2027 will serve four thousand eight hundred seventy (4,870) individuals, which includes two thousand five hundred eighty-three (2,583) existing cases plus two thousand two hundred eighty-seven (2,287) additional cases. FY 2027–2028 represents a five percent (5%) increase from FY 2026–2027, and FY 2028–2029 represents a five percent (5%) increase from FY 2027–2028.

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

Early Identification and Intervention Services (EIIS)

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

Outreach
Access and Linkage: Assessments
Access and Linkage: Referrals
Access and Linkage: Other
Treatment Services and Supports: Other

Please specify "other" type of Access and Linkage

Provide "other" types of access and linkage to various mental health providers to ensure individuals receive appropriate care and support.

Please specify "other" type of Treatment Services and Supports

Parent Child Interaction Therapy (PCIT), Medication Support Services

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

The Early Identification and Intervention Services (EIIS) program provides services to children under the age of nine (9) who are not demonstrating age-appropriate interactions and attachment. EIIS offers comprehensive treatment services, including assessments, individual and family therapy, targeted case management, rehabilitative services, intensive home-based services, and intensive care coordination.

DRAFT

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	1645
FY 2027 – 2028	1728
FY 2028 – 2029	1814

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

There were one thousand one hundred eighty-eight (1,188) children who qualified in this category during a twelve (12)-month period. It is estimated that All County Letter (ACL) 25-10 will require the Early Identification and Intervention Services (EIIS) program to conduct four hundred fifty-seven (457) additional initial assessments, which qualify as early intervention. Therefore, fiscal year (FY) 2026–2027 will serve one thousand six hundred forty-five (1,645) individuals, which includes one thousand one hundred eighty-eight (1,188) existing cases plus four hundred fifty-seven (457) additional cases. FY 2027–2028 represents a five percent (5%) increase from FY 2026–2027, and FY 2028–2029 represents a five percent (5%) increase from FY 2027–2028.

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

One Stop TAY Center Early Intervention Services

DRAFT

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

Outreach
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

Engage Transitional Age Youth (TAY) who are in need of mental health or Substance Use Disorder (SUD) services and connect them to Full Service Partnership (FSP) or non-FSP 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

Yes

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

Additional priority name	Description
childhood trauma: Eligible children and youth in populations with identified disparities in behavioral health.	BHSS requires 35% of EI services to address the needs of children and youth under 25 years of age. Metric: Total TAY who receive at least one EI service: screening, linkage, referral to services (CBO, SUD, or similar services), or enrollment into FSP. Outcome metrics will be monitored quarterly to adjust estimates as appropriate.

DRAFT

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	15
FY 2027 – 2028	15
FY 2028 – 2029	15

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

In fiscal year (FY) 2023–2024, System Development (SD) served one hundred five (105) unduplicated clients, as reported in the Exhibit 6 Annual Report. Since FY 2023–2024, the program has restructured its intake process to expedite enrollment into Full Service Partnership (FSP), thereby reducing the number of non-FSP clients receiving services. However, we anticipate a small number of clients will seek Early Intervention (EI) services, which include screening, linkage, referral to services such as Community-Based Organizations (CBO), Substance Use Disorder (SUD) programs, or similar services, or enrollment into FSP. Youth who do not immediately transition to FSP enrollment will receive Behavioral Health Services Act (BHSA) EI services to maintain engagement until they fully commit to the FSP program.

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

Family Resource Center (FRC)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Access and Linkage: Other

Please specify "other" type of Access and Linkage

warm hand-offs

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

The goal is to reduce prolonged suffering associated with untreated mental health illness. Early Intervention (EI) activities accomplish this by providing counseling and treatment that lead to reduced symptoms and improved recovery, including enhanced mental, emotional, and relational functioning.

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	4000
FY 2027 – 2028	4000

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Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	4000

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on performance from fiscal year (FY) 2024–2025.

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
Native American Resource Center (NARC)

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
Outreach

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 serves as a one-stop center offering early intervention and linkage to behavioral health services for Native American community members of all ages. Services include talking circles, wellness circles, drumming circles, Daughters of Tradition, cultural education and awareness, cultural arts therapy, and cognitive therapy groups.

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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	1750
FY 2027 – 2028	1750
FY 2028 – 2029	1750

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

For fiscal years (FY) 2026 through 2029, the program projects a stable number of individuals served with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and funding expectations.

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

Older Adult Community Services (OACS)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Individual and group therapy

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

To address key indicators that can contribute to mental health challenges, such as depression, isolation, chronic physical health conditions, and lack of family support.

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	583
FY 2027 – 2028	583
FY 2028 – 2029	583

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

Based on performance from fiscal year (FY) 2024–2025.

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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
Department of Aging and Adult Services (DAAS)

Please select which of the three EI components are included as part of the program or service
Outreach
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
The target population includes older adults aged sixty (60) years and older, along with their families or caregivers, who experience disparities in accessing mental health services. This population also includes individuals impacted by the psychosocial effects of trauma and/or bereavement, fear of stigma and discrimination, and those at risk of suicide. Additionally, it encompasses older adults who may be experiencing the onset of a serious psychiatric illness or a relapse. The Department of Aging and Adult Services (DAAS) will refer clients to appropriate mental health services and resources, assist in obtaining access to mental and physical health services and screenings, provide case management, and make referrals as appropriate. These efforts aim to reduce risk factors for mental illness among older adults experiencing serious chronic medical conditions, prolonged isolation, and existing mental health challenges.

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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	603
FY 2027 – 2028	603
FY 2028 – 2029	603

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

For fiscal years (FY) 2026 through 2029, the program projects a stable number of individuals served, with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and anticipated funding levels.

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

Juvenile Public Defender (CYC)

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

Outreach
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

Increase early access and linkage to medically necessary care and treatment. Ensure that children and youth with severe mental illness (SMI) are connected to care as early as possible in the onset of these conditions, facilitating timely access to medically necessary care and treatment. Reduce and circumvent stigma and discrimination associated with being diagnosed with a mental health condition, living with a mental health condition, or seeking services for mental health conditions.

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)

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	4472
FY 2027 – 2028	4472
FY 2028 – 2029	4472

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

For Fiscal Year (FY) Two Thousand Twenty-Six (2026) through Fiscal Year (FY) Two Thousand Twenty-Nine (2029), the program projects a stable number of individuals served, with no year-over-year change. This flat

projection reflects a conservative approach informed by historical service trends, capacity constraints, and anticipated funding levels.

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
Military Services and Family Support (MSFS)

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
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
The Military Services and Family Support (MSFS) program is a prevention and early intervention program that targets active-duty military service members from all branches, veterans, retired military personnel, and their families. This program addresses the unique challenges that military members and their families experience due to circumstances specific to military life. MSFS services include screening and assessments, therapeutic treatment, resource navigation, and education.

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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	2759
FY 2027 – 2028	2759
FY 2028 – 2029	2759

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

Based on performance from FY 24/25.

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

Student Assistance Program (SAP)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

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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 provides targeted services to students in Kindergarten through Grade Twelve (K–12) who require interventions for substance use, mental health, academic, emotional, and/or social challenges. Services include mental health and substance use screenings and assessments, mental health educational presentations, critical incident stress debriefing, individual and group counseling, alcohol and drug education, and intervention. The Student Assistance Program (SAP) team members are trained to identify potential learning barriers and make recommendations that benefit both the student and their families. The program is designed to minimize barriers to learning, support students in achieving academic and personal success, and reduce the duration of untreated mental illness to reach potential responders.

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	813
FY 2027 – 2028	813
FY 2028 – 2029	813

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

For Fiscal Year (FY) Two Thousand Twenty-Six (2026) through Fiscal Year (FY) Two Thousand Twenty-Nine (2029), the program projects a stable number of individuals served, with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity limitations, and anticipated funding expectations.

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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
Building Blocks for Success (BBS)

Please select which of the three EI components are included as part of the program or service
Outreach
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
Building Blocks for Success (BBS) is an early intervention mental health service provided to preschool-aged children in school or at home to reduce escalated behaviors and decrease the likelihood of classroom injuries. Services are offered to children ages two (2) through five (5) years old who are enrolled in the State Head Start Preschool Program, as well as to parents, caregivers, and teachers.

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

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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	120
FY 2027 – 2028	120
FY 2028 – 2029	120

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

For Fiscal Year (FY) Two Thousand Twenty-Six (2026) through Fiscal Year (FY) Two Thousand Twenty-Nine (2029), the program projects a stable number of individuals served, with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and anticipated funding expectations.

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

Resilience Promotion in African American Children (RPiAAC)

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

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

DRAFT

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

Resilience Promotion in African American Children (RPiAAC) aims to strengthen resilience and self-efficacy, reduce truancy, school dropouts, suspensions, and expulsions, increase knowledge of risk and resilience/protective factors, alleviate family stress and discord, reduce violence, improve school performance, and decrease involvement with law enforcement and the courts. This program provides early intervention services for African American/Black children and youth. Services offered include cultural awareness and empowerment workshops, professional development presentations, mental health and substance use disorder screenings, mental health and substance use disorder education, counseling services, case management, homework assistance, and parenting workshops. Successful treatment is indicated when the participant has met all treatment goals at case closure.

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	5666
FY 2027 – 2028	5666
FY 2028 – 2029	5666

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

For Fiscal Year (FY) Two Thousand Twenty-Six (2026) through Fiscal Year (FY) Two Thousand Twenty-Nine (2029), the program projects a stable number of individuals served, with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and anticipated funding expectations.

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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
Community Wholeness and Enrichment (CWE)

Please select which of the three EI components are included as part of the program or service
Outreach
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
The program aims to address mental health disorders early in their development by utilizing prevention and early intervention services to avert or lessen the severity of mental illness. It seeks to identify and help manage early mental health symptoms while providing support and education to families. This program offers early intervention services such as evidence-based treatments, therapies, and relapse prevention strategies. Services include screenings and assessments, case management, linkage and referrals, support groups (including suicide bereavement), mental health education, and early intervention counseling. The program serves Transitional Age Youth (TAY) ages sixteen (16) through twenty-five (25).

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

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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	1948
FY 2027 – 2028	1948
FY 2028 – 2029	1948

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

For FY2026–FY2029, the program projects a stable number of individuals served (no year-over-year change). This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and funding expectations.

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

Improving Detection and Early Access (IDEA) Program

CSC program description

The Innovative Direction for Early Access (IDEA) Program is dedicated to supporting Transitional Age Youth (TAY), ages sixteen (16) through twenty-five (25), who are at high risk of developing psychosis or are experiencing their first episode of psychosis. The program provides a comprehensive range of mental health services, including screenings and assessments, individual and group counseling, case management, family education and support, and assistance with educational and employment goals. IDEA focuses on early identification and intervention to promote recovery, resilience, and long-term wellness.

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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	<11*
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	1
Number of Teams Needed to Serve Total Eligible Population	1

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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	1	1	1
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
No

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
Public Relations and Outreach Services (PROS)

Please describe the program or activity
The Public Relations and Outreach Services (PROS) division promotes services for individuals who have experienced mental illness or substance use disorders. PROS works to reduce stigma through education, awareness, and outreach. By utilizing strategic communication and community engagement, the division advocates for all individuals to achieve optimal wellness.

DRAFT

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	87804
FY 2027 – 2028	90439
FY 2028 – 2029	93152

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

Public Relations and Outreach Services (PROS) outreach and engagement efforts continue to experience steady growth as community demand for Department of Behavioral Health (DBH) presence at local events increases each year. Beginning with an estimated eighty-five thousand two hundred forty-seven (85,247) community touchpoints, projections reflect a consistent three percent (3%) annual increase driven by expanding requests for DBH participation in health fairs, school events, cultural gatherings, and neighborhood activities. This growth is further supported by the rising popularity and promotion of DBH-led community events, which attract residents seeking information, connection, and support. The upward trend also reflects the continued expansion of the Outreach Taskforce—trained staff from various DBH programs who strengthen the department's capacity to deliver high-quality outreach, presentations, and resource navigation countywide. Together, these efforts demonstrate the community's growing trust in DBH as a source of mental health education and support, while highlighting the department's commitment to meeting residents where they are and expanding access to behavioral health services.

DRAFT

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

Office of Suicide Prevention

Please describe the program or activity

The Office of Suicide Prevention leads initiatives to promote mental health and prevent suicide throughout San Bernardino County. Through the Take Action for Mental Health project, the office provides comprehensive mental health and suicide prevention training to diverse audiences while actively engaging youth through the Directing Change program. Additionally, the office offers Technical Assistance (TA) to support countywide efforts, including crisis response, capacity building, strategic guidance, and resource navigation. These services focus on reducing stigma, preventing suicide, and improving student mental health.

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	2305
FY 2027 – 2028	2305
FY 2028 – 2029	2305

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

For Fiscal Year (FY) Two Thousand Twenty-Six (2026) through Fiscal Year (FY) Two Thousand Twenty-Nine (2029), the program projects a stable number of individuals served, with no year-over-year change. This flat projection reflects a conservative approach based on historical service trends, capacity constraints, and anticipated funding expectations.

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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
The Department of Behavioral Health (DBH) is committed to reducing workforce disparities through inclusive hiring practices, offering bilingual compensation, and providing training and development initiatives that build a culturally and linguistically competent workforce. Such as Language skills training for bilingual staff and interpreter training for users of interpreter services.

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
Financial Incentives

DRAFT

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
The Department of Behavioral Health (DBH) is committed to reducing workforce disparities by implementing financial incentive programs that attract and retain a diverse, culturally competent workforce. To address these gaps; DBH offers financial incentives such as student loan repayment assistance and tuition reimbursement. By reducing financial barriers and offering competitive benefits, DBH encourages individuals from underrepresented groups to pursue careers in behavioral health.

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 .

DRAFT

Program or activity name
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
The Department of Behavioral Health (DBH) is committed to addressing workforce disparities by expanding internship programs that create pathways for diverse candidates to enter the behavioral health field. These

programs provide hands-on experience, mentorship, and training in culturally responsive care, helping interns transition into full-time positions within DBH. By creating a pipeline for underrepresented groups, DBH strengthens its ability to meet community needs and improve language access. To ensure the success of these programs, DBH must also address staffing considerations for supervision. Interns who are not yet licensed require oversight from licensed professionals, which means evaluating current capacity and ensuring adequate supervisory resources. This approach not only supports compliance but also enhances the quality of training and prepares interns for future roles within the department.

