YOLO COUNTY
Health & Human Services Agency

Behavioral Health Services Act (BHSA)

Integrated Plan

2026-2029

YOLO COUNTY
Health & Human Services Agency
Resource · Partner · Support System

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The Yolo County 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan comes forward at a moment of meaningful transformation – and opportunity – for California's public behavioral health system. With voter approval of Proposition 1 in March 2024, the longstanding Mental Health Services Act has evolved into the Behavioral Health Services Act (BHSA), opening the door to a more responsive, inclusive, and person-centered system of care. This new framework strengthens our ability to serve those with the most significant behavioral health needs, while expanding access to substance use disorder treatment, deepening investments in housing, supporting a stronger workforce, and advancing transparency and accountability across county programs.

At the same time, these changes challenge us to think differently – and better – about how we deliver care. While counties must navigate new funding structures, increased administrative responsibilities, and ongoing workforce and fiscal pressures, these shifts also create space to reimagine a system that more effectively reaches those who have too often been left behind. The new funding model, organized into: Full-Service Partnerships; Behavioral Health Services and Supports; and Housing Interventions, provides a clearer pathway to align resources with the people and outcomes most in need.

In Yolo County, we see this not just as a transition, but as a call to action. We are committed to building a more equitable and compassionate system that prioritizes outreach, engagement, and connection to care, especially for individuals experiencing homelessness and those with complex behavioral health needs. By strengthening pathways into treatment and housing, expanding targeted services, and investing in innovative approaches, we aim to meet people where they are and support lasting recovery and stability. This plan is grounded in the voices of our community. We are deeply grateful to the many residents, partners, and stakeholders who shared their experiences, ideas, and hopes for a better system. Your input has shaped a plan that reflects both the urgency of today's challenges and the promise of what we can achieve together.

Looking ahead, the Yolo County Health and Human Services Agency remains steadfast in its commitment to collaboration, innovation, and shared accountability. Together, we are building a behavioral health system that is more responsive, more coordinated, and more centered on the dignity and potential of every individual we serve. This is our vision for the future – stronger, more connected, and grounded in resilience – the Yolo way.

In partnership,

Tony Kildare, LCSW

Behavioral Health Director

2026 - 2029 Integrated Plan

Yolo County

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

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Yolo County

Behavioral Health Agency Name
Yolo County Health and Human Services Agency

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County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	1086
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	000
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	<11*
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	1088

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	<11*
Were chronically homeless or experiencing homelessness or at risk of homelessness	764
Were in the juvenile justice system	198
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	104
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	185

Adults and Older Adults

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

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	433
Received Medi-Cal SMHS	1806
Received DMC or DMC-ODS services	704
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	192
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	891

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	626
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	265
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	551
Were in the justice system (on parole or probation and not currently incarcerated)	1599
Were incarcerated (including state prison and jail)	276
Reentered the community from state prison or county jail	167
Received acute psychiatric services	108

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

Admitted or detained for 72-hour evaluation and treatment rate

1331

Admitted for 14-day and 30-day periods of intensive treatment
672

Admitted for 180-day post certification intensive treatment
73

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
<11*

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
<11*

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

Please explain
Table 5
Data Availability and Context:

The state's reporting requirements encompass several important indicators for understanding youth behavioral health needs. While comprehensive data specific to Behavioral Health service utilization are not readily available for all requested metrics, we have compiled the best available proxy data from partner agencies and systems to provide meaningful context. The following narratives describe the data sources used and acknowledge current limitations.

…Were chronically homeless or experiencing homelessness or at risk of homelessness: County schools report 764 students experiencing homelessness (2.5% of total enrollment), with 220 students (28.8%) in highly unstable situations including emergency shelters, hotels/motels, and unsheltered settings. These figures reflect the total homeless student population rather than the subset served by Behavioral Health, as BH-specific utilization data are currently unavailable. Research indicates that youth experiencing homelessness have elevated rates of mental health and substance use needs, and this data can inform targeted outreach strategies even as the county works to develop systems for tracking BH service utilization within this population.

…Were in the juvenile justice system: In 2024, 198 youth were referred to Probation Services (including both

in-custody and out-of-custody referrals), though data specific to those who received Behavioral Health services are not currently available. This total provides a benchmark for understanding the scale of justice-involved youth in the county and can help inform capacity planning and service development efforts for this population.

…Have reentered the community from a youth correctional facility: The number of youth released from State Youth Treatment Facilities is redacted due to small population size (fewer than 10 individuals), consistent with historically low numbers reported in county plans. This small population size is a positive indicator and reflects successful diversion and community-based intervention efforts within the county's youth services system.

Table 6
Data Availability and Context:
The state's reporting requirements encompass several important indicators for understanding adult and older adult behavioral health needs. While comprehensive data specific to Behavioral Health service utilization are not readily available for all requested metrics, we have compiled the best available proxy data from partner agencies and systems to provide meaningful context. The following narratives describe the data sources used, acknowledge current limitations, and outline the datasets that can help inform service planning efforts.

…Were chronically homeless, or experiencing homelessness, or at risk of homelessness / Experienced unsheltered homelessness: The 2024 Continuum of Care (CoC) Homeless Populations and Subpopulations Report documents the total adult homeless population and the subset experiencing unsheltered homelessness, though data specific to those who received Behavioral Health services are not currently available. These figures provide important context for understanding the scale of homelessness locally and highlight the most vulnerable individuals who may benefit from targeted outreach and behavioral health services.

… Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing): The 2024 CoC report documents adults in emergency shelters or transitional housing at the time of reporting, though it is not possible to determine how many previously experienced unsheltered homelessness or when they entered shelter. This figure provides a snapshot of shelter utilization but does not capture transitions into permanent housing or the pathways individuals took to reach emergency or transitional settings. Additionally, the reported value reflects the adult unhoused population, not the subset who were served by Behavioral Health.

…Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing: California System Performance Measure M3 ("Exits to Permanent Housing") reflects total exits to permanent housing rather than specifically those who moved from unsheltered situations. While this metric differs from the state's specified indicator, it provides valuable

context about successful housing placements and system performance in supporting housing stability. Additionally, the reported value reflects the adult unhoused population, not the subset who were served by Behavioral Health.

…Were in the justice system (on parole or probation and not currently incarcerated): The Yolo County Community Corrections Partnership Annual Report (2023-2024) documents individuals under felony probation supervision. This total provides a benchmark for understanding the scale of community supervision and can help inform service coordination efforts between corrections and behavioral health systems. The reported value reflects the total justice-involved population, not the subset who were served by Behavioral Health.

… Reentered the community from state prison or county jail: The CDCR Recidivism Dashboard reflects individuals who reentered the community from state prison. Though the reported value reflects the total reentry population, not the subset who were served by Behavioral Health, and does not include releases from county jail, this data provides context for understanding the scale of reentry from state facilities.

Please describe the local data used during the planning process
The county primarily used the data provided by DHCS and the CalMHSA dashboards, in combination with local data in the county's electronic health record system.

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

Local CARE Act Implementation

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.
Yolo County will support CARE Court participants through existing Full-Service Partnership (FSP) and intensive community-based behavioral health services identified within the County's three-year Integrated Plan. CARE participants who meet medical necessity and program eligibility criteria will be prioritized for enrollment into FSP services, ensuring access to comprehensive treatment, rehabilitation, and recovery supports.
FSP services available to CARE participants include:
• Intensive care coordination and case management
• Psychiatric assessment and medication support
• Individual and group behavioral health treatment
• Substance use disorder screening, treatment, and recovery support services

• Peer support services
• Benefits acquisition and linkage
• Housing navigation and tenancy sustaining services
• Crisis intervention and stabilization services
• Employment, educational, and community integration supports

CARE participants will receive coordinated service planning. Individuals experiencing homelessness or housing instability will receive priority consideration for available housing resources and housing-related services consistent with program eligibility requirements.

The County will utilize existing behavioral health care coordination structures to ensure timely engagement, service linkage, monitoring of CARE Agreement goals, and ongoing communication among treatment providers and court partners.

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

Yolo County will integrate CARE referrals into existing behavioral health access, outreach, assessment, and service delivery pathways. Referrals originating through CARE Court petitions will be coordinated through the County's CARE team and Behavioral Health Access processes to ensure individuals receive timely screening, assessment, and linkage to appropriate services.

CARE participants will enter the behavioral health continuum through established pathways that may include:

• Behavioral Health Access and Crisis Services
• Full-Service Partnership (FSP) programs
• Assisted Outpatient Treatment (AOT), when appropriate
• Specialty Mental Health Services
• Substance Use Disorder treatment services
• Homeless outreach and engagement teams
• Collaborative court programs
• Community-based behavioral health providers

The County will leverage existing referral, care coordination, and case conferencing processes to minimize duplication of services and ensure seamless transitions between levels of care. CARE participants will be tracked and monitored through established behavioral health care coordination processes to support engagement, service utilization, and progress toward recovery goals.

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

Yolo County recognizes that some individuals who may initially be considered for CARE Court may be more appropriately served through existing behavioral health programs and services without the need for a formal CARE petition. When appropriate, the County will utilize a clinical review and care coordination process to identify alternative service pathways that can meet the individual's needs in the least restrictive and most clinically appropriate manner.

Potential alternative pathways may include:

- Full Service Partnership (FSP) services
- Assisted Outpatient Treatment (AOT)
- Specialty Mental Health Services
- Crisis services and stabilization programs
- Substance Use Disorder treatment services
- Homeless outreach and engagement services
- Community-based behavioral health treatment and support services

For individuals redirected from CARE, the County will document referral outcomes through existing clinical documentation and care coordination processes. Successful connection to services may be confirmed through completed assessments, enrollment in services, attendance at initial appointments, acceptance into treatment programs, housing placement activities, or documented engagement with assigned providers.

County Behavioral Health Technical Infrastructure

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

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

Yes

Please select which of the following EHRs the county uses
Netsmart

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

Please select which QHIO the county participates in
SacValley MedShare

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://www.yolocounty.gov/home/showpublisheddocument/81307/638960469490712788

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

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

County Behavioral Health System Service Delivery Landscape

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

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

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
No

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

Community Mental Health Services Block Grant (MHBG)

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

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

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

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

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

Please select all set-asides that the county behavioral health system participates in under SUBG

Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside

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

No

Opioid Settlement Funds (OSF)

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

Yes

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

Address The Needs of Criminal Justice-Involved Persons
Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)
Training

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

No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
Not Applicable

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

Public Safety Realignment (2011 Realignment)

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

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

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
Peer Support Services

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

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

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

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

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

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

Other Programs and Services

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

Program or service
Department of State Hospitals Incompetent to Stand Trial Diversion Program
Department of State Hospitals Jail Based Competency Treatment Program

PATH JI

Neighborhood Court Expansion

CARE Court

Mental Health Student Services Act Grant (MHSSA)

BSCC- Proposition 47

Behavioral Health Bridge Housing (BHBH)

Care Transitions

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

Yes

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

Yes

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

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

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

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Not Applicable

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Access to Care PowerBI Dashboards, which utilizes 2022 data.

SMHS Penetration Rates [Adults] – Demographic groups performing below the county rate (2.5%) are residents aged 69+ (1.2%), Females (2.0%), Hispanic (1.2%), Asian or Pacific Islander (0.8%), and residents with races other than those specified by the U.S. Census (2.0%).

SMHS Penetration Rates [Youth] – Demographic groups performing below the county rate (3.5%) are children aged 0-2 (0.7%), 3-5 (2.4%), 6-11 (3.3%), Males (3.3%), Asian or Pacific Islander (1.1%), Hispanic (2.7%), residents with races other than those specified by the U.S. Census (2.4%), and residents with unknown race/ethnicity (3.2%).

NSMHS Penetration Rates [Adults] – Demographic groups performing below the county rate (15.4%) are residents aged 57 – 68 (14.0%), 69+ (10.0%), Males (11.4%), and Asian or Pacific Islander (8.3%), Hispanic (13.3%), residents with races other than those specified by the U.S. Census (11.6%), individuals whose written language is Spanish (10.0%), Russian (7.9%), Other Non-English language (10.3%), and unknown written language (10.1%)

NSMHS Penetration Rates [Youth] – Demographic groups performing below the county rate (18.3%) are children aged 3-5 (12.3%), 6-11 (14.5%), 18-20 (15.8%), Females (18.0%), Asian or Pacific Islander (14.6%),

Hispanic (18.2%), residents with races other than those specified by the U.S. Census (14.3%), individuals whose written language is Spanish (17.4%), and whose written language is Russian (7.8%).

DMC-ODS [Adults] – Demographic groups performing below the county rate (1.5%) are Hispanic/Latino (0.8%) and Asian/Pacific Islander (0.3%) residents.

Access to care: Cross-Measure Questions

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

Yolo County Behavioral Health (BH) currently uses a level of care tool for all members seeking substance use disorder (SUD) treatment services, and uses a screening tool for youth seeking mental health treatment. While the LOCUS assessment is used for adult members seeking mental health, Yolo County has an opportunity standardize the use of level of care tools (for youth, adults and older adults) in the context of the system of care as outlined in the Behavioral Health Services Act, specifically for Full Service Partnership programs. Behavioral Health will train staff and develop policy and procedures for its consistent use across the entire Behavioral Health system of care. Using this tool will allow Behavioral Health to ensure equitable access to care, and enable the BH plan to identify potential access needs and actionable strategies to strengthen the full specialty mental health services (SMHS) continuum of care. With the expansion and requirement of evidence-based practices within the Full Service Partnership program, using the LOCUS consistently will ensure adults and youth are appropriately triaged into the level of care that best meets their clinical need.

To address the disparities identified in SMHS specific to older adults and youth Yolo County BH will strengthen partnerships with community groups/organizations. In Behavioral Health- Early Interventions, HHSA will continue working closely to provide access points for SMHS for youth through the Early Childhood Mental Health Access & Linkage Program and the K-12 School Partnership Programs. Both of these programs and partnerships engage children and families in the community to provide an access point for SMHS. To address the disparities impacting older adults, HHSA intends to formalize a partnership with the Yolo Adult Day Health Centers to conduct outreach efforts to further engage these members to provide access to SMHS.

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Please identify the category or categories of funding that the county is using to address the access to care goal
BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
2011 Realignment
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
State General Fund

Homelessness: Primary measures

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

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

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

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

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

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

Homelessness: Supplemental Measures

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

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

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

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

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

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

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

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

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

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

People Experiencing Homelessness PIT Count –Demographic groups performing below the County rate (42.7 per 10,000) are residents age 25-34 (57.8), 35-44 (78.5), 45-54 (85.3), 55-64 (84.0), males (55.4), Alaskan Native or American Indian (316.4), Black (197.2), and White (54.1) residents.
Homeless Student Enrollment by Dwelling Type –Demographic groups performing above the County rate (2.4%) are county residents who identified as Alaskan Native or American Indian (11.9%), African American (6.5%), Hispanic or Latino (3.0%), youth identifying as two or more races (2.5%), youth in transitional kindergarten (3.0%), Kindergarten (2.8%), Grades 1 (2.6%), 2 (2.5%), 5 (2.7%), 9 (3.0%), 11 (2.6%) and 12 (2.8%), English language learners (4.1%), migrant students (3.9%), and students with disabilities (2.6%).
People Experiencing Homelessness Who Accesses Services from CoC – Demographic groups performing below the county rate (70 per 10,000) are residents 18-24 (19), 65+ (23), 25-34 (46), 55-65 (64), 45-54 (64), cisgender men (46), cisgender women (46), Asian or Asian American residents (5), White residents (42), and Hispanic/Latina/e/o (47).

Homelessness: Cross-Measure Questions

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

Yolo County Behavioral plans to implement a Housing Interventions Program that will operate in coordination with the Homeless Outreach and Enhanced Care Management (ECM) Team. The Outreach/ECM team will serve as the primary entry point, connecting unhoused individuals, including those in encampments—to physical health, behavioral health, and social services. This team will work concurrently with the Yolo County Homeless Continuum of Care (CoC) system to link clients to interim housing and place them on the community queue through the Coordinated Entry System for the opportunity of permanent housing. As part of their role, the Outreach/ECM team will ensure that individuals fully utilize all available community supports before transitioning them through a warm handoff to the Housing Interventions Team.

The Housing Interventions Team will focus on individuals who have either exhausted available community supports or individuals that are not eligible for CS but remain eligible under BHSA. This team will provide critical financial and housing-related assistance, including security deposits, application fees, participant assistance funds, and other housing supports. In addition, the team will emphasize housing stabilization services and proactive landlord engagement to support long-term housing retention. Data from the 2024 Point-in-Time (PIT) Count highlights the urgency of this approach: 40.8% of individuals were identified as chronically homeless, and 47% reported either severe mental illness (192 of 942) or chronic substance use disorder (251 of 942). By integrating the Housing Interventions Program with the Homeless Outreach/ECM Team, Yolo County will create a more seamless and coordinated system that aligns Homeless and Housing Services across the Continuum of Care, CalAIM services, and behavioral health programs. This integrated approach will ensure that appropriate funding streams are leveraged effectively, clients receive the right level of care, and systems are better aligned. Ultimately, this model aims to reduce homelessness, improve service coordination, and provide individuals with the supports necessary to achieve and maintain stable housing.

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

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

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

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

Conservatorships, FY 2021 - 2022

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

Temporary Conservatorships
Not Applicable

Permanent Conservatorships
Above

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

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

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Below

For children/youth
Not Applicable

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

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Institutionalization PowerBI Dashboards.

SMHS Crisis Utilization, Crisis Intervention for Adults (DHCS), FY 2023 – Compared to the County average (132.2 minutes), higher rates of crisis intervention service utilization exist for the following groups: adults age 21 – 32 (153.5), 33 – 44 (172.7), and 45 – 56 (133.2); Black (144.0), Hispanic (162.9), White (163.2), and a race other (151.0) than those identified by the U.S. Census; females (157.0), males (149.8); and individuals whose primary written language is English (155.2).
SMHS Crisis Utilization, Crisis Intervention for Children/Youth (DHCS), FY 2023 – Compared to the County average (152.0 minutes), higher rates of crisis intervention service utilization exist for the following groups: children age 12 – 17 (213.52) and 18-20 (157.99); Hispanic (188.6) and White (191.4); females (235.7), males (165.4); and individuals whose primary written language is English (222.8).
SMHS Crisis Utilization, Crisis Residential for Adults (DHCS), FY 2023 – Compared to the County average (14.6 days), higher rates of crisis residential treatment services exist for the following groups: White (16.7) and males (15.9).
SMHS Crisis Utilization, Crisis Stabilization for Adults (DHCS), FY 2023 – Compared to the County average (19.3 hours), higher rates of crisis stabilization service utilization exist for the following groups: adults age 21 – 32 (21.2); White (22.8) ; females (20.3), males (24.0); and individuals whose primary written language is English (23.0).

Institutionalization: Cross-Measure Questions

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

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Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)
Yolo County Behavioral Health is initiating a pilot program with WellSpace Heath Crisis Receiving for Behavioral Health to offer 24/7, voluntary, short-term (4-12 hours, up to 24) care for individuals with mental health or substance use crises. The crisis receiving center is a therapeutic alternative to hospitals or jail, featuring medical monitoring, and crisis stabilization. There is an intersection of this program with the larger Yolo County Crisis Continuum. It will be through interactions with the crisis clinicians and/or law enforcement that individuals may access the crisis receiving beds. Expanding the continuum of care to include crisis receiving beds allows for crisis staff to address an individual's crisis at the lowest level of intervention that is clinically appropriate. Expanding this level of care in the larger system of care should reduce institutionalization by having an alternative to hospitalization or jail when someone is in an acute crisis.

Additionally, the expanded levels of care within the Full Service Partnership Programs is another program that may impact institutionalization. Again, by expanding the levels of care, and providing services at the level of care clinically indicated, fewer individuals should need to be hospitalized because their behavioral health needs can be met through ACT, FACT or FSP-ICM.

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Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
BSCC Grant, Local cities, local hospitals

Justice-Involvement: Primary Measures

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

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

For adults/older adults
Below

For juveniles
Below

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

Justice-Involvement: Supplemental Measures

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

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

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

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

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

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

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
For all measures, disparity data were extracted from the CalMHSA Justice-Involvement PowerBI Dashboards. Data for Adult Recidivism Conviction Rate was sourced from the CDCR convictions dashboard. Adult Arrest Rates – Adult demographic groups performing above the County rate (2,137 per 100,000) include adults aged 40 – 69 (2,709), adults aged 30 – 39 (5,878), and adult males (4,003).

Juvenile Arrest Rates – Juvenile demographic groups performing above the County rate (224 per 100,000) include juvenile males (480).

For this measure, race/ethnicity-stratified rates are only available at the population level. The overall Yolo County population rate for adults and juveniles is 2,102 per 100,000.

At the population-level, the following demographic groups have higher arrest rates than the county: Black (10,720) and Hispanic (2,369) residents specifically, Black females (5,512), Black males (16,185), and Hispanic males (3,887). Arrest rates of White males (5,815) were also higher than the overall County rate.

Adult Recidivism Conviction Rate –Compared to the county recidivism rate (32.3%), individuals aged 30 – 35 (37.8%) and 35 – 39 (51/5%) are Males (51.6%), Black/African American (35.5%), and White individuals (35.3%) also had higher three-year adult recidivism conviction rates compared to the County. Additionally, males (32.5%) had a higher recidivism rate than the County.

Justice-Involvement: Cross-Measure Questions

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

Yolo County has invested in several initiatives to reduce the level of justice-involvement for those living with significant behavioral health needs. Those programs include, the Department of State Hospitals IST diversion program, the Jail Based Competency Program, Mental Health Court, Addiction Intervention Court, the Justice Assistance Grant, which is an expansion of Neighborhood Court, CARE court, and the EASS program coupled with SUD in-custody programming and our jail health partners, Wellpath/Recovery Solutions. Upcoming we are launching CalAIM PATH JI/reentry services, Prop 36 partnership utilizing the BH Prop 36 RFI funding, and have begun collaboration with CDCR for their reentry initiatives.

In response to identified disparities, Yolo County Behavioral Health will implement the following strategies beginning July 1, 2026:

• Expand pre-arrest, pretrial, and post-booking diversion programs to reduce entry into the justice system. Efforts will prioritize populations with elevated arrest rates, including adult males and communities of color.

• Implement Forensic Assertive Community Treatment (FACT), FSP, and intensive case management services to serve individuals with complex behavioral health needs who are at high risk of recidivism. These services will focus on individuals with repeated justice system involvement.

• Address racial and ethnic disparities by expanding culturally responsive behavioral health services and strengthening partnerships with community-based organizations serving Black and Latino populations/communities.

• The County will strengthen reentry services through the CalAIM PATH JI and CDCR JI initiatives improving coordination between custody and community-based care. Utilizing ECM, access to housing and supportive services with a focus on high-risk populations.

• Address elevated juvenile arrest rates among males, expanding early intervention and increased opportunities to connect to services to improve long-term outcomes.
Where County performance falls below statewide averages or medians, these targeted investments are designed to:
• Reduce arrest rates among disproportionately impacted demographic groups
• Decrease recidivism among high-risk adult populations
• Improve equitable access to behavioral health services
• Strengthening early intervention pathways for youth

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

Removal Of Children from Home: Primary Measures

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

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

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

Removal Of Children from Home: Supplemental Measures

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

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Children in Foster Care PIT Count – Disparity data were extracted from the CalMHSA Removal of Children from Home PowerBI Dashboards. Yolo County children two years old or younger (under 1 = 1,163; 1 to 2 = 736) are placed in foster care at a rate higher than the County overall (512 per 100,000 children).

Open Child Welfare Cases SMHS Penetration Rate – Disparity data were extracted from the CalMHSA Removal of Children from Home PowerBI Dashboards. Demographic groups performing below the County rate (42.0%) are males (42.2%); youth aged 0 – 2 years old (12.5%), 3 – 5 years old (42.5%), 18 – 20 years old (42.5%); Hispanic youth (39.5%), and Black youth (42.1%).

Child Maltreatment Substantiations – Disparity data were extracted from the California Child Welfare Indicators Project (CCWIP) as this data source contained more recent data (2024) compared to the CalMHSA Dashboard (2022). Demographic groups performing above the County rate (7.1) are youth under 1 (27.6), 1 - 2 years old (11.3), 3 – 5 years old (8.0); Black (45.0) youth; and females (7.6).

Removal Of Children from Home: Cross-Measure Questions

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

Yolo County has age-related disparities for entries of children to foster care and substantiations of abuse or neglect. To some degree, this disparity is expected because younger children (especially those 0-5) lack protective capacity and are in need of greater protection from CWS when there is a safety risk. To address this priority goal, with a focus on the age-related disparity, the County will be funding the Early Childhood Mental Health Access and Linkage (ECMH) program under the BHSS Early Intervention component. The ECMH Access and Linkage program is also known as "Help Me Grow" and is currently operated by Yolo First 5. The Help Me Grow program emphasizes a reduction in mental illness in children and youth through social, emotional, developmental, and behavioral services and supports in early childhood. The program includes outreach, access and linkage to care and mental health early treatment and services.

Early Intervention is critical for preventing the need for children to enter the CWS system and supportive in successful transition out of the CWS system. Addressing developmental needs early can improve children's ability to succeed in school, form healthy relationships, and reduce long-term mental health challenges—factors that are critical for family reunification and placement stability. Children with disabilities are 2–3 times more likely to experience abuse or neglect than children without disabilities, largely due to increased caregiver stress and unmet support needs (CDC; U.S. Department of Health & Human Services). 72% of the CWS-involved children served by HMG scored in the "monitor" or "concern" range in at least one developmental area, compared to 52% of children without CWS involvement. The differences are stark in areas such as social emotional, personal social, and program solving development. This is a population at high risk for early mental health concerns. For children in the foster care system, addressing developmental needs early can improve children's ability to succeed in school, form healthy relationships, and reduce long-term mental health challenges—factors that are critical for family reunification and placement stability.

In terms of Early Intervention, national evidence shows that many children are not identified with developmental delays until after child welfare involvement, when BH needs are more severe and interventions are more costly—highlighting the importance of early, community-based screening and referral systems. HMG can assist by screening the population at-risk for CWS involvement and reduce entry or re-entry rates.

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Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA BHSS

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Above

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

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

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

For the full population measured
Below

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Below

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

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Disparity data were extracted from the CalMHSA Untreated Behavioral Health Conditions PowerBI Dashboards.

Adults Who Needed Help – Compared to the County rate(41.0%), rates for adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in the past year are higher among residents aged 65+ (42.6%) and Asian (59.3%) residence. Looking across race and sex, Asian males (81.0%), Asian females (49.4%), and Latino females (43.2%) all had higher rates than the County.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
To address the primary goal of Follow up After Emergency Department Visits - Mental Illness, the county is implementing policy and procedure to improve this measure. The County convened a workgroup to evaluate current processes and identify strategies to improve outcomes. The purpose of this workgroup is to develop a plan that addresses identified barriers and supports improved performance on the measure.

As part of this effort, a resource guide has been developed to instruct clinical staff to conduct follow-up with

each client referred after psychiatric hospitalization within 30 days of discharge and to attempt to provide a service that qualifies for inclusion in the FUH performance measure. This guidance will be distributed to the County's provider network to promote consistent protocols and support improvement in FUH performance.
Additionally, when the County submits referrals for Specialty Mental Health Services (SMHS) following hospitalization, the referral will clearly highlight the discharge date and include relevant guidance to ensure timely follow-up.

Finally, the Behavioral Health Department will provide training to internal staff and contracted providers to reinforce this guidance and standardize follow-up practices. Through the implementation of clear written guidance and targeted training, the County aims to improve the rate of follow-up visits following psychiatric hospitalization.

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Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
Federal Financial Participation (SMHS, DMC/DMC-ODS)
2011 Realignment
BHSA FSP
BHSA BHSS

Additional statewide behavioral health goals for improvement

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

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

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

Care Experience: Primary Measures

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

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

For adults/older adults
Below

For children/youth
Below

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

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

For adults/older adults
Above

For children/youth
Not Applicable

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

For the full population measured
Below

For adults/older adults
Below

For children/youth
Below

Overdoses: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

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

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

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

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

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

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

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Below

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Below

Suicides: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

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

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Care experience

Care experience

Please describe why this goal was selected
Yolo County has selected Care Experience as the 7th additional goal based on performance data indicating that the county does not meet the state benchmark for Perception of Cultural Appropriateness/Quality Domain Score. This applies to families of youth, youth, and adults receiving behavioral health services. Data for older adults is not currently available.

Performance below the benchmark in cultural appropriateness may affect service engagement, treatment

retention, and outcomes. For Yolo County's diverse population, improving cultural appropriateness can support better access to and experience with behavioral health services. Cultural appropriateness is a component of effective behavioral health care, and evidence indicates that culturally responsive services are associated with improved engagement, retention, and outcomes. When clients experience services as aligned with their cultural values and context, they may be better positioned to participate in their care and recovery.

Selecting Care Experience as an additional goal aligns with state priorities around health equity and person-centered care. Focusing on cultural appropriateness allows Yolo County to support trust-building between behavioral health services and community members, address potential barriers to care for diverse populations, enhance service quality and client experience, inform clinical practice and outcomes across demographic groups, and support workforce development in cultural responsiveness.
By prioritizing Care Experience with a focus on cultural appropriateness, Yolo County aims to improve performance relative to the state benchmark. This goal will inform service delivery practices, staff training, community partnerships, and incorporation of client feedback in system planning. The county's objective is to ensure that individuals seeking behavioral health services experience care that is respectful and responsive to their cultural context.

