



Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: March 17, 2025

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Berkeley/ Albany Mental Health Commission

AGENDA

**Regular Meeting
Thursday, March 27, 2025**

All Agenda Items are for Discussion and Possible Action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less. The meeting may be recorded by staff to review the minutes to get accurate motions on record.*

Time: 7:00 p.m. - 9:00 p.m.

Location: North Berkeley Senior Center
1901 Hearst Ave. Berkeley, Poppy Room

- 1. Roll Call (1 min)**
- 2. Preliminary Matters**
 - a. Action Item: Approval of the March 27, 2025 meeting agenda
 - b. Public Comment (non-agenda items)
 - c. Action Item: Approval of the February 27, 2025 meeting minutes
- 3. Review, Discuss and Actions regarding the By-Laws for Berkeley Behavioral Health Commission.**
- 4. Interview and vote for new applicant – Patricia Fontana-Narell**
- 5. Interview and vote for new applicant – Maya Ezekiel**
- 6. Proposed Motion: Request City Council recommend local participation in local-based innovative behavioral health innovations**
- 7. Mental Health Manager’s Report and Caseload Statistics – provided by Jeff Buell**
 - a. MHC Manager Report
 - b. Caseload Statistic March 2025
- 8. Subcommittee Reports –**
 - a. **Membership Subcommittee – Discuss recruitment for Veteran’s and Education representative**



**Health, Housing & Community
Service Department
Mental Health Commission**

- b. Financial Subcommittee**
- c. Care Court Subcommittee**
- d. Evaluation Subcommittee**
 - i. Discussion and Possible Action on Mental Health Commission Annual Report**

9. Information concerning current Berkeley Behavioral Health services for children.

10. Following five domestic violence homicides, San Mateo County launches co-response pilot.

11. Adjournment

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. **Please note: Email addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record.** If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing and Community Services Department does not take a position as to the content.

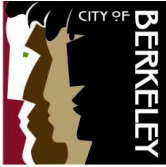
Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@berkeleyca.gov



*Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. **Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs. Thank you.***

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 2640 MLK Jr. Way, Berkeley, CA 9470



Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission Draft Minutes – Regular Meeting

7:00 pm
North Berkeley SC 1901 Hearst

Regular Meeting
February 27, 2025

Members of the Public Present: Jonah Markowitz, Eric Panganibau, Minali Aggamhl, Patricia Fontana, Ian Hunt, Ann Hawkins, Carole Marasovic

Staff Present: Jeff Buell, Karen Klatt, Scott Gilman Jamie Works-Wright

1) Call to Order at 7:05 pm

Commissioners Present: Andrea Prichett, Monica Jones; Edward Opton, Glenn Turner (7:10), Maria Sol, Ajay Krishnan; Lisa Teague; Ashley Gu **Absent:** Igor Tregub

2) Preliminary Matters

a) Approval of the February 27, 2025 agenda

M/S/C (Jones, Opton) Motion to approve the agenda.

PASSED

Ayes: Gu, Jones, Krishnan, Opton, Prichett, Sol, Teague; **Noes:** None; **Abstentions:** None; **Absent:** Tregub, Turner

b) Public Comment- 1 public comments

c) Approval of the January 23, 2024 Minutes

M/S/C (Jones, Turner) Motion to approve the minutes

PASSED

Ayes: Gu, Jones, Krishnan, Opton, Prichett, Sol, Teague, Turner; **Noes:** None; **Abstentions:** None; **Absent:** Tregub

3) Action to vote for Commission Chair –

M/S/C (Jones, Prichett) Jones motion to nominate Ajay Krishnan to take the Chair position and Ajay Krishnan accepted the nomination.

PASSED

Ayes: Gu, Jones, Krishnan, Opton, Prichett, Sol, Teague, Turner; **Noes:** None; **Abstentions:** None; **Absent:** Tregub

**4) Action to vote for Commission Vice Chair –
M/S/C (Sol, Prichett)**

Glen Turner self-nominated herself for Vice Chair. Ashley Gu was nominated by Maria and Ashley Gu accepted the nomination. Ashley Gu won 4 votes vs. Glenn Turners 2 vote.

PASSED

5) MHSA FY 26 annual update and BHSA – Karen Klatt – No Motion

6) Update about RDA and Bonita House SCU- Scott Gilman - No Motion

*8:54 Meeting extension

(Turner, Gu) Motion to extend the meeting to 9:15

PASSED

Ayes: Gu, Krishnan, Prichett, Opton, Sol, Teague, Turner; **Noes:** Jones; **Abstentions:** None

Absent: Tregub

7) Review Commissioner Prichett' s letter to HHCS Director Scott Gilman – No Motion

8) Mental Health Manager's Report and Caseload Statistics – provided by Jeff Buell – No Motion

- a. MHC Manager Report
- b. Caseload Statistic February 2025
- c. BHSA Transition Napa PPT.2.7.25.pdf

9) Review, Discuss and Actions regarding the By-Laws for Berkeley Behavioral Health Commission. No Motion

10) Subcommittee Reports – Did not get to items

- a) **Membership Subcommittee – welcome package for new members including a manual**
- b) **Financial Subcommittee**
- c) **Care Court Subcommittee**
- d) **Evaluation Subcommittee**
 - i) **Discussion and Possible Action on Mental Health Commission Annual Report**

**11) Discuss Role of MHC in advising on scope of BH (“behavioral health”) services. –
Did not get to item**

**12) Information concerning current Berkeley Behavioral Health services for children. -
Did not get to item**

- 13) Following five domestic violence homicides, San Mateo County launches co-response pilot. - Did not get to item
- 14) Adjournment - 9:15 PM

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

DRAFT

**BYLAWS OF THE
CITY OF BERKELEY BEHAVIORAL HEALTH COMMISSION**

ARTICLE I – NAME

The name of this Commission shall be the **Berkeley Behavioral Health Commission**.

ARTICLE II - AUTHORITY

The authority of the **Berkeley Behavioral Health Commission** is established pursuant to California Welfare and Institutions Code (WIC) 5604.

ARTICLE III - DUTIES

The duties of the Behavioral Health Commission (as defined in section 5604.2 and 5963.03 of the Welfare and Institutions Code) are as follows:

1. Review and evaluate the community’s public behavioral health needs, services, facilities, and special problems in any facility within the jurisdiction where behavioral health evaluations or services are being provided, including, but not limited to: schools, emergency departments, and psychiatric facilities.
2. Review any City agreements entered into pursuant to Section 5650. The local behavioral health commission may make recommendations to the City Council regarding concerns identified within these agreements.
3. Advise the Berkeley City Council and the Berkeley Behavioral Health Division Manager as to any aspect of the local behavioral health program. Local behavioral health commissions may request assistance from the local patients’ rights advocates when reviewing and advising on mental health or substance use disorder evaluations or services provided in public facilities with limited access.
4. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. Involvement shall include individuals with lived experience of mental illness and/or substance use disorder and their families, community members, advocacy organizations, and behavioral health professionals. It shall also include other professionals that interact with individuals living with mental illnesses/substance use on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.
5. Submit an annual report to the City Council on the needs and performance of the behavioral health system of the City of Berkeley.
6. Review and make recommendations on applicants for the appointment of a local director or manager of behavioral health services. The commission shall be included in the selection process prior to the vote of the governing body.

7. Review and comment on the City’s performance outcome data and communicate its findings to the California Mental Health Planning Council.
8. Assess the impact of the realignment of services from the state to the City on services delivered to clients and on the local community.
9. Perform such additional duties as may be assigned to the Behavioral Health Commission by the Berkeley City Council.
10. Behavioral Health Services Act (BHSA) Duties from WIC Code Section (5963.03)
 - a. Conduct BHSA Hearing: The Behavioral Health Commission established pursuant to Section 5604 shall conduct a public hearing on the draft three-year integrated plan [optional: “and annual updates”] at the close of the 30-day comment period.
 - b. Review/Recommendations on Adopted BHSA Plan: The Behavioral Health Commission shall review the adopted plan or update and make recommendations to the local mental health agency or local behavioral health agency, as applicable, for revisions. The local mental health agency or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the State Department of Health Care Services for any substantive [see (f) below] recommendations made by the local mental health commission that are not included in the final plan or update.

For the purposes of this section, "substantive recommendations made by the local behavioral health commission" refers to any recommendation presented to the commission and approved by a majority vote of the members present at a public hearing, provided that a quorum has been established.

ARTICLE IV - MEMBERSHIP

A. **Membership Requirements:** Membership is defined in accordance with California Welfare & Institutions Code (WIC) Section 5604 to include:

1. The Behavioral Health Commission shall consist of 11 members appointed by the City Council.
2. One (1) member shall be a designated Berkeley City Council member appointed by the City of Berkeley, Mayor.
3. Fifty percent (50%) of the commission membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received behavioral health services. Within these categories:
 1. One (1) of these members shall be an individual who is 25 years of age or younger.
 2. At least twenty percent (20%) of the total membership shall be consumers, and at least 20 percent (20%) shall be families of consumers.
4. In counties/cities with a population of 100,000 or more, at least one (1) member of the commission shall be a veteran or veteran advocate.
 1. For purposes of this section, "veteran advocate" means either a parent, spouse, or adult child of a veteran, or an individual who is part of a veterans organization, including the Veterans of Foreign Wars or the American Legion.
 2. To comply with clause (i), the City shall notify its county veterans service officer about vacancies on the commission, if a county has a veterans service officer.
5. At least one member (1) of the commission shall be an employee of a local education agency. (ii) To comply with clause (i), a county/city shall notify its county office of education about vacancies on the commission.
6. Membership should reflect the ethnic, cultural, racial and LGBTQ+ diversity of the clients served in the county/city.
7. The Behavioral Health Commission is encouraged to include individuals who have experience with and knowledge of the mental health system, such as members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.
8. Except as provided in the next paragraph, a member of the commission or the member's spouse shall not be a full-time or part-time City employee of a City behavioral health service, a full-time or part-time County employee of a County behavioral health service, or an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a behavioral health contract agency.
9. A consumer of mental health services who has obtained employment with an employer described in paragraph (10) and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the commission. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the commission.
10. If it is not possible to secure membership as specified from among persons who reside in the City, the Berkeley City Council may substitute representatives of the public interest in behavioral health who are not full-time or part-time employees (except as noted below*) of a City behavioral health service, a full-time or part-time County employee of a County behavioral health service, or an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a

behavioral health contract agency. *Section 5604 of the California Welfare and Institutions Code (3) (d) (1) and (2) states that Consumers may be employed by City or county behavioral health services or behavioral health contract agency as long as they don't have any financial or contractual interest, and are not allowed to vote on any financial or contractual issues concerning their employer that may come before the Commission.

11. Terms of Office: Terms for each member of the Behavioral Health Commission shall be three years. Members shall be limited to three consecutive, three-year terms unless waived by a majority vote of the Berkeley City Council.
12. Compensation: No member shall be compensated for duties performed as a member of the Behavioral Health Commission. Notwithstanding the previous sentence, a member may be reimbursed for the actual costs of attending meetings, conferences or similar gatherings if attendance at the meeting, conference or similar gathering is approved in advance in writing by the Behavioral Health Commission Chair and the Berkeley Behavioral Health Division Manager.

B. Process and Participation Requirements: A member of the Behavioral Health Commission must:

1. Be appointed by the Berkeley City Council.
2. Take the Oath of Office administered by the Clerk of the Berkeley City Council.
3. Maintain a satisfactory meeting attendance record to Behavioral Health Commission meetings and other assignments.
4. Comply with all applicable regulations of the Fair Political Practices Commission, including, but not limited to, preparing and filing FPPC Form 700, if required, within 30 days of appointment and annually prior to April 1st of each year.
5. Keep any confidential information obtained while performing duties as a Behavioral Health Commission member confidential.
6. Participate in site visits of a behavioral health facility or program, at least once per year, unless excused by the Executive Committee.
7. The activities and affairs of individual members of the Behavioral Health Commission, when acting as Commission members, shall be conducted, and powers exercised, by and under the direction of the Behavioral Health Commission and these bylaws.

C. Recruitment of Members

1. Responsibility for Recruitment. Recruitment of prospective members of the Berkeley Behavioral Health Commission shall be the responsibility of individual members of the Berkeley City Council and members of the Behavioral Health Commission who may recommend appointees to the City Council. An effort will be made to recruit individuals who have experience with and knowledge of the behavioral health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education,

large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, veteran's programs and community and nonprofit service providers.

2. Berkeley City Council Recruitment. City Council members are encouraged to nominate individuals from their respective district to facilitate wider representation across the City of Berkeley, for a total of ten Behavioral Health Commission members to be nominated and appointed by the City Council. The City Council may accept more than one nomination from each district based on interest and willingness of community members to serve.
3. Recruitment by the Behavioral Health Commission- Interview and Recommendation. All applicants, except those nominated directly by the City Council, shall be interviewed at the commission meeting by members of the Behavioral Health Commission. Names of the applicants recommended shall be presented to the full Behavioral Health Commission for its consideration. Those applicants recommended by the Behavioral Health Commission shall then be referred to the City Council with a recommendation they be appointed to the Berkeley Behavioral Health Commission.

ARTICLE V - MEETINGS

1. Annual Meetings. There shall be a regular meeting, which shall constitute the annual meeting of the Behavioral Health Commission, to be held on the fourth Thursday of January of each year at which time a meeting schedule (that includes regular meeting day, time and location will be adopted for the next twelve months, and elections held. If the fourth Thursday of January falls on a Holiday, the meeting shall be held on the third Monday of July.
2. Regular Meetings of the Behavioral Health Commission may be held at such time and place as is established by the annual meeting schedule.
3. Special Meetings. Special meetings, for any purpose or purposes related to the business of the Behavioral Health Commission, may be called at any time by the Chair of the Commission or by a majority of the Commission members.
4. Notice of Annual and Regular Meetings. Meeting agendas shall be posted 72 hours in advance on the city's website and given to each member of the Behavioral Health Commission by one or more of the following methods: (a) by personal delivery of written notice; (b) by first class mail, postage prepaid; (c) by fax transmittal or e-mail of written notice; or (d) by telephone, text or email, either directly to the member or to a person at the member's office or home who would reasonably be expected to communicate that notice promptly to the member. Notices sent by first class mail shall be deposited in the U.S. Mail not less than five days before the time set for the meeting. Notice given by personal delivery, fax, E-mail, or telephone shall occur at least 72 hours before the time set for the meeting. The notice shall be posted at least 72 hours prior to the meeting in a location that is freely accessible to members of the public.
5. Notice of Special Meeting. A special meeting may be called at any time by the Chair of the Behavioral Health Commission or by a majority of the Behavioral Health Commission members. Notice of special meetings shall be posted 24 hours in advance on the city's website and shall be provided to each member of the Behavioral Health Commission and to local media that has requested notice. The notice

shall be delivered personally or by any other means and shall be received at least 24 hours before the time of the meeting as specified in the notice. The notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Commission. The notice shall be posted at least 24 hours prior to the special meeting in a location that is freely accessible to members of the public.

ARTICLE VI - OFFICERS

1. Officers of the Commission. The officers of the Commission shall consist of a Chair and Vice-Chair.
2. Election of Officers. The offices of Chair and Vice-Chair shall be elected at the annual meeting of the Commission and those elected shall serve for a term of at least one but not more than two consecutive years. It is the non-binding policy of the Commission that the Vice-Chair will be the person that will normally be elected to serve as Chair in the year following service as Vice-Chair.

If the Chair's office is vacated prior to the end of the one year term, the Vice Chair shall assume the Chair's office and a replacement Vice Chair shall be nominated at the next regularly scheduled meeting. The election vote for the new Vice Chair shall be held at the next regularly scheduled meeting following the nomination meeting.

ARTICLE VII - DUTIES OF OFFICERS AND OTHER COMMISSION POSITIONS

Duties of the Officers of the Commission. The duties of the officers of the Behavioral Health Commission shall be as follows:

1. Chair: It shall be the duty of the Chair to prepare the agenda for and preside over all regular and special meetings of the Commission; to appoint Committee and Work Group chairs; coordinate existing Committees and Work Groups; serve as an ex-officio member of all Committees and Work Groups; call special meetings of the Commission when necessary; and be in regular consultation with the Manager of the Behavioral Health Division.
2. Vice-Chair: It shall be the duty of the Vice-Chair to assist the Chair in the execution of duties and to perform Chair duties during the Chair's absence. In case of the resignation, leave of absence, or the death of the Chair, the Vice-Chair shall perform such duties as are imposed on the Chair until such time as the Behavioral Health Commission elects a new Chair.
3. Upon the expiration of his or her term of office, or in the case of resignation, each Officer shall turn over to his or her successor, without delay, all records and materials pertaining to the office.

ARTICLE VIII - COMMITTEES

1. The following Standing Committee is created:

An Executive Committee. The Executive Committee, will be composed of the current and past Chair, Vice Chair, and three Members-at-Large. The term of Executive Committee members shall coincide with their terms as members of the Commission. The Executive Committee shall be responsible for the overall management of the activities and business of the Behavioral Health Commission. This includes, but is not necessarily limited to, the following:

- a. Establishing and overseeing of Ad Hoc Committees (short term workgroups); coordinating selection and implementation of site visits; approving Behavioral Health Commission agendas; drafting policies and procedures for Behavioral Health Commission approval; and selecting Work Group and Committee chairs on the recommendation of the Behavioral Health Commission Chair.
 - b. Selection of Members-at-Large. Any member of the Behavioral Health Commission, other than the Chair, Vice-Chair and past Chair, can potentially be a Member-at-Large. In February of each year, the Chair, Vice-Chair and past Chair, will make recommendations for three Members-at-Large to be approved by vote of the Behavioral Health Commission each March. Prior to the vote on these recommendations, the floor will be open to Commission members for additional nominations. Members-at-Large will attend and participate in Executive Committee meetings. Members-at-Large will have voting rights during Executive Committee meetings.
2. Standing Committees may be established or eliminated by the Behavioral Health Commission. Standing Committees have ongoing responsibilities concerning a particular subject matter that is not time limited. Committees and Work Groups will conduct meetings in accordance with the Brown Act (Government Code Section 54950 et seq.) to the extent applicable.

ARTICLE IX - ATTENDANCE & VACANCIES ON THE COMMISSION

1. All Behavioral Health Commission members are required to contact the Behavioral Health Commission Chair or staff liaison to the Behavioral Health Commission prior to a meeting if they are unable to attend. Failure to do so will result in an unexcused absence.
2. A Commission member may be deemed by the Executive Committee to have ceased their duties as a Behavioral Health Commission member based on attendance and/or performance of other assigned duties. If after review the Executive Committee determines the member should be removed, a recommendation will be made to the full Behavioral Health Commission. Upon two thirds vote, the Behavioral Health Commission may recommend the removal of the member to the Commission of Supervisors.
3. When a vacancy occurs, the staff liaison to the BHC shall advise the Commission and the Executive Committee will commence the recruitment for a replacement.

ARTICLE X - RESIGNATIONS AND LEAVES OF ABSENCE

1. Any member may resign effective upon giving notice to the Chair, the Vice Chair, staff liaison of the Behavioral Health Commission or City Clerks' office.
2. A Commission Member who does not wish to resign and who needs leave from Commission commitments, may request a leave of absence for personal reasons. The request must be submitted in writing to the Chair of the Behavioral Health Commission. The Executive Committee and or City Council/ Mayor may approve his or her request for a period of time that does not exceed 6 months.

ARTICLE XI - MEETINGS, QUORUMS, AND RULES OF ORDER

1. The Behavioral Health Commission shall meet monthly or as scheduled on the Commission's approved annual calendar of meetings.
2. A quorum shall consist of 50% plus one of the appointed members. Members who are on an approved leave of absence will not count toward establishing a quorum.
3. Meetings of the Behavioral Health Commission shall be governed by Rosenberg's Rules of Order [Link](#) and shall comply with the Brown Act.

ARTICLE XII - AMENDMENTS TO BYLAWS

These bylaws may be amended at any meeting of the Behavioral Health Commission by a two-thirds vote of its membership when reasonable advance notice has been given as described below.

The Behavioral Health Commission shall use the following procedure when amending the Bylaws.

1. Proposals for change shall be noticed on the Behavioral Health Commission agenda and a written copy sent to all Behavioral Health Commission members a minimum of five days prior to the meeting date on which proponents wish consideration and a vote on the change.
 - a. The Behavioral Health Commission must approve the change by a two-thirds majority of those members in attendance at a regular or special meeting at which a quorum is present.
 - b. The change, as approved, is to be signed and dated by the Behavioral Health Commission Chair.
 - c. The changed and revised copy of the Bylaws is then forwarded to the City Council Commission for their review and approval.
 - d. A copy of approved changed Bylaws is to be provided to each City of Berkeley Behavioral Health Commission member at the next regularly scheduled meeting.
 - e. Approved Bylaws are to be filed with the Behavioral Health Agency staff liaison. Additionally, an appropriate historical log of all Bylaw changes and the date of the change are to be maintained by the

Internal

behavioral health agency staff liaison. The historical log is to be distributed to all Behavioral Health Commission members whenever “Proposals for Changes” are distributed.

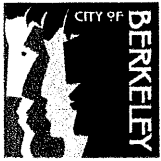
- f. All members will be provided with a set of the current Behavioral Health Commission Bylaws and Policies and Procedures.

ARTICLE XIII - POLICIES AND PROCEDURES

The Behavioral Health Commission may establish Policies and Procedures on matters not covered by these Bylaws.

Applicant's Name _____

Mental Health Commissioner Applicant Criteria	Application	Interview
Interest - Demonstrates interest in community mental health services		
Commitment - Ready to commit to Commission duties; preparation & attendance at meetings; timely paperwork		
Diversity - Reflects the diversity of the community		
Cooperation - Able to constructively handle conflict & differences of opinion		
Welcoming - Willing and able to work alongside consumers, family members & diverse members		
Effective - Able to work with City staff, management & Berkeley & Albany City Councils		



APPLICATION FOR APPOINTMENT TO BERKLEY/ALBANY MENTAL HEALTH COMMISSION

Notwithstanding... CITY OF BERKELEY - CITY CLERK... 2024 NOV 13 PM 3:18... City Clerk to verify.

NAME: PATRICIA FONTANA-NARELL

PREFERRED PRONOUN(S):

Residence Address: 1326 SANTA FE BERKELEY CA 94702

Business Name/Address:

Occupation/Profession: ARCHITECT (RET.)

Business Phone: Home Phone: 510-847-1785

Email address: prfontana@comcast.net

Employer's Name:

Name of Spouse's Employer: SELF EMPLOYED

(Please note that pursuant to Welfare and Institutions Code Section 5604(d), no member of the City of Berkeley's Mental Health Commission or his or her spouse may be: (a) a full or part time employee of City of Berkeley's mental health division, (b) a full or part time county employee of a county mental health service, (c) an employee of the California Department of Health Care Services, or (d) an employee of, or paid member of the governing body of, a mental health contract agency. If you are unsure whether your employment or your spouse's employment falls within this restriction and are interested in applying for the Commission, please contact the Commission Secretary.)

The following individuals are qualified to comment on my capabilities:

Table with 3 columns: NAME, ADDRESS, PHONE NO. Includes entries for GLEN U TURNER and LINDA MAIO.

The City of Berkeley's Conflict of Interest Code requires members of all City of Berkeley Commissions except the Youth Commission and Commission on Status of Women to file Statements of Economic Interests - FPPC Form 700. The Form 700 is a public document. For more information, please contact the City Clerk's Department at 981-6900, or visit our website at https://berkeleyca.gov/your-government/public-records/conflict-interest-reports.

Name: Patricia Fontana-Narell

I have been a resident of Berkeley Albany since: 1973

**APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION**

I qualify for appointment under the following:

- Representative of General Public Interest who shall be persons representing a broad range of disciplines, professions, and fields of knowledge.
- Representative of Special Public Interest who shall be consumers who are receiving or have received mental health services or family members (parents, spouses, siblings, or adult children) of consumers. Please indicate at least one:
- Consumer Family member

Signature of Applicant: Patricia Santana-Narell **Date:** 11/15/24

AFFIDAVIT OF RESIDENCY

I, PATRICIA SANTANA-NARELL hereby declare, under penalty of perjury, that I am a resident of the City of Berkeley. I understand that, with the exception of a temporary relocation outside of Berkeley not to exceed six months, I may no longer serve on a Berkeley Commission should this cease to be true.

Signature of Applicant: Patricia Santana-Narell **Date:** 11/15/24

DEMOGRAPHIC SURVEY (Optional):

Please indicate gender: Male Female Nonbinary Prefer not to say

Please indicate whether you are currently a student: Yes No

Please indicate the racial / ethnic category which you most closely identify with below (response optional - please check only one category):

- WHITE (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East
- BLACK or AFRICAN AMERICAN (not of Hispanic or Latino origin):** All persons having origins in any of the Black racial groups of Africa
- HISPANIC or LATINO:** All persons of Central / South America or other Spanish culture or origin, regardless of race
- ASIAN (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent. This includes, Cambodia, China, Japan, India, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- AMERICAN INDIAN / ALASKAN NATIVE (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of North, Central, and South America, and who maintain cultural identification through tribal affiliation or community recognition.
- NATIVE HAWAIIAN / PACIFIC ISLANDER (not of Hispanic or Latino origin):** All persons having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- TWO or MORE RACES (not of Hispanic or Latino origin):** All persons who identify with more than one of the above six races

**APPLICATION FOR APPOINTMENT TO
BERKELEY/ALBANY MENTAL HEALTH COMMISSION**

ANSWERS TO SUPPLEMENTAL QUESTIONNAIRE

1. My son was diagnosed with a Serious Mental Illness while he was a student at UC Berkeley. In trying to get the support and care he needed I encountered instead a system that seemed designed to obstruct and delay the delivery of care. I educated myself about the laws and policies that constrained providers' ability to help those in their care and became involved in Mental Health activism. My son has been a client of BMH for most of the last two decades, so I have a lot of experience with the agency through several leadership and policy iterations.
2. I have been involved in advocacy at the city, county, state and national level. I co-founded a group, *Voices of Mothers*, that spearheaded the successful drive to get Assisted Outpatient Treatment adopted by the Board of Supervisors in Alameda County. I am on the Steering Committee of *FASMI (Families Advocating for the Seriously Mentally Ill.)* I am a member of a state wide advocacy group, the *Grave Disability Workgroup*, that works with legislators and administrators on policy proposals. I have represented the family stakeholder on numerous ACBH Advisory Committees, including the *Justice Involved Mental Health Committee*, the *CARE Court Workgroup*, and the committees that instituted CIT training and Behavioral Health Courts.
3.
 - 1) Understaffing at Berkeley Mental Health.
 - 2) Lack of Supportive Housing for those with SMI.
 - 3) Failure to partner with family members/caregivers.
 - 4) Laws and policies that make it difficult to access care early on when the potential for recovery is greatest.
4.
 - 1) Search for ways to accelerate hiring at BMH.
 - 2) Pursue BHCIP and other revenue streams to increase the number and types of Supportive Housing in Berkeley.
 - 3) Incorporate Family Advocates into Case Management Teams.
 - 4) Create an Early Intervention Pilot Program in Berkeley.
5. I have worked with the FASMI Steering Committee to try to bring diversity to the membership. FASMI also collaborates with community partners like the *ICJJ*, the *Care First Task Force*, and *African-American Support Group*, that advocate for equity and diversity.
6. I have written articles addressing topics relating to Mental Illness for various publications.
I have a Masters of Architecture degree with a focus on alternate housing typologies that foster community.

Patricia Fontana-Narell
11.15.2024



APPLICATION FOR APPOINTMENT TO BERKLEY/ALBANY MENTAL HEALTH COMMISSION

Thank you for your interest in improving community mental health in Berkeley and Albany. Below is some important information about the Berkeley/Albany Mental Health Commission you should review before completing your application.

Background

Created by California Welfare and Institutions Code Section 5604 and Berkeley City Resolution 65,945-N.S., the Berkeley/Albany Mental Health Commission is composed of mental health consumers, family members of consumers and Berkeley/Albany residents with a broad range of disciplines, professions and fields of knowledge.

Composition of the Commission

The Commission consists of thirteen members. Commissioners are appointed by Berkeley City Council for three year terms, with a limit of three consecutive terms.

To meet state requirements, more than half the seats are designated as Special Public Interest. Special Public Interest members shall be consumers or the parents, spouses, siblings or adult children of consumers who are receiving or have received mental health services from a City or County Program or any of its contract agencies, a state hospital, or any private nonprofit mental health agency. This helps to ensure that people who are impacted by mental health services have a voice in the oversight process.

The specific membership of the Commission is as follows: (a) one member of the Commission is the Mayor or a City Council designee, (b) two shall be residents of the City of Albany (at least one Special Public Interest), and (c) the remaining members shall be residents of the City of Berkeley. Of the total membership, at least seven members of the Commission shall be Special Public Interest, with at least 20% of the total Commission members direct consumers and at least 20% family members. The remaining Commission members represent the General Public Interest and are from a variety of fields and professions.

The City of Berkeley's Conflict of Interest Code requires members of the Berkeley/Albany Mental Health Commission to file Statements of Economic Interest – FPPC Form 700, which is a public document. For more information, please contact the City Clerk's Department at 981-6900, or visit the website at <https://berkeleyca.gov/your-government/public-records/conflict-interest-reports>

In addition, Commissioners are required to participate in the AB 1234 Ethics Training, which is offered on line. Additional trainings are offered annually through the California Association of Local Mental Health Boards/Commissions (CALMHB/C) and California Institute for Mental Health (CiMH).

General Commissioner Qualifications:

APPLICATION FOR APPOINTMENT TO BERKLEY/ALBANY MENTAL HEALTH COMMISSION

- Demonstrates interest in community mental health services;
- Ready to commit to Commission duties, including preparation for and regular attendance at monthly Commission and Committee meetings, timely review of meeting materials and completion of Commission paperwork and training;
- Willing and able to work alongside mental health consumers and members of diverse communities;
- Able to constructively handle conflict and differences of opinion;
- Reflects the diversity of the Berkeley/Albany community;
- Willing and able to work with City staff, Mental Health management, Albany and Berkeley City Councils; and
- The Commissioner or their spouse is not a full or part time employee of: the City of Berkeley's mental health division, a county mental health service, the California Department of Health Care Services, a mental health contract agency or a paid member of the governing body of a mental health contract agency.

Please be aware that, as with other City Boards and Commissions, once an application is filed with the City of Berkeley, it becomes public information. Further, in order to confirm that the Commission membership is representative of the various categories set forth in state law and City resolution, applicants need to indicate on the application form whether they are applying to represent the Special Public Interest or General Public Interest category, and if Special Public Interest, whether they are a consumer or family member as defined above.



APPLICATION FOR APPOINTMENT TO BERKLEY/ALBANY MENTAL HEALTH COMMISSION

Redistricting Commissioners may not be eligible to serve. Contact the City Clerk to verify.

NAME: Maya Ezekiel

PREFERRED PRONOUN(S): She/her

Residence Address: 2545 Hillegass Avenue, Berkeley, CA 94704

Business Name/Address:

Occupation/Profession: Student/Qualitative Nutrition Researcher

Business Phone: Home Phone: (510) 292-7775

Email address: mayasezekiel@gmail.com

Employer's Name: UC Berkeley

Name of Spouse's Employer:

(Please note that pursuant to Welfare and Institutions Code Section 5604(d), no member of the City of Berkeley's Mental Health Commission or his or her spouse may be: (a) a full or part time employee of City of Berkeley's mental health division, (b) a full or part time county employee of a county mental health service, (c) an employee of the California Department of Health Care Services, or (d) an employee of, or paid member of the governing body of, a mental health contract agency. If you are unsure whether your employment or your spouse's employment falls within this restriction and are interested in applying for the Commission, please contact the Commission Secretary.)

The following individuals are qualified to comment on my capabilities:

Table with 3 columns: NAME, ADDRESS, PHONE NO. Rows include Elise Joshi and Greg Aponte.

The City of Berkeley's Conflict of Interest Code requires members of all City of Berkeley Commissions except the Youth Commission and Commission on Status of Women to file Statements of Economic Interests - FPPC Form 700. The Form 700 is a public document. For more information, please contact the City Clerk's Department at 981-6900, or visit our website at https://berkeleyca.gov/your-government/public-records/conflict-interest-reports.

Name: Maya Ezekiel

I have been a resident of: Berkeley / Albany since: 2001 (circle one)

**APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION**

I qualify for appointment under the following:

- Representative of General Public Interest who shall be persons representing a broad range of disciplines, professions, and fields of knowledge.
- Representative of Special Public Interest who shall be consumers who are receiving or have received mental health services or family members (parents, spouses, siblings, or adult children) of consumers. Please indicate at least one:
 - Consumer
 - Family member

Signature of Applicant: Maya Ezekiel **Date:** 01/08/2025

AFFIDAVIT OF RESIDENCY

I, Maya Ezekiel, hereby declare, under penalty of perjury, that I am a resident of the City of Berkeley. I understand that, with the exception of a temporary relocation outside of Berkeley not to exceed six months, I may no longer serve on a Berkeley Commission should this cease to be true.

Signature of Applicant: Maya Ezekiel **Date:** 01/08/2025

DEMOGRAPHIC SURVEY (Optional):

Please indicate gender: Male Female Nonbinary Prefer not to say

Please indicate whether you are currently a student: Yes No

Please indicate the racial / ethnic category which you most closely identify with below (response optional - please check only one category):

- WHITE (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East
- BLACK or AFRICAN AMERICAN (not of Hispanic or Latino origin):** All persons having origins in any of the Black racial groups of Africa
- HISPANIC or LATINO:** All persons of Central / South America or other Spanish culture or origin, regardless of race
- ASIAN (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent. This includes, Cambodia, China, Japan, India, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- AMERICAN INDIAN / ALASKAN NATIVE (not of Hispanic or Latino origin):** All persons having origins in any of the original peoples of North, Central, and South America, and who maintain cultural identification through tribal affiliation or community recognition.
- NATIVE HAWAIIAN / PACIFIC ISLANDER (not of Hispanic or Latino origin):** All persons having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- TWO or MORE RACES (not of Hispanic or Latino origin):** All persons who identify with more than one of the above six races

**APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION**

**Supplemental Questionnaire
Berkeley/Albany Mental Health Commission**

In addition to completing the application form, candidates are requested to provide the following information to assist the Mental Health Commission in their process to recommend applicants for appointment by Berkeley City Council. Please use an additional sheet if necessary.

1. Please explain why you are interested serving on the Berkeley/Albany Mental Health Commission.

As a lifelong resident of Berkeley, CA, I've interacted with the city's mental health services at a variety of points. I grew up sitting in the old Berkeley Mental Health offices on MLK with my parents, both of whom were mental health practitioners for the city for most of my childhood. I have also benefitted from the city's mental health services, specifically those offered through the school district. I believe that all people have a right to mental health care and that we must prioritize mental health practitioners and recipients of services in order to improve the overall wellness of the City of Berkeley.

2. Are you involved in other community activities? If so, which ones?

I am a graduate student at UC Berkeley's School of Public Health, where I work as a graduate student instructor in the nutrition department. Furthermore, I have been a passionate volunteer at the Berkeley Food Network and have done significant nutrition research with the Nutrition Policy Institute and pandemic recovery research with UCSF and Youth Speaks, a spoken word non-profit. I am engaged in the East Bay's food and nutrition spheres, as well as a passionate exerciser at the YMCA, climbing gyms, and as one of many avid cyclists. I participate in Jewish culture with Urban Adamah and am an appreciator of Berkeley's arts scene which I participated in heavily as a child. Lastly, I serve as the social manager for a graduate student cooperative at UC Berkeley.

3. What, in your opinion, are the most important mental health issues in Berkeley and/or Albany?

Mental health issues in Berkeley and Albany differ between communities. As a lifelong resident of Berkeley turned UC Berkeley student, I have seen two sides of this complex issue. I see UC students struggling with the high pressure environment of the elite academic institution that cannot sufficiently support the ever-increasing student body. As a resident of Berkeley, I see mental health crises among my peers, who struggle to access resources that are hidden in the depths of bureaucracy. I see mental health crises of individuals with unstable or insufficient housing and practitioners stretched too thin as private insurers fail to protect the mental health of their members. Mental health must be considered as urgent a crisis as physical health, and we must improve access and protect practitioners from burn out.

4. What do you recommend doing about them?

My parents both left Berkeley Mental Health because of burn out. Mental health care is a heavy burden to bear in any context, however, serving as a civil servant and mental health counselor offers less pay, increased bureaucracy, and an increased number of challenging cases. We must address the well-being of mental health practitioners in order to address the well-being of civilians. Additionally, we must consider the vastness of needs across our city of nearly 200,000 individuals. Mental health is not one-size-fits-all, and we must diversify the mental health care offered in order to serve all people. Mental health crises are not the only aspect of mental health that should be considered as urgent - prevention is more cost-effective and reduces more harm than crisis intervention. Preventative care opportunities like Berkeley High Schools' Health clinic should be considered as a tool that can be applied outside of Berkeley's youth population.

5. It is important that Berkeley Mental Health be responsive to the needs of our culturally diverse

community. What knowledge and experience do you have that could help provide insight on how to make Berkeley Mental Health even more inclusive of under-served communities?

Living in Hillegass Parker House, a graduate student cooperative housing primarily low-income individuals on the southside of campus, has offered me significant insight into communities often forgotten by the City's mental health services. As young people transition into adulthood, financial responsibility increases and with that, so does the mental burden of care. Additionally, I have volunteered at the Berkeley Food Network, where I chat with lower-income individuals about their nutrition and well-being. I've existed in the City of Berkeley since birth, and I've befriended every stranger possible - I intend to continue this mission of inclusion and care for life, and I believe that my constant desire to understand the lived experiences of Berkeleyans will allow me to serve as an effective member of the Mental health commission.