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
Psychiatric Residency

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
The Department of Behavioral Health (DBH) is committed to addressing workforce disparities by expanding its psychiatric residency program to develop a pipeline of culturally and linguistically competent psychiatrists. Through structured training, mentorship, and exposure to community-based behavioral health settings, this program encourages participation from underrepresented groups and strengthens the psychiatric workforce in high-need areas. To ensure the success of this initiative, DBH must also address supervisory capacity. Residents require oversight from licensed professionals, which means evaluating

DRAFT

current staffing resources and ensuring adequate supervision is available. This approach not only supports compliance with training requirements but also enhances the quality of education and prepares residents for future roles within the department.

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
Volunteer Services

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
The purpose of Department of Behavioral Health (DBH's) Volunteer Services Program is to strengthen and sustain the behavioral health workforce by intentionally recruiting and developing future professionals. The program actively engages a diverse range of individuals, including students, individuals exploring new career pathways, and community members who are interested in pursuing careers in behavioral health. Through hands-on experience, mentorship, and exposure to real-world public service environments, the program builds a pipeline of knowledgeable, culturally responsive, and community-centered professionals. Volunteer Services plays a critical role in cultivating interest in behavioral health careers, increasing workforce diversity, and supporting long-term workforce development efforts across San Bernardino County. In addition, this program providing structured, supervised, and relevant experiential learning opportunities that expose volunteers to the real-world application of behavioral health services and

DRAFT

outreach activities.

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
Peer and Family Advocates

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
The Department of Behavioral Health (DBH) is actively addressing disparities in the behavioral health workforce through its Peer Program, which promotes cultural responsiveness and workforce diversity. This program provides specialized training, certification support, and career development opportunities to ensure individuals with lived experience are prepared for success in professional roles. Over the next three years, DBH plans to expand the peer workforce by 10 full-time equivalent (FTE) positions to meet Behavioral Health Services Act (BHSA) Transformation requirements and mandates. Certified Peer Support Specialists are integral to delivering Evidence-Based Practices (EBPs) with fidelity and meeting state performance measures, including Follow-up After Emergency Department visits for Mental Illness (FUM) and Substance Use (FUA). Currently, DBH employs 55 Peer and Family Advocate (PFA) staff members, with 22 certified to bill Medi-Cal. Increasing the number of certified peers will enhance compliance with BHSA requirements and expand Medi-Cal billable services. Peer support became a Medi-Cal benefit in 2022, and DBH provides training and funding for peers to obtain and maintain certification, which includes

DRAFT

completing 20 hours of Continuing Education Units (CEUs) every two years. Certification and training are funded through the Mental Health Services Act (MHSA) Workforce Education and Training Component and will continue under the BHSA Behavioral Health Services and Support Component (BHSS). These efforts not only strengthen cultural responsiveness but also create pathways for individuals from diverse backgrounds to enter and advance within the behavioral health workforce. DBH maintains ongoing recruitment for these positions to ensure sustainability and growth.

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
Leadership Development

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
The Department of Behavioral Health (DBH) is committed to cultivating a robust, diverse, and equitable leadership pipeline. By addressing professional development gaps and fostering internal talent, DBH ensures that its leadership team is equipped to drive innovation and maintain high-quality behavioral health services. Key leadership initiatives include: 1. DBH Employee Scholarship Program (ESP) - To promote a diverse and resilient workforce, the DBH Employee Scholarship Program (ESP) awards annual tuition assistance to employees pursuing a range of clinical and non-clinical degrees. From foundational certificates to doctoral studies, the ESP empowers staff to advance their careers and strengthens the

DRAFT

department's commitment to professional growth and long-term stability. 2. Franklin Covey Leadership Training - Through a partnership with the Southern Counties Regional Partnership (SCRP), DBH offers world-class performance improvement training. Participants engage in a 10-month instructor-guided program based on The 6 Critical Practices for Leading a Team. Additionally, employees receive an All-Access Pass to the Franklin Covey library, featuring: The 7 Habits of Highly Effective People®: Foundational personal and interpersonal effectiveness. The 4 Essential Roles of Leadership™: Focusing on trust, vision, execution, and coaching. Leading at the Speed of Trust®: Improving collaboration and organizational efficiency. The 4 Disciplines of Execution® (4DX): A framework for achieving strategic goals amidst daily operations. 3. Leadership Workshops (SCRP) - In collaboration with SCRP, DBH provides targeted workshops to address specific supervisory challenges: Transitioning into New Supervisor Roles, Managing Change in Changing Times, Intergenerational Supervision Dynamics, Clinical Supervision 4. Internal County Leadership Development Programming -Leadership Development Program (LDP) was a year-long initiative DBH employees at all levels, designed to build core competencies in areas such as communication, project management, team building, and supervisory skills. It fostered professional growth and operational excellence across the organization. Management and Leadership Academy (MLA) the County's MLA is a high-level professional development program. The MLA prepares employees for management roles by focusing on strategic planning, executive coaching, bias awareness, and advanced team leadership. 5. Reality-Based Leadership Management Training - Based on the principles of Cy Wakeman, this six-month instructor-guided program (led by presenter Alex Dorr) challenges traditional management philosophies. It equips leaders to eliminate workplace drama and focus on accountability and results.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
myAvatar EHR

Please select the type of project
Technological needs project

DRAFT

If Technological Needs Project, please select the focus area(s) of the project
Data exchange and interoperability
Data security and privacy
Electronic health record system
Online information resources for individuals/families
System maintenance costs
Telemedicine

Please describe the project
Continued use of myAvatar, as well as system enhancements to maximize efficiency for staff use and end-user utilization. Automating processes via artificial intelligence (AI) technologies, assessing clinical AI assistants, and product add-ons will be evaluated and implemented when applicable.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

DRAFT

Project name
Administrative Services Process Automation

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Imaging/paper conversion
Monitoring
Online information resources for individuals/families

Please describe the project
Procure or develop automated solutions to replace manual processes for contract review, fiscal budget tracking, and approval procedures.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Behavioral Health Services Act (BHSA) data tracking and Integration Plan software solution for project tracking and monitoring

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Other

Please describe the other focus area of the project
Process automation

Please describe the project
Developing or procuring software solutions to track and monitor data elements required for Behavioral Health Services Act (BHSA) compliance as well as having the ability to assist with the development and monitoring of BHSA Integrated Plans.

DRAFT

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
SB 929 Data Collection Portal

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Other

Please describe the other focus area of the project
Data collection

Please describe the project
Working with County Information Technology (IT) to develop a public-facing web portal that will allow entities within San Bernardino County to submit their SB 929 data to the Department of Behavioral Health (DBH), which will, in turn, submit that data to the state. Phase 2 of this project may include implementing form upload capabilities to further automate data submissions.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Substance Use Disorder Bed Tracking Application

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Monitoring

Please describe the project
Development of a software solution for tracking and monitoring bed availability for Substance Use Disorder (SUD) members.

DRAFT

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

DRAFT

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	31267
Number of Uninsured Individuals	4722

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	2714

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	890
Number of Uninsured Individuals	135

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	445
Number of Uninsured Individuals	67

DRAFT

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	145	145	145
Total Number of Teams	25	25	25

DRAFT

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	5917
Number of Uninsured Individuals	896

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	275
Number of Teams Needed to Serve Total Eligible Population	55

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	199	243	276

DRAFT

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	30	35	40

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1875
Number of Uninsured Individuals	525

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	329
Number of Teams Needed to Serve Total Eligible Population	114

DRAFT

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	303	321	329
Total Number of Teams	104	111	114

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	9538
Number of Uninsured Individuals	1477

DRAFT

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	690
Number of Teams Needed to Serve Total Eligible Population	276

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	15	17	17
Total Number of Teams	5	9	9

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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?

Yes

Please describe how the estimated practitioners will provide more than one EBP

Estimated practitioners may provide more than one evidence-based practice (EBP) through an integrated approach within individual client interactions. While practitioners will primarily deliver services under a designated EBP category, they will often incorporate complementary EBPs to enhance engagement and treatment effectiveness. For example, a practitioner may apply Motivational Interviewing techniques within the framework of Cognitive Behavioral Therapy during client sessions. This blended approach allows practitioners to adapt interventions to client needs while maintaining fidelity to core program models. It also ensures that clients benefit from multiple evidence-based strategies without requiring separate service tracks, which is particularly valuable in harder-to-reach areas where flexibility and resource optimization are essential.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports

The county employs a whole-person, trauma-informed approach within its Full-Service Partnership (FSP) programs by addressing the comprehensive needs of each participant. FSP programs provide or facilitate access to mental health treatment, substance use treatment, physical health services, and supports related to employment, education, and other essential aspects of life. As part of this approach, all new participants receive a comprehensive clinical assessment, conducted in a compassionate and collaborative manner. An output of this assessment is the Adult Needs and Strengths Assessment (ANSA), which helps facilitate capturing the individual's needs and strengths, including support from family and other significant people. This assessment explores issues related to trauma, which are represented in the ANSA as well. Through engagement efforts, the needs and strengths captured in the ANSA are monitored and updated every six months to ensure ongoing accuracy and responsiveness to participants' needs. FSP staff participate in regular training focused on trauma-informed care and practices to maintain high standards of service delivery. Additionally, FSP teams make every effort to engage and collaborate with a participant's family and/or natural support network, when available, and include them in the treatment process in alignment with the participant's preferences and applicable privacy laws. For participants without an existing support network, the development of natural supports within the community is integrated into the ongoing treatment plan, ensuring that care remains holistic and person-centered.

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

San Bernardino County Department of Behavioral Health (DBH) is committed to reducing disparities among Full-Service Partnership (FSP) participants by promoting equitable access, cultural responsiveness, and inclusivity in service delivery. Recognizing that systemic inequities, social determinants of health, and historical trauma contribute to gaps in behavioral health outcomes, DBH strives to implement strategies that ensure services are accessible, respectful, and effective for all populations. Key priorities include fostering culturally responsive practices, strengthening community engagement, and building partnerships to reach underserved populations. DBH emphasizes equity-driven approaches that align with participants' cultural values and needs, supported by continuous improvement through data-informed decision-making.

DRAFT

Monitoring demographic and outcome trends helps identify gaps and guide resource allocation to improve enrollment, engagement, and success across diverse groups. Over the next three years, programs will review services to ensure alignment with Behavioral Health Services Act (BHSA) requirements, supporting ongoing improvements and compliance with evolving standards. DBH places a strong focus on reducing disparities among children, adolescents, and transition-age youth by delivering developmentally responsive, trauma-informed, and culturally relevant services. These efforts address risk factors such as trauma, child welfare involvement, juvenile justice involvement, and homelessness, while providing mental health and substance use treatment tailored to the cultural and linguistic needs of diverse communities. Through approaches such as High-Fidelity Wraparound (HFW), youth are supported in safe, welcoming environments that promote individualized care planning and family engagement. DBH recognizes that incorporating family voice and choice, shared goals, and cross-system collaboration is critical to improving outcomes and fostering resilience. Strategies also include addressing developmental needs, reducing barriers such as transportation and stigma, and creating empowering environments where youth can heal from trauma and build skills for successful transitions into adulthood. By engaging families as partners, connecting youth to natural supports, and coordinating comprehensive care, DBH works to close gaps in access and ensure equitable opportunities for recovery and wellness for all FSP participants. These efforts reflect DBH's commitment to person-centered care that is responsive to the unique needs of individuals and communities.

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
Care experience
Engagement in school
Engagement in work
Overdoses
Prevention of co-occurring physical health conditions
Quality of life
Social connection
Suicides

DRAFT

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

San Bernardino County Department of Behavioral Health (DBH) promotes ongoing engagement for individuals receiving Full-Service Partnership (FSP) Intensive Case Management (ICM) through approaches that prioritize accessibility, trust, and individualized care. Engagement is viewed as a continuous process that adapts to the evolving needs of participants, ensuring services remain aligned with personal goals and preferences. DBH emphasizes person-centered planning and the importance of creating supportive environments that reduce barriers to care. Family involvement and natural supports are considered essential to strengthening engagement and promoting resilience, while culturally responsive practices help ensure services reflect the diverse needs of participants. For children, adolescents, and transition-age youth, DBH incorporates developmentally appropriate and trauma-informed approaches that recognize the unique challenges faced during critical life transitions. Peer and family advocates play an important role in building trust and encouraging participation, while collaboration with community partners supports outreach and engagement efforts. DBH's commitment to equity and inclusion ensures that engagement strategies are responsive to cultural and linguistic needs and address factors that may impact access to care. By maintaining a focus on individualized support and community connection, DBH seeks to promote sustained recovery, resilience, and long-term success for all FSP participants.

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

not applicable

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.)

San Bernardino County Department of Behavioral Health (DBH) will comply with the required FSP levels of care by strategically transitioning existing teams and establishing new teams to meet the standards outlined in the BHSA Evidence-Based Practice (EBP) manual for Assertive Community Treatment (ACT) and ACT fidelity models. Several current programs that provide intensive case management (ICM) will continue offering ICM services until they can fully implement ACT-level services to fidelity. For example, certain court-linked programs and outreach teams will maintain ICM while focusing on linking clients to the appropriate level of care, including ACT FSP, as needed. DBH will also transition existing FSP teams, such as those serving transition-age youth (TAY), into ACT and ICM teams, adding staff positions to ensure compliance with ACT fidelity requirements. Coordination between DBH-operated FSP ICM teams and contracted providers will be prioritized to facilitate smooth transitions for clients between ACT and Intensive Case Management (ICM) services. In addition to transitioning existing teams, DBH will stand up new ACT teams through contracted providers, while regional outpatient clinics will continue to provide FSP ICM services. These outpatient teams will work closely with ACT teams to ensure continuity of care and

DRAFT

seamless transitions for clients who no longer require FSP-level services, moving them into regular outpatient specialty mental health services. DBH leadership is actively engaging with the DHCS Center of Excellence to develop a strategic rollout plan for ACT implementation and fidelity monitoring. Furthermore, DBH will maintain specialized programs such as Age Wise and Community Reintegration Services to provide FSP ICM for targeted populations, while contracted ACT providers will deliver ACT-level services for individuals with the most intensive needs. Alongside these efforts, DBH will also focus on restructuring its children's programs to align with High Fidelity Wraparound (HFW) evidence-based practice (EBP) requirements. HFW will incorporate a developmentally appropriate, trauma-informed, and family-centered care approach that emphasizes family voice and choice, individualized planning, and cross-system collaboration to promote resilience and reduce disparities among younger populations. Through these coordinated strategies, DBH will ensure compliance with required FSP levels of care while maintaining a client-centered approach that supports recovery and long-term stability for individuals across the lifespan.