Additionally, Yolo County selected Care Experience, focusing on Perception of Cultural Appropriateness because the need for cultural responsiveness was identified as a theme in the Community Program Planning process. Non-English speaking populations face significant difficulties accessing therapeutic services due to insufficient multilingual provider capacity. Immigrant communities experience distrust of systems and fear related to immigration enforcement, leading to disengagement from services. Generational attitudes create stigma, particularly among older adults. Services designed without cultural input fail to effectively reach and serve diverse populations. While the community planning findings don't specifically address 'perception of cultural appropriateness', the community has identified a need for cultural responsiveness.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
No disparity data available.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Care experience and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Yolo County will address the perception gap through targeted community engagement. Doing this, we will

investigate why overall cultural appropriateness perceptions (Consumer Perception Survey scores) are lower than state averages despite strong treatment experience ratings. Conduct listening sessions with families of youth, adolescents, adults, and community members who are not currently receiving services to identify barriers related to outreach, accessibility, facility environment, language access, and community trust. Use findings to implement low-cost improvements such as culturally relevant marketing materials, multilingual signage, community office hours in trusted settings, and partnerships with cultural brokers

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

BHSA BHSS
BHSA FSP
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

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

Stakeholder Engagement

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

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

Key informant interviews with subject matter experts
Focus group discussions
Survey participation
County outreach through social media
Meeting(s) with county
Workgroups and committee meetings
Other

Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders

A Yolo BHSA Community Engagement Work Group (CEWG) was held on September 10, 2025 to officially kick off the stakeholder engagement process including education and outreach related to community planning. Four online listening sessions were conducted via Zoom between September 24, 2025 and October 16, 2025. Each 90-minute session focused on one of the BHSA's main funding components: Full Service Partnerships (FSP), Behavioral Health Services and Supports (BHSS), and Housing Interventions (HI). Due to scheduling conflicts around a holiday and to ensure maximum participation, two sessions were held for the Housing Interventions component. A total of 144 participants attended across all sessions. Each session followed a structured format designed to promote transparent, two-way dialogue between the county and community stakeholders. A tailored presentation guided each conversation and included:
1. Educational Overview – Introduction to the BHSA, the CPP, and services included under the specific funding component being discussed
2. Data Transparency – Presentation of Yolo County's current performance on behavioral health goal measures related to the component, providing participants with context for understanding service gaps and needs

3. Facilitated Discussion – Structured conversation using discussion questions designed to capture diverse perspectives on the data and its implications for local communities

Additionally, the county completed 35 key informant interviews, held six focus groups, and received 268 community survey responses. In total, the CPP engaged 514 community members through a combination of data collection efforts, informational sessions, and interviews.

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

Type of engagement
Workgroups and committee meetings

Date
9/10/2025

Type of engagement
Meeting(s) with county

Date
9/24/2025

Type of engagement
Meeting(s) with county

Date
9/30/2025

Type of engagement
Meeting(s) with county

Date
10/2/2025

Type of engagement
Meeting(s) with county

Date
10/16/2025

Type of engagement
Focus group discussions

Date
11/5/2025

Type of engagement
Focus group discussions

Date
11/5/2025

Type of engagement
Focus group discussions

Date
11/17/2025

Type of engagement
Focus group discussions

Date
11/18/2025

Type of engagement
Focus group discussions

Date
11/20/2025

Type of engagement
Survey participation

Date
9/15/2025

Type of engagement
Survey participation

Date
10/2/2025

Type of engagement
Survey participation

Date
11/6/2025

Type of engagement
Survey participation

Date
11/19/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/14/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/20/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/22/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/24/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/27/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/28/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/30/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/3/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/4/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/5/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/7/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/10/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/18/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/20/2025

Type of engagement
Key informant interviews with subject matter experts

Date
11/21/2025

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

Date
8/27/2025

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

Date
9/3/2025

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

Date
9/15/2025

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

Date
10/2/2025

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

Date
2/10/2026

Type of engagement
County outreach through social media

Date
9/16/2025

Type of engagement
County outreach through social media

Date
9/24/2025

Type of engagement
County outreach through social media

Date
9/30/2025

Type of engagement
County outreach through social media

Date
10/9/2025

Type of engagement
County outreach through social media

Date
10/11/2025

Type of engagement
County outreach through social media

Date
10/13/2025

Type of engagement
County outreach through social media

Date
10/14/2025

Type of engagement
County outreach through social media

Date
10/15/2025

Type of engagement
County outreach through social media

Date
10/16/2025

Type of engagement
County outreach through social media

Date
10/18/2025

Type of engagement
County outreach through social media

Date
10/19/2025

Type of engagement
County outreach through social media

Date
10/20/2025

Type of engagement
County outreach through social media

Date
10/23/2025

Type of engagement
County outreach through social media

Date
10/24/2025

Type of engagement
County outreach through social media

Date
10/25/2025

Type of engagement
County outreach through social media

Date
10/30/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Alta CA Regional Center, Brown Issues, Catholic Charities of Yolo-Solano, City of Davis, City of West Sacramento, City of Winters, City of Woodland, CommuniCare+OLE Health Centers, Davis Community Meals, Empower Yolo, Esparto Community Services District, First 5 Yolo, Food Bank of Yolo County, Homeless and Poverty Action Coalition (HPAC) – Yolo County, Independent Living Centers, Mercy Housing, MILPA, NAMI Yolo County, NAMI Yolo County, Native Dads Network Inc., Northern Valley Indian Health

(NVIH), Partnership HealthPlan of California, Rise, Inc, Shingle Springs TANF, Stanford Sierra Youth & Families, UC Davis, Student Health & Wellness, Victor Community Support Services, Woodland Ecumenical and Multi-faith Ministries, Woodland Memorial Hospital, Yolo Adult Day Health Center, Yolo County Child Abuse Prevention Council, Yolo County Children's Alliance (YCCA),Yolo County Commission on Aging & Adult Services, Yolo County District Attorney, Yolo County District Attorney Victim Services, Yolo County Emergency Medical Services Agency, Yolo County Health and Human Services Agency (HHSA), Yolo County Health Council, Yolo County Housing Authority, Yolo County Labor Unions, Yolo County Law Enforcement, Yolo County Library, Yolo County Maternal Child Adolescent Health Advisory Board, Yolo County Office of Ed- Head Start, Yolo County Office of Education-Youth Civic Initiative & Youth Commission, Yolo County Probation, Yolo County Provider Stakeholder Work Group, Yolo County Public Authority, Yolo County School Districts, Yolo County Substance Use Disorder System Provider Work Group, Yolo County Transportation Department, Yolo County Veterans Services Office, Yolo Family Strengthening Network, Yolo Interfaith Immigration Network, Yolo People Power, Yolo Rainbow Families-Davis Phoenix Coalition, Yolo Veterans Services Office, YoloCares

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

	City name
1	Davis
2	Woodland
3	West Sacramento
4	Winters
5	

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

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Yolo County employed a comprehensive and inclusive approach to community engagement in the

development of the BHSA Integrated Plan. Broad, ongoing input from diverse community stakeholders served as a foundation for shaping the plan. Yolo held a BHSA Community Engagement Work Group (CEWG) kickoff meeting, completed 35 key informant interviews, held six focus groups, and received 268 community survey responses. In total, the CPP engaged 514 community members through a combination of data collection efforts, informational sessions, and interviews. The accompanying BHSA Community Planning Process document captures the demographics, diverse stakeholder viewpoints, strengths, and priorities.

Upload File
Yolo BHSA_Community Planning Process Report final (Rev 3.30.26).pdf

Local Health Jurisdiction (LHJ)

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

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Other

Please explain why or describe an alternate approach taken.
The Yolo County Health and Human Services Agency (HHSA) is an integrated agency that includes behavioral health, social services, and public health which serves as the Local Health Jurisdiction (LHJ) and facilitates coordination and collaboration. The Local Health Jurisdiction's (LHJ's) CHA/CHIP (2023-2025) was already established at the time this Integrated Plan was developed. In the absence of a current Community Health Assessment (CHA) or Community Health Improvement Plan (CHIP) in development, BHSA key informant interviews were conducted with the Local Public Health Director and the CHA/CHIP Manager, who oversee local CHA/CHIP efforts. In addition, the LHJ shared available CHA/CHIP resources to inform the BHSA IP plan. There is an update to the CHIP as of January 2026 and the details were informed by community and partner input during the original formation of the CHIP which push forward action items through 2028.

Collaboration

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

Please describe the other way the county collaborated with LHJs and MCPs in developing the CHA/CHIP
County BHSA has partnered with the LHJ through data sharing, key informant interviews, introductions to community collaborators, and early discussions on coordinating future participation in both LHJ and BHSA planning efforts. The Public Health Director also leads the Behavioral Health Services Act (BHSA) community planning process, which includes stakeholder and partner engagement, and provides monthly updates to the County Health Council. Council membership includes representatives from local health systems, ensuring system-wide partners remain informed of activities and have opportunities to participate in all community planning efforts, including BHSA and CHA/CHIP initiatives.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

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

Please describe

Data related to all Behavioral Health goals were shared with CHA/CHIP leadership and managed care plans (Partnership Health and Kaiser) prospectively to inform future planning. BHSA staff will also share integrated plan community stakeholder feedback and recommendations and participate in upcoming CHA/CHIP meetings in spring 2026. These meetings will be used to provide updates, share data and BHSA planning materials, and identify opportunities to braid community feedback and engagement across BHSA planning and CHA/CHIP cycles moving forward.

Was data shared?

Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g.,

counties do not need to conduct each of these activities)
Other

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
The county will engage with the local health jurisdiction through a series of collaborative discovery sessions to share strategies, identify barriers and future opportunities to align and coordinate efforts. BHSA staff will also share integrated plan community stakeholder feedback and recommendations and participate in upcoming CHA/CHIP meetings in spring 2026.

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

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

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
The Local Health Jurisdiction's (LHJ's) Community Health Assessment and Community Health Improvement Plan (CHA/CHIP; 2023-2025) was already established at the time this Integrated Plan was developed. Findings from the CPP aligned closely with priorities identified in the CHA/CHIP (2023-2025), particularly around mental/behavioral health access, housing and homelessness, and adolescent risk behaviors. CHA/CHIP reports were summarized in the CPP to capture health disparities, at-risk populations, community health needs, priorities, and strategic actions. These insights were added to emphasize or expand CPP report findings and recommendations, particularly where quantitative health data reinforced qualitative community-voiced concerns around access barriers and systemic inequities. The LHJ plans to partner with the county through data sharing and community engagement.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

Partnership Health Plan
Kaiser

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

The MCP Community Reinvestment Plan is not due to DHCS until Q3 2026, and early internal discussions have just begun. The plan will involve input from key stakeholders, including the County Behavioral Health and Public Health Directors. Submission is only required if the MCP reports net profits, and currently only Partnership Health Plan will be working on the Community Reinvestment Plan and Kaiser will not be required in this cycle. Given this, it is too early to determine alignment with the BHSA community planning process or the county's Integrated Plan (IP). The county will continue to monitor progress and collaborate with the MCP as planning develops.

Comment Period and Public Hearing

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

Comment Period and Public Hearing

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
4/1/2026

Date the stakeholder comment period closed
4/30/2026

Date of behavioral health board public hearing on draft IP
5/6/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting
Revised Public Comments with Summary and Documentation of Public Hearing_Yolo Draft BHSA IP FY 2629 (Rev 5.15.26).pdf

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page
www.yolocounty.gov/bhsa

File Upload

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

Please specify the other process the draft plan was circulated to stakeholders
Social Media, Email distribution list, County Webpage

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

Stakeholder group that provided feedback
Community, faith, or cultural organization

Summarize the substantive revisions recommended this stakeholder during the comment period
Consideration to fund a range of evidence-based and community-informed approaches as part of implementation and future planning efforts (i.e. Village is Possible-Early Intervention; whole-family approach, complement FSP; complement Housing Interventions).

Stakeholder group that provided feedback
Private Citizen

Summarize the substantive revisions recommended this stakeholder during the comment period
Emphasis on directing resources to individuals in need of housing and behavioral health services (i.e. tighten county budget).

Stakeholder group that provided feedback
Appointee Health Council; Retired Mental Health Provider

Summarize the substantive revisions recommended this stakeholder during the comment period
Recommendation to capture more of the challenges provided by the data and the community plan within the Executive Summary.

Stakeholder group that provided feedback
Healthcare or health plan provider

Summarize the substantive revisions recommended this stakeholder during the comment period
Community concern regarding individuals experiencing homelessness and serious mental illness with emphasis on identifying effective long-term solutions. (e.g. locked facility).

Stakeholder group that provided feedback
Community Provider: Mental health, substance use, or social services provider; Housing; Homeless shelter/resource center/permanent supportive housing

Summarize the substantive revisions recommended this stakeholder during the comment period
Consideration to fund community partners with range to support rental subsidies, participant assistance, “housing shelter,” and navigation services as important components of a comprehensive housing continuum (i.e. Davis Community Meals and Housing).

Stakeholder group that provided feedback
Client/Consumer

Summarize the substantive revisions recommended this stakeholder during the comment period
Importance of the program services provided by National Alliance on Mental Illness (NAMI) in supporting individuals living with mental health conditions and their family members.

Stakeholder group that provided feedback
Mental health, substance use, or social services provider

Summarize the substantive revisions recommended this stakeholder during the comment period
Recommendation to provide additional details on funding allocations (i.e. amount allocated to individual contractors).

Stakeholder group that provided feedback
Community Advocate

Summarize the substantive revisions recommended this stakeholder during the comment period
Recommendation to provide additional details on funding allocations (i.e. amount allocated to individual contractors).
• Recommendations related to community engagement training and technical assistance models (e.g. University of the Pacific Transformational Change Partnership model).
• Opportunities to enhance data, outcomes measurement, and system improvement efforts, for Full-Service Partnership services (i.e. Third Sector Capital).

Stakeholder group that provided feedback
Community Organizations; Community Advocates; Philanthropic Partners

Summarize the substantive revisions recommended this stakeholder during the comment period
Recommendation to provide at least $5 million in funding for rehabilitation of and improvements to existing homes in the continuum of care (i.e. annual $1m/$2m fund balance).
• Develop a prioritization and community engagement process for rehabilitation and improvement of existing housing and other residential care options (i.e. Physical needs assessment contractor funding, prioritize needs, RFP's).
• Fund a long-term study and funding strategy to define the need for additional housing and other residential care options (i.e. $250k).
• Encourage HHSA to develop community partnerships to raise funds to jointly invest in priority projects identified through above referenced recommendations.

Stakeholder group that provided feedback
Person with Lived Experience

Summarize the substantive revisions recommended this stakeholder during the comment period
Personal statement from community member with lived experience on system failures.

Stakeholder group that provided feedback
Community Advocate

Summarize the substantive revisions recommended this stakeholder during the comment period
Recommendation to include a summary describing how HHSA will evaluate outcome measures and assess whether each program achieves its service goals and intended outcomes.

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

Substantive recommendations
N/A

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

Yolo County FY25-26 Final QIP.pdf

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

Yes

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

Yolo County FY25-26 Final QIP.pdf

Contracted BHSA Provider Locations

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

Services Provided	**Number of contracted BHSA provider locations**
Mental Health (MH) services only	12
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	2

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

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	11
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	1

All BHSA Provider Locations

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

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

17

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

Yolo County Behavioral Health is supporting the contracted providers with connecting them to the Managed Care plans for Medi-Cal reimbursement. Contractors are being encouraged by the Behavioral Health department to contract with the MCP, with HHSA providing technical assistance to support providers.

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

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

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

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

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

No

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

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

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

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

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

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

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

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

Please select the service types provided under Program

Mental health services
Substance Use Disorder (SUD) treatment services
Supportive services

Please describe the specific services provided

Yolo County's Adult Outpatient Treatment Program provides accessible, community-based behavioral health services for adults experiencing mild to moderate mental health and/or co-occurring substance use conditions. Services are designed to promote early intervention, stabilization, and recovery, while ensuring alignment with California's Specialty Mental Health Services (SMHS) requirements and other applicable state and federal regulations. Adult Outpatient Services are provided to adults who need this level of care upon entry to services, and as a step down treatment from Full Service Partnership Intensive Case Management (FSP-ICM).

Services are delivered using a whole-person, trauma-informed, and culturally responsive approach that addresses behavioral health needs alongside physical health and social determinants of health. Core services include screening and comprehensive assessment, psychiatric evaluation and medication management, individual and group therapy, crisis intervention, rehabilitation services, targeted case management, and care coordination, consistent with Specialty Mental Health Services (SMHS) service definitions and medical necessity criteria. The program also provides linkage and referrals to community resources, including primary care, housing, employment, and substance use treatment services.

The program emphasizes timely access to care in accordance with Medi-Cal access standards and reduces barriers through flexible service delivery, including in-person and telehealth modalities. Outreach and engagement efforts prioritize individuals who are underserved or experience disparities in access to care.

Services are individualized, recovery-oriented, and guided by evidence-based and evidence-informed practices. Family members and natural supports are included in treatment planning when appropriate and consistent with client choice, confidentiality, and state requirements.

Through collaboration with community-based organizations and cross-system partners, Yolo County's Adult Outpatient Treatment Program ensures coordinated, compliant, and high-quality care that supports improved functioning, wellness, and long-term recovery.

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

Plan Period by FY	**Projected Number of Individuals Served**

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1100
FY 2027 – 2028	1100
FY 2028 – 2029	1100

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

Projections are based on past data pulled from the county's electronic health record system to approximate the numbers served in adult outpatient treatment services. Projections expect that there will be a stable client count served in this program. The expected stability is due to the program operating at, or near maximum capacity, coupled with the potential workforce shortages and contracting budget, preventing the addition of staff or increase in services.

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

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

Please select the service types provided under Program

Mental health services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

This Yolo County Crisis Continuum Services includes both Co-Responder and Mobile Crisis Response services designed to provide timely, community-based support for individuals experiencing mental health or substance use-related crises. County crisis clinicians are embedded with local law enforcement to form co-responder teams that respond to mental health-related calls, helping to de-escalate situations that might otherwise result in arrest and assessing whether individuals should be referred for immediate behavioral health intervention. The program currently includes seven clinicians (six filled, one vacant) assigned across Woodland, West Sacramento, Davis Police Departments, and in partnership with the Yolo

County Sheriff's Office and Probation Department. The cities contribute to the funding of the co-responder positions. Staff provide both phone and in-person responses to 911 calls, requests from family members or concerned individuals, self-referrals, and outreach from community providers. Mobile Crisis Response services deliver rapid, on-site intervention wherever individuals are located, including homes, schools, workplaces, or public spaces, using multidisciplinary teams to conduct assessments and provide stabilization with the goal of reducing immediate risk and avoiding unnecessary emergency department visits, hospitalizations, or law enforcement involvement. Crisis response services for children and youth have been integrated into the broader county crisis continuum, aligning with adult services to ensure a coordinated system of care.

Yolo County's comprehensive crisis services program provides individuals and the broader community with access to crisis intervention, assessment, referral, and linkage to appropriate levels of care, including crisis residential or inpatient psychiatric placement when necessary. Intended outcomes include reducing unnecessary emergency room visits and involuntary psychiatric holds, decreasing repeat crises and inpatient admissions, and minimizing unnecessary arrests of individuals in crisis. The program also aims to prevent crisis escalation that could result in harm to individuals, families, or the community, ensure timely access to appropriate mental health services before crises worsen, and strengthen connections to supportive resources, including city and county homeless services for individuals in need of housing or shelter.

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

Plan Period by FY	**Projected Number of Individuals Served**
FY 2026 – 2027	1450
FY 2027 – 2028	1450
FY 2028 – 2029	1450

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

Projections are based on past MHSA data averages for the Crisis programs. Projections expect that there will be a stable client count served in this program. The expected stability is due to the program operating at, or near maximum capacity, coupled with the potential workforce shortages and contracting budget, preventing the addition of staff or increase in services.

Early Intervention (EI) Programs

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

Program or service name
Early Childhood Mental Health Access and Linkage Program

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

Please specify "other" type of Treatment Services and Supports
In home therapy for caregivers

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

Please describe intended outcomes of the program or service
The Early Childhood Mental Health (ECMH) Access and Linkage Program provides universal screenings for parents/caregivers and their children ages 0–5 to identify those at risk of or beginning to develop mental health challenges that may affect healthy development. Based on screening results, the program connects children and their families to early intervention services by offering screening, identification, and referral in community settings to ensure timely access to coordinated care at the appropriate level of intensity. Children are linked to the most suitable services regardless of funding source or setting, and the program also provides in-home therapy for caregivers to promote resilience, support children remaining in their homes, and reduce barriers to treatment. The program prioritizes reaching unserved or underserved families and connects them to family-centered, culturally and linguistically responsive services. Key

activities include conducting assessments and referrals, addressing barriers to access, maintaining up-to-date knowledge of available programs, building partnerships to facilitate linkages, and performing community outreach. Intended outcomes include connecting children to appropriate mental health and supportive services, expanding access to care, preventing the escalation of mental health challenges through early identification, addressing existing needs promptly, and strengthening access to community-based services for children and their families.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1000
FY 2027 – 2028	1000
FY 2028 – 2029	1000

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on past MHSA data averages and estimates from the community-based organization for their current year unique client count for the ECMH Access and Linkage Program. Projections expect that there will be a stable client count served in this program. The expected stability is due to the program operating at, or near maximum capacity, coupled with the potential workforce shortages and contracting budget, preventing the addition of staff or increase in services.

Early Intervention (EI) Programs

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

Program or service name
K-12 School Partnership Programs

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please describe intended outcomes of the program or service
The K–12 School Partnerships Program provides access to mental health professionals across schools throughout the county, delivering services such as universal screening, assessment, referral, and treatment for children and youth ages 6–18. The program identifies students in need of support and ensures timely access to appropriate services, including direct care, small-group and individual interventions, and referrals to higher levels of care when needed. Using evidence-based, culturally responsive approaches, it emphasizes outreach and engagement for at-risk youth to build resilience and support overall mental health. Operating within an interconnected systems framework focused on the whole child, the program integrates academic, behavioral, and socioemotional development and aligns with school districts' Multi-Tiered Systems of Support (MTSS) model. It also addresses barriers to service access and maintains strong partnerships with community providers and Local Education Agencies to ensure coordinated, sustainable care. Intended outcomes include increased access to a continuum of mental health services for students and families, expanded service capacity and delivery, earlier identification and intervention for behavioral health needs, improved school engagement and wellness, and strengthened social, emotional, and coping skills that support long-term stability.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1130
FY 2027 – 2028	1130
FY 2028 – 2029	1130

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

Projections are based on past MHSA data averages and estimates from the community-based organizations for their current year unique client count for the K12 School Partnership Program. Projections expect that there will be a stable or reduced client count (from the current year) served in this program. The expected stability is due to the program operating at, or near maximum capacity, coupled with the potential workforce shortages and contracting budget, preventing the addition of staff or increase in services.

Early Intervention (EI) Programs

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

Program or service name

Children's Outpatient Treatment

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

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

Treatment Services and Supports: Services to address first episode psychosis (FEP)
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please select the EBPs and CDEPs that apply
Child Parent Psychotherapy (CPP)
Parent Child Interaction Therapy (PCIT)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Eye Movement Desensitization and Reprocessing (EMDR)
Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Cue Centered Therapy (CCT)

Please describe intended outcomes of the program or service
The county-operated, and contracted, Children's Outpatient treatment program provides access, linkage, case management, and individual and family therapy services for children and youth up to age 20, including specialized services for Latino children and English learners delivered by bilingual and bicultural clinicians. Services are available countywide in offices, community settings, and in the home when clinically appropriate, using a client-centered, strength-based approach to support recovery, wellness, and resilience. The program offers a comprehensive array of services, including assessment; individual, group, and family therapy; medication support; and case management assistance such as transportation, care coordination, and linkages to community resources, along with evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy, Child–Parent Psychotherapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing, Cue Centered Therapy, and Theraplay, as well as group services like social skills groups, trauma-informed parenting groups, and Girls Circle and Boys Council. Additional support includes post-hospitalization planning, coordination for youth placed on psychiatric holds, and follow-up for those accessing emergency departments, as well as embedded clinicians in the Juvenile Detention Facility and Multi-Disciplinary Interview Center to provide specialized care. The program primarily serves children and youth with significant mental health needs who are unserved, underserved, or

facing barriers to care, including those involved in child welfare or the juvenile justice system or at risk of outcomes such as homelessness, school expulsion, substance use, or hospitalization. Key activities include delivering intensive, trauma-informed, community-based services; developing integrated care plans across mental health, physical health, education, and social domains; supporting academic success; providing mobile and telehealth services to overcome access barriers; and linking families to community resources. The program aims to improve psychosocial well-being, reduce hospitalizations and justice system involvement, decrease homelessness, enhance functioning across home, school, and community settings, expand equitable access to care, increase engagement among diverse families, reduce disparities, improve service effectiveness, and sustain reductions in institutionalization and out-of-home placements.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	400
FY 2028 – 2029	400

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on current census of clients served by the community based organizations and the HHSA internal children's behavioral health team. Client counts are projected to be stable as all providers are operating close to capacity and revenues are not expected to increase during this plan cycle.

Early Intervention (EI) Programs

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

"Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Behavioral Health Access Services

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Outreach
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please describe intended outcomes of the program or service
Yolo County's Behavioral Health Access Services provide a centralized, "no wrong door" point of entry for individuals seeking behavioral health support. Services are designed to ensure timely screening, assessment, and linkage to appropriate care, supporting early identification, prevention of condition escalation, and improved outcomes.

Access Services include a 24/7, high-tech call center that offers immediate support, screening, triage, and referral, and is coordinated with the 988 Suicide and Crisis Lifeline and the County's broader crisis continuum of care. This integration ensures individuals in crisis are connected to the most appropriate level of care, including mobile crisis response, crisis stabilization services, and ongoing behavioral health treatment.

Services are available via phone, in-person, and telehealth, and include brief assessment, determination of medical necessity, and linkage to Specialty Mental Health Services (SMHS), substance use disorder treatment, primary care, and community-based supports. When appropriate, individuals may receive brief interventions and short-term support while awaiting connection to ongoing services.

Services are delivered through a culturally responsive, trauma-informed approach that prioritizes equity

and reduces barriers to care. Interpretation and translation services are available to ensure meaningful access. Outreach and engagement efforts focus on populations experiencing disparities, including Latino/Spanish-speaking communities, rural residents, transition-age youth, and individuals experiencing homelessness.

Through strong collaboration with community partners and coordinated entry across systems, Yolo County's Behavioral Health Access Services promote timely, equitable access to care and help prevent the progression of behavioral health conditions.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2400
FY 2027 – 2028	2400
FY 2028 – 2029	2400

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on past data pulled from the county's electronic health record system to approximate the numbers served in behavioral health access services. Projections expect that there will be a stable client count served in this program. The expected stability is due to the program operating at, or near maximum capacity, coupled with the potential workforce shortages and contracting budget, preventing the addition of staff or increase in services.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

CSC program name
Coordinated Specialty Care for First Episode Psychosis

CSC program description
Yolo County's Coordinated Specialty Care for First Episode Psychosis (CSC FEP) program will provide comprehensive, coordinated, and recovery-oriented services for individuals experiencing early signs and symptoms of psychosis. The program will emphasize early identification and intervention to improve long-term outcomes for youth, young adults, and their families.

Services will include outreach and education across Yolo County to increase awareness and support early identification through partnerships with schools, community-based organizations, healthcare providers, and other stakeholders. The program will engage individuals who may be unserved or underserved and connects them to care.

The CSC FEP program will offer screening and assessment to determine eligibility, linkage to coordinated specialty care services, and referrals to appropriate supports. Individuals not eligible for direct services are provided with information and resources to ensure connection to care. Eligible individuals will be provided with CSC for FEP services. Family members are included in the treatment process and offered education and support.

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

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

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	27
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	4.25
Number of Teams Needed to Serve Total Eligible Population	1

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

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	4	4	4
Total Number of Teams	1	1	1

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

Please list the other funding source(s)
Mental Health Block Grant

County Workforce, Education, and Training (WET) Program

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

Program or activity name
Behavioral Health Professional Development

Please select which of the following categories the activity falls under
Other

Please define the other activity
The Behavioral Health Professional Development program is designed to strengthen the skills and capacity of internal and external mental health providers through comprehensive training and workforce development activities, including clinical training in evidence-based and promising practices, online courses through HHSA's e-learning platform, and leadership development using a strengths-based approach such as Gallup's StrengthsFinder. The program also promotes cultural competence through targeted training and technical assistance, supports providers in screening for perinatal mental health concerns, advances trauma-informed care across all staff and programs, and offers BBS clinical supervision to help unlicensed staff meet licensure requirements. Additional efforts include maintaining up-to-date resources such as the HHSA website, crisis cards, and community materials to ensure access to accurate information. By expanding formal training and skill-building opportunities, the program enhances workforce capacity, supports staff retention in a competitive environment, and reduces burnout by providing necessary supervision and professional support. This program also includes Professional Licensing and/or Certification Testing and Fees.

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The program also promotes cultural competence through targeted training and technical assistance, supports providers in screening for perinatal mental health concerns, advances trauma-informed care across all staff and programs.