6. What unique contributions (work experience, education, attributes and training) do you have to make to the Mental Health Commission?

In my academic and professional experience is largely in the field of nutrition, which I approach as a social science. I have experience as a nutrition counselor and educator, and have significant experience working with children throughout the city at Berkeley Youth Recreation Camps and in various arts programs. These experiences have allowed me to flex my empathetic communication skills and have provided me experience working with diverse groups. I am a passionate conversationalist and enjoy engaging in dialogue regarding both similarities and differences in opinion. I represent both the UC Berkeley community as well as the youth of the City of Berkeley.

Return this form to the City Clerk Department: 2180 Milvia Street, Berkeley, CA 94704



Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Behavioral Health Commission
From: Jeffrey Buell, Behavioral Health Division Manager
Date: 3/19/2025
Subject: Behavioral Health Manager Report

Behavioral Health Services Report

The Behavioral Health Services report for February 2025 is not available this month. Also note that fiscal fields continue to not be updated in this template. Commissioners may seek to meet again with the Division Manager and Health, Housing, and Community Services (HHCS) Fiscal Services Manager to discuss helpful data and structure for future service reports (Initial meeting on 11/18/25).

Information Requested by Behavioral Health Commission

No new questions were submitted by Commissioners in this time frame.

Mental Health Division Updates

Questions about safety net funding

- Federal changes to various programs may ultimately include Medicaid (Medi-Cal in California), which covered about 40% of the California population in 2023. While it is not yet clear what future changes may look like, there are many questions about the people who will lose access to services and/or the service organizations whose services will be impacted
- California had opted to expand Medi-Cal, and with the state's current budget projected deficit, legislators will need to cover a \$2.8 billion shortfall in addition to \$3.4 billion loan from other programs to cover the current deficit.
- A report from the Urban Institute and the Robert Wood Johnson Foundation warns that up to 5 million adults could lose their Medicaid coverage by 2026 — not because they fail to meet work criteria, but due to bureaucratic hurdles and reporting challenges. With hospitals and health systems already grappling with financial pressures, this policy shift could further strain emergency departments, disrupt continuity of care and exacerbate health disparities, particularly in rural

A Vibrant and Healthy Berkeley for All

and underserved communities.

<https://www.beckershospitalreview.com/finance/work-requirements-could-strip-5m-people-of-medicaid-report/>

Facility Tours for Commissioners

- The Division Manager lead two facility tours during March 2025 for Behavioral Health Commissioners. These are available to the Commission periodically and may be requested by the Commission. A number of new Commissioners have joined in recent months, with more to come. The Commission may seek future tours by arranging with the Commission Secretary and the Division Manager.
- The High School Health Center has not hosted a Commissioner tour at this point, but this may be available if desired by the Commission. As a Berkeley Unified School District facility, the High School Health Center may be made available with some coordination and advance planning.

Opportunities to Connect

- The Division Manager continues to offer collaborative meeting opportunities with Commissioners and sub-committees. While advance planning is important to arrange such meetings, these are chances for connection and discussion.
- Karen Klatt, the City's MHSA coordinator, also still keeps her offer on the table for discussion or questions related to MHSA and BHSA. The Community meetings for this coming MHSA Annual Update will be starting shortly, which include other ways to engage with the Community and solicit feedback and ideas.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, March 20, 2025 10:23 AM
To: Works-Wright, Jamie
Subject: FW: Commission membership

Internal

Hello Commissioners,

At the meeting we need to discuss the number of commissions to have on our by-laws and I believe city council will make the final recommendation.

We have two new people who want to apply but we need to consider the new requirements.

Currently all spots for the general public are filled (even though that category no longer is label that way) and we have a person who is applying for that position.

Hello Commissioner,

In the new by-laws I made the change to have 11 members from 13, eliminating the Albany seats. If we decide with the new by-laws to have 11 seats, we have to designate certain seats to categories.

The current by laws with 13 members

3 seat to consumers, 3 seats to family members, 4 general public, 1 consumer Albany seat, 1 city council member, 1 Albany council member

If we keep the numbers at 13, this would be the breakdown:

7 members who are consumers OR family members– minimum needed to meet 50%

Of the 7 members, at least 4 should be consumers AND at least 3 should be family members (this meets the 20% of total minimum)

4 consumers

3 family members (one of these 7 needs to be 25 or younger)

1 veteran

1 education agency rep

3 any of the above including people with knowledge of behavioral health.

***(the plus is if the 4 consumers or 3 family members also meet the criteria for veteran or educational agency rep.)**

1 Council member

13 total

We would need to see if members could meet more than one category to keep it under 13.

11 members

3 consumers

3 family members

4 general interest knowledge of the behavioral health

1 council member

Under 25, education rep and veteran would have to fall in the other categories as well.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, March 12, 2025 8:13 PM
To: Works-Wright, Jamie
Subject: FW: Significant changes in allocation of behavioral health funding

Please see the information below from Commissioner Opton.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



From: Edward Opton <eopton1@gmail.com>
Sent: Wednesday, March 12, 2025 6:55 PM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: Significant changes in allocation of behavioral health funding

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

3.12.25

Please distribute to the Mental Health Commission and to others who may be interested.

To: Berkeley Behavioral Health Commission
Berkeley mental health administrators

From: Edward Opton

Summary from today's BHSOAC (statewide) meeting handouts_ . . . (acrobat.adobe.com/id/urn:aaid:sc:US:345b5df3-8981-4987-9526-b440eccf4d47).

"Date: 3.12.25

From: P. Moreno-Gonzales

Re: BHT Partner's Forum Meeting Recap 03-12-25

To: "Behavioral Health Partner's [sic] Forum" participants

*"Changes Under the BHSA Innovation Partnership Fund: . . . county innovation will be eliminated and the [statewide] Commission will then oversee and administer the Innovation Partnership Fund grant program. This program will be one of the largest competitive grants in the Commission's portfolio and represents the Commission's key responsibility under the BHSA. Amount: **\$20 million annually Fiscal Year (FY) 26-27 through FY 30-31 (\$100 million over 5 years)**" {emphasis supplied}*

The above e-mail does not address the role of local behavioral health commissions, such as Berkeley's and Alameda County's, in the new "Innovation Partnerships."

Participation might be required, encouraged, permitted, discouraged, or prohibited.

I recommend that the issue of Berkeley's, and potentially Alameda County's, participation in planning and evaluation concerning the \$100 million fund be included in the agenda for the MHC's March meeting. The MHC may want to propose to the City Council that it communicate to the state agency on this subject. (The MHC's charter provides that letters from the city to state agencies come from the Council, not the Commission.)

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, March 6, 2025 10:50 AM
To: Works-Wright, Jamie
Subject: FW: Please forward: Specialized Care Unit Survey

Hello Commissioner,

Please take the time to fill out the survey for the SCU.

The evaluation of Berkeley's Specialized Care Unit (SCU) has been underway, and the community survey has officially launched! The City has contracted with RDA Consulting to assess SCU's first year, focusing on its impact and identifying successes, opportunities for improvement, and possibilities for program sustainability and/or expansion.

As part of this effort, the RDA is gathering community feedback through a voluntary and anonymous survey, open until March 16. **Please share the flyer and message below with your networks** to help ensure broad participation and valuable insights.

Thank you for your support in spreading the word!



We Want to Hear from You!

Help shape the future of behavioral health crisis response in Berkeley by sharing your feedback on the Specialized Care Unit (SCU).

<https://bit.ly/4h0VDPL>

This **voluntary and anonymous** survey takes about **10 minutes** to complete and is open until **March 16, 2025**.

Hello,

We're writing to share an opportunity to provide feedback on Berkeley's Specialized Care Unit Pilot Project! RDA Consulting is supporting the City of Berkeley's Health, Housing, and Community Services Department (HHCS) in evaluating the Specialized Care Unit (SCU). **To support this evaluation, we invite you to complete [this survey](#) to gather your insight and perspective on the first year of the SCU! This survey is voluntary and anonymous and will take approximately 10 minutes to complete.** You can also access the survey by scanning the QR code below with your phone or mobile device:



You do not have to take this survey if you do not want to, and you may choose to skip any questions you do not feel comfortable answering. Your participation and individual responses will not be shared with the City of Berkeley or the Specialized Care Unit and will not affect your ability to receive mental health or social services.

We value your experience and input! The information you share can help make crisis response services better for you and others. **Please share this survey with your friends, family, and colleagues! The survey will remain open from February 24 - March 16.**

As a reminder: The SCU is a partnership program between the City of Berkeley and Bonita House, Inc., and is a behavioral health crisis service, separate from Police, available to all Berkeley community members. The evaluation aims to identify successes, opportunities for improvement, and possibilities for program sustainability and/or expansion.

If you have any questions or concerns with the evaluation or survey please contact Sarah Ferrell at sferrell@rdaconsulting.com or 510-369-5680. Thank you for your support with this evaluation!

The RDA Evaluation Team

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, March 4, 2025 10:29 AM
To: Works-Wright, Jamie
Subject: Questions for Manger report

Hello Commissioners,

If you would like Jeff to answer any specific questions in his manger report. Please have those questions no later than Monday, March 10th

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, March 4, 2025 10:27 AM
To: Works-Wright, Jamie
Subject: Agenda Items for March

Hello Commissioners,

The next commission meeting will be on Thursday, March 27, 2025 from 7-9pm. Please arrive before 7 to start and end on time.

Please submit your agenda items for the meeting by **Monday, March 10** and anything you would like to be in the packet by **Monday, March 17th**.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



Works-Wright, Jamie

From: Office of the Director of Police Accountability
Sent: Monday, March 3, 2025 1:31 PM
To: Office of the Director of Police Accountability
Subject: Recap of Honoring Black Voices, Advancing Justice
Attachments: 2025-02-26 Visioning Session Informational Packet.pdf

Dear Community Members,

On February 26th, the Office of the Director of Police Accountability hosted a community visioning session, **Honoring Black Voices, Advancing Justice**. Community members were able to engage with Equity in **Policing Expert Carlton Mayers** and **City of Berkeley Diversity, Equity, and Inclusion Officer Rex Brown** on crucial topics such as the future of police accountability and public safety in Berkeley.

We have attached a [recording](#) for the event and an informational packet with details about the speakers and other important resources. We also encourage you to stay engaged with future events and initiatives as we continue to work together toward a more just and accountable community.

As we close out Black History Month, we're reminded of the importance of Black voices in shaping our progress. February honors their contributions, while also reminding us of the ongoing need to address systemic inequities, especially within policing and public safety. Our work at the ODPa remains focused on ensuring transparency, equity, and justice year-round, and we're grateful for your continued engagement in these efforts.

Thank you for your participation, and we look forward to your continued involvement.

In solidarity,

Office of the Director of Police Accountability
1900 Addison Street, 3rd Floor
Berkeley, CA 94704
(510) 981-4950

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HONORING BLACK VOICES, ADVANCING JUSTICE: A COMMUNITY VISIONING SESSION

BLACK COMMUNITIES AND POLICE ACCOUNTABILITY: LESSONS
FROM THE PAST, ACTIONS FOR THE FUTURE

MODERATED BY: CARLTON MAYERS II & REX BROWN

WEDNESDAY, FEBRUARY 26TH, 6 PM - 8:30 PM

Carlton T. Mayers II



As the Founder, Owner, and CEO of Mayers Strategic Solutions, LLC, Carlton T. Mayers, II, Esq. works with communities nationwide to solve public safety challenges by using the Community Empowerment-Centered® Approach to identify, strategize, and implement long-term and positive change in practices, policies, and culture through the C.A.T. Method®, which stands for Community Empowerment, Accountability, & Transparency.

Mr. Mayers brings over 15 years of experience advocating for racial justice and criminal justice reform, which includes advancing policy reforms in more than 30 states and on Capitol Hill. He directed the National Criminal Justice Reform

program at NAACP National Office. In this role, Mr. Mayers co-authored the NAACP report called “Born Suspect: Stop-And-Frisk Abuses & the Continued Fight to End Racial Profiling in America,” which was published in 2014 and provides the public with resources for ending racial profiling by state and local law enforcement.

Mr. Mayers also worked for NAACP Legal Defense and Educational Fund, Inc. in Washington, D.C. as Policy Counsel for the Policing Reform Campaign. In this role, he supported advocacy efforts in Ferguson, Missouri, Baltimore, Maryland, North Charleston, South Carolina, New York City, and on Capitol Hill during President Obama’s Administration. Additionally, he advocated for juvenile justice reform in Florida at Southern Poverty Law Center and advanced reentry reform in Illinois as the Senior Policy Manager of Criminal Justice Reform at Heartland Alliance.

Likewise, Mr. Mayers has been published multiple times in the Chicago Tribune and featured on BBC News as a national expert on public safety and policing reform. Indeed, in 2020 and 2021, he advised state lawmakers in Illinois, Wisconsin, Missouri, Indiana, and Maryland on policing reform legislation passed into law in 2021. Moreover, Mr. Mayers volunteers as the Criminal Justice Chair for the NAACP Chicago Westside Branch and, in this role, works on implementation of the Chicago Consent Decree.

Rex Brown



In his current role as City of Berkeley’s inaugural Diversity, Equity & Inclusion Officer, Rex Brown champions the City’s commitment to DEI efforts across the entire organization and the larger community. Rex will develop an anti-racist framework in partnership with the Government Alliance on Race and Equity (GARE), a project of Race Forward and the University of California, Berkeley’s Othering and Belonging Institute.

Rex has extensive experience developing teams and creating results-based strategic frameworks with leaders at all levels to drive comprehensive enterprise-level transformations. As the Senior Director of Diversity at the largest state agency, Department of Social and Health Services, and Executive Administrator for the Governor’s first Business Diversity Subcabinet — he built DEI initiatives as an inaugural and early-stage leader. Prior to his selection as City of Berkeley’s Diversity, Equity & Inclusion Officer, Rex led the Seattle Human Services Department’s Division of Safe and Thriving Communities focusing on social impact investments in Black and Indigenous People of Color (BIPOC) community safety and violence prevention.

Prior to this, Rex led the Washington Subcabinet on Business Diversity at the Office of Minority and Women’s Business Enterprises (OMWBE). Rex has a Law Degree from Boston College Law School (BC Law) and a Bachelor of Arts & Sciences Degree with a double-major in English and Philosophy at Boston College.

Resources and Relevant Links

Police Accountability Board Reports

<https://berkeleyca.gov/safety-health/police-accountability/police-accountability-board-reports>

Office of the Director of Police Accountability LinkedIn

<https://www.linkedin.com/company/office-of-the-director-of-police-accountability/>

Policy Committee: Public Safety

<https://berkeleyca.gov/your-government/city-council/council-committees/policy-committee-public-safety>

Reimagining Public Safety Task Force Reports

<https://berkeleyca.gov/your-government/boards-commissions/reimagining-public-safety-task-force>

Boards & Commissions

<https://berkeleyca.gov/your-government/boards-commissions>

American Civil Liberties Union

<https://www.aclu.org/know-your-rights/stopped-by-police>

Mayers Strategic Solutions LLC

<https://www.mayersolutions.com/>

National Association for Civil Oversight of Law Enforcement (NACOLE)

<https://www.nacole.org>

Data on Crime, Calls for Service, Stops, and Use of Force

<https://berkeleyca.gov/safety-health/police/data-crime-calls-service-stops-and-use-force>

Police Review Project – Berkeley Law

<https://www.law.berkeley.edu/experiential/pro-bono-program/slps/current-slps-projects/police-review-project/>

How to file a complaint/compliment against (or in support of) a police officer:

Concerning Berkeley Police Department (BPD)

Complaint:

<https://berkeleyca.gov/safety-health/police-accountability/file-complaint-against-berkeley-police-officer>

<https://berkeleyca.gov/safety-health/police-accountability/policy-complaints>

Compliment:

<https://berkeleyca.siviltech.com/>

Concerning BART Police

Complaint:

<https://www.bart.gov/about/policeauditor>

Concerning Oakland Police Department (OPD)

Complaint:

<https://www.oaklandca.gov/departments/community-police-review-agency>

Compliment:

<https://www.oaklandca.gov/services/send-a-compliment-to-an-opd-officer-or-employee>

Concerning University of California - Berkeley Police Department (UCPD)

Complaint:

<https://ucpd.berkeley.edu/feedback/file-complaint>

{Concerning any department through the State process} Commission on
Peace Officer Standards and Training (POST)

Complaint:

<https://post.ca.gov/public-complaints>

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, February 27, 2025 7:59 PM
To: Works-Wright, Jamie
Subject: FW: BHT manual (module 1)
Attachments: Behavioral-Health-Services-Act-County-Policy-Manual.pdf

Please see the attachment that Karen reference at the commission meeting.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

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From: Buell, Jeffrey <JBuell@berkeleyca.gov>
Sent: Thursday, February 27, 2025 7:52 PM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: BHT manual (module 1)

Hi Jamie, this is the final draft of the first DHCS manual for BHSA, references Karen tonight. Please share with our commission when you get the chance, please!

Jeffrey Buell, LCSW
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Health, Housing & Community Services
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Please note that I'm out of the office every Monday.

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Department of Health Care Services

Behavioral Health Services Act County Policy Manual

February 2025

FINAL

DocuSigned by:
Marlies Perez
C595D8936F1F429...

Behavioral Health Services Act County Policy Manual..... 1

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1. Policy Manual Introduction

This policy manual provides counties and two city-operated mental health authorities with guidance necessary to implement Behavioral Health Transformation (BHT),¹ a package of behavioral health policy reforms enacted by California voters through Proposition 1 (2024) and will take effect according to statutory timelines. Counties, providers, and other behavioral health stakeholders will find information on county planning, reporting, and fiscal requirements in this policy manual. The manual also contains information about the Behavioral Health Services Act (BHSA) service and program implementation requirements. Per Welfare and Institutions Code section 5963.05, DHCS has the authority to implement, interpret, or make specific amendments to the Behavioral Health Transformation through county letters, information notices, plan or provider bulletins, and other similar instructions, including this manual. The guidance in this manual will serve as regulations. Throughout the manual, there are footnote references to relevant Department of Health Care Services webpages, Behavioral Health Information Notices, the Welfare & Institutions Code, and the California Code of Regulations for more information. The policy manual will be updated on a continual basis and will include a summary of changes between each version.

¹ [W&I Code § 5963.05, subdivision \(a\)](#)

2. Behavioral Health Transformation

A. Introduction to Behavioral Health Transformation

In recent years, California has undertaken historic efforts to re-envision the state's publicly funded mental health and substance use disorder (SUD) services, with a special focus on county-administered specialty mental health and substance use disorder services. In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT).

The primary goals of BHT are to improve access to care, increase accountability and transparency for publicly funded, county-administered behavioral health services, and expand the capacity of behavioral health care facilities across California. Under BHT, county reporting will be uniform to allow for comprehensive and transparent reporting of the Behavioral Health Services Act (BHSA) funding in relation to all public local, state, and federal behavioral health funding.

BHT builds upon and aligns with other major behavioral health initiatives in California including the [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#), the California [Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment \(BH-CONNECT\)](#) initiative, the [Children and Youth Behavioral Health Initiative \(CYBHI\)](#), [Medi-Cal Mobile Crisis services](#), the [Behavioral Health Bridge Housing](#) program, the [Community Assistance, Recovery, and Empowerment \(CARE\) Act](#), [Lanterman-Petris-Short Conservatorship reforms](#), [988 expansion](#), and the [Behavioral Health Continuum Infrastructure Program \(BHCIP\)](#).

California continues to face behavioral health challenges impacted by many factors, including but not limited to the lack of affordable housing and increasing homelessness,¹ the behavioral health workforce shortage,² a youth mental health crisis,³

¹ California Budget and Policy Center. "[The Rise of Homelessness Among California's Older Adults](#)." (May 2024).

² Cal Matters. "[Mental health workers: Why California faces a shortage](#)." (September 2022).

³ Xiang, A., Martinez, M., & Chow, T. "[Depression and anxiety among US children and young adults](#)." *Journal of American Medical Association Open*. (2024).

an older adult mental health crisis,⁴ and a shortage of culturally-responsive and diverse care.⁵ Many of these challenges make it difficult for individuals to navigate California’s behavioral health care delivery systems and access services at the right time and in the right place. For example, 2022 survey research suggests that 23.5 percent of adult Californians across all payers living with a mental illness reported they did not receive the treatment they needed.⁶

A.1 Bond

In addition to reforming the MHSA, Proposition 1 includes the Behavioral Health Infrastructure Bond Act of 2023. This bond authorizes \$6.38 billion to build new behavioral health treatment beds and supportive housing units to help serve more than 100,000 people annually. This investment creates new, dedicated housing for people experiencing or at risk of homelessness who have behavioral health needs, with a dedicated investment to serve veterans. These settings will provide Californians experiencing behavioral health conditions with places to stay while safely stabilizing, healing, and receiving ongoing support.

- Department of Health Care Services (DHCS) will administer \$4.4 billion of these funds to provide grants to public and private entities for behavioral health treatment and residential settings. \$1.5 billion of the funds administered by DHCS will be awarded only to counties, cities, and tribal entities (with \$30 million set aside for tribes).
- The California Department of Housing and Community Development (HCD) will administer up to \$2 billion to support permanent supportive housing for individuals, including veterans, at risk of or experiencing homelessness and behavioral health challenges.

⁴ UCLA Health. "[California must build workforce to serve older adults’ behavioral health needs, UCLA report says.](#)" (January 2019).

⁵ Kaiser Family Foundation. "[Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health.](#)" (May 2024).

⁶ Mental Health America. "[The State of Mental Health in America.](#)" (2022).

A.2 Behavioral Health Continuum Infrastructure Program

In 2021, DHCS was authorized to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) and award \$2.1 billion in funding to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. DHCS has been releasing these funds through multiple grant rounds targeting various gaps in the state’s behavioral health facility infrastructure.

The Behavioral Health Bond Act of 2023 leverages the success of BHCIP and authorizes DHCS to award up to \$4.4 billion for BHCIP competitive grants.⁷ Please refer to the [BHCIP webpage](#) for the latest information.

B. Overview of the Behavioral Health Services Act

B.1 Behavioral Health Services Act Goals

The Behavioral Health Services Act (BHSA) is the first major structural reform of the Mental Health Services Act (MHSA) since it was passed in 2004. The MHSA imposed a 1 percent tax on personal income over \$1 million. Counties and two city-operated mental health authorities receive these funds monthly to provide community-based mental health services. The MHSA was designed to serve individuals with serious mental illness (SMI) and individuals that may be at risk of developing serious mental health conditions.⁸ The MHSA created a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements. MHSA has been a crucial resource to increase access to mental health services for all eligible populations.

The reforms within the BHSA expand the types of behavioral health supports available to Californians who are eligible for services and are in need by focusing on historical gaps and emerging policy priorities. The key opportunities for transformational change within the BHSA include:

1. Reaching and Serving High Need Priority Populations

⁷ [BHCIP Request for Applications](#)

⁸ [W&I Code § 5600.3](#)

- Restructures funding allocations for the BHSA program components by focusing allocations on the areas of most significant need among Californians, including individuals across the lifespan at risk of or experiencing justice and system involvement, homelessness, and institutionalization.
- Prioritizes early intervention, especially for children and families, youth, and young adults, to provide early linkage to services and prevent mental health conditions, co-occurring disorders, and substance use disorders from becoming severe and/or disabling.
- Prioritizes serving individuals experiencing homelessness or at risk of homelessness, especially individuals and families experiencing long-term homelessness. The BHSA dedicates revenue for counties to assist those with severe behavioral health needs to be housed and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Updates Full Service Partnerships (FSP) requirements to better serve individuals with the most significant needs by requiring FSP programs to include specified, evidence-based delivery models, community-defined evidence practices, and standardized levels of care.
- Aligns with initiatives aimed at improving care for Medi-Cal members living with significant behavioral health needs such as the [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#), the California [Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment \(BH-CONNECT\)](#) initiative, the [Children and Youth Behavioral Health Initiative \(CYBHI\)](#), [Medi-Cal Mobile Crisis Services](#), the [Behavioral Health Bridge Housing](#) program, the [Community Assistance, Recovery, and Empowerment \(CARE\) Act](#), [Lanterman-Petris-Short Conservatorship](#) reforms, [988 expansion](#), and the [Behavioral Health Continuum Infrastructure Program \(BHCIP\)](#).

2. Increasing Access to Substance Use Disorder Services, Housing Interventions, and Evidence-Based and Community-Defined Practices, and Building the Behavioral Health Workforce

- Expands the categories of services that may be funded with BHSA dollars to include treatment for substance use disorders, regardless of the presence of a co-occurring mental health condition.
- Provides ongoing funding for counties to assist people living with significant mental health conditions, substance use disorder needs and co-occurring behavioral health needs with housing and provides a path to long-term recovery, including one-time and allowable ongoing capital to build more housing options.
- Increases investments in the behavioral health workforce including efforts to support more culturally, linguistically, and age-appropriate care by building a more representative workforce.
- Requires implementation of specified evidence-based and community-defined evidence practices to improve outcomes for youth and adults with complex behavioral health conditions.

3. Focusing on Outcomes, Transparency, Accountability, and Equity

- Requires counties to complete a county Integrated Plan for behavioral health services and outcomes, which will include information on all local behavioral health funding and services, including Medi-Cal and non-Medi-Cal specialty behavioral health programs and funding streams.
- Requires counties to complete an annual county Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) to provide public visibility into county spending, disparities, and results.
- Utilizes data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts.
- County BHSA programs must include culturally responsive and linguistically appropriate interventions. These interventions must be able to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

B.2 Timeline for Implementation

Table B.2.1. Timeline for Implementation

Requirement	Effective Date
County Board of Supervisors Approve Fiscal Year (FY) 2026-2029 County Integrated Plan	June 30, 2026
Counties Submit FY 2026-2029 County Integrated Plan to the Department of Health Care Services for Review and Approval	No later than June 30, 2026
County Integrated Plans Are Effective	July 1, 2026
County Board of Supervisors Approve FY 2027-2028 County Annual Update	June 30, 2027
Submit Draft FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)	January 30, 2028
Submit Final FY 2026-2027 County Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)	January 30, 2029

B.3 Eligible Populations

Eligible populations are those that may receive services funded by the Behavioral Health Services Act (BHSA) and include children and youth, adults, and older adults who meet BHSA eligibility criteria.

Eligibility criteria for BHSA services are aligned with Medi-Cal specialty mental health services (SMHS) access criteria,⁹ and include individuals with substance use disorders as described below. However, it is important to note that BHSA eligible populations are not required to be enrolled in the Medi-Cal program.¹⁰

⁹ [BHIN 21-073](#)

¹⁰ [W&I Code § 5892, subdivision \(k\)](#)

Eligible children and youth means persons who are 25 years of age or under who meet either of the following:

- Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance¹¹ (includes individuals 21-25 years of age who meet this criteria) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.¹²

Eligible adults and older adults means persons who are 26 years of age or older who meet either of the following:

- Meet SMHS access criteria specified in [W&I Code section 14184.402, subdivision \(c\)](#) and implemented in DHCS guidance¹³ (only applies to individuals 26 years of age and older) OR
- Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.¹⁴

Priority Populations

In addition to defining the populations eligible for services, the BHSA also requires counties to prioritize BHSA services for the populations listed below.¹⁵ While counties must prioritize BHSA services for the priority populations listed below, access to BHSA services is not limited to these priority populations. At-risk populations should be identified by counties based on local need and local planning processes, except for the

¹¹ [BHIN 21-073](#)

¹² [W&I Code § 5891.5, subdivision \(c\)](#)

¹³ [BHIN 21-073](#)

¹⁴ [W&I Code § 5891.5, subdivision \(c\)](#)

¹⁵ [W&I Code §5892, subdivision \(d\)](#)

criteria for at-risk of homelessness which can be found in the [Housing Interventions chapter](#) and below.

Eligible children and youth who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness¹⁶
- Are in, or at risk of being in, the juvenile justice system¹⁷
- Are reentering the community from a youth correctional facility
- Are in the child welfare system pursuant to W&I Code sections [300](#), [601](#), or [602](#)
- Are at risk of institutionalization¹⁸

Eligible adults and older adults who satisfy one of the following:

- Are chronically homeless or experiencing homelessness or at risk of homelessness¹⁹
- Are in, or at risk of being in, the justice system
- Are reentering the community from state prison or county jail
- Are at risk of conservatorship²⁰
- Are at risk of institutionalization²¹

For additional information about criteria or priority populations for Full Service Partnerships and Housing Interventions, including the definition for “chronically homeless”, please refer to the corresponding sections within this manual.

¹⁶ Additional information and definitions should be referenced in the Housing chapter below. Chapter 7.C.

¹⁷ [BHIN-21-073](#)

¹⁸ The DHCS [ECM Guide](#) defines institutionalization as “broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.”

¹⁹ Additional information and definitions should be referenced in the Housing chapter below. Chapter 7.C.

²⁰ [W&I Code § 5350](#)

²¹ The DHCS [ECM Guide](#) defines institutionalization as “broad and means any type of inpatient, Skilled Nursing Facility, long-term, or emergency department setting.”

C. Statewide Vision for Behavioral Health Quality and Equity

The state is committed to boldly taking action to provide Californians with quality, culturally responsive behavioral health services when, how, and where they need them.²² It will take cross-system collaboration and partnership across service delivery systems to address the statewide behavioral health goals discussed in this Policy Manual. DHCS, county behavioral health, Medi-Cal Managed Care Plans (MCPs), commercial plans, commercial plan regulators, and other key delivery system partners such as child welfare, public health, schools and others will share responsibility for improving the well-being of Californians in need of behavioral health services.

C.1 A Population Health Approach to Behavioral Health

The Behavioral Health Transformation presents a historic opportunity to transform behavioral health service delivery by:

- Taking a population health approach to align expectations across California’s behavioral health delivery system.
- Establishing a vision for quality and equity and setting statewide goals to drive progress across the behavioral health delivery system.
- Using data to support continuous quality improvement.

A population health²³ approach aims to address these gaps in access to care and connect individuals to the right services, in the right place, and at the right time.

A population health approach for the behavioral health delivery system²⁴:

²² California Health and Human Services. "[Policy Brief: Understanding California’s Recent Behavioral Health Reform Efforts](#)." (March 2023).

²³ Population health is defined as the health of all individuals in a defined group, and the interdisciplinary, cross-sector approach that brings health-related resources together with medical care to achieve positive health outcomes for a defined group. This definition is derived from the American Journal of Public Health’s article, "[What is Population Health?](#)".

²⁴ The population health approach for behavioral health is adapted from the population health strategy for DHCS’ [Population Health Management](#).

- Considers the entire population eligible for public behavioral health services, not just those currently receiving behavioral health services and those seeking care (shown in Figure 2.C.3).
- Deploys whole-person care²⁵ interventions, including addressing social drivers of health, which are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality of life outcomes and risk factors.²⁶
- Coordinates across service delivery systems, including cross-system collaboration and partnership across county behavioral health, Medi-Cal MCPs, commercial plans, commercial regulators, public health, and other key service delivery partners.
- Uses data to:
 - Identify underserved and unserved population groups for targeted interventions.
 - Improve quality²⁷ across the [behavioral health care continuum](#).
 - Monitor effectiveness of interventions across populations.
 - Support continuous improvement.
 - Identify and track racial and ethnic disparities²⁸ in behavioral health outcomes.

²⁵ Whole-person care is an approach that coordinates physical, behavioral, and social services in a patient-centered manner to address needs comprehensively and improve the overall health and wellbeing of individuals. This definition is derived from DHCS' [Whole Person Care Pilots](#).

²⁶ SDOH definition is derived from the [DHCS Population Health Management Policy Guide](#).

²⁷ The Agency for Healthcare Research and Quality (AHRQ) defines "quality [in healthcare]" as "providing the right care at the right time in the right way for the right person and having the best results possible": [Best Practices in Public Reporting No. 2: Maximizing Consumer Understanding of Public Comparative Quality Reports: Effective Use of Explanatory Information](#).

²⁸ "Disparities" is defined as the preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations. Source: [Center for Medicare and Medicaid Services, adapted from CDC](#).



Figure 2.C.3. Population Health Approach to Behavioral Health Quality and Equity

Like the Population Health Management (PHM) Program²⁹ for Medi-Cal MCPs implemented in January 2023, a population health approach to behavioral health will reorganize and strengthen existing contract requirements, particularly requirements related to collaboration across the delivery system,³⁰ and is targeted to the delivery system that DHCS oversees.

DHCS will work to align priorities and desired outcomes across the behavioral health delivery system, payers (e.g., Medi-Cal MCP Non-Specialty Mental Health Services (NSMHS) and Medi-Cal Specialty Mental Health Services (SMHS)), initiatives and funding

²⁹ DHCS' [Population Health Management \(PHM\) Program](#) is a cornerstone of CalAIM.

³⁰ See for example the [Memorandum of Understanding between \[Medi-Cal Managed Care Plan\] and \[Mental Health Plan\] template](#)

sources (e.g., BHSA,³¹ BH-CONNECT, and Realignment and Block Grants), while still allowing for initiative-specific goals.

As outlined in [W&I Code section 5963.02, subdivision \(c\)\(3\)\(A\)](#), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with statewide behavioral health goals and their associated measures. DHCS will begin by defining statewide population behavioral health goals to define the improvements that counties and the state should be working towards together across the behavioral health delivery system. Measures associated with these goals will be developed in phases.

Phase 1 will use population-level behavioral health measures, which are defined as measures of community health and wellbeing associated with the statewide behavioral health goals. Phase 1 measures must be used in the county BHSA planning process and should inform resource planning and implementation of targeted interventions to improve outcomes. They are statewide indicators for which counties are not exclusively responsible; it will take cross-service delivery system collaboration and partnership to move the needle on Phase 1 measures. As part of the 2025 PHM strategy (guidance forthcoming), Medi-Cal MCPs will also be working towards the statewide behavioral health goals and measures.

In Phase 2, measures will be used for monitoring and accountability purposes and will focus on performance of county behavioral health and Medi-Cal MCPs, respectively. The BHSA-funded interventions (e.g., Housing Interventions, Behavioral Health Services and Supports, Full Service Partnerships), as well as county behavioral health SMHS and Medi-Cal MCP NSMHS, should impact the goals outlined in C.3. and their associated measures.

In both phases, counties should utilize the [Community Planning Process](#) detailed in the Policy Manual to work with key stakeholders to address the statewide population behavioral health goals.

³¹ The Behavioral Health Services Act replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders (SUD), expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels [Behavioral Health Services Act](#).

C.2 Statewide Population Behavioral Health Goals

DHCS, in consultation with behavioral health stakeholders and subject matter experts, has identified 14 statewide behavioral health goals³² focused on improving wellbeing (e.g., quality of life, social connection) and decreasing adverse outcomes (e.g., suicides, overdoses). These behavioral health goals (shown in Figure 2.C.4) will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals under BHT.

Note that health equity, defined as the “reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations”,³³ will be incorporated in each of the statewide behavioral health goals. DHCS will endeavor to provide measures that can be stratified (e.g., by demographics such as age group and race/ethnicity, etc.) to enable visibility into disparities. In addition to identifying disparities, DHCS will ask counties and Medi-Cal Managed Care Plans (MCPs) to address disparities and DHCS will consider disparities when developing accountability measures.

³² [W&I Code § 5963.02\(c\)\(3\)\(A\).](#)

³³ Sourced from [DHCS MCP Boilerplate Contract.](#)

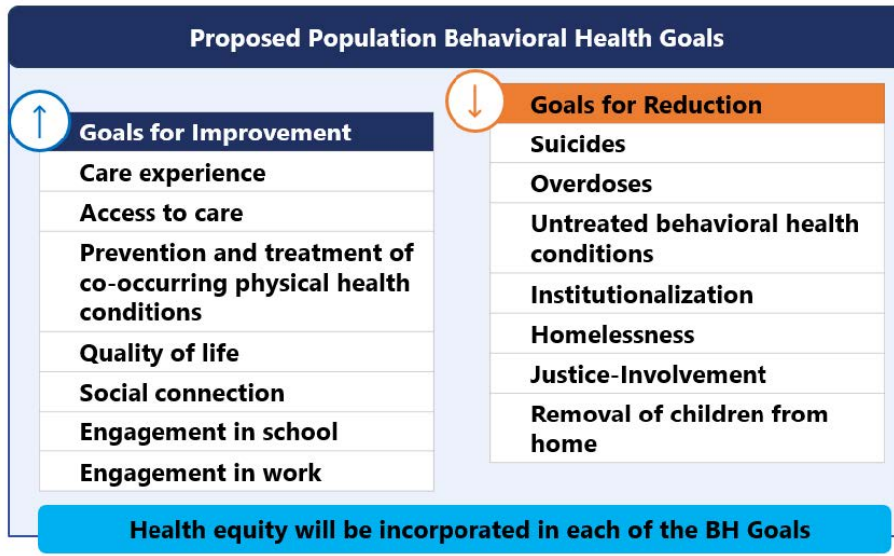


Figure 2.C.4. Statewide Population Behavioral Health Goals

DHCS selected these goals based on their strong indication of the health and wellbeing of Californians living with significant behavioral health needs. In alignment with the mission of BHT to improve behavioral health for Californians, the statewide population behavioral health goals lay out the vision that the state, counties, MCPs, and other key stakeholders must work towards to improve the overall well-being of Californians who are living with behavioral health needs (see Tables 2.C.1 and 2.C.2 for the goals’ definitions and rationale for inclusion).