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

not applicable

Primary substance use disorder (SUD) FSPs

No

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

San Bernardino County Department of Behavioral Health (DBH) employs a comprehensive, multi-pronged outreach strategy to identify and enroll individuals living with significant behavioral health needs into Full-Service Partnership (FSP) programs. These efforts are designed to reduce barriers, build trust, and ensure equitable access to intensive, community-based services. DBH conducts proactive outreach in natural settings where individuals live and gather, including homes, hospitals, senior centers, nutrition programs, and community events. For older adults, outreach includes presentations at senior centers and events, as well as home visits for those who are isolated or have mobility limitations. These activities help reduce stigma, raise awareness of available services, and provide direct access for individuals who may otherwise be reluctant to engage. To engage youth and young adults, DBH provides orientations for referred or self-referred individuals, distributes program brochures and beneficiary handbooks, and schedules intake and assessment appointments. Outreach emphasizes education about available support,

DRAFT

including counseling, housing assistance, and vocational services, while fostering a welcoming environment that encourages participation. FSP teams utilize a "whatever it takes" approach to connect with individuals in the community, including those experiencing homelessness, hospitalization, or involvement in the criminal justice system. Teams provide field-based services and maintain frequent contact—often multiple times per week—to build rapport and link individuals to care. Outreach begins by addressing immediate needs such as food, clothing, hygiene items, and transportation, creating an entry point for ongoing engagement. DBH partners with hospitals, law enforcement, schools, other county programs, and community-based organizations to identify individuals with high behavioral health needs and provide warm referrals into FSP programs. Peer and family advocates with lived experience play a critical role in outreach, offering mentorship and shared understanding to build trust and encourage enrollment. Outreach strategies are culturally and linguistically tailored to meet the needs of diverse communities. Staff provide education about FSP services—including housing support, intensive case management, peer services, and 24/7 availability, so individuals understand the benefits of enrollment. Engagement is relationship-driven and persistent, with repeated contacts and follow-ups for individuals who may initially decline or hesitate to participate. Additionally, the County's Public Relations Office collaborates with the Behavioral Health Services Act (BHSA) Administration to educate the community about FSP services through Community Program Planning meetings, tabling events, and coordinated efforts with Managed Care Plans, community organizations, and County partners. These efforts help raise awareness, reduce stigma, and ensure that individuals and families understand the resources available to them. Through these coordinated strategies, community-based engagement, family involvement, peer support, culturally responsive practices, and public education, DBH ensures that individuals with the highest behavioral health needs are identified, supported, and successfully enrolled into FSP programs, where they can access comprehensive services that promote stability, recovery, and long-term wellness.

DRAFT

Other recovery-oriented services

Yes

Please describe the other recovery-oriented services the county's FSP program will include

San Bernardino County Department of Behavioral Health (DBH) offers a comprehensive array of recovery-oriented services that complement Full-Service Partnership (FSP) care and help individuals achieve their personalized recovery goals. Agencies engaged for High-Fidelity Wraparound (HFW) also provide Specialty Mental Health Services (SMHS), including therapy, rehabilitation, and psychiatric services, ensuring continuous clinical support alongside family-centered planning. In alignment with Assertive Community Treatment (ACT) principles, DBH delivers therapeutic groups, medication support, advocacy, and peer services, providing flexible, field-based care that sustains engagement and promotes wellness. FSP teams provide intensive case management, teach symptom management and recovery skills, and deliver individualized support across multiple life domains. These services include assistance with physical health needs, employment and educational opportunities (e.g., general education diploma (GED)

preparation and vocational support), housing stability (including navigation and in-home support), and the development of social support through peer and family advocate involvement. Finally, the FSP programs will continue to collaborate with peer-run Clubhouses to enhance recovery - oriented services for FSP participants. Clubhouse services include support groups, social activities, community connection opportunities, and other wellness services. By addressing behavioral health and social determinants holistically and in a person-centered manner, DBH's recovery-oriented services help participants build resilience, enhance independence, and sustain long-term wellness.

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"

not applicable

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 Bernardino County Department of Behavioral Health (DBH) engaged in a comprehensive planning process to ensure that the unique needs of children and youth, including those in or at risk of involvement in the juvenile justice system, were considered in the development of the county's Full-Service Partnership (FSP) program. This process focused on understanding service gaps, risk factors, and disparities impacting this population, as well as identifying trends and social determinants of health that influence behavioral health outcomes. Stakeholder input was incorporated to ensure that services reflect the priorities and needs of youth and families. The planning process emphasized approaches that are developmentally appropriate, trauma-informed, and culturally responsive, with a focus on individualized care, family involvement, and cross-system collaboration. These efforts aim to promote resilience, reduce disparities, and support successful transitions away from juvenile justice involvement toward long-term recovery and wellness.

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

San Bernardino County Department of Behavioral Health (DBH) engaged in the planning process to ensure the unique needs of LGBTQ+ children and youth were considered in the development of the county's Full-Service Partnership (FSP) program. This process focused on understanding disparities, risk factors, and service gaps impacting this population, as well as identifying factors that influence behavioral health outcomes. Stakeholder input was incorporated to ensure services are inclusive, culturally responsive, and affirming. The planning process emphasized approaches that prioritize safety, inclusion, and individualized care, while recognizing the importance of trauma-informed practices, family engagement, and

DRAFT

cross-system collaboration. These efforts aim to reduce disparities, promote resilience, and improve outcomes for LGBTQ+ youth by ensuring that FSP programs reflect their unique needs and support long-term recovery and wellness.

In the child welfare system

San Bernardino County reviewed the current level of services provided to youth involved with child welfare via Full-Service Partnerships (FSPs) that would need High Fidelity Wraparound (HFW), as well as stakeholder engagement and participation in community partnership workgroups, and continuous communication with County Child Welfare Agencies.

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

San Bernardino County has multiple approaches to meeting the needs of FSP adults, which are determined by information gathered from various sources. Demographic data is compiled on a monthly and annual basis, allowing for the identification of who is being provided with services and consideration of how to outreach to those with barriers to services, as well as how to engage stakeholders in these efforts. The County discusses the input of its clients and partners (like Adult Protective Services and any other agencies that serve older adults) to be fully aware of older adult needs and potential service gaps, and shares this information through the Community Program Planning process to gather feedback for department consideration. These efforts allow the County to ensure that FSP services remain appropriate and effective for the older adult population in San Bernardino County and that the needs of the community are being taken into consideration during these planning efforts.

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

San Bernardino County Department of Behavioral Health (DBH) engaged in the planning process to ensure the unique needs of LGBTQ+ eligible adults were considered in the development of the County's Full Service Partnership (FSP) program. This process focused on understanding disparities, risk factors, and service gaps impacting this population, as well as identifying factors that influence behavioral health outcomes. Stakeholder input was incorporated to ensure services are inclusive, culturally responsive, and affirming. The planning process emphasized approaches that prioritize safety, inclusion, and individualized care, while recognizing the importance of trauma-informed practices and cross-system collaboration. Service data and stakeholder feedback from contracted providers was utilized to develop the County's FSPs. These efforts aim to reduce disparities, promote resilience, and improve outcomes for LGBTQ+ adults by ensuring that FSP programs reflect their unique needs and support long-term recovery and wellness.

DRAFT

In, or are at risk of being in, the justice system

To address the unique needs of eligible older adults who are in, or at risk of involvement in, the justice system, the San Bernardino County Department of Behavioral Health (DBH) engaged in several key actions during the development of the County's Full-Service Partnership (FSP) programs. DBH reviewed service data and incorporated stakeholder feedback from contracted providers to ensure FSPs reflect the needs of this population. The department analyzed research and collaborated with community partners to identify gaps in care and housing stability for older adults with serious mental illness. These efforts informed strategies to provide comprehensive, integrated services that promote independence, safety, and access to housing resources. DBH's planning aligns with Behavioral Health Services Act (BHSA) goals and California Advancing and Innovating Medi-Cal (CalAIM) priorities, focusing on reducing suffering, improving resiliency, and enhancing life functioning for older adults.

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

Mobile Wellness Outreach Unit Operations

DRAFT

Program descriptions
Targeted mobile outreach program informed by geocoded overdose data from San Bernardino County's Opioid Data Analytics and Surveillance for Harm Reduction (ODASH) system.

Current funding source
DMC-ODS and for the vehicle: ARPA grant

BHSA changes to existing programs to meet BHSA requirements
Mobile wellness vehicle partners substance use disorder staff with Homeless outreach staff to provide life-saving overdose prevention and response services and infectious disease prevention services to high-risk individuals.

Expected timeline of operation
Already implemented

Mobile-field based programs

Existing programs
Homeless Outreach Support Team (Host)

Program descriptions
Outreach in the field includes assistance to complete applications, assistance to gain necessary documentation, and linkage to benefits and other resources including SUD treatment.

Current funding source
MHSA and SUBG

BHSA changes to existing programs to meet BHSA requirements
Field based outreach by Mental Health and SUD staff to chronically homeless individuals including homeless encampments.

Expected timeline of operation
Already implemented

DRAFT

Open-access clinics

Existing programs
1. Emergency Department (ED) Bridge 2. Narcotic Treatment Programs (NTP) Providers 3. No wrong door policy

Program descriptions
1. Emergency Department (ED) Bridge program: Supports same-day 24/7 access to Medications for Addiction Treatment (MAT) services by approaching substance use disorder (SUD) as a treatable chronic illness. 2-3. Narcotic Treatment Program (NTP) Providers and No Wrong Door Policy: Contracted MAT providers that service all regions of the county, including partnerships with neighboring counties for rural areas such as Trona and Yucca Valley.

Current funding source
DMC-ODS, SUBG, MHSA

BHSA changes to existing programs to meet BHSA requirements
Local Hospitals provide same-day access to Medications for Addiction Treatment (MAT). Narcotic Treatment Program (NTP) providers offer same-day service. San Bernardino County follows a "No Wrong Door" (NWD) policy for behavioral health services, ensuring Medi-Cal beneficiaries receive timely mental and substance use treatment without being turned away if they seek help from an incorrect entry point.

Expected timeline of operation
All programs already implemented

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Predictive modeling outreach

Program descriptions
Guidance based on predictive modeling offered by statistics and applied mathematics faculty from local universities will provide optimal targeted outreach based on available statistical methods.

DRAFT

Planned funding
DMC-ODS

Planned operations
Academic partners will provide their recommendations in ongoing collaborative meetings in which both county and community resources are coordinated to maximize impact on overdose events based on best available predictions.

Expected timeline of implementation
2029

Mobile-field based programs

New programs
Mobile Clinic

Program descriptions
Provide field-based Medications for Addiction Treatment (MAT) services via mobile clinic

Planned funding
SUBG, OSF, DMC-ODS

Planned operations
Leverage technology such as satellite internet access and telehealth to provide clinical field-based services in remote areas.

Expected timeline of implementation
2026-2027

Open-access clinics

New programs
1. Expand Medications for Addiction Treatment (MAT) same-day service availability and 2. Walk-in Clinic

DRAFT

Program descriptions
Add County run and contracted providers

Planned funding
DMC-ODS, SUBG

Planned operations
1. Target expansion of Medication for Addiction Treatment (MAT) providers to high-need or underserved regions of the county and target. 2. Open walk-in clinic to provide low-barrier access to MAT services

Expected timeline of implementation
2029

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
Currently, we cross-reference initial contact log entries with Medications for Addiction Treatment (MAT) client episodes to determine timeliness. Further analysis of this data provides insights into needs in specific regions and populations. The department is pursuing multiple paths to increase access and capacity to meet the need for MAT services. These paths include expanding internal MAT service capacity, establishing new partnerships with Narcotic Treatment Program (NTP) providers, leveraging technology to ease access for field-based staff to medical providers, and predictive modeling to anticipate areas of need.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
Operate MAT clinics directly
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)
Partner with neighboring counties
Contract with MAT providers in other counties
Other strategy

DRAFT

Please provide the names of the neighboring counties the county will partner with
Kern County and Riverside County

Please provide the names of other counties the contracted MAT providers are located in
Kern County and Riverside County

Please explain what other strategy the county will use
not applicable

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine
Methadone
Naltrexone
Other

Please specify other forms of MAT
long acting injectable Vivitrol, Acamprosate, and Disulfiram

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

DRAFT

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
Medium gap

Housing in mobile home communities
Medium gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Not applicable

(Permanent) Tiny homes
Not applicable

Shared housing
Medium gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Large gap

DRAFT

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Small gap

License-exempt room and board
Not applicable

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Not applicable

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
Medium gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
No gap

Peer Respite
Not applicable

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

DRAFT

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 ?

The county behavioral health system currently utilizes time-limited Behavioral Health Bridge Housing (BHBH) funding, set to expire June 30, 2027, in conjunction with the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) to support Recovery Residences. The County partners with the Housing Authority of the County of San Bernardino (HACSB) and the Office of Homeless Services (OHS) to secure Permanent Supportive Housing (PSH) vouchers for individuals with Serious Mental Illness (SMI) and co-occurring conditions, leveraging State and Federal Continuum of Care (CoC) resources. To expand housing access, the County employs a comprehensive network of local, state, and federal programs that create a full housing continuum—from emergency shelter to long-term PSH—while addressing affordability and stability barriers. Key resources include the Homeless Housing Assistance and Prevention (HHAP) program, which supports flexible housing interventions and outreach, and Project Homekey, which funds acquisition and rehabilitation of motels and hotels for permanent housing. Collaboration with HACSB, city housing departments, and community-based organizations ensures prioritized referrals, dedicated voucher set-asides, and supportive housing operations. Grants fund housing navigation and case management, while the Coordinated Entry System (CES) prioritizes individuals for housing opportunities. Regional homelessness task force participation aligns strategies with public health, probation, and social services. Additional supports include Interim Assistance for individuals in board-and-care settings without income while seeking SSI or employment, and Mental Health Block Grant funding to maintain housing stability through treatment access. These partnerships and resources collectively strengthen the housing continuum and increase access to safe, affordable, and stable housing paired with supportive services that promote recovery and long-term wellness for BHSA-eligible individuals. Furthermore, the County maintains a data-sharing agreement led by the County Administrative Office (CAO) to coordinate homeless reduction efforts across systems of care. The Homeless Multi-Disciplinary Team (MDT) works across departments to increase housing access and leverage non-BHSA funds for long-term housing solutions.

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?