County Workforce, Education, and Training (WET) Program

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

Program or activity name

Crisis Intervention Training

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

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The Yolo County crisis staff delivers Crisis Intervention Training (CIT) modeled after the nationally recognized, evidence-based CIT Memphis Model, equipping law enforcement personnel and first responders to recognize and respond effectively to signs of mental illness during crisis situations. The Peace Officers Standards and Training approved curriculum provides 40 hours of training at no cost and emphasizes compassionate, appropriate responses to individuals and families in crisis, along with an annual 8-hour refresher course developed in collaboration with local agencies to ensure relevant, up-to-date content that addresses diverse populations. Key activities focus on improving recognition of mental health needs and strengthening intervention skills by training participants to identify signs of mental illness, apply de-escalation strategies in crisis and non-crisis situations, and better understand community and cultural needs. Intended outcomes include more effective de-escalation of individuals in crisis, implementation of a community-oriented and evidence-based approach to psychiatric emergencies, reduced arrests and incarcerations among individuals with mental illness, stronger relationships between law enforcement and the community, and decreased trauma associated with emergency interventions and hospitalizations.
The program also promotes cultural competence through targeted training and technical assistance, supports providers in screening for crisis, and advances trauma-informed care across all staff and programs throughout the community.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Yolo County Semi-Statewide Enterprise Health Record

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system

Please describe the project
Yolo County's encumbered MHSA Innovation Project "Semi-Statewide Enterprise Health Record" focuses on improving behavioral health data sharing, care coordination, and system integration across county and state partners. The project is designed to address long-standing fragmentation in behavioral health information systems by developing or participating in a more unified electronic health record approach that can support interoperability across providers, programs, and potentially multiple counties. Its goals include improving real-time access to clinical and service data, reducing duplication of documentation, strengthening continuity of care for individuals receiving services across multiple systems, and supporting more accurate reporting for Medi-Cal, BHSA, and other accountability requirements. The initiative also aims to enhance decision-making through improved data analytics and outcome tracking, while reducing administrative burden on providers and supporting more coordinated, person-centered care delivery.

On March 18, 2025, HHSA published the draft Innovation Plan for the 30-day public comment period. The public hearing was held during the Local Behavioral Health Board (LBHB) meeting on April 16, 2025. The Local Behavioral Health Board held a vote in conditional support of the proposed Innovation Plan with the Yolo County Board of Supervisors approving the proposal on April 29, 2025. The Innovation Plan was approved at the Commission for Behavioral Health's meeting (formerly Mental Health Oversight and Accountability Commission- MHSOAC) on May 22, 2025. The MHSA Innovation Plan is available on the MHSA website (www.yolocounty.org/mhsa).

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

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

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	452
Number of Uninsured Individuals	73
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	137

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

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

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	53

ACT Eligible Population	Estimates
Number of Uninsured Individuals	<11*

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	26
Number of Uninsured Individuals	4

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	<11*
Number of Teams Needed to Serve Total Eligible Population	<11*

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

County Actuals	FY 26-27	FY 27-28	FY 28-29

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	10	10	10
Total Number of Teams	1	1	1

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	373
Number of Uninsured Individuals	60

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	20

FSP ICM Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	4

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	15	15	15
Total Number of Teams	2	2	2

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	141

HFW Eligible Population	Estimates
Number of Uninsured Individuals	29

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	53
Number of Teams Needed to Serve Total Eligible Population	2

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	4	4	4
Total Number of Teams	1	1	1

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	659
Number of Uninsured Individuals	106

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	50
Number of Teams Needed to Serve Total Eligible Population	20

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	1	1	1

Full Service Partnership (FSP) Program Overview

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

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
Yes

Please describe how the estimated practitioners will provide more than one EBP
Yolo County Behavioral Health Services will implement a flexible staffing model in which FSP practitioners may deliver more than one evidence-based practice (EBP) to maximize capacity and ensure continuity of care. Staff, including clinicians, case managers, and peer support specialists, will be cross-trained across FSP Level 1 Intensive Case Management (ICM) and Level 2 models such as Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), as these programs are developed. Yolo County is exploring whether to provide all of the FSP levels of care internally or to contract with community-based providers for the Level 2 FSP (ACT/FACT) services. If the agency elects to contract out some of the levels of care, there will be fewer practitioners providing more than one EBP; however, initially staff will be cross trained to maximize capacity given staffing and budgetary shortages.

Peer support specialists will be utilized across all applicable EBPs to enhance engagement and provide continuity through shared lived experience. Clinical and case management staff will also be cross-trained to support multiple service models, allowing Behavioral Health to respond to workforce limitations and shifting client acuity.

Yolo County anticipates integrating Individual Placement and Support (IPS) supported employment services within ACT, FACT, and ICM programs to promote recovery and community integration. Additionally, staff may be shared across teams to support step-up and step-down transitions between levels of care, ensuring individuals receive the appropriate intensity of services while maintaining consistent provider relationships.

This flexible, cross-trained staffing approach will allow Yolo County to efficiently utilize resources, maintain

fidelity to evidence-based practices, and adapt to evolving system needs over time.

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

Yolo County employs a whole-person, trauma-informed approach within its Full Service Partnership (FSP) programs that addresses the behavioral health, physical health, and social determinants impacting an individual's well-being. Services are person-centered, culturally responsive, and grounded in principles of safety, trust, empowerment, and choice, with a strong emphasis on recovery-oriented care and resilience.

FSP programs integrate an understanding of trauma and adverse experiences into all aspects of service delivery, including screening, assessment, treatment planning, and ongoing care. Staff receive ongoing training in trauma-informed practices, cultural humility, motivational interviewing, and crisis intervention to ensure services are delivered in a manner that promotes healing and avoids re-traumatization.

Partnership with individuals, families, and natural supports is central to the FSP model. Individuals are recognized as the experts in their own lives and are actively engaged in shared decision-making. When appropriate and desired, family members and other trusted supports are included in treatment planning and service delivery. For individuals with limited natural supports, FSP teams assist in identifying and building meaningful connections within their communities. For the children's FSP program, the utilization of Child and Family Team Meetings (CFT) is central to engaging a participant's natural supports.

Yolo County FSP programs utilize multidisciplinary, team-based approaches that may include clinicians, peers, and care coordinators to support individuals and their families. Services extend beyond behavioral health to include linkages to medical care, housing, education, employment, and other community-based supports. Collaboration with community partners and cross-system agencies helps ensure coordinated, holistic care that is responsive to each individual's unique strengths, needs, and goals.

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

Yolo County is committed to reducing disparities among Full Service Partnership (FSP) participants by ensuring services are accessible, equitable, and culturally and linguistically responsive. Using data to inform planning, the County identifies disparities in access, engagement, and outcomes, particularly among Latino/Spanish-speaking communities, individuals experiencing homelessness, justice-involved individuals, and transition-age youth (TAY), and prioritizes these populations for outreach and engagement.

FSP services are delivered through culturally responsive and trauma-informed practices, supported by ongoing staff and contractor training in cultural humility and inclusive care. Interpretation and translation services, including bilingual staff and language access supports, are utilized to ensure meaningful access. Treatment planning incorporates culturally relevant, gender-affirming, and family-centered approaches when appropriate.

Multidisciplinary FSP teams—including clinicians, peers, and case managers provide flexible, “whatever it takes” services to reduce barriers, including meeting individuals in community settings and supporting navigation across behavioral health, physical health, housing, and social service systems. Teams provide intensive care coordination and advocacy, particularly for individuals with complex needs or limited natural supports.

Through continuous community engagement, cross-system collaboration, and data-driven quality improvement, Yolo County works to reduce disparities and improve outcomes for its most underserved and disproportionately impacted populations

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

Access to care
Homelessness
Institutionalization
Justice involvement
Untreated behavioral health conditions
Care experience

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

The Yolo County Behavioral Health Full Service Partnership (FSP) team provide ongoing engagement through a client-centered, trauma-informed approach that emphasizes trust, cultural responsiveness, and individualized care. Services are tailored to each client’s strengths and recovery goals, with care plans developed collaboratively with the individual and, when appropriate, their family or supports.

FSP Intensive Case Management (ICM) teams deliver field-based services in homes and community settings, conducting regular check-ins and coordinating behavioral health, substance use, primary care, housing support, and benefits advocacy. Staff collaborate with housing providers and community partners, while multidisciplinary team meetings ensure services remain responsive to changing needs.

Engagement is supported through consistent outreach, strength-based strategies, motivational interviewing, and peer support. Teams offer flexible scheduling, appointment accompaniment, and intensive support during key transitions such as hospital discharge or reentry from incarceration.

This coordinated approach promotes stability, reduces crises and hospitalizations, and supports long-term recovery and community integration for individuals served through FSP ICM programs.

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

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)
Yolo County Behavioral Health will comply with required Full Service Partnership (FSP) levels of care by aligning program design, staffing, and service delivery with state-defined models, including FSP Level 2 (Assertive Community Treatment [ACT] and Forensic Assertive Community Treatment [FACT]) and FSP Level 1 Intensive Case Management (ICM). Yolo County is in the process of developing ACT/FACT capacity and is exploring contracting with community-based providers to deliver these services, while maintaining existing FSP ICM teams to ensure a full continuum of care.

Yolo County is assessing community need, acuity, and service gaps to guide the transition of appropriate individuals from ICM to higher levels of care, as well as the development of new ACT/FACT teams. These efforts are intended to ensure individuals receive the right level of support at the right time.

To support model fidelity, Yolo County is partnering with the Centers of Excellence for all FSP evidence-based-practices, to ensure staff and contracted providers are trained in evidence-based practices, including ACT, FACT, and other applicable models. This includes guidance on eligibility, staffing requirements, service intensity, and expected outcomes.

FSP teams will collaborate across programs to monitor client needs and support timely transitions between levels of care. Yolo County will establish clear FSP eligibility criteria and referral pathways to promote seamless movement between FSP levels and outpatient services. Program leadership will monitor implementation to ensure appropriate utilization of each level of care, continuity of services, and delivery of individualized, recovery-oriented care.

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

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
No

Other recovery-oriented services
No

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

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

In, or at-risk of being in, the juvenile justice system
Yolo engaged stakeholders, including organizations serving youth with mental health/substance use needs, social services/child welfare, law enforcement, probation, and local education agencies, and youth service providers. The County Behavioral Health Department also continues to meet with community representatives to gather information about needs for individuals in or at-risk of being in the juvenile justice system, such as the schools, Department of Social Services, and County Probation. Additionally, HHSA leadership continue to participate in the county's Juvenile Justice council, to best identify and respond to the community's changing Juvenile Justice needs. This council is charged with developing a comprehensive, multiagency plan that identifies the resources and strategies for providing an effective continuum of responses for the prevention, intervention, supervision, treatment and incarceration of male and female justice involved youth, including strategies to develop and implement locally-based or regionally-based out-of home placement options.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Yolo engaged in a comprehensive CPP process which included representatives from the LGBTQ+ community and organizations serving LGBTQ+ youth. Additionally, seven percent of CPP survey participants identified as part of the LGBTQ+ community. Representatives from this population engaged in community feedback sessions and key informant interviews. Yolo will continue to work with community leaders and local advocacy and educational organizations to ensure youth & TAY in the LGBTQ+ community are having their voices heard.

In the child welfare system
Yolo engaged in a comprehensive CPP process which included representatives with experience with the child welfare system including transitional age youth. We partnered with Child Welfare Services and community-based providers to conduct targeted outreach and invite participation in CPP focus groups, key informant interviews, the community needs survey, and community forums. Youth and caregivers with lived experience, as well as organizations serving this population, including county Welfare Services, participated in at least one engagement activity.

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

Older adults
Yolo engaged in a comprehensive CPP process which included older adults and organizations serving this population. Twenty-nine percent (29%) of the participants identified as older adults. Input gathered through the community engagement process informed program planning to ensure FSP services are responsive to the unique needs of older adults. Older adults were identified as a subpopulation with significant needs, including services to address social isolation, grief, dementia, and financial insecurity. One interviewee stated, "I would also highlight the elderly. I think just social isolation. COVID, post-COVID, a lot of folks lost their spouses or partner. Loved ones lost their friends during COVID. I think it's a huge problem that we really don't have a very good handle on." The pandemic compounded isolation among seniors, creating mental health challenges that the current system is not adequately equipped to address. Yolo regularly engages with stakeholders who represent the unique needs of older adults. Additionally, HHSA leadership continue to participate in the county's Commission on Aging & Adult Services.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Yolo engaged in a comprehensive CPP process which included representatives from the LGBTQ+ community. Seven percent of CPP survey participants identified as part of the LGBTQ+ community. Representatives from this population engaged in community feedback sessions and key informant interviews. Efforts will be made across the Yolo system of care, including FSP programs, to provide training in culturally responsive care including gender-affirming care.

In, or are at risk of being in, the justice system
Yolo engaged in a comprehensive CPP process which included participants with lived experience, family members, focus groups, key informant interviews, law enforcement, forensic diversion programs, and community organization representatives serving the eligible adults including older adults to gather feedback and input into the planning process. Additionally, HHSA will continue to partner with the Yolo County Mental Health Court (MHC). Founded in 2013, MHC serves up to 15 Yolo County residents at a given time who suffer from serious mental illnesses and charged with Misdemeanor or Felony offenses. The

program focuses on 4 goals for program participants: improving treatment engagement, reducing recidivism, reducing jail bed days, and decreasing local and state hospital bed stays. The program is a partnership between the Yolo County Superior Court, Probation Department, Health and Human Services Agency, the Public Defender, and the District Attorney. MHC is a strategic program designed to effectively address the increasing number of seriously mentally ill defendants cycling through the courts and jails. MHC is a minimum 18-month collaborative court-based treatment and monitoring system for adult offenders with serious mental illnesses.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

Yolo County participates in the EMS Bridge program, which connects individuals experiencing substance use-related emergencies with treatment and recovery resources. This program supports engagement with individuals following emergency medical response events, including opioid overdoses.

Program descriptions

Through EMS Bridge, emergency medical services personnel provide individuals who have experienced an overdose or other substance use-related emergency with information and referral to treatment providers, including medication-assisted treatment (MAT) services. The program promotes rapid connections to care and helps link individuals to outpatient and residential SUD treatment programs in the community.

Current funding source
Sierra Health Foundation MAT SOR3. This funding source is ending, and Emergency Services would only be able to keep the current programming as-is unless they have a new funding source.

BHSA changes to existing programs to meet BHSA requirements
Under BHSA, Yolo County will strengthen coordination between emergency response systems, outreach providers, and SUD treatment providers to improve follow-up engagement and linkage to treatment services for individuals identified through EMS Bridge.

Expected timeline of operation
EMS Bridge services are currently operational and will continue throughout the BHSA implementation period.

Mobile-field based programs

Existing programs
CommuniCare+OLE (CCOLE) operates a mobile medical van that provides healthcare services in community settings, including medication-assisted treatment (MAT) for individuals with substance use disorders.

Program descriptions
The mobile medical unit delivers field-based healthcare services in locations throughout the community, improving access to treatment for individuals who face barriers to clinic-based services, including encampments. Services include screening, medication management, preventative health and connection to ongoing treatment, education, resource referrals and supportive services.

Current funding source
Mobile services are supported through CommuniCare+OLE healthcare operations and are funded through a temporary grant and claiming for provider visits through Medi-Cal.

BHSA changes to existing programs to meet BHSA requirements
Under BHSA, Yolo County plans to expand the mobile medical van program in partnership with CommuniCare+OLE to increase the availability of field-based medication-assisted treatment and improve engagement with individuals experiencing barriers to accessing traditional clinic services.

Expected timeline of operation
Mobile medical services are currently operational and will continue throughout the BHSA implementation period, with expansion planned during the early years of BHSA implementation.

Open-access clinics

Existing programs
Yolo County residents can access medication-assisted treatment (MAT) through several existing providers including C.O.R.E. Medical Clinic, CommuniCare+OLE health centers, Wellpath services within the county jail, and the MAT program operated within the Yolo Wayfarer Center residential SUD treatment program.

Program descriptions
C.O.R.E. Medical Clinic provides MAT services through an open-access outpatient clinic model. CommuniCare+OLE provides MAT as part of its Federally Qualified Health Center (FQHC) services. Wellpath provides MAT services for individuals while in custody at the county jail, and the Yolo Wayfarer Center provides MAT as part of its residential substance use disorder treatment program.

Current funding source
Funding for MAT services varies by provider. C.O.R.E. Medical Clinic services are supported through Medi-Cal federal financial participation (FFP) and realignment funding. MAT services within the county jail are supported through Community Corrections Partnership (CCP) funding. CommuniCare+OLE services are supported through healthcare funding sources, and MAT services at Yolo Wayfarer Center are supported through SUD treatment funding streams.

BHSA changes to existing programs to meet BHSA requirements
Under BHSA, Yolo County will continue supporting these MAT providers while strengthening referral pathways from outreach, mobile services, and emergency response programs to ensure individuals can access timely treatment services. To align with Section 7.B.6.2.4 of the BHSA Policy Manual, the County will enhance current service delivery to meet open-access clinic requirements through the following:
• Expanded open-access scheduling: Same-day screening, assessment, and MAT initiation without prior appointments, with increased walk-in/drop-in availability
• Drop-in outpatient capacity: Formalization of low-barrier, on-demand service access within existing providers
• Field-to-clinic coordination: Strengthened linkage between AFBSUD outreach and clinic services, including warm handoffs and engagement support
• Harm reduction services: Expanded naloxone distribution, overdose prevention education, safer use supplies, and exploration of syringe service integration
• Medication access enhancements: Support for same-day MAT initiation and exploration of mobile or

field-based medication service delivery models
Yolo County will collaborate with community-based providers, including Northern Valley Indian Health, to ensure services are accessible, culturally responsive, and coordinated across the system.

These changes will ensure existing programs operate within a low-threshold, open-access framework that improves timely access and engagement in SUD treatment.

Expected timeline of operation
These services are currently operational and are expected to continue throughout the BHSA implementation period.

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Yolo County plans to expand targeted outreach to individuals with substance use disorders who are not currently connected to treatment services. Outreach efforts will prioritize individuals experiencing homelessness, individuals in rural communities, and individuals who are justice- involved or transitioning from incarceration to the community.

Program descriptions
Expanded outreach activities will include field-based engagement, screening, harm reduction education, and direct linkage to treatment services including medication-assisted treatment (MAT). Outreach teams will collaborate with emergency medical services, healthcare providers, homeless service providers, and community-based organizations to identify individuals who may benefit from treatment services. Outreach efforts will also support follow-up engagement with individuals identified through the EMS Bridge program and individuals transitioning from incarceration through CalAIM justice-involved reentry initiatives.

Planned funding
Expanded outreach services will be supported through Behavioral Health Act (BHSA) funding, with potential supplementation through Medi-Cal reimbursement and other available behavioral health funding sources.

Planned operations
Outreach activities will occur in community settings such as encampments, shelters, community resource centers, and other locations where individuals experiencing substance use disorders may be present. Outreach teams will coordinate closely with mobile medical services, justice system partners, and treatment providers to facilitate rapid connection to care.

Expected timeline of implementation
Planning and coordination for expanded outreach services will begin during the early phases of BHSA implementation, with gradual expansion of services over the subsequent fiscal years.

Mobile-field based programs

New programs
Yolo County plans to expand mobile field-based substance use disorder treatment services by increasing the capacity and availability of the existing mobile medical van program.

Program descriptions
Expanded mobile services will provide field-based healthcare services including screening, medication-assisted treatment (MAT), medication management, and connection to ongoing treatment and recovery support services. Mobile services will improve access to treatment for individuals who face barriers to clinic-based care, including individuals experiencing homelessness, individuals living in rural or underserved areas of the county, and individuals transitioning from incarceration.

Planned funding
Expansion of mobile treatment services will be supported through Behavioral Health Services Act (BHSA) funding, with additional support through Medi-Cal reimbursement and healthcare funding sources where applicable.

Planned operations
The expanded mobile medical van program will operate in locations throughout Yolo County with a focus on communities and areas with higher need for SUD treatment services. Mobile services will coordinate with outreach teams, EMS Bridge, justice system partners, and healthcare providers to provide low barrier access to treatment and facilitate linkage to ongoing care.

Expected timeline of implementation
Planning and coordination with a provider will begin during the initial BHSA implementation period, with expansion of mobile services anticipated within the first few years of BHSA implementation.

Open-access clinics

New programs
Yolo County will work with existing treatment providers to strengthen access to open access medication assisted treatment services and improve continuity of care across service settings, including services for transitioning from custody to the community.

Program descriptions
Enhanced open-access services will support timely entry into treatment for individuals referred through outreach programs, mobile medical services, emergency response systems, and justice system partners. Services will include screening, assessment, medication assisted treatment initiation, and referral to ongoing outpatient or residential treatment programs.

Planned funding
Enhancements to open-access treatment services will be supported through BHSA funding in coordination with Medi-Cal reimbursement and existing substance use disorder treatment funding streams.

Planned operations
Open-access services will continue to be provided through existing treatment providers including outpatient MAT providers, healthcare partners, and residential treatment programs. These services will coordinate closely with mobile and outreach programs and with CalAIM justice-involved reentry initiatives to ensure individuals receiving MAT while in custody can be connected to community-based treatment providers upon release.

Expected timeline of implementation
Service enhancements will occur during the BHSA implementation period as resources, partnerships, and service coordination are further developed.

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
Yolo County will identify gaps between existing Medication Assisted Treatment (MAT) resources and the estimated need for services among individuals with Substance use Disorders (SUD), particularly Opioid Use Disorder (OUD).

We will inventory current MAT providers and programs, including contracted providers, federally qualified health centers (FQHCs), Narcotic Treatment Programs (NTPs), EMS Bridge and hospital-based programs. We will review penetration rates, wait times, and geographic distribution of clients receiving MAT services. Using local data such as overdose rates, emergency department visits, treatment admissions, and prevalence estimates of OUD and other SUDs to estimate population rates. We will review challenges, such as transportation, stigma and workforce shortages and include input from stakeholders and those with lived experience. These findings will inform targeted expansion strategies to ensure equitable, timely and

clinically appropriate access to MAT services, including same-day initiation.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
Partner with neighboring counties

Please provide the names of the neighboring counties the county will partner with
Sacramento

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

Please specify other forms of MAT
contingency management, medications for alcohol use disorder

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting

and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) **to inform responses to this question.**

Supportive housing
Large gap

Apartments, including master-lease apartments
Large gap

Single and multi-family homes
Large gap

Housing in mobile home communities
Not applicable

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Not applicable

(Permanent) Tiny homes
Large gap

Shared housing
Medium gap

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

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

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

License-exempt room and board
Large gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Large gap

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Medium gap

Peer Respite
Large gap

Permanent rental subsidies
Large gap

Housing supportive services
Large gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Yolo Behavioral Health collaborates closely with County Social Services and Continuum of Care (CoC) providers to expand access to supportive housing and improve housing retention outcomes for individuals experiencing homelessness. County Behavioral Health refers eligible behavioral health clients to permanent supportive housing (PSH) through the coordinated entry system. PSH beds are administered by partner agencies and funded through multiple sources, including the U.S. Department of Housing and Urban Development CoC Program, Housing Authority Housing Choice Vouchers (HCV) and project-based vouchers, and Homeless Housing, Assistance and Prevention (HHAP) funds. Yolo County works collaboratively with the local CoC, Homeless and Poverty Action Coalition (HPAC), and jointly applies for HHAP funding to support both Behavioral Health Services Act (BHSA) and non-BHSA clients. To further expand housing opportunities, Yolo County is utilizing the Behavioral Health Bridge Housing (BHBH) Program to increase the supply of transitional housing. Through this program, clients are connected to CalAIM Enhanced Care Management (ECM) and Community Supports (CS), ensuring access to housing navigation and supportive services. The goal is to support clients in transitioning from temporary placements into permanent housing upon program exit. However, housing capacity remains a significant challenge. Since 2023, the Yolo County Housing Authority has experienced intermittent voucher shortfalls, limiting the availability of Housing Choice Vouchers for individuals experiencing homelessness. Additionally, the Housing Authority is prioritizing the transition of households currently utilizing Emergency Housing Vouchers (EHV) into the HCV program or waitlist to preserve their housing stability. As these households receive top priority, voucher availability for new applicants has been further constrained. Without additional federal funding for the HCV program, voucher capacity in Yolo County is expected to remain extremely limited. Looking ahead, the County plans to apply for an Encampment Resolution Grant to enhance outreach efforts to local encampments. This funding would support identifying individuals eligible for BHSA services and providing immediate access to emergency shelter, ensuring a safe environment to meet basic needs. The County is also exploring workforce development grant opportunities to provide job training and employment pathways for BHSA-eligible individuals. Yolo County continues to strengthen its data and coordination infrastructure through its partnership with HPAC, serving as the local Homeless Management Information System (HMIS) lead, with a formal agreement in place for data entry and analysis. Internally, Behavioral Healht has established a Housing Manager role that plays a central leadership function. This position actively participates as an HPAC board member and subcommittee lead, while overseeing a team of Enhanced Care Management staff who connect clients to comprehensive physical, behavioral, and social services. The Housing Manager also collaborates with managed care partners, including Partnership HealthPlan of California and Kaiser Permanente, to expand access to housing through CalAIM ECM and Community Supports. In addition, the County supports local nonprofit

organizations in becoming ECM and Community Supports providers, increasing system-wide capacity for housing-related services. HHSA also partners with Turning Point Community Programs, the Transitional Rent provider, to further increase housing access. Overall, Yolo County is leveraging cross-sector partnerships, multiple funding streams, and CalAIM service models to expand housing opportunities and improve long-term housing stability for vulnerable populations.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions are designed to address critical service gaps for individuals who reach the end of the six-month Transitional Rent assistance period. These funds will support BHSA-eligible individuals who have exhausted Transitional Rent benefits, including those participating in demonstration periods, ensuring continuity of housing stability. Housing Intervention funds may also be used for landlord damage reimbursement when costs exceed the security deposit, helping to reduce barriers to housing placement and retention for high-acuity clients. These interventions will align closely with the Behavioral Health Bridge Housing (BHBH) Program, allowing Yolo County to sustain and continue housing supports beyond the current grant period ending June 30, 2027. Additionally, 7% of Housing Intervention funding will be allocated to support Behavioral Health Services and Supports (BHSS), strengthening the broader system of care. Because BHSA Housing Interventions are only accessible after Community Supports and Transitional Rents have been exhausted, Yolo County Behavioral Health has established a strong collaborative partnership with Turning Point Community Programs, the County's Transitional Rent provider. This partnership has resulted in a coordinated referral process that brings together managed care plans, Behavioral Health providers, probation, Enhanced Care Management (ECM) and Community Supports providers, local Continuum of Care partners, and housing providers. This integrated approach promotes cross-system collaboration and ensures services are delivered through a person-centered framework. In addition to direct rental assistance and damage mitigation, Yolo County will conduct a procurement process to allocate 25% of Housing Intervention funds toward capital development. These investments may include new property acquisition, new construction, and rehabilitation or renovation of existing housing units to preserve and expand the county's housing inventory. Recognizing service gaps among individuals not currently enrolled in Full Service Partnership (FSP) programs, the County will also use funding to establish a dedicated Housing Interventions Team. This team will identify and engage individuals who meet BHSA criteria but are not connected to FSP services. The Housing Interventions Team will provide comprehensive supportive services, including but not limited to:
• Linkage to physical, behavioral, and social health services
• Conflict resolution and mediation
• Housing navigation and stabilization support
• Education on available housing and support programs
• Linkage to available income/employment or workforce development
These programs include:
• Homeless Disabled Assistance Program (HDAP)

• HomeSafe
• Housing and Disability Advocacy Program (HSP)
• Bringing Families Home
• Behavioral Health Bridge Housing (BHBH)
• Services available through the local Homeless and Poverty Action Coalition Continuum of Care
Through these combined efforts, Yolo County aims to close service gaps, expand access to housing resources, and improve long-term housing stability for individuals with Behavioral Health needs.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Yolo County recognizes housing as a critical social determinant of health and a foundational component of treatment and recovery for individuals experiencing serious mental illness and/or substance use disorders. The County's approach is grounded in a Whole Person Care model, which prioritizes stable housing as the essential first step in helping individuals achieve long-term stability. By securing safe and stable housing, individuals are better able to meet their basic needs including physical, behavioral, and social health which in turn supports their ability to engage meaningfully in treatment and recovery services. Housing stability enables individuals to build support systems through wraparound services, creating the conditions necessary for Behavioral Health interventions to be effective. Each component of these wraparound services plays a vital role in promoting successful stabilization both in housing and within the broader community. This integrated approach ensures that housing and services work in tandem, reinforcing one another to improve outcomes. The County's overarching goal is to rapidly connect individuals to a coordinated system of care that includes:
• Coordinated Entry through the local Homeless and Poverty Action Coalition
• Enhanced Care Management (ECM)
• Community Supports (CS)
• Behavioral Health treatment services
• Workforce development and income supports
• Permanent and transitional housing resources
To operationalize this strategy, Yolo County's Housing Interventions Team—alongside Enhanced Care Management case managers—will conduct outreach to unsheltered individuals, particularly those residing in encampments. The team will provide warm hand-offs into BHSA-funded services, ensuring a seamless transition into care. This includes connecting individuals to initial Behavioral Health assessments, ongoing treatment, and specialized services such as housing-focused case management. These supports are specifically designed to promote housing stability and long-term retention, helping individuals maintain permanent housing and improve overall health outcomes.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

Yolo County Behavioral Health provides comprehensive Behavioral Health treatment, including case management and wraparound services, to increase housing stability and retention among individuals placed in permanent supportive housing (PSH). These services are specifically designed to support individuals with serious mental illness (SMI) and/or substance use disorders (SUD) in successfully maintaining housing. Behavioral Health works in close coordination with the Yolo County Housing Authority and the local Continuum of Care, Homeless and Poverty Action Coalition, through the Coordinated Entry process. This collaboration ensures that BHSA-eligible clients are prioritized for tenant-based vouchers and connected to all available housing opportunities. Behavioral Health, alongside community-based providers, delivers the supportive services necessary for clients to effectively utilize housing subsidies and sustain long-term housing placement. Under this BHSA plan, the housing component includes a multi-faceted investment strategy aimed at expanding and sustaining housing opportunities for individuals experiencing homelessness, including those who are chronically homeless. This strategy includes:

• Funding rental subsidies for homeless and chronically homeless individuals
• Providing operating subsidies to support existing PSH programs
• Investing in capital development during the first year, including:
• New acquisition of PSH units
• New construction of PSH developments
• Rehabilitation or renovation of existing PSH housing stock

Despite these efforts, housing access continues to be significantly constrained by limited voucher availability. Since 2023, the Yolo County Housing Authority has experienced intermittent shortfalls in Housing Choice Vouchers (HCV), reducing access for individuals experiencing homelessness. Additionally, the Housing Authority is actively transitioning households currently utilizing Emergency Housing Vouchers (EHV) into the HCV program or onto the HCV waitlist. These households are prioritized to ensure housing retention, which further limits the availability of vouchers for new applicants. Without additional federal investment in the Housing Choice Voucher program, voucher capacity in Yolo County is expected to remain extremely limited, posing an ongoing challenge to expanding access to permanent housing for vulnerable populations.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

Yolo County Behavioral Health is committed to ensuring that Behavioral Health services are accessible and fully integrated across all housing settings. Central to this effort is the development of a robust Housing

Interventions Team that supports individuals at every stage of the housing continuum. The Housing Interventions Team will serve as a key liaison between housing providers, landlords, internal Behavioral Health teams, community-based Behavioral Health providers, the local Continuum of Care, Homeless and Poverty Action Coalition, local homeless and housing providers and the managed care plans. This coordination will ensure that services are aligned and responsive to both client and housing provider's needs. The team will work collaboratively with housing providers and landlords to promote successful housing placements and long-term stability. Recognizing that success varies based on individual circumstances, the team will take a person-centered approach to identify each client's unique needs and ensure appropriate supports are in place to promote stabilization and retention in housing. To support this work, the Housing Interventions Team will leverage Enhanced Care Management (ECM) and Community Supports (CS) to connect individuals to comprehensive care, including Behavioral Health treatment, housing services, and physical health care. In addition to supporting clients, the team will build the capacity and knowledge of the housing providers and landlords by ensuring they are informed about available resources to support the individuals' stabilization in housing. These resources include, but are not limited to:

- Peer support and recovery groups
- Crisis intervention services
- Behavioral Health treatment programs
- Workforce development and employment services

The Housing Interventions Team will also prioritize developing and maintaining strong relationships with landlords and housing providers across the housing continuum. This ongoing engagement will strengthen system coordination and ensure continuity of care for individuals as they move between different housing settings and ultimately remain stabilized in permanent housing. Finally, the team will ensure that all individuals placed in BHSA-funded housing are connected to appropriate Behavioral Health services, including Full Service Partnerships (FSP), access services, Forensic services, outpatient mental health services, and/or substance use disorder treatment. This integrated approach will help ensure that individuals not only obtain housing but are supported in maintaining long-term stability and improving overall health outcomes.