Measures associated with each goal are forthcoming.

Table 2.C.1. Statewide Population Behavioral Health Goals: Goals for Improvement – Definition and Rationale

Goals for Improvement	Definition and Rationale
Care experience	Care experience refers to the range of interactions and quality of care that patients have and receive from the healthcare system

Goals for Improvement	Definition and Rationale
	<p>that can impact level of engagement and length of treatment.³⁴ Improving the care experience (e.g., care is culturally congruent and responsive, trauma-informed, etc.) in California’s behavioral health delivery system is important; positive experiences with care can lead to greater treatment engagement, adherence, and remaining in treatment longer, leading to positive health outcomes.</p>
<p>Access to care</p>	<p>Access to care is defined as the timely and appropriate use of health services to achieve the best possible health outcomes, inclusive of all modalities.³⁵ Improving Californians’ access to care is necessary for improving outcomes. Compliance with provider availability as outlined in network adequacy requirements, strategies for navigating the complex care delivery system, and improving wait times for appointments will enable Californians to better access the right care at the right time.</p>
<p>Prevention and treatment of co-occurring physical health conditions</p>	<p>Co-occurrence in this goal refers to the prevention or treatment of a physical health condition in an individual with an existing BH condition. An integrated care approach that addresses both behavioral and physical health needs of individuals can lead to earlier treatment of uncontrolled chronic physical health conditions.</p>
<p>Quality of life</p>	<p>Quality of life is defined as an individual’s “perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations,</p>

³⁴ Definition derived from “[Patient Experience](#)” definition from the Agency for Healthcare Research and Quality, from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

³⁵ Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. [Access to Health Services - Healthy People 2030](#).

Goals for Improvement	Definition and Rationale
	standards, and concerns.” ³⁶ Individuals living with behavioral health conditions face challenges from symptoms and associated stigma, which can negatively impact daily functioning, wellbeing, and overall quality of life.
Social connection	Social connection refers to the degree to which an individual has the number, quality, and variety of relationships that they want to feel and have belonging, support, and care. ³⁷ Establishing and maintaining supportive relationships is vital for preventing and managing significant behavioral health needs along with other behavioral health conditions associated with loneliness and isolation.
Engagement in school	In this context, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards school and related activities, including their enrollment and participation in as well as graduation from school. ³⁸ Enhancing engagement through prevention and treatment of behavioral health conditions can enable individuals to participate actively and meaningfully, leading to improvements in quality of life, independence, and wellbeing.
Engagement in work	Similar to above, engagement refers to the degree of attention, curiosity, interest, passion, and optimism that an individual has towards work and related activities. Enhancing engagement in the workplace as part of paid employment or unpaid work through prevention and treatment of behavioral health conditions can enable individuals to participate actively and

³⁶ World Health Organization. [WHOQOL - Measuring Quality of Life](#). Division of Mental Health and Prevention of Substance Abuse. World Health Organization. March 2012.

³⁷ Center for Disease Control and Prevention. [Social Connection](#).

³⁸ Derived from “[Student Engagement](#)” definition on The Glossary of Education Reform.

Goals for Improvement	Definition and Rationale
	meaningfully, leading to improvements in job performance, productivity, job satisfaction, and overall personal wellbeing.

Table 2.C.2. Statewide Population Behavioral Health Goals: Goals for Reduction – Definition and Rationale

Goals for Reduction	Definition and Rationale
Suicides	Suicide, including suicide attempts is defined as death or non-fatal, potentially injurious harm caused by self-directed injurious behavior with the intent to die as a result of the behavior. ^{39,40} Strengthening California’s behavioral health delivery system and providing targeted and tailored suicide prevention efforts is critical for reducing California’s suicide rate.
Overdoses	A drug-related overdose can occur when a toxic amount of a drug, or combination of drugs, including prescription, illicit, or alcohol, overwhelms the body. ⁴¹ In California, drug-related overdose deaths have doubled since 2017, reaching 10,898 in 2021, ⁴² with the greatest impact among racial and ethnic

³⁹ Definition sourced from the [National Institute of Mental Health](#). In relation, “suicide attempt” refers to the non-fatal, self-directed, potentially injurious behavior with intent to die as a result of behavior, and “suicidal ideation” refers to thinking about, considering, or planning suicide.

⁴⁰ DHCS does not have a formal definition for “suicide,” but acknowledges it as a complex public health challenge involving many biological, psychological, social, and cultural determinants. More on its program can be found in the [DHCS Suicide Prevention Fact Sheet](#).

⁴¹ Referenced from the [California Department of Public Health](#).

⁴² Referenced from the [California Department of Public Health](#). Statistic is sourced from the [California Overdose Surveillance Dashboard](#).

Goals for Reduction	Definition and Rationale
	<p>minorities, and individuals experiencing homelessness, unemployment, and incarceration.</p>
<p>Untreated behavioral health conditions</p>	<p>Untreated behavioral health conditions refer to an individual’s behavioral health condition that has not been diagnosed or attended to with appropriate and timely care. Living with untreated behavioral health conditions can lead to worsening symptoms, diminished quality of life, unemployment, reduced educational attainment, homelessness, and higher risk of severe outcomes such as suicide or self-harm.</p>
<p>Institutionalization</p>	<p>Minimize time in institutional settings by ensuring timely access to community-based services across the care continuum and in a clinically appropriate setting that is least restrictive. Reducing institutionalization entails maximizing community integration and making supportive housing options with intensive, flexible, voluntary supports and services available to all individuals who would benefit. Stays in institutional settings are sometimes clinically appropriate and therefore the goal is not to reduce institutionalization to zero.</p>
<p>Homelessness</p>	<p>Homelessness is defined below in Section 7.C.4.1.1 of the Housing Interventions chapter. Addressing the increase in statewide homelessness is crucial to ensuring unhoused individuals living with significant behavioral health needs receive regular access to behavioral health treatment and safe and stable housing where they can recover.</p>
<p>Justice-Involvement</p>	<p>Reducing justice involvement refers to reducing adults and youth living with behavioral health needs who are involved in the justice system - including those who have been arrested, are living in, who are under community supervision, or who have transitioned from a state prison, county jail, youth</p>

Goals for Reduction	Definition and Rationale
	<p>correctional facility, or other state, local, or federal carcel settings where they have been in custody of law enforcement authorities. More than 50 percent of incarcerated individuals living with a behavioral health condition.⁴³ While incarcerated, justice-involved individuals living with behavioral health needs have limited access to treatment. Formerly incarcerated individuals are more likely to experience poor health outcomes, including higher risk for injury and death due to violence, overdose, and suicide.⁴⁴ Promoting coordinated systems of care between the legal system and behavioral health plans and providers can have an impact on reducing justice involvement and improving outcomes for those who are justice-involved.</p>
<p>Removal of children from home</p>	<p>Removal of children from home, specifically those with an open child welfare status, refers to when children may be removed from their home due to abuse and/or neglect. Providing early intervention and intensive BH services to parents and additional members of the family unit living with a behavioral health condition can prevent family disruption and improve child welfare outcomes, as children are less likely to be placed in foster care and exposed to early childhood trauma.</p>

C.3 Population Behavioral Health Framework

Under BHT, DHCS will partner with counties to participate in a cycle of continuous improvement to drive progress on the statewide behavioral health goals (shown in Figure 2.C.5):

⁴³ Substance Abuse and Mental Health Services Administration. [About Criminal and Juvenile Justice](#).

⁴⁴ Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "[Release from Prison — A High Risk of Death for Former Inmates](#)." *New England Journal of Medicine*, January 2007.

1. Establish [statewide behavioral health goals](#).
2. In consultation with behavioral health stakeholders and subject matter experts, identify at least one measure for each behavioral health goal.
3. Deliver measures to counties describing their performance on the statewide behavioral health goals.

DHCS recognizes that shifting to a coordinated, data-driven, population behavioral health approach will take time. As with the PHM Program, DHCS will phase in requirements and provide technical assistance to counties and other key stakeholders.

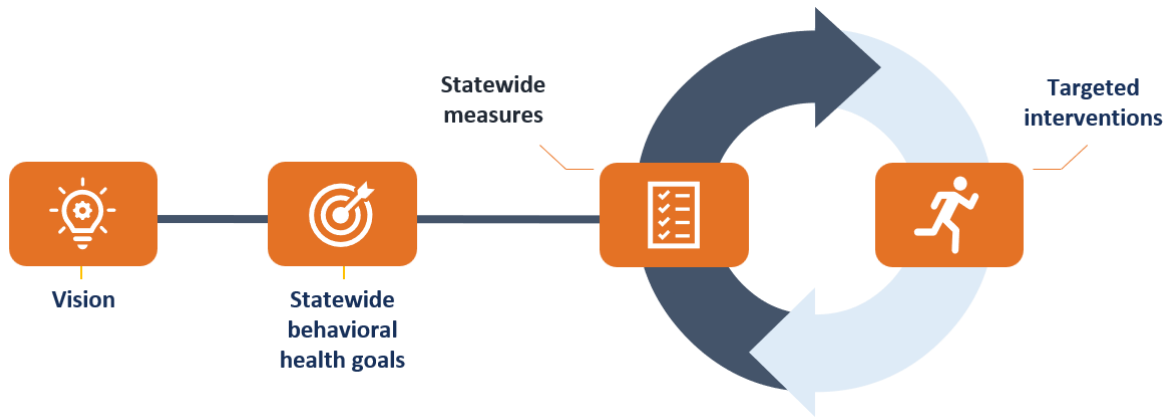


Figure 2.C.5. Population Behavioral Health Framework

3. Integrated Plan

A. Purpose of the Integrated Plan

The Behavioral Health Services Act (BHSA) requires counties¹ to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. Whereas the Three-Year Program and Expenditure Plan required under the Mental Health Services Act (MHSA) focused exclusively on MHSA dollars, the BHSA establishes the IP to serve as a three-year prospective global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local funding, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. In accordance with the BHSA, the IP provides a description of how counties will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the [Behavioral Health Care Continuum](#) for the plan period.² The Department of Health Care Services (DHCS) is developing an IP Template which will include the required elements for each county to submit in their IPs. A copy of the IP Template will be released in this policy manual to inform county planning. Counties will submit the IP through a DHCS web-based county portal.

IPs require counties to conduct a thorough data-informed local service planning process and provide transparency into county planning for expending BHSA funding and all other behavioral health funding sources overseen by counties. All BHSA services and programming must be planned in accordance with local data. In particular [W&I Code section 5963.02, subdivision \(b\)\(2\)](#) requires the county to use local SUD prevalence data and unmet SUD needs data. IPs will also facilitate local and statewide data collection by providing baseline data on services and planned expenditures and supporting analysis of county goals and outcomes.

¹ [W&I Code §§ 5963, subdivision \(a\); 5963.02, subdivision \(a\)](#)

² [W&I Code § 5963, subdivision \(a\)\(1\)](#)

A.1 Reporting Period

The first IP will cover Fiscal Years 2026–2029 and will be due on June 30, 2026.³ County board of supervisor approval is required for submission. The board of supervisors is also required to confirm in each IP that the county will meet their realignment obligations.⁴ The board of supervisors will attest that the county is meeting their realignment obligations, including but not limited to time and distance standards and appointment time standards as set forth [W&I Code section 14197.7](#) without utilizing waitlists, through the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) (see [Chapter 4](#) of this policy manual for BHOATR requirements). DHCS will post each county’s IP on the DHCS website.

A.2 Contents of Integrated Plan

The Integrated Plan (IP) Template requires counties to report planned activities and projected expenditures for all county behavioral health department services provided under the following funding sources, services, and programs⁵:

- Bronzan-McCorquodale Act (1991 Realignment)
- 2011 Realignment
- Medi-Cal behavioral health programs, including:
 - Specialty Mental Health Services (SMHS)
 - Drug Medi-Cal (DMC)
 - Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Federal block grants, including:
 - Community Mental Health Services Block Grant (MHBG)
 - Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)
 - Projects for Assistance in Transition from Homelessness (PATH) grant
- BHSA funds
- Any other federal, state, or local funding directed towards county behavioral health department services, including:
 - Commercial/private insurance

³ [W&I Code § 5963.02, subdivision \(a\)\(3\)](#)

⁴ [W&I Code § 14197.71, subdivision \(c\)\(2\)](#)

⁵ [W&I Code § 5963.02, subdivision \(c\)\(1-2\)](#)

- Opioid settlement funding (only funds received by the County Behavioral Health Department)
- County general fund
- Grant revenue
- Other

The IP Template will include required sections on the following topics:

- County Demographics and Behavioral Health Needs
- Plan Goals and Objectives
- Community Planning Process
- Comment Period and Public Hearing
- County Behavioral Health Care Continuum Capacity
- Services by Total Funding Source
- Behavioral Health Services Fund Programs
- Workforce Strategy
- Budget and Prudent Reserve

A.3 Function of Annual Updates and Intermittent Updates

Counties will be required to update their Integrated Plan (IP) through annual updates in the second and third years of the IP cycle. Annual updates will require the county to complete and submit all sections of the IP. Counties may prepare intermittent updates to their IP at any time during the IP cycle. For intermittent updates, counties must notify DHCS in advance of submission. Annual and intermittent updates will allow counties to be responsive to changes at the local level during the plan period.

Annual and intermittent updates are not subject to the stakeholder engagement requirements for the IP that are outlined in section 3.B.1 of this policy manual. However, DHCS encourages stakeholder engagement on the annual and intermittent updates. Counties are required to post the annual updates and intermittent updates to their IP with a summary and justification of the changes made by the updates for a 30-day comment period prior to the effective date of the updates. Counties maintaining their local stakeholder engagement in developing the annual or intermittent updates must continue to comply with the local behavioral health board public hearing requirements outlined in section 3.B.3 of this policy manual.

A.3.1 Reporting Period

Counties are required to submit annual updates for the second and third year of the IP period. Annual updates will be submitted by June 30 prior to the fiscal year the update will cover. Counties may submit intermittent updates to their IP as needed.

Table A.3.1 Reporting Periods for Integrated Plans, Annual Updates, and Intermittent Updates

	Integrated Plan	Annual Updates	Intermittent Updates
Counties are Required to Complete and Submit⁶	Yes	Yes	If changes are requested
Submission Timeframe	Every 3 years	Second and third years of IP cycle	Counties may submit at any time
Submission Deadline⁷	June 30 of year prior to fiscal years IP covers	June 30 of year prior to fiscal year annual update covers	Counties may submit at any time during the 3-year IP cycle
Community Planning Process Required⁸	Yes	No, but encouraged	No, but encouraged
30-day Public Comment Period Required⁹	Yes	Yes	Yes

⁶ [W&I Code § 5963.02, subdivision \(a\)\(1\)](#)

⁷ [W&I Code § 5963.02, subdivision \(a\)\(3\)](#)

⁸ [W&I Code § 5963.03, subdivision \(a\)](#)

⁹ [W&I Code § 5963.03, subdivision \(c\)\(B\)](#)

Behavioral Health Board Hearing Required¹⁰	Yes	If county engages stakeholders	If county engages stakeholders
Board of Supervisors Approval¹¹	Yes	Yes	Yes

A.3.2 Required Contents

Annual updates will include all sections required in the Integrated Plan (IP) template. If there are no changes to a given section of the county’s IP at the time of the annual update, the county may resubmit the information provided in the original IP as part of the update. Counties may update information in any section of the IP as needed through an intermittent update.

B. Community Planning Process

B.1 Stakeholder Involvement

Stakeholder engagement requirements for the Integrated Plan (IP) are effective January 1, 2025.¹² Counties must engage with local stakeholders to develop each element of their IP.¹³ The stakeholders that must be engaged include, but are not limited to¹⁴:

- Eligible adults and older adults¹⁵ (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults¹⁶ (families with lived experience)

¹⁰ [W&I Code § 5963.03, subdivision \(b\)](#)

¹¹ [W&I Code §§ 5963.03, subdivision \(c\)\(10\)-\(11\)](#)

¹² [W&I Code §5963.03, subdivision \(e\)](#)

¹³ [W&I Code §5963.02, subdivision \(c\)](#)

¹⁴ [W&I Code §5963.03, subdivision \(a\)\(1\)](#)

¹⁵ [W&I Code § 5892, subdivision \(d\)\(1\)](#)

¹⁶ [W&I Code § 5892, subdivision \(d\)](#)

- Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Local education agencies
- Higher education partners
- Early childhood organizations
- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans' organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal Managed Care Plans (MCPs)¹⁷
- Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106, subdivision (b))
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties with a population greater than 200,000
- Area agencies on aging
- Independent living centers
- Continuums of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents

In addition to the required stakeholders listed above, stakeholders shall include participation of individuals representing diverse viewpoints,¹⁸ including, but not limited to:

- Representatives from youth from historically marginalized communities

¹⁷ [W&I Code § 14184.101, subdivision \(j\)](#)

¹⁸ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(A\)\(ii\)](#)

- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse
- People with lived experience of homelessness

Counties are required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health and substance use disorder policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations.¹⁹ Meaningful stakeholder engagement requires that counties conduct a community planning process that is open to all interested stakeholders and that stakeholders have opportunities to provide feedback on key planning decisions. Stakeholder engagement should not be limited to individuals who belong to organizations or advocacy groups.

Counties must demonstrate a partnership with constituents and stakeholders²⁰ as part of their community planning processes. Examples of meaningful partnership with stakeholders may include, but are not limited to, the following types of stakeholder engagement:

- Education and engagement to support meaningful involvement, including on policies that govern the behavioral health delivery system
- Listening sessions
- Conference calls
- Client advisory meetings
- Consumer and family group meetings
- Town hall meetings
- Video conferences
- Media announcements
- Targeted Outreach
- Public comment
- Public hearings

¹⁹ [W&I Code § 5963.03\(a\)\(2\)\(A\)\(i\)](#)

²⁰ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(A\)\(i\)](#)

- Stakeholder workgroups and committees
- Focus groups
- Surveys
- Key informant interviews or engaging with subject matter experts
- Training, education, and outreach related to community planning
- Other strategies that demonstrate meaningful partnerships with stakeholders

To ensure that the community planning process is adequately staffed, the county may designate positions and/or units responsible for:

- The overall community planning process.
- Coordination and management of the community planning process.
- Ensuring that stakeholders have the opportunity to meaningfully and sufficiently participate in the community planning process.²¹

Training should be provided by the county as needed to their staff designated responsible for any of the functions that will enable staff to establish and sustain a community planning process.

A county may also provide supports, including, but not limited to, training and technical assistance, to ensure stakeholders, including peers and families, receive sufficient information and data to meaningfully participate in the development of Integrated Plans and annual updates.

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs.²² For additional information on how counties can fund the community planning process, please refer to the [County Planning Funds Chapter B.4](#).

B.2 Considerations of Other Local Program Planning Processes

This section focuses on the requirements for Integrated Plan (IP) development related to collaboration with Medi-Cal Managed Care Plans (MCPs) and local health jurisdictions

²¹ [W&I Code §5963.03, subdivisions \(a\)\(2\)\(A\)\(i\) and \(ii\)](#)

²² [W&I Code §5892, subdivision \(e\)\(1\)](#)

(LHJs).²³ Specifically, the Behavioral Health Services Act (BHSA) requires that each county must:

- Work with its LHJ on the development of its Community Health Improvement Plan (CHIP) ([W&I Code section 5963.01, subdivision \(b\)](#)).
- Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update ([W&I Code section 5963.02, subdivision \(b\)\(4\)](#)).
- Work with each MCP that covers residents of the county on the development of the MCP's Population Needs Assessment (PNA) ([W&I Code section 5963.01, subdivision \(a\)](#)).
 - The BHSA was written prior to the 2024 DHCS redesign of PNA requirements. MCPs no longer develop and submit a PNA to the Department of Health Care Services (DHCS). MCPs now fulfill their PNA requirement by meaningfully participating in the Community Health Assessments (CHA) and CHIPs conducted by LHJs.²⁴
- Consider the PNA of each MCP that covers residents of the county in preparing their IP and annual update ([W&I Code section 5963.02, subdivision \(b\)\(3\)](#)).

DHCS is focused on building bridges across public health, MCPs, and behavioral health delivery systems. The BHSA transforms the Mental Health Services Act (MHSA) planning process into a broader county and regional planning process. The targeted points of integrations of BHSA community planning processes with the community- and population-level assessment and planning efforts led by public health with MCPs and other stakeholders will reduce siloes and increase cross-system collaboration to enable strategic alignment of funding for coordinated and complementary approaches. DHCS' goal is to improve upstream interventions²⁵ and health outcomes for, and thus more effectively improve the lives of, community members. While perspectives and focus areas may vary, local public health, MCPs, and counties serve common communities,

²³ Per HSC [Section 124030](#), subdivision (f) a "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of HSC §101185.

²⁴ [CalAIM: Population Health Management Policy Guide \(May 2024\)](#)

²⁵ Upstream interventions include those that link to public health and social services and support members staying healthy through wellness and prevention services. For further details and additional context, see the [PHM Policy Guide \(p.4\)](#) and [CalAIM Population Health Management Initiative webpage](#).

and local integration and partnerships are essential to paving a path toward better understanding the needs of local communities, strategizing appropriate interventions, addressing social determinants of health, and advancing health equity. With this goal in mind, in January 2024, DHCS coordinated with the California Department of Public Health (CDPH) and issued a new policy requiring the MCP PNA to be more closely aligned with LHJ local planning processes, as detailed further below. As the BHSA was written prior to the 2024 DHCS PNA policy change, this guidance explains the BHSA IP requirements in the context of these other recent policy developments.

This guidance addresses requirements for counties' IP submissions, specific to collaboration with MCPs and LHJs on Community Health Assessments (CHAs) and CHIPs, to promote greater alignment among public health, managed care, and behavioral health.

B.2.1. Local Planning Overview

This section provides background on MCP and LHJ local planning processes.

B.2.1.1 Background: LHJ, CHA and CHIP

As part of its local planning processes, most LHJs develop both a CHA and a CHIP, which emphasize participatory and collaborative practices centered on the community.²⁶

- The CHA describes the status of population health within a jurisdiction.²⁷
- Informed by the CHA, the CHIP identifies how the public health entity will work with community partners to address key issues elevated in the CHA.

An array of tools and processes may be used to conduct a CHA and develop a CHIP; the essential feature is that these processes are informed by community collaboration and participation. Since the CHA and CHIP processes are tailored to address local

²⁶ For further details and additional context, see the [California Department of Public Health December 26, 2023 Memo to All Local Health Jurisdictions](#) and the [CalAIM PHM Policy Guide \(p. 8-10\)](#)

²⁷ Although the BHSA does not specifically reference the CHA and only the CHIP, the CHA and CHIP are part of the same local LHJ planning process, and the CHA is the essential precursor step to developing the CHIP.

community needs, there is no requirement to include prescribed topic areas such as specialty or non-specialty mental health, or other content areas.

At present, most LHJs complete or update their CHAs and CHIPs every five years when seeking to obtain and maintain voluntary [Public Health Accreditation Board \(PHAB\)](#) accreditation. Some LHJs are on a three-year submission cycle to align with local processes, such as non-profit hospital community health needs assessments. Currently, non-accredited LHJs can choose not to formally conduct CHAs and CHIPs.

Starting in 2028, as a part of the collaborative state efforts to improve local integration in community planning, the CHA and CHIP will be mandatory for all LHJs, and all LHJs will implement the same three-year submission cycle, as described below in Figure 3.B.2.1. This timeline is intentionally designed to align with and inform BHT IP planning processes as well as simplify the new PNA-CHA policy for MCPs operating in multiple local health jurisdiction areas.

B.2.1.2 Background: MCP PNA

The PNA is the mechanism that MCPs use to identify (1) priority needs of their local communities and members and (2) health disparities. Under the CalAIM Population Health Management (PHM) Program, since January 1, 2024, MCPs have fulfilled their PNA requirement by meaningfully participating in the development of LHJ CHAs and CHIPs in the service areas where MCPs operate.

MCP meaningful participation includes²⁸:

- **Collaboration.** MCPs must participate in every LHJ CHA and CHIP in their service area and collaborate with other MCPs within the same service areas to foster a unified planning process.
- **Data-Sharing.** MCPs are expected to share data with LHJs in ways that support the CHA and CHIP process.
- **Stakeholder Engagement.** MCPs must attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, as requested by LHJs.

²⁸ See the [CalAIM PHM Policy Guide](#) for additional details on MCP PNA Requirements (p. 7-10)

- Funding and/or In-Kind Staffing.** Starting on January 1, 2025, MCPs are required to contribute funding and/or in-kind staffing to support LHJ CHA and CHIP processes.

MCPs are required to complete an [“MCP-LHJ Collaboration Worksheet”](#) to demonstrate that they are meeting their PNA requirement.²⁹

DHCS and CDPH collaborated to create a regulatory environment that supports effective and efficient joint work on CHAs and CHIPs between LHJs and MCPs. Thus, aligned with [CDPH guidance](#), the cycles for LHJs’ CHA and CHIP development will become standardized across California starting in 2028, as previously noted, and as displayed in the timeline below.

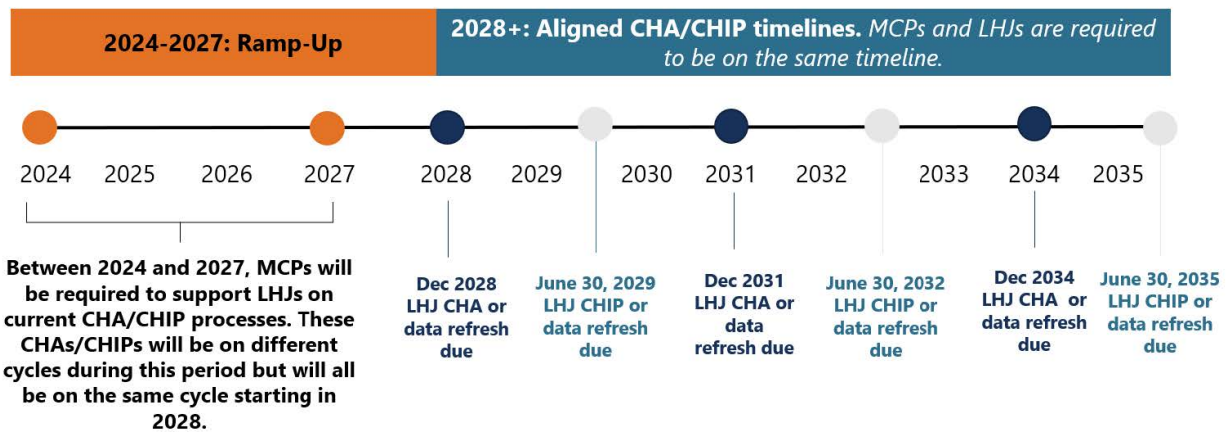


Figure 3.B.2.1. LHJ CHA and CHIP Submission Cycle Alignment Timeline

B.2.2 Overlap and Alignment with Other Local Program Planning Processes

County behavioral health departments (counties), LHJs, and MCPs share a common interest in identifying the needs of the populations and communities they serve. Points of integration existed before SB 326 and its IP mandate, and some counties, LHJs, and MCPs have been collaborating on CHA/CHIP processes for many years.

²⁹ MCPs are not required to submit MCP-LHJ Collaboration Worksheet unless requested by DHCS. In addition, all MCPs are required to submit a PHM Strategy which provides details on MCPs’ meaningful participation on LHJs’ CHA and CHIP.

Specific to BHSA mandates that counties work with and consider LHJ CHAs and CHIPs, and MCP PNAs, DHCS has established the following guiding principles to work toward the achievement of common goals:

- Counties, LHJs, and MCPs serve overlapping local communities and should collectively be aware of key, population-level needs and challenges.
- There is an opportunity to employ complementary and coordinated strategies and interventions across delivery systems.
- As counties begin to engage in the PNA, CHA, and CHIP processes, alignment should lead to more integrated, *upstream*, and effective community health initiatives and prevention strategies to improve population health.
- Given the distinct focus areas and different populations that LHJs, MCPs, and counties serve, DHCS intends for this alignment to supplement the broader county IP requirements.

Figure 3.B.2.2 depicts the initial level of overlap anticipated as counties and LHJs embark on, or in some cases continue, collaborative efforts related to the development and alignment of community needs assessments and planning processes. Additionally, it demonstrates that the IP has numerous requirements unrelated to the LHJ CHA and CHIP. However, over time, as relationships advance, collaboration strengthens, and timelines align, county, MCP, and LHJ overlap on CHAs and CHIPs will likely increase, and the overlap in these circles will expand.

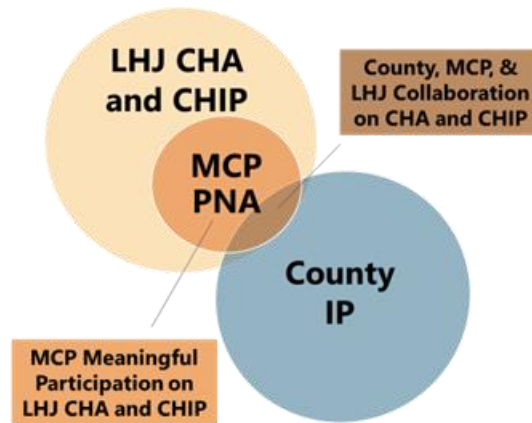


Figure 3.B.2.2 LHJ CHA and CHIP, MCP PNA, and County IP Overlap

B.2.3 County Requirements

This section provides county requirements, effective January 2025, for alignment with LHJs and MCPs in support of the IP submissions due in June 2026.

1. Engagement with Other Local Program Planning Processes

Counties are required to engage with LHJs and MCPs on CHAs and CHIPs, across the three areas described below. However, given that counties’ IPs and LHJs’ CHAs and CHIPs are driven by unique local needs, DHCS will allow for flexibility in how counties may work with LHJs and MCPs. For example, specific behavioral health topics and focus areas may vary from county to county.

Area 1: Collaboration. Over time, counties, LHJs, and MCPs can partner to focus on coordinated strategies for upstream interventions that can improve population health. To advance meaningful collaboration, counties are required to:

- Work with LHJs on the development of the CHA and CHIP in that county (or city, recognizing three city LHJs),³⁰ along with MCPs, in fulfillment of their meaningful participation requirements. If multiple MCPs are present in the county or city, they will already be aligned in support of the LHJ in accordance with DHCS PHM Policy Guide mandates.

³⁰ For a complete list of LHJs, see CDPH’s [listing of local health services/offices](#).

- Attend key CHA and CHIP meetings and serve on CHA and CHIP governance structures, including CHA and CHIP subcommittees, at the request of LHJs when discussions are relevant to behavioral health issues.

Area 2: Data-Sharing. Counties, LHJs, and MCPs all have access to their own siloed data. When this data is shared among these partners, it can be used to improve population health by creating a more holistic picture of the multiple factors contributing to a community’s health. Counties are expected to work with LHJs and MCPs to determine the types of relevant data to be shared, taking into consideration the specific nature of CHAs and CHIPs, the needs of the counties, and how data should be de-identified/disaggregated, if needed. Counties are required to begin to identify priority areas to:

- Share data to support behavioral health-related focus areas of the CHA and CHIP.³¹
- Utilize and stratify data from LHJs and MCPs to inform IP development.

Counties are subject to various and specific mandates regarding data sources, uses, and stratification for IP development that exceed the integration of LHJs’ and MCPs’ data. DHCS expects that counties must continue to meet any broader data requirements required by the IP that may not be fulfilled through the LHJ CHA and CHIP processes.

Area 3: Stakeholder Engagement. Given that BHSA identifies more than twenty specific populations and stakeholder groups that counties must engage in the development of the IP, counties should work with LHJs to look for opportunities where IP stakeholder engagement could be combined or integrated with CHA/CHIP processes to reduce duplication and community fatigue. LHJs generally involve a wide array of community stakeholders in the CHA and CHIP development processes. In order to streamline community input and reduce redundancy, counties are required to:

³¹ Counties will need to adhere to applicable federal and state privacy laws and regulations (e.g., consent requirements) and relevant frameworks (e.g. the [California Health and Human Services Agency Data Exchange Framework](#) if county is a signatory) while fulfilling the BHSA requirements to share and utilize data, as will MCPs and LHJs. BHSA includes broader data sharing and utilization requirements that counties must fulfill for their IP submissions.

- Coordinate stakeholder activities for IP development with LHJ engagement on the CHA and CHIP to the extent possible.
- Consider input from diverse populations and a wide range of community stakeholders.

DHCS expects that counties must continue to meet any broader stakeholder engagement requirements that may not be fulfilled through the LHJ CHA and CHIP processes.

Because LHJ stakeholder engagement on CHAs and CHIPs is uniquely focused on the individual needs of each community, there are no prescribed topics or mandated focus areas. However, behavioral health may be a key focus area identified by communities. Counties are expected to participate in the CHA and CHIP as described above, and where behavioral health-specific needs arise through the progress, work with LHJs and MCPs to incorporate addressing such needs in its IP.

The county requirements across all three areas noted mirror MCP requirements for meaningful participation on LHJs’ CHAs and CHIPs.³²

As mentioned previously, due to the current disparate submission cycles for LHJ CHAs and CHIPs, counties should consider the most recent CHA and CHIP on record, which could be up to four years old (depending on the submission cycle) and/or may not be available in all LHJs, when preparing their 2026 IP submissions. For the LHJs without CHAs or CHIPs available, counties should reach out to their respective LHJ to determine if a Strategic Plan is available for their review.

2. Monitoring and Oversight

In alignment with MCP PNA requirements and to support successful partnerships among counties, LHJs, and MCPs, DHCS has developed, and will require submission of, a “County-LHJ-MCP Collaboration Worksheet” (see Appendix; *placeholder- Worksheet to be added when finalized*). This Worksheet will require input from all three partners attesting to their efforts across the three areas of collaboration, data sharing, and

³² DHCS does not require or expect counties to provide funding and/or in-kind staffing to support the LHJ CHA and CHIP processes. Per the PHM Policy Guide, however, MCPs are required to work with LHJs to determine what combination of funding and/or in-kind staffing the MCP will contribute to the LHJ CHA/CHIP process.

stakeholder engagement. Completion of the Worksheet will offer insight into these cross-sector partners' experiences as they build relationships and begin working together towards shared goals.

Additionally, LHJs will be separately surveyed to provide their insight on the collaboration with counties.

3. Iterative Approach for Overlap and Alignment

Figure 3.B.2.3 below details the timeline for implementation of the county, LHJ, and MCP collaboration requirements for the first IP submission in 2026 through the June 2029 IP submission.

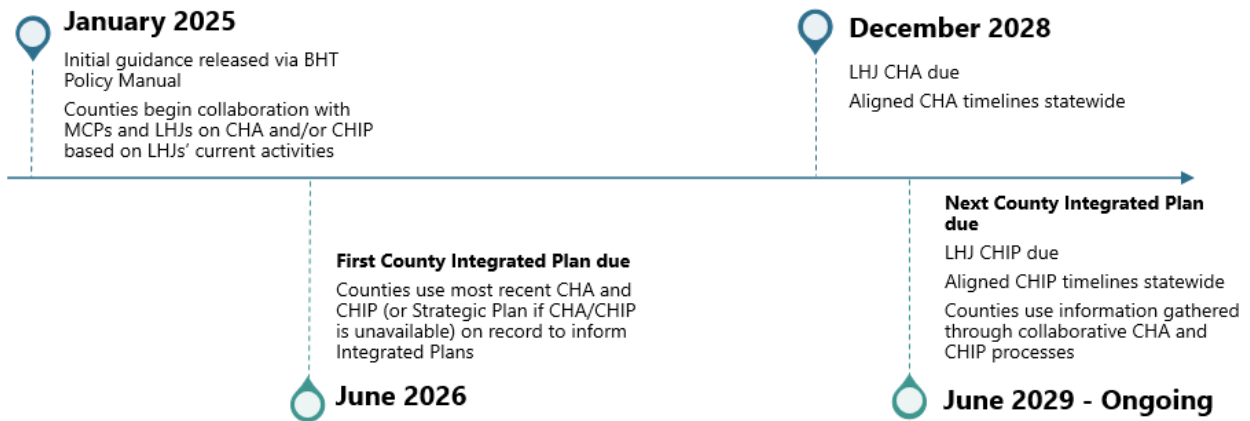


Figure 3.B.2.3 Timeline for Implementation of County, LHJ, and MCP Collaboration

Counties, LHJs, and MCPs should take time in 2025 to come to a common understanding of the respective key facts, goals, and language in each system.

- Opportunities should be identified for each entity to share background on their respective requirements and processes (relative to the IP, the PNA, and the CHAs and CHIPs) and how they utilize these tools.
- Counties, MCPs, and LHJs should ensure all parties are aligned on one another's roles and responsibilities, the populations they serve, and the services they are responsible for providing.