Behavioral Health Services Act (BHSA) Housing Interventions intersect with federal, state, and local resources to strengthen and expand the housing continuum for BHSA-eligible individuals through a highly integrated approach. These interventions operate within the County's Coordinated Entry System (CES), ensuring consistent prioritization across Housing and Urban Development (HUD), state, and local programs. After the six months of transitional rent provided by Managed Care Plans (MCPs) beginning January 1, 2026, BHSA can extend support by covering additional rental assistance and essential needs such as utilities, emotional support animal accommodations, and household items. To maximize impact, the County employs layered funding strategies that combine BHSA subsidies with Section 8 vouchers, No Place Like Home units, Project Homekey properties, and Homeless Housing Assistance Program (HHAP) resources, reducing financial barriers and expanding housing capacity. BHSA also provides intensive

DRAFT

supportive services—including case management and behavioral health care—to complement housing-focused services offered by other programs, ensuring individuals maintain housing stability. Partnerships with housing authorities, community-based providers, and programs such as Innovative Remote Onsite Assistance Delivery (InnROADs) further enhance outreach and engagement, connecting individuals, including those living in encampments to housing and supportive services. Additionally, the County maintains a data-sharing agreement led by the County Administrative Office (CAO) to coordinate homeless reduction efforts across systems of care. The Homeless Multi-Disciplinary Team (MDT) works across departments to increase housing access and leverage non-BHSA funds for long-term housing solutions. This flexibility allows individuals to transition seamlessly between temporary, transitional, and permanent housing while receiving continuous behavioral health support. Through these integrated strategies, BHSA Housing Interventions strengthen the housing continuum and promote long-term stability, recovery, and wellness 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?

The county behavioral health system employs a comprehensive, collaborative approach to promote permanent housing placement and retention for individuals receiving Behavioral Health Services Act (BHSA) Housing Interventions. The strategy begins with effective outreach and engagement when relevant housing opportunities become available, ensuring a timely connection to resources. At the leadership level, regular meetings coordinated through the County Administrative Office (CAO) focus on building a robust housing continuum, managing funds through the Department of Community Development and Housing (CDH), and implementing structural shifts that enable departments to work collectively toward shared goals. A key component of this strategy is the Homeless Multi-Disciplinary Team (MDT), which operates across multiple departments to increase housing access and leverage non-BHSA funding sources for long-term housing solutions. To strengthen housing stability, the County will explore building in incentives and milestones for providers and exploring opportunities to pivot shelter programs into month-to-month lease arrangements, creating a pathway to permanent housing. Supportive services delivered through Evidence-Based Practices (EBPs), Managed Care Plans (MCPs), and Enhanced Care Management (ECM) are integrated to promote long-term success and retention. Partnerships with the Office of Homeless Services (OHS) further enhance coordination and resource alignment, ensuring individuals have access to housing navigation, case management, and wraparound supports in a timely manner. This multi-pronged approach maximizes available resources, fosters collaboration, and supports sustainable housing outcomes for individuals served by BHSA programs.

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)?

DRAFT

The county behavioral health system offers a housing continuum designed to support individuals experiencing homelessness and behavioral health challenges. The Recovery Residence program provides a supervised, substance-free, peer-supported environment that promotes sustained recovery from substance use disorders while preparing clients for permanent housing rather than serving as a permanent housing solution. Stays are individualized based on treatment needs and do not exceed 24 months, with rental assessments conducted at admission to determine affordability. Clients without income have 60 days to secure employment or benefits before paying rent, while those with income contribute no more than 40% of their adjusted monthly income, with allowances for utilities. Rent collected may offset program costs or be placed in trust funds to assist clients with future housing expenses, such as deposits and move-in costs. Rapid Re-Housing (RRH) complements these efforts by providing short-term financial assistance and intensive case management to help individuals quickly transition from homelessness to permanent housing, focusing on self-sufficiency and stability. For individuals with Serious Mental Illness (SMI) or co-occurring conditions, the County's Permanent Supportive Housing (PSH) system relies on the Department of Behavioral Health's Homeless Outreach Support Team (HOST) program for housing navigation and ongoing supportive services, working closely with the Housing Authority, Office of Homeless Services (OHS), and Community Development and Housing (CDH) to prioritize units and align resources. HOST also offers bridge housing during navigation. The Innovation Remote Onsite Assistance Delivery (InnROADs) program expands outreach to individuals in encampments, connecting them to the housing continuum. These efforts are supported by a countywide data-sharing agreement led by the County Administrative Office (CAO) and coordinated through the Homeless Multi-Disciplinary Team (MDT), which fosters cross-department collaboration and leverages resources to provide a full continuum of services from outreach and shelter placement to long-term supportive housing. Additionally, the county behavioral health system is participating in an initiative led by Chief Administrative Officer (CAO) to identify and improve access and referral points to the County's housing and supportive services.

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

The County Behavioral Health (DBH) system delivers housing intervention services through a recovery-focused, multidisciplinary team that includes DBH Homeless Outreach Support Team (HOST) staff, contracted providers, and Innovation Remote Onsite Assistance Delivery (InnROADs) outreach specialists. This collaborative approach addresses both clinical needs and daily living skills to promote client wellness and long-term housing stability. All participants receive comprehensive behavioral health care, including therapy, case management, life skills development, employment support, and connections to community resources. Individualized service plans integrate treatment and housing goals, ensuring tailored support throughout the housing process. Clients also benefit from high-intensity, on-site therapeutic groups, skills training, and structured peer and staff support designed to strengthen functioning and promote stability. Regular multidisciplinary team meetings foster coordinated communication, early identification of challenges, and timely intervention. As individuals transition into housing, the team

DRAFT

maintains ongoing involvement, linking them to continued services and ensuring access to all necessary supports. This integrated approach provides a consistent pathway from engagement to placement to long-term community stability. Contracted Recovery Residence providers are required to establish collaborative community partnerships to ensure linkages with additional service organizations. These efforts align with Federal, State, and County goals to prevent relapses through community supports, reduce fragmentation of care, and improve communication among local providers. Additionally, Lighthouse referrals, managed by DBH, serve as a dedicated point of contact to collaborate with Lighthouse staff and ensure access to housing resources. Lighthouse Social Services assists participants in achieving permanent housing and maintaining stability through programs, services, and resources that break the cycle of homelessness. Screening and assessment for substance use disorder are required for program referral. Through Evidence-Based Practices (EBPs) under California Advancing and Innovating Medi-Cal (CalAIM) initiatives, Full-Service Partnerships (FSPs) play a critical role in supporting individuals to secure and maintain housing. These efforts are strengthened by a countywide data-sharing agreement, led by the County Administrative Office (CAO) and coordinated through the Homeless Multi-Disciplinary Team (MDT), fostering cross-department collaboration and resource integration. Together, these strategies leverage collective expertise to deliver a full continuum of care, from outreach and shelter placement to long-term supportive housing, ensuring a seamless and coordinated approach to client stability and recovery.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

Referrals are facilitated through multiple coordinated behavioral health pathways to ensure individuals with significant treatment needs are appropriately linked to housing and community-based supports. The Innovation Remote Onsite Assistance Delivery (InnROADs) program conducts initial screening during outreach and engagement encounters, and when necessary, a full clinical assessment is completed in the field. Referrals may originate from the Department of Behavioral Health's Long-Term Care (LTC) program or Centralized Hospital Aftercare Services, which assist individuals transitioning from higher levels of locked psychiatric care into community settings. The LTC team evaluates referrals, conducts eligibility assessments, and connects individuals to contracted partners for further assessment and admission. Upon placement, a Client Resource Evaluation is completed to identify additional needs and guide service planning. Referrals may also come from contracted Crisis Residential Treatment facilities as part of coordinated discharge planning. Together, these pathways ensure timely assessment, appropriate placement, and smooth transitions into community-based housing and services. Clients must be in recovery and identified as part of the continuum of care population. Outpatient and Intensive Outpatient Treatment clients are assessed at admission to determine individualized treatment services and identify supportive services necessary for sustainable recovery. Recovery Residences may be recommended as a supportive service, with referrals submitted to the Substance Use and Recovery Services Administration for outpatient clients. Perinatal clients must be enrolled in a Perinatal Treatment program and maintain

DRAFT

attendance throughout their Recovery Residence stay. Any Department of Behavioral Health (DBH)-linked client is eligible for Lighthouse services, and referrals can be submitted by any DBH staff member who identifies a housing need. A streamlined referral process is currently being developed within the new behavioral health continuum in partnership with Community Development Housing and the Office of Homeless Services to align referral pathways and ensure timely access to care. This will include a structured referral process that establishes clear entry points, integrates access lines for mental health and substance use services, and enables tracking and monitoring of progress. It ensures housing interventions meet required timeframes while supporting smooth transitions to appropriate levels of care. By embedding access lines into the workflow, clients receive timely connections to behavioral health and supportive housing resources, reinforcing a coordinated approach that promotes stability and recovery.

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
San Bernardino County Department of Behavioral Health (DBH) engaged in multiple actions to consider the unique needs of eligible children and youth involved in, or at risk of involvement in, the juvenile justice system when developing Housing Intervention services. DBH reviewed service data and incorporated stakeholder feedback to identify gaps and inform program design. The department implemented targeted programs such as the Juvenile Justice Reintegration Program, which provides individualized case planning, home visits, and referrals to community resources for youth transitioning from detention or probation. DBH also operates One Stop Transitional Age Youth (TAY) Centers for youth ages 16–25, including those re-entering from the justice system, offering drop-in access to basic needs such as showers, food, and laundry, along with counseling, vocational support, and housing referrals. Additionally, DBH funds the STAY, a 14-bed crisis residential facility for transitional-age youth, providing short-term stays, counseling, and connections to permanent housing and community supports, and has designated shelter beds within its provider network for youth and TAY populations. These programs were developed through collaboration with probation and local nonprofits to ensure justice-involved youth have access to safe housing and comprehensive wraparound services that promote stability and successful reintegration. DBH reviewed data from these programs to guide housing intervention planning.

DRAFT

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

To address the housing needs of eligible children and youth who identify as LGBTQ+, the San Bernardino County Department of Behavioral Health (DBH) engaged in several actions. DBH reviewed service data and gathered stakeholder feedback through its Office of Equity and Inclusion and the Cultural Competency Advisory Committee, which includes an LGBTQ+ Awareness Subcommittee. These groups informed culturally responsive strategies and policy improvements. DBH analyzed research and developed resources such as the Inland Empire LGBTQ+ Resource Guide to ensure providers have access to affirming practices. The department also partnered with community organizations, including Rainbow Pride Youth Alliance, to provide free, gender-affirming therapy and support services. For housing interventions, DBH implemented the "Welcome Home" Family Assistance Program, offering housing and case management for LGBTQ+ transitional-age youth (TAY) experiencing homelessness, and designated shelter beds within its provider network for LGBTQ+ youth. Additionally, DBH promotes inclusion through multilingual services, resource sharing, and participation in local LGBTQ+ Pride events to strengthen community engagement. DBH utilized stakeholder engagement in the development of housing intervention services. These efforts ensure housing interventions are equitable, affirming, and responsive to the unique needs of LGBTQ+ youth in San Bernardino County.

In the child welfare system

To address the unique housing needs of children and youth in the child welfare system, the San Bernardino County Department of Behavioral Health (DBH) engaged in multiple actions. DBH reviewed service data and collaborated with stakeholders, including San Bernardino County Children and Family Services (CFS), to inform housing interventions. Through its Transitional Age Youth (TAY) program, DBH is establishing a Memorandum of Understanding (MOU) with CFS to coordinate referrals and services for youth eligible for the Independent Living Program (ILP). This partnership involves working closely with ILP staff, youth, community agencies, and other counties to strengthen communication, create clear referral pathways, and enhance linkage to housing resources. Both agencies actively engage in community outreach to ensure effective service delivery. These efforts align with Behavioral Health Services Act (BHSA) goals to reduce suffering associated with serious mental illness and emotional disorders, while improving resiliency and functioning in critical areas such as housing, education, employment, and interpersonal relationships for youth transitioning from the child welfare system.

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

The County Behavioral Health System engages in ongoing, targeted efforts to support older adults by collaborating closely with programs such as Agewise Full-Service Partnership (FSP) to identify and address the unique needs of this population. We place a strong focus on the unique needs of older adults who are

DRAFT

experiencing homelessness in our county, ensuring they receive specialized attention and resources. Through these partnerships, the County provides access to appropriate behavioral health services, care coordination, and supportive resources that promote wellness, stability, and quality of life for older adults. In addition, the County actively participates in committees focused on older adult services, working collaboratively to develop strategies that enhance service delivery and address emerging needs within this vulnerable population.

In, or are at risk of being in, the justice system

The County Behavioral Health System maintains ongoing collaboration with the Sheriff's Department, local law enforcement agencies, and justice partners to support individuals at risk of involvement in the criminal justice system. These efforts include coordinated case management, diversion planning, and linkage to behavioral health services to prevent justice involvement and promote stabilization, treatment, and access to community-based supports. This collaboration extends across all justice partners, including probation, the Sheriff's Department, the State Department of Corrections, the Department of State Hospitals, the courts, and Arrowhead Regional Medical Center (ARMC). These initiatives align with California Advancing and Innovating Medi-Cal (CalAIM) priorities and focus on a targeted population requiring comprehensive and integrated care. While resources in this area remain limited, expanding capacity to meet these needs is a key focus for future planning and development. DBH utilized stakeholder engagement in the development of housing intervention services.

In underserved communities

The County Behavioral Health System actively facilitates and participates in multiple county initiatives, including the Criminal Justice Collaborative, the countywide Multi-Disciplinary Team (MDT), and the Continuum of Care (COC). Through ongoing collaboration with the Housing Authority and the Office of Homeless Services (OHS), the County works to expand access to housing and supportive services for underserved communities. These partnerships strengthen efforts to address housing insecurity while ensuring individuals receive the behavioral health care necessary for stability and recovery. In addition to housing initiatives, the County has implemented strategies that have successfully reduced the state hospital population, aligning with state requirements and improving community-based care options. Continued utilization of the Community Assistance Recovery and Empowerment (CARE) Court and Assisted Outpatient Treatment (AOT) further enhances support for individuals with complex behavioral health needs. All efforts remain focused on priority populations identified under the Behavioral Health Services Act (BHSA), ensuring equitable access to services and resources for those most in need. Stakeholders with lived experience are actively engaged in the development and planning of housing intervention services, reinforcing a person-centered approach to care.