Eligible Populations

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

Yolo County Behavioral Health has established a comprehensive and accessible referral process in partnership with Turning Point Community Programs, the County's Transitional Rents provider. Referrals can be submitted from a wide range of sources across the community to ensure broad access. These include internal county partners such as Health and Human Services Agency (HHSA) programs (e.g., Full Service Partnership (FSP), Access, Forensics, Adult Protective Services (APS), Child, Youth and Family services, CalWORKs), as well as Probation, the District Attorney's Office, Board of Supervisors, law

enforcement, Public Health, clinicians, and Enhanced Care Management (ECM)/Homeless Outreach teams. External partners may also submit referrals, including hospitals, cities, community-based organizations, Continuum of Care providers, sober living environments (SLEs), recuperative care and post-hospitalization facilities, Behavioral Health providers, California Department of Transportation (CalTrans), faith-based organizations, primary care providers, managed care plans such as Partnership HealthPlan of California and Kaiser Permanente, as well as self-referrals All referrals require submission of standardized forms to Turning Point. There are two types of referral forms:

• Transitional Rents Referral Form

• Behavioral Health Bridge Housing (BHBH) Referral Form

If an individual requests only Transitional Rents, the Transitional Rents Referral Form must be completed. If the individual is seeking placement in one of Yolo County's BHBH facilities, both forms must be submitted. Once referral forms are received, Turning Point conducts a pre-screening review, assessing factors such as diagnosis, enrollment in Enhanced Care Management (ECM) and Community Supports (CS), prior use of recuperative care or post-hospitalization services, and whether the individual has already utilized six months of Transitional Rents during a demonstration period. If the individual is determined ineligible for Transitional Rents or BHSA funding, Turning Point will deny the referral, submit the denial to the County Housing Interventions Team for validation and tracking, and refer the individual to the local Continuum of Care, Homeless and Poverty Action Coalition, for Coordinated Entry assessment and placement on the community housing queue. If the individual is eligible, Turning Point will contact the client and develop a Housing Support Plan. For individuals who have exhausted Transitional Rents but are requesting BHBH placement, Turning Point will submit the BHBH Referral Form and documentation of the Transitional Rents denial to the County Housing Interventions Team for coordination and potential placement in BHBH, contingent on bed availability. When Turning point pre-screening confirms eligibility for both Transitional Rents and BHBH, Turning Point submits the full referral packet—including both referral forms and the Housing Support Plan—to the County Housing Interventions Team. The Housing Interventions Team then:

• Tracks all referrals

• Verifies eligibility for BHSA funding and Yolo County Specialty Behavioral Health services

• Confirms whether the individual is already connected to County services

If the County determines the individual is not eligible, the referral is denied and the individual is redirected to the Coordinated Entry system through Homeless and Poverty Action Coalition. If eligibility is confirmed, the Housing Interventions Team convenes a Multi-Disciplinary Team (MDT) meeting to coordinate care and plan next steps. The MDT evaluates:

• The client's full range of support needs

• The Housing Support Plan

• The client's pathway following the six-month Transitional Rents period and determines if the client will be self-sufficient after receiving transitional rents

Through the MDT process, several outcomes may be determined:

- Placement into BHBH (if requested and available)
- Transition to permanent housing with self-sufficiency supports
- Connection to additional housing and service programs (e.g., HDAP, HomeSafe, HSP) while receiving

Transitional Rents
- Transition to BHSA Housing Interventions following the exhaustion of Transitional Rents, including determining the anticipated duration of support

This coordinated, multi-system referral and review process ensures that individuals are matched with the most appropriate housing resources and supportive services, while maintaining accountability, data tracking, and continuity of care across Behavioral Health, housing, and community-based service systems.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only **?**

Yes

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

In, or at-risk of being in, the juvenile justice system

Yolo engaged stakeholders, including organizations serving youth with mental health/substance use needs, social services/child welfare, law enforcement, probation, and local education agencies, and youth service providers. The County Behavioral Health Department also continues to meet with community representatives to gather information about needs for individuals in or at-risk of being in the juvenile justice system, such as the schools, Department of Social Services, and County Probation. Additionally, HHSA leadership continue to participate in the county's Juvenile Justice council, to best identify and respond to the community's changing Juvenile Justice needs. This council is charged with developing a comprehensive, multiagency plan that identifies the resources and strategies for providing an effective continuum of responses for the prevention, intervention, supervision, treatment and incarceration of male and female justice involved youth, including strategies to develop and implement locally-based or regionally-based out-of home placement options.

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

Yolo engaged in a comprehensive CPP process which included representatives from the LGBTQ+ community and organizations serving LGBTQ+ youth. Additionally, seven percent of CPP survey participants identified as part of the LGBTQ+ community. Representatives from this population engaged in community feedback sessions and key informant interviews. Yolo will continue to work with community leaders and local advocacy and educational organizations to ensure youth & TAY in the LGBTQ+ community are having their voices heard.

In the child welfare system

Yolo engaged in a comprehensive CPP process which included representatives with experience with the child welfare system including transitional age youth. We partnered with Child Welfare Services and community-based providers to conduct targeted outreach and invite participation in CPP focus groups, key informant interviews, the community needs survey, and community forums. Youth and caregivers with lived experience, as well as organizations serving this population, including county Welfare Services, participated in at least one engagement activity.

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

Older adults

Yolo engaged in a comprehensive CPP process which included older adults and organizations serving this population. Representatives and participants from this population engaged in community feedback sessions, community surveys, and key informant interviews. Twenty-nine percent (29%) of the participants identified as older adults. Input gathered through the community engagement process informed program planning to ensure services are responsive to the unique needs of older adults. Older adults were identified as a subpopulation with significant needs. Additionally, HHSA leadership will continue to participate in the county's Commission on Aging & Adult Services and work with community leaders, local advocacy and educational organizations, municipalities, and community members to align programs and support for this population to ensure their voices are heard.

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

Yolo engaged in a comprehensive CPP process which included participants with lived experience, family members, focus groups, key informant interviews, law enforcement, forensic diversion programs, and community organization representatives serving the eligible adults including older adults to gather feedback and input into the planning process. Additionally, HHSA will continue to partner with the Yolo County Mental Health Court (MHC). Founded in 2013, MHC serves up to 15 Yolo County residents at a given time who suffer from serious mental illnesses and charged with Misdemeanor or Felony offenses. The program focuses on 4 goals for program participants: improving treatment engagement, reducing recidivism, reducing jail bed days, and decreasing local and state hospital bed stays. The program is a partnership between the Yolo County Superior Court, Probation Department, Health and Human Services Agency, the Public Defender, and the District Attorney. MHC is a strategic program designed to effectively address the increasing number of seriously mentally ill defendants cycling through the courts and jails. MHC is a minimum 18-month collaborative court-based treatment and monitoring system for adult offenders with serious mental illnesses.

In underserved communities

Yolo County conducted a comprehensive Community Planning Process (CPP) to gather feedback and ensure that housing planning efforts reflected the lived experiences of individuals facing homelessness, housing instability, language barriers, and limited access to services. As part of this effort, the County held two focus groups with individuals experiencing homelessness, convened two housing listening sessions, conducted key informant interviews, and engaged representatives from community-based organizations serving underserved populations. Findings from the CPP were further informed by a review of the County's 2023–2025 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), which identified housing and homelessness as priority concerns, along with the need for culturally and linguistically responsive services. These findings aligned with CPP input highlighting cultural and linguistic barriers to care. Additionally, Yolo County reviewed statewide behavioral health data on homelessness to identify disparities that housing intervention services can address, consistent with new Behavioral Health Services Act (BHSA) statewide population health metrics guiding program development. Moving forward, the County will continue to engage the community on housing needs through ongoing partnerships with agencies serving underserved populations, including immigrants and low-income communities disproportionately impacted by homelessness.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

Yolo County Behavioral Health maintains a strong and active partnership with the local Continuum of Care, Homeless and Poverty Action Coalition, through a dedicated Housing Manager role embedded within the department. The County Housing Manager serves as an ex officio board member of HPAC, actively participates in multiple CoC subcommittees, and leads the CoC's Technical Subcommittee. The role works in close collaboration with HPAC leadership, including the Chair and Executive Director, and partners with the CoC to jointly apply for Homeless Housing, Assistance and Prevention (HHAP) funding. In addition, the Housing Manager and County staff participate in CoC-administered procurement processes to support system-wide housing investments. Operationally, the Housing Manager oversees the County's Homeless Outreach Team, which engages daily with individuals experiencing homelessness and coordinates closely with CoC providers. The manager also supervises an analyst team that works in partnership with the CoC to support data-driven decision-making. Although the County previously served as the HMIS Lead for the CoC, it continues to play a critical supporting role in Homeless Management Information System (HMIS) functions. These responsibilities include data analysis, data quality and clean-up efforts, coordination with the HMIS administrator for project setup and system improvements, and support for key system-wide efforts such as the Point-in-Time (PIT) Count and Housing Inventory Count (HIC). The County further strengthens coordination by actively participating in CoC service provider meetings and delivering presentations to local nonprofit organizations on available housing and Behavioral Health resources. As a contracted provider of Enhanced Care Management (ECM) and Community Supports (CS), Behavioral

Health receives referrals from Partnership HealthPlan of California, as well as from local jurisdictions, California Department of Transportation, law enforcement, the Board of Supervisors, internal County programs, and community members. Additionally, the County—alongside Turning Point Community Programs—has conducted outreach and training for CoC partners, housing providers, and Behavioral Health organizations on the Transitional Rents referral process. Finally, Yolo County serves as a key resource to the community by providing ongoing guidance and technical assistance to providers and residents. This includes helping stakeholders understand how to navigate the full continuum of housing and Behavioral Health services and clarifying eligibility requirements for BHSA Housing Interventions.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

In addition to the collaborative efforts described above, Yolo County Behavioral Health takes an active and strategic approach to partnership with the local Continuum of Care, Homeless and Poverty Action Coalition. Behavioral Health serves as a key voice in communicating emerging Behavioral Health initiatives, policy changes, and system transformations, ensuring alignment with CoC policies, procedures, and strategic goals. This role helps integrate Behavioral Health priorities into broader homeless response efforts and promotes a cohesive, system-wide approach. The County also prioritizes listening to and supporting the goals of local jurisdictions. Behavioral Health works collaboratively to identify opportunities where County resources and funding streams may align with jurisdiction-led projects and initiatives, helping to strengthen and expand the regional housing and homelessness response system. Further reinforcing this coordination, the Behavioral Health Housing Manager serves as the administrator of the Executive Commission to Address Homelessness in Yolo County. This commission is a cross-jurisdictional body composed of elected officials from each local jurisdiction, along with leadership from Homeless and Poverty Action Coalition. The Commission convenes at least every other month to coordinate homeless services, align priorities, and advance countywide strategies to address homelessness. In addition, Behavioral Health actively participates in the Coordinated Entry system by submitting referrals and engaging in case conferencing. This ensures that Behavioral Health clients are fully integrated into the housing prioritization process and are connected to appropriate housing resources and supportive services.

Public Housing Agency

Yolo County Behavioral Health maintains strong coordination with both the local Continuum of Care, Homeless and Poverty Action Coalition, and the Yolo County Housing Authority through its dedicated Housing Manager role embedded within the Behavioral Health department. The Housing Manager serves as an ex officio board member of the CoC and actively participates in CoC subcommittees alongside key system partners, including leadership from the Housing Authority. This collaboration ensures alignment between Behavioral Health services, housing resources, and broader homelessness response strategies. Behavioral Health works closely with the Housing Authority to monitor the availability of housing vouchers and coordinate timely access for eligible individuals. In addition, the County partners with the Housing Authority on homelessness prevention efforts by providing rental assistance to low-income individuals and families at risk of eviction. This proactive approach helps stabilize households, reduce inflow into homelessness, and strengthen overall system effectiveness.

MCPs

Yolo County Behavioral Health maintains close collaboration with Managed Care Plans (MCPs) through its Housing Manager, who is embedded within the department. The Housing Manager has an established partnership with Partnership HealthPlan of California, working side by side over the past three years to develop the County's Enhanced Care Management (ECM) team, support other providers in becoming ECM-certified, and now assist in the rollout of the Transitional Rents program. The Housing Manager, along with the analyst team, has actively participated in MCP collaborative and learning sessions over the past three years. This experience will be leveraged to integrate MCP-provided Transitional Rents and ECM services to support individuals who are homeless or at risk of homelessness, reduce duplication of services, and expand system reach. Behavioral Health will collaborate with MCPs on key operational functions, including referral tracking, utilization of MCP benefits, and monitoring client outcomes. This partnership ensures coordinated care, efficient resource use, and improved housing stability for vulnerable populations.

ECM and Community Supports Providers

Yolo County Behavioral Health aligns its services to ensure that Enhanced Care Management (ECM) and Community Supports (CS) providers operate collaboratively with Behavioral Health clinicians, Full Service Partnerships (FSPs), and peer support staff to provide integrated, team-based care. Behavioral Health maintains an internal ECM team that accepts referrals from Behavioral Health clinicians, FSPs, the Forensics team, the Access team, as well as from Partnership HealthPlan of California, local jurisdictions, hospitals, law enforcement, primary care providers, community members, yolo county housing and homeless service provider and yolo county Behavioral Health providers. The Behavioral Health internal ECM team population of focus is homeless, chronically homeless, medically fragile, aging, and individuals that meet FSP level services but are not enrolled in FSP. When the internal ECM team is at capacity, the Behavioral Health Housing Manager connects internal and external partners to other identified ECM and Community Supports (CS) providers to ensure that all clients receive appropriate services. Additionally, the County's Homeless

Outreach Team engages individuals living in encampments and provides ECM and CS resources during outreach activities. Behavioral Health also collaborates closely with other local ECM and CS providers to ensure that services are delivered methodically and are responsive to each client's unique needs and preferences. This coordinated approach ensures comprehensive, person-centered care that supports housing stability, recovery, and long-term wellness for individuals experiencing homelessness or at risk of housing instability.

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

Yolo County Behavioral Health Housing Manager works closely with Yolo County CalWORKs and Child, Youth, and Family Services to ensure families and youth have access to stable housing and prevention resources. The Housing Manager coordinates with CalWORKs to connect families to housing assistance and prevention funding, helping households remain safely housed. In partnership with CYF, the Housing Manager and Behavioral Health analyst team convene case conferences to support linkages between CYF's Family Unification Program (FUP) and the Housing Authority, facilitating access to vouchers for Transitional Age Youth (TAY). This collaboration also identifies unhoused or at-risk youth and connects them to BHSA housing resources. Behavioral Health partners with local nonprofit agencies that provide permanent supportive housing for youth experiencing or at risk of homelessness. County contracts with these nonprofit providers include requirements to allocate a portion of funding specifically for youth-focused services. Additionally, Behavioral Health works proactively with housing developers to integrate Behavioral Health services into new permanent supportive housing (PSH) projects whenever opportunities arise. Through these coordinated efforts, Behavioral Health supports youth and families in accessing stable housing, supportive services, and pathways to long-term self-sufficiency.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

To date, the County of Yolo has not received Homekey+ funding. However, previous Homekey funds were awarded to the City of Woodland and Friends of the Mission to develop 60 Permanent Supportive Housing (PSH) units. These units provide affordable housing for homeless individuals and extremely low-income households. Yolo County Behavioral Health will support these units by staffing three full-time Behavioral Health Case Managers (FTEs) to provide Behavioral Health services, case management, and wraparound supports to residents, ensuring stability and long-term housing retention.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?

Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?

The county has a pending application for HHAP funds. If awarded the county will be allocating:

- $382,479.49 to permanent supportive housing services to keep people stably housed and improve retention in permanent housing.
- $70,319.84 to Rapid Rehousing to quickly move people experiencing homelessness into permanent housing by providing short-term rental assistance, move-in cost assistance and voluntary case management services
- $900,000 to prevention and diversion-to maintain existing housing and stability for households at risk of homelessness (prioritizing income less than or equal to 30% AMI households)Eligibility project activities include but are not limited to Problem-solving/diversion services that keep people from entering shelter (conflict mediation, landlord negotiation, housing problem-solving), rental assistance and other prevention programs that prioritizing income less than or equal to 30% AMI households; rapid rehousing/rental assistance is also allowable here when used as prevention. Prevention/RRH to include housing relocation & stabilization and short/medium-term rental assistance including but not limited to application fees, deposits, arrears, utility assistance, case management.
- $320,000.00 Interim Housing-low barrier temporary options that rapidly connect people to temporary, short-term, or crisis shelter options beyond traditional emergency shelters such as navigation centers and some transitional housing, all towards permanent housing. Activities may include but are not limited to Navigation Centers/low barrier emergency shelters, Motel/Hotel vouchers as bridge shelter, operating expenses for congregate and non-congregate shelters, and youth transitional housing, interim housing: build/convert non-congregate sites; clinically enhanced shelter; convert congregate to non-congregate, improvements to existing shelter to lower barriers/increase privacy (rehab, renovation, conversions, maintenance).
- $150,000 Non-Housing Solutions-Purpose: unsheltered solutions that are not housing placements or shelter, but that reduce harm and connect people to housing. Projects may include but are not limited to Street Outreach and evidence-based engagement, housing navigation in the field, harm-reduction services, coordination with street-based health care, Hygiene supports for encampments/unsheltered individuals, lived-experience participation costs (youth/adult advisory boards, stipends)
- $49,992.60 Rapid Rehousing (same services as listed above) for youth
- $100,000 Prevention/Diversion (same services as listed above) for Youth
- $50,000 Interim Housing (same services as listed above) for youth

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?

180

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

90

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

90

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

The County of Yolo is currently serving a total of 130 Full-Service Partnership (FSP) clients under the BHSA plan. Not all clients will require rental assistance simultaneously; some may need support for only one month, while others may require assistance for multiple months or on an ongoing basis. This projection ensures that all clients are considered in planning and resource allocation. The County has assumed that all Permanent Supportive Housing (PSH) beds and time-limited transitional beds will be occupied by one individual for the full year. In Year Two, the number of clients receiving rental subsidies is expected to increase due to the conclusion of the Behavioral Health Bridge Housing (BHBH) program. This transition will add approximately 55 additional individuals who may require rental support, totaling approximately 235 individuals, further emphasizing the need for coordinated housing interventions and resource planning.

For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

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

This intervention provides individualized rental subsidies based on each person's unique needs and their Housing Support Plan. Subsidies may be structured as a one-time payment or multiple monthly payments, depending on the individual's circumstances and the housing placement setting. Non–time-limited rental subsidies may be provided in a variety of permanent housing settings to eligible individuals living with serious mental illness or co-occurring conditions. The primary goal of this intervention is to remove cost as a barrier to housing stability, thereby promoting recovery, independence, and long-term wellness. Rental subsidies are provided for as long as needed or as determined by the Housing Support Plan in consultation with a Multi-Disciplinary Team (MDT). This approach ensures that individuals have a pathway to

independence and self-sufficiency whenever possible, which may include transitioning successfully to another permanent housing resource or an alternative rental subsidy. Expected outcomes of this intervention include increased housing stability, reduced homelessness, and improved Behavioral Health outcomes. By leveraging BHSA funds alongside federal, state, and local resources, this intervention maximizes impact while ensuring individuals receive both the housing and supportive services necessary to achieve long-term stability.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

Over the past five years of MHSA implementation, Yolo County Behavioral Health has developed multiple Permanent Supportive Housing (PSH) units for individuals who are BHSA-eligible. Building on this foundation, Behavioral Health plans to utilize BHSA HI to implement a capital development procurement process utilizing BHSA funding to further expand housing options. The capital development initiative may include one or more of the following activities:

- Acquisition of new housing units
- New construction of PSH units
- Renovation or rehabilitation of existing units

In addition to capital development, the procurement will allocate funding to support operating subsidies for PSH and/or interim housing units serving BHSA-eligible individuals. Behavioral Health works closely with the Homeless and Poverty Action Coalition, the local Continuum of Care responsible for coordinating Yolo County's homelessness response and prevention efforts. Through this partnership, Behavioral Health participates in countywide collaboratives and holds a seat on the HPAC board, helping guide decisions on the allocation of homelessness funding to ensure the needs of the most vulnerable populations including BHSA-eligible individuals are effectively addressed.

Total number of units funded with BHSA Housing Interventions per year

180

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units

Yolo County seeks to provide flexible, person-centered rental subsidies that meet each BHSA-eligible individual where they are and support them in achieving self-sufficiency. The County recognizes that

clients' needs vary: some may require a one-month rental subsidy, others may need support for several months, and some may require a longer-term arrangement By not tying rental subsidies to a fixed number of units, the County increases its capacity to serve multiple clients and tailor housing support to each individual's unique circumstances. This flexible approach ensures that resources are used efficiently while maximizing housing stability, recovery, and long-term wellness for BHSA-eligible individuals.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
28

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Behavioral Health will utilize Behavioral Health Services Act (BHSA) Housing Intervention funding to provide operating subsidies that support the long-term affordability and sustainability of permanent supportive housing for individuals with serious behavioral health conditions. This intervention addresses housing instability by covering the gap between tenant rent contributions and the full cost of operating housing units.

Funds will be used to offset ongoing operational costs, including property management, utilities, maintenance, and service coordination, in both County-supported and partner-operated housing. Behavioral Health will leverage partnerships with community-based providers to expand and sustain housing capacity.

Priority will be given to individuals experiencing or at risk of homelessness, including those enrolled in Full Service Partnership (FSP) programs. By maintaining affordable housing, this intervention supports housing stability, engagement in treatment, and reduces reliance on crisis and institutional care.

Behavioral Health will coordinate with housing and service partners to ensure alignment with Housing First principles and will monitor implementation to ensure effective use of funds and positive housing outcomes.

Yolo County will be sustaining existing operating subsidies using BHSA HI funds, and will be looking to solicit proposals for additional operating subsides as funding is available.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
28

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
20

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
The Housing Interventions Behavioral Health Case Managers (BHCMs) will work closely with individuals to identify housing options that best meet their unique needs. BHCMs will also engage directly with landlords, advocating on behalf of clients and assuring landlords that the case managers will serve as an ongoing support system for tenants. BHCMs will provide guidance to clients on housing rules, expectations, and responsibilities to promote successful tenancy and long-term stability. Through this hands-on approach, BHCMs help bridge the gap between clients and landlords, ensuring both parties have the support needed to maintain stable and sustainable housing arrangements.

Total number of units funded with BHSA Housing Interventions per year
90

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
Landlord outreach and mitigation funds will be utilized on a case-by-case basis to incentivize landlords for placement security and to fund staffing of BHCMs to provide the landlord outreach activities.

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
20

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Yolo County Behavioral Health has allocated a limited portion of Behavioral Health Services Act (BHSA) Housing Interventions funding to cover allowable housing-related costs. These may include, but are not limited to, housing application fees, credit report fees, storage costs, security deposits (when other community supports have been exhausted), and pet-related deposits or fees. The Housing Interventions Team will ensure that all eligible community support services have been fully utilized prior to accessing BHSA funds.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
<11*

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

Yolo County Behavioral Health will provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services to individuals who are not eligible to receive these services through a Medi-Cal Managed Care Plan (MCP). In addition, the County is a contracted Enhanced Care Management (ECM) and Community Supports (CS) provider and maintains a small ECM team. This team assists in verifying clients' eligibility status and supports coordination by connecting individuals to the appropriate funding stream and services.

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

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

The county is prioritizing HI funding to other interventions. Outreach and Engagement as an activity is embedded within various housing interventions and will not be funded as an individual intervention.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?

1

Capital Development Project

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
Yolo County BHSA Capital Development Project

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Tiny Homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Recuperative Care
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Capacity (Anticipated number of individuals housed at a given time)
50

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
50

Total number of units funded with Housing Interventions funds only
50

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
n/a

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
12/31/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
20000

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
n/a

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year
0

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
In year two of the BHSA Plan, the Behavioral Health Bridge Housing Program will be ending and Behavioral Health is budgeting to continue the program(s) by utilizing BHSA Housing Intervention funding.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Transitional Rent

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
Undecided

Recuperative Care
Undecided

Day Habilitation
Undecided

Transitional Rent
No

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
As previously stated, Yolo County Behavioral Health Housing Interventions Team has an established referral process with the County's Transitional Rent provider, Turning Point Community Programs. All referrals for Transitional Rent and the Behavioral Health Bridge Housing (BHBH) Program are submitted through Turning Point Community Programs, which conducts an initial pre-screening to determine individual eligibility for these programs. If an individual is deemed eligible, Turning Point Community Programs will develop a Housing Support Plan and submit the referral(s), along with the plan, to the County Housing Interventions Team for final eligibility validation. For individuals who are not requesting Transitional Rent but are seeking other Community Supports, Yolo County Behavioral Health maintains an Enhanced Care Management (ECM) and Community Supports (CS) team that provides the "housing trio," which includes Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy Sustaining Services. The ECM team will support these individuals directly when capacity allows. If the County ECM team is at capacity or does not provide the specific Community Supports being requested, the ECM team will connect individuals to Partnership HealthPlan of California for referral to an appropriate Community Supports provider with available capacity or the ability to deliver the services needed.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county
As previously stated, the Yolo County Behavioral Health Housing Interventions Manager has been working collaboratively with Turning Point Community Programs, the County's Transitional Rent provider, to conduct outreach and education across a variety of settings. These include the local Continuum of Care (CoC), Behavioral Health provider networks, and other community service provider meetings. These efforts focus on educating the public and community partners about available housing interventions, how to access services, and the established referral process. In addition, the Behavioral Health Housing Interventions Manager meets with this community partner weekly to track, analyze and problem solves any issues that may arise in the Transitional Rent/BHBH referral process. In addition, the Behavioral Health

Housing Interventions Manager oversees other prevention programs, which further expand the County's ability to engage with community partners and reach underserved populations. The Behavioral Health Housing Interventions Manager also actively participates in three public-facing bodies in different capacities, including as a board member, meeting administrator, and representative of Yolo County Behavioral Health:

• Community Services Action Board – This board assesses the needs of low-income individuals and families in Yolo County and supports the development and delivery of services to address those needs.

• Executive Commission to Address Homelessness – This commission includes local jurisdiction representatives, a member of the Board of Supervisors (BOS), and the Housing and Poverty Action Coalition (HPAC) Chair. The group focuses on policy discussions, system impacts on the unhoused population, and strategic planning efforts aimed at achieving functional zero homelessness.

• Housing and Poverty Action Coalition (HPAC) – The local Continuum of Care (CoC), which coordinates regional efforts to address homelessness and housing instability.