B.3 Public Comment and Updates to the Integrated Plan

Comment Period

Counties are required to provide 30 days for stakeholder comment on each draft IP. A draft IP and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.³³

Local Behavioral Health Board

The local behavioral health board shall conduct a public hearing on the draft IP at the close of the 30-day comment period.³⁴

Once an IP has been drafted and is ready for public comment, the local behavioral health board is required to review the draft plan and make recommendations to the local behavioral health agency for revisions. The local behavioral health board is not required to approve county Integrated Plans.³⁵

The local behavioral health agency is also required to provide an annual report to the local governing body, which is the local Board of Supervisors or city council, and DHCS that includes written explanations in response to any substantive recommendations³⁶ made by the local behavioral health board that are not included in the final IP or update.³⁷

Revisions to the Integrated Plan

After the 30-day comment period and public hearing are complete, counties are required to make the following revisions to the IP:

- Each draft IP should include a summary of substantive written recommendations.³⁸
- The draft IP should also include a summary and analysis of the revisions made as a result of stakeholder feedback.³⁹

Annual Updates and Intermittent Updates

Counties must prepare annual updates to their IP and may prepare intermittent updates, although intermittent updates are not required. When preparing Annual and

³³ [W&I Code § 5963.03, subdivision \(a\)\(2\)\(B\)](#)

³⁴ [W&I Code § 5963.03, subdivision \(b\)\(1\)](#)

³⁵ [W&I Code § 5963.03, subdivision \(b\)](#)

³⁶ [W&I Code § 5963.03, subdivision \(d\)](#)

³⁷ [W&I Code § 5963.03, subdivision \(b\)\(5\)](#)

³⁸ [W&I Code § 5963.04, subdivision \(d\)](#)

³⁹ [W&I Code § 5963.03, subdivision \(b\)\(3\)](#)

Intermittent Updates, counties are not required to comply with the stakeholder process outlined in W&I Code section [5963.03, subdivision \(a\)](#) and W&I Code section [5963.03, subdivision \(b\)](#). Counties may choose to elicit participation from stakeholders when preparing annual and intermittent updates. If counties choose to request stakeholder feedback, the county must comply with the local behavioral health board public hearing requirements outlined above.⁴⁰

Counties must post Annual and Intermittent Updates to their IP and a summary and justification of changes to their website for a 30-day comment period prior to the effective date of the updates.⁴¹ Counties will submit annual and intermittent updates to DHCS through the county portal. Counties can download their completed IP from the county portal and submit to the Behavioral Health Services Oversight and Accountability Commission (BHSOAC).

B.4 County Planning Funds

B.4.1 Planning Costs

Counties may allocate up to 5 percent of the total annual revenue received from the local Behavioral Health Services Fund (BHSF) to fund planning costs. All allocations and expenditures for planning costs must be included in the county IP and Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). These planning costs shall include funds for county mental health and substance use disorder programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process.⁴²

Planning costs may be used to help pay for infrastructure and technologies that will support robust stakeholder engagement. Examples may include but are not limited to:

- Laptops and other technologies to help stakeholders participate in the planning process
- Web-based meeting platforms
- Virtual engagement tools
- Accessibility services

⁴⁰ [W&I Code § 5963.03, subdivision \(b\)\(1\)](#)

⁴¹ [W&I Code § 5963.03, subdivision \(c\)\(2\)\(B\)](#)

⁴² [W&I Code § 5892, subdivision \(e\)\(1\)\(B\)-\(C\)](#)

- Stipends, wages, and contracts to be paid to consumers and family members
- Translation/interpretation services
- Travel and transportation for stakeholders
- Childcare
- Eldercare
- Training and technical assistance (TTA) for stakeholders to be meaningfully involved including TTA on fiscal policies
- Other supports to help with stakeholder engagement

Counties may use planning funds to assess public behavioral health workforce needs required as part of the IP, including the number of providers and vacancies in the county, the county’s ability to develop and maintain a robust workforce that provides adequate access to services and supports, and address statewide behavioral health goals described in Section 2.C of this policy manual. Counties will no longer be required to submit a separate Workforce Needs Assessment beyond what is included in the IP.

Planning costs do not include costs incurred as administrative costs or program expenditures. Additional information on administrative costs, including direct and indirect costs, can be found in Chapter 6.B.

C. Behavioral Health Care Continuum

C.1 Background

Each county’s Integrated Plan (IP) and its associated budget template is required to describe how it will spend behavioral health dollars across a care continuum. Specifically, each county is required to demonstrate, per [Welfare and Institutions \(W&I\) Code section 5963, subdivision \(a\)\(1\)](#), how it will:

“utilize various funds for behavioral health services to deliver high quality, culturally responsive, and timely care along the continuum of services in the least restrictive setting from prevention and wellness in schools and other settings to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports.”

To provide counties with more specificity as to what it means to provide care along “the continuum of services,” the California Department of Health Care Services (DHCS) has defined a Behavioral Health Care Continuum. The Behavioral Health Care Continuum is

composed of two distinct frameworks for substance use disorder (SUD) and mental health (MH) services. These frameworks will allow counties to describe their expenditures across key service categories, identify gaps in their service continuum, and articulate the investments they will make to expand access, close identified gaps, and improve performance as indicated through statewide behavioral health goals. The use of a standardized Behavioral Health Care Continuum also enables state-level analysis and comparison over time and across counties.⁴³ The information that counties provide through the Behavioral Health Care Continuum in the IP will not be used to evaluate compliance with expenditure requirements for Behavioral Health Service Act (BHSA) funds.

C.2 Behavioral Health Care Continuum

Counties will report on *planned* service delivery and expenditures in the IP and budget template, and *actual* service delivery and expenditures in the Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR) and expenditure template, disaggregated by child/youth under age 21 and adults aged 21 and older, within the Behavioral Health Care Continuum service categories outlined below. Counties will plan expenditures in the IP by *totaling* the dollar amount *across all* behavioral health funding streams for each Behavioral Health Care Continuum service category and will report actual expenditures in the BHOATR by *listing* the dollar amount from *each* behavioral health funding stream for each Behavioral Health Care Continuum service category.

The Behavioral Health Care Continuum (shown in Figure 3.C.1) has eight service categories across discrete SUD and MH frameworks, which capture behavioral health programs and services delivered by county behavioral health agencies.⁴⁴ One category, Housing Intervention Services, will be reported as a single total across the SUD and MH

⁴³ While informed by national behavioral health frameworks, the Behavioral Health Care Continuum is tailored to California's specific landscape and adjusted to reflect input from California stakeholders. The Continuum is also informed by [DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system.

⁴⁴ The Behavioral Health Care Continuum includes services provided in facilities designated as Institutions for Mental Disease (IMD) and services in non-IMD facilities. The IMD exclusion is only applicable to billing for Medi-Cal services.

frameworks within the IP. For the BHOATR, DHCS will ask counties to report actual spending on Housing Intervention Services distinctly in each of the SUD and MH frameworks.



Figure 3.C.1 Behavioral Health Care Continuum

The Behavioral Health Care Continuum does not include county expenditures on: 1) workforce investment activities; 2) capital infrastructure activities; 3) quality and accountability, data analytics, plan management, and administrative activities; and 4) other *non-clinical service* county behavioral health agency activities (e.g. Public Guardian, forensic activities, Community Assistance, Recovery and Empowerment (CARE) Act). Counties will report these expenditures in the IP and BHOATR distinctly from the Behavioral Health Care Continuum. These non-Continuum expenditure categories will be described in forthcoming guidance on IP and BHOATR reporting.

Tables 3.C.1 and 3.C.2 below describe each of the categories that span the SUD and MH frameworks. The tables below offer descriptions of each service category as well as examples of the specific services that should be reported under the SUD and MH frameworks. A more detailed inventory cataloging DHCS’s recommended approach to reporting service expenditures across categories in the Behavioral Health Care Continuum will be provided with the release of the IP and BHOATR. Some services, like peer supports, medication services, and case management, may cut across several categories in the Behavioral Health Care Continuum; the funding for these services should be allocated according to the setting in which services are delivered (i.e., peer support services delivered within an outpatient setting should be categorized within “outpatient services”).

SUD and MH frameworks include county reporting on population prevention services. While DHCS recognizes BHSA funds for population prevention are exclusively with the

California Department of Public Health (CDPH), counties have other funds that they may use for population prevention (e.g., Substance Abuse and Mental Health Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), opioid settlement, Realignment, etc.) which DHCS anticipates this category will capture.

Table 3.C.1 Substance Use Disorder Care Continuum Service Categories, Definitions,⁴⁵ and Example Services

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
Population Prevention Services ⁴⁷	Includes services and activities that educate and support individuals to prevent substance misuse and substance use disorders from developing. These services/activities offer communities support in identifying and addressing issues, tools for coping with stressors and information on ways to promote resiliency. They may also include services and public health campaigns focused on overdose prevention.	<ul style="list-style-type: none"> • Substance use disorder education, such as paid media campaigns regarding “fentapills” • Targeted prevention, such as SUBG-funded prevention screenings and referrals

⁴⁵Definitions are informed by [DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

⁴⁶ Services referenced reflect the ASAM 3rd edition. Medi-Cal guidance on the ASAM 4th edition is forthcoming. Available [here](#).

⁴⁷ While BHSAs funds for population prevention are exclusively with the California Department of Public Health (CDPH), counties have other funds that they may use for population prevention (e.g., SAMHSA SUBG block grant, opioid settlement, Realignment, etc.) which this category will capture.

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
Early Intervention Services ⁴⁸	Includes interventions that take a proactive approach to identifying and addressing substance use issues among individuals who are showing early signs, or are at risk, of a substance use disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles.	<ul style="list-style-type: none"> • Screenings • Brief intervention, American Society of Addiction Medicine (ASAM) level 0.5 • Evidence-based practices, like motivational interviewing
Outpatient Services ⁴⁹	Includes a variety of therapeutic substance use disorder services that can be provided anywhere an individual is located, such as in school, home, clinic, office, or other outpatient settings. These services may help avert the need for, or be provided after, crisis care, inpatient, or residential treatment. These services are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation.	<ul style="list-style-type: none"> • ASAM level 1.0, including individual and group therapy • Contingency Management • Narcotic/Opioid Treatment Programs
Intensive Outpatient Services	Includes services to support individuals living with higher acuity SUD needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based	<ul style="list-style-type: none"> • ASAM levels 2.1-2.5

⁴⁸ [W&I Code § 5840, subdivisions \(b\)\(1\)-\(3\)](#)

⁴⁹ [W&I Code § 5887, subdivision \(a\)\(4\)](#)

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
	<p>approach. These services offer structure and monitoring when more support than routine outpatient visits is necessary.</p>	
<p>Crisis and Field-Based Services</p>	<p>Includes a range of services that engage, assess, stabilize, treat, and/or coordinate care for individuals in need of substance use disorder services in field settings (e.g., homeless encampments, shelters, or syringe service programs). Services may be delivered in non-traditional settings where individuals work or reside.</p>	<ul style="list-style-type: none"> • Mobile crisis • Assertive field-based initiation for substance use disorder treatment services⁵⁰ • Post overdose follow up
<p>Residential Treatment Services</p>	<p>Includes low- to high-intensity clinically managed residential treatment. Services may be delivered in short-term residential settings of any size.</p>	<ul style="list-style-type: none"> • ASAM level 3.1-3.5 care
<p>Inpatient Services</p>	<p>Includes 24-hour, intensive treatment services to individuals who require medical management or medical monitoring for substance use disorder needs.</p>	<ul style="list-style-type: none"> • ASAM levels 3.7-4.0 • SUD services within a general acute care hospital (GACH), acute psychiatric hospital (APH), psychiatric health facility (PHF), or mental

⁵⁰ [W&I Code § 5887, subdivision \(a\)\(3\)](#)

Service Categories	Service Category Definition	Example SUD Services ⁴⁶
		health rehabilitation center (MHRC)
Housing Intervention Services <i>(reporting is aggregated with the mental health framework)</i>	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	<ul style="list-style-type: none"> • Permanent supportive housing • Housing tenancy and sustaining services • Recovery residences and sober living homes • Rent • Interim Settings

Table 3.C.2 Mental Health Care Continuum Service Categories, Definitions,⁵¹ and Example Services

Service Categories	Service Category Definition	Example MH Services
Population Prevention Services	Includes services and activities that educate and support individuals to prevent acute or chronic conditions related to mental health from ever developing. These services/activities may offer communities support in identifying and addressing issues before they turn into	<ul style="list-style-type: none"> • Mental health education, such as public health campaigns for suicide prevention or adverse

⁵¹ Definitions are informed [by DHCS's previous assessment](#) of California's Medi-Cal behavioral health service delivery system and tailored to the county landscape.

Service Categories	Service Category Definition	Example MH Services
	problems, tools for coping with stressors and information on ways to promote resiliency.	childhood experiences (ACEs) awareness <ul style="list-style-type: none"> Community Health Workers
Early Intervention Services ⁵²	Includes interventions that take a proactive approach to identifying and addressing mental health issues among individuals who are showing early signs, or are at risk, of a mental health disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles.	<ul style="list-style-type: none"> Screenings Evidence-based practices, such as coordinated specialty care for first episode psychosis
Outpatient ⁵³ & Intensive Outpatient Services	Includes a variety of therapeutic mental health services that can be provided anywhere an individual is located, such as in school, home, clinic, office, field settings (e.g. homeless encampments, shelters, etc.) or other outpatient settings. Also includes services to support individuals living with higher acuity mental health needs who may require assistance at a higher frequency and/or intensity, sometimes via a team-based approach. These services may help avert the	<ul style="list-style-type: none"> Individual therapy Group therapy Assertive Community Treatment/ Forensic Assertive Community Treatment (ACT/FACT)

⁵² [W&I Code § 5840, subdivisions \(b\)\(1\)-\(3\)](#)

⁵³ [W&I Code § 5887, subdivision \(a\)\(4\)](#)

Service Categories	Service Category Definition	Example MH Services
	<p>need for, or be provided after, crisis care, inpatient or residential treatment and are provided, if necessary, as part of stabilization and continued recovery/ongoing evaluation. They may also offer structure and monitoring when more support than routine outpatient visits is necessary.</p>	<ul style="list-style-type: none"> • High Fidelity Wraparound (HFW) • Intensive Outpatient Treatment/Day Treatment • Intensive
<p>Crisis Services</p>	<p>Includes a range of services and supports that assess, stabilize, and treat individuals experiencing acute distress. Services are designed to provide relief to individuals experiencing a mental health crisis, including through de-escalation and stabilization techniques, and may be delivered in clinical and non-clinical settings.</p>	<ul style="list-style-type: none"> • Crisis call centers • Crisis stabilization • Crisis residential services • Mobile Crisis
<p>Residential Treatment Services</p>	<p>Includes intensive treatment services that are provided in a structured, facility-based setting to individuals who require consistent monitoring for mental health needs on a longer-term basis. Services may be delivered in short-term residential settings to divert individuals from or as a step-down from hospital and acute services.</p>	<ul style="list-style-type: none"> • Adult residential treatment services
<p>Hospital and Acute Services</p>	<p>Includes treatment services that are provided in structured, hospital settings to individuals who require consistent monitoring and stabilization. These services may include comprehensive</p>	<ul style="list-style-type: none"> • Services within a psychiatric health facility (PHF), acute psychiatric hospital (APH), or

Service Categories	Service Category Definition	Example MH Services
	psychiatric treatment, including medication adjustments, and acute withdrawal services.	psychiatric unit within a general acute care hospital (GACH).
Subacute and Long-Term Care Services	Includes intensive licensed skilled nursing care provided to patients with mental health needs, most frequently delivered in a skilled nursing facility (SNF) and special treatment programs (STPs).	<ul style="list-style-type: none"> • Services within a SNF & SNF-STP • Services within a MHRC
Housing Intervention Services <i>(reporting is aggregated with the substance use disorder framework)</i>	Includes services and supports designed to enable individuals to remain in their homes or obtain housing to support recovery and improved health outcomes. Services help individuals find and retain housing, support recovery and resiliency, and/or maximize the ability to live in the community.	<ul style="list-style-type: none"> • Permanent supportive housing • Housing tenancy and sustaining services • Residential Care Facilities for the Elderly (RCFE) and Adult Residential Care Facilities (ARF) • Rent • Interim Settings

D. County Integrated Plan Alignment with Statewide Population Behavioral Health Goals

As outlined in [W&I Code section 5963.02, subdivision \(c\)\(3\)\(A\)](#), each county shall develop an Integrated Plan (IP) and annual update (AU) aligned with their associated measures. DHCS will identify and provide counties with measures of their performance relative to the statewide behavioral health goals. Counties will use those measures to inform resource planning in their IPs and AUs, as well as their approach to population health management and implementation of targeted interventions to drive progress on statewide behavioral health goals. In forthcoming guidance, DHCS will describe its approach to calculating performance measures and delineate expectations for counties, MCPs, and other stakeholders as part of a monitoring and accountability framework. See [Section 2.C](#) for more detailed information.

4. Behavioral Health Outcomes, Accountability, and Transparency Report

A. Purpose of the Behavioral Health Outcomes, Accountability, and Transparency Report

The Behavioral Health Services Act (BHSA) requires counties¹ to submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis. Whereas limited information is publicly available regarding the provision of services that are funded with federal grant programs and other county-administered behavioral health funding sources outside of Medi-Cal, the BHSA establishes the BHOATR to provide California with greater transparency into how counties spend behavioral health dollars and administer behavioral health care. Counties will use the BHOATR Template to report on implementation of the county Integrated Plan (IP) and the related annual and intermittent updates. Counties are required to report on behavioral health spending, service utilization, and achievement of goals and outcomes outlined for the reporting period. County boards of supervisors are required to attest that the BHOATR is complete and accurate before it is submitted to DHCS.² Additionally, in accordance with [Welfare and Institutions \(W&I\) Code section 14197.71, subdivision \(c\)\(2\)](#), county boards of supervisors are required to attest that the county is meeting its realignment obligations, including but not limited to time and distance standards and appointment time standards set forth in [W&I Code section 14197.7](#) without utilizing waitlists, and will do so through the BHOATR.

DHCS will review county BHOATRs. After DHCS approves the county BHOATR, DHCS will develop a statewide BHOATR describing activities and opportunities in behavioral health delivery across California. DHCS will post each county's BHOATR and an aggregated statewide BHOATR on the DHCS website.³

¹ [W&I Code § 5963.04, subdivision \(a\)\(1\)](#)

² [W&I Code § 5963.04, subdivision \(c\)](#)

³ [W&I Code § 5964.04, subdivision \(d\)](#)

A.1 Reporting Period

The first BHOATR will cover fiscal year (FY) 2026-27. The due date for the first BHOATR will be January 30, 2029. Counties will submit a draft BHOATR for FY 2026-27 due January 30, 2028. This one-time draft submission will allow DHCS to provide technical assistance.

A.2 Required Contents

The BHOATR template will mirror the reporting requirements within the IP template. A detailed list of sections required for inclusion in the BHOATR template is forthcoming.

5. County Portal

Department of Health Care Services (DHCS) has developed an online county portal for each county to submit their Integrated Plans (IP), Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATR), and annual and intermittent updates. To facilitate county reporting and ensure comparability between county reports, data from publicly available sources will be pre-populated into each county's IP county portal where possible. Detailed information on how to use the county portal will be available in the DHCS Integrated Plan County Portal User Manual.

6. BHT Fiscal Policies

B. BHSA Fiscal Policies

B.4 Funding Transfer Requests

Starting with the fiscal year (FY) 2026-2029 Integrated Plan (IP), all counties can request changes to the funding allocation percentages outlined in Table B.5.1 below. Counties may ask to transfer funds between these three components to change their funding allocation percentages. However, these changes in funding allocation percentages cannot exceed 7 percent of total funds allocated to the county in one fiscal year from any one component. Counties may only request a maximum of 14 percent of total funds allocated to the county to transfer in any given fiscal year.¹ Adjusting the distribution of funds within a county according to these guidelines does not exempt the county from adhering to any additional applicable laws or to the sub-allocation requirements.²

In a fiscal year, a county may transfer from its housing intervention funds up to 7 percent of its total BHSA allocation for that fiscal year. However, if a county uses 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 must be decreased by a corresponding amount.³ For example, if County A chooses to use 3 percent of its annual Housing Intervention funds for outreach and engagement, then County A would be able to transfer no more than 4 percent out of its Housing Interventions component into another funding component. Counties are not required to utilize Housing Interventions funding for outreach and engagement. Counties are also not required to transfer funds out of Housing Interventions. Counties shall retain discretion to transfer up to a total of 14 percent of its total BHSA allocation in a fiscal year.

All transfer requests between Housing Interventions, Full Service Partnerships (FSP), and/or Behavioral Health Services and Supports (BHSS) components must be submitted to DHCS through the county portal and include all required information and

¹ [W&I Code § 5892, subdivision \(c\)\(1\)](#)

² [W&I Code § 5892, subdivision \(c\)\(2\)](#)

³ [W&I Code § 5892, subdivision \(c\)\(4\)](#)

documentation.⁴ This includes details and rationale for the funding allocation transfer request. The rationale must specify how the transfer request is responsive to community needs and include local data and community input in the planning process. For instance, a county might demonstrate significant need within a particular component by showing that programs are unable to meet the demand of their community. Or, if a county is interested in decreasing a funding allocation percentage for a component, a county should demonstrate that there is limited need or show where there is sufficient funding from other sources.

Counties may submit their funding transfer request within the county portal prior to developing their IP in order to support planning efforts.

DHCS will review transfer requests based on compliance with statutory requirements, evidence of alignment with local priorities, and community input.⁵ For transfer requests, counties are also required to adhere to local stakeholder consultation requirements.⁶ Additional information about the community planning process can be found in [Chapter 3.B.1](#) of this policy manual.

B.5 Funding Component Allowances

The table below lays out the funding allocations and their corresponding sub-allocations for each Behavioral Health Services Act component, beginning July 1, 2026.⁷

Table B.5.1 Overview of Funding Allowances

Statute	Allocation	Sub-Allocations	Special Considerations
	Housing Intervention	50% of these funds shall be directed	These housing interventions are focused on the chronically

⁴ [W&I Code § 5892, subdivision\(c\)\(4\)](#)

⁵ [W&I Code § 5892, subdivision \(c\)\(4\)\(A\)](#)

⁶ [W&I Code §§ 5963.02](#) and [5963.03](#)

⁷ [W&I Code § 5892, subdivision \(l\)](#)

Statute	Allocation	Sub-Allocations	Special Considerations
W&I Code section 5892, subdivision (a)(1)(A)	Programs (30%)	towards housing interventions for persons who are chronically homeless.	homeless, with a focus on encampments.
		No more than 25% shall be used for capital development projects.	Housing Intervention funds may be used for capital development, under the provisions of W&I Code section 5831 , and only for eligible populations under W&I Code section 5830, subdivision (a) . If a county elects to use housing intervention funds for capital development, the units shall be available in a reasonable timeframe as specified by DHCS (W&I Code section 5830, subdivision (b)(2)(B)).
W&I Code section 5892, subdivision (a)(2)(A)	Full Service Partnership Program (FSP) (35%)	N/A	The sub-allocations of Housing Intervention services may be used towards individuals enrolled in a FSP program.

Statute	Allocation	Sub-Allocations	Special Considerations
W&I Code section 5892, subdivision (a)(3)(A) W&I Code section 5892, subdivision (a)(3)(B)(i-ii)	Behavioral Health Services and Supports (BHSS) (35%)	At least 51% of BHSS services shall be used exclusively for early intervention programs.	Of the BHSS funds allocated for early intervention programs, at least 51% shall be used for early intervention programs to serve individuals aged 25 years and younger.

B.5.1 Adjusting a Previously Approved Funding Allocation Percentage Change

Approved funding allocation percentage changes are final and cannot be adjusted again for the duration of the three-year plan, unless an annual change is approved by DHCS due to a state or local emergency.⁸ To be granted an annual change, a county shall demonstrate to DHCS that it is experiencing a state⁹ or local¹⁰ emergency, and the change is necessary because of the emergency. Counties may only request an annual change in funding allocations percentages for previously approved funding allocation percentage changes.¹¹ If a county seeks to adjust the percentage allocations that were previously approved by DHCS as part of the IP, the county will submit the funding allocation percentage change request in the county portal. Counties are required to adhere to local stakeholder consultation requirements to adjust funding allocations.¹²

B.5.2 Process for Approval and Denial

DHCS has 30 calendar days to approve or deny funding allocation transfer requests following receipt of the request. The approval and/or denial of the transfer request will

⁸ [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

⁹ [Gov. Code, § 8625](#)

¹⁰ [Gov. Code, § 8630](#)

¹¹ [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

¹² [W&I Code § 5963.03\(c\)\(1\)](#)

be completed through the county portal. If DHCS does not respond within 30 calendar days, the funding allocation transfer request will be considered approved.¹³

If the transfer request is approved, funding allocation adjustments cannot be changed during the three-year IP period, unless an annual change is approved by DHCS.¹⁴ If the transfer request is denied, justification will be included with the decision. The county will be required to update their Integrated Plan (IP) to reflect the denial. Counties should be transparent with stakeholders throughout the community planning process and acknowledge where the IP will need to be adjusted if the exemption request is not approved.

If the county does not agree with DHCS’s decision to deny the transfer request, the county may submit an appeal to DHCS within 30 calendar days of receipt of the denial. The appeal must include an explanation stating the basis of the appeal and supporting documentation. Appeals must be submitted through the county portal. DHCS has 30 calendar days to approve and/or deny the appeal, starting with the date that DHCS confirmed receipt of the appeal.

DHCS will have 10 calendar days from confirming receipt of the appeal to request additional documentation from the county. Counties will supply additional documentation within 10 calendar days of confirming receipt of the request.

If the appeal is denied, justification will be included with the decision. If an appeal is submitted after 30 calendar days from receipt of the denial, the appeal will be automatically denied.

If the county already submitted their IP and budget and the county receives notice that their funding transfer request was denied, the county is required to update the IP and budget to reflect the correct allocation amounts within 90 days of receipt of the denial from DHCS, unless the county receives approval for an extension to this timeframe.

B.5.3 Reporting Requirements

Transfers between components will change the required allocation of BHSA funds dedicated to Housing Interventions (30 percent), FSP (35 percent), and BHSS (35 percent). As a result, counties are required to report approved transfers and updated

¹³ [W&I Code § 5892, subdivision\(c\)\(4\)](#)

¹⁴ [W&I Code § 5892, subdivision \(c\)\(4\)\(C\)](#)

BHSA allocations on the BHOATR, consistent with the transfers approved as part of the IP.¹⁵

Funds transferred between FSP, Housing Interventions, and BHSS components are subject to the same reversion requirements as before the transfer. Transferring funds does not alter the reversion period associated with those funds. The reversion period is the length of time a county has to spend its local Behavioral Health Services Fund (BHSF) money; the reversion period begins the fiscal year in which funds are transferred from the state BHSF to the local BHSF. For more information on reversion, please see the Reversion Section of this policy manual in [Chapter 6.B](#).

¹⁵ [W&I Code § 5963.04, subdivision \(a\)](#)

7. BHSA Components and Requirements

C. Housing Interventions

C.1 Housing Interventions Funding

Counties are required to use 30 percent of the funds distributed by the State Controller's Office into their Behavioral Health Services Fund (BHSF) for Housing Interventions.

Of the funding distributed to counties for Housing Interventions:

- 50 percent must be used to support the housing needs of individuals who are chronically homeless, with a focus on those in encampments.
- Up to 25 percent may be used for capital development projects.
 - If a capital development project identifies chronically homeless individuals as a priority population, the project funding will contribute toward the 50 percent requirement.

C.2 Introduction and Background

Using the Behavioral Health Services Act (BHSA) Housing Interventions funding, counties can develop an ongoing behavioral health housing program to increase access to permanent supportive housing for people meeting BHSA eligibility who are chronically homeless, experiencing homelessness, or are at risk of homelessness.

These policies have been developed to give counties flexibility so that each community can develop a program that is reflective of its needs. The flexibilities of Housing Interventions are also intended to build upon other housing initiatives, including but not limited to Homekey+, Behavioral Health Bridge Housing (BHBH), No Place Like Home (NPLH), Homekey, Project Roomkey, the Community Care Expansion (CCE) Program, the Housing and Homelessness Incentive Program (HHIP), the Encampment Resolution Fund (ERF), and the Homeless Housing Assistance and Prevention Grant Program (HHAP). Housing Interventions are also intended to complement CalAIM Community Supports and Transitional Rent available through Medi-Cal Managed Care Plans (MCPs). The Transitional Rent benefit available through MCPs specifically to seamlessly connect

BHSA eligible individuals receiving Transitional Rent to BHSA-funded Housing Interventions.

In the following sections, the Department of Health Care Services (DHCS) identifies a number of policies and procedures that counties must develop to support the implementation of Housing Interventions. Those policies and procedures are not subject to approval by DHCS but must be provided to DHCS upon request.

C.3 Program Priorities

The development of Housing Interventions has been driven by the following priorities:

- Reduce homelessness among BHSA eligible individuals experiencing homelessness with a behavioral health condition, focusing efforts on the chronically homeless, with a focus on those in encampments.
- To the extent possible, provide individuals with permanent supportive housing, including voluntary, flexible, and intensive supports and services available such as Assertive Community Treatment, Intensive Case Management, and other supports funded under the BHSA and Medi-Cal consistent with best practice.
- Provide flexibility for counties to respond to local conditions and needs, and to innovate.
- Provide individuals receiving Housing Interventions access to clinical and supportive behavioral health services.
- Support the provision of low-barrier, harm reduction, and Housing First principles.
- Complement ongoing state, county, city, Continuum of Care, and tribal efforts to address homelessness, including but not limited to those provided through Medi-Cal.

C.4 Eligible and Priority Populations

C.4.1 Eligible Populations for Housing Interventions¹

Individuals must meet the BHSA eligibility requirements, identified in this policy manual² and meet the definition of:

- [At-Risk of Homelessness](#), or
- [Experiencing Homelessness](#), or
- [Chronically Homeless](#), with a focus on those in encampments.

C.4.1.1 Experiencing Homelessness and At Risk of Homelessness

[W&I Code section 5892, subdivision \(k\)\(3\)](#) provides that for purposes of the BHSA, “experiencing homelessness or at risk of homelessness” means people who are homeless or at risk of homelessness as defined by [24 CFR section 91.5](#) or as otherwise defined by the State Department of Health Care Services for purposes of the Medi-Cal program.

For purposes of the BHSA, DHCS is adopting the [definitions of experiencing homelessness and at risk of homelessness consistent with CalAIM Community Supports](#), which are the same as the definitions provided at [24 CFR section 91.5](#) with three modifications, as follows:

- Individuals exiting an institution or carceral setting are considered homeless if they were homeless immediately prior to entering that institutional or carceral stay or become homeless during that stay, regardless of the length of the institutionalization or incarceration.
- The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness to 30 days.

¹ [W&I Code § 5830](#)

² Pursuant to [W&I Code § 5891.5, subdivision \(a\)\(2\)](#), the provision of Housing Interventions to individuals with a substance use disorder (SUD) is optional for counties in alignment with the requirements in Section 5963.02(b)(2) . However, when Housing Interventions are provided to an individual living with a SUD, all housing intervention requirements in [W&I Code § 5830](#) must be met.

- An individual or family is not required to have an annual income below 30 percent of median family income for the area.

Additionally, anyone who was homeless or at risk of homelessness prior to the receipt of Transitional Rent (as covered by a Medi-Cal managed care plan) or prior to the receipt of housing funded by MHSA is considered homeless for BHSA purposes.

C.4.1.2 Chronically Homeless

[W&I Code section 5892, subdivision \(k\)\(2\)](#) provides that for purposes of the BHSA, "chronically homeless" means an individual or family that is chronically homeless as defined in [42 U.S. Code section 11360](#) or as otherwise modified or expanded by the State Department of Health Care Services.

DHCS is adopting the Department of Housing and Urban Development (HUD) definition of chronic homelessness, identified under [24 CFR section 91.5](#) with two modifications, as follows:

- The requirement that a discontinuous period of 12 months of homelessness over the last three years occur on at least four separate occasions is eliminated; any number of occasions will suffice so long as the combined duration equals at least 12 months.
- Consistent with the Medi-Cal modification to the definition of "homeless," anyone residing in an institutional care facility, defined according to the [HMIS definition](#) of "institutional situations," who was chronically homeless prior to entry retains that status upon discharge, regardless of length of stay.

Additionally, anyone who was chronically homeless prior to the receipt of Transitional Rent or prior to the receipt of housing funded by MHSA and is transitioning from either of these services to Housing Interventions services will be considered chronically homeless under Housing Interventions.

Regarding the requirement that 50 percent of Housing Interventions be directed to individuals experiencing chronic homelessness, the determination that an individual meets the definition of chronically homeless will be made by counties at enrollment and may maintain their status as such for the duration of their enrollment in Housing Interventions services.

C.4.1.3 People in Encampments

The BHSA requires that 50 percent of a county’s Housing Interventions funds be used for Housing Interventions for persons eligible for BHSA funding who are chronically homeless, “with a focus on those in encampments.”³ The BHSA definition for encampments is in alignment with the Department of Housing and Urban Development (HUD)⁴ definition. An encampment includes the following:

- A group of people sleeping outside in the same location for a sustained period.
- The presence of some type of physical structures (e.g., tents, tarps, lean-to’s).
- The presence of personal belongings (e.g., coolers, bicycles, mattresses, clothes).
- The existence of social support or a sense of community for residents.

Counties are expected to prioritize serving individuals living in encampments with methods consistent with the U.S. Interagency Council on Homelessness’ [19 Strategies for Communities to Address Encampments Humanely and Effectively](#). It is essential that counties provide Housing Interventions services that are relevant and responsive to the needs of individuals in encampments who are chronically homeless and are BHSA eligible, including the provision of housing and behavioral health interventions that will help individuals transition out of encampments and into permanent supportive housing.

C.4.2 Priority Populations

In addition to specifying the populations who are eligible for Housing Intervention services (“Eligible Populations”), the BHSA identifies a smaller subset of populations who should be prioritized for BHSA services ([see BHSA requirements here](#)).

Priority Populations⁵:

Children and youth in the Eligible Population who also satisfy one of the following:

- In, or at risk of being in, the juvenile justice system;
- Reentering the community from a youth correctional facility;
- In the child welfare system; or
- At risk of institutionalization.

³ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(ii\)](#).

⁴ [Unsheltered Homeless and Homeless Encampments in 2019](#)

⁵ [W&I Code § 5892, subdivision \(d\)](#)

Adults or older adults in the Eligible Population who also satisfy one of the following:

- In, or are at risk of being in, the justice system;
- Reentering the community from prison or jail;
- At risk of conservatorship; or
- At risk of institutionalization.

C.4.3 Individuals Transitioning from MHSA to BHSA

For individuals housed under the MHSA as of June 30, 2026, the following policies apply:

1. Counties may transfer individuals housed in permanent housing directly to BHSA-funded Housing Interventions without eligibility redetermination.
2. Individuals receiving interim housing under the MHSA who are not enrolled in an MCP may also be transferred to BHSA Housing Interventions without eligibility redetermination.
3. For individuals in interim housing who are in an MCP, the county should connect the individual to their MCP for assessment of eligibility for Transitional Rent. The goal is for this to be seamless to the individual being served. This will require the delivery systems to put processes in place for effective coordination.
 - Those determined eligible for Transitional Rent may be transferred to the MCP and may not receive rental assistance or housing under BHSA Housing Interventions until they are no longer eligible for Transitional Rent.
 - Those determined ineligible for Transitional Rent may be transferred directly to BHSA Housing Interventions without eligibility redetermination.
4. Anyone who was chronically homeless when housed under MHSA, and who was transferred from MHSA to BHSA, will be considered chronically homeless for purposes of the requirement to direct 50 percent of Housing Interventions to individuals who are chronically homeless.

C.5 Program Requirements

In addition to the eligibility requirements, [W&I Code section 5830, subdivision \(a\)](#) specifies the following:

- Housing Interventions shall not be limited to individuals enrolled in either a Full Service Partnership or Medi-Cal.

- Counties shall not discriminate against or deny access to housing for individuals that are utilizing medications for addiction treatment or other authorized medications, or individuals who are justice-involved.
- Housing Interventions shall comply with the core components of Housing First, as defined in subdivision (b) of [W&I Code section 8255](#), and may include recovery housing. See additional information in the [C.9.5.1 Housing First](#) section below.
- All Housing Interventions settings must be combined with access to clinical and supportive behavioral health care and housing services that will promote the individual’s health and functioning and long-term stability. Access does not necessitate co-location. Housing Interventions may not be used for behavioral health services; however, these activities can be covered under Behavioral Health Services and Supports or other behavioral health funding sources.
- Counties may utilize up to 7 percent of Housing Intervention funds on identified Outreach and Engagement activities. If Housing Intervention funds are used for Outreach and Engagement activities under the Housing Intervention component, counties must adhere to transfer requirements, including required documentation, in [section C.6 Transfers and Exemptions](#).

C.6 Transfers and Exemptions

C.6.1 Transfers

Beginning in Fiscal Year 2026, counties may request to transfer funds distributed to the counties Behavioral Health Services Fund to spend more than or less than 30 percent of their local BHSF on Housing Interventions.⁶ Please refer to the [Funding Transfer Requests section](#) for more information.

Transfer of funds into or out of Housing Interventions funds does not relieve the county from complying with:

- The requirement to use 50 percent of Housing Interventions funds on services for the chronically homeless.
- The requirement to use no more than 25 percent of Housing Interventions funds on capital development projects.

⁶ [W&I Code § 5892, subdivision \(c\)](#).

C.6.2 Exemptions

State law permits counties to request exemptions to Housing Interventions spending requirements. Exemptions are necessary for counties requesting a funding adjustment beyond the seven percent allowed through the transfer process. Counties with a population of less than 200,000 may request exemptions beginning with the 2026-29 Fiscal Years' county Integrated Plan (IP), and all counties regardless of size may do so beginning with the 2032-35 Fiscal Years' county IP. Exemption requests are subject to DHCS approval; counties may request exemptions from one or more of the following requirements⁷:

- 30 percent of the BHSF funds distributed to the county for Housing Interventions services.
- 50 percent of the county's Housing Interventions funds on those who are chronically homeless.
- No more than 25 percent of Housing Interventions funds on capital development projects.