DRAFT

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 Behavioral Health System collaborates extensively with cities and other departments to strengthen infrastructure under the Multi-Disciplinary Team (MDT) initiative, which includes developing systems for data sharing and implementing a bed capacity tracking system through the Office of Homeless Services' (OHS) Homeless Management Information System (HMIS). Housing interventions are coordinated through the Continuum of Care (CoC) in partnership with the Housing Authority of the County of San Bernardino (HACSB), which serves as the primary point of contact for referrals organized through the Coordinated Entry System (CES). This coordination is facilitated by the Department of Behavioral Health's Homeless & Supportive Services division, ensuring streamlined access to housing and supportive services. When potential clients are identified, DBH works closely with the CoC to initiate referrals, which are submitted to the Behavioral Health Bridge Housing (BHBH) inbox for review by Department of Behavioral Health (DBH) staff. For clients already connected to DBH, referrals are forwarded to Lighthouse for additional housing support. For individuals not yet engaged with DBH but presenting with mental health or substance use needs, DBH ensures linkage to appropriate behavioral health services before submitting a referral to Lighthouse. This collaborative process promotes timely access to housing resources and behavioral health care, supporting stability and recovery for individuals experiencing homelessness while reinforcing a coordinated, person-centered approach across county systems.

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

The County Behavioral Health System collaborates extensively with cities and other departments to strengthen infrastructure under the Multi-Disciplinary Team (MDT) initiative, which includes developing systems for data sharing and implementing a bed capacity tracking system through the Office of Homeless Services' (OHS) Homeless Management Information System (HMIS). Housing interventions are coordinated through the Continuum of Care (CoC) in partnership with the Housing Authority of the County of San Bernardino (HACSB), which serves as the primary point of contact for referrals organized through the Coordinated Entry System (CES). This coordination is facilitated by the Department of Behavioral Health's Homeless & Supportive Services division, ensuring streamlined access to housing and supportive services. When potential clients are identified, DBH works closely with the CoC to initiate referrals, which are submitted to the Behavioral Health Bridge Housing (BHBH) inbox for review by Department of Behavioral Health (DBH) staff. For clients already connected to DBH, referrals are forwarded to Lighthouse for

DRAFT

additional housing support. For individuals not yet engaged with DBH but presenting with mental health or substance use needs, DBH ensures linkage to appropriate behavioral health services before submitting a referral to Lighthouse. This collaborative process promotes timely access to housing resources and behavioral health care, supporting stability and recovery for individuals experiencing homelessness while reinforcing a coordinated, person-centered approach across county systems.

Public Housing Agency

The County Behavioral Health System is actively building capacity in partnership with Community Development and Housing (CDH), the Office of Homeless Services (OHS), the Housing Authority (HA), and the Continuum of Care (CoC). Recently, the County agreed to serve as co-lead for the Managed Care Plans' (MCP) Transitional Residential (TR) and Community Support (CS) services, a role that requires strong partnerships and ongoing collaboration. DBH works closely with CDH and HA to implement housing interventions and coordinates directly with Public Housing Authorities to assist clients throughout the housing process. Staff provide hands-on support by scheduling and attending appointments, offering coaching, and guiding clients through requirements to ensure successful outcomes. This approach helps individuals access permanent supportive housing and connect to community-based services while reinforcing partnerships with local CoC, housing developers, and other providers. These efforts strengthen the County's ability to address housing insecurity and behavioral health needs, promoting stability and recovery for vulnerable populations.

MCPs

The Department of Behavioral Health (DBH), in collaboration with the County Office of Homeless Services (OHS) and Community Development and Housing (CDH), will serve as the transitional rent provider for the county. This role requires strong partnership and ongoing collaboration with Medi-Cal Managed Care Plans (MCPs) to ensure successful implementation of the county's housing interventions. Through this coordinated effort, DBH and its partners aim to remove barriers to housing access and support individuals in achieving stability.

ECM and Community Supports Providers

The County Behavioral Health System collaborates closely with Enhanced Care Management (ECM) and Community Supports providers through ongoing coordination and regular meetings with the Office of Homeless Services (OHS) and other community partners. The program links individuals to appropriate services and supports, assisting with enrollment and completion of necessary paperwork to ensure seamless access to housing interventions. This approach facilitates coordinated care, supports smooth transitions during discharge or placement, and strengthens connections between behavioral health services and housing resources, including permanent supportive housing and other community-based supports.

DRAFT

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)

The County Behavioral Health System collaborates with a broad network of housing partners, including California Work Opportunity and Responsibility to Kids (CalWORKs)/Temporary Assistance for Needy Families (TANF) housing programs, child welfare housing programs, permanent supportive housing (PSH) developers, and other community-based providers, to implement housing interventions that promote stability and recovery. The program assists individuals in connecting to appropriate services and programs, supporting enrollment and completion of necessary paperwork, including during discharge planning, to ensure smooth transitions and sustained access to resources. This coordinated approach strengthens partnerships across housing and supportive service providers, enhances client access to permanent supportive housing, and promotes long-term well-being for individuals with behavioral health needs. Additionally, Lighthouse provides housing support services for CalWORKs clients under a separate Memorandum of Understanding (MOU), which operates independently of Behavioral Health Services Act (BHSA) funding. While these efforts represent significant progress, we acknowledge the need to continue building and refining this process. Currently, many operations occur in silos, which can limit efficiency and collaboration. Moving forward, our focus will be on breaking down these silos, fostering stronger integration among partners, and ensuring a seamless, client-centered approach to housing and behavioral health services.

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?

Eligible individuals can be enrolled through the Homeless Outreach Support Team (HOST) program, and its existing Mental Health Services Act (MHSA) policies already align with Housing Intervention support. Additional coordination will be needed to incorporate the Managed Care Plan (MCP) covered transitional rent for the first six months. The Innovative Remote Onsite Assistance Delivery (InnROADs) will provide Housing Intervention outreach and engagement for Homekey+ and other supportive housing sites. This may include locating individuals already identified by the county's behavioral health system or referring eligible clients to appropriate programs. Enhanced services (PACES) and Community Reintegration Services (CRS) deliver coordinated onsite clinical and case-management support to individuals placed in contracted residential treatment settings, including Enhanced Board and Care and Enhanced Assisted Living facilities. These supportive services are designed to help individuals stabilize and maintain their housing successfully. When individuals are ready for discharge, the adult residential treatment certified in social rehabilitation model services will facilitate transitions by making appropriate referrals and assisting with required paperwork to ensure continuity of care and housing stability.

DRAFT

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

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?
The County Behavioral Health System anticipates serving approximately 720 individuals annually through the Behavioral Health Services Act (BHSA) Housing Interventions program, providing rental subsidies to support housing stability for those with behavioral health needs. This number includes individuals receiving services for mental health and/or substance use disorders, ensuring comprehensive support for priority populations as part of an integrated approach to recovery and long-term wellness.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
20

DRAFT

How many of these individuals will receive rental subsidies for interim housing on an annual basis?

700

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's approach to estimating total rental subsidies and the annual number of individuals served is grounded in known, ongoing commitments and identified program needs. Specifically, the methodology accounts for the 20 established units or vouchers that currently receive consistent, ongoing rental subsidies. In addition, projections incorporate the expectation that all Enhanced Services for Supportive Housing (ESS) model clients will require assistance with interim housing rental subsidies. Together, these factors form the foundation for estimating both the total subsidy requirements and the number of individuals served in interim and permanent housing settings each year. For Substance Use Disorder (SUD) services, the estimated cost per client is $15,832, which includes all Rapid Rehousing (RRH) services such as temporary housing, navigation, and rental subsidies. This figure is derived by dividing the total contract amount by the projected number of clients served.

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
Time Limited Interim Settings: Hotel and motel stays
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: Short-Term Post-Hospitalization housing
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single and multi-family homes

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Behavioral Health Services Act (BHSA) Housing Interventions funding supports a range of housing-related services that promote stability and recovery for individuals experiencing homelessness or housing

DRAFT

insecurity, addressing both mental health and substance use disorder (SUD) needs. The Homeless Outreach Support Team (HOST) program utilizes this funding to provide interim housing for clients awaiting placement into Permanent Supportive Housing (PSH), ensuring a safe and stable environment during the transition period, and offers rental assistance to individuals already placed in PSH to maintain housing stability and prevent returns to homelessness. Complementing these efforts, the Innovative Remote Onsite Assistance Delivery (InnROADs) program provides outreach and engagement, connecting individuals to housing resources and supporting them through navigation and placement. The Recovery Residence Program prioritizes perinatal clients, including pregnant and postpartum women and their children, Post Release Community Supervised clients referred by County Probation, Screening Assessment and Referral Center (SARC) referrals, and CalWORKs-eligible clients. Referrals are submitted by Department of Behavioral Health (DBH) staff, and any staff member identifying a housing need may initiate a referral. Rapid Rehousing (RRH) services are available to families as long as one household member is connected to DBH services, ensuring comprehensive support for housing stability and recovery.

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?

Project-based
Tenant-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

To identify a portfolio of available units for placing Behavioral Health Services Act (BHSA) eligible individuals with mental health and substance use disorder (SUD) needs, the County Behavioral Health system engages in strategic collaboration with key partners, including the Housing Authority and the Coordinated Entry System (CES). Through ongoing coordination, programs such as Homeless Outreach Support Team (HOST) and Innovative Remote Onsite Assistance Delivery (InnROADs) work to identify eligible clients for housing voucher opportunities and ensure timely placement into appropriate housing units. HOST actively collaborates with the Housing Authority and CES to match individuals with available housing resources, including vouchers and Permanent Supportive Housing (PSH) options, while InnROADs provides critical outreach and engagement services to help clients navigate the housing process. Additionally, the County explores the use of Flex Pools, such as Master Leasing, to expand the portfolio of available units and increase housing options for BHSA-eligible individuals. These efforts are complemented by landlord outreach activities conducted by Lighthouse to secure additional housing opportunities. For recovery residence services, the Department of Behavioral Health Substance Use Disorder and Recovery Services (DBH SUDRS) currently contracts with Inland Valley Recovery Services, New Hope, and Veterans Alcoholic Rehabilitation Program (VARP), with two additional providers, Avector Community Group, Inc., and Momentum Behavioral Health Services, Inc., pending approval by the Board of Supervisors on

DRAFT

December 16, 2025. Collectively, these collaborative strategies aim to streamline housing placements, reduce barriers, and promote long-term stability for individuals with behavioral health needs.

Total number of units funded with BHSA Housing Interventions per year
520

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
The County's includes the housing strategy Enhanced Services for Supportive Housing (ESS) model, which provides up to 500 interim housing beds that are not tied to specific units. This flexible approach ensures that individuals with behavioral health needs, both mental health and substance use disorder (SUD), have access to safe, temporary accommodations while awaiting placement into permanent housing solutions. By maintaining a pool of available beds rather than fixed units, the Enhanced Services for Supportive Housing (ESS) model allows for rapid response to client needs, reduces barriers to housing access, and supports continuity of care during the transition period. This model complements other housing interventions, such as the Homeless Outreach and Support Team (HOST) and Innovative Remote Onsite Assistance Delivery (InnROADs), which focus on permanent supportive housing placements, rental assistance, and navigation services, collectively promoting housing stability and recovery for Behavioral Health Services Act (BHSA) eligible individuals.

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
144

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Behavioral Health Services Act (BHSA) Housing Interventions funding is used to support housing stability and operational sustainability within Adult Residential Treatment facilities. A portion of the daily rate is allocated to cover essential operating costs associated with the day-to-day physical management of these facilities. This includes expenses such as utilities, maintenance and repairs, property taxes and insurance, property management services, office supplies, legal and accounting services, cleaning fees, and other

DRAFT

housing-related incidentals. By funding these operational components, the intervention ensures that facilities remain safe, functional, and supportive environments for BHSA-eligible individuals receiving residential treatment services.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

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
72

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
not applicable

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
The County is not providing this intervention because it falls outside the scope of the programs referenced. Specifically, Homeless Outreach Support Team (HOST) and Innovative Remote Onsite Assistance Delivery (InnROADs) do not currently provide Landlord Outreach and Mitigation Funds. Additionally, several programs are not applicable as they focus on supportive services rather than landlord engagement. For example, certain programs are designed to assist clients in maintaining housing or obtaining permanent housing, while others, such as adult residential treatment programs, provide on-site services to individuals once placed. These programs do not include landlord outreach or mitigation activities as part of their service model.

DRAFT

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Landlord Outreach and Mitigation Funds administered through Lighthouse are utilized to encourage and incentivize property owners to rent to eligible individuals. These funds help reduce perceived risks for landlords by offering financial support and resources, thereby expanding housing opportunities for individuals with behavioral health needs. This approach strengthens partnerships with property owners and promotes housing stability for vulnerable populations.

Total number of units funded with BHSA Housing Interventions per year
0

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
The county behavioral health system in collaboration with Community Development and Housing will utilize outreach and mitigation funds to outreach and engage landlords and property owners in becoming behavioral health housing providers. Funds will be used to support landlords and property owners in meeting housing requirements and to establish incentives to grow the counties inventory of permanent supportive housing. Funds will also be used to provide training and education to landlord and property owners on behavioral health topics with the goal of participant retention in housing. Mitigation funds will be used for any damages caused by a participant, rental insurance, eviction prevention or unit hold costs. Mitigation funds use and cost will be informed and updated by stakeholders through ongoing stakeholder engagement with housing intervention providers.

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

DRAFT

Anticipated number of individuals served per year
800

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The Homeless Outreach Support Team (HOST) program leverages Behavioral Health Services Act (BHSA) Housing Interventions funding to address critical barriers to housing stability by covering a wide range of essential costs that support individuals in securing and maintaining permanent housing. These costs include fees for obtaining identification and vital documents, housing application fees, and credit report fees. Funding also supports security and utility deposits, move-in expenses such as food, hygiene products, and moderate furnishings, as well as items needed for emotional support animals (e.g., crates or kennels). Additionally, BHSA funds may be used to assist with rent and utility arrears, helping clients overcome financial obstacles to housing access. Complementing these efforts, Lighthouse provides security deposits, utility assistance, and household goods required for new placements, further ensuring that individuals have the resources necessary for a successful transition into stable housing.