Lastly, the Yolo County Behavioral Health Housing Interventions Manager oversees a Proposition 47 grant program and participates in regular monthly and quarterly meetings with key partners, including the District Attorney's Office, Public Defender's Office, an Intensive Case Management provider, and a local housing provider. These meetings focus on evaluating successes and addressing barriers for individuals transitioning from encampments or incarceration and reintegrating into the community. Program efforts emphasize intensive case management, workforce development, and progression through various stages of housing stability. These meetings also serve as an opportunity for the Behavioral Health Housing Interventions Manager to inform and educate community partners about available housing intervention services and strengthen cross-system collaboration.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

Yes

Please describe the county behavioral health system's coordination efforts to align network development

The Yolo County Housing Interventions team collaborates closely with the Transitional Rent provider, Turning Point Community Programs, to ensure client eligibility through cross-system verification. Turning Point conducts the initial pre-screening, and if a client is deemed eligible, the referral is submitted to the County for secondary verification of the provided information. Referrals are submitted electronically via Smartsheet, which tracks client demographic data, service requests, duration of assistance, and eligibility status, thereby maintaining a comprehensive and ongoing record of community supports provided. Additionally, the Yolo County Behavioral Health ECM team tracks Community Supports (CS) clients through the Homeless Management Information System (HMIS), and eligibility information is further validated directly with Partnership. Due to the Housing Interventions Manager serving as both a board member and

subcommittee lead for the local Continuum of Care (CoC), HPAC, strong working relationships have been established with local nonprofits and ECM/CS service providers. Through this collaboration, the County and its partners ensure that individuals receiving ECM and Community Supports services can access care from their provider of choice. This coordinated approach also ensures that services are tailored to meet everyone's unique needs. Ongoing communication and collaboration across agencies help prevent duplication of services and support a streamlined, client-centered system in which individuals receive comprehensive care through a single provider whenever possible.

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
While many individuals with significant Behavioral Health conditions are connected to the Full-Service Partnership (FSP) programs, others are served through the Behavioral Health Bridge Housing (BHBH) program, where they receive housing case management support. Because the BHBH program is overseen within the Housing Interventions Team, participants benefit from enhanced, integrated support. The Housing Interventions Manager meets weekly with BHBH providers to offer guidance and consultation, particularly when providers encounter individuals exhibiting signs of Behavioral Health episodes or changes in functioning that may jeopardize housing stability. When such situations are identified, the Housing Interventions Manager coordinates with internal Behavioral Health services and the crisis response team to ensure individuals are promptly connected to appropriate care. Also embedded within the Housing Interventions Team is the Homeless Outreach/Enhanced Care Management (ECM) team, which provides additional support as needed. This team works closely with CalTrans and local jurisdictions to conduct encampment in-reach efforts. Additionally, when providers within the local Continuum of Care (CoC) identify individuals requiring a higher level of care, the Homeless Outreach/ECM team can intervene to facilitate timely linkage to appropriate services and supports. Lastly, although the Homeless Outreach/Enhanced Care Management (ECM) team is housed within the Housing Interventions Unit, the unit also includes analysts who actively pursue grant funding to support this population. These efforts help expand resources and services, ultimately reducing gaps in care and ensuring individuals are less likely to fall through the cracks.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

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

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
Yolo County will be evaluating Flex Pools, but is not currently including this intervention

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?
No

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
18

Upload any data source(s) used to determine vacancy rate
Workforce Vacancy Report 01302026.xlsx

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Psychiatric Technician (PT)
Psychiatrist
Licensed Marriage and Family Therapist
Mental Health Rehabilitation Specialist
Licensed Clinical Social Worker

Please describe any other key workforce gaps in the county
Yolo County is Federally designated as a low-income Mental Health Professional Shortage Area (HPSA), reflecting significant unmet need for behavioral health services and an insufficient supply of mental health providers to adequately serve the community. The county continues to face persistent workforce gaps across the behavioral health continuum, including shortages of psychiatrists, licensed clinicians, substance use disorder treatment providers, peer support specialists, and bilingual and bicultural staff. These challenges are further impacted by provider burnout, recruitment and retention difficulties, increasing demand for services, and expanded BHSA and CalAIM implementation requirements. Workforce shortages are particularly pronounced for specialty populations, including children and youth, individuals with

co-occurring disorders, people experiencing homelessness, and residents in rural and underserved communities.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Over the next three fiscal years, new requirements under BHT and BH-CONNECT will significantly increase workload, complexity, and administrative demands for behavioral health staff. Yolo County does not anticipate having any additional funding to support implementation of these, and other, initiatives. The result is that current staff will likely be required to absorb this workload. The county expects that with these additional demands, there may be increasing vacancies due to burnout, higher turnover and ongoing challenges with recruitment and retention stemming from limited resources and increasing work demands.

Implementation of BHT, BH-CONNECT, BHSA, CalAIM, CARE Court, enhanced documentation and reporting requirements, and new evidence-based and community-defined practices will require significant shifts in workforce roles, operational responsibilities, and staff competencies across the behavioral health continuum. The county anticipates growing demand for clinicians, care coordinators, peer support specialists, substance use disorder treatment staff, mobile crisis personnel, housing-related service staff, and bilingual and bicultural providers capable of supporting increasingly complex clinical and social needs. Additional staffing pressures are expected in utilization management, quality improvement, fiscal operations, contract oversight, compliance, data collection, outcome reporting, and information technology functions needed to support expanded state reporting and accountability requirements, including Individual Service Level (ISL) and Behavioral Health Outcomes, Accountability, and Transparency Reporting (BHOATR).

The county also anticipates expanded training and workforce development needs for both existing and newly hired staff to ensure alignment with evolving BHSA and Medi-Cal requirements. Training priorities are expected to include implementation of new evidence-based practices; trauma-informed and culturally responsive care; co-occurring mental health and substance use treatment; enhanced care management and care coordination; documentation and claiming requirements; housing intervention models; crisis response protocols; recovery-oriented and peer-integrated services; community-defined evidence practices; and use of new data and reporting systems. Additional training and supervision capacity may be needed to support peer workforce integration, clinical licensure pathways, and workforce pipeline development. Given the pace and volume of system transformation efforts occurring simultaneously, the county anticipates ongoing operational strain and the need for phased implementation strategies, cross-training, and technical assistance to support workforce sustainability and continuity of care.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Yolo County is positioning itself to engage in the initiative, and staff are assigned to track BH-CONNECT workforce initiatives.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Yolo County is positioning itself to engage in the initiative, and staff are assigned to track BH-CONNECT workforce initiatives. The county will work with community based providers to encourage their participation in this initiative.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Yolo County is positioning itself to engage in the initiative, and staff are assigned to track BH-CONNECT workforce initiatives.

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
Due to significant budget constraints, all County departments are currently operating under a hiring freeze. Ongoing workforce shortages, combined with fiscal limitations, have also required the elimination of long-vacant positions over the past two years. These challenges are not unique to Yolo County.

Behavioral health systems across the state are facing a complex set of pressures, including rising demand for services, reductions in state and federal funding, a statewide workforce shortage, and an already overextended service delivery system. At the same time, new and evolving State mandates are further straining available resources.

In response, Behavioral Health leadership is actively working to restructure the system of care to ensure compliance with mandates, support staff, and maintain high-quality services for vulnerable community members. Ongoing efforts include improving communication with staff, fostering morale and team cohesion, and engaging staff in program evaluation and system transformation.

Our goal is to build a trauma-informed organization where staff feel valued, work more effectively and sustainably, and where the community receives welcoming, high-quality mental health and substance use services.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Yolo BHSA Integrated Plan Budget-Resubmission 2.xlsx
Yolo BHSA Integrated Plan Budget - Draft Resubmission.xlsx
Yolo BHSA Integrated Plan Budget - Draft.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A- the county is already below the 20% prudent reserve limit.

Full Service Partnership (FSP)
N/A- the county is already below the 20% prudent reserve limit.

Housing Interventions
N/A- the county is already below the 20% prudent reserve limit.

Enter date of last prudent reserve assessment
5/4/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A- the county is already below the 20% prudent reserve limit.

FSP
N/A- the county is already below the 20% prudent reserve limit.

Housing Interventions
N/A- the county is already below the 20% prudent reserve limit.

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Yolo Behavioral Health Director Certification TK.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
03.27.26 - Yolo County Administrator or Designee Certification - Signed by MW.pdf

Board of supervisor certification

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

Please upload the completed Board of supervisor certification template

Requests

Funding Transfer Request

Please enter the proposed allocation adjustments to the tables below

	Plan year one	Plan year two	Plan year three
Behavioral Health Services and Supports (Base 35%)	42	42	42
Full Service Partnership (Base 35%)	35	35	35
Housing Intervention (Base 30%)	23	23	23
Housing Interventions for Outreach and Engagement	0	0	0

Behavioral Health Services and Supports Transfers

Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred from Housing Intervention	1361372	1344637	1348409
Dollars transferred into Full Service Partnerships	0	0	0
Dollars transferred into Housing Intervention	0	0	0

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

Yolo County is requesting a transfer of funds from Housing Intervention (HI) to Behavioral Health Services and Supports (BHSS) to sustain critical treatment services and programs serving Behavioral Health Services Act (BHSA) priority populations. As the County transitions from prior MHSA Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) funding structures into the BHSA framework this transfer ensures continuity of care and maintains access to essential outpatient, rehabilitative, and supportive services that address the local needs of individuals with serious mental illness, substance use disorders, crisis services, and those at risk of institutionalization or homelessness. This funding transfer request aligns available funding with current service demand, program utilization trends, and data

collected through the County's community program planning (CPP) process and Board of Supervisor feedback on budget approach. This action supports system stability, prevents service disruptions, and ensures ongoing compliance with BHSA requirements to prioritize high-need populations.

Full Service Partnership Transfers

Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Housing Intervention	0	0	0
Dollars transferred into Behavioral Health Services and Supports	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Housing Intervention	0	0	0

For Full Service Partnership, please include a rationale for the funding allocation transfer request

N/A

Housing Interventions Transfers

Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Full Service Partnerships	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Behavioral Health Services and Support	1361372	1344637	1348409
Dollars transferred into Full Service Partnerships	0	0	0

For Housing Intervention, please include a rationale for the funding allocation transfer request

Housing Interventions (HI) are a cornerstone of recovery, supporting stability and long-term health outcomes for individuals living with serious mental illness or substance use disorder. Yolo County recognizes the essential role housing plays in recovery and remains committed to sustaining and expanding housing supports. The proposed 7% reallocation to BHSS is approximately $1.4M annually between FY2026-29 and will not diminish the County's ability to deliver housing interventions. Yolo County will continue to invest in housing through a variety of funding and local partnerships. These funding streams, coupled with the County's ongoing commitment, ensure that housing supports remain viable and effective even with the transfer. Importantly, stakeholders have consistently emphasized that housing and early intervention must go hand in hand. Without strong behavioral health services, housing alone cannot meet the full spectrum of client needs. This reallocation ensures that the treatment and service side of the continuum is adequately resourced. The BHSS investments will reduce reliance on emergency departments, maintain access to crisis services, and provide timely outpatient care-all of which directly support the effectiveness of housing interventions. By addressing behavioral health needs more effectively, individuals are better able to maintain housing stability, achieve recovery goals, and avoid repeated cycles of crisis and homelessness. Thus, the reallocation not only protects but also enhances the overall integration of housing and treatment supports in the County.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?

This funding request is directly supported by community-identified needs through the Community Planning Process (CPP). The CPP process included the solicitation of system strengths, needs and gaps, and focus priority populations. CPP findings were used to ensure that service planning reflects lived experience perspectives, addresses disparities, and responds to local community conditions. Through these combined efforts, Yolo utilized data to guide program design, funding strategy, and system transformation priorities, ensuring that the Integrated Plan is community-informed, equitable, and aligned with BHSA goals.

Across educational sessions, listening sessions, focus groups, key informant interviews, and community forums, stakeholders consistently emphasized the importance of early invention services including crisis services, recovery-oriented supports, and accessible community-based engagement programs. Participants across age groups and priority populations identified wellness and recovery services, peer supports, navigation assistance, and timely crisis response as essential components of the behavioral health continuum. In addition, community members and system partners repeatedly highlighted the value of outreach and ongoing engagement strategies to ensure individuals are connected to care before needs escalate. Stakeholders prioritized early intervention approaches that respond to warning signs rather than waiting for crisis thresholds.

Please include local data supporting the funding transfer request

Yolo BHSA_Community Planning Process Report final (Rev 3.30.26).pdf

Data Suppression Notice:

Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"

Acknowledgements

Yolo County extends sincere gratitude to all community members and system partners who participated in the Community Planning Process. Your voices, experiences, and insights were essential to shaping this plan and will continue to guide our work. We extend our appreciation to the Yolo County Board of Supervisors and the Local Behavioral Health Board for their leadership, guidance, and continued support throughout this effort. We also thank County staff for their dedication and contributions in supporting and advancing this work.

Yolo County BHSA 26-29 Community Planning Process
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Yolo County Community Planning Process

Introduction

For two decades, California's county behavioral health systems have operated under the Mental Health Services Act (MHSA), also known as Proposition 63, which was approved by voters in 2004. With the passage of Proposition 1, California has now transitioned to the Behavioral Health Services Act (BHSA), marking a shift in how behavioral health services are funded, delivered, and shaped by community voice.

The BHSA represents an opportunity to examine which services receive funding, how counties can most effectively serve their communities, and how transparency and accountability are maintained with the public. This transition is funded by the same mechanism established under MHSA: a 1% tax on personal incomes exceeding $1 million annually. However, the BHSA expands the scope and structure of behavioral health planning to better integrate services and strengthen community participation.

Under the BHSA, counties are required to develop a comprehensive Behavioral Health Integrated Plan covering 2026-2029, with ongoing community engagement as a central and continuous responsibility. The BHSA expands the scope of required stakeholder engagement, mandating consultation with a broader array of community groups and populations than previously required. This expansion underscores the importance of cultivating meaningful and sustained relationships with diverse community stakeholders. It ensures that planning processes are inclusive of voices that may have been underrepresented in previous cycles.

This first Integrated Plan outlines Yolo County's plans for allocating BHSA funds during the next three fiscal years. It was developed through an inclusive Community Planning Process (CPP) that engaged a wide range of stakeholders across the county, including individuals with lived experience of mental health challenges, substance use disorders, and homelessness; families and caregivers; youth and young adults; behavioral health providers; public safety and education partners; healthcare organizations; county agencies; veterans; Tribal representatives; disability and aging service providers; and individuals from diverse racial, ethnic, cultural, and linguistic backgrounds.

The planning process reflects Yolo County's commitment to creating BHSA-funded programs that are recovery-oriented, client- and family-driven, culturally responsive, and grounded in authentic collaboration across systems and communities.

Community Engagement

Yolo County views genuine community participation as both a continuous commitment and an everyday practice rather than a singular activity. The CPP builds upon the county's existing efforts to connect with individuals who live and work in the county, system partners, establish trust within communities, and address emerging local priorities. To support this work, Yolo County Health and Human Services Agency (HHSA) partnered with EVALCORP to design and implement the Community Planning Process.

The CPP was intentionally structured to promote accessibility, equity, and responsiveness, establishing varied opportunities for participation and prioritizing the perspectives of individuals and communities whose voices have often been historically marginalized. Through this methodology, Yolo County aimed not merely to collect information but to deepen partnerships and establish a sustainable framework for collaborative service delivery.

The BHSA CPP was implemented in three phases between May and November 2025.

Phase 1: Baseline Analysis and Planning (May–August 2025)

The CPP began with an analysis of the Statewide Behavioral Health Goals and Yolo County's performance metrics, as well as a review of past Community Health Assessments (CHA) and Community Health Improvement Plans

(CHIP), to identify service gaps, disparities in access and outcomes, and populations experiencing inequities. This baseline assessment informed the development of engagement strategies, prioritization of outreach efforts, and identification of priority themes to explore through community engagement activities.

In August 2025, the county conducted stakeholder mapping to identify representatives from each of the 30 state-mandated stakeholder groups. The county then developed a multi-modal engagement strategy and CPP Community Engagement Plan (see Appendix A) designed to offer multiple participation options and accessible pathways for diverse stakeholders to inform planning decisions.

Phase 2: Community Launch (September 2025)

On September 10, 2025, the CPP was formally launched through an online Community Engagement Workgroup (CEWG) meeting. The meeting provided participants with information on BHSA requirements, funding structure changes, new plan components, and upcoming data collection activities. The session included a Q&A segment to address questions, clarify processes, and ensure community members feel informed and equipped to participate in future planning activities.

Phase 3: Data Collection (September–November 2025)

From September 11, 2025 to November 21, 2025, Yolo County implemented a mixed-methods engagement approach. A total 514 individuals participated across the following activities:

- **Community Engagement Workgroup (CEWG) meeting** – Forum for input and information sharing.
- **Community Behavioral Health Survey** – A survey available online and in hard copy format, offered in four languages (English, Spanish, Russian, and Farsi) with versions designed for children and youth, caregivers, and system partners.
- **Focus groups** – Facilitated discussions with individuals with lived experience of mental health challenges, substance use disorders, and homelessness.
- **Listening sessions** – Sessions focused on each of the BHSA's main funding components.
- **In-depth key informant interviews** – Individual conversations with system partners and service providers regarding service delivery, coordination, and system improvement.

This combination of methods provided multiple pathways for participation, accommodating different preferences and capacities for engagement related to language, technology access, scheduling, and participation format.

Participation and Representation

Participation data across all activities are summarized in **Table 1**. Detailed demographic breakdowns by activity type are available in Appendix B. The comprehensive list of stakeholder engagement dates and methods will be included in the 2026-2029 Integrated Plan and is available upon request.

Table 1. Community Planning Process: Engagement Activities and Participation Summary

Engagement Activity	Format	Number of Activities	Number of Participants
Community Engagement Work Group (CEWG)	Virtual (Zoom)	1	41
Community Behavioral Health Survey	Online and Hardcopy	1	268
Focus Groups	In-Person and Virtual (Zoom)	6	26
Listening Sessions	Virtual (Zoom)	4	144
In-Depth Key Informant Interviews	Virtual (Zoom)	29	35
Totals		**41**	**514**

Community Behavioral Health Survey Findings

The Community Behavioral Health Survey was available online and in hard copy format from September 10, 2025, to December 1, 2025. The survey was offered in four languages (English, Spanish, Russian, and Farsi) with tailored versions designed for children and youth, caregivers, and system partners. A total of 268 respondents completed the survey. Respondents were asked about their perceptions of the most pressing behavioral health challenges, the availability of mental health, substance use, and housing services, barriers to accessing care, and recommendations for improving access to support.

The findings below reflect community perspectives and highlight opportunities for improvement in Yolo County's behavioral health system.

Survey respondents were comprised of majority (71%) females, with more than half (54%) of respondents falling between the ages of 26 and 59 (Mean Age = 49 years old). Nearly two-thirds of respondents (62%) identified as White, and almost 9 out of every 10 respondents (87%) reported their primary language to be English. A more detailed demographic overview of survey respondents is included in Appendix B, offering additional context on the individuals who contributed to this data collection effort.

The survey engaged a variety of community members, including youth, system providers/partners, and caregivers. As shown in **Table 2**, slightly more than half of all respondents identified as providers or system partners, with slightly fewer than half of respondents being general community members. Just under half of all participants indicated that they were a caregiver who regularly cared for or helped a family member or someone close to them who had ongoing mental health and/or substance use challenges. Four additional youth participants under the age of 18 completed a version of the survey designed for the youth population.

Table 2. Community Survey Respondent Types

Respondent Type	N	Percent
Community Member	122	45%
Provider or System Partner	142	53%
Youth (Under 18 years old)	4	2%
Caregiver*	128	48%
Total	**268**	

*Both Community Members and Providers/System Partners could identify as caregivers, so total percentage across all respondent types > 100%.

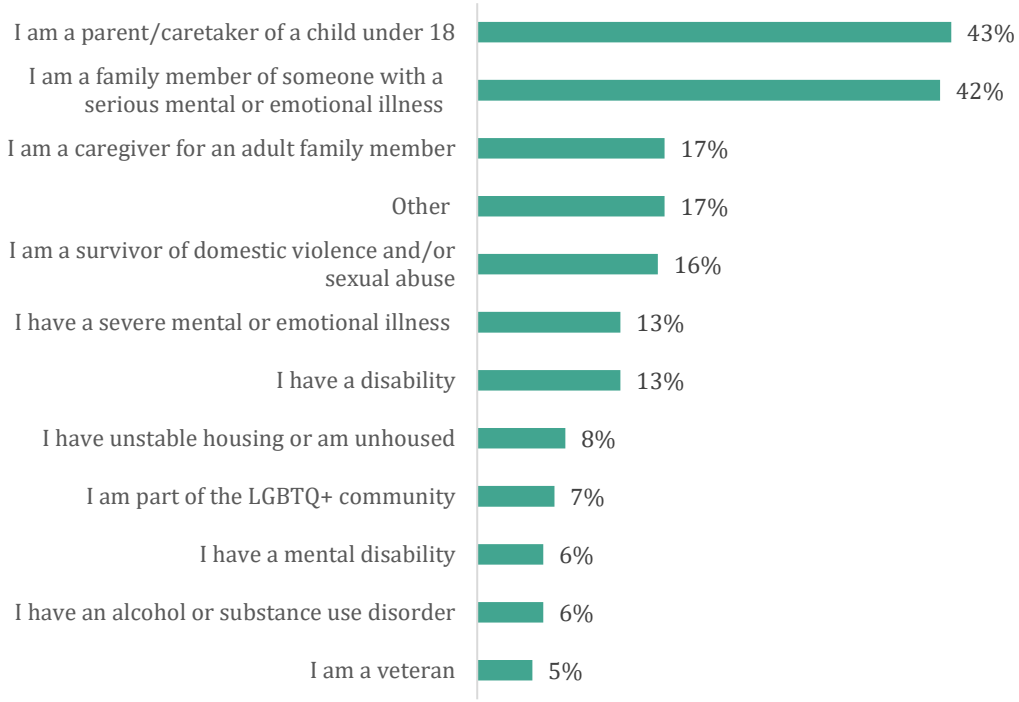
Additional Personal Identities

Community Behavioral Health Survey respondents were asked about additional identities they held. Understanding the various identities of respondents aids in ensuring that insights gained through the Community Behavioral Health Survey are inclusive and effective. As shown in **Figure 1**, nearly half of the respondents identified as being a *parent/caretaker of a child under 18* (43%), and nearly as many identified as having a *family member with severe mental or emotional illness* (42%). Nearly one in five identified as being a *caregiver for an adult family member* (17%). Percentages were calculated based on the number of individuals who answered this item about additional personal identities (n = 176).

Almost one-fifth (17%) of Community Health Survey respondents indicated that they had identities beyond those listed in **Figure 1**. "Other" identities included pediatric primary care provider, service provider, Nurse Practitioner, mental health specialist, resident, concerned citizen, assisting family with childcare, support, family member of individuals struggling with anxiety, physician, school psychologist, private attorney, advocate, speech pathologist, community volunteer, family member of an individual with SUD, county employee, individual with early family trauma and complex PTSD, retired psychiatrist, family member with cognitive impairment, attorney who assists

with mental health issues, spouse of an individual with ASD and ADHD, executive director of a nonprofit organization serving older adults, firefighter, first responder, and a parent of child with ADHD and OCD.

Figure 1. Additional Identities of Community Behavioral Health Survey Respondents*
(N = 176)



*As respondents were allowed to choose more than one option, the total percentage of responses is greater than 100%.

Throughout the following report, survey items may include subgroup response rates based on the identities listed above, as well as based on survey type (provider versus community member) in cases where the subgroup response pattern deviates markedly from the total population response pattern.

Additionally, respondents identifying as system partners or providers were asked to specify the type of organization with which they were affiliated, allowing for a better understanding of representation across organizations that support behavioral health, substance use, and homelessness. The most common responses included individuals who represented *early childhood services* (23%), *K-12 education* (22%) and *organizations serving adults with mental health or substance use needs* (20%). Percentages were calculated based on the number of individuals who answered this item about organizational identities (n = 103). Several respondents identified other organizational affiliations, including primary care and behavioral health for PEDs, home visiting for 0-3, public guardian, affordable housing organization, West Sacramento Commission on Parks, Recreation, and Intergenerational Services, Yolo County Commission on Aging and Adult Services, Yolo County Disaster Relief Services, Yolo County Voting Accessibility Advisory Committee, and Davis Community Church (see Appendix B).

Behavioral Health Issues

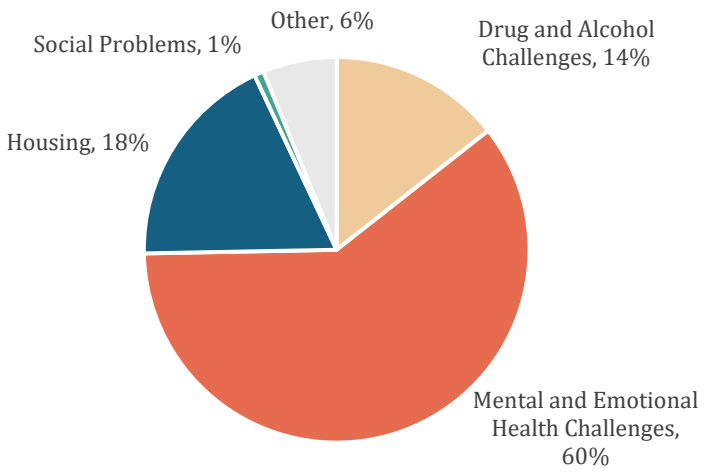
Understanding the behavioral health challenges most frequently cited by community members is essential for guiding responsive planning and resource allocation. Through the Community Health Survey, respondents shared their top concerns, highlighting specific issues they believed require greater attention and support within the current system.

Figure 2 presents the behavioral health issues identified by survey respondents as the most important in the community. Three out of every five respondents (60%) indicated that *mental and emotional health challenges*

were the most important behavioral health issue, above and beyond *drug and alcohol challenges*, *housing*, *social problems* (for youth), and *other behavioral health issues*.

Figure 2. Most Important Behavioral Health Issues Identified by Survey Respondents

N = 257



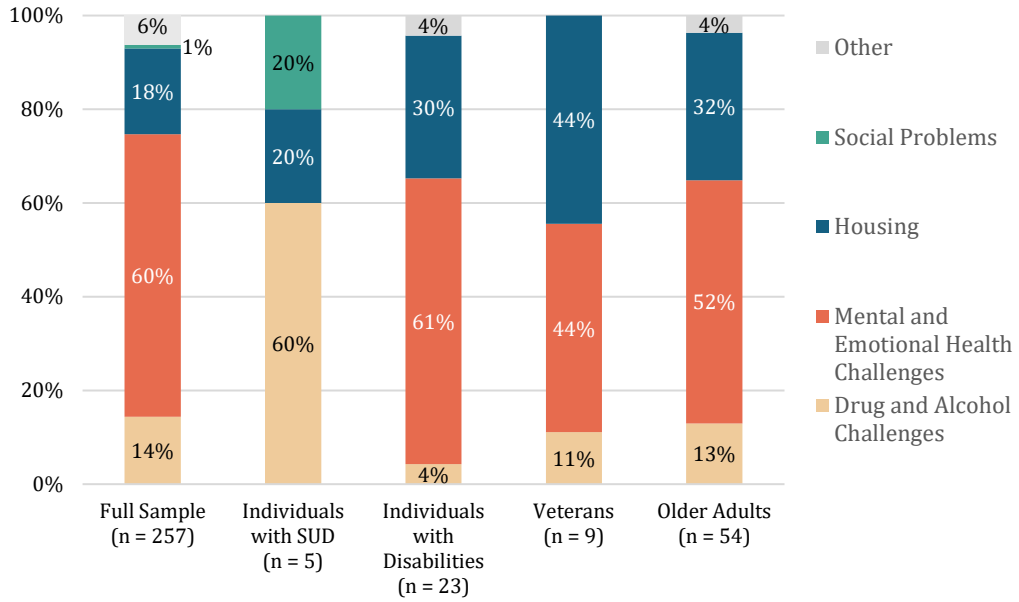
Note: the Social Problems option was only presented in the youth survey (n = 4 respondents)

Of respondents who selected *other*, several noted the interconnectedness across these issues, emphasizing that mental health, substance use, and housing are equally important and must be addressed simultaneously. Others mentioned early intervention and early childhood mental health services (including services for children 0-5), school-based services, and other specific populations.

The perception of the most important behavioral health issue differed across subgroups of respondents. **Figure 2b** presents the behavioral health issues identified as most important in the community by survey respondents across different identities, highlighting only response patterns that differ from those seen in the full sample of respondents.

As seen in **Figure 2b**, individuals with SUD prioritized *drug and alcohol challenges* (60%) above and beyond what was seen in the full sample of respondents (14%) or from any other subgroup. Conversely, individuals with disabilities were less likely to select *drug and alcohol challenges* (4%) as the most important issue. While selection of *mental and emotional health challenges* was fairly consistent across some subgroups, it is notable that no individuals with substance use disorder (0%) selected this as the most important issue and fewer survivors of domestic violence (44%) selected this option compared to others. Survivors of domestic violence were much more likely to select *housing* (44%) as the most important issue, compared to the full sample (18%) as were several other subgroups, including older adults (32%) and individuals with disabilities (30%). Finally, *social problems* (an item available only for youth respondents) was selected by individuals with substance use disorder more often (20%) than in any other group or the full sample (1%).

Figure 2b. Most Important Behavioral Health Issues Identified by Survey Respondents Across Subgroups



Note: Some subgroups have small sample sizes (n < 10); therefore, findings should be interpreted with caution.