Table C.6.2.1 Criteria for Housing Exemption Requests

Requirement	Exemption Request Criteria
<p>30 percent of BHSF for Housing Interventions</p>	<p>Criteria for increased/reduced percentage (beyond transfer allowance):</p> <ul style="list-style-type: none"> • Very significant or very limited need (e.g., small/large eligible population). • Sufficient/insufficient funding from other sources to address housing needs. • Other considerations, subject to evidence requirements and DHCS review. <p>Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., Point in Time Count (PIT), Housing</p>

⁷ [W&I Code § 5892, subsections \(a\)\(1\)\(B\)-\(C\)](#)

Requirement	Exemption Request Criteria
	<p>Inventory Count (HIC), HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.).</p>
<p>50 percent of the county’s Housing Intervention funds on persons who are chronically homeless</p>	<p>Criteria for reduced percentage:</p> <ul style="list-style-type: none"> • Very limited need (e.g., small number of BHSA eligible individuals experiencing chronic homelessness). • Sufficient funding from other sources to address housing needs. • Other considerations, subject to evidence requirements and DHCS review. <p>Requests for exemptions must include information and data demonstrating that the exemption request criteria provided above are met (e.g., PIT, HIC, HMIS data, Coordinated Entry System data, Electronic Health Record data, etc.).</p>
<p>No more than 25 percent of the county’s Housing Intervention funds on capital development projects</p>	<p>Criteria for increased percentage:</p> <ul style="list-style-type: none"> • Significant capital development required to meet housing needs of eligible population (e.g., demonstrated lack of existing suitable housing facilities within the county). • Other funding sources insufficient to address need • Costs of accessibility improvements exceed 25 percent capital improvement limits. • Other considerations, subject to evidence requirements and DHCS review. <p>Requests for capital development exemptions must include documentation demonstrating that the exemption request criteria provided above are met (e.g., a detailed budget with funding breakdown, partnership agreements/letters of support, evidence of need for housing production, and other supporting data).</p>

C.7 Relationship to Medi-Cal Funded Housing Services

Per W&I Code section 5830, subdivision (c)(2), Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Accordingly, counties must work closely with MCPs to ensure that Housing Interventions funds are used to complement, not supplant, MCP-covered services. By working closely with MCPs to coordinate the delivery of housing-related Community Supports covered by MCPs prior to expending the Behavioral Health Services Act (BHSA) Housing Interventions funding, counties and MCPs will play a key role in the prudent stewardship of taxpayer dollars and help ensure that funding sources other than the BHSA also contribute to meeting the housing-related needs of BHSA eligible Californians with behavioral health conditions. This statutory requirement will maximize the total amount of the BHSA Housing Interventions funding available to counties, allowing these dollars to go further to improve outcomes for Californians. The close coordination will also facilitate appropriate referrals to additional Community Supports, Enhanced Care Management, and other services delivered by MCPs.

C.7.1 Prohibition on Housing Interventions Coverage of Managed Care Plan-Covered Services

Housing Interventions “shall not be used for housing interventions covered by a Medi-Cal Managed Care Plan.”⁸ Under CalAIM, MCPs are authorized to cover five housing-related “Community Supports”^{9,10}:

⁸ [W&I Code § 5830, subdivision \(c\)\(2\)](#).

⁹ As of September 6, 2024, 100 percent of MCPs cover the Housing Trio and 92 percent cover Recuperative Care and Short-Term Post-Hospitalization Housing. An additional six Medi-Cal managed care plans will offer Recuperative Care and Short-Term Post-Hospitalization Housing by 1/1/25. On 1/1/25, MCPs will have the option to cover Transitional Rent and on 1/1/26, coverage will be mandatory.

¹⁰ [DHCS Medi-Cal Community Supports Policy Guide. July 2023](#).

Table C.7.1. Coverage of Housing-related Community Supports

Service	Coverage ^{11,12}
Housing Deposits	Covered by all MCPs in all counties
Housing Transition Navigation Services	Covered by all MCPs in all counties
Housing Tenancy and Sustaining Services	Covered by all MCPs in all counties
Recuperative Care	Varies by MCP
Short-Term Post-Hospitalization Housing	Varies by MCP
Transitional Rent¹³	All MCPs required to cover for the behavioral health population beginning January 1, 2026

Housing Interventions may not be used to cover any of the services identified above when the individual is eligible for the service through their MCP. BHSa funding can be used if the MCP is not offering the Community Support in a county or if the individual has expended a benefit with a timeline restriction (e.g., the six month aggregate annual cap across Transitional Rent, Short-Term Post-Hospitalization Housing, and Recuperative Care; the limitation of six months per demonstration period for Transitional Rent). Additionally, if a Medi-Cal member is receiving housing services from their MCP, this does not preclude the individual from receiving simultaneous Housing Interventions not covered by the MCP. For example, an individual who is receiving Transitional Rent could also receive utility assistance funded by the BHSa Housing Interventions because

¹¹ [DHCS CalAIM Community Supports – Managed Care Plan Elections. Updated July 2024.](#)

¹² Coverage depicted as of date of publication – please refer to website for current status.

¹³ [DHCS Transitional Rent Concept Paper. August 2024.](#)

Transitional Rent will only cover landlord-paid utilities that are part of rent, not utilities that the tenant is responsible for paying separately.

C.7.2 Expectations for Coordination with MCPs

Counties will be expected to coordinate closely with MCPs to:

1. Ensure that Housing Interventions are not used for services that are covered by the MCP.
2. Support seamless connections from the county to the MCP for coverage of housing services and vice versa.
3. Provide whole-person care and integrated housing services for MCP-enrolled members with significant behavioral health needs who meet BHSA eligible criteria.

At a minimum, counties are required to establish detailed policies and procedures for issuing referrals to MCPs for housing-related Community Supports (including Transitional Rent) in alignment with forthcoming DHCS guidance and receiving referrals for BHSA Housing Interventions services (guidance forthcoming). DHCS may provide additional information in the future regarding minimum standards for coordination with MCPs regarding housing-related Community Supports and the BHSA Housing Interventions funding.

In addition, counties are strongly encouraged to participate as providers of housing-related Community Supports covered by MCPs, including but not limited to: Transitional Rent, Housing Deposits, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services in particular. The BHSA Housing Interventions funding is intended to serve as a permanent rental subsidy for housing following MCP-covered Transitional Rent for BHSA eligible individuals, providing seamless continuity and supporting Californians with behavioral health conditions in achieving long-term housing sustainability. As such, it is critical to ensure that counties and MCPs work in full partnership to connect individuals to Transitional Rent and integrate this service with specialty behavioral health services. To that end, DHCS is designing a comprehensive policy approach to standardize processes and streamline requirements for the Transitional Rent benefit with the goal of directly enabling counties to serve as MCP-contracted providers of Transitional Rent and other housing-related Community

Supports. Such arrangements will amplify MCP-county coordination of housing-related services and improve the experience of individuals receiving these supports.

C.8 Flexible Housing Subsidy Pools

While not required, Flexible Housing Subsidy Pools (“Flex Pools”) are a strategy to support local partners, including counties, in braiding complementary funding sources and resources to provide permanent supportive housing. Flex Pools provide a model for administering and coordinating multiple streams of funding for rental subsidies and a model which shows potential for the coordination and administration of housing supports. This model for housing payments could facilitate the centralized deployment of housing location, navigation, and rental subsidy payments and supports administrative billing functions. With a Flex Pool, a centralized administrative entity can efficiently connect individuals to the units that best meet their needs from with collective “housing pool”. Flex Pools provide a solution to create economies of scale, reduce the burden of subsidy administration, and braid together resources seamlessly so that members are accessing housing more quickly and efficiently, and ensures individuals who become housed, remain housed.

Technical assistance will be made available on the use of Flex Pools to coordinate the administration of the Behavioral Health Services Act (BHSA) Housing Interventions, housing-related Community Supports (including Transitional Rent), and other sources of housing support funding.

C.9 Allowable Expenditures and Related Requirements

Housing Interventions may be used for the following expenditures and are subject to the identified program requirements as discussed in the remainder of this chapter, which is organized as follows:

1. Rental Subsidies
2. Operating Subsidies
3. Allowable Settings
4. Other Housing Supports
 - a. Landlord Outreach and Mitigation Funds
 - b. Participant Assistance Funds

- c. Housing Transition Navigation Services and Tenancy and Sustaining Services
- d. Outreach and Engagement (up to 7 percent)
- 5. Other Housing Interventions Requirements
- 6. Capital Development Projects

C.9.1 Rental Subsidies

The terms rental subsidies and rental assistance as used in the manual are inclusive of multiple, specific types of rental assistance described in detail in this section. The intent of Housing Interventions is to place and sustain individuals in permanent housing settings including permanent supportive housing developed through the Homekey+ program and other state and locally funded supportive housing programs. While counties may establish short and medium-term rental assistance programs, particularly in interim settings as described below, the goal 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. Rental subsidies can be established either as scattered-site (multiple locations) or project-based assistance (one location), including master leasing. Counties are encouraged to work with housing providers in their regions to prioritize the Behavioral Health Services Act (BHSA) Housing Interventions for projects serving BHSA eligible individuals within their regions.

C.9.1.1 Rental Assistance Requirements

All rental subsidies must be issued directly to property owners, managers, or providers contracted to administer BHSA-funded rental assistance.

Counties opting to provide rental subsidies must develop policies and procedures that, at a minimum, address the following:

- The setting in which the rental subsidy will be used (see Allowable Settings, below).
- The duration of payments (to be determined based on individual need and, to the extent possible, to continue as long as necessary or until an alternative subsidy or arrangement is in place).

- The calculation of rental assistance for permanent settings. The method elected must use either the [rent reasonableness](#) methodology or [Fair Market Rents](#)¹⁴ (FMRs), to calculate allowable rental rates. Rent Reasonableness assesses rent based on similar unassisted units in the local area, considering factors like location, size, type, quality, and amenities. It adapts to the actual market dynamics and can be more accurate for specific neighborhoods or property types.
- The calculation and types of utilities that are allowed (e.g., electricity, natural gas, water, sewer services, trash collection and internet).
- The calculation of individual contribution towards rent. Counties may establish individual contribution requirements of zero to 30 percent of individual income, and the individual contribution requirements may vary by program or setting.¹⁵ Importantly, BHSA-eligible individuals may not be denied Housing Interventions assistance due to lack of income (i.e., if income is zero, tenant pays zero). DHCS recommends 30 percent of adjusted income for permanent settings to match federal vouchers.
- The housing-related supportive services and resources that will be made available to individuals who are receiving rental subsidies that will remove barriers and help them obtain and/or maintain supportive housing.
- Fraud prevention measures, along with a designated and regular audit process.
- Record-keeping methods, including the process for the documentation of all payments issued.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.1.2 Project-Based Housing Assistance

Project-Based Housing (PBH) assistance is a form of rental assistance that is tied to a particular housing unit. PBH differs from tenant-based rental assistance, which is a subsidy or federal voucher assigned to the program participant, and which may relocate with the participant to another unit if needed. PBH can occur in unit(s) of an apartment

¹⁴ Fair Market Rent includes Small Area Fair Market Rent or up to 120% Fair Market Rent or Small Area Fair Market Rent.

¹⁵ Time-limited interim settings must not require tenants to pay rent.

complex, duplex, triplex, or other structure that is leased, purchased, and/or otherwise subsidized for the purpose of providing housing to eligible individuals. Counties are encouraged to work with housing providers in their region constructing permanent supportive housing and other affordable housing for the eligible population to assess opportunities for project-based rental subsidies, especially through the Homekey+ program. Counties are also encouraged to assess the full pipeline of permanent supportive housing and affordable housing being built within their region so that this funding can be paired with eligible projects that meet the housing needs of BHSA priority populations.

In addition to the policies required for all rental assistance projects (See “Rental Assistance Requirements” section), counties providing PBH are responsible for ensuring policies and procedures governing such units, such as a property management guide for each property meet the requirements identified under “[Program Requirements](#).” The property management guide must also include tenant selection and occupancy procedures (for example, rent contributions, if any; and other core program and fiscal policies to be required by DHCS).

C.9.1.3 Master Leasing

A master lease is a legal agreement through which a master tenant (the county or its subcontracted provider or county grantee) leases a unit or multiple units from a property owner, and then subleases units to subtenants. Under a master lease strategy, the county or subcontracted provider enters into a lease with the property owner, specifying the county/property owner roles and responsibilities, including tenant selection and responsibility for damage and repair. The county then would serve as a master tenant, and then enter into subleases or occupancy agreements with individual(s) who are eligible for Housing Interventions.

Master leasing can be used by counties to provide scattered-site or PBH. Units can include but shall not be limited to single and multi-family homes, apartments, and other privately owned properties.

C.9.2 Operating Subsidies

Housing Interventions allows the use of funds for operating subsidies for either new or existing housing on the allowable settings list provided below. Operating costs are those costs associated with the day-to-day physical operation of housing projects and may include utilities (including internet), maintenance and repairs, marketing and leasing costs taxes and insurance, property management, office supplies and expenses, legal and accounting services, security and/or site monitors, cleaning fees, and housing incidentals (refrigerators/appliances, water heater, transportation, furnishings, food, hygiene products etc.). Operating costs may not include costs for behavioral health services; however, these can be covered under Behavioral Health Services and Supports (BHSS) and other behavioral health funding sources. Operating costs may not include costs for housing transition navigation or tenancy sustaining services; however, the costs for these services are included as allowable expenditures in the “other housing supports” component of Housing Interventions (see [section C.9.4](#) below). Counties opting to provide operating subsidies as a Housing Intervention service must develop policies and procedures that, at a minimum, address the types of expenses which may be covered with Housing Interventions.

C.9.3 Allowable Settings

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.

However, Housing Interventions may also be used in connection with placement in interim settings for a limited time. For BHSA eligible individuals who have exhausted the Transitional Rent benefit, counties may use the BHSA Housing Interventions funding to provide an additional six months of subsidy for placement in an interim setting. For BHSA eligible individuals who are not eligible for Transitional Rent, 12 months of coverage in an interim setting may be provided. After the 6- or 12-month time limit has expired, Housing Interventions funds may only be used for placement in a permanent setting.

Housing Interventions funding will be permissible in the following settings:

Non-Time-Limited Permanent Settings:

- Supportive housing
- Apartments, including master-lease apartments
- Single and multi-family homes
- Housing in mobile home communities
- Single room occupancy units
- Accessory dwelling units, including Junior Accessory Dwelling Units
- Tiny Homes¹⁶
- Shared housing
- Recovery/Sober Living housing, including recovery-oriented housing¹⁷
- Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- License-exempt room and board
- Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings:

- Hotel and motel stays
- Non-congregate interim housing models
- Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)¹⁸ (does not include behavioral health residential treatment settings)
- Recuperative Care
- Short-Term Post-Hospitalization housing
- Tiny homes, emergency sleeping cabins, emergency stabilization units
- Peer respite
- Other settings identified under the Transitional Rent benefit

¹⁶Tiny homes would only be considered permanent if the settings have the hallmarks of a permanent setting such as requiring a lease, require payment of rent, has reasonable and ease of access to private bathrooms, kitchen areas, and utilities. Additionally, the settings must not have restrictive rules pertaining to curfews or having guests and has sufficient infrastructure to function as a permanent site.

¹⁷ 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 who are not eligible for Transitional Rent. Please see [Appendix B](#) for a crosswalk of coverage by select programs.

¹⁸ Congregate settings do not include behavioral health residential treatment settings. Housing Interventions may not be used to cover room & board in residential treatment settings.

Counties must ensure that individuals are voluntarily placed in the least restrictive, most community-integrated setting that can accommodate their physical and behavioral health needs.

Individuals should be placed in settings that reflect their preferences and goals, enables them to stay in their “home” communities and provides for community integration in accordance with all applicable federal and state law.

C.9.3.1 Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a proven and cost-effective model that provides long-term housing coupled with intensive case management services linking individuals with medical, behavioral health, and other services such as income supports. Those supports can be referrals to community-based providers or delivered onsite, depending on the nature of the project or the tenants’ needs. When integrated with voluntary, flexible, intensive community-based services, PSH is an evidence-based practice that is nationally recognized as the standard solution for meeting the housing needs of people with serious mental illness. Basic tenets of PSH, including those enumerated in [Housing First](#), include:

- **Permanent:** Tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent.
- **Supportive:** Tenants have access to the supportive services that they need and want to retain housing.
- **Housing:** Tenants have a private or shared and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

PSH programs may be administered through tenant-based rental subsidies, which may be used in the private rental market, or through site-based subsidies or vouchers (rental assistance), that are attached to particular units. PSH requires a rental contract or lease between the tenant/program participant and a property owner/landlord. The tenant may pay a portion of the rent (typically no more than 30 percent of the tenant’s adjusted monthly income) and the PSH program covers the remaining portion of rent to the owner/landlord/property.

County-led PSH rental subsidy programs should adopt policies that outline the parameters and procedures of the administration of the subsidies. Among those are

definition of eligible participants, eligible units (i.e., compliance with rent reasonableness and housing quality standards), and rental contribution income calculation methodology. Counties are encouraged to adhere to the Department of Housing and Urban Development (HUD) [standards for PSH rental calculations](#).

Leases are required, and those leases or other occupancy agreements shall comply with state and local laws and not impose additional barriers or behavioral standards not contained in standard lease agreements.

PSH is an effective model even for individuals with significant and complex behavioral health conditions; individuals with frequent and long-term hospitalizations, homelessness, and incarceration succeed in PSH with intensive supports, such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM). An [independent evaluation](#) from 2020 using a randomized control trial in Santa Clara County, for example, found that PSH is associated with increases in housing placement, increases in housing retention, increases in outpatient mental health service utilization, and decreases in psychiatric-related emergency department utilization among individuals with the most acute needs. Counties are encouraged to assess the opportunity to leverage BHSA Housing Interventions with other programs providing capital funding for PSH units for BHSA eligible individuals, including Veterans, such as Homekey+, No Place Like Home (NPLH), and Community Care Expansion (CCE).

C.9.3.2 Shared Housing

Many communities have programs that use rental assistance for shared housing, which is when more than one person or household agrees to share a housing unit. Each person (or couple as they choose) must have their own bed and locked cabinet/bureau. In some cases, programs will offer private bedrooms. In all cases, participants must have access to common areas such as the kitchen, bathroom, and living room. Shared housing is an effective way to make housing more affordable, to maximize available housing stock, and to decrease isolation for people not used to living alone.

Typically, each household has its own lease or sublease, and shares expenses like utilities. Rent is split by the number of bedrooms, and the rent reasonableness standard is applied per tenant/household. The tenant's contribution may be based on percent of income as described above.

Shared Housing is a subset of rental assistance, and counties opting to provide shared housing should develop policies and procedures with specific callouts for best practices for shared housing. Those practices include the following:

- **Participant choice** is one of the hallmarks of success in shared housing programs. Participants should opt into shared housing and feel informed about the logistics and pros and cons of the arrangement as well as feel empowered in the creation of shared household rules and norms.
- **Roommate matching** is key to success; some roommate matches may occur organically, through meetings at shelter or in other programs. Many providers use a roommate matching process, much like those used for college dorms or other roommate situations, to help participants define preferences. For example, individual preferences for roommates may include gender, pets, substance use rules, quiet hours, or cleanliness.
- **Roommate agreements** can help support roommates in living in a shared space; and some programs will have peer or case management facilitation for this process and for dispute resolution.

C.9.3.3 Recovery Housing

Recovery housing is a housing intervention that is recognized by both Substance Abuse and Mental Health Services Administration (SAMHSA) and HUD as an important housing option for individuals with substance use disorders.¹⁹ Recovery housing, also referred to as sober living or recovery residences, offers shared housing in a milieu that is supportive of recovery and that builds a sense of community and mutual support. Recovery housing, including recovery-oriented housing, can provide valuable support for those in outpatient treatment, leaving residential treatment, or others seeking to live in an alcohol and drug-free environment that supports recovery and wellness. The American Society of Addiction Medicine (ASAM) Criteria, Fourth Edition, includes recovery residences as a part of the continuum of care.

People who want to live in a recovery environment should have access to recovery housing; however, individuals who prefer low-barrier housing must not be limited to

¹⁹ Substance Abuse and Mental Health Services Administration. [Best Practices for Recovery Housing](#). Publication No. PEP23-10-00-002. Rockville, MD: Office of Recovery, Substance Abuse and Mental Health Services Administration, 2023.

recovery housing. In other words, recovery housing should be an option but must never be the only option available to individuals in need of housing interventions.

Recovery housing should be designed to promote community, prosocial behaviors, and mutual support. Additionally, recovery housing providers must ensure the rights of privacy, dignity, and respect of residents and have policies in place that allow for all medications for addiction treatment approved by the FDA to treat substance use disorders. Other requirements include providing a lease or at minimum a participant agreement, supportive services for both relapse prevention and relapse support, and appropriate referrals for an individual who chooses not to stay or must leave. Recovery housing providers are encouraged to meet the National Association of Recovery Residences [national standards](#) for recovery housing.

Most recovery housing is transitional with people staying up to one year then moving to permanent housing once they have built their recovery capital and found supportive, affordable housing. There are different levels of recovery housing starting with varying staffing and services and requirements. Some recovery housing providers require participation in outpatient treatment. There is some recovery housing that is permanent housing with no maximum length of stay. There are also some recovery housing options designed for specific populations including transition age youth, families with children, LGBTQIA+ populations, and faith communities.

C.9.3.4. Assisted Living (Adult Residential Care Facilities, Residential Care Facilities for the Elderly, and Licensed Board and Care Facilities)

Housing Interventions may help to cover stays in Adult Residential Facilities, Residential Care Facilities for the Elderly, Board and Care facilities, and license-exempt room and board facilities. Such facilities provide 24/7 care to people who require it due to cognitive impairment or inability to perform activities of daily living (ADLs), along with room and board. These settings may be appropriate for some people experiencing homelessness who have serious behavioral health conditions, require assistance with ADLs, or have severe cognitive impairment.

Housing Interventions funding for these facility types is not time-limited. However, [Title II of the Americans with Disabilities Act](#), as affirmed by the U.S. Supreme Court in [Olmstead v. L.C. \(1999\)](#), requires states to provide services to individuals with disabilities in the most integrated setting appropriate to their needs. This means that eligible

individuals should only be placed in such settings where medically necessary and only for as long as medically necessary. Eligible individuals who are able to reside in PSH or other more independent settings should be transitioned as soon as possible.

C.9.3.5 Recuperative Care

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

Recuperative Care is available as a Medi-Cal Community Support. If Recuperative Care can be covered by a Medi-Cal Managed Care Plan (MCP), the Medi-Cal service must be used before Housing Interventions. Housing Interventions may be used for the costs of room and board in Recuperative Care for BHSA eligible individuals not eligible to receive coverage of this service from their MCP. Behavioral health services provided during Recuperative Care cannot be funded through Housing Interventions.

C.9.3.6 Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing provides BHSA eligible individuals who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient facility (either acute or psychiatric or Chemical Dependency Recovery hospital, or psychiatric health facility), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or Recuperative Care and avoid further utilization of these services.

This setting must make available ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, utilizing case management, and accessing other housing supports. This setting may include an

individual or shared interim housing setting, where residents receive the services described above.

Short-Term Post-Hospitalization Housing is available as a Medi-Cal Community Support. If Short-Term Post-Hospitalization Housing can be covered by an MCP, the Medi-Cal service must be used before Housing Interventions. Housing Interventions funds may be used for the costs of room and board in Short-Term Post-Hospitalization Housing for BHSA eligible individuals not eligible to receive coverage of the service from their MCP. Behavioral health services provided during Short-Term Post-Hospitalization Housing cannot be funded through Housing Interventions.

C.9.4 Other Housing Supports

Counties may provide other housing supports as identified by DHCS in this guide, in addition to the housing interventions specifically identified in [W&I Code section 5830, subdivision \(b\)](#), including, but not limited to, those listed in the [Medi-Cal Community Supports Policy Guide](#).²⁰ Pursuant to this authority, counties may provide under the category of "other housing supports": (1) Landlord Outreach and Mitigation Funds, (2) Participant Assistance Funds, (3) Housing Transition Navigation Services and Housing Tenancy and Sustaining Services and (4) Outreach and Engagement (up to 7 percent). However, as described throughout this section, BHSA funds may not be used for Medi-Cal services that can be covered and funded through the individual's Medi-Cal managed care plan (MCP). In other words, BHSA funds can only be used for Community Supports if the MCP has chosen not to administer the service, the individual is not eligible for the service, or the individual's needs exceed service limitations and as such the service cannot be covered as a Community Support.

C.9.4.1 Landlord Outreach and Mitigation Funds

Landlord Outreach and Mitigation Funds may be used to support outreach to, and engagement of, landlords and property owners, which may include the development of presentations, outreach materials, campaigns, and support to help properties meet the requirements of Housing Interventions. Landlord Outreach and Mitigation Funds may also be used by counties to encourage and incentivize property owners to rent to eligible individuals. Additionally, counties may establish a mitigation fund to offset any

²⁰ [W&I Code § 5830, subdivision \(b\)\(1\)\(F\)](#).

damages caused by a Housing Interventions participant and/or for use in connection with potential or actual evictions as further described below.

Counties opting to provide Landlord Outreach and Mitigation Funds as part of their Housing Interventions must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of landlord outreach costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
 - Development of outreach materials (e.g., graphic design).
 - Costs associated with advertising and campaigns focused on landlord recruitment, including networking events (e.g., attending/presenting at local landlord associations).
 - Landlord incentives (e.g., one-time incentives, signing bonus, referral bonus).
 - Holding fees (short term costs to hold a vacant unit before a tenant moves in).
- Enumerate the types of landlord mitigation costs that Housing Interventions will cover and the maximum allowable reimbursement, examples include:
 - Damage reimbursement outside of usual wear and tear.
 - Unit hold related costs and vacancy payment (if tenant leaves early) or if PBH unit is vacant for a specified number of days after sufficient marketing.
 - Eviction prevention costs which may include financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources (if necessary for someone to maintain their housing or be relocated).
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse
- Identify any overlap with other community funds and create procedures to avoid duplication.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.4.2 Participant Assistance Funds

Counties may use Housing Interventions to establish Participant Assistance Funds that seek to remove barriers to housing and support people in meeting their immediate housing needs. Any support provided should be based on individualized assessment of needs. Examples of services and activities to be covered under a Participant Assistance Fund may include, but would not be limited to:

- Costs associated with obtaining government-issued identification and other vital documents
- Housing application fees
- Fees for credit reports
- Security deposits
- Utility deposits
- Storage fees
- Pet deposits and other pet fees
- Move-in costs, including costs associated with establishing a household such as:
 - Transportation
 - Food
 - Hygiene products
 - Moderate furnishings (including but not limited to items such as a bed, tables and chairs, cleaning tools, and other supplies that people need to settle into housing)
- Rent and utility arrears

The Medi-Cal Housing Deposits Community Support covers many of the expenses identified above.²¹ Housing Interventions may not be used to cover expenses that an individual's MCP would cover under the Housing Deposits Community Support (assuming the individual is enrolled in an MCP and eligible for Housing Deposits). However, Housing Interventions may be used for expenses not covered under Medi-Cal Housing Deposits, such as pantry stocking. For individuals not eligible for Housing Deposits or who have exhausted the Housing Deposits covered by their MCP, Housing

²¹ See [DHCS Medi-Cal Community Supports Policy Guide](#).

Interventions may be used for the complete list of expenses covered by the county’s Housing Interventions under its Participant Assistance Fund.²²

Counties opting to provide Participant Assistance Funds as a Housing Interventions service must develop policies and procedures that, at a minimum, address the following:

- Enumerate the types of costs that may be covered.
- Identify protocols for approving allowable costs and mechanisms for documenting costs.
- Identify processes for the prevention of fraud, waste, and abuse.
- Identify any overlap with other community resources (for example, the Housing Deposits Community Support or other rental assistance deposit funds) and create procedures to avoid duplication of services.

These policies and procedures are not subject to review and approval by DHCS but must be provided to DHCS upon request.

C.9.4.3 Housing Transition Navigation Services and Housing Tenancy Sustaining Services

Counties may fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services for individuals not eligible for these services through a Medi-Cal MCP. Counties using Housing Interventions to fund Housing Transition Navigation Services and Housing Tenancy Sustaining Services shall refer to the [Community Supports policy guide](#) for a list of allowable activities but are not subject to the eligibility, restrictions/limitations, or licensing/allowable provider requirements set forth in the Medi-Cal guidance or any other requirements established for Medi-Cal, if not additionally specified as applicable to BHSA Housing Interventions. Counties may also become contracted Community Supports providers which enables counties to provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services to individuals enrolled in Medi-Cal.

²² For example, if an MCP covers the costs of Housing Deposits up to \$8,000 and the individual has additional needs related to securing or establishing a home that cannot be met under this amount, additional expenses could be paid by Housing Interventions component. If the individual must pay fees or needs items not covered by the MCP, those too could be covered by Housing Interventions component.

C.9.4.4 Outreach and Engagement

Outreach and engagement activities may only represent up to 7 percent of the Housing Interventions funding allocation in accordance with the transfer guidelines in C.6 Transfers and Exemptions. Outreach and engagement activities should be tracked and entered into HMIS to inform key metrics such as the number of individuals contacted, the percentage of individuals who received housing assistance, the housing retention rate, the number of new community partnerships formed, and qualitative feedback from participants and community partners.

In alignment with the engagement activities identified as allowable under the United States Department of Housing and Urban Development Emergency Solutions Grant funding, engagement activities may include the activities necessary to locate, identify, and build relationships with individuals or families living in unsheltered settings for the purpose of providing immediate support, intervention, and connections with homeless assistance programs or mainstream social services and housing programs. Outreach and engagement activities shall not duplicate services provided by Medi-Cal MCPs per [W&I Code \(5830\(c\)\(2\)\)](#).

Activities may include but not limited to:

- Building relationships either through one-on-one engagement or by conducting regularly-scheduled broad outreach in high-need areas in conjunction with community partners.
- The purchase and distribution of items like food, hygiene products, clothing, blankets, and water to provide immediate support and foster future service engagement.
- Providing immediate, onsite direct navigation to housing resources.
- Coordinating behavioral health service and housing resources for unsheltered individuals in collaboration with other outreach and engagement efforts.
- Travel by outreach workers, social workers, medical professionals, or other service providers during the provision of eligible street outreach services. Also includes the costs of transporting unsheltered people to emergency shelters or other service facilities.
- Harm reduction activities and the distribution of harm reduction supplies.

C.9.5 Other Housing Interventions Requirements and Policies

This section discusses other requirements and policies that apply to Housing Interventions services.

C.9.5.1 Housing First

Housing Interventions must be operated in compliance with the core components of Housing First and “may include recovery housing.”^{23,24} Housing First is defined in statute²⁵ as “the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible.”

Consistent with the national Housing First model and [W&I Code section 8255, subdivision \(b\)](#), abstinence from alcohol or other substances cannot be a requirement or prerequisite for Housing Interventions services. Additionally, the use of alcohol or other substances in and of itself cannot be grounds for eviction and Housing Interventions services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and substance use disorder (SUD) as a part of tenants’ lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use; and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the individual so chooses. However, Housing Interventions may be used to support recovery housing and sober living environments for individuals who request them. Counties must ensure that in their implementation of Housing Interventions, neither they, nor entities that receive the BHSA Housing Interventions dollars, discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.

In alignment with the California Interagency Council on Homelessness “[Guide to California’s Housing First Law](#)” Housing First law applies to both permanent and interim housing settings. While the requirement of a lease may not be applicable to interim

²³ [W&I Code § 8255, subdivision \(b\)](#).

²⁴ [W&I Code § 5830, subdivision \(a\)\(5\)](#).

²⁵ [W&I Code §§ 8255, subdivisions \(d\)\(1\)-\(2\)\(A\)](#).

settings, they must use Housing First components and principles for screening and selecting participants and in providing services and other engagement with participants. The Department of Housing and Urban Development (HUD) provides valuable resources on Housing First that a county may look to for guidance on how to apply Housing First principles.

C.9.5.2 Family Housing

All Housing Interventions, as appropriate, must be available to support Family Housing. As defined by [HUD](#), "Family" includes, but is not limited to, regardless of marital status, actual or perceived sexual orientation, or gender identity, any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether or not a member of the household has a disability. A child who is temporarily away from the home because of placement in foster care is considered a member of the family.

Family Housing means housing that prioritizes not separating individuals meeting the definition of family. Family housing includes housing that accommodates the family caregiver of a BHSA eligible child, adult, older adult, or a person living with a disability.

Family housing for children and youth considerations include:

- Design, location, and environmental impacts of the housing interventions provided to the family. Dedicated space for children and youth, including green space, open space, secure play areas and courtyards, as well as indoor space in which children may play and learn are some examples.
- Access to public transportation, walkable neighborhoods or bike path access benefit children and youth and their parents.
- Where a child is eligible for Housing Interventions, the family is eligible for Housing Interventions services, even if the parent or guardian is not independently eligible, provided that the parent or guardian lives with the child. Emancipated minors are eligible to receive Housing Interventions services directly. In the reverse situation (parent or guardian is eligible but child is not), the housing provided should accommodate the whole family living together (including children).

Family housing for adults and older adults considerations include:

- Accommodations that meet the needs of the BHSA eligible individual (e.g., wheelchair ramps) as well as proximity to amenities such as community spaces, public transportation, and clinical care.

C.9.5.3 Habitability Standards

Housing Interventions may only be used in connection with housing settings that meet minimum standards for habitability. Effective October 1, 2025, all units subject to HUD quality requirements will be required to meet a new set of standards titled the National Standards for the Physical Inspection of Real Estate (NSPIRE).²⁶ This will replace the HUD Housing Quality Standards. While DHCS expects counties to seek to fund settings that meet NSPIRE standards whenever possible, an attestation that the housing is habitable as defined by state law²⁷ and meets applicable state and local building standards will meet the minimum requirement for Housing Interventions funding. These standards will be implemented in alignment with the standards identified under Transitional Rent. Inspection costs are an allowable expense under Housing Interventions.

C.9.5.4 Minimum Quality Standards

Counties must ensure that all settings for which Housing Interventions are expended meet minimum quality standards. Many of the settings eligible for coverage serve populations with significant needs but are unlicensed and have been found to be of widely varying quality. This would include, for example, recovery residences and sober living environments as well as license-exempt room and board facilities. These standards will be implemented in alignment with the standards identified under Transitional Rent.

C.9.5.5 Homeless Management Information System Requirements

Counties are required to operate Housing Interventions in accordance with the [Homeless Management Information System \(HMIS\)](#) reporting requirements.²⁸

Counties are required to enter into the local HMIS the [Universal Data Elements](#) (Items 3.01-3.917) and the [Common Data Elements](#) (Items 4.02-4.20 and Item W5 of the Individual Federal Partner Program Elements as defined by the [HUD HMIS Data](#)

²⁶ [NSPIRE Final Rule](#).

²⁷ See, e.g., [California Civil Code §§ 1941, 1941.1, 1941.3](#).

²⁸ [W&I Code § 8256, subdivision \(d\)\(3\)\(A\)](#).

[Standards](#)) on the individuals and families served, as required by [W&I Code section 8256, subdivision \(d\)\(8\)](#).

Every Continuum of Care (CoC) must designate an HMIS lead entity. The HMIS lead is responsible for administering, implementing, and managing the HMIS database as well as training and supporting HMIS users. Counties should work closely with the HMIS lead in their community to complete program setup and ensure data quality is meeting expectations. This [list of CoC leads in California](#) includes the HMIS leads for most communities. Coordination with the local Coordinated Entry System (CES) is strongly encouraged but counties are not required to route referrals for housing interventions through the CES.

C.10 Capital Development Projects

Increasing the supply of Permanent Supportive Housing (PSH) and other affordable housing is critical to addressing California's homelessness crisis. Housing Interventions may include capital development projects that increase the supply of PSH, or affordable units that provide long-term housing stability and supportive services to eligible individuals and their families. For individuals who meet the eligibility and priority populations criteria, maintaining residential stability without greater assistance can be difficult. Many of these individuals and families are challenged by health conditions, social isolation, and deep poverty, and face significant barriers to both work and housing. However, studies have shown that even high-risk individuals can be successfully housed if PSH is available.²⁹

Counties will be required to detail their proposed capital development projects in their Integrated Plans (IPs) and annual updates (AUs). The Department of Health Care Services (DHCS) encourages counties to employ and include in their IP innovative practices to develop permanent supportive housing and other affordable housing in the most efficient, timely and cost-effective manner available to the county. This section provides guidance regarding the requirements for capital development projects.

²⁹ [Study](#) finds Permanent Supportive Housing is effective for highest risk chronically homeless people.

C.10.1 Capital Development Project Funding

Counties may use no more than 25 percent of their Housing Interventions on capital development projects.³⁰ Counties may use capital development project funds to fully fund a capital development project or to fill gaps in funding within a larger development that includes a set number of units dedicated to PSH for BHSA eligible individuals and their families.

Key elements of capital development funding:

- Counties may accrue their capital development project funding for multiple years to cover the cost of a project provided that the county complies with the rules regarding reversion. See [Chapter 6](#) for more details about the reversion of funding to the state.
- Generally, there is no single funding source for PSH developments. Consequently, counties and project developers may also combine funding from other federal, state, and local sources to develop properties that include PSH units provided that the project meets the requirements for capital development projects. Counties are encouraged to align their capital development funding requirements with other local, state and federal programs that will help braid requirements and funding from multiple programs – this practice can reduce administrative burden and related costs for counties and housing sponsors.
- The maximum amount of capital development funds that a county may use to fund the construction and/or rehabilitation of housing units under this program is \$450,000 per unit.