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
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The County is not currently providing (California Advancing and Innovating Medi-Cal) CalAIM Housing Transition Navigation Services and Tenancy Sustaining Services through the Homeless Support Outreach Team (HOST) and Innovative Remote Onsite Assistance Delivery (InnROADs) programs, as staff responsible for these functions have transitioned to the Office of Homeless Services (OHS). This transition supports a

DRAFT

more centralized and coordinated approach to delivering housing-related services under the CalAIM framework. While CalAIM-specific services are not offered through these programs, other County initiatives focus on providing supportive services that assist individuals in maintaining or obtaining housing. For example, Adult Residential Treatment facilities certified under the social rehabilitation model operate as residential programs offering on-site services to individuals once placed. The Placement After Stabilization (PAS) program helps clients transition from Crisis Residential Treatment facilities or temporary emergency shelter room-and-board housing into permanent housing. Additionally, programs such as the Program for Assisting and Coordinating Enhanced Services (PACES) and Community Reintegration Services (CRS) provide ongoing support to help clients sustain housing stability. Furthermore, services defined in the Community Supports Policy Guide are incorporated through housing navigation activities within the Rapid Rehousing (RRH) process. Collectively, these efforts ensure that individuals with mental health and substance use disorder (SUD) needs receive comprehensive support to secure and maintain housing, even as CalAIM-specific services are centralized under OHS.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

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
3520

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Innovative Remote Onsite Assistance Delivery (InnROADs) is a multi-disciplinary, field-based team that provides housing intervention services through outreach and engagement with individuals experiencing homelessness across San Bernardino County. Utilizing Behavioral Health Services Act (BHSA) Housing Interventions funding, InnROADs staff travel throughout the county to conduct direct outreach, facilitate navigation of housing resources, and implement harm reduction strategies. The housing programs play a critical role in connecting individuals to appropriate behavioral health services and housing opportunities. This includes coordinating care for individuals placed in contracted residential treatment facilities and emergency shelters through the Department of Behavioral Health. BHSA funding supports these efforts by enabling staff to engage individuals in the community, assess housing needs, and provide linkage to services that promote housing stability and recovery.

DRAFT

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
Over the next year, this effort will be developed in collaboration with the County Administrative Office, the Office of Homelessness Services, and other relevant departments to identify and advance capital development opportunities.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
The County provides a range of housing-related supportive services through various programs that are not categorized under traditional housing interventions. These services are designed to help individuals maintain or obtain stable housing by addressing behavioral health needs and promoting overall wellness. Some programs offer Full Service Partnership (FSP) services, which include therapy, case management, crisis intervention, and therapeutic groups, all aimed at supporting individuals in maintaining their housing for as long as possible. Other programs focus on linkage services to connect individuals with permanent housing opportunities, while also providing therapy, crisis intervention, and case management to ensure continuity of care. Additionally, the County operates adult residential treatment programs that deliver on-site services to individuals once placed. These programs are not housing interventions per se, but they provide essential residential behavioral health treatment and support.

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
400

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)
To ensure continuity and stability in housing support services, Behavioral Health Services Act (BHSA)

DRAFT

Housing Interventions will be utilized to assist Behavioral Health Bridge Housing (BHBH) rapid rehousing rental assistance clients, as well as individuals placed in hotel/motel interim housing, in coordination with Managed Care. To ensure continuity and stability in housing support services, BHSA Housing Interventions funding will be utilized to assist BHBH rapid rehousing rental assistance clients, as well as individuals placed in hotel and motel interim housing. Coordination with Managed Care Plans (MCP) will be essential to align with the six-month rental assistance period covered by MCP funding. Sustained funding for the BHBH Enhanced Shelter is also critical to maintain operations and continue providing essential shelter and supportive services to individuals experiencing homelessness. Currently, time-limited BHBH funding, which expires June 30, 2027, is being used in conjunction with the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) to fund Recovery Residences. To maintain housing supply, expand capacity, and increase access for BHSA-eligible individuals, BHSA resources will be required beyond the expiration of BHBH funding. Additionally, the County anticipates transitioning the Lighthouse program, currently funded by BHBH to BHSA funding to ensure ongoing support for housing placements and stability.

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
Undecided

Housing Deposits
Undecided

Housing Tenancy and Sustaining Services
Undecided

DRAFT

Short-Term Post-Hospitalization Housing
Undecided

Recuperative Care
Undecided

Day Habilitation
Undecided

Transitional Rent
Undecided

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)?
The County Behavioral Health System will identify, confirm eligibility, and refer members through the Homeless Outreach Support Team (HOST) program to housing-related community supports covered by the Managed Care Plans (MCPs), in partnership with Public Health Services (PHS), which serves as the County's Community Supports (CS) provider.

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
The county behavioral health system will maintain the Managed Care Plans (MCPs) informed of the behavioral health contracted provider network for Housing Interventions through their agreement with Community Development and Housing (CDH) and leadership meetings with the MCPs. CDH is the transitional rent provider for the county.

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?
San Bernardino County Department of Behavioral Health (DBH) has multiple processes to ensure Medi-Cal

DRAFT

members with significant behavioral health conditions do not experience gaps in care when Managed Care Plan (MCP) housing supports are exhausted, subject to resource availability. The county provides intensive services through Full-Service Partnerships (FSP), which offer comprehensive support, including housing assistance, case management, and linkage to community resources for individuals with severe mental illness. DBH also enforces a Continuity of Care policy that allows beneficiaries to maintain services with their current provider for up to 12 months during transitions, preventing disruptions that could lead to hospitalization. Additionally, DBH uses a Tier Transition Protocol to move clients who no longer meet medical necessity for specialty mental health services to MCP-provided mild/moderate services, ensuring coordination with plans like Inland Empire Health Plan (IEHP), Molina, Kaiser, and Health Net. When MCP housing benefits end, DBH leverages Behavioral Health Services Act (BHSA) housing funds and partnerships with programs such as LightHouse Health & Housing to provide rental subsidies and supportive housing. Crisis and engagement services, including 24/7 crisis lines, mobile crisis teams, and outreach programs like Recovery Based Engagement Support Team (RBEST), are available to stabilize individuals during transitions. These efforts align with state requirements for MCP and county coordination, ensuring continuity of care and housing stability for high-need Medi-Cal members.

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

DRAFT

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
No

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
DBH Response: Portal updated with this information: The County does not have plans to support or launch a flex pool. However, the County Behavioral Health system is coordinating with the County's Community Development and Housing Department and Office of Homeless Services as part of the broader Housing Interventions and Homelessness Strategic Planning efforts led by the County Administrative Office (CAO) to address homelessness. These efforts include coordinating funding, increasing the portfolio of available housing units, and identifying potential capital development projects.

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 innovative Teen 311 mobile application will help build the evidence base for the effectiveness of new statewide strategies by demonstrating how technology can reduce barriers to mental health access among adolescents. Currently, research shows that approximately 30% of teens have a clinically significant mental

DRAFT

health need, yet only 25% of those in need receive services due to stigma, lack of awareness, and logistical challenges. By providing a confidential, user-friendly platform that directly links students to mental health and supportive services, this pilot addresses these barriers head-on. By tracking usage patterns, referral rates, and outcomes, this pilot will generate actionable evidence on whether mobile-based interventions can effectively enhance statewide strategies for adolescent mental health. If successful, this model can be scaled to other districts, supporting a data-driven approach to policy and program development.

Please describe intended outcomes of the project

The Teen 311 mobile application aims to increase access to mental health and supportive services for adolescents by reducing common barriers such as stigma, lack of awareness, and logistical challenges. Implemented across Adelanto High School, Silverado High School, Victor Valley High School, and one middle school, the pilot will serve approximately 7,598 students, with an estimated 2,279 teens likely to have clinically significant mental health needs based on national prevalence data. By providing a confidential, user-friendly platform that directly links students to care, the project intends to boost help-seeking among teens in need from the current 25% to 40%, thereby narrowing the gap between identified needs and actual service delivery. The program will also generate actionable evidence to inform statewide strategies by tracking app usage, referrals, and service engagement, ultimately supporting improvements in student well-being and academic success while establishing a scalable model for adolescent mental health access.

DRAFT

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

DRAFT

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)?
15

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Professional Clinical Counselor
Licensed Clinical Social Worker
Substance Use Disorder Counselor
Licensed Psychologist
Licensed Marriage and Family Therapist

Please describe any other key workforce gaps in the county
The San Bernardino County Department of Behavioral Health (DBH) provides critical behavioral health and substance use disorder services to a community of over 2.2 million residents across one of California's largest geographic counties. DBH currently employs more than 1,500 full-time equivalent (FTE) positions dedicated to the delivery of care across outpatient, crisis, residential, and community-based programs. Despite this scale, DBH is experiencing an approximate 15% vacancy rate, with the most significant gaps occurring in the classifications of Clinical Therapist, Alcohol and Drug Counselor, and Social Worker. These vacancies directly affect service capacity, access to timely care, and the County's ability to meet increasing demand for integrated behavioral health services. Documented labor market conditions drive recruitment challenges at both the state and national levels. According to the U.S. Bureau of Labor Statistics,

DRAFT

occupations central to DBH's workforce are projected to grow faster than average through the next decade, including substance abuse, behavioral disorder, and mental health counselors (17% growth), marriage and family therapists (13%), and social workers (6%), with tens of thousands of annual openings nationally due to growth and replacement needs. In California, projections are even more pronounced, with mental health and substance abuse counselors projected to grow by more than 20% and mental health social workers by approximately 19% over the next decade. These trends indicate sustained competition among counties, hospitals, health systems, and private providers for a limited pool of qualified candidates. Compounding these pressures, DBH's highest-vacancy classifications require graduate education, extensive supervised clinical hours, and state licensure, resulting in a lengthy pipeline from education to independent practice. While new graduates continue to enter the workforce, national workforce analyses project persistent shortages in behavioral health professions well into the future due to demand growth, retirements, burnout, and training capacity constraints. Without targeted workforce investments, DBH anticipates continued difficulty recruiting and retaining qualified staff. Integrated Plan funding is therefore critical to support workforce development strategies that expand the pipeline, accelerate time-to-practice, and stabilize staffing levels necessary to sustain integrated, high-quality behavioral health services for San Bernardino County residents.

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)?

Over the next three fiscal years (FY 2026–2029), the San Bernardino County Department of Behavioral Health (DBH) expects workforce needs to shift toward larger, more flexible, and more clinically skilled teams to implement new evidence-based practices and community-based service models required under Behavioral Health Transformation (BHT) and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). This shift emphasizes integrated care, culturally responsive practice, and timely access across the continuum, which will require increasing staffing levels, realigning roles, and introducing new classifications that better match evolving operational needs. DBH will evaluate its current structure, reviewing vacancy rates, assessing whether existing roles meet program requirements, and reallocating resources from areas of overcapacity to areas of greatest need, to ensure the workforce reflects the populations served and can deliver at scale. As of February 20, 2026, DBH's vacancy rate is 14.5%, with 1,415 filled positions and 240 vacancies, concentrated in key classifications: Clinical Therapist I (35), Clinical Therapist II (28), Social Worker II (17), and Alcohol and Drug Counselors (16). To meet BHT and BH-CONNECT expectations, DBH's three year plan includes: same day offer hiring events (including spring and winter fairs for new clinical graduates); allowing graduates to apply three months before graduation to secure employment contingent on completion; and establishing a Pre Licensed Clinical Therapist Trainee classification for graduates awaiting registration with the California Board of Behavioral Sciences, with advancement to Pre Licensed Clinical Therapist upon obtaining registration and meeting performance standards. DBH has also updated minimum qualifications for Clinical Therapist II,

DRAFT

reducing required licensed experience from two years to one, to widen the candidate pool and support a career trajectory that includes Clinic Supervisor and Program Manager pathways for those seeking long-term service with the County. To sustain recruitment and retention aligned with BHT and BH-CONNECT, DBH is developing targeted promotional materials highlighting staff only perks (license exam prep, employee scholarships, educational internships) and opportunities (loan repayment, tuition assistance, Good Neighbor programs), and is determining the optimal timing to share these materials with candidates (e.g., at recruitment, interview, or offer stages). DBH is producing client success stories and employee testimonial videos to convey the impact and meaning of the work; conducting employee surveys to refine recruitment and retention strategies; and expanding advertising across alumni job boards, local radio, movie theaters, the DBH website, targeted e-publications, and culturally diverse media venues to strengthen a workforce that represents the community served. Operationally, DBH is reevaluating group requests to fill positions across multiple divisions to maximize applicant volume (similar to hiring events), re-engaging at local community events to reach potential candidates, and expanding the Employee Educational Internship Program to include interested County employees from non-clinical departments, to convert them into DBH behavioral health providers upon graduation. To guide continuous improvement, DBH is investing in enhanced tracking tools and/or additional staff to monitor turnover, identify effective hiring strategies, measure average length of employment by classification, and produce regular and ad hoc reports on vacancies and recruitment outcomes. Taken together, these actions describe how workforce needs will shift: DBH will grow and diversify clinical capacity, create and adapt roles to match integrated, evidence-based, community-based practice requirements, accelerate hiring and onboarding, strengthen retention through supports and career pathways, and use data to dynamically deploy resources where they are most needed. The department's target is to reduce the vacancy rate to below 10% on an ongoing basis, while "leveling up" the workforce to meet the demands of a transformed behavioral health system and ensure timely, equitable, and effective services under BHT and BH-CONNECT.

DRAFT

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 plans to fully leverage the BH-CONNECT workforce initiative to address critical workforce challenges and prepare for upcoming requirements under Behavioral Health Transformation and BH-CONNECT to the best of its ability. These initiatives emphasize integrated, evidence-based practices, culturally responsive care, and community-based service delivery, which will require a workforce that is both clinically skilled and reflective of the populations served. However, the county's ability to fully utilize the Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP) is complicated by collective bargaining agreements and labor union constraints regarding recruitment and retention bonus distributions. Additionally, the program presents operational and financial risks as the program lacks funding for administrative costs and requires the county to assume full responsibility for recouping funds if employees fail to meet service obligations. To navigate these obstacles, the county will focus on strengthening workforce capacity, evaluating current structures, and ensuring alignment with evolving needs. This includes reviewing vacancy rates, assessing existing roles, and determining where adjustments or new classifications may be necessary. These efforts will help ensure timely access to care and sustain high-quality behavioral health services.

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 Department of Behavioral Health (DBH) Workforce Education and Training team is actively reviewing BH-CONNECT workforce programs to identify opportunities that align with county priorities and address critical workforce needs. As part of this effort, the team collaborates with the department's Public Information Office to ensure timely and accurate dissemination of program information. This includes sharing updates, promotional materials, and relevant details with internal staff and contracted providers to increase awareness and encourage engagement. By maintaining ongoing review and communication, DBH aims to support workforce development initiatives that promote integrated, evidence-based, and culturally responsive care across the 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

DRAFT

Please explain any actions or activities the county is engaging in to leverage the program

The county is reviewing opportunities to leverage the BH-CONNECT workforce initiative, including the Behavioral Health Community-Based Provider Training Program, as part of its broader workforce development strategy. The Department of Behavioral Health (DBH) Workforce Education and Training team is actively monitoring BH-CONNECT programs to stay informed about available resources and potential benefits for both county staff and contracted providers. To support awareness and engagement, the team collaborates with the department's Public Information Office to disseminate program information through targeted communications to applicable internal staff and contracted agencies. These efforts ensure that stakeholders are informed about training opportunities that align with BH-CONNECT objectives, such as promoting integrated, evidence-based, and culturally responsive care. Through this ongoing review and communication process, the county aims to position its workforce to meet evolving requirements under Behavioral Health Transformation and strengthen capacity for community-based service delivery.