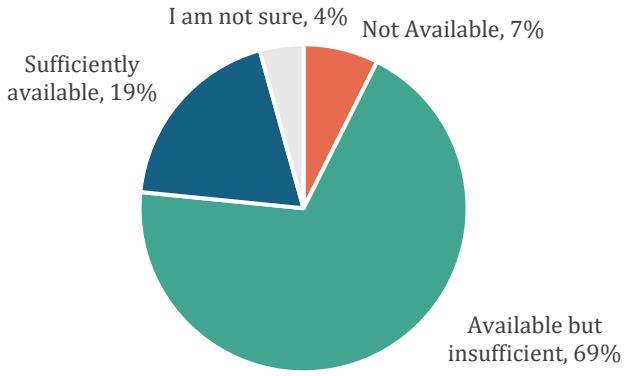
Assessment of Service Availability

Survey respondents were invited to identify where services may be lacking by assessing the availability of existing services addressing mental health, substance use, and housing-related challenges in the community. Their responses revealed gaps in service availability and effectiveness. **Figures 3**, **4,** and **5** show that, although some services were seen as available, nearly or more than two-thirds of respondents felt that these services were either not available or not sufficient to meet the community's needs. Housing services were perceived to be the least available across the three service types. **Figures 3b**, **4b**, and **5b** display respondents' perceptions of availability of services across different subgroups.

Figure 3 shows that more than two out of every three respondents perceived mental health services to be *available but insufficient to meet the needs*.

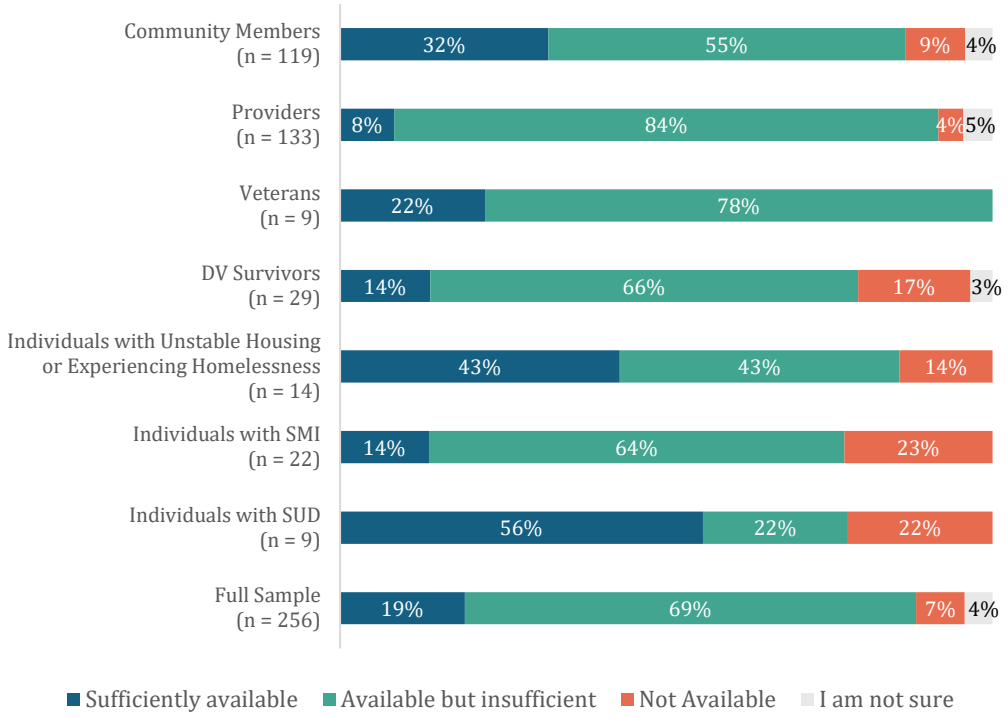
Figure 3. Overall Availability of Mental Health Services in the County as Identified by Survey Respondents

(N = 256)



As seen in **Figure 3b** many subgroups experience lower levels of mental health service availability compared to the overall population. Compared to providers, community members were more likely to report that mental health services were *sufficiently available*. Providers were least likely of all subgroups to describe mental health services as *sufficiently available*. Domestic violence (DV) survivors and individuals with serious mental illness (SMI) were also less likely to indicate *sufficient availability* of services compared to the full sample. While individuals with unstable housing or experiencing homelessness and those with SUD (substance use disorder) more commonly indicated services were *sufficiently available*, they also had more instances of reporting resources were *unavailable* compared to the full sample, with fewer individuals from these groups reporting services were *available but insufficient*. Finally, veterans reported greater overall availability of mental health services compared to other subgroups.

Figure 3b. Overall Availability of Mental Health Services in the County as Identified by Survey Respondents Across Subgroups



Note: Some subgroups have small sample sizes (n<10), and findings should be interpreted with caution.

As seen in **Figure 4**, more than half of the respondents indicated that substance use services in the county were available but insufficient to meet the need. It is also worth noting that a greater proportion of respondents (19%) were uncertain about the availability of services related to substance use.

Figure 4. Overall Availability of Substance Use Services in the County as Identified by Survey Respondents

(N = 256)

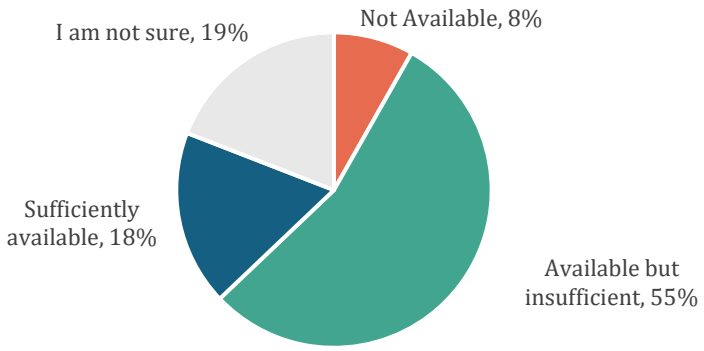
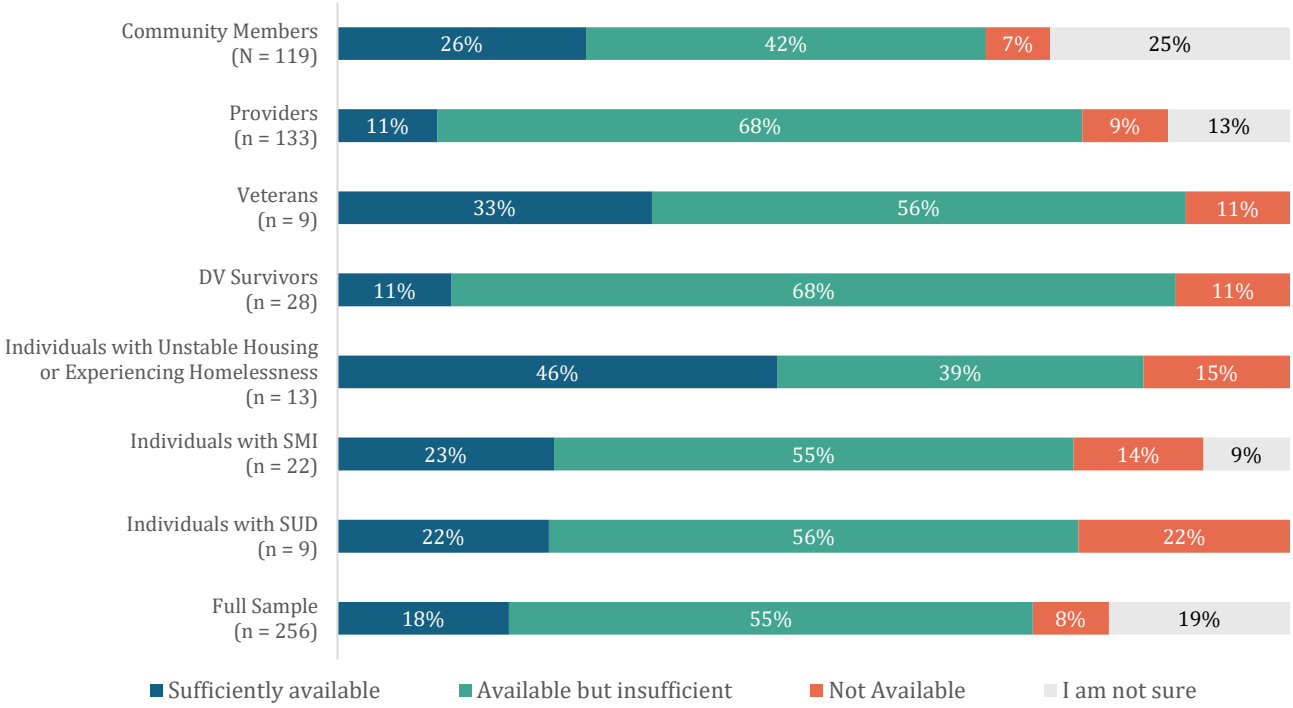


Figure 4b displays the variation in substance use availability seen across subgroups. Community members were again more likely to report that substance use services were *sufficiently available*, in comparison to providers. Along with DV survivors, providers were least likely of all subgroups to describe substance use services as *sufficiently available*. Other subgroups more likely to report substance use services as *available* included individuals with SUD, individuals with SMI, veterans, and individuals with unstable housing or experiencing homelessness. Each of these groups also contained more individuals who reported that substance use services were *not available* at all, compared to the full sample.

Figure 4b. Overall Availability of Substance Use Services in the County as Identified by Survey Respondents Across Subgroups

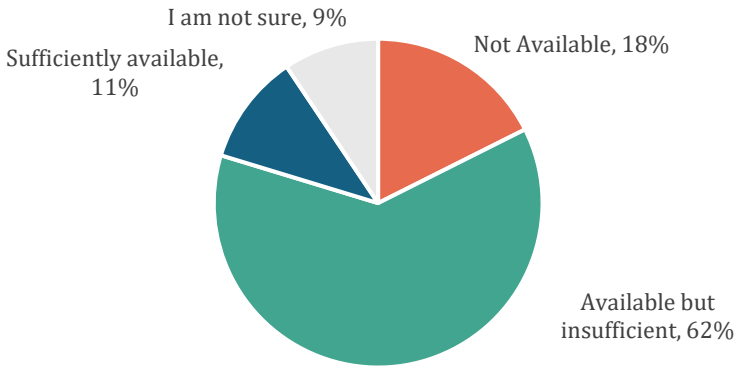


Note: Some subgroups have small sample sizes (n<10), and findings should be interpreted with caution.

Figure 5 illustrates that only one in every ten respondents perceived housing services in the county as being *sufficiently available*. Again, the majority (three out of every five) of respondents found services to be available but insufficient to meet their *needs*.

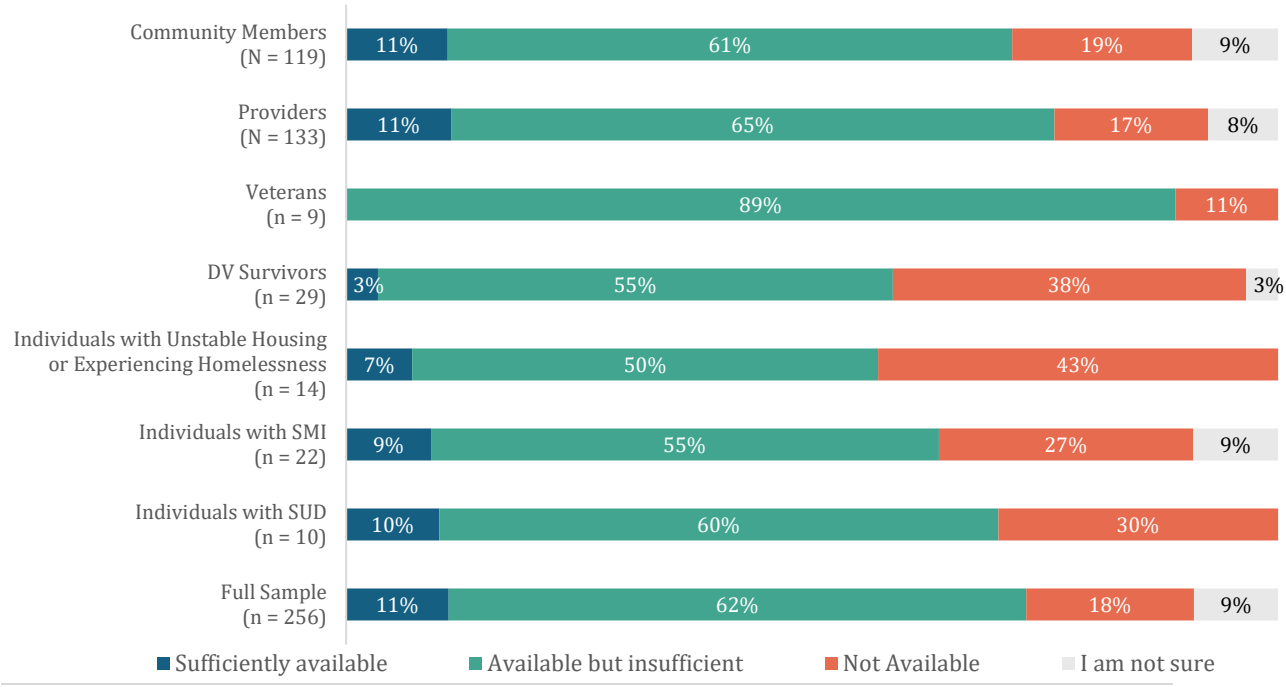
Figure 5. Overall Availability of Housing Services in the County as Identified by Survey Respondents

(N = 256)



While **Figure 5** reveals that housing services received the fewest ratings of *sufficiently available* compared to other services, **Figure 5b** reveals additional disparities perceived among subgroups. Notably, no veteran respondents indicated that housing services were *sufficiently available,* and only 3% of DV survivors reported *sufficient availability*. Individuals with unstable housing or experiencing homelessness, those with SMI, and those with SUD all had slightly fewer reports of housing services being *sufficiently available* compared to the full sample. Each of these groups also had substantially more ratings of *not available.* In contrast to previous patterns, community members and providers had similar perceptions of housing service availability.

Figure 5b. Overall Availability of Housing Services in the County as Identified by Survey Respondents Across Subgroups



Note: Some subgroups have small sample sizes (n < 10); therefore, findings should be interpreted with caution.

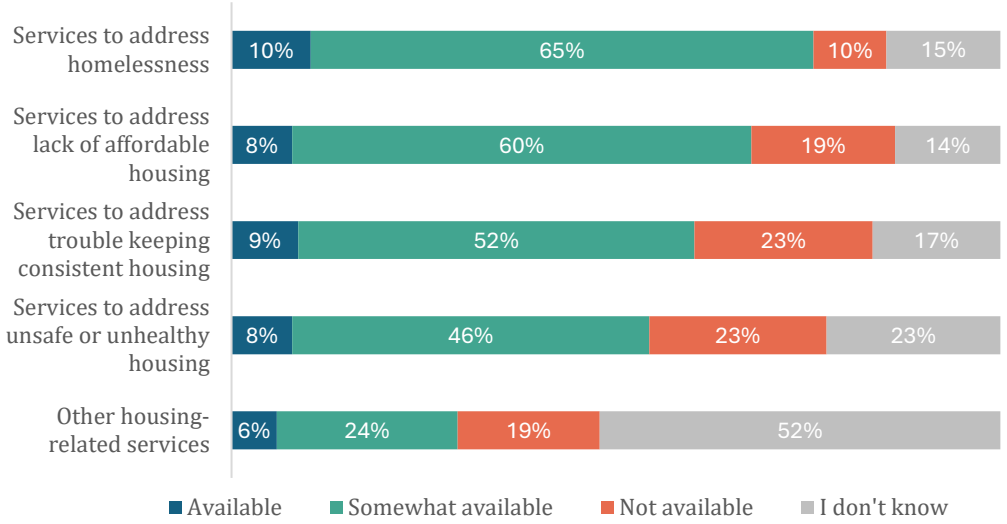
Availability of Specific Housing Services for Individuals with Substance Use Disorder and/or Serious Mental Illness

Community Health Survey respondents were asked about the availability of specific housing services for individuals with substance use disorder and/or serious mental illness. **Figure 6** shows that survey respondents were most likely to say housing services were available to address *homelessness* and the *lack of affordable housing*. In contrast, fewer felt there were services available for *trouble keeping consistent housing* and *unsafe or unhealthy housing*.

In addition to these gaps, it is noteworthy that many respondents were unsure whether certain services existed in their community. Roughly 1 to 2 respondents in 10 reported not being aware of the availability of individual housing services.

Figure 6. Availability of Individual Housing Services in the County as Identified by Survey Respondents*

(N = 119-243)



*Percentages are calculated based on the number of respondents who responded to each item.

Respondents identified additional housing-related services that may present limited availability for individuals with substance use disorder and/or serious mental illness:

- *Specialized Housing Options:* Sober living facilities, residential care homes that accept individuals with SMI and/or SUD at Supplemental Security Income and board and care rental rates, homeless shelters, housing for parents with young children, alternative housing models such as small home communities, and temporary housing options with adequate support.
- *Wrap-Around Housing Supports:* Comprehensive support services to help residents obtain and maintain housing, including on-site childcare, transportation to appointments (not just busing), on-site counseling and community space for appointments, access to AA support groups, safe spaces for scheduled visitors, and assistance with basic needs such as bills.

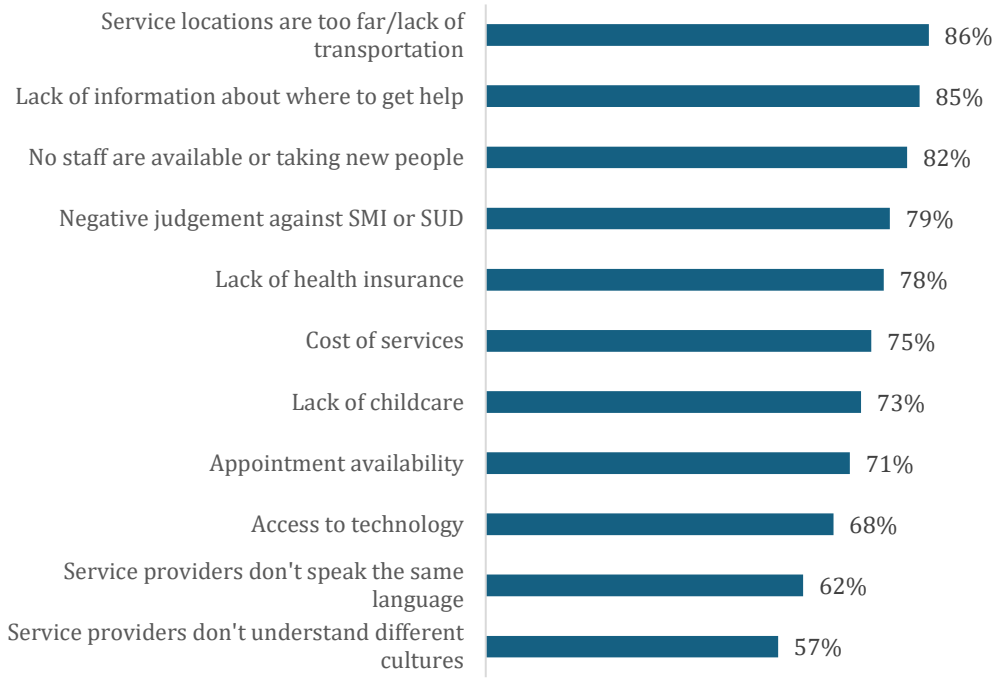
In comparison to the full sample, individuals with substance use disorder were more likely to report availability of *services to address homelessness* and *lack of affordable housing*. Individuals with unstable housing or experiencing homelessness had higher ratings of availability for *services to address the lack of affordable housing, trouble keeping consistent housing*, and *unsafe or unhealthy housing*, but lower ratings of availability for *services to address homelessness*. Veterans showed a contrasting pattern with greater likelihood of reporting availability of *services to address homelessness* a lower likelihood of reporting availability of *services to address the lack of affordable housing* and *unsafe or unhealthy housing*.

Barriers to Services

Community Behavioral Health Survey respondents were asked to identify the barriers people in the community face when trying to access behavioral health and substance use services and resources. Most respondents indicated that all the listed issues were barriers (**Figure 7**). The most commonly reported barriers included *service locations being too far away/lack of transportation* (86%), *not knowing where to get help* (85%), and *lack of provider availability* (82%).

Figure 7. Barriers* to Accessing Mental Health and Substance Use Resources in the County Identified by Survey Respondents

(N = 212-215)

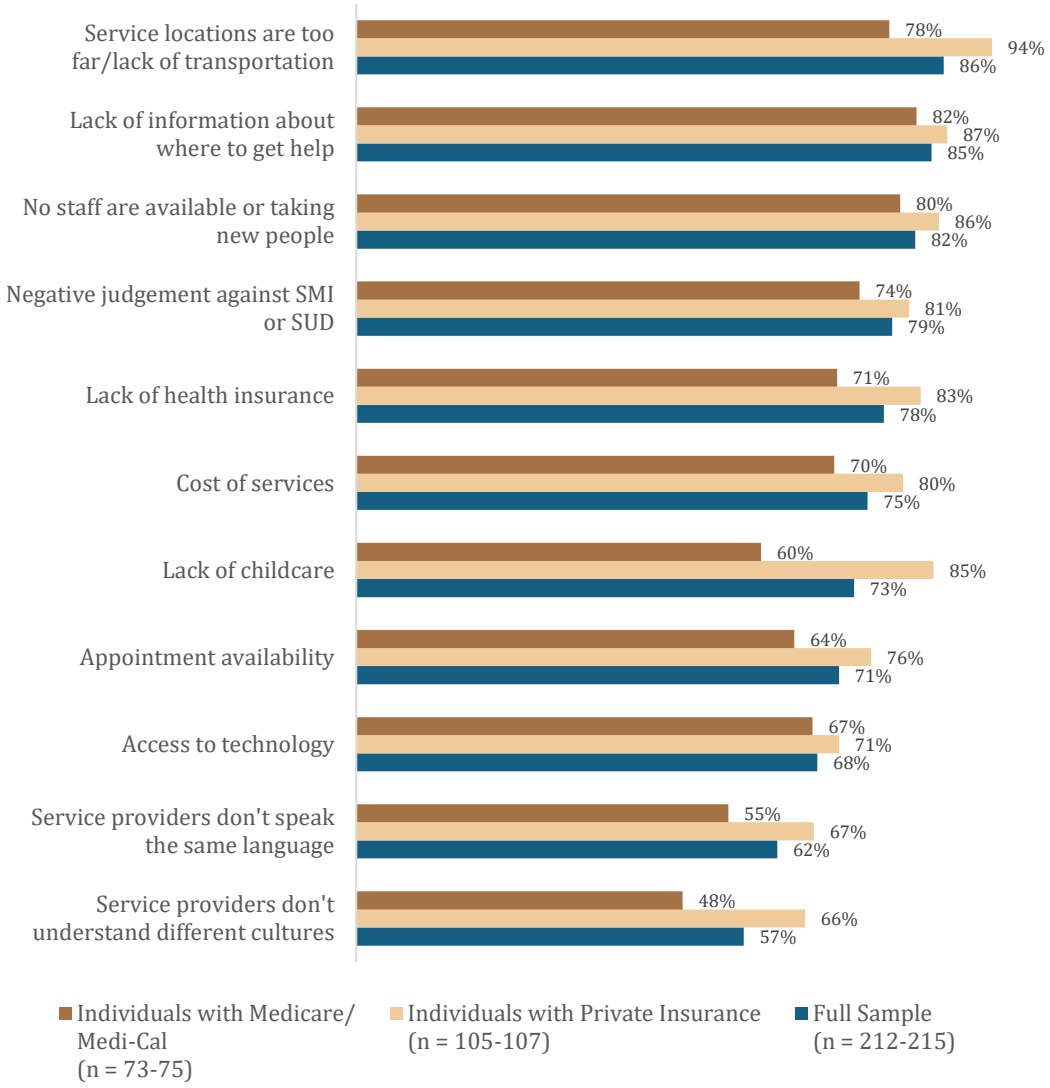


*Barriers represent the percentage of respondents who indicated an issue gets in the way of mental health or substance use resources a lot or a little

Veterans reported the highest rates of barriers when it came to accessing mental health and substance use services, with 100% of respondents identifying several listed items as barriers and no less than three-quarters of veteran respondents reporting each additional issue as a barrier. Domestic violence survivors also reported barriers at higher rates than the full sample. Compared to community members, providers were generally more likely to report the listed issues as barriers.

Figure 7b shows that when comparing barrier perceptions between individuals with Medicare/Medi-Cal to those with private insurance, private insurance holders reported barriers at higher rates across all items, at a rate that consistently exceeded ratings of the full sample.

Figure 7b. Barriers* to Accessing Mental Health and Substance Use Resources in the County Identified by Survey Respondents Across Subgroups



*Barriers represent the percentage of respondents who indicated an issue gets in the way of mental health or substance use resources a lot or a little

Additional barriers identified by survey respondents are summarized below:

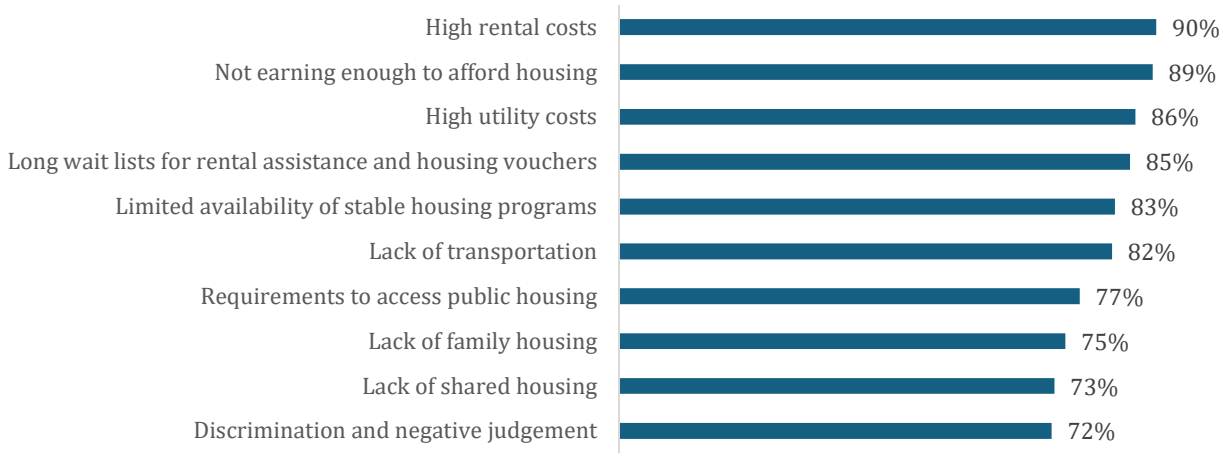
- *System Structure & Crisis Response:* Mental health system criteria require individuals with SMI to meet crisis levels (danger to self/others or grave disability) before accessing highest level of care, often resulting in significant deterioration before intervention; lack of accessible crisis response assessment center; crisis response personnel not available 24/7; law enforcement lacks skills to recognize mental health crises and may respond with criminal justice interventions rather than medical/therapeutic approaches.
- *Workforce & Provider Challenges:* Insufficient service capacity and staffing availability; no providers able to accept new patients; high staff turnover requires clients to repeatedly establish new therapeutic relationships and retell traumatic histories; limited frequency and duration of psychiatric appointments that may miss critical mental health issues; contracted agencies reporting insufficient training and clinical supervision; inconsistent psychiatric support across subcontractors rather than full-time psychiatrists in centralized locations for service continuity.

- *Information & Navigation Barriers:* Limited outreach, programs, and nonprofit organizations offering community engagement opportunities; insufficient communication about available support services; 211 directory updates needing funding and prioritization; lack of public awareness about where to access help in the local community.
- *Early Childhood-Specific Barriers:* Limited information for parents, insufficient diagnostic services, long waitlists for early childhood mental health needs, transportation and language barriers, cultural beliefs, and inadequate funding to support additional services.
- *Individual & Social Barriers:* Limited self-awareness or insight regarding need for services; challenges supporting individuals who do not recognize their need for help; insufficient support and education from family and friends; community stigma on social media; competing life demands and financial constrains; pet ownership creating housing barriers, lack of clarity about appropriate services; caregivers not taken seriously during crises; fragmented coordination between healthcare and law enforcement systems.

Respondents were also asked to identify the barriers people with substance use disorder and/or serious mental illness face when trying to access housing. Again, most respondents indicated that all the listed issues were barriers (**Figure 8**). The most commonly reported barriers were related to affordability, including *high rental costs* (90%), *not earning enough to afford housing* (89%), and *high utility costs* (86%).