C.10.2 Eligibility and Access Requirements

Counties may use capital development funding for the construction and/or rehabilitation of housing units provided that the projects meet the following eligibility and access requirements:

1. The housing units must be made available to individuals and families who meet the eligibility and priority populations criteria as defined in [Chapter 7.C.4.1](#) “Eligible Populations”.

³⁰ [W&I Code § 5892, subdivision \(a\)\(1\)\(A\)\(iii\).](#)

2. Access to housing units may not be limited to individuals enrolled in Full Service Partnerships (FSP) or to those enrolled in Medi-Cal.
3. Capital development projects may not discriminate against or deny access to housing for individuals who are utilizing medications for addiction treatment or other authorized medications.
4. Capital development projects must comply with the core components of Housing First.

C.10.3 Capital Development Project Requirements

The following additional requirements apply to projects receiving capital development project funding:

1. The housing units constructed and/or rehabilitated must be affordable and satisfy the definition of “supportive housing.” As provided in [California Government Code section 65582, subdivision \(g\)](#), “supportive housing” means “housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community.”
2. The housing units must be available for Eligible individuals and their families within a reasonable timeframe that is consistent with each county’s approved Integrated Plan.
3. To constitute a “use by right” the project must meet all of the requirements under [W&I Code section 5831, subdivision \(a\)\(1\)](#).
4. The project must comply with any other requirements specified by DHCS for purposes of administering county capital development programs.
5. Funding for capital development projects are subject to the three and five-year reversion periods.

C.10.4 Exemption from the Low Rent Housing Project Requirements

Capital development projects are exempt from the low rent housing project requirements in the California Constitution and related statutes, which require voter approval of such projects. While there are multiple criteria for an exemption, the Behavioral Health Services Act (BHSA) projects are identified as one of the exemption criteria. Specifically, if the capital development project consists of the “acquisition,

rehabilitation, reconstruction, alterations work or new construction or any combination” of these with respect to lodging facilities or dwelling units funded using moneys from the Behavioral Health Services Fund (BHSF), the project is exempt from the low rent housing project requirements in Section 1 of Article XXXIV of the California Constitution.³¹

C.10.5 Exemptions Available to Projects that Meet “Use by Right” Requirements

To allow for the efficient use of capital development project funds and the timely construction and/or rehabilitation of PSH units, [W&I Code section 5831](#) limits the application of permitting, land use requirements and environmental requirements to capital development projects that satisfy the “use by right” requirements and meet specified criteria. These rules are intended to prevent capital development projects from being delayed by time-consuming subjective and discretionary approval processes and related litigation.

As further specified in the Appendix, the BHSA limits local governmental review of such projects to the application of objective zoning, subdivision, and design standards which must be applied within strictly limited timeframes. It also exempts BHSA-funded projects that meet the “use by right” requirements from the California Environmental Quality Act.

³¹ [W&I Code § 5830, subdivision \(e\)\(8\).](#)

Appendix

A: Select Definitions

1. Experiencing Homelessness

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
 - a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
 - b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
 - c. An individual who is exiting an institution and was considered homeless immediately prior to entering the institution or becomes homeless during the institutional stay, regardless of the length of stay.
2. An individual or family who will imminently lose their primary nighttime residence, provided that:
 - a. The primary nighttime residence will be lost within 30 days of the date of application for homeless assistance;
 - b. No subsequent residence has been identified; and
 - c. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.
3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
 - a. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act ([42 U.S.C. 5732a](#)), section 637 of the Head Start Act ([42 U.S.C. 9832](#)), section 41403 of the Violence Against Women Act of 1994 ([42 U.S.C. 14043e-2](#)), section 330(h) of the Public Health Service Act ([42 U.S.C. 254b\(h\)](#)), section 3 of the Food and Nutrition Act of 2008 ([7 U.S.C. 2012](#)),

section 17(b) of the Child Nutrition Act of 1966 ([42 U.S.C. 1786\(b\)](#)), or section 725 of the McKinney-Vento Homeless Assistance Act ([42 U.S.C. 11434a](#));

- b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
 - c. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
 - d. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.
4. Any individual or family who:
- a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
 - b. Has no other residence; and
 - c. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

2. At-Risk of Homelessness

1. An individual or family who:
 - a. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
 - b. Meets one of the following conditions:
 - i. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - ii. Is living in the home of another because of economic hardship;
 - iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 30 days after the date of application for assistance;
 - iv. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;
 - v. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - vi. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - vii. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.
 - c. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act ([42 U.S.C. 5732a\(3\)](#)), section 637(11) of the Head Start Act ([42 U.S.C. 9832\(11\)](#)), section 41403(6) of the Violence Against Women Act of 1994 ([42 U.S.C. 14043e-2\(6\)](#)), section 330(h)(5)(A) of the Public Health Service Act ([42 U.S.C. 254b\(h\)\(5\)\(A\)](#)), section 3(m) of the Food and Nutrition Act of 2008 ([7](#)

[U.S.C. 2012\(m\)](#)), or section 17(b)(15) of the Child Nutrition Act of 1966 ([42 U.S.C. 1786\(b\)\(15\)](#)); or

- d. A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act ([42 U.S.C. 11434a\(2\)](#)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

3. Chronically Homeless

1. A homeless individual with a disability as defined in section 401, subdivision (9) of the McKinney-Vento Assistance Act ([42 U.S.C. section 11360, subdivision \(9\)](#)), who:
 - a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
 - b. Has been homeless as defined in [7.C.4.1.1 Experiencing Homelessness and At Risk of Homelessness](#) on any number of occasions in the last 3 years, as long as the combined occasions equal at least 12 months; or
2. An individual who is exiting an institution and met all of the criteria in paragraph (1) immediately prior to entering the institution regardless of the length of stay; or
3. A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2), including a family whose composition has fluctuated while the head of household has been homeless.

B: Coverage of Settings

	Assisted Living	Community Residential Treatment <i>(Settings eligible under BHCIP)</i>	Interim Housing	Housing
Settings	<ul style="list-style-type: none"> • Adult Residential Facilities¹ • Residential Care Facilities for the Elderly² • Licensed Board and Care³ 	<ul style="list-style-type: none"> • Adult Residential Substance Use Disorder (SUD) Treatment Facilities⁴ • Children’s Crisis Residential Programs (CCRP)⁵ • Peer Respite • Perinatal Residential SUD Facilities⁶ 	<ul style="list-style-type: none"> • Hotels/Motels • Peer Respite • Recovery Housing • Recuperative Care~ • Non-congregate interim housing models • Congregate settings with small number of individuals per room (i.e., not larger dormitory sleeping halls) • Short-Term Post-Hospitalization Housing~ • Tiny Homes, emergency sleeping cabins, emergency stabilization units • Single room occupancy (SRO) units 	<ul style="list-style-type: none"> • Single-family and multi-family homes (e.g., apartments, duplexes, etc.) • Housing in mobile home communities • Accessory Dwelling Units (ADU) and Junior Accessory Dwelling units (JADUs) • Tiny Homes • Project-Based or Scattered Site Supportive Housing • Recovery/Sober living Housing • Apartments • Shared housing • License-exempt room and board • SRO units

¹ Licensure: CDSS

² Licensure: CDSS

³ Licensure: CDSS

⁴ Licensure: DHCS

⁵ Licensure: CDSS

⁶ Licensure: DHCS

	Assisted Living	Community Residential Treatment (<i>Settings eligible under BHCIP</i>)	Interim Housing	Housing
BHT Housing Interventions	Yes	Peer respite only	Yes, can be used for an additional 6 months if member is receiving Transitional Rent under managed care or up to 12 months if member is not eligible for Transitional Rent. The aim is to transition individuals to permanent housing as quickly as possible.	Yes ⁷
Transitional Rent	No	Peer respite, when provided as transitional or recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming	Yes (see note) <i>~Note: Transitional rent is not available for Recuperative Care and Short-Term Post-Hospitalization.</i>	Yes

⁷ DHCS will seek to align the list of eligible settings under BHT and Transitional Rent to ensure seamless transitions between funding sources.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, February 25, 2025 10:59 AM
To: Works-Wright, Jamie
Subject: FW: SCU Issues
Attachments: Mobile-Crisis-FAQ.pdf; SCU Talking Points_October 2024 - Copy (1).docx

Hello Commissioners,

Please see the email below for Commissioner Opton

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
JWorks-Wright@berkeleyca.gov
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365



From: Edward Opton <eopton1@gmail.com>
Sent: Tuesday, February 25, 2025 2:07 AM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Cc: Gilman, Scott <SGilman@berkeleyca.gov>; Buell, Jeffrey <JBuell@berkeleyca.gov>
Subject: Fwd: SCU Issues

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

2.25.25 -- 1 am

Re: SDU — Recent Correspondence between Commissioner Pritchett and Director Gilman

Jamie,

Thanks for distributing the items that follow to the members of Berkeley's Mental Health Commission and to Director Gilman. The memo below responds to those items. Please distribute this memo and its attachments via e-mail to the Commissioners, to Director Gilman and to others whose names/addresses appear in the attached documents. I hope they can arrive before this week's meeting of the Commission

Edward Opton
Member, Mental Health Commission

February 24-25, 2025

To:
Members, Mental Health Commission
Director Scott Gilman

Re: Special Care Unit (“SCU”)

This memo comments on SCU-related issues related to Commissioner Pritchett’s February 21, 2025, memo to Commission members (“the memo”) and to the memo's several attachments, which I will attempt to attach below.

1. I appreciate Director Gilman’s response to Commissioner Pritchett (“SCU Updates . . .”). So far as I can recall, this is the first written communication and almost the only communication of any sort, during my several years as a commissioner, between the Commission, or its members, and the director of our city’s Department of Health, Housing, and Community Services. The Commission’s principal purpose is to serve as an independent advisor to the department’s managers and to other elements of our city’s administration, so I hope that the current exchange will lead to more such communication, both formal and informal.

One might put this another way. Advice may be helpful or useless. Helpful advice almost always is advice that has been requested. Unsolicited advice almost always is ignored, resented, or both.

2. Director Gilman’s February 21 response to MHC Commissioner Pritchett (“Gilman e-mail”) notes that the Special Care Unit (“SCU”) is a Medi-Cal *entitlement* and is to be funded by Medi-Cal. This came as news to me—important news. Services required by law are in a very different category than services it would be nice to provide if, but only if, funds were readily available. The Commission’s efforts to discuss funding of the SCU with city officials might have been more productive if the Commissioners had been told that the SCU or its equivalent is a legal requirement, not merely an optional experiment.

3. Director Gilman's e-mail alludes to “the Crisis Now best practice toolkit, <https://crisisnow>.” That document may be important, but I don’t recall receiving it or seeing it mentioned, and my effort today to access it on-line has been unsuccessful. Can the Commission be provided a copy of this document as well as the “Sequential Intercept model for law enforcement,” mentioned in the same paragraph?

4. Director Gilman’s e-mail seems to be an effort to provide reassurance as to funding:

“ . . . we concur that two-person [SCU] teams work well when all support systems, referral networks, and coordination with other service providers are in place.”

Should the Mental Health Commission and the City Council be reassured in the face of the multiple reservations, i.e., that potential problems among “all support systems,” “referral networks,” and “coordination with other service providers” must have been resolved in order for two-person SCU teams to operate effectively?

What are the “support systems?”

Which “referral networks” must be the subjects of concern?

What (or who) are the “other service providers” that are “in place” or, perhaps, out of place.

Should the Mental Health Commission seek reassurance on these points, especially if law enforcement agencies are among the unspecified “other service providers?”

5. The “911 Dispatch” paragraph in Director Gilman’s e-mail is concerning. This is not a criticism of the e-mail. If the facts are concerning—as they well may be—it is altogether proper that the e-mail state the concerns. If there are concerns, our city needs to deal with them. However my experience in negotiating and litigating organizational issues among the organizational and human components of California’s largest public agency has been that competition, and hence conflict, among an organization’s component elements—its organizational “parts” such as personnel, labor unions, programs, departments, occupations, professions, and customers—is frequently a major source of organizational friction. That friction can, and often does, produce painful organizational “heat,” heat that can impair the organization’s mission and threaten the careers of the organization’s directors, executives, managers, and employees, as well as the welfare of its customers. A principal means of deflecting the heat of intra-organizational conflict is to avoid talking about it.

The City of Berkeley is, among other things, its Behavioral Health Division, its Specialized Care Unit (“SCU”), its law enforcement agency, the labor union that represents the law enforcement officers, as well as the city’s dispatchers and their employee organization, and, of course, the City Council, the city’s executives and the city’s managers. The people who comprise these components of government try to live together as one medium-sized happy family, and they often do so with success. But the realities of allotting money and power intrude, as they most likely have done in the case of the SCU.

It is possible that the Mental Health Commission may be useful in resolving this problem. Among all those involved in issues concerning the SCU, the Mental Health Commissioners may be the only participants who have no personal, reputational, or financial stake in the outcome except the desire to alleviate the distresses that bring our city’s residents to seek help.

6. I am confident that all members of the Mental Health Commission want the Commission to contribute to Berkeley’s mental health efforts. To make the MHC’s efforts worthwhile, we—the MHC and the city’s administrators—need to collaborate. Let’s do it.

Edward Opton

Begin forwarded message:

From: "Works-Wright, Jamie" <JWorks-Wright@berkeleyca.gov>
Subject: FW: SCU Questions
Date: February 24, 2025 at 3:41:15 PM PST
To: "Works-Wright, Jamie" <JWorks-Wright@berkeleyca.gov>

Hello Commissioners,

Please see the information below and attached from Scott Gilman

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



From: Gilman, Scott <SGilman@berkeleyca.gov>
Sent: Monday, February 24, 2025 3:28 PM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>; Buell, Jeffrey <JBuell@berkeleyca.gov>
Subject: FW: SCU Questions

Internal

Hi Jamie, could you please forward the email below to the Commission. Thank you.

Dear Mental Health Commission,

I'm looking forward to seeing you Thursday night. I am asking that the information below that we provided to Andrea also be sent to you.

Thank you!

Scott Gilman
Director of Health, Housing, and Community Services
SGilman@berkeleyca.gov
(510) 981-5404

From: Gilman, Scott
Sent: Friday, February 21, 2025 5:15 PM
To: Andrea Prichett <prichett@locrian.com>; Lunaparra, Cecilia <CLunaparra@berkeleyca.gov>; Bartlett, Ben <BBartlett@berkeleyca.gov>; Berkeley Mayor's Office <Mayor@berkeleyca.gov>
Cc: Buell, Jeffrey <JBuell@berkeleyca.gov>; Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>; Hernandez Story, Ruben <RHernandezStory@berkeleyca.gov>; Tervalon, Tasha <TTervalon@berkeleyca.gov>; Taplin, Terry <ttaplin@berkeleyca.gov>
Subject: RE: SCU Questions

Subject: SCU Updates and Responses to Your Questions

Hi Andrea,

Sorry for my delay. I'll expand more on each of your questions next week at the Mental Health Commission, but wanted to get this information to you in advance.

Funding:

- The mobile crisis service provided by the SCU is now a Medi-Cal entitlement benefit. The county is required to ensure this service is available to every resident within 60 minutes, and Medi-Cal covers the cost. I am thankful for this resource as it would be challenging for the City to continue to fund the SCU as it stands (FAQ attached).
- The state has utilized the Crisis Now best practices toolkit <https://crisisnow> to ensure consistency. You may remember I circulated this when I first arrived along with the Sequential Intercept model for law enforcement. This toolkit provides communities with resources for

designing and implementing mobile crisis services, and it outlines most of the relevant performance standards. This is a significant development and will allow us to adapt the SCU to meet billing requirements and bill for services.

- We hope to use the remaining one-time funding allocated by the City to ensure no service gap for our residents after June 2025.

Staffing:

- I totally agree with your observations. The current 3 FTE model is not required for billing the service, and we concur that two-person teams work well when all support systems, referral networks, and coordination with other service providers are in place.

Performance:

- I agree that there is a significant disconnect between community expectations and the scope of services currently contracted for. There are many lessons to be learned.
- I'm hoping that these issues will be addressed in the retrospective evaluation, allowing us to learn and make adjustments.
- There are also evident structural issues (as you know). For example, response times are unacceptable. However, with only one team, responses may be delayed by hours when they are already on a call.
- Our goal is to better collaborate with other county-operated teams. They will be building 10 teams in total, and our goal is to have one located in downtown Berkeley, rather than the current location.

911 Dispatch:

- The Specialized Care Unit (SCU) was launched with a separate phone number to ensure rapid deployment and maintain separation from law enforcement.
- The integration of SCU into the 911 dispatch system is a complex, ongoing process requiring time, coordination, and technical upgrades.
- Furthermore, SCU integration with 911 is hindered by staffing shortages and technical challenges, including the current dispatch system's inability to transfer calls to SCU's 10-digit number and concerns about non-public safety staff accessing encrypted radio traffic. Labor and legal issues are also being considered as this integration progresses.

Mayor Arreguin's Press Conference:

- I've attached a copy of the briefing sheet distributed at the event.

If you'd like, I'm happy to meet prior to next week's MH Commission to go over any of this in more detail.

Scott Gilman

Director of Health, Housing, and Community Services

SGilman@berkeleyca.gov

(510) 981-5404

From: Andrea Prichett <prichett@locrian.com>

Sent: Thursday, January 30, 2025 4:38 PM

To: Gilman, Scott <SGilman@berkeleyca.gov>; Lunaparra, Cecilia <CLunaparra@berkeleyca.gov>;

Bartlett, Ben <BBartlett@berkeleyca.gov>; Berkeley Mayor's Office <Mayor@berkeleyca.gov>

Cc: Buell, Jeffrey <JBuell@berkeleyca.gov>; Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>;

Hernandez Story, Ruben <RHernandezStory@berkeleyca.gov>; Tervalon, Tasha

<TTervalon@berkeleyca.gov>; Taplin, Terry <ttaplin@berkeleyca.gov>

Subject: Re: SCU Questions

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Dear Scott,

Thanks for your response. I appreciate it. The MHC has received very little information about the performance or the outcomes of the SCU over the last few months.

We have a number of concerns, too. Maybe I can list some of the current ones:

1. Funding: Are you aware of any efforts to extend the funding for this program beyond the end of the contract in June 2025? Is this decision contingent upon the evaluation by RDA of the SCU? If that doesn't happen till May, how will the program be funded or some alternative be identified without a major disruption in service?

2. Staffing: I know that the current model is built around the idea that a behavioral health specialist will ride in the van with the peer specialist and the EMT, but I have never believed that was necessary. Can't the behavioral health specialist be the person answering phone calls and advising/directing teams in the field? Two person teams should be adequate for what we are asking them to do.

3. Performance: Based on anecdotes and my direct observation, it seems that the SCU is unclear on its mission. The idea of a "crisis" response suggests that the team will encounter aggravated people. Someone may even be holding an object and yelling at the same time but that does not necessarily equate to an extreme safety risk for the team. Yet, I have heard several times that the SCU won't respond or will contact police if the person "seems agitated". Is that true?

I am also concerned that the teams are not spending their time in the community and building relationships with some of our "frequent flyers". In fact, I have never seen them on patrol or among people in the community. Are they out in the field proactively meeting and helping people in need? When it rained on unhoused people and they were shivering and wet, why couldn't the Special CARE Unit pitch in and help? When I called Dr. Flores he informed me that the SCU was "not a taxi service". Yet, the model of [Cahoots!](#) in Oregon (which is the model from which our SCU model was created) reports that 70% of their time is spent transporting people to services. And doesn't that make sense? We have lots of services that exist, but don't actually encounter the people most in need of those services.

Recently, I watched the Lifelong van as it pulled up to the encampment at Civic Center Park. The caregiver/nurse was jovial, kind, knew people by name and offered care in ways that were small and large. I wished the SCU staff could see that. Instead, when I called SCU to report that someone in the encampment was highly distressed, I was told that they have been directed NOT to go to encampments. I believe that it was Dr. Flores who gave that directive.

4. 911 Dispatch: It is still very unclear as to why the SCU is not receiving 911 calls for help. Years have gone by and it seems that there has been no progress made in this area. Why can't the dispatch center agree to a script that is standard in directing non-criminal calls to a civilian service? What is the position of the Chief of Police on this issue? This should be a top priority within this city and yet, we have no evidence that these issues are being addressed.

If former Mayor Arreguin had a press conference about the launch of the SCU, myself and members of the MHC would love to know more about that. If you can provide any link that affirms such an event happened, I would be grateful. Members of the Steering Committee were never informed of such an event. Instead, we have asked for almost two years to have some kind of visibility campaign to popularize the number for the SCU, put it on posters and billboards around town. This kind of outreach is also something that the SCU staff could do in-between calls. To date, we have very little evidence that any outreach beyond a few hundred postcards has actually taken place.

I look forward to your report on this topic. I fear that this project is like water slipping through our fingers...

sincerely,

Andrea Prichett

On 1/30/25 2:57 PM, Gilman, Scott wrote:

Hi Andrea,

I received your message that you were seeking updates on status of CSU. We are planning on coming to give a complete update to the Mental Health Commission in March. Sadly, we and stakeholders continue to have concerns about the performance of the SCU and its ability to meet 24/7 and response time expectations. The state now requires 24/7 and response within 60 minute. I believe some of the performance issues are related to structure, and only having one team. That said, I don't want to get too far ahead of the retrospective evaluation findings.

Some specific's

1. The City allocated \$5.35 million in one-time ARPA and grant funds, with approximately 60% already used. I am waiting for an updated budget Bonita House, I should have that next week.
2. Mayor Arreguin held a press conference announcing the SCU last fall.
3. Regarding sustainability, Thanks to Cal-AIM, Alameda County is contractually responsible for providing or contracting for crisis response services under Medi-Cal, making County integration the key to sustainability. The county is supportive of this position and we are actively working with the county so Bonita House can begin billing.
4. RDA's retrospective evaluation is underway (community survey not out yet, focus groups, stakeholder interviews).I anticipate initial numbers and types of call data before the March meeting. Bonita House is providing information directly to Evaluator for crunching. RDA eval will be done no later than May 2025.

Let me know if you have any other questions. Thanks Andrea.



Scott Gilman

Director of Health, Housing, and Community Services

Pronouns: He/him/his

2180 Milvia Street, 2nd Floor

Berkeley, CA 94704

(510) 981-5404

SGilman@berkeleyca.gov

This document includes DHCS' responses to frequently asked questions from county representatives, providers, and other stakeholders related to the Medi-Cal Mobile Crisis Services benefit. Find additional information about mobile crisis services on the [DHCS website](#), and submit questions to MCBHPD@dhcs.ca.gov.

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Medi-Cal Mobile Crisis Services

General Questions

1) When will mobile crisis services be available under Medi-Cal?

In July 2023, the Centers for Medicare & Medicaid Services approved DHCS' State Plan Amendment [22-0043](#) to cover qualifying community-based mobile crisis intervention services under Medi-Cal, effective January 1, 2023. The majority of counties will have the Mobile Crisis Services benefit implemented by December 31, 2023. Alpine, Amador, Colusa, Del Norte, Glenn, Inyo, Mariposa, Modoc, Mono, Plumas, Sierra, and Trinity have until June 30, 2024, to implement the benefit. All requirements for counties to begin implementing mobile crisis services are outlined in Behavioral Health Information Notice (BHIN) [23-025](#).

2) Why do some counties have a delayed mobile crisis implementation date of June 30, 2024?

DHCS used the [Crisis Resources Need Calculator](#), a tool developed for the National Association of State Mental Health Program Directors (NASMHPD), as a data source to develop mobile crisis services rates for each county. This tool estimates the number of mobile crisis services encounters, travel time, and number of needed mobile crisis teams for each county.

DHCS created a rate methodology using data from the Crisis Resources Need Calculator to develop a mobile crisis encounter rate for each county. The methodology is designed to develop encounter rates that accounts for the following components of the benefit: travel time, face to face time with the member, follow up time, translation/interpretation services, and standby time. The Crisis Resources Need Calculator estimates 12 counties to have a low number of mobile crisis encounters, which is not enough to have at least one mobile crisis team. Because of this, DHCS was initially unable to develop an appropriate mobile crisis encounter rate for these counties. Therefore, DHCS announced a six-month delay, to June 30, 2024, for these 12 counties to implement the benefit and used this additional time to develop encounter rates for these 12 counties.

3) How do mobile crisis services differ from existing crisis services that are currently coverable under Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS)?

DHCS is not making any changes to the existing crisis intervention services and substance use disorder (SUD) crisis intervention services benefits covered under SMHS, DMC, and DMC-ODS. Medi-Cal behavioral health delivery systems shall continue

covering these services in accordance with existing federal and state, and contractual requirements.

Medi-Cal mobile crisis services¹ provide rapid response, individual assessment, and community-based stabilization to individuals who are experiencing a mental health or substance use crisis. They are delivered by a multidisciplinary mobile crisis team at the location where an individual is experiencing a crisis, including at home, school, work, or on the street. Mobile crisis services provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reducing the immediate risk of danger and subsequent harm; and avoiding unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

4) Do mobile crisis services need to be coordinated across SMHS and DMC/DMC-ODS delivery systems?

Medi-Cal behavioral health delivery systems in each county shall collaborate with each other to implement mobile crisis services. All mobile crisis teams, regardless of delivery system, must meet the same set of requirements and a single encounter may be claimed only once through one delivery system. DHCS strongly encourages counties to implement a fully integrated approach across mental health and SUD delivery systems in which a single mobile crisis services infrastructure serves the entire county. A single integrated system may include multiple mobile crisis teams that are equipped to respond to members regardless of whether they otherwise are served by the county Mental Health Plan (MHP) or the county's SUD delivery system (DMC or DMC-ODS). If a county opts not to establish a single integrated system, it shall document, as part of its mobile crisis implementation plan, how it will ensure mobile crisis services are coordinated across the Medi-Cal behavioral health delivery systems in the county. All mobile crisis teams should be equipped to provide immediate coordination with other providers involved in the member's care and with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, etc.).

5) What requirements do counties need to meet in advance of claiming for Medi-Cal mobile crisis services?

¹ SPA 22-0043 proposes to add qualifying community-based mobile crisis intervention services, as authorized by section 9813 of the American Rescue Plan Act of 2021, [codified as Title 42 of the United States Code \(U.S.C.\), section 1396w-6](#), to the Medicaid State Plan as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service.

In general, Medi-Cal behavioral health delivery systems shall undergo a comprehensive, standard implementation process prior to claiming for mobile crisis services. This implementation process includes submission of an Implementation Plan for review and approval by DHCS at least 30 days before the planned go-live date, but no later than the deadlines outlined in [BHIN 23-025](#). Medi-Cal behavioral health delivery systems with experience providing mobile crisis services or that otherwise are prepared to implement mobile crisis services more expeditiously may use an expedited implementation process and begin services immediately following approval by DHCS. Additional information about the standard and expedited implementation processes are available in [BHIN 23-025](#).

6) Do counties need to have 24/7 staffing in place to begin claiming Medi-Cal for mobile crisis services?

Per federal requirements, Medi-Cal behavioral health delivery systems are required to provide mobile crisis services 24 hours a day, 7 days a week, and 365 days a year in order to bill Medi-Cal for mobile crisis services. However, no single mobile crisis team must be available 24/7, and multiple shifts of multiple teams can be scheduled accordingly to ensure coverage throughout the 24/7 period.

7) Are there restrictions on the settings in which mobile crisis services can be delivered?

The initial mobile crisis response must be provided where the member is experiencing a crisis, or at an alternate location of the member's choosing. Mobile crisis services may **not** be provided in the following settings, due to restrictions in federal law and/or because these facilities and settings are already responsible for providing crisis services:

- Inpatient Hospital;
- Inpatient Psychiatric Hospital;
- Emergency Department;
- Residential SUD treatment and withdrawal management facility;
- Mental Health Rehabilitation Center;
- Psychiatric Health Facility;
- Special Treatment Program;
- Skilled Nursing Facility;
- Intermediate Care Facility;
- Settings subject to the inmate exclusion such as jails, prisons, and juvenile detention facilities;
- Other crisis stabilization and receiving facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, crisis residential treatment programs, etc.).

8) Can mobile crisis services be delivered at Short-Term Residential Therapeutic Program (STRTP) settings?

It is allowable for mobile crisis teams to respond to a crisis that is happening at an STRTP; however, it would likely be a rare occurrence as STRTPs are required to provide crisis intervention services.

9) Do all mobile crisis teams need to include a licensed behavioral health professional as part of the initial two-person response?

Mobile crisis teams must include at least two providers for the duration of the initial mobile crisis response. The two-person team must **include** or **have access to** a Licensed Practitioner of the Healing Arts (LPHA) or a Licensed Mental Health Professional, including a licensed physician, licensed psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurse, or licensed psychiatric technician. A mobile crisis team could consist of one LPHA and one peer support specialist. It also could consist of two peer support specialists who have access to a LPHA via telehealth or telephone for the initial mobile crisis response. Follow-up may be conducted by one mobile crisis team member. Additional information on mobile crisis team composition requirements for initial crisis response are available in [BHIN 23-025](#).

10) Who can perform a crisis assessment?

All mobile crisis team members and service providers must complete a core training in crisis assessment. Any mobile crisis team member that has been trained to conduct a crisis assessment as part of required mobile crisis services training can deliver the initial face-to-face crisis assessment. At least one onsite mobile crisis team member shall be able to conduct a crisis assessment, and it must be done onsite.

11) Is a psychiatric advance directive (PAD) required as part of the crisis planning?

When appropriate, crisis planning may include, but is not required to include, the development of a written crisis safety plan. A PAD may be appropriate as a part of the crisis safety plan. The PAD may be drafted when a person is well enough to consider preferences for future mental health treatment. In some circumstances, this may occur during mobile crisis follow-up services or upon linkage to ongoing care.

12) Can a “co-response” team that consists of a behavioral health professional and law enforcement officer deliver qualifying mobile crisis services?

It is considered a national best practice for a mobile crisis team to respond without law enforcement accompaniment unless special safety concerns warrant inclusion.² A law enforcement officer may accompany a mobile crisis team for the initial mobile crisis response when necessary for safety reasons; however, the law enforcement officer does **not** qualify as a member of the mobile crisis team. This means that the mobile crisis team must include two or more qualified providers who participate in the initial mobile crisis response in addition to the law enforcement officer to be a qualifying mobile crisis service.

13) What is defined as a “timely response” for mobile crisis teams?

A “timely response” is within 60 minutes of dispatch in urban areas and within 120 minutes in rural areas. Consistent with [Alternative Access Standards](#) for Medi-Cal Managed Care Health Plans, “rural” is defined to include all areas with less than 50 people per square mile. (See p. 345.) DHCS will provide ongoing technical assistance to Medi-Cal behavioral health delivery systems to review response times and adjust timeliness standards, as needed.

14) Will tribal areas be included or excluded from the definition of rural for the purposes of meeting timeliness standards?

Tribal areas will be evaluated and expected to meet the timeliness standards in the same way as other rural or urban areas as outlined in the [Alternative Access Standards](#) for Medi-Cal Managed Care Health Plans. A timely mobile crisis response is considered within 60 minutes of dispatch in urban areas and within 120 minutes in rural areas.

15) Does the crisis services hotline have to be able to dispatch directly, or can they warm transfer to another number for dispatch?

Counties must identify a single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage member calls. The number can be the same as the county’s 24/7 access line or an existing county crisis line, if the Medi-Cal behavioral health delivery system ensures the line has the capacity to respond to members in crisis and to dispatch mobile crisis teams when appropriate.

² SAMHSA [national-guidelines-for-behavioral-health-crisis-care-02242020.pdf \(samhsa.gov\)](#).

16) When does the clock start running for the purpose of measuring a “timely response”?

The clock starts when a crisis line operator has determined a member requires a mobile crisis response. For example, a person may call 988 and then be transferred to a county’s crisis line for further assessment. The crisis line operator may talk with the member and use a standardized tool and set of procedures to determine when a mobile crisis team should be dispatched. After the operator determines on-site help is required and dispatches the mobile crisis team, the mobile crisis team should arrive on-site within no more than 60 minutes for urban areas and 120 minutes for rural areas.

Training & Technical Assistance

17) What are the core training requirements for mobile crisis team members that conduct follow-up check-ins?

All members of mobile crisis teams, including those providing follow-up, must complete core training delivered by DHCS’ training contractor(s) or by an outside source. Required core trainings include:

- Crisis intervention and de-escalation strategies;
- Harm reduction strategies;
- Delivering trauma-informed care;
- Conducting a crisis assessment; and
- Crisis safety plan development.

18) What other trainings and tools will be available to support mobile crisis services providers?

In addition to the core trainings described above, DHCS’ training contractor(s) also developed a series of [required enhanced trainings](#), [recommended supplemental trainings](#), and technical assistance [tools](#) to support mobile crisis teams and county behavioral health delivery systems. Enhanced and supplemental trainings include, but are not limited to, training in provider safety, delivering culturally responsive crisis care, and crisis response strategies for special populations (e.g., children, youth and families, tribal communities, and members with intellectual and/or developmental disabilities (I/DD)).

19) Are other crisis continuum partners, such as law enforcement officers, able to participate in mobile crisis services trainings offered by DHCS?

It is a best practice for all entities working across the crisis care continuum to be trained in the core elements of mobile crisis services. Mobile crisis teams who will be implementing mobile crisis services under Medi-Cal will be given first priority in training

registration. If there are no space limitations, all entities that may be involved in the delivery of mobile crisis services are welcome and encouraged to participate in trainings, including law enforcement officers (note: even if trained, law enforcement staff do not count as team members for the qualifying Medi-Cal mobile crisis service). All trainings are recorded and training resources and registration for trainings are housed on the [Medi-Cal Mobile Crisis Training and Technical Assistance Center's \(M-TAC\) website](#). To receive announcements for upcoming trainings/webinars, please subscribe to the M-TAC distribution list [here](#).

20) Where can I find templates and tools?

Templates and tools for mobile crisis services providers and county behavioral health delivery systems can be found on the [M-TAC website](#).

Reimbursement for Medi-Cal Mobile Crisis Services

21) What mobile crisis service components must be delivered for the service to be reimbursable under Medi-Cal?

To be reimbursable under Medi-Cal, each mobile crisis services encounter must include, at minimum:

- An initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning, as appropriate; and
- A follow-up check-in, or documentation that the member could not be contacted for follow-up.

When appropriate, mobile crisis services encounters should also include:

- Referrals to ongoing services; and/or
- Facilitation of a warm handoff to a higher level of care.

22) What service components are included in the bundled encounter rate?

DHCS has developed county-specific bundled encounter rates for mobile crisis services. The encounter rate is inclusive of the mobile crisis service components delivered by a mobile crisis team during the mobile crisis services encounter. DHCS made informed assumptions in establishing the encounter rate (e.g., duration of a service component).

Reimbursement for each mobile crisis services encounter is considered all-inclusive (with the exception of transportation, see Question 24 below), and Medi-Cal behavioral health delivery systems must not submit separate claims on behalf of individual members of the mobile crisis team for services delivered as part of the individual encounter (e.g.,

separate claims for peer support services when a peer support specialist is acting as a member of a mobile crisis team).

If services are provided to members after the mobile crisis response (and not as part of required follow-up), counties should claim separately for those additional services (e.g., if a Medi-Cal member is connected with a peer support specialist who provides peer support services on an ongoing basis after the initial mobile crisis response).

23) How did DHCS calculate the hourly rate for a team of two mobile crisis services providers?

The hourly labor rate for two mobile crisis service providers includes a county-specific outpatient services rate for one LPHA or Licensed Mental Health Professional and one other qualified provider. The hourly labor rate for one mobile crisis team member to provide follow-up is an average of the two-person rate. Providers on the same mobile crisis team should not claim separately for the same encounter.

24) How will mobile crisis teams be reimbursed for transportation?

If the mobile crisis team provides transportation or accompanies a member who is being transported by a non-medical transport (NMT) provider, emergency medical services (EMS), or law enforcement, the mobile crisis services provider may receive an add-on reimbursement in addition to the county encounter rate.

The circumstances under which this add-on reimbursement could occur are:

- If a mobile crisis team member drives the member to an alternate setting such as an emergency department, the county may claim for transportation mileage using code A0140.
- If a mobile crisis team member spends staff time during the journey stabilizing the individual or assists the member by waiting with them for the next level of care (e.g., waits until they can be admitted), the county may claim for staff time using code T2007.

25) What administrative costs are covered and how do counties receive reimbursement for administrative costs?

Administrative costs related to mobile crisis services should be claimed through the existing administrative claiming process and include activities outlined in [Mental Health Plan Letter 05-10](#).

26) How should a county claim for mobile crisis activities that occur outside of the initial mobile crisis response?

All activities that occur as part of the mobile crisis services encounter, including follow-up and connections with ongoing services and supports, are included in the all-inclusive mobile crisis services encounter rate. Transportation to another level of care and staff time spent assisting the individual during or after the transportation time are the only components of mobile crisis services that are claimed as add-ons to the all-inclusive rate (See question 24).

27) If a mobile crisis team that includes a Community Health Worker (CHW) delivers a service that cannot be claimed under the new benefit (e.g., responds to a hospital emergency department and ends up providing crisis intervention), does the CHW then need to meet qualifications for a SMHS “other qualified provider” for that service to be reimbursable as a SMHS?

If a crisis response is provided in a restricted setting, as outlined in [BHIN 23-025](#), it would not meet the requirements of a qualifying mobile crisis services encounter. If a CHW provided crisis intervention services during the response, the crisis intervention services would be reimbursable if the CHW meets the qualifications of “other qualified provider” and is employed by the MHP or works for a Medi-Cal provider contracted with the MHP to provide crisis intervention services.

28) How should a county behavioral health delivery system claim for more than one response to the same member in a short period of time (e.g., in a 24, 48, or 72 hour period)?