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

The County is committed to addressing disparities in the behavioral health workforce through strategic initiatives that promote diversity, cultural responsiveness, and language access. A key effort includes fully leveraging the Behavioral Health-CONNECT (BH-CONNECT) workforce initiative to address critical workforce challenges and prepare for upcoming requirements under Behavioral Health Transformation and BH-CONNECT. These initiatives emphasize integrated, evidence-based practices, culturally responsive care, and community-based service delivery, which require a workforce that is clinically skilled and reflective of the populations served. To achieve these goals, the County is focusing on strengthening workforce capacity, evaluating current structures, and ensuring alignment with evolving needs. This includes reviewing vacancy rates, assessing existing roles, and determining where adjustments or new classifications may be necessary. These efforts will help ensure timely access to care and sustain high-quality behavioral health services. The Department of Behavioral Health (DBH) will continue to strengthen language capacity through targeted recruitment and retention strategies to increase bilingual staff across threshold and emerging languages. All DBH job postings include bilingual skills as a desired qualification. While Spanish remains a primary threshold language, DBH will expand outreach efforts to recruit individuals fluent in languages such as Cambodian, Thai, Mandarin, Vietnamese, American Sign Language (ASL), and other languages spoken by clients. In addition, DBH maintains contracted language service vendors to supplement workforce capacity and ensure meaningful access to care while long-term workforce capacity efforts continue. Vendors provide timely access to over 25 languages and dialects. Currently, DBH has 287 Spanish-speaking bilingual staff, 152 of whom are direct service providers. The

DRAFT

remaining staff have direct contact with clients and assist clients in navigating our system of care at their various program locations. Additionally, DBH has bilingual staff for the following languages: Farsi, Vietnamese, ASL, and Arabic. For a total of 291 bilingual staff. English, Spanish, Mandarin, Vietnamese, and Cambodian are the top 5 most requested languages from our clients. Language requests are monitored on an ongoing basis to assess language access needs from our clients and inform recruitment efforts. These figures highlight the continued need for targeted recruitment in emerging languages to meet the linguistic and cultural needs of diverse communities. Through these efforts, DBH is actively working to reduce disparities and ensure a behavioral health workforce that reflects and effectively serves the County's population.

DRAFT

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
SBC DBH BHSA Integrated Plan Budget Template - CAO 022026 TS 2.0.xlsx

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)
The County does not have funds in excess of the maximum allowed prudent reserve limit. Therefore, there are no additional allocations planned for any Behavioral Health Services Act (BHSA) components beyond what is already reflected in the budget. All prudent reserve funds remain within the allowable limit in compliance with BHSA requirements.

Full Service Partnership (FSP)
The County does not have funds in excess of the maximum allowed prudent reserve limit. Therefore, there are no additional allocations planned for any Behavioral Health Services Act (BHSA) components beyond what is already reflected in the budget. All prudent reserve funds remain within the allowable limit in compliance with BHSA requirements.

DRAFT

Housing Interventions
The County does not have funds in excess of the maximum allowed prudent reserve limit. Therefore, there are no additional allocations planned for any Behavioral Health Services Act (BHSA) components beyond what is already reflected in the budget. All prudent reserve funds remain within the allowable limit in compliance with BHSA requirements.

Enter date of last prudent reserve assessment
9/12/2024

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
The County does not have excess prudent reserve funds drawn down from the local prudent reserve. However, the County remains committed to ensuring that any future allocations or adjustments will align with the goals and priorities outlined in the Integrated Plan to support comprehensive and coordinated behavioral health services.

FSP
The County does not have excess prudent reserve funds drawn down from the local prudent reserve. However, the County remains committed to ensuring that any future allocations or adjustments will align with the goals and priorities outlined in the Integrated Plan to support comprehensive and coordinated behavioral health services.

Housing Interventions
The County does not have excess prudent reserve funds drawn down from the local prudent reserve. However, the County remains committed to ensuring that any future allocations or adjustments will align with the goals and priorities outlined in the Integrated Plan to support comprehensive and coordinated behavioral health services.

DRAFT

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

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

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

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Appendix A

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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 Table One.

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.

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.

Row 44: 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 26 through 42.

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) 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 Counties must promote access to care through efficient use of state and county resources as outlined 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.

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			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older	Eligible
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 4,387,864.89	$ 4,519,500.84	$ 4,655,085.86	$ 2,563,194.33	$ 2,640,090.16	$ 2,719,292.87	2330	2547
Early Intervention Services	☑	$ 2,515,848.03	$ 2,591,323.47	$ 2,669,063.17	$ 154,647.75	$ 159,287.18	$ 164,065.80	1011	1091
Outpatient Services	☑	$ 16,861,262.61	$ 17,367,100.49	$ 17,888,113.51	$ 587,340.40	$ 604,960.61	$ 623,109.43	1348	1455
Intensive Outpatient Services	☑	$ 2,333,556.86	$ 2,403,563.56	$ 2,475,670.47	$ 184,687.70	$ 190,228.33	$ 195,935.18	338	364
Crisis and Field-Based Services	☑	$ 324,478.87	$ 334,213.24	$ 344,239.63	$ 139,062.37	$ 143,234.24	$ 147,531.27	1404	1366
Residential Treatment Services	☑	$ 14,923,012.38	$ 15,370,702.75	$ 15,831,823.83	$ 1,362,538.58	$ 1,403,414.74	$ 1,445,517.18	367	365
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 10,630,774.37	$ 10,949,697.60	$ 11,278,188.53	$ 3,282,900.64	$ 3,381,387.66	$ 3,482,829.29	674	727
Early Intervention Services	☑	$ 14,191,306.58	$ 14,617,045.78	$ 15,055,557.15	$ 30,995,118.98	$ 31,924,972.55	$ 32,882,721.73	4044	4364
Outpatient and Intensive Outpatient Services	☑	$ 126,371,227.06	$ 130,162,363.87	$ 134,067,234.78	$ 192,420,960.44	$ 198,193,589.26	$ 204,139,396.94	15447	16821
Crisis Services	☑	$ 30,457,916.54	$ 31,371,654.04	$ 32,312,803.66	$ 20,972,666.30	$ 21,601,846.29	$ 22,249,901.68	3033	3273
Residential Treatment Services	☑	$ 40,172,949.16	$ 41,378,137.63	$ 42,619,481.76	$ 5,651,815.64	$ 5,821,370.11	$ 5,996,011.22	674	727
Hospital and Acute Services	☑	$ 64,114,874.10	$ 66,038,320.32	$ 68,019,469.93	$ 14,981,839.75	$ 15,431,294.95	$ 15,894,233.79	337	364
Subacute and Long-Term Care Services	☑	$ 112,220.83	$ 115,587.45	$ 119,055.07	$ 28,055.21	$ 28,896.86	$ 29,763.77	337	364
Housing Services (MH + SUD)									
Housing Intervention Component Services	☑	$ 15,029,285.56	$ 15,480,164.12	$ 15,944,569.05	$ 433,053.20	$ 446,044.79	$ 459,426.13	2359	2546
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)	-	$ 342,426,577.83	$ 352,699,375.16	$ 363,280,356.42	$ 273,757,881.30	$ 281,970,617.74	$ 290,429,736.27	33703	36374

DRAFT

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activites, other than those that are part of the Behavioral Health Care Continuum in Table Two.

Rows 19 through 22: 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 Table One, "BH CoC Expenditures."

Row 24: total projected expenditures will be auto-populated from rows 19 through 22.

Note:

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	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 23,733,452.48	$ 24,445,456.05	$ 25,178,819.73
Workforce Investment Activities	$ 6,158,209.97	$ 6,342,956.27	$ 6,533,244.96
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 44,666,621.59	$ 46,006,620.24	$ 47,386,818.84
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs	$ 3,659,407.65	$ 3,769,189.88	$ 3,882,265.58
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 78,217,691.69	$ 80,564,222.44	$ 82,981,149.11

DRAFT

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 Table Three.

Rows 19 through 34: counties shall report projected expenditures for each funding source/program.

Row 22: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 27: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 36: total expenditures will be auto-populated from rows 19 through 34.

Row 37: will be auto-validated by DHCS against rows 36, 38, and 39. Validation: total projected unspent BHSA funds should total out to $0.

Rows 38 and 39: will be auto-validated by DHCS against total projected expenditures in Tables 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 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.

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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	$ 257,203,093.04	$ 263,241,358.34	$ 269,460,771.60
1991 Realignment (Bronzan-McCorquodale Act)	$ 71,206,565.25	$ 74,288,076.96	$ 77,462,034.03
2011 Realignment (Public Safety Realignment)	$ 106,290,855.80	$ 109,479,581.47	$ 112,763,968.92
State General Fund	$ 4,237,500.00	$ 4,364,625.00	$ 4,495,563.75
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 197,699,409.86	$ 205,308,219.65	$ 213,145,293.73
Projects for Assistance in Transition from Homelessness (PATH)	$ 526,611.00	$ 542,409.33	$ 558,681.61
Community Mental Health Block Grant (MHBG)	$ 5,233,073.00	$ 5,390,065.20	$ 5,551,767.15
Substance Use Block Grant (SUBG)	$ 10,509,884.00	$ 10,825,180.52	$ 11,149,935.94
Commercial Insurance	$ 1,150,000.00	$ 1,184,500.00	$ 1,220,035.00
County General Fund	$ 2,110,492.00	$ 2,110,492.00	$ 2,110,492.00
Opioid Settlement Funds	$ 8,834,666.86	$ 9,099,706.87	$ 9,372,698.07
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 0.00	$ 0.00	$ 0.00
Other county mental health or SUD funding	$ 29,400,000.00	$ 29,400,000.00	$ 29,400,000.00
Other foundation funding	$ -	$ -	$ -
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)	$ 694,402,150.82	$ 715,234,215.34	$ 736,691,241.80
Total projected unspent BHSA funds	$ 0.00	$ 0.00	$ 0.00
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 616,184,459.13	$ 634,669,992.90	$ 653,710,092.69
Auto-validation: Table 2: Other County Expenditures	$ 78,217,691.69	$ 80,564,222.44	$ 82,981,149.11

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Instructions

Counties shall report all of their planned transfers and approved Housing Intervention Component Exemption 1 in Table Four.

Rows 38-47: this section will be auto-populated from the sections below it.

Rows 38, 41, and 44: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 39, 42, and 45: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 46: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 47: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Row 50: enter the base funding for Housing Interventions in dollars in D50. The base percentage will be auto-populated in C50.

Note: the base funding available for all three components is net of BHSA plan administration expenses as detailed on tab "8. BHSA_PlanAdmin." For example, a total BHSA allocation of $1 million - 9% Plan Admin (4% I&M for a small county + 5% IP annual planning) = $910,000 total allocation available for all three components. This would result in $273,000 in base funding for HI (30% of $910,000) and $318,500 for both FSP and BHSS (35% of $910,000)".

Row 51: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components in C51. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Row 52: 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 in C52. Enter this percentage as a positive value.

Row 55: enter the base funding for Full Service Partnerships, in dollars, in D55. The base percentage will be auto-populated in C55. See the "Note" for Row 50 related to the total BHSA allocation and plan admin.

Row 59: enter the base funding for Behavioral Health Services and Supports, in dollars, in D59. The base percentage will be auto-populated in C59. See the "Note" for Row 50 related to the total BHSA allocation and plan admin.

Rows 56 and 60: enter the percentage transferred from Housing Interventions for Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 53, 57, and 61: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively.

Rows 65, 71, and 77: auto-populated.

Rows 66, 72, and 78: Enter the transfer-out percentage as a positive number. It will automatically display as a negative value in the cell.

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 66) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 67, 73, and 79: enter your transfer in percentage as a positive number.

Rows 68, 74, and 80: the new base percentage is auto-populated for each year.

Row 83-87: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Unspent MHSA funds do not include encumbered WET, CFTN, or INN projects that were operational prior to July 1, 2026. Please see Policy Manual Chapter 6, Section 7 for additional information regarding MHSA to BHSA transitions.

Row 88: the total dollar amount is auto-populated.

Row 91: enter the dollar amount of prior year prudent reserve ending balance

Row 92: enter the prudent reserve maximum for your county.

Row 93: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate.

Row 94-96: enter the amount of excess prudent reserve funds to allocated to each component.

Row 97: 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 Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ -	$ -	$ -
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%

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Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ -	$ -	$ -
Unspent Mental Health Services Act (MHSA) to BHSA	$ 12,726,726.61	$ 18,813,163.13	$ 212,039,230.26	$ 243,579,120.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Component Percentage**	**Housing Intervention Funds**
Base Percentage	30%	$ -
Amount Transferring Out	0%	$ -
Amount Transferring In	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ -
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage	35%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ -
Transferred To/From	**Behavioral Health Services and Support Percentage**	
Base Percentage	35%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ -

Funding Transfer Request Allocations			
Year 1			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 2			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 3			
	Housing Intervention Component (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%

MHSA Transfers to BHSA				
MHSA Component	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention Component**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
CSS	$ 185,120,131.20	$ 9,672,312.22	$ 14,298,003.98	$ 161,149,815.00
PEI	$ 46,280,032.80	$ 2,418,078.06	$ 3,574,501.00	$ 40,287,453.75
INN	$ 12,178,956.00	$ 636,336.33	$ 940,658.16	$ 10,601,961.51

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WET	$ -				$ -
CFTN	$ -				$ -
Total (auto-populated)	$ 243,579,120.00	$ 12,726,726.61	$ 18,813,163.13	$ 212,039,230.26

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	$ 21,655,429.00
Local Prudent Reserve Maximum (2)	$ 33,634,228.00
Excess Prudent Reserve Funding that must be transferred	**$ (11,978,799.00)**
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 totalfunds distributed to the county Behavioral Health Services Fundover 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.

4. W&I Code § 5892, subdivision (b)6)(A) states counties must spend prudent reserve funds Housing Intervention, FSP, and/or BHSS programs or services only.

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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 Table Five.

Rows 35-37: input the estimated total Housing Intervention component allocation received for each year. Row 35 will include projected BHSA funding received. Row 36 will include unspent MHSA dollars carried over. Row 37 will auto-populate the sum of Rows 35-36 to account for total funding.

Rows 42-57: input the projected expenditures and projected slots for each Housing Intervention component service category or program for each year.