Figure 8. Barriers* to Accessing Housing for Individuals with Substance Use Disorder and/or Serious Mental Illness in the County Identified by Survey Respondents

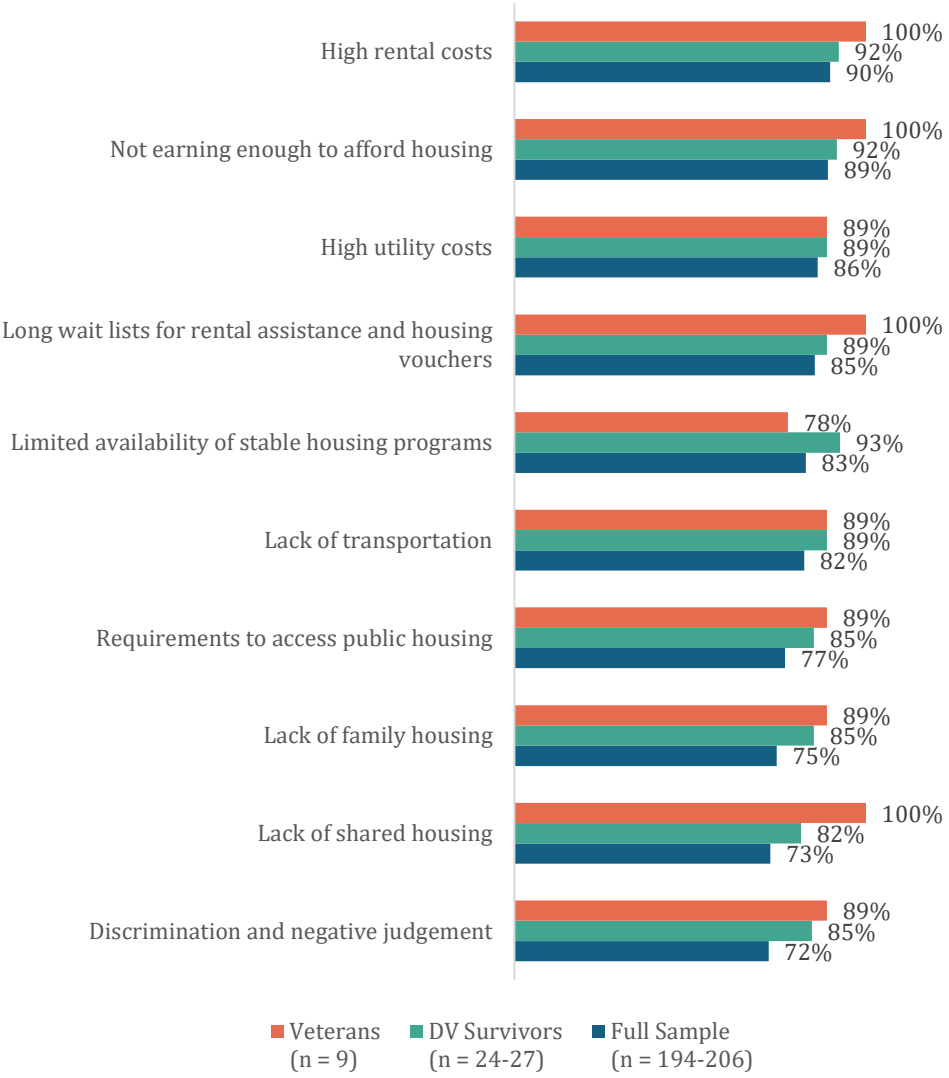
(N = 194-206)



*Barriers represent the percentage of respondents who indicated an issue gets in the way of accessing housing a lot or a little

As seen in **Figure 8b**, overall, veterans and domestic violence survivors perceived barriers related to accessing housing at greater rates compared to the full sample. One exception emerged where veteran perceptions of obstacles related to *limited availability of stable housing programs* were below that of the full sample. In contrast, this was the most frequently reported barrier among domestic violence survivors. Another notable distinction in perceptions of veterans was the unanimous rating of *lack of shared housing* as a barrier, compared to approximately three-fourths of the full sample reporting this issue as a barrier.

Figure 8b. Barriers* to Accessing Housing for Individuals with Substance Use Disorder and/or Serious Mental Illness in the County Identified by Survey Respondents Across Subgroups



*Barriers represent the percentage of respondents who indicated an issue gets in the way of accessing housing a lot or a little

Note: Some subgroups have small sample sizes (n < 10); therefore, findings should be interpreted with caution.

When asked to list additional barriers that people with substance use disorder and/or serious mental illness face when trying to access housing, respondents supplied the following insights:

- *Stigma & Community Opposition:* Stigma from other residents and neighbors with concerns for personal security/safety, community members opposing housing for individuals with SMI/SUD near their homes or schools.
- *Housing Supply & Affordability:* Insufficient affordable housing; inadequate number of Section 8 vouchers; lack of available units; housing location challenges; absence of housing continuum allowing individuals to identify all units meeting their care level through one application and fee.
- *Application & Navigation Complexity:* Overwhelming paperwork and procedures that lead individuals to give up and choose homelessness; lack of knowledge about available programs and resources; uncertainty about where to start; confusion around Social Security benefits and marriage eligibility; complexity of accessing services while disabled discourages provider engagement.

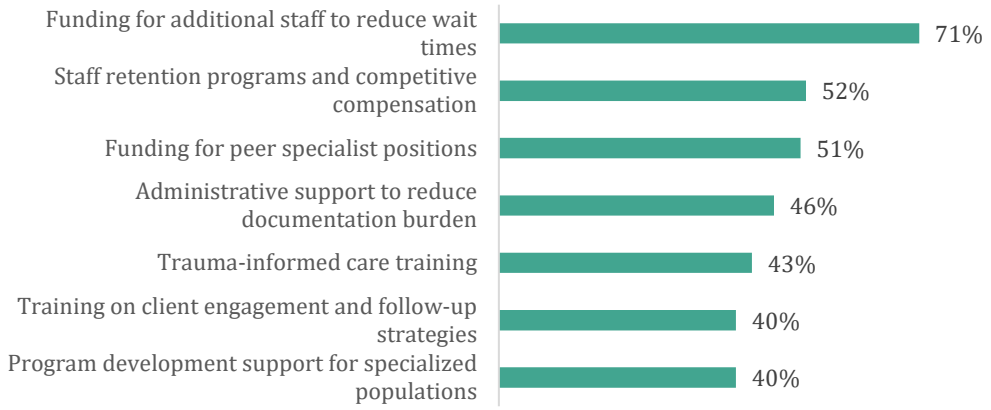
- *Support & Advocacy Gaps:* Lack of advocacy support; absence of personal support systems; closed waitlists for subsidized housing preventing individuals from knowing scope of needs or their place in queue.
- *Housing Quality & Service Continuity:* Housing offered to people with mental illness does not meet code for safe and proper standards; Inconsistent availability of ongoing services for clients with mental health conditions; safety concerns preventing homeless individuals from using existing shelters due to staff and resident behaviors.

Improving Access to Drug Medi-Cal and Specialty Mental Health Services

Respondents who self-identified as system partners or providers were asked which resources would best support their organization in helping more eligible people access Drug Medi-Cal and specialty mental health services. The most commonly identified resources included *funding for additional staff to reduce wait times* (71%), *staff retention programs and competitive compensation* (52%), and *funding for peer support specialist positions* (51%) (**Figure 9**).

Figure 9. Resources to Support Provider Organizations in Helping People Access Drug Medi-Cal and Specialty Mental Health Services as Identified by System Partner and Provider Respondents*

(N = 106)



*As respondents were allowed to choose more than one option, the total percentage of responses is greater than 100%.

Respondents also had the opportunity to provide additional open-ended responses to this item. Respondents identified needs spanning workforce, service delivery, administrative support, and program coordination as described below:

- *Staffing & Workforce Development:* Increase funding for adequate staffing levels, recruit more qualified case managers and psychiatrists, and provide mental health supports for educators from daycare providers through high school teachers to address workforce shortages.
- *Service Delivery & Access Improvements: Reduce* wait times for immediate service access, expand field-based mobile mental health services to reach people on the streets, at encampments and shelters, restore roving mental health teams, provide in-person appointments with competent doctors, and establish locked facilities for individuals requiring acute stabilization.
- *Administrative & Operational Support:* Reduce administrative burden in billing practices and program requirements, provide access to county databases to track existing client connection, offer health literacy and continuous quality improvement training to simplify communication and processes, and educate staff on available resources.

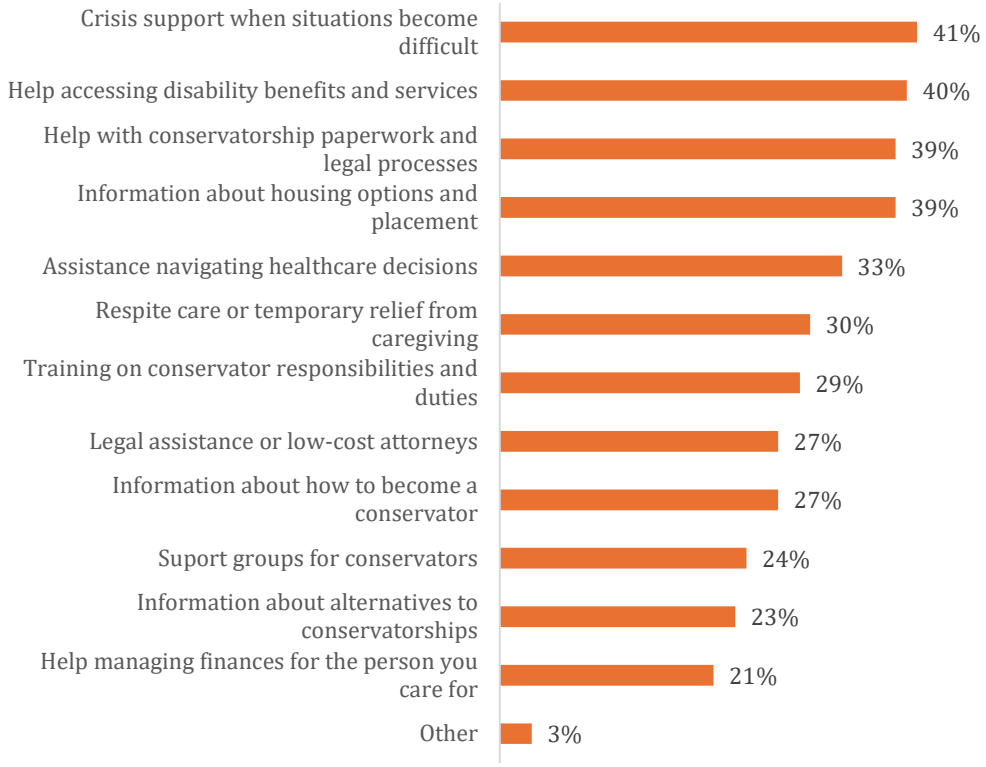
- *Program Coordination & Family Services:* Continue investment in existing effective programs that provide warm handoffs and closed-loop follow-up rather than creating new silos, expand family engagement and education services tailored to specific needs, ensure supervisors and managers fully understand required work, and provide adoption/foster care training on grief and loss.

Resources to Support Conservators or Individuals Considering Conservatorship

Respondents who self-identified as caregivers for family members or someone close to them who had ongoing mental health challenges or problems with drugs and alcohol were asked what resources would be most helpful for conservators or potential conservators. The most commonly identified resources included *crisis support when situations become difficult* (41%), *help accessing disability benefits and services* (40%), *help with conservatorship paperwork and legal processes* (39%), and *information about housing options and placement* (39%). (**Figure 10**)

Figure 10. Resources for Conservators as Identified by Caregivers for Individuals with SUD/SMI*

(N = 96)



*As respondents were allowed to choose more than one option, the total percentage of responses is greater than 100%.

Youth Perspectives

Youth completed a survey explicitly adapted for their age group. Due to the lower number of respondents, results from youth-specific items are summarized in narrative form. Youth respondents were asked to identify resources that would make it easier for people their age to get help with mental or emotional challenges, drug and alcohol challenges, and in cases where their family members had drug or alcohol challenges.

When discussing mental and emotional health support, free help emerged as a commonly identified resource, with most youth indicating this would make it easier to access support. Help available at school was also frequently

reported as an important resource for addressing mental or emotional challenges.

For youth facing their own drug or alcohol challenges, all respondents selected adults who don't judge and getting help without parents knowing as resources that would make it easier to seek support. Most respondents also selected help that stays completely private.

Finally, when asked about resources for youth whose family members struggle with alcohol or substance use, all respondents selected free help and adults who understand family problems. Most respondents also selected support groups with other kids in similar situations, learning how to cope and stay safe, help that stays private from family, and help at school as resources that would make it easier to get help in these situations.

Focus Groups Findings

Three in-person focus groups were conducted in partnership with trusted community-based organizations and providers, with a total of 26 participants representing behavioral health consumers, individuals with unstable housing or experiencing homelessness, parents of those with behavioral health needs, and survivors of domestic and/or sexual assault, with intentional outreach to historically marginalized communities. Each 90-minute session included compensation in the form of gift cards to acknowledge participants' time and expertise. Three additional online focus groups were organized for children and youth; however, no participants attended these sessions.

Participants were asked to share their perspectives across six topic areas: building trust and engagement with the system, housing and basic needs, quality of care and service delivery, crisis response and safety, access and system design, and vision and priorities. The following sections summarize the key themes that emerged within each area.

Building Trust and Engagement

Focus group participants were asked how the continuum of care could build trust and increase engagement with community members. Participants identified two key factors: Person-Centered and Empathetic Customer Service Approach, and Peer Support.

Person-Centered and Empathetic Customer Service Approach

Participants emphasized that building trust requires a person-centered and empathetic approach to customer service. They highlighted the critical importance of staff who listen actively, offer non-judgmental support, and approach individuals with genuine care and respect. "The support we need is just for them to listen to us and then go from there."

Peer Support

Peer support emerged as another critical strategy for building trust and fostering community engagement. Participants emphasized the profound positive influence of shared lived experience, informal networks, and trusted relationships in navigating complex systems, providing authentic support, and fostering a sense of belonging. One participant shared: "To be able to come here and be around people that I can relate to, that's priceless to me. You know, that, that works in my eyes. This works." This sentiment captures how peer connections create spaces where individuals feel understood and valued in ways that traditional service relationships may not achieve.

> *"To be able to come here and be around people that I can relate to, that's priceless to me. You know, that, that works in my eyes. This works."*

Housing and Basic Needs

Participants were asked about their experiences finding housing and addressing their basic needs. Two key themes emerged: Navigating Bureaucracy and Access Gaps, and the Impact of Stigma and Discrimination.

Navigating Bureaucracy and Access Gaps in Housing/Basic Needs

Structural and procedural challenges create significant barriers when individuals attempt to secure housing, financial assistance, and other necessities. Participants highlighted problems with eligibility criteria, timeliness, access to information, and geographical disparities that prevent those in greatest need from accessing support.

One participant described the frustration of receiving inconsistent information and responses depending on location: "Like today, like I even went into human services…and they straight up told me they couldn't help me. They didn't care if I was living out of my car. They didn't care if I was pregnant; they couldn't help me. And then if I go to Davis, they tell me a completely different thing. They give me all the resources and everything else. It just depends where you go." This experience highlights the importance of consistent processes and coordinated information across service locations to better support individuals seeking assistance during vulnerable circumstances.

Impact of Stigma and Discrimination

Stigma and discrimination create barriers for individuals seeking housing and basic needs. Participants described experiencing societal prejudice and discriminatory practices by service providers, reporting being judged based on their appearance, past, or perceived conditions, which led to denial of services and disrespectful treatment. One participant explained how past involvement with the criminal justice system continues to affect access to employment and services: "If you've been locked up before and you go get a job, they say they're not going to discriminate against race [or] any of that stuff. They do, though. They really do." This experience reflects how stigma associated with criminal history creates ongoing barriers to stability, even when official policies prohibit discrimination.

> *"If you've been locked up before and you go get a job, they say they're not going to discriminate against race [or] any of that stuff. They do, though. They really do."*

Quality of Care and Service Delivery

Focus group participants were asked about their experiences receiving various types of help and support throughout the continuum of care. Three key themes emerged related to quality of care and service delivery: Organizational Barriers, the Need for Sustained Individualized Support, and the Need for Proactive Services.

Organizational Barriers

Structural and procedural barriers hinder access to and receipt of effective care. Participants identified challenges with coordination between services, bureaucratic processes, and uneven resource availability across different locations or for various needs. One participant described frustration with eligibility requirements that leave available resources unused while individuals remain in need: "There are tiny homes out here that are not full. They're empty. But you have to have a mental issue. [I know someone who] can't get on it because she doesn't have a mental issue. She doesn't have a drug issue. She doesn't qualify." This experience illustrates how narrow eligibility criteria can create situations where resources remain underutilized even as community members struggle to access housing and support.

Need for Sustained Individualized Support

Participants emphasized their need for sustained, individualized support to access quality care and receive services. This theme focuses on experiences of feeling unheard, judged, or receiving generic, short-term care that does not address nuanced long-term needs. One participant described the disconnect between rigid processes and individual circumstances: "A lot of the workers don't listen to anything that we have to say. They just say we have to go by these rules and that's it." This experience reflects how inflexible application of procedures can prevent the personalized problem-solving needed to address individual situations effectively. The discussion emphasized the desire for genuine human connection, understanding, and tailored care plans that evolve with the individual.

Need for Proactive Services

Proactive rather than reactive services are essential for quality care, according to participants. They described how narrow definitions of "crisis" require individuals to reach heightened levels of danger before intervention becomes possible. A parent with lived experience captured this frustration: "I mostly feel like my hands are tied. I feel like I am just waiting for a crisis to occur because that's when resources are available." This experience reflects the challenge families face when they recognize warning signs and seek help early but cannot access support until situations escalate to a crisis level. Participants identified concerns about the reactive nature of the continuum of care, gaps in early intervention, the need for preventive strategies, the importance of enhanced first responder training, and the necessity of providing safe and stable environments that prevent crises from escalating.

"I mostly feel like my hands are tied. I feel like I am just waiting for a crisis to occur because that's when resources are available."

Crisis Response and Safety

Participants were asked about crisis situations and what happens in the continuum of care when people need urgent help. The central recommendation that emerged was the need for Proactive Crisis Services.

Proactive Crisis Services

According to participants, the continuum of care should provide proactive crisis services that intervene before situations escalate. Current crisis response focuses primarily on acute, life-threatening situations (suicidal or homicidal crises) as the trigger for intervention, leaving individuals and families without support during escalating pre-crisis periods. One participant suggested an approach that addresses warning signs early: "Maybe a visit by a social worker and a medical professional, you know, like a wellness check or something... Maybe some case management that begins before the crisis because there have been warning signs [and] there has been [a] crisis in the past." This recommendation highlights the value of early intervention strategies that respond to warning signs rather than waiting for situations to reach crisis thresholds, particularly when individuals have experienced crises previously.

"Maybe a visit by a social worker and a medical professional, you know, like a wellness check or something... Maybe some case management that begins before the crisis because there have been warning signs [and] there has been [a] crisis in the past."

Access and System Design

Participants were asked about what makes it easy or hard for people to get help. Two key barriers emerged: Coordination of Care and Stigma. Participants also recommended Enhanced Customer Service as a strategy to improve access.

Barrier: Coordination of Care

Fragmented coordination of care creates difficulties in receiving help. Participants identified problems with communication between providers, service integration, and follow-up processes. One participant described the challenge of navigating multiple systems without clear pathways: "[If] you go to mental health [services], you're getting help…and you need other resources. I believe [the] mental health [agency] should…know easily where to…send you." This reflects the need for providers to have comprehensive knowledge of available resources and established referral pathways to connect clients with needed services across systems.

"[If] you go to mental health [services], you're getting help…and you need other resources. I believe [the] mental health [agency] should…know easily where to…send you."

Barrier: Stigma

Stigma creates an environment that deters individuals from seeking services. Participants described experiencing negative perceptions and discriminatory practices when attempting to access care. One participant shared an experience with law enforcement during a crisis: "I've had an officer like ridicule me during one of those interactions and like, essentially, you know, act like I was being crazy for even reporting it." This experience illustrates how stigmatizing responses from first responders can compound distress and discourage future help-seeking, particularly during vulnerable moments.

Recommendation: Enhanced Customer Service

Participants emphasized that enhanced customer service could facilitate access to services. This includes

prioritizing genuine care and understanding, tailoring approaches to individual circumstances, hiring more staff with lived experience, and focusing on long-term well-being. One participant expressed frustration with interactions that felt inauthentic: "I feel like there needs [to be] more customer service, more people that care about helping people. Oh, and another thing. They need to stop being liars, man. Keep it 100, please. Because I'm tired of running into these workers and all these people. They never walked in your shoes, but they'll lie and act like they know where you're coming from or they can understand you." This perspective underscores the importance of authenticity and humility in provider interactions, with participants valuing honesty about what staff can and cannot understand over claims of relatability that feel disingenuous.

Vision and Priorities

Participants were asked about what the continuum of care should prioritize, including their vision for elements of the system they would change or create. Four key recommendations emerged: Cultivating Trust and Empathy in Service Delivery; Integrated, Responsive, and Individualized Care; Overcoming Systemic Barriers and Stigma; and Redefining Crisis and Prioritizing Early Intervention. These are presented in alphabetical order.

Cultivating Trust and Empathy in Service Delivery

Building trust and empathy in service delivery emerged as a priority. Participants emphasized the importance of genuine care, active listening, and staff who can relate to clients' experiences, ideally through shared lived experience. Community-based outreach and engagement were identified as essential strategies for building rapport and addressing mistrust. One participant highlighted the importance of training first responders to recognize and appropriately respond to behavioral health crises: "I would hope that there's better training for our law enforcement partners because they are so essential to this piece. Right? They do get called often. They should at least be equipped to assess the situation and understand that a mental health crisis is occurring and to [call] the mental health crisis team to have them be the…people who step in to interact rather than have them with their limited capacity interact in their very specific way." This recommendation underscores the necessity for law enforcement to receive specialized training in crisis de-escalation and mental health recognition, enabling them to connect individuals with suitable behavioral health resources rather than relying solely on traditional law enforcement approaches.

"I would hope that there's better training for our law enforcement partners because they are so essential to this piece. Right? They do get called often. They should at least be equipped to assess the situation and understand that a mental health crisis is occurring and to [call] the mental health crisis team to have them be the…people who step in to interact rather than have them with their limited capacity interact in their very specific way."

Integrated, Responsive, and Individualized Care

Participants prioritized integrated, responsive, and individualized care. They described the need for a seamless system where various services (mental health, substance use treatment, and housing) are connected and communicate effectively. This includes personalized approaches that recognize individual differences and needs, as well as timely responsiveness from service providers. One participant described the importance of sustained attention to individual needs: "If they could just focus on one individual at a time and get them taken care of first [before] moving to the…next person. [I'd like to see] a place that's designed to just focus on that individual and help them on their way [before getting] another individual in there." This vision emphasizes the value of comprehensive case resolution over high-volume processing, ensuring individuals receive the sustained attention needed to achieve stability before providers move to the next case.

Overcoming Systemic Barriers and Stigma

Addressing systemic barriers and stigma was identified as essential for improving the continuum of care. Participants expressed frustration with rigid eligibility requirements, discrimination based on past incarceration, homelessness, or substance use, delays in service delivery, and lack of empathy in provider interactions. One participant described the cumulative impact of facing discrimination across multiple dimensions: "You get frustrated because…you're getting discriminated [against] one way or another. Whether you're homeless, whether you've been in prison, whether you've been to jail, whether you have a mental problem, whether you have a drug addiction, it doesn't matter." This experience reflects how stigma operates across multiple identities

and circumstances, creating compounding barriers for individuals who may face discrimination on several fronts simultaneously. It underscores the need for comprehensive approaches that address bias at all levels of the system and promote equity in service delivery regardless of a person's history or current circumstances.

Redefining Crisis and Prioritizing Early Intervention

Participants prioritized redefining the concept of "crisis" and increasing early intervention. They recommended shifting from reactive, crisis-driven responses to proactive strategies that intervene earlier. This involves broadening the definition of "crisis" beyond situations of immediate danger and creating accessible pathways for support before situations escalate.

Listening Sessions Findings

Four online listening sessions were conducted via Zoom between September 24, 2025 and October 16, 2025. Each 90-minute session focused on one of the BHSA's main funding components: Full Service Partnerships (FSP), Behavioral Health Services and Supports (BHSS), and Housing Interventions (HI). Due to scheduling conflicts around a holiday and to ensure maximum participation, two sessions were held for the Housing Interventions component. A total of 144 participants attended across all sessions. A comprehensive breakdown of participant demographics and community affiliations is provided in Appendix B.

Each session followed a structured format designed to promote transparent, two-way dialogue between the county and community stakeholders. A tailored presentation (available here) guided each conversation and included:

1. **Educational Overview** – Introduction to the BHSA, the CPP, and services included under the specific funding component being discussed
2. **Data Transparency** – Presentation of Yolo County's current performance on behavioral health goal measures related to the component, providing participants with context for understanding service gaps and needs
3. **Facilitated Discussion** – Structured conversation using discussion questions designed to capture diverse perspectives on the data and its implications for local communities

The facilitated discussion explored three key areas:

Understanding Community Reality – Participants were asked to reflect on whether county performance data aligned with their lived experiences and observations, what aspects of the data stood out as most significant, and what contextual factors the quantitative measures might not capture.

Addressing Barriers and Gaps – Participants identified obstacles preventing community members from accessing services within each funding component and discussed systemic or community-level changes needed to improve service accessibility and outcomes.

Identifying Strengths and Solutions – The conversation explored potential interventions and program approaches that participants believed would most effectively improve outcomes, as well as existing community strengths and successful initiatives that could be leveraged for expansion.

This structured approach ensured that participants had the necessary information to provide informed feedback while creating space for authentic dialogue about their lived experiences, community strengths, and system challenges. The discussions generated rich insights into service gaps and opportunities for improvement. Participants raised questions about whether the quantitative data presented during the sessions captured the full scope of behavioral health needs in the County. Several noted that specific data collection methods, such as point-in-time counts, may provide incomplete information due to circumstances like weather conditions during count periods. Access to services emerged as a concern, with participants questioning whether lower rates of crisis service utilization might reflect barriers to accessing care rather than a lower need. Some participants attributed positive outcomes in certain areas to specific partnerships, such as school-based services making behavioral health support more accessible to youth. The discussion highlighted the need for additional context beyond the numbers to understand what factors influence service access and utilization patterns. Participants emphasized that community members see only parts of the service system and requested more comprehensive written information from the county about available programs. These reflections on the data revealed important context about barriers and system challenges that help explain county performance patterns. A summary of the most

salient themes that emerged across all listening sessions is provided below, organized into barriers and gaps, followed by strengths and solutions.

Addressing Barriers and Gaps

Continuum of Care for Overlooked Populations

Critical gaps in the continuum of care were identified for specific populations. Parents of adults with serious mental illness described feeling their options were limited when individuals did not meet the criteria for particular interventions. One participant stated, "I am a parent of an adult child with undiagnosed serious mental illness. He experiences an anosognosia... and his status as an [adult] makes me feel like my hands are completely tied. I certainly don't know what resources are available for someone in a situation like mine." This highlights a vulnerable population that falls through systemic cracks: adults with undiagnosed serious mental illness who do not recognize their need for help, do not meet thresholds for involuntary intervention, and whose families lack clear pathways to support them. Current service structures may require self-referral or high intervention thresholds, leaving families without resources when their loved ones are unwell but do not fit existing service pathways.

Participants also noted insufficient ADA-compliant housing units for individuals with physical disabilities and mobility needs. Questions were raised about whether veterans' housing needs were being addressed under the new funding structures, with particular concern for veterans with disabilities who face compounded barriers.

Information Access and Coordination Challenges

Participants described challenges in navigating a system where information about available services is scattered across multiple locations without apparent centralization or a single point of contact. Individuals seeking help often do not know where to begin or which services match their needs. Those working in the field for extended periods indicated that they know how to find information due to their professional experience, but recognized that community members without this background face significant difficulty in identifying and accessing appropriate resources.

The lack of a coordinated entry point creates confusion for individuals seeking help, requiring them to contact multiple agencies, repeatedly explain their situation, and piece together information from various sources. Administrative processes create additional obstacles, particularly for individuals in crisis who need immediate support but must navigate enrollment requirements, eligibility determinations, insurance verification, and other bureaucratic steps before receiving services.

Workforce and Funding Instability

Workforce challenges, including provider shortages, limit the availability of services. The cost of providing 24/7 access was mentioned as a barrier when there are insufficient providers. The reliance on short-term grant funding cycles was described as creating instability. One participant explained, "One of the structural problems is [that] every agency in the homeless continuum of care is run on grants. And so, these are a three-year cycle, and each grant has a different objective... It's very difficult to build collaboration when you have attrition because a grant ran out, and now they don't have enough money to support the staff that they have."

Payment processing delays create cash flow issues for nonprofit organizations that must utilize reserves to cover payroll while awaiting invoice payment. These administrative and financial challenges affect provider capacity and service continuity.

Housing Infrastructure, Affordability, and Tailored Solutions

Housing emerged as a barrier to progress on other behavioral health goals. One participant stated, "Until we get the housing need addressed... it's really difficult to support them with any progress on any other goals, such as, you know, any substance use, anxiety, depression, anything like that..."

"Until we get the housing need addressed... it's really difficult to support them with any progress on any other goals, such as, you know, any substance use, anxiety, depression, anything like that..."

Some individuals are housed outside the county, separating them from family and community connections. One participant noted, "The need to bring those people closer to their family and friends. In [Redacted] County, I think there's at least 60... who are housed outside of the county." For these individuals, distance from familiar support

networks may increase isolation, limit family engagement in care, and compound the challenges of navigating behavioral health recovery.

The absence of transitional housing options that support independent living skill development was identified as creating barriers to progression from higher levels of care. One participant noted, "We used to have programs to teach independent living skills and then apartments where they could graduate from an adult residential facility or other 24-hour care facility into independent living... there is currently no [transitional] program [with] apartments to help people with independent living [skills]." Participants also noted insufficient ADA-compliant housing units for individuals with physical disabilities and mobility needs. Questions were raised about whether veterans' housing needs were being addressed under the new funding structures.

The limited supply of affordable housing was noted as a concern, particularly for populations with fixed incomes. Participants described supporting families who lack sufficient income to afford rent, with a particular focus on seniors whose benefit amounts do not increase enough to keep pace with annual rent increases, despite cost-of-living adjustments. Specific gaps were identified for individuals with physical disabilities who require ADA-compliant units.

Cultural Barriers: Stigma, Distrust, and Immigration-Related Fears

Concerns about immigration enforcement have affected service engagement. One participant noted, "We have seen many Latino and Hispanic families disengage from services because of immigration related fears for themselves or family members. Our medical partners report the same with families missing well child [routine preventive health appointments] visits due to these concerns."