The mobile crisis team should claim separately for each mobile crisis services encounter that includes the required elements of a mobile crisis response outlined in Question 21 above. A member may experience more than one behavioral health crisis in one day. For example, a member may experience an initial crisis that is resolved by a mobile crisis team, and then experience a subsequent crisis later that day or within the following days. In those cases, it may be appropriate for a mobile crisis team to engage in multiple mobile crisis services encounters with the same member over a short period of time.

29) What if there are multiple crises within a period of a few days? Can there be one follow up for multiple mobile crisis responses?

Follow-up is a key component of the mobile crisis services encounter to support continued resolution of the crisis, make referrals to ongoing supports, and create or update a crisis safety plan. Mobile crisis teams are expected to conduct a follow-up check-in within 72 hours of each initial mobile crisis response. If multiple mobile crisis

services encounters occur within a short period of time, mobile crisis teams are expected to coordinate follow-up to ensure the member is receiving appropriate services and supports. However, mobile crisis teams should ensure that any follow-up check-ins include outreach on the specific issues that arose during each crisis.

30) Can crisis planning be done as part of a follow-up check-in?

Crisis planning, which may include the development of a written crisis safety plan, can help a member avert future crises, including through identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps the member can take to avert or address a crisis. In some cases, it may not be appropriate to engage a member in crisis planning during the initial mobile crisis response if they are in distress or need to be transported to a higher level of care. In those cases, it may be appropriate to conduct crisis planning as part of a follow-up check-in.

31) Will mobile crisis teams be reimbursed for “no shows”?

In some cases, a mobile crisis team may be dispatched to respond to a crisis and when they arrive onsite, the member is no longer able to be reached. If a mobile crisis team does not deliver all required components of the mobile crisis services encounter, they will not be reimbursed for services.

32) What happens if counties operationalize their mobile crisis teams differently than what the rate methodology accounts for? Can a county have a unique and distinct rate methodology?

Rate setting and operationalization of the Medi-Cal Mobile Crisis Services benefit are different issues. Counties may not request to have a unique rate methodology; however, Medi-Cal behavioral health delivery systems shall be prepared to work with DHCS to review the appropriateness of the assumptions for any given county. DHCS made informed assumptions and accounted for county variability in establishing encounter rates (e.g., county size and geography, anticipated volume of encounters/year, estimated stand by time, hourly provider rates). Counties do, however, have discretion in determining how best to operationalize the benefit and deliver the required services outlined above in Question 21. For example, counties can determine the team composition (based on the qualified providers outlined in [BHIN 23-025](#)) used to respond to a crisis (e.g., a peer support specialist and a LPHA, or two peer support specialists with back up from a LPHA via telehealth) regardless of the provider team assumptions used by DHCS when establishing rates.

33) Are counties able to claim for mobile crisis services through either the SMHS or DMC/DMC-ODS delivery systems?

Yes, counties may claim for mobile crisis services through either the SMHS or DMC/DMC-ODS delivery systems. However, claims should only be submitted to one delivery system per encounter. Oversight will be the same for both systems. In addition, each county's mobile crisis services implementation plan should include information about how a county intends to coordinate mobile crisis services across delivery systems. DHCS will conduct regular monitoring and oversight of mobile crisis services to ensure mobile crisis teams are not "double billing" for mobile crisis services in both delivery systems.

34) How does the encounter rate calculate standby time per team per day?

Under federal requirements, teams must be available 24/7, 365 days per year, which means there will inevitably be times when teams are on call, but not needed to respond to a crisis. The amount of stand-by time, however, will vary based on demand for mobile crisis services. To account for this, DHCS used a county-specific average hourly wage for two providers (one LPHA and one other qualified provider) and multiplied this two-person wage by the amount of standby time per shift.

Specifically, for rate setting purposes, the amount of standby time for mobile crisis teams in each county was estimated by multiplying the county's predicted average daily encounters per team by the total estimated time per encounter (including travel time, direct service, and follow-up time) for a total number of hours of active labor time per team on an 8-hour shift. The formula subtracts this total active labor time from an 8-hour shift and the remaining time is estimated to be the required stand-by time based on demand. Note, however, that DHCS also assumed that regardless of demand, each mobile crisis team will require at least one hour of standby time per 8-hour shift. Thus, a county's rate reflects a standby time of one hour per 8-hour shift or a longer period based on expected demand, whichever is higher.

35) How does the encounter rate incorporate the time that mobile crisis team members must spend getting to the site of a member's crisis?

DHCS' rates take into account that mobile crisis team members must travel to where members are in crisis. To build this travel time cost into the encounter rate, DHCS looked at one way travel time according to the [Crisis Resource Need Calculator](#) developed for the NASMHPD. The encounter rate formula multiplies this estimate by two to account for a round trip to and from the site. Travel time is multiplied by an average two-person hourly rate for one LPHA and one other qualified provider, inclusive of clinic overhead.

36) How does a mobile crisis team claim for a consultation with a specialist via telephone/telehealth?

If a consultation with a specialist is required during the mobile crisis response, the mobile crisis team would not submit a claim for those services. The clinician providing the specialist consultation would bill for the telehealth services provided, using the appropriate modifier (93 audio only or 95 audio and video).

37) How will counties claim if additional follow-up occurs after the 72-hour follow-up time frame? For example, there are three additional follow-ups over the course of the next two months to engage the individual in services.

Follow-up is required to take place within 72 hours of providing on-site services. Follow-up that occurs within this 72-hour window is part of the encounter rate – whether it results in multiple calls, one call, or the individual is unable to be reached. It is expected counties will have a mix of these outcomes in providing follow up services. Outreach to the member after the follow-up requirements that are part of the encounter have been met can be claimed separately as in accordance with the service that is provided, e.g., mental health services, crisis intervention services, etc.

SCU Press Event Details

Date & Time:

- Wednesday, October 16, 10:00am – 10:30am
- Set-up at 9:45, cleanup at 10:30am.

Location & Logistical Needs:

- [Cul-de-sac at Strawberry Creek Park](#) (West St off of Addison)
- SCU Van
- BPD Car
- Podium

Speakers:

- Mayor (Arreguin)
- Representative from HHCS (Scott Gilman)
- Representative from Bonita House (Dr. Flores)
- Representative from BPD (Chief Louis)

Staff Attendees:

- Anne Cardwell (CMO)
- Cari Arredondo (CMO)
- Katie Hawn (HHCS)

SCU Overview and Key Points

The Specialized Care Unit (SCU) was developed as part of the City of Berkeley's broader initiative to reimagine public safety, aiming to provide a non-police response to non-violent crises, including mental health and substance use emergencies. The SCU began as a pilot program in September 2023 and continues to expand its services.

Emergency Contact Information and Crisis Response Resources

- **911:**
 - **Use for life-threatening emergencies and in-progress crimes**, such as assaults, robberies, injury collisions, or medical emergencies.
- **Berkeley Police Emergency (510-981-5911):**
 - A good number to program into your cell phone for reporting emergencies in Berkeley. Some cell phone 911 calls may be routed to the California Highway Patrol (CHP), causing slight delays, but dialing **510-981-5911** directly connects to Berkeley Police for 911-type emergencies.
- **Berkeley Police Non-Emergency (510-981-5900):**
 - This number should be programmed into your phone for reporting non-life-threatening situations, such as non-injury collisions, crimes where the suspect is not present, or seeking advice on neighborhood disputes.
- **Mobile Crisis Team (MCT):**

- A co-response model in which mental health professionals work alongside police officers in mental health crisis responses. You can determine if MCT is on duty by calling the **BPD non-emergency number (510-981-5900)**. MCT services include crisis evaluation, information, and referrals. For non-urgent situations, community members can leave a message at **510-981-5254**.
- **Specialized Care Unit (SCU) (510-948-0075):**
 - SCU is a completely separate resource from the police department and is nearing 24/7 availability. It addresses wellness checks, mental health crises, and substance use situations. The SCU team includes a mental health clinician, a peer, and an EMT, and their services are voluntary. While SCU typically operates independently from emergency services, it can coordinate with the police or fire departments if immediate danger or injury is involved.

Current SCU Operations

- **SCU Hours of Operation:**
 - **Sunday, Monday, and Tuesday:** 24-hour services
 - **Wednesday, Thursday, Friday, and Saturday:** 20 hours per day, excluding 4 PM to 8 PM (12 AM - 4 PM and 8 PM - 11:59 PM)
 - The team is still working to fill vacancies to achieve full 24/7 operations.
- **Staffing and Team Composition:**
 - Each SCU team consists of:
 - one EMT,
 - one Peer Support Specialist,
 - and one Clinician.

The team responds to an **average of 2-5 calls per day**, and this volume is expected to rise as SCU expands its hours.

- **Funding:**
 - SCU is funded by the American Rescue Plan Act and a grant from the California Department of Health Care Services. Additional funding streams, such as Medi-Cal billing, are being explored to ensure the long-term sustainability of the program.

SCU Services and Response Protocols

- **Types of Services Provided:**
 - SCU assists with safety planning, clinical assessments, transportation to local community-based organizations or hospitals, and voluntary mental health or substance use interventions.
 - SCU may issue psychiatric holds (5150 or 5585) in rare situations where a person poses a risk to themselves or others.
- **De-Escalation Success and Protocols:**
 - SCU is trained in de-escalation techniques, and most calls do not require law enforcement involvement. However, in rare cases involving severe safety risks, the team may call 911 for first responder support.

Call Volume and Eligible Responses

- **Current Call Volume:**

- Since launching in September 2023, SCU has responded to approximately 1400 calls for service and sent a team to approximately 800 calls. The volume continues to increase as more community members become aware of the service.
- **Service Success:**
 - SCU has successfully de-escalated the vast majority of situations without needing police or fire department involvement. The team continues to refine its data collection processes to report on the outcomes of their interventions.
- **RDA Report and Future Analysis:**
 - RDA will provide an updated analysis in their Spring 2025 report to assess the proportion of calls that could be directed to SCU. The report will focus on the challenges of implementing crisis responses through the 911 dispatch system and national trends in similar programs.
- **Eligible Calls for SCU:**
 - While the city auditor's 2022 report identified that about 12% of police calls could be related to mental health, not all of these would necessarily qualify for SCU response. SCU uses specific criteria to assess eligibility.
 - Welfare checks, which comprise around 5% of calls for service, are broad in scope, and the Communications Center is not yet equipped to determine whether SCU or law enforcement is better suited for certain welfare checks.

Coordination with Other Departments

- **SCU Coordination with Police and Fire Departments:**
 - SCU operates separately from law enforcement but may request assistance from Berkeley Police or Fire in situations involving significant safety concerns, such as a client being unresponsive or posing an immediate threat.
 - SCU staff participated in briefings with Berkeley Police to ensure smoother coordination when both departments are dispatched to the same call.
- **911 and SCU Dispatch Coordination:**
 - Currently, 911 does not directly dispatch SCU, but dispatchers are aware of the service and may refer callers to SCU's number when appropriate. Full dispatch integration is expected in the future as labor and technical issues are resolved.

Evaluation and Expansion Plans

- **Program Evaluation:**
 - The City of Berkeley contracted Resource Development Associates (RDA) to evaluate SCU's performance. This includes assessing the number of calls that can be handled by SCU, its effectiveness, and the potential for 911 integration.
 - The evaluation will be crucial in guiding the expansion of SCU and making informed decisions on its integration with emergency services.

Public Communication and Engagement

- **Community Outreach and Awareness:**
 - SCU works with the SCU Steering Committee and City staff to publicize its services through listservs, flyers, brochures, and website updates.
 - Future outreach plans include larger campaigns such as advertisements in high-traffic areas like BART stations as SCU expands its hours and services.

Labor and Technical Challenges in SCU Expansion and 911 Integration

- **Initial Implementation and 911 Integration:**
 - The Specialized Care Unit (SCU) was launched with a separate phone number to ensure rapid deployment and maintain separation from law enforcement. The integration of SCU into the 911 dispatch system is a complex, ongoing process requiring time, coordination, and technical upgrades.
 - SCU integration with 911 is hindered by staffing shortages and technical challenges, including the current dispatch system's inability to transfer calls to SCU's 10-digit number and concerns about non-public safety staff accessing encrypted radio traffic. Labor and legal issues are also under consideration as this integration progresses.
- **Communications Center Staffing and Technical Issues:**
 - The Berkeley Communications Center is currently operating with 15 fully trained dispatchers, out of an authorized 36 positions, which contributes to delays in integrating SCU with 911 dispatch.
 - The City is negotiating labor agreements and addressing technical hurdles, including encrypted radio communication, to facilitate smooth integration.
- **Integration into 911 Dispatch:**
 - RDA's recommendations include the eventual integration of SCU into 911 dispatch, but the SCU Steering Committee has expressed concerns about embedding behavioral health clinicians directly into the dispatch center. They propose that SCU dispatchers receive specialized training while maintaining a clear distinction from law enforcement.
- **Program Adjustments:**
 - As SCU continues to expand, program adjustments will be made based on RDA's evaluation and ongoing feedback from stakeholders, ensuring that SCU can provide effective, independent crisis care while coordinating with other emergency services when necessary.

Common FAQs

- **Can I call 911 to reach SCU?**
 - No, SCU can currently only be reached at **510-948-0075**. The city is working on the integration of SCU into the 911 system, but this requires overcoming technical, legal, and labor hurdles.
- **Why aren't SCU hours later in the evening?**

- SCU is actively working to expand its hours, and additional staffing is required to ensure 24/7 operations. Once fully staffed, SCU will extend its availability into evening hours and beyond.
- **How does SCU differ from the Mobile Crisis Team (MCT)?**
 - The Mobile Crisis Team operates as a co-response model with law enforcement, while SCU operates independently of police and focuses specifically on mental health and substance use crises.
- **Why is SCU separate from law enforcement?**
 - SCU was designed to provide crisis services without involving law enforcement, except in cases of immediate danger or injury. This model helps ensure that individuals in crisis receive appropriate care without the presence of police unless absolutely necessary.
- **How does SCU handle situations where clients refuse services?**
 - SCU services are voluntary, and clients have the right to refuse. In these cases, the team may provide follow-up or leave materials for the client to access services later if they choose.
- **What is the SCU complaint process?**
 - Complaints about SCU services can be submitted by emailing HHCS@berkeleyca.gov.

Works-Wright, Jamie

From: Office of the Director of Police Accountability
Sent: Monday, February 24, 2025 4:47 PM
To: Office of the Director of Police Accountability
Subject: {EVENT REMINDER} Honoring Black Voices, Advancing Justice, a community visioning session hosted by the Office of the Director of Police Accountability_6:00 PM – 8:30 PM
Attachments: BHM Community Visioning Session Flyer.pdf; parking garages.PNG; free two hour parking.PNG

Dear Community Members,

This is a friendly reminder that our upcoming event, **Honoring Black Voices, Advancing Justice**, is just around the corner—**this Wednesday, February 26, 2025!** Don't miss this important opportunity to join the community for a visioning session hosted by the Office of the Director of Police Accountability. We are excited to engage with Equity in Policing Expert Carlton Mayers and City of Berkeley Diversity, Equity, and Inclusion Officer Rex Brown on crucial topics such as the future of police accountability and public safety in Berkeley.

Event Details:

- **Date & Time:** Wednesday, February 26, 2025 | 6:00 PM – 8:30 PM
- **Hybrid**
 - **Location:** Office of the Director of Police Accountability, 1900 Addison Street, 3rd Floor
 - **Zoom**

Space is limited, and we need your RSVP by TODAY—Monday, February 24, 2025, to secure your spot.

- **In-person attendance:** 35 participants
- **Virtual (Zoom):** 40 participants (Zoom link will be provided upon registration)

RSVP now to ensure your participation: <https://tinyurl.com/odpabhm>

Please Note:

- **Parking:** Limited parking is available on-site. We encourage carpooling or public transportation when possible (Please see attached maps for off-site parking locations).
- **Food and Drinks:** Food and drinks with vegetarian and vegan options will be available.

We look forward to your participation as we work together to shape a more just and accountable future

In solidarity,

Office of the Director of Police Accountability
1900 Addison Street, 3rd Floor
Berkeley, CA 94704
(510) 981-4950

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HONORING BLACK VOICES, ADVANCING JUSTICE: COMMUNITY VISIONING SESSION



BLACK COMMUNITIES & POLICE ACCOUNTABILITY: LESSONS FROM THE PAST, ACTION FOR THE FUTURE

Join the Office of the Director of Police Accountability (ODPA) for a community visioning session in honor of Black History Month.

We want to hear your thoughts on how to improve oversight and build trust with the Berkeley Police Department.

MODERATED BY



CARLTON MAYERS,
EQUITY IN POLICING EXPERT
CEO FOR MAYERS STRATEGIC SOLUTIONS, LLC*



REX BROWN
DEI OFFICER FOR THE CITY OF
BERKELEY

TO REGISTER:

GO TO

<https://tinyurl.com/odpabhm>, OR
SCAN THE QR CODE, OR
EMAIL DPA@BERKELEY.GOV



DATE & TIME

Wednesday, February 26
6:00 PM- 8:30 PM

ZOOM



Link will be emailed to registered participants before the event starts

LOCATION

1900 Addison Street,
3rd Floor,
Berkeley, CA 94704

PROMOTING PUBLIC TRUST THROUGH INDEPENDENT, OBJECTIVE, CIVILIAN OVERSIGHT OF THE BERKELEY POLICE DEPARTMENT

✉ dpa@berkeleyca.gov



510-981-4950



<https://berkeleyca.gov/dpa>

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Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, February 24, 2025 10:57 AM
To: Works-Wright, Jamie
Subject: FW: Sharing Forward: CBH Agenda for the February 27, 2025 Meeting

Here is information about attending the commission for behavioral health on February 27.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



From: CAL BHBC <cal@calbhbc.com>
Sent: Thursday, February 20, 2025 3:31 PM
Subject: Sharing Forward: CBH Agenda for the February 27, 2025 Meeting

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

*From the **Commission for Behavioral Health** (formerly the Mental Health Services Oversight & Accountability Commission)*

Commission for Behavioral Health Meeting (Hybrid)

February 27, 2025, 9 am - 3:30 pm

1812 9th Street, Sacramento

[Zoom Registration](#)

[Link to Agenda and Meeting Materials.](#)

Agenda Includes:

- [School-Based Universal Mental Health Screening Legislative Report](#) (10:50 am)

- [Behavioral Health Student Services Act Legislative Report](#) (11:30 am)
- **Innovation Partnership Fund** (For grants to private, public and nonprofit partners (\$100 million over 5 years)) (1 pm)
- [Behavioral Health Student Services Act Evaluation](#) (2 pm)
- [Full Service Partnership Legislative Report](#) (2:30 pm)

More information is below.



AGENDA PREVIEW

Key topics and links
Commission for Behavioral Health meeting
February 27, 2025

Key agenda topics

- **School-Based Universal Mental Health Screening Legislative Report**
The Commission will receive and consider adoption of a draft legislative report and recommendations on school-based universal mental health screenings (SUMHS) for children and youth. This report presents findings from a landscape analysis of statewide SUMHS policies and practices and a set of recommendations for implementing SUMHS in support of California's broader youth behavioral health initiatives; presented by Kali Patterson, Research Scientist Supervisor.
- **Behavioral Health Student Services Act Legislative Report**
The Commission will receive and consider adoption of the draft biennial report to the legislature on the Behavioral Health Student Services Act; presented by Kai LeMasson, PhD., Research Scientist Supervisor.
- **Innovation Partnership Fund**
The Commission will hear a presentation on the mandates of the Innovation Partnership Fund, which shall be used in a grant program, as outlined in the BHSA. The Commission will review initial concepts for developing the Commission goals and discuss next steps; presented by Will Lightbourne, Interim Executive Director.
- **Behavioral Health Student Services Act Evaluation**
The Commission will consider approval of a contract up to \$4 million for phase 2 of the Behavioral Health Student Services Act evaluation; presented by Melissa Martin-Mollard, PhD., Chief of Research and Evaluation.
- **Full Service Partnership Legislative Report**
The Commission will receive and consider adoption of the draft biennial report to the legislature on the outcomes for those receiving community mental health services under a full service partnership model; presented by Kallie Clark, PhD., MSW, Research Scientist Supervisor.

[Click for the full agenda](#)



Join the meeting in person

Join the meeting in person:

1812 9th Street, Sacramento, CA 95811



Join the meeting remotely

[Click to register online](#). Once you register, you will receive a link to join online and a phone number to join remotely.



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[Click to read more about making a public comment](#), or [email the Commission your comment](#).

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CALBHB/C supports the work of CA's 59 local Mental/Behavioral Health Boards and Commissions

www.calbhbc.org [News/Issues](#) [Resources](#)

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Sunday, February 23, 2025 6:26 PM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting (February 24, 2025)
Attachments: MHAB Main Board Agenda (February 2025).pdf; MHAB Main Board Meeting UNAPPROVED Minutes (January 2025) .pdf; ACBHD Annual Departmental Update (February 2025).pdf; ACBHD FY 2024-2025 Budget Presentation.pdf

Please see the information below and attached.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

JWorks-Wright@berkeleyca.gov

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365



From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>

Sent: Friday, February 21, 2025 3:05 PM

Cc: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>

Subject: Mental Health Advisory Board Meeting (February 24, 2025)

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Good afternoon,

Please find attached materials for the Mental Health Advisory Board meeting scheduled for Monday, February 24, 2025, from 3:00 PM to 5:00 PM.

This will be an in-person meeting to be held at 2000 Embarcadero Cove, Suite 400 (*Gail Steele Conference Room*) in Oakland. Members of the public are invited to observe and participate in person or remotely via Zoom.

To participate virtually, please click on the meeting link below:

<https://us06web.zoom.us/j/84285334458?pwd=bURyU1JqS2YvVGhRU2g4SW5yL0xRQT09>

Webinar ID: 842 8533 4458

Passcode: 269505

Or Telephone:

(404) 443-6397

(877) 336-1831

Conference code: 988499



Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

February 24, 2025 | 3:00 PM – 5:00 PM

2000 Embarcadero Cove, Suite 400 (Gail Steele Room) Oakland

This meeting will also be conducted through videoconference and teleconference

<https://us06web.zoom.us/j/84285334458?pwd=bURyU1JqS2YyVGVhRU2g4SW5yL0xRQT09>

Teleconference: (877) 336-1831 | Teleconference Code: 988499

Webinar ID: 842 8533 4458 | Webinar code: 269505

MHAB Members:	Brian Bloom (Chair, District 4) Terry Land (Vice Chair, District 1) Jennifer DeGroat-Penney (District 1) Carolynn Gray (District 2) Gina Lewis (District 2)	Thu Quach (District 2) Ashlee Jemmott (District 3) Shannon Johnson (District 3) Yuliana Wisner-Leon (District 3) Warren Cushman (District 4)	Mary Hekl (District 4) Larry Brandon (District 5) Olivia Daprile (District 5) Juliet Leftwich (District 5) Erin Armstrong (BOS Rep.)
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Committees

Adult Committee
Terry Land, Co-Chair
Thu Quach, Co-Chair

Children’s Advisory Committee
Vacant, Chair

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

MHAB Mission Statement
The Alameda County Mental Health Advisory Board has a commitment to ensure that the County’s Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy, and respect. This shall be accomplished through advocacy, education, review, and evaluation of Alameda County’s mental health needs.

- 3:00 PM I. Call to Order and Roll Call
- 3:05 PM II. Approval of Minutes
- 3:05 PM III. Public Comment
- 3:10 PM IV. MHAB Chair’s Report
- 3:15 PM V. MHAB Announcements
- 3:20 PM VI. ACBHD Annual Departmental Update
- 4:00 PM VII. ACBHD FY 2024-2025 Budget Presentation and Discussion
- 4:40 PM VIII. Committee and Liaison Reports
 - A. Adult Committee
 - B. Criminal Justice Committee
 - C. Children’s Advisory Committee
 - D. Care First, Jails Last Ad Hoc Committee
 - E. MHSA Stakeholder Committee
 - F. Budget Stakeholder Advisory Committee
 - G. Berkeley Mental Health Committee
- 4:50 PM IX. Public Comment
- 5:00 PM X. Adjournment

Contact the Mental Health Advisory Board at ACBH.MHBCommunications@acgov.org



ALAMEDA COUNTY
Board of Supervisors



Behavioral Health Department
Alameda County Health

Alameda County Behavioral Health Department Mental Health Advisory Board (MHAB) Presentation

ACBHD Annual Departmental Update

February 24, 2025



Presented by:

Karyn Tribble, PsyD, LCSW | Director

OVERVIEW

- **Departmental Systems Overview**
- **Budget**
- **Initiatives & Strategic Planning**
- **ACBHD Next Steps**
(90 Days, 6 Months, & Beyond)

Departmental Systems Overview

Leadership, Budget & Guiding Principles



ACBHD Executive Leadership Team



Karyn Tribble, PsyD, LCSW
ACBH Director

- ❖ Office of Health Equity
- ❖ Workforce, Education, & Training
- ❖ Compliance & Privacy Office
- ❖ Public Information Office



James Wagner, LMFT, LPC
Deputy Director, Clinical Operations

- ❖ Clinical Support Services & Programs
- ❖ Mental Health Services
- ❖ Substance Use Services
- ❖ Forensic Services



Vanessa Baker, LMFT
Deputy Director, Plan Administration

- ❖ Quality Management
- ❖ Financial Services
- ❖ Mental Health Services Act
- ❖ Information Systems & Data Analytics



Aaron Chapman, MD
Chief Medical Officer

- ❖ Acute & Crisis Services
- ❖ Psychiatry, Pharmacy, & Nursing Services
- ❖ Emergency Management & Response
- ❖ Integrated Primary Care Services



Cecilia Serrano
Finance Director



Kate Jones, RN, MS, MSN
Director, Adult & Older Adult System of Care



Laphonsa Gibbs, LCSW
Director, Child & Young Adult System of Care



Stephanie Lewis, LMFT
Acting Director, Crisis System of Care



Juan Taizan, MPA
Director, Forensic, Diversion, & Re-Entry Services



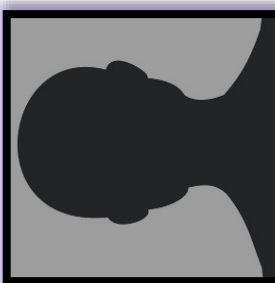
Stephanie Montgomery, MSW
Director, Office of Health Equity
Health Equity Division Director



Karen Capece, LCSW
Quality Management (QM)
Program Director

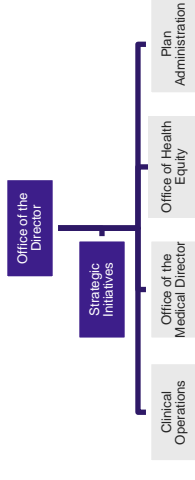


Kinzi Richholt, MSN, APRN
Chief Nursing Officer



Appointment Pending
Director, Substance Use
Continuum of Care

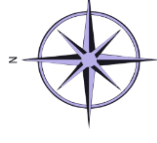
Office of the Director:



The “How”

- *Alignment, Communication, & Organizational Structure (December 2019)*

The “What” – ACBHD True North Framework



- *Quality, Investment in Excellence; Accountability; Financial Sustainability; & Outcome-Driven Goals (February 2021)*

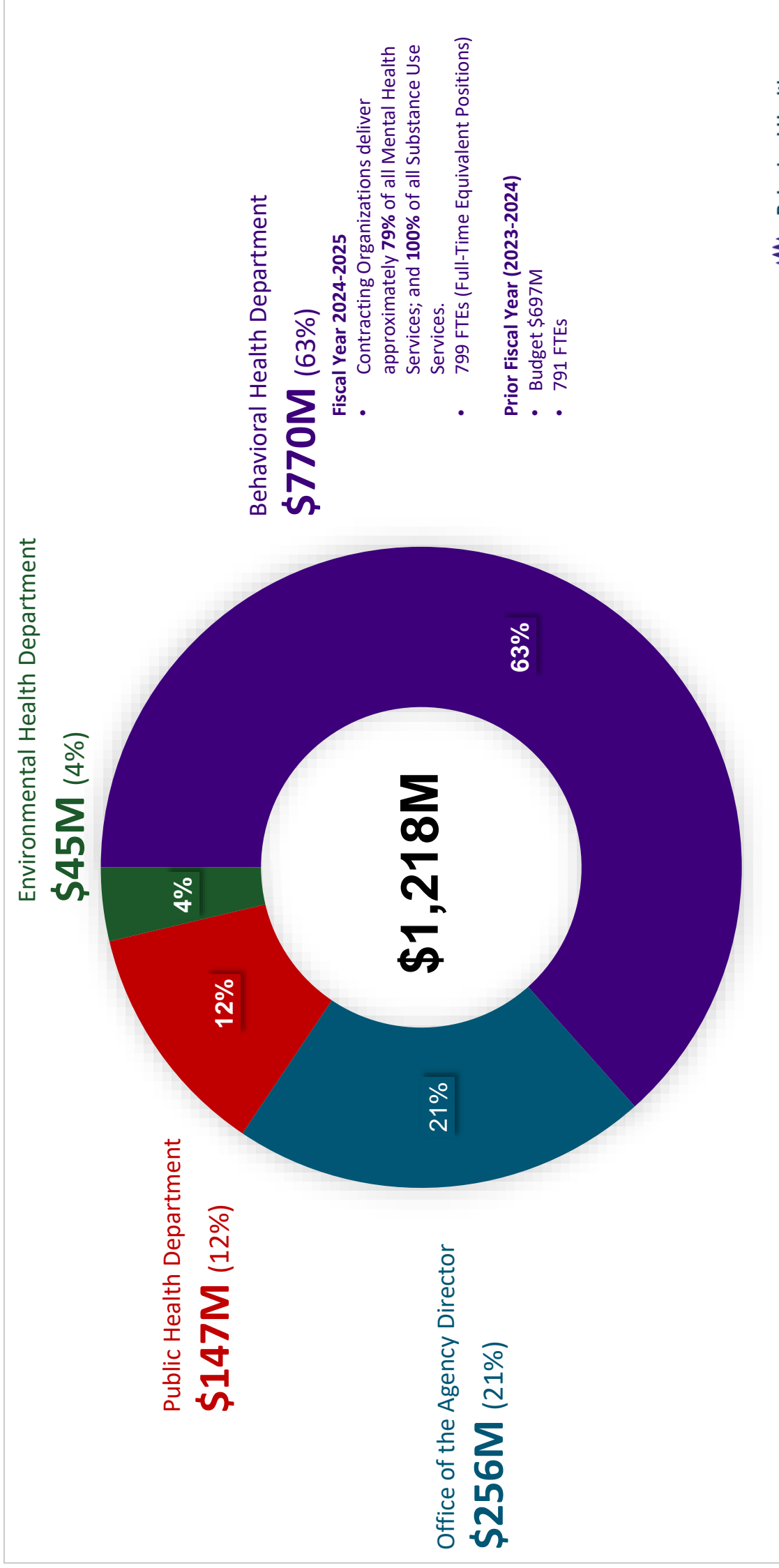
The “Why” – ACBHD Mission, Vision, Values

Our Path

- *ACBH System Goals, Results Based Accountability (RBA), & Stakeholder Engagement (February 2021)*

Departmental Goals, & True North Pillars, Strategic Priorities, & Metrics

ACBHD Fiscal Year (FY) 2024-2025 Budget (AC Health)



*Note: Includes Hospital Finance (Intergovernmental Transfers) and Measure A (included in each Department total).



Initiatives & Strategic Planning

Local, Statewide, and other Transformational Projects



Office of the ACBHD Director
& Executive Leadership
Accountability

Departmental Initiatives & System Work

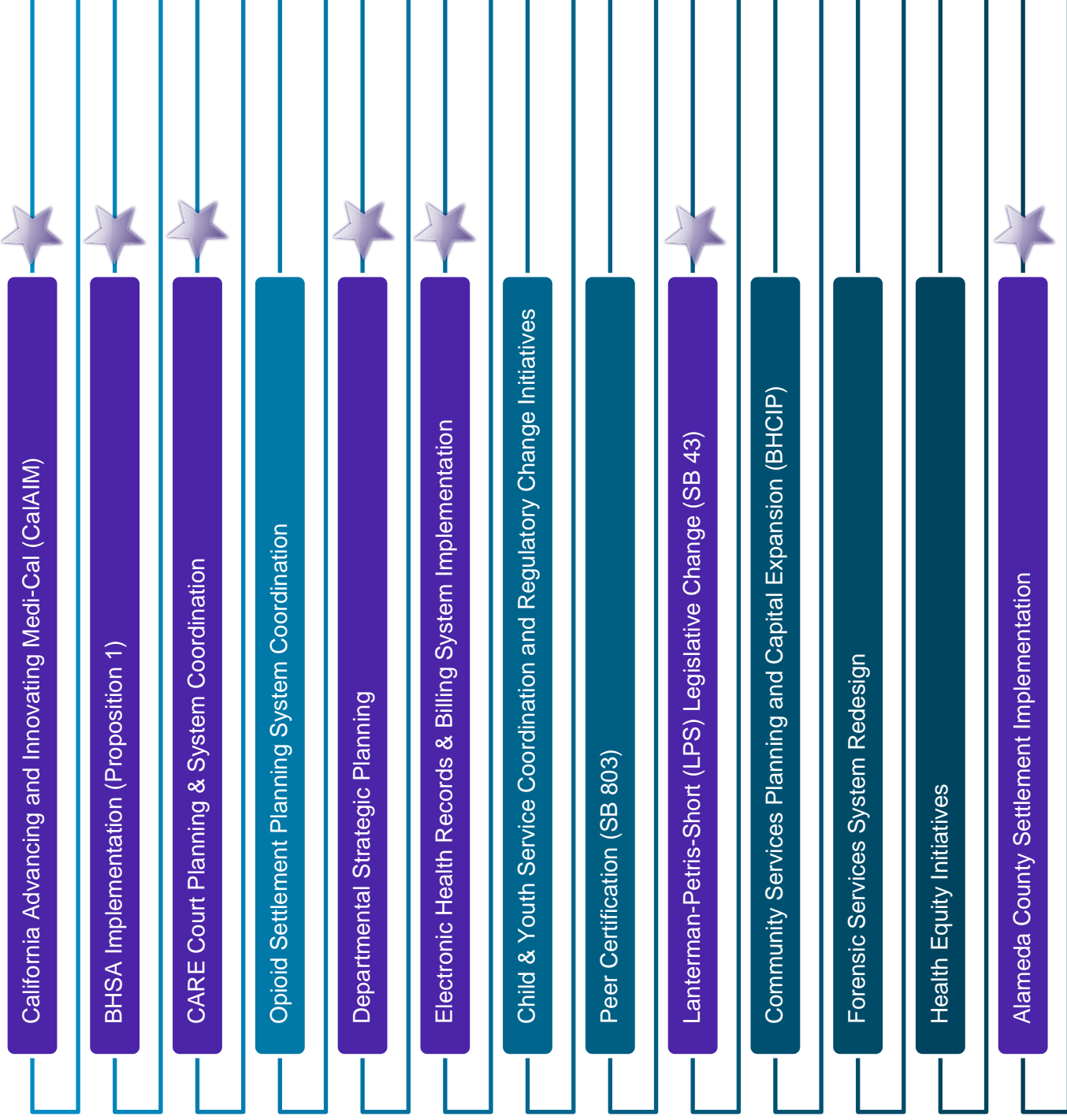


- California Advancing and Innovating Medi-Cal (CalAIM)
- BHSA Implementation (Proposition 1)
- CARE Court Planning & System Coordination
- Opioid Settlement Planning System Coordination
- Departmental Strategic Planning
- Electronic Health Records & Billing System Implementation
- Child & Youth Service Coordination and Regulatory Change Initiatives
- Peer Certification (SB 803)
- Lanterman-Petris-Short (LPS) Legislative Change (SB 43)
- Community Services Planning and Capital Expansion (BHCIP)
- Forensic Services System Redesign
- Health Equity Initiatives
- Alameda County Settlement Implementation



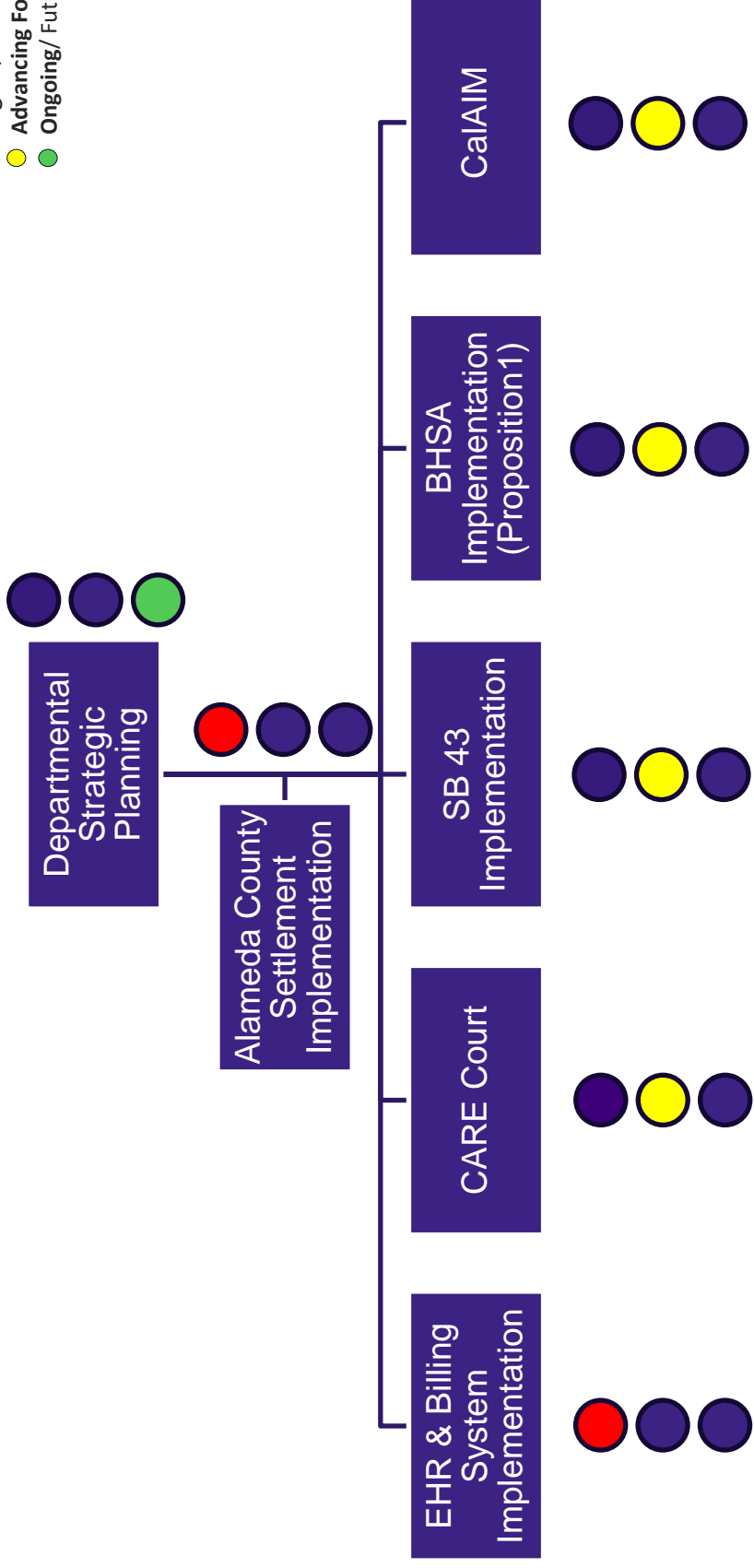
Office of the ACBHD Director
& Executive Leadership
Accountability

Departmental Initiatives & System Work

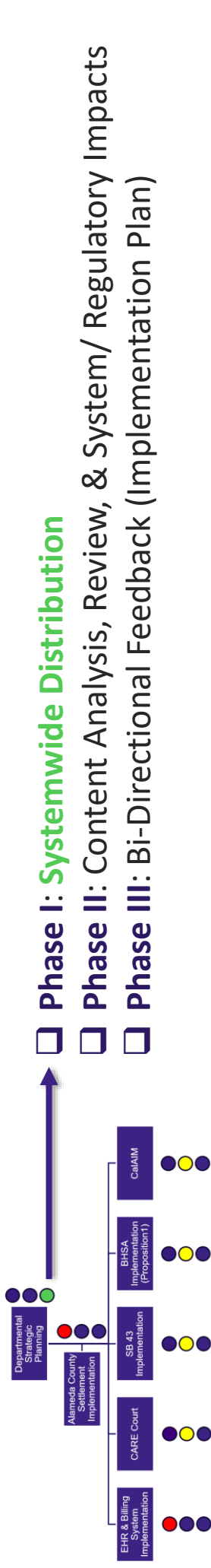


Emergent, Urgent, & System-Changing Initiatives

Strategic Initiative Color Key:
 ● Urgent/ Immediate & Time Sensitive (Short-Term)
 ● Advancing Forward/ Intermediate (Medium-Term)
 ● Ongoing/ Future Aim (Long-Term)



Emergent, Urgent, & System-Changing Initiatives



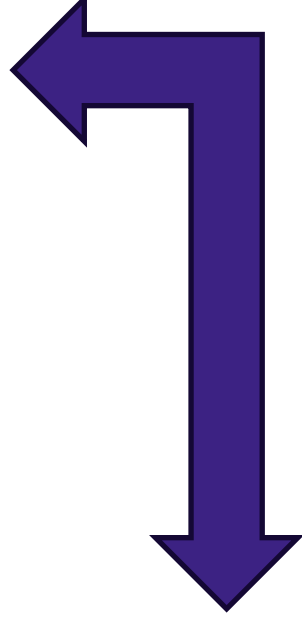
- Phase I: **Systemwide Distribution**
- Phase II: Content Analysis, Review, & System/ Regulatory Impacts
- Phase III: Bi-Directional Feedback (Implementation Plan)

Feedback Highlights:

- Increase access.
- Uplift community expertise.
- Increase vital employment.
- Improve programs to advance culturally relevant services and supports.
- Increase equity in funding for substance use and mental health (reduce stigma).
- Increase equitable care for communities facing the greatest behavioral health inequities.
- Seek alternatives to the criminal justice system.