Row 41: 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 46: 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, E, and G. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns I - K.

Row 58: the sub-total of rows 42 - 57 will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 60: input the projected expenditures for Housing Interventions component's administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).

Row 61: the overall total of Housing Intervention expenditures will be auto-populated from rows 58 and 60.

Row 63: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. allocations. This amount should equal 50% of Housing Interventions component

Row 64: input the total dollar amount for Housing Intervention components 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 63.

Row 66: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69: the proportion of funds dedicated to capital development funds will be auto-populated from rows 55 and 37.

Row 70: the proportion of funds dedicated to the chronically homeless population will be auto-populated from rows 63 and 37.

Rows 72 and 73: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

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 (1)			
	Year 1	**Year 2**	**Year 3**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 61,609,490.50	$ 63,457,775.21	$ 65,361,508.47

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Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 61,609,490.50	$ 63,457,775.21	$ 65,361,508.47

	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - All Other Funding Sources		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
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	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 32,298,439.19	$ 32,298,439.19	$ 32,298,439.19	$ -	$ -	$ -
% 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	$ 15,283,161.02	$ 15,283,161.02	$ 15,283,161.02	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$3,331,275.28	$ 3,431,213.54	$ 3,534,149.94	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%

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Other Housing Supports: Landlord Outreach and Mitigation Funds) (2)	$ 10,000,000.00	$ 11,748,346.46	$ 13,549,143.31	$ -	$ -	$ -
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)	$ -	$ -	$ -	$ -	$ -	$ -
Innovative Housing Intervention Pilots and Projects	$ 696,615.00	$ 696,615.00	$ 696,615.00			
Subtotal (auto-populated)	$ 61,609,490.50	$ 63,457,775.21	$ 65,361,508.47	$ -	$ -	$ -

Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Administration	$ 2,121,121.10	$ 2,184,754.73	$ 2,250,297.38
Total Housing Interventions Expenditures (auto-populated)	$ 63,730,611.60	$ 65,642,529.95	$ 67,611,805.84

Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 750,533.85	$ 773,049.87	$ 796,241.36

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Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$246,020.32	$ 253,400.93	$ 261,002.96
Housing Interventions Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0%	0%	0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	1%	1%	1%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY	3638	3638	3638
Eligible Adults/Older Adults	3371	3371	3371

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.

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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.

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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 Table Six.

Rows 22-24: input the total estimated FSP component allocation received for each year. Row 22 will include projected BHSA funding received. Row 23 will include unspent MHSA dollars carried over. Row 24 will auto-populate the sum of Rows 22-23 to account for total funding.

Rows 29-37: 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 29 - 34. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 35 and 36, accordingly.

Row 38: the subtotal of FSP programs/services will be auto-populated from rows 29 through 37.

Row 40: input the projected expenditures for the FSP component's administration for each year (see Policy Manual Chapter 6, Section B.8 Cost Principals).

Row 41: total projected expenditures for FSP for each year will be auto-populated from rows 38 and 40.

Row 43: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable.

Row 44: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Rows 46 and 47: input the estimated unduplicated count of individuals that will be served across all FSP programs.

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 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 71,877,738.91	$ 74,034,071.08	$ 76,255,093.21
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 71,877,738.91	$ 74,034,071.08	$ 76,255,093.21

Full Service Partnership Category (1)										
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**			
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	
FSP Programs/Services										
Assertive Community Treatment (ACT)(2)	$ 289,331.63	$ 298,011.57	$ 306,951.92	$ 289,331.63	$ 298,011.57	$ 306,951.92	$ -	$ -	$ -	
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 1,774,934.00	$ 1,774,934.00	$ 1,774,934.00	$ 1,774,934.00	$ 1,774,934.00	$ 1,774,934.00	$ -	$ -	$ -	
FSP Intensive Case Management	$ 13,635,614.00	$ 14,097,930.43	$ 14,574,116.37	$ 13,635,614.00	$ 14,097,930.43	$ 14,574,116.37	$ -	$ -	$ -	
High Fidelity Wraparound	$ 39,451,140.27	$ 39,451,140.27	$ 39,451,140.27	$ 39,451,140.27	$ 39,451,140.27	$ 39,451,140.27	$ 29,400,000.00	$ 29,400,000.00	$ 29,400,000.00	
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 178,294.40	$ 183,643.23	$ 189,152.52	$ 178,294.40	$ 183,643.23	$ 189,152.52	$ -	$ -	$ -	
Assertive Field-Based Initiation for SUD Treatment Services	$ 5,526,345.26	$ 5,692,135.62	$ 5,862,899.69	$ 5,526,345.26	$ 5,692,135.62	$ 5,862,899.69	$ -	$ -	$ -	
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc,.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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Innovative FSP Pilots and Projects	$ 8,657,025.33	$ 8,657,025.33	$ 8,657,025.34						
Subtotal (auto-populated)	$ 69,512,684.88	$ 70,154,820.45	$ 70,816,220.11	$ 60,855,659.55	$ 61,497,795.12	$ 62,159,194.77	$ 29,400,000.00	$ 29,400,000.00	$ 29,400,000.00
FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**						
Full Service Partnership Administration	$ 5,500,581.23	$ 5,665,598.66	$ 5,835,566.62						
Total Full Service Partnership Expenditures (auto-populated)	$ 75,013,266.10	$ 75,820,419.12	$ 76,651,786.73						
FSP Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers into FSP component from Local Prudent Reserve	$ -	$ -	$ -						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**						
Eligible Children/TAY	16339	16339	16339						
Eligible Adults/Older Adults	13932	13932	13932						

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.

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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 Table Seven.

Row 26-28: input the total estimated BHSS component allocation received for each year. Row 26 will include projected BHSA funding received. Row 27 will include unspent MHSA dollars carried over. Row 28 will auto-populate the sum of Rows 26-27 to account for total funding.

Rows 31-43: input the projected expenditures for each BHSS service category or program for each year.

Row 44: the subtotal for projected expenditures will be auto-populated from rows 31-33, 36, 37, 40, and 43.

Row 46: input the total projected expenditures for BHSS administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).

Row 47: the total for projected BHSS expenditures will be auto-populated from rows 44 and 46.

Row 49: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable).

Row 50: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 52: the proportion of EI funds will auto-populate from rows 33 and 28. Note: MHSA WET and CF/TN funds in Row 61-62 will be deducted from the revenue.

Row 53: the proportion of Youth-Focused EI funds will auto-populate from rows 33 and 34.

Rows 55 and 56: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 58 and 59: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 61 and 62: auto-populates projected estimated amount of MHSA WET and CF/TN 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									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 71,877,738.91	$ 74,034,071.08	$ 76,255,093.21						
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -						
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 71,877,738.91	$ 74,034,071.08	$ 76,255,093.21						
Behavioral Health Services and Supports Category (1)									
BHSS Programs/Services									
Children's System of Care-Non FSP	$ 11,503,867.50	$ 11,848,983.53	$ 12,204,453.03	$ 11,503,867.50	$ 11,848,983.53	$ 12,204,453.03	$ -	$ -	$ -

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Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)((1) and 5892(a)((2)-Non FSP	$ 8,258,991.50	$ 8,506,761.25	$ 8,761,964.08	$ 8,258,991.50	$ 8,506,761.25	$ 8,761,964.08	$ -	$ -	$ -
Early Intervention Expenditures	$ 36,942,925.95	$ 38,051,213.73	$ 39,192,750.14	$ 6,025,645.05	$ 6,206,414.40	$ 6,392,606.83	$ -	$ -	$ -
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 33,506,776.45	$ 34,511,979.74	$ 35,547,339.14	$ 5,912,960.55	$ 6,090,349.37	$ 6,273,059.85	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 638,545.50	$ 657,701.87	$ 677,432.92	$ 112,684.50	$ 116,065.04	$ 119,546.99	$ -	$ -	$ -
Outreach and Engagement	$ 22,542,315.00	$ 23,218,584.45	$ 23,915,141.98	$ 22,542,315.00	$ 23,218,584.45	$ 23,915,141.98	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 5,897,017.00	$ 6,073,927.51	$ 6,256,145.34	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 6,046,381.00	$ 6,227,772.43	$ 6,414,605.60	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Innovative BHSS Pilots and Projects	$ 7,819,417.67	$ 7,819,417.67	$ 7,819,417.67						
Subtotal (auto-populated)	$ 99,010,915.62	$ 101,746,660.56	$ 104,564,477.85	$ 48,330,819.05	$ 49,780,743.62	$ 51,274,165.93	$ -	$ -	$ -
BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**						
Behavioral Health Services and Supports Administration	$ 5,072,751.94	$ 5,224,934.50	$ 5,381,682.54						
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 104,083,667.56	$ 106,971,595.06	$ 109,946,160.38						
BHSS Prudent Reserve Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers into BHSS component from Local Prudent Reserve	$ -	$ -	$ -						
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -						

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Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	Year 1	Year 2	Year 3
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	51%	51%	51%
Youth-Focused Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	91%	91%	91%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY	16397	16397	16397
Eligible Adults/Older Adults	16400	16400	16400
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**
BHSS transfer to WET	$ -	$ -	$ -
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET and CF/TN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
Estimated MHSA WET Funds	$ -	$ -	$ -
Estimated MHSA CF/TN Funds	$ -	$ -	$ -

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.

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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.

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Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Table Eight.

Row 30: the total dollar amounts 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.

Row 31: the total dollar amount 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.

Row 32: The total dollar amounts for new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 34: the total projected annual revenues of the Local Behavioral Health Services Fund.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 30 and 34.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 31 and 34.

Row 37: For counties with a population under 200,000: add any Improvement and Monitoring expenditures that exceed 4% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

For counties with a population over 200,000: add any Improvement and Monitoring expenditures that exceed 2% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

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Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures	$ 4,107,299.37	$ 4,230,518.35	$ 4,357,433.90
Total Projected County Integrated Plan Annual Planning Expenditures	$ 10,268,248.42	$ 10,576,295.87	$ 10,893,584.74
New and Ongoing Administrative Costs	$ -	$ -	$ -

Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 205,364,968.32	$ 211,525,917.37	$ 217,871,694.89
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2%	2%	2%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	5%	5%	5%
Supplemental BHT Implementation Funding (1)	$ -	$ -	$ -

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.

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Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Table Nine.

Rows 18 and 19: dollar amounts will be auto-populated from Table 4 rows 91 and 92

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18 and 19.

Rows 21-23: total dollar amounts will be auto-populated from Table 4, rows 94-96.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21 through 23.

Row 25: auto-validates from rows 20 and 24 to ensure the dollar amounts match with "equal" or "does not equal" statements.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations for each plan year will be auto-populated from Table 5 row 65, Table 6 row 42, and Table 7 row 46.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations for each plan year will be auto-populated from Table 5 row 64, Table 6 row 41, and Table 7 row 45.

Table Nine: Estimated Local Prudent Reserve Balance		
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$	21,655,429.00
Local Prudent Reserve Maximum (1)	$	33,634,228.00
Excess Prudent Reserve Funds (auto-populated)	$	(11,978,799.00)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$	-
Total prudent reservice funds above maximum allocated to Full Service Partnerships	$	-
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$	-

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Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	DOES NOT EQUAL
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 totalfunds distributed to the county Behavioral Health Services Fundover past five years (25% for counties with a population of less than 200,000).

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Instructions

Counties will complete Tables One through Nine prior to completing Table Ten. Data on other tables will auto-populate to Table Ten.

Row 22: the new base percentage for each component will be auto-populated from Table 4, row 38.

Rows 23-25: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Table 5, row 35; Table 6, row 22; and Table 7, row 25, respectively.

Row 28: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Table 4 row 46.

Rows 30, 37, and 44: The total amount of funding transfered from each BHSA component into the prudent reserve for each plan year will be auto-populated from Table 5, row 67; Table 6, row 44; and Table 7, row 49.

Rows 31, 38, and 45: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Table 5, row 66; Table 6, row 43; and Table 7, row 48.

Rows 32, 39, and 46: estimated available funding will be auto-populated from rows 28 through 31, 35 through 38, and 42 through 45.

Rows 33, 40, and 47: estimated expenditures for each component will be auto-populated from Table 5, row 61; Table 6, row 41; and Table 7, row 46.

Rows 35 and 42: The estimated unspent funds from prior fiscal years will be auto-populated from rows 32 and 33 and rows 39 and 40, respectively.

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**
Allocation Percentage, with Transfers	30%	35%	35%	100%
Year One Component Allocations	$ 61,609,490.50	$ 71,877,738.91	$ 71,877,738.91	$ 205,364,968.32
Year Two Component Allocations	$ 63,457,775.21	$ 74,034,071.08	$ 74,034,071.08	$ 211,525,917.37
Year Three Component Allocations	$ 65,361,508.47	$ 76,255,093.21	$ 76,255,093.21	$ 217,871,694.89
BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) ***(Unspent Carryover MHSA Funds)***	$ 12,726,726.61	$ 18,813,163.13	$ 212,039,230.26	$ 243,579,120.00
Estimated Year One Component Allocations ***(BHSA Funding Only)***	$ 61,609,490.50	$ 71,877,738.91	$ 71,877,738.91	$ 205,364,968.32
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers From PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year One	$ 74,336,217.11	$ 90,690,902.04	$ 283,916,969.17	$ 448,944,088.32

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Estimated Total Year One Expenditures	$ 63,730,611.60	$ 75,013,266.10	$ 104,083,667.56	$ 242,827,545.26
Year Two				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 10,605,605.51	$ 15,677,635.94	$ 179,833,301.61	$ 206,116,543.06
Estimated New Year Two Component Allocations ***(BHSA Funding Only)***	$ 63,457,775.21	$ 74,034,071.08	$ 74,034,071.08	$ 211,525,917.37
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Two	$ 74,063,380.72	$ 89,711,707.02	$ 253,867,372.69	$ 417,642,460.43
Estimated Total Year Two Expenditures	$ 65,642,529.95	$ 75,820,419.12	$ 106,971,595.06	$ 248,434,544.12
Year Three				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 8,420,850.77	$ 13,891,287.91	$ 146,895,777.63	$ 169,207,916.31
Estimated New Year Three Component Allocations ***(BHSA Funding Only)***	$ 65,361,508.47	$ 76,255,093.21	$ 76,255,093.21	$ 217,871,694.89
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Three	$ 73,782,359.24	$ 90,146,381.12	$ 223,150,870.84	$ 387,079,611.20
Estimated Total Year Three Expenditures	$ 67,611,805.84	$ 76,651,786.73	$ 109,946,160.38	$ 254,209,752.96

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