One participant raised concerns about adults aged 85 and older, noting generational experiences that may create barriers to seeking behavioral health support: "Just want to raise the need of people who are 85 and older. Although a relatively small population, this tends to be a generation that predates the term mental health, let alone behavioral health. These folks grew up at a time when they could be institutionalized if someone deemed them senile or crazy. They'll still hold that stigma even at because of their advanced age, they are highly vulnerable to isolation, loneliness, depression and anxiety that is often exacerbated by financial and high housing insecurity." While experiences vary widely among older adults, historical stigma and systemic barriers may affect willingness to engage with services for some individuals in this age group.

Cultural and social factors create barriers to engagement. Community agencies reported being mistaken for law enforcement or child welfare, which creates reluctance to engage with services. Distrust of systems and confusion about how to access services were identified as concerns, particularly among immigrant communities unfamiliar with how systems work in the United States.

Identifying Strengths and Solutions

Enhancing System Navigation, Awareness, and Access to Care

Given the challenges individuals face in navigating scattered information and complex systems, participants emphasized the need for improved navigation support. This includes having someone help individuals identify appropriate services, make connections, and follow up to ensure linkage occurs.

Suggestions included developing mobile outreach capacity to reach underserved areas. One participant proposed, "So what if there is something [like a] mobile mental health unit that could go to those really difficult places to access where… people might be in need or at least to spread the word, providing information on services in the various language needs and be able to promote these services to help with access..." Provider participants across systems indicated that clear referral guidelines and better understanding of access pathways would support their ability to connect clients with appropriate services. Participants also noted that school-based partnerships have been effective in improving access to behavioral health services for children and youth, with K-12 collaborations identified as a factor contributing to positive outcomes for this population.

Sustaining and Strengthening Existing Programs and Infrastructure

Participants expressed concern about maintaining programs and infrastructure that produce positive outcomes. Questions were raised about what needs to be sustained to maintain current performance levels. The importance of stable funding to prevent loss of capacity was emphasized, with concerns that financial instability could lead to program closures, reduced services, or inability to retain qualified staff. The need for consistent and timely payment processes for contracted providers was identified as critical to organizational sustainability.

Housing infrastructure provided a concrete example of these sustainability concerns. Infrastructure maintenance

for existing housing facilities was identified as essential to prevent loss of current capacity through deterioration or closure. Participants noted the absence of mid-level housing options with supportive services that allow individuals to develop independent living skills before transitioning to complete independence. Two priorities emerged: improving contracting and payment timelines to support provider stability, and rehabilitating existing housing to prevent the loss of what currently exists.

Addressing Diverse Population Needs and Systemic Integration Barriers

Participants discussed the need for services that are responsive to the unique circumstances and challenges faced by diverse populations. Cultural barriers, including distrust of systems among immigrant communities and confusion about how to navigate services, were identified as factors affecting engagement. These barriers require tailored approaches that acknowledge different cultural perspectives on mental health, varied experiences with systems of care, and the specific concerns of communities that may have experienced discrimination or marginalization.

Provider participants noted that they often learn about available resources through direct collaboration with other agencies, but recognized that this informal knowledge-sharing is insufficient. They expressed interest in having more comprehensive, centralized information about available services across systems to share with clients, enabling more effective cross-system referrals and coordination of care.

The need to address stigma through culturally appropriate outreach methods was emphasized. Participants suggested using communication channels tailored to different generations and cultural groups, such as social media for younger populations and television and radio for older adults. They trusted community messengers to reach populations that may be wary of government agencies. Outreach should be available in multiple languages and designed with input from the communities being served.

Breaking down silos between housing and behavioral health systems was identified as essential for integrated care. Participants noted that housing, as a fundamental social determinant of health, should be integrated into individual behavioral health service plans rather than treated as a separate issue. This requires coordination across systems, shared data and communication protocols, and recognition that stable housing is often a prerequisite for meaningful progress on behavioral health goals.

Key Informant Interview Findings

Twenty-nine in-depth key informant interviews (KIIs) were conducted via Zoom, each lasting 60 minutes. Interviews engaged executive directors, program managers, clinical supervisors, county department heads, and elected officials representing county behavioral health and social services, healthcare and public health agencies, housing and homeless services, community-based organizations, emergency and veterans services, early childhood programs, and municipal government. These interviews explored system strengths, subpopulations and needs, collaboration opportunities, and funding priorities across the Yolo County continuum of care.

System Strengths

Interviewees were asked about system strengths, or areas that contribute to the effectiveness of behavioral health services in Yolo County. Three key strengths emerged: Robust Collaboration and Partnership Networks, a Dedicated and Mission-Driven Workforce, and Effective Specialized Programs and Access Points.

Robust Collaboration and Partnership Networks

Strong collaboration and partnership networks emerged as a major strength of the Yolo County continuum of care. Interviewees described inter-agency cooperation and the ability to address complex needs by leveraging relationships across county departments, nonprofits, and community-based organizations (CBOs). This collaborative approach was identified as a distinguishing factor from other counties. One interviewee noted, "I think one of the things that the county has done well for a number of years is building partnerships and collaborating. Recognizing that one entity can't meet all of [its] goals on [its] own." This recognition that no single organization can address the full spectrum of community needs has fostered a culture of partnership that strengthens the overall system.

> *"I think one of the things that the county has done well for a number of years is building partnerships and collaborating. Recognizing that one entity can't meet all of [its] goals on [its] own."*

Dedicated and Mission-Driven Workforce

The dedication and mission-driven nature of the workforce was consistently highlighted as a core strength. Interviewees described staff and leadership within the county and partner organizations as demonstrating commitment, passion, and genuine care for the communities they serve. One interviewee emphasized, "I really want to highlight the commitment of county staff from the executive administration levels down to the line. People who work for Yolo County HHSA really deeply care about the people and the communities that they're serving and trying to help." This commitment across all levels of the organization creates a foundation for quality service delivery and drives staff to go above and beyond for community members.

Effective Specialized Programs and Access Points

Interviewees commended the continuum of care for effective, specialized programs and established access points. Specific, well-regarded programs were identified particularly in crisis response, supportive housing initiatives, and children's behavioral health: "So I would say... the children's behavioral health system is in great shape…In the sense that we…do contract out a majority of the services, but we have a very strong manager... and she has built all these relationships with the providers, has well respected in the local community." Another interviewee stated, "I think we have fairly good crisis response and stabilization as a county. We do have some transitional housing and subsidized housing." These programs were seen as essential for stabilizing individuals and families experiencing behavioral health crises.

Subpopulations and Needs

Interviewees were asked about subpopulations and needs within the Yolo County continuum of care. Four critical areas emerged where specific groups require tailored and enhanced support: Complex Needs of Individuals with Unstable Housing or Experiencing Homelessness, Barriers for Culturally and Linguistically Diverse Communities, Vulnerabilities and Gaps in Child, Youth, and Family Support, and Addressing the Unique Challenges of Older Adults.

Complex Needs of Individuals with Unstable Housing or Experiencing Homelessness

Individuals with unstable housing or experiencing homelessness were identified as a subpopulation with significant needs. This group faces multifaceted challenges often compounded by serious mental illness (SMI), substance use disorders (SUD), and frequent involvement with crisis services or the justice system. One interviewee described, "Chronically homeless obviously are a big issue, and they…have comorbidities with health issues. So that's something we're seeing more and more of, which is that people with severe health issues are also presenting with severe mental illness." This intersection of housing instability, physical health challenges, and behavioral health needs creates complex situations requiring comprehensive, coordinated support.

Barriers for Culturally and Linguistically Diverse Communities

Culturally and linguistically diverse communities face specific difficulties accessing appropriate behavioral health services due to language barriers, cultural stigma, fear, and a lack of culturally appropriate services and outreach. One interviewee explained the challenge: "Populations that are non-English speaking [have] been currently the biggest challenge that I've come across over the last few months when we've had openings to take on new patients. We have several. Non-English speaking or [English is] their second or third language. And so it's difficult to do therapy with [them]." This language barrier restricts access to essential therapeutic services, underscoring the need for multilingual providers and culturally responsive treatment approaches. There's a Russian speaking population. And I, I should say I don't know what their issue, what the issues are, but we also have a, a fairly significant. I think it's an Afghani refugee population too. I don't know their mental health needs, but I know we don't provide a whole lot of service for them

"Populations that are non-English speaking [have] been currently the biggest challenge that I've come across over the last few months when we've had openings to take on new patients. We have several. Non-English speaking or [English is] their second or third language. And so it's difficult to do therapy with [them]."

Vulnerabilities and Gaps in Child, Youth, and Family Support

Children, youth, and families emerged as a subpopulation with significant unmet needs. Systemic issues and resource gaps particularly impact children in foster care and young adults struggling with mental health challenges. One interviewee described persistent problems in the system: "I repeatedly saw those kids being failed by our mental health system and through, not through any fault of any individual person, but more just kind of the broader system... the kids in foster care who have the most complex mental health needs, complex trauma, were typically being assigned to clinicians who were the newest... And then because they have to move foster homes so often, there was a real lack of continuity in mental health care that anytime a child moved to a new foster placement, they typically had to start over with a new therapist." This reflects how system structures (including staffing patterns and foster care instability) create barriers to consistent, quality mental health care for vulnerable youth.

"I repeatedly saw those kids being failed by our mental health system and through, not through any fault of any individual person, but more just kind of the broader system... the kids in foster care who have the most complex mental health needs, complex trauma, were typically being assigned to clinicians who were the newest... And then because they have to move foster homes so often, there was a real lack of continuity in mental health care that anytime a child moved to a new foster placement, they typically had to start over with a new therapist"

Older adults were identified as a subpopulation with significant needs, including services to address social isolation, grief, dementia, and financial insecurity. These needs are acute because existing support programs are underfunded or have been discontinued. One interviewee stated, "I would also highlight the elderly. I think just social isolation. COVID, post-COVID, a lot of folks lost their spouses or partner. Loved ones lost their friends during COVID. I think it's a huge problem that we really don't have a very good handle on." The pandemic compounded isolation among seniors, creating mental health challenges that the current system is not adequately equipped to address.

Collaboration Opportunities

Interviewees were asked about strengths of, and barriers to, collaborating with HHSA. One key strength emerged: Willingness to Collaborate. Three barriers were also identified: Fragmented Systems and Communication Gaps, Resource Limitations (Funding and Staffing Shortages), and Navigating Bureaucracy and Misaligned Directives.

Strength: Willingness to Collaborate

A widespread willingness to collaborate emerged as a key factor that facilitates partnership with HHSA. Interviewees emphasized the value of established relationships, trust, and a shared commitment to community well-being as foundational for successful collaborative initiatives. One interviewee highlighted, "I think our strengths are our size and relationships and communication at the county level with the nonprofits, [and] with the cities. Yolo is pretty small, but we're large enough that we can come together with some resources and do some cool things. So I think our network, the ability to network and connect and communicate, is definitely a strength." The county's manageable size combined with sufficient resources creates an environment conducive to effective cross-sector collaboration.

Barrier: Fragmented Systems and Communication Gaps

Fragmented services and lack of clear, consistent communication channels among organizations and county departments create significant barriers to collaboration. Interviewees expressed difficulty knowing who to contact, what services exist, and how information flows within the broader behavioral health and housing system. One interviewee stated directly, "I mean the fragmented care system for one, is huge. We have such a fragmented system of care."

Another elaborated on the coordination challenges: "It seems like there's a lack of overseeing, coordination of all the different services that are out there... half the time we still are finding that someone else within the county or our connected partners that are all working on this is still kind of out in the cold and we don't even get connected." This fragmentation prevents seamless coordination and results in duplicated efforts or missed opportunities to

serve individuals who fall between organizational silos.

> *"The fragmented care system for one, is huge. We have such a fragmented system of care."*

Barrier: Resource Limitations (Funding and Staffing Shortages)

Insufficient funding and resulting staffing shortages emerged as critical barriers to effective collaboration and service delivery. Funding constraints directly limit organizational capacity to engage in or expand collaborative efforts. One interviewee explained, "I mean, I think the single biggest factor is funding and the downstream secondary impact of the lack of funding resulting in lack of systems and infrastructure that can be built to support those goals."

Budget deficits compound these challenges. Interviewees noted that significant financial shortfalls prevent adequate staffing and limit the system's ability to respond to identified needs at a timely pace.

Unfunded state mandates exacerbate these resource limitations. One interviewee stated, "Well, there is not going to be enough money, I'll tell you that right now. But kind of hand in hand with not enough money is too many unfunded state mandates." This creates tension between compliance with the mandate and maintaining adequate staffing for effective service delivery and collaboration.

Barrier: Navigating Bureaucracy and Misaligned Directives

Bureaucratic processes and misaligned directives across governmental levels create barriers to fluid collaboration and effective service delivery. Interviewees described tension between top-down state mandates, internal organizational procedures, and local implementation realities. One interviewee expressed frustration with the pace and volume of state requirements: "I mean, the state just wants too much too soon. That, I mean, the state, it's just initiative fatigue."

Conflicting directives across governmental levels compound these challenges. One interviewee explained, "The state, the municipality and the federal government just need to get on the same page. Let me give you an example. The state would say housing first... where at the federal level they're saying, get rid of that housing first thing." These contradictory mandates create confusion and complicate collaborative efforts that span multiple funding streams.

The complexity of navigating multiple funding streams with different requirements creates additional barriers. One interviewee described the challenge: "Every program has very different requirements, different regulations, different funding streams. Is it state, is it federal interpretation of law... So there's internal barriers and external barriers depending on how strict the requirements are for specific programs of funding." This regulatory complexity makes coordination across programs and organizations more difficult, particularly when trying to serve individuals with needs that cross multiple funding categories.

Funding Priorities

Interviewees were asked about their priorities among the three BHSA funding components: Behavioral Health Services and Supports (BHSS), Full-Service Partnerships (FSPs), and Housing Interventions. Perspectives varied based on interviewees' areas of focus and the populations they serve.

Behavioral Health Services and Supports (BHSS)

Some interviewees prioritized BHSS funding, emphasizing the importance of prevention and early intervention services, particularly for children and youth. One interviewee expressed concern about the shift from MHSA's prevention focus: "MHSA [Mental Health Services Act] had…prevention and early intervention. I worked in the rural communities, and prevention intervention was key. It was huge to be able to have clinicians on site to do a lot of the prevention piece, which is now [what] BHSA has gone away from." For some interviewees, BHSS represents the component best suited to support preventive approaches that can stop behavioral health issues from escalating into severe or chronic conditions, particularly in underserved rural communities where early access to care is critical.

> *"MHSA [Mental Health Services Act] had…prevention and early intervention. I worked in the rural communities and prevention intervention was key. It was huge to be able to have clinicians on site to do a lot of the prevention piece, which is now [what] BHSA has gone away from."*

Full-Service Partnerships (FSPs)

Other interviewees identified FSPs as their top priority due to the intensive, comprehensive support this component provides for individuals with serious mental illness. One interviewee explained their rationale: "I would probably put that [FSP] as my highest because we also see that [it] also tends to interact with the justice system. You know, like all of them kind of go together, right? Like, so someone's in the justice system, but they, you know, to get released, they need housing, and they need a full-service partnership slot. Neither of those is available." For those working at the intersection of behavioral health and justice systems, FSPs represent the most effective intervention for individuals with complex needs who cycle through multiple systems, providing the wraparound support necessary for successful community transitions.

Housing Interventions

Still other interviewees prioritized Housing Interventions, viewing stable housing as foundational to all other behavioral health outcomes. One interviewee stated, "I would say housing…I think the ability to provide all of those and meet all those goals really goes back to having a stable, supportive place to call home and then getting all the appropriate supports with that to then respond to all those different things." From this perspective, housing is not one service among many but rather the prerequisite for effective engagement with behavioral health treatment, making it the most critical investment for achieving lasting outcomes with vulnerable populations.

Behavioral Health Services Act Priority Goals

The Behavioral Health Services Act established six priority goals that counties are required to address. Interviewees were asked to identify enablers and obstacles to achieving progress toward these goals. The findings below present key factors and services that facilitate progress (enablers) and barriers that hinder achievement (obstacles) for each goal.

Access to Care
Ensuring people get timely behavioral health and substance use treatment

Access to Care: Enablers

1. Stable Housing and Basic Needs
2. Robust Collaboration and Partnerships
3. Accessible and Diverse Service Delivery Models
4. Targeted and Intensive Programs
5. Culturally and Linguistically Competent Services
6. Effective System Navigation and Referral Pathways

Access to Care: Obstacles

1. Funding and Resource Scarcity
2. Workforce Shortages and Turnover
3. Scarcity Housing and Shelters
4. Issues with System Fragmentation and Coordination
5. Gaps in the Continuum of Care (Prevention, Mild-to-Moderate, Aftercare)

Homelessness
Preventing and addressing homelessness among individuals with behavioral health needs

Homelessness: Enablers

1. Accessible and Stable Housing with Integrated Support (Permanent Supportive Housing – PSH)
2. Comprehensive Case Management and Wraparound Services (e.g., Full Service Partnerships - FSP)
3. Cross-Sector Collaboration and Coordination
4. Prevention and Early Intervention Programs

Homelessness: Obstacles

1. Severe Scarcity of Appropriate and Affordable Housing
2. Barriers to Access and Sustained Engagement for High-Need

Institutionalization
Reducing unnecessary hospitalizations or other institutional placements

Institutionalization: Enablers

1. Implementing Intensive, Wraparound Behavioral Health Services (e.g., Full Service Partnerships - FSPs)
2. Enhancing Crisis Response and Diversion Programs

Institutionalization: Obstacles

1. Scarcity of Step-Down Options
2. Scarcity of Housing with

Justice Involvement
Decreasing involvement in the criminal justice system for people with behavioral health needs

Justice Involvement: Enablers

1. Collaborative Courts and Diversion Programs
2. Intensive Individualized Support (Full Service Partnerships - FSP)
3. Permanent Supportive Housing (PSH) with Integrated Services
4. Crisis Co-Responder Teams and Mobile Crisis Response
5. Seamless Reentry and Transition of Care Programs

Justice Involvement: Obstacles

1. Scarcity of Services for Justice-Involved Individuals
2. Scarcity of Funding and Resource Allocation for Diversion/Reentry
3. Issues with System Coordination

Removal of Children from Home
Supporting families so children are not removed due to behavioral health issues

Removal of Children from Home: Enablers

1. Early Intervention and Prevention Programs (especially for 0-5-year-olds and their families)
2. Stable and Supportive Housing, Coupled with Basic Needs Support
3. Robust Inter-Agency and Cross-System Collaboration/Coordination
4. Support for Caregivers and Family Systems

Removal of Children from Home: Obstacles

1. Scarcity of Behavioral Health Services for Children and Families (including Prevention and Early Intervention)
2. Scarcity of Family-Specific Housing and Essential Basic Needs Support
3. Issues with Coordination of Services

Untreated Behavioral Health Conditions
Ensuring individuals receive appropriate care for mental health and substance use conditions

Untreated Behavioral Health Conditions: Enablers

1. Holistic and Integrated Services (Addressing Basic Needs and Wraparound Support)
2. Early Intervention and Prevention (Especially for Youth and Rural Communities)
3. Specialized Crisis Response and Access Lines
4. Culturally Competent and Peer-Led Services

Untreated Behavioral Health Conditions: Obstacles

1. Issues with Coordination of Services
2. Stigma and Patient Engagement Barriers

Conclusions and Recommendations

The Yolo County Community Planning Process engaged 514 participants across multiple engagement methods—surveys, focus groups, listening sessions, and key informant interviews—to inform behavioral health and housing service priorities under the Behavioral Health Services Act (BHSA). This comprehensive engagement effort captured perspectives from individuals with lived experience, family members, service providers, system partners, and community stakeholders. The findings reveal both strengths within Yolo County's behavioral health system and key areas requiring attention to improve access, equity, and outcomes.

Importantly, findings from the BHSA Community Planning Process align with and reinforce

priorities identified in Yolo County's 2023-2025 Community Health Assessment (CHA) and 2023 Community Health Improvement Plan (CHIP) (see Appendix C). The CHA identified 11 Significant Health Needs (SHNs), including Access to Mental/Behavioral Health and Substance Use Services, Housing and Homelessness, and Adolescent Risk Behaviors, all of which emerged as central themes in this Community Planning Process. This convergence across independent assessment processes strengthens the evidence base for recommended actions and demonstrates consistent community priorities across multiple planning efforts.

Key Cross-Cutting Themes

Several themes emerged consistently across all engagement methods, indicating systemic issues that transcend individual programs or populations:

Fragmentation and Coordination Challenges

Across surveys, focus groups, listening sessions, and interviews, participants identified fragmented services and a lack of coordination as fundamental barriers. Information about available services is scattered across multiple locations without centralization. Communication gaps exist both between organizations and within county departments. Community members struggle to navigate the system, and even service providers report difficulty knowing where to refer clients. This fragmentation leads to duplicated efforts, missed opportunities to serve individuals, and leaves many without access to the necessary support, despite the availability of services.

Housing as Foundation for Behavioral Health

The critical role of stable housing emerged as a central theme across all data sources. Participants emphasized that addressing behavioral health goals is difficult when individuals lack stable housing. Housing instability intersects with serious mental illness, substance use disorders, and involvement with crisis services and the justice system, creating complex situations requiring coordinated support. The absence of transitional housing options limits progression through levels of care. Affordable housing shortages, particularly for populations with fixed incomes, create ongoing barriers to stability and recovery.

Need for Early Intervention and Prevention

Participants across multiple engagement methods expressed frustration with crisis-driven systems that require situations to escalate before intervention becomes available. Families described feeling helpless while waiting for crises to occur so they could access resources. The shift from MHSA's prevention focus raised concerns about losing capacity for early intervention, particularly in underserved areas. Participants emphasized the value of proactive approaches that respond to warning signs rather than waiting for crisis thresholds.

Cultural and Linguistic Barriers

Language barriers, cultural stigma, and a shortage of culturally responsive services create significant obstacles to accessing behavioral health support. Non-English-speaking populations face difficulties accessing therapeutic services. Immigrant communities experience distrust of systems and fear related to immigration enforcement, leading to disengagement from services. Generational attitudes about mental health create stigma, particularly among older adults. Services designed without cultural input fail to reach and effectively serve diverse populations.

Resource Constraints and Workforce Challenges

Insufficient funding and staffing shortages limit service capacity and collaborative efforts. Budget deficits prevent adequate staffing to meet caseload demands. Provider shortages make it difficult to sustain services like 24/7 crisis access. Grant-funded structures often create instability when funding cycles come to an end. Delayed invoice payments affect nonprofit cash flow and ability to maintain staff. These resource limitations are compounded by unfunded state mandates that create tension between compliance requirements and service delivery capacity.

Importance of Relationships and Trust

Despite systemic challenges, strong relationships, shared commitment to community wellbeing,

and dedicated staff emerged as foundational strengths. Yolo County's manageable size facilitates relationship-building across sectors. Staff demonstrate genuine care and commitment from leadership to frontline positions. Collaborative spirit and willingness to partner distinguish Yolo County from larger systems. These relationships create opportunities to address fragmentation and build more integrated approaches.

Service Delivery Insights

Navigation and Access Support

Community members often need assistance in identifying suitable services, establishing connections, and following up to ensure a successful linkage. Administrative processes create obstacles, particularly during a crisis when individuals lack the capacity to manage complex requirements independently. Models where dedicated staff help navigate systems, make appointments, and wait with individuals until connections are made were identified as essential. Clear referral guidelines and centralized information would benefit both community members and providers making referrals.

Person-Centered and Trauma-Informed Care

Participants emphasized the importance of genuine care, active listening, and staff who understand lived experience. Generic, short-term care does not address nuanced long-term needs. Sustained, individualized support that evolves with the person is necessary. Rigid application of procedures prevents personalized problem-solving. Authenticity matters, participants value honesty about what staff can and cannot understand over claims of relatability that feel disingenuous.

Peer Support

Shared lived experience creates trust and connection that traditional services cannot replicate. Peer support helps navigate complex systems, provides authentic understanding, and fosters belonging. Participants described the value of being around people who understand their experiences as transformative and essential for engagement and recovery.

Timely and Consistent Processes

Payment processing delays create cash flow issues for nonprofit partners, impacting their ability to sustain staffing and operations. Timely contracting and payment are essential for organizational sustainability. Inconsistent processes across locations create confusion and inequitable access, individuals receive different information and responses depending on where they seek help.

System-Level Considerations

Bureaucratic and Regulatory Challenges

Conflicting directives across federal, state, and local levels create confusion and complicate collaborative efforts. State mandates often come too quickly without adequate implementation time or resources, leading to "initiative fatigue." Multiple funding streams with different requirements make coordination challenging when serving individuals with needs that span multiple categories. Decision-making processes often lack input from those with frontline experience, resulting in a disconnect between policy and practical realities.

Siloed Services

Despite strong collaborative relationships, services remain fragmented across organizations and county departments. Housing and behavioral health are often treated separately rather than integrated, even though housing is a fundamental social determinant of health. Lack of coordinated entry points requires individuals to navigate multiple systems independently. Breaking down silos requires both structural changes and intentional cultivation of relationships.

Data and Transparency

Participants questioned whether the BHSA Statewide Behavioral Health measures capture the full scope of needs. Point-in-time counts may provide incomplete information due to methodology limitations. Lower service utilization rates may reflect access barriers rather than

lower need. Community members see only parts of the service system and request more comprehensive written information from the county about available programs. Tracking funding flows and making information understandable for both the community and staff would improve transparency.

Recommendations

Based on the comprehensive community engagement findings, the following recommendations address systemic barriers while building on identified strengths. These recommendations align with and are reinforced by findings from Yolo County's CHA and CHIP, which identified Access to Mental/Behavioral Health and Substance Use Services, Housing and Homelessness, and Adolescent Risk Behaviors among the 11 Significant Health Needs (SHNs) for the county. The convergence of findings across the BHSA Community Planning Process, CHA, and CHIP underscores the critical importance of these priorities, providing a unified foundation for action.

1. Strengthen System Navigation and Coordination

The 2023-2025 CHA found that 56% of respondents identified mental health as a top health issue, with 35% reporting a need for professional help in the past year. Providers noted barriers "especially for kids" requiring removal of obstacles through increased providers, reduced stigma, and affordability.

- Establish centralized access points for information and connection across systems
- Develop clear referral pathways accessible to community members and providers
- Enhance care coordination roles across housing, behavioral health, and substance use services, aligning with CHIP strategies for case managers and community health workers
- Standardize processes across locations for equitable access

2. Invest in Culturally and Linguistically Responsive Services

The CHA identified communities of color, families living in poverty, and rural communities as Priority Communities, aligning with BHSA findings on cultural and linguistic barriers.

- Expand multilingual provider capacity and therapeutic services in multiple languages
- Develop culturally specific outreach with input from Priority Communities
- Address immigration-related fears through explicit privacy protections and trust-building through community-based organizations
- Create programming that acknowledges diverse cultural perspectives on behavioral health

3. Expand Housing Options Across the Continuum

The latest Annual Partnership County Data Report recounted that half (51.6%) of homeless members experience chronic homelessness. The CHIP identifies housing as a Significant Health Need, reinforced by BHSA CPP findings positioning housing as foundational to behavioral health outcomes.

- Increase transitional housing with supportive services for independent living skill development
- Address ADA compliance gaps for individuals with physical disabilities
- Prioritize in-county housing to maintain family and community connections
- Invest in infrastructure improvements for affordable housing, as outlined in CHIP

4. Strengthen Prevention and Early Intervention

The CHIP identifies Adolescent Risk Behaviors as a Significant Health Need, with strategies supporting school-based services and suicide prevention aligning with BHSA CPP engagement priorities.

- Expand early intervention capacity for children, youth, and families
- Broaden crisis definitions to allow intervention before escalation
- Enhance first responder training in behavioral health crisis recognition
- Advocate for increased after-school programs and school-based services, building on K-12 partnerships

- Support evidence-based health education for substance use prevention
- Conduct community-wide suicide prevention assessment for youth, per CHIP

5. Address Workforce and Resource Stability

The Annual Partnership County Data Report identifies significant workforce shortages and infrastructure limitations constraining service capacity, aligning with these report findings on resource barriers.

- Streamline payment processes for nonprofit partners
- Support workforce development with focus on staff with lived experience and competitive compensation
- Address unfunded mandate concerns through state advocacy

6. Enhance Service Delivery Quality

- Prioritize person-centered, sustained support over generic interventions
- Expand peer support services across programs
- Strengthen trauma-informed practices
- Create procedural flexibility for personalized problem-solving

7. Improve Integration and Break Down Silos

- Integrate housing and behavioral health as interconnected social determinants
- Strengthen communication channels within and between organizations
- Develop shared data and communication protocols
- Create regular cross-system coordination meetings

8. Address Population-Specific Needs

The CHA identifies Priority Communities, and the CHIP includes youth coalition strategies, aligning with BHSA findings on population-specific gaps.

- Develop pathways for families of adults with serious mental illness
- Strengthen services for isolated older adults
- Ensure foster youth care continuity across placements
- Create supports for co-occurring conditions
- Convene youth coalition per CHIP
- Prioritize services for families in poverty and rural communities

9. Enhance Transparency and Community Engagement

- Provide comprehensive written information on programs and services
- Report back on how community input shaped decisions
- Continue ongoing community engagement

10. Balance BHSA Funding Component Investments

- Maintain balanced investment across behavioral health services, full-service partnerships, and housing

Conclusion

Yolo County's Community Planning Process revealed a system with significant strengths, including a collaborative spirit, dedicated staff, established relationships, and effective specialized programs, alongside critical challenges related to fragmentation, resource constraints, and gaps in serving specific populations. The consistent themes across all engagement methods provide clear direction for system improvement.

The recommendations