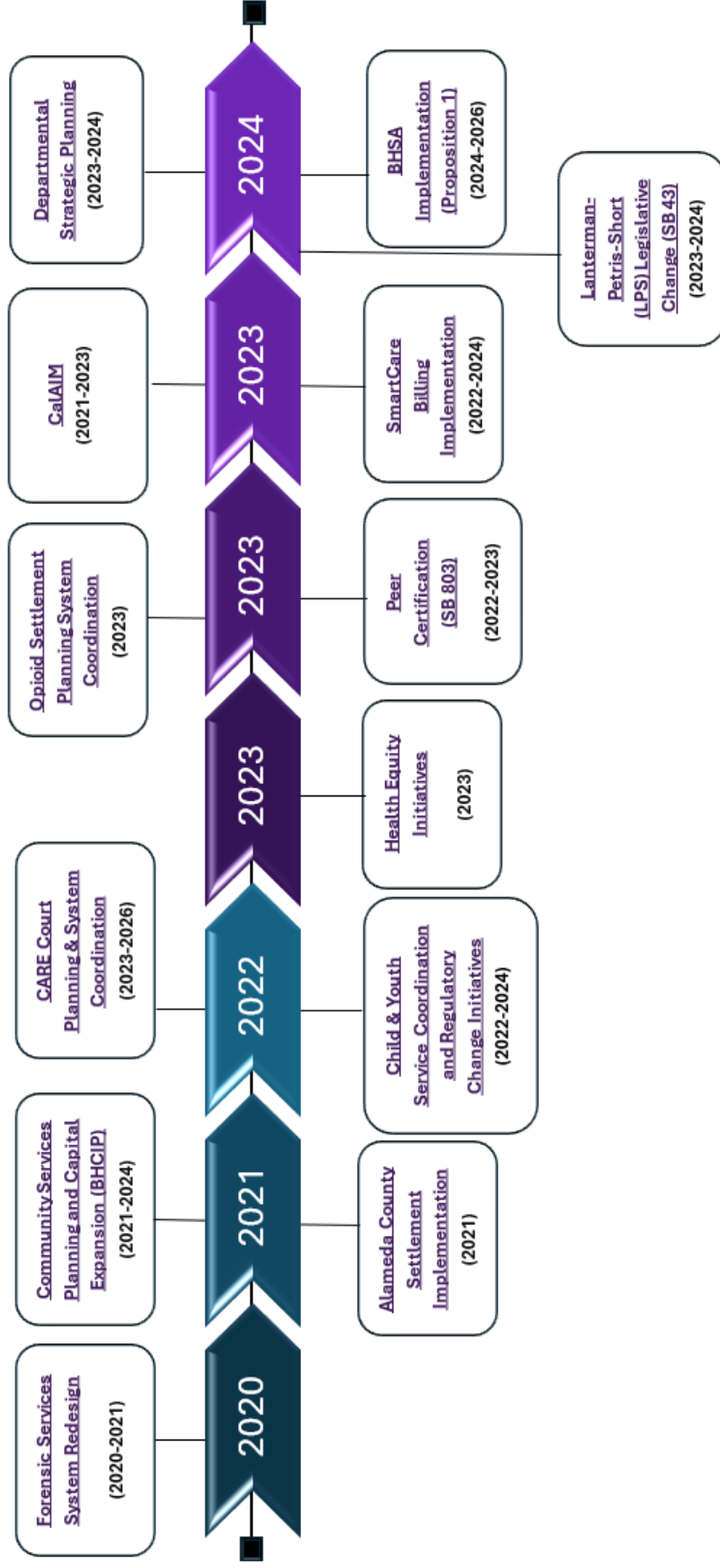
Proposed Strategic Direction:

- **Housing** (collaborate and increase employment).
- **Programs** (evaluate & improve).
- **Equitable Care** (outreach, recruitment, & programs).
- **Re-Entry & Criminal Justice** (increase collaboration).
- **Acceptable & Equitable Distribution of Funds** (MH/SUD).
- **Access** (establish co-designed strategies).
- **Community Expertise** (policy & program development).



Departmental Initiatives & System Work

Years in Review: 2020-2024



90-Days,
6 Months,
& Beyond...

2020-2024 In Review...

ACBHD Next Steps

2025: Key Updates & 90 Days, 6 Months, & Beyond



Continued Quality Improvement & System Change

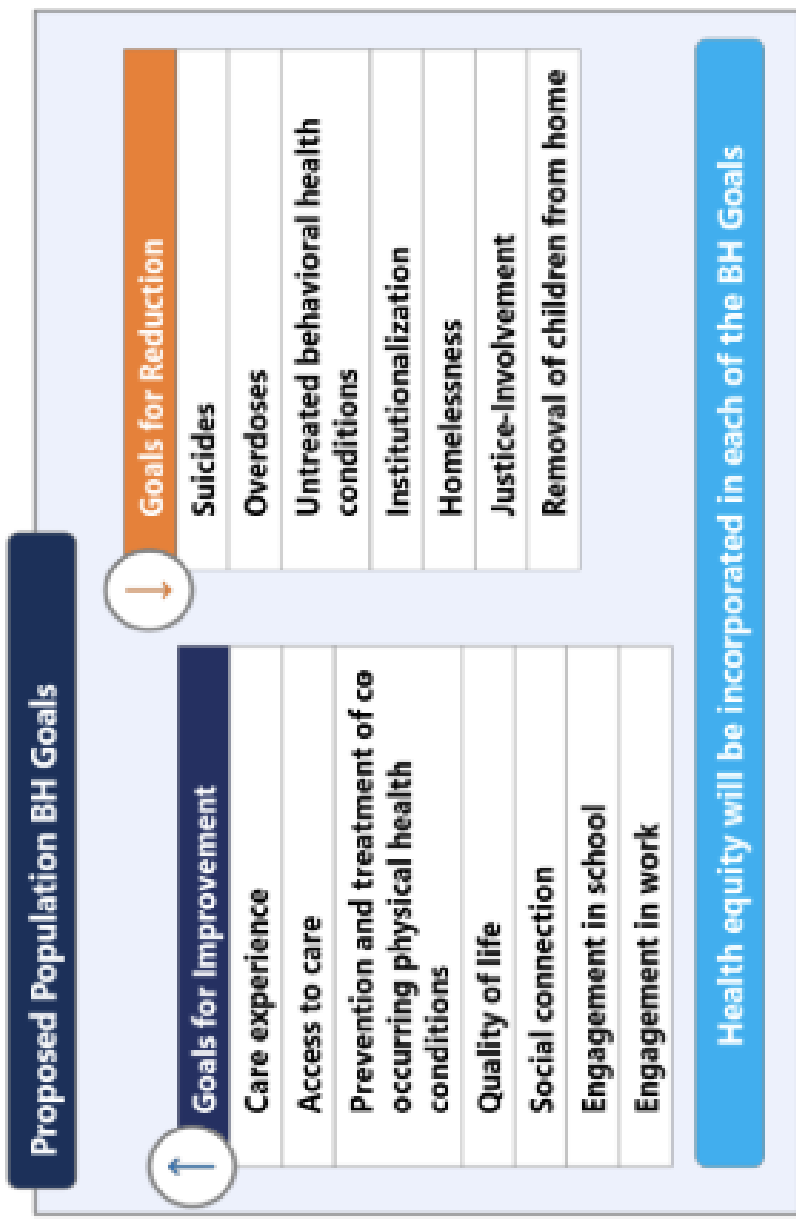
- Electronic Health Records (EHR) – [EPIC Systems](#)
- ACBHD Health Equity Dashboard – [Public Link](#)
- [Update: Mobile Crisis Assessment & Report – Indigo Project](#)
- Behavioral Health Performance Indicators Dashboard (Statewide) – California Mental Health Services Authority (CalMHSA)

Continued Quality Improvement & System Change

- Electronic Health Records (EHR) – [EPIC Systems](#)
- ACBHD Health Equity Dashboard – [Public Link](#)
- Update: Mobile Crisis Assessment & Report – [Indigo Project](#)
- Behavioral Health Performance Indicators Dashboard (Statewide) – [California Mental Health Services Authority \(CalMHSA\)](#)



Statewide Behavioral Health Goals



- **Important:**
 - County Performance – *Statewide*
 - **Non-Behavioral Health Data** has also been included (i.e., not simply from County BHDs).
 - Metrics will determine ‘County’ **accountability.**

ACBHD Next Steps



Karyn Tribble, PsyD, LCSW
ACBH Director

- ◆ Office of Health Equity, Workforce, Education & Training
- ◆ Compliance & Privacy Office
- ◆ Public Information Office

James Wagner, LMFT, LPC
Deputy Director, Clinical Operations

- ◆ Clinical Support Services & Programs
- ◆ Mental Health Services
- ◆ Substance Use Services
- ◆ Forensic Services

Vanessa Baker, LMFT
Deputy Director, Plan Administration

- ◆ Quality Management
- ◆ Financial Management
- ◆ Mental Health Services Act
- ◆ Information Systems & Data Analytics

Aaron Chapman, MD
Chief Medical Officer

- ◆ Acute & Crisis Services
- ◆ Primary Care
- ◆ Psychiatric & Nursing Services
- ◆ Emergency Management & Response
- ◆ Integrated Primary Care Services

Cecilia Serrano
Finance Director



Appointment Pending
Director, Substance Use Continuum of Care

Kate Jones, RN, MS, MSN
Director, Adult & Older Adult System of Care

Laphonsa Gibbs, LCSW
Director, Child & Young Adult System of Care

Stephanie Lewis, LMFT
Acting Director, Crisis System of Care

Health Equity Initiatives

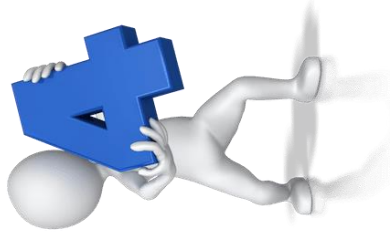
EQRO & Integration

CaAIM

BHSA

Child & Youth Initiatives

SB 43



Electronic Health Records & Billing

BHCIP & Other Capital Projects

CARE Court



Next Steps...

- **Continued system engagement, stakeholder planning, implementation of critical initiatives (required).**
- **Communication & Updates (ongoing).**
- **Opportunities for System Change analysis (metrics & feedback).**

THANK YOU



Mental Health Advisory Board UNAPPROVED Minutes
Monday, January 27, 2025 | 3:00 PM - 5:00 PM

Meeting Conducted In-Person and through Video/Telephone Conference



MHAB Members:	<input checked="" type="checkbox"/> Brian Bloom (<i>Chair, District 4</i>) <input checked="" type="checkbox"/> Thu Quach (<i>District 2</i>) <input checked="" type="checkbox"/> Mary Hekl (<i>District 4</i>) <input checked="" type="checkbox"/> Terry Land (<i>Vice Chair, District 1</i>) <input checked="" type="checkbox"/> Ashlee Jemmott (<i>District 3</i>) <input checked="" type="checkbox"/> Lawrence Brandon (<i>District 5</i>) <input checked="" type="checkbox"/> Jennifer DeGroat-Penny (<i>District 1</i>) <input type="checkbox"/> Shannon Johnson (<i>District 3</i>) <input checked="" type="checkbox"/> Juliet Leftwich (<i>District 5</i>) <input checked="" type="checkbox"/> Carolynn Gray (<i>District 2</i>) <input checked="" type="checkbox"/> Yuliana Wisner-Leon (<i>District 3</i>) <input type="checkbox"/> Olivia Daprile (<i>District 5</i>) <input type="checkbox"/> Gina Lewis (<i>District 2</i>) <input checked="" type="checkbox"/> Warren Cushman (<i>District 4</i>)
ACBH Staff:	<input checked="" type="checkbox"/> Dr. Karyn Tribble (<i>ACBHD Director</i>) <input checked="" type="checkbox"/> Dainty Castro (<i>MHAB Liaison</i>) <input type="checkbox"/> James Wagner (<i>ACBHD Deputy Director, Clinical Operations</i>) <input checked="" type="checkbox"/> Asia Jenkins (<i>ACBHD Admin Support</i>) <input checked="" type="checkbox"/> Vanessa Baker (<i>ACBHD Deputy Director, Plan Administration</i>)
Excused Absences:	

Meeting called to order at 3:01 PM by Chair Brian Bloom.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call / Introductions	Roll call was completed.	
Approval of Minutes	The meeting minutes from November 18, 2024, were adopted with minor revisions and unanimously approved.	
Public Comments	There were no public comments given.	
MHAB Chair's Report	MHAB Chair Bloom provided the following report: Main Board Meeting for February: The February main board meeting will be rescheduled to February 24, 2025, due to a county holiday. <u>MHAB Website</u> : A follow-up reminder for members to submit their headshots and biographies for the MHAB webpage.	

ITEM	DISCUSSION	DECISION/ACTION
	<p><u>Member Contact Information:</u> Chair Bloom has sent contact information for all members and a reminder to be mindful of quorum, as the Brown Act still applies.</p> <p><u>Children's Committee:</u> Co-Chairs have not been confirmed and no meeting dates have been set.</p> <p><u>New BOS Representative:</u> Erin Armstrong has been appointed as the BOS liaison to the MHAB and is expected to attend next month's meeting.</p> <p><u>BOS Composition:</u> With the new BOS member, there are new committee assignments for the 2025 Health Committee. Supervisor Miley is the Chair, and Supervisor Tam will be on this committee. Chair Bloom announced the supervisors assigned to each committee.</p> <p><u>District Attorney Update:</u> Seven candidates have been selected from twenty applications for the District Attorney position. These candidates were interviewed and participated in a public meeting. The BOS will make their decision at their upcoming BOS meeting. The selected DA will fill the remaining two years of previous term and will run in 2026.</p>	
MHAB Announcements	No announcements were given.	
ACBHD Director's Report	<p>Update and announcements from Alameda County Behavioral Health Department (ACBHD) Director, Dr. Karyn Tribble:</p> <p><u>Board of Supervisors (BOS) Committee Chairs and members</u></p> <ul style="list-style-type: none"> • <i>Health:</i> Supervisor Miley (Chair), Supervisor Tam • <i>Personnel, Admin and Legislation:</i> Supervisor Tam (Chair), Supervisor Bas • <i>Public Protection:</i> Supervisor Marquez (Chair), Supervisor Miley • <i>Transportation & Planning:</i> Supervisor Haubert (Chair), Supervisor Miley • <i>Social Services:</i> Supervisor Tam (Chair), Supervisor Bas • <i>Procurement and Contracting:</i> Supervisor Miley (Chair), Supervisor Marquez • <i>Unincorporated Services:</i> Supervisor Miley (Chair), Supervisor Tam • <i>Budget Work Group:</i> Supervisor Haubert (Chair), Supervisor Tam 	

ITEM	DISCUSSION	DECISION/ACTION
	<p><u>SB 43 BOS Update:</u> Due to recent changes within the BOS, there has been significant activity and the presentation is still being finalized. An update will be shared once the date and time has been confirmed.</p> <p><u>Health Equity Dashboard:</u> The interactive Health Equity dashboard has been posted on ACBHD's website. Everyone is encouraged to review it. This dashboard is a result of a settlement agreement between the Alameda County, Disability Rights of California and the Department of Justice, promoting transparency.</p> <p><u>CARE Court Update:</u> Alameda County officially started CARE Court on December 1st. Since then, nearly 28 petitions have been filed, with 25 completed and 3 additional in queue. This indicates the number of individuals referred to CARE Court and those who have completed the process. Of the 25 completed petitions, 12 were initiated by ACBHD, 8 by parents or family members, 2 by the Department of State Hospitals, and 2 by ACBHD's crisis response team. The 3 in queue are now enrolled in the program who are getting the services they needed.</p>	
<p>MHAB Amended Bylaws</p>	<p>Chair Bloom announced that the proposed changes are shown in red font and most of the changes involve updating the terminology from "Mental Health" to "Behavioral Health," including the addition of "Substance Use Disorder (SUD)" where appropriate. The discussions were as follows:</p> <p><u>Section IV – Membership</u></p> <ul style="list-style-type: none"> • Due to a change in law, Section IV.E. was added, specifying that at least one member shall be an employee of a local education agency. • Section IV.D. has been added as it was previously missing from the MHAB bylaws but should be included. • Sections IV. J. and IV. K. clarify the number of terms for the members. • Section IV. L. requires each member to abide by the required code of ethics as stated in the administrative code. 	

ITEM	DISCUSSION	DECISION/ACTION
	<p><u>Section XV – Removal from the Board</u></p> <ul style="list-style-type: none"> Update absences to a total of “four” General Board meetings” instead of three. Additional language to address the submission of a leave of absence <p>The motion to adopt the revised bylaws with minor changes/edits were presented. All were in favor, with no objection nor opposition. The motion passed.</p>	
<p>Site Visit to Cherry Hill Sobering & Detox Facility Report</p>	<p>Member Carolyn Gray organized a site visit to Cherry Hill, operated by Horizon Services. She provided the following highlights from the visit:</p> <ul style="list-style-type: none"> There are two separate buildings on the same campus, which also includes other facilities including Jay Mahler, Willow Rock, and John George nearby. The location is beneficial for transitioning clients to other types of care. Cherry Hill is a 30-bed center, offering services for 23 hours and 59 minutes with a very short-term program. Their purpose is to support individuals with medical needs during detoxification. Medication Assisted Treatments (MAT) services are available. Approximately 800 clients per month are received for sobering services. 60% of detox clients transition to one of the county’s residential facility programs. There are difficulties in exchange of health records and a lack of referrals from the law enforcement despite the Sheriff’s Building being conveniently located nearby. The program is currently receiving a grant from the Sierra Health Foundation which expires in June 2025. 	
<p>MHAB FY 2023-2024 Annual Report Recommendations</p>	<p>There was an open discussion regarding the Annual Report and the board continued their review of the final recommendations, specifically focusing on numbers 7 through 9. The highlights of the discussion were as follows:</p> <ul style="list-style-type: none"> It was suggested to reword Recommendation 8 to reiterate that the BOS has already recommended that ACBHD identify funding sources for the recommendations and implementation plan. Although the Children’s Advisory Committee has been on hiatus for a while, Recommendation 9 is derived from discussions between the members where they share their experience working with the young populations. 	

ITEM	DISCUSSION	DECISION/ACTION
	<ul style="list-style-type: none"> • Grave disability standards • It was suggested to remove Recommendation 5 from the 2024 Annual Report • Additional language regarding election or the change in administration was mentioned • Not to name a specific provider but to make a point across the recommendations <p>The motion was presented to allow revisions/edits discussed, to finalize the 2024 Annual Report before the next main board meeting, submit to the Board of Supervisors and their staff, and posted on the MHAB website. The motion was adopted with all in favor without objection or opposition. Motion passed.</p>	
Committee & Liaison Reports	This item was not discussed.	
Public Comment	Public comments were given.	
Adjournment	This meeting was adjourned at 5:00 PM.	

Alameda County Behavioral Health Department Fiscal Year 2024-25 Budget

Mental Health Advisory Board Meeting
February 24, 2025

Presented by:
Jill Louie, ACBHD Budget Director

Agenda

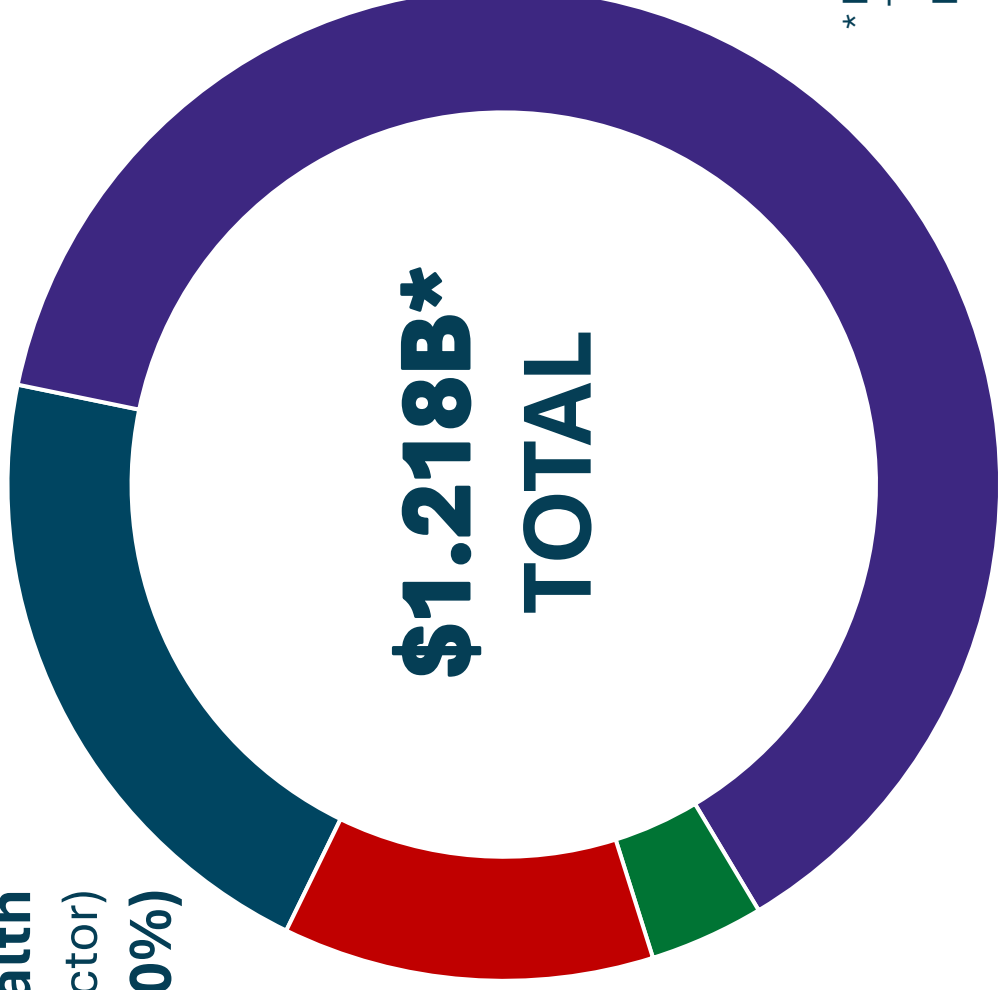
1. Alameda County (AC) Health Fiscal Year (FY) 2024-25 Budget by Department
2. AC Behavioral Health Department (BHD) Financial and Infrastructure Overview
3. ACBHD FY 2024-25 Approved Budget
4. Financing by Revenue Source
5. Major Revenue Sources
6. Budget by Program

Alameda County Health FY 2024-25 Budget by Department

Alameda County Health
(Office of the Agency Director)
\$255.84M (21.0%)

Public Health
Department
\$147.16M (12.1%)

Environmental Health
Department
\$45.40M (3.7%)



Behavioral Health
Department
\$769.53M (63.2%)

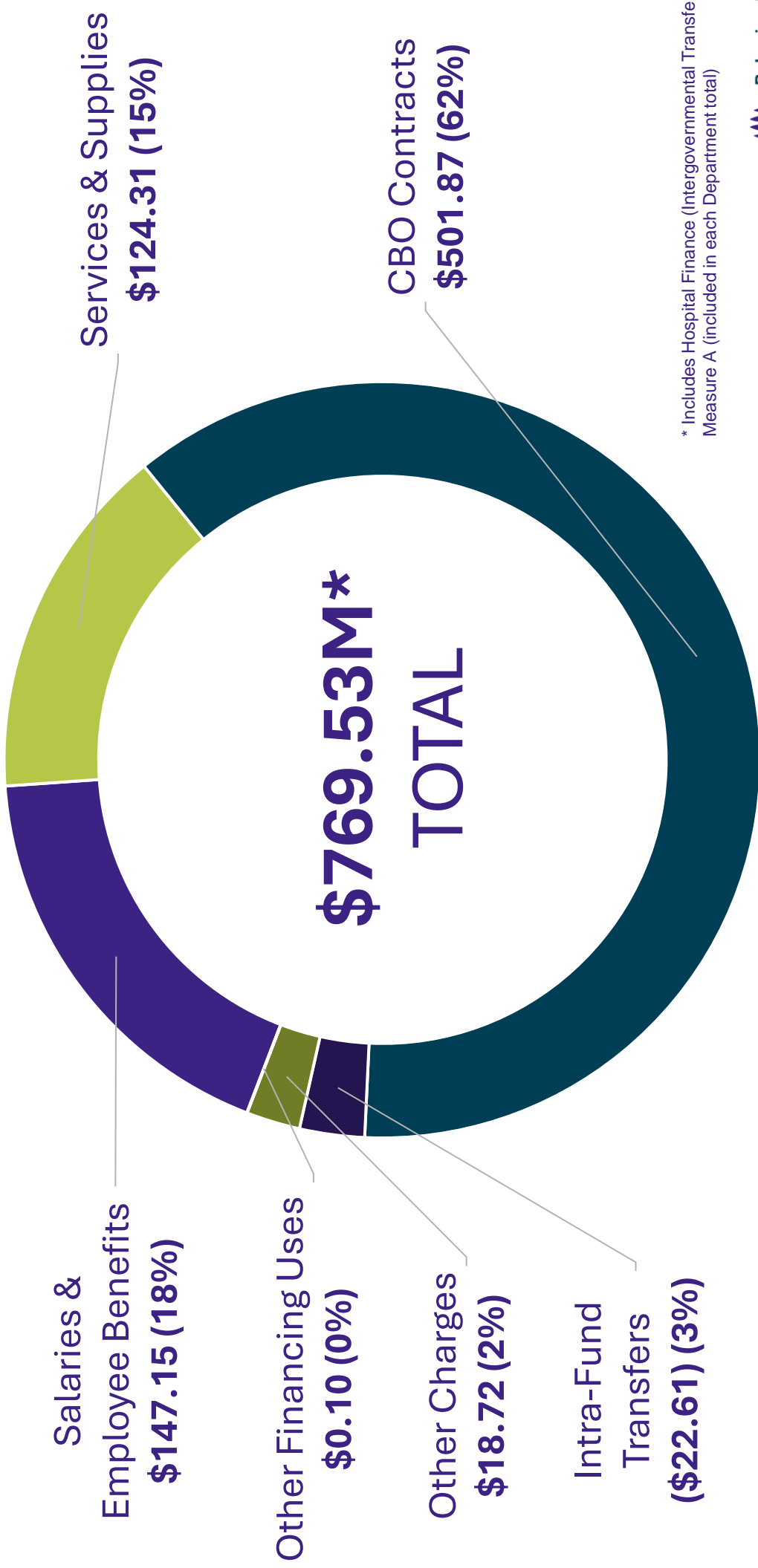
* Includes Hospital Finance (Intergovernmental Transfers) and Measure A (included in each Department total)

ACBHD Financial and Infrastructure Overview

- **Fiscal Year (FY) 2024-2025 Budget:**
 - \$770 Million Dollars
 - 799+ FTE County Civil Service Positions
- **Prior FY 2023-2024 Budget:**
 - \$697 Million Dollars
 - 791+ FTE County Civil Service Positions
- Contracting Organizations deliver approximately 79% of all Mental Health Services and **100% of all Substance Use Services**
- **\$502M allocated to the Community-Based Organizations (65% of the ACBHD budget)**

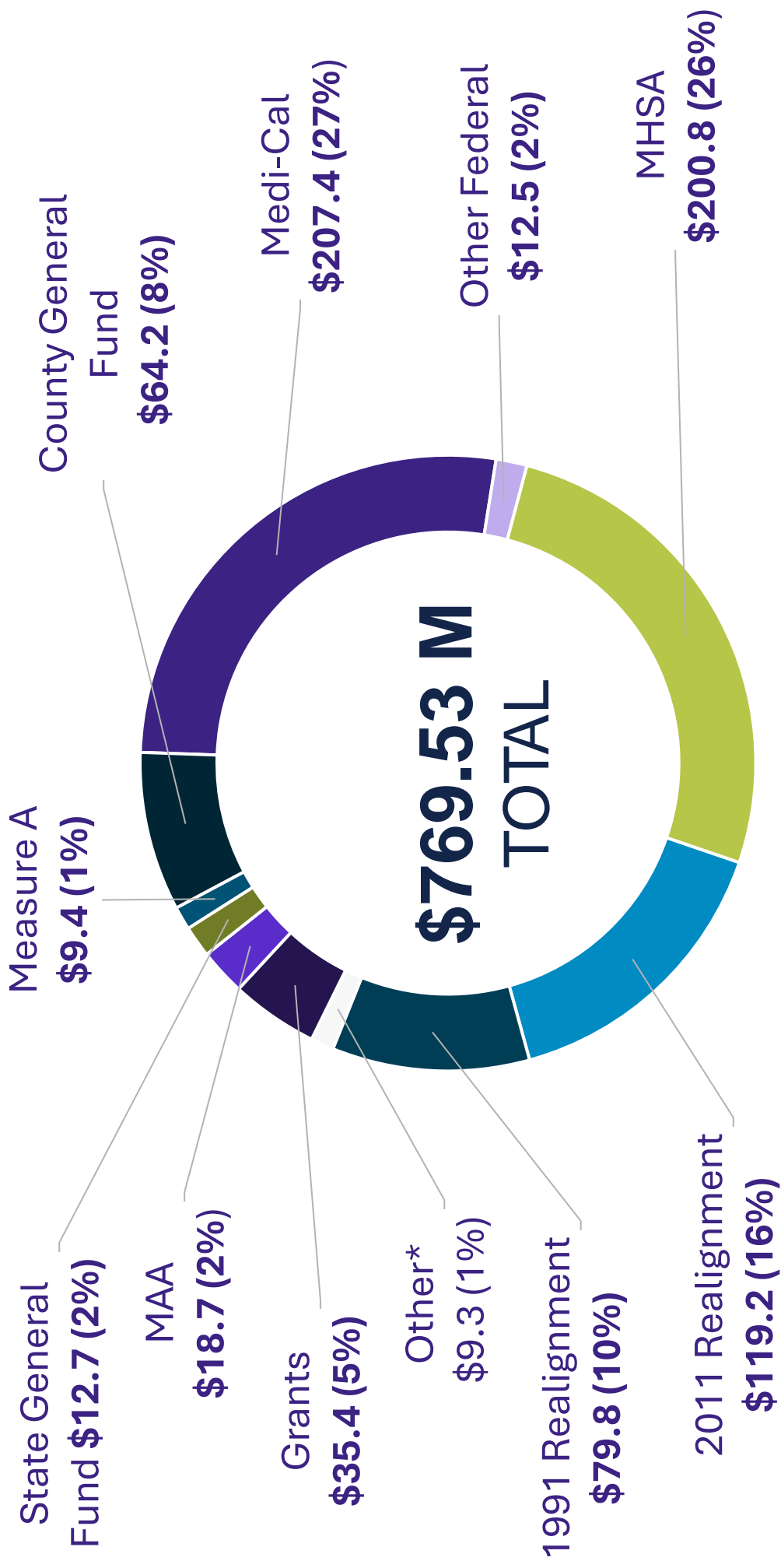
ACBHD Fiscal Year 2024-25 Approved Budget

Appropriation by Type (\$ in millions)



* Includes Hospital Finance (Intergovernmental Transfers) and Measure A (included in each Department total)

ACBHD FY 2024-25 Financing by Revenue Source (in Millions)



*Other includes Tobacco Tax Settlement, Motor Vehicle Fees, City of Berkeley, Cost Report Settlements, and more.

ACBHD Major Revenue Sources (in millions)

Funding Sources	Amount	%
Medi-Cal	\$207.4	29.8%
Mental Health Services Act	\$200.8	28.9%
2011 Realignment	\$119.2	17.1%
1991 Realignment	\$79.8	11.5%
Medi-Cal Administrative Activities (MAA)	\$18.7	2.7%
State Grant – Behavioral Health Bridge Housing	\$14.7	2.1%
State General Funds	\$12.7	1.8%
State Grant - Various	\$9.4	1.4%
Opioid Settlement Funds	\$9.2	1.3%
Federal Grant – Substance Use Block Grant	\$9.1	1.3%
Federal Grant - Various	\$3.5	0.5%
All Other Funding Sources	\$11.2	1.6%

Appropriations are also supported by \$64.2M of County General Funds and \$9.4M of Measure A.

ACBHD Budget by Program (in millions)

Programs	Budget	%
Outpatient	\$260.8	33.9%
Administration	\$141.2	18.3%
24-Hour Service	\$117.2	15.2%
Forensic (includes In-Custody programs)	\$54.7	7.1%
Full-Service Partnership	\$39.7	5.2%
Client Support Services	\$34.1	4.4%
Day Treatment	\$28.0	3.7%
Authorization/Referral/Eligibility	19.9	2.6%
Prevention	\$19.2	2.5%
Outreach	\$18.7	2.4%
Opioid Treatment Program	\$11.9	1.5%
Innovation	\$6.6	0.9%
Residential	\$6.4	0.8%
Legal Advocacy	\$4.0	0.5%
Other	\$7.0	1.0%
TOTAL	\$769.53	100%

Questions?

Thank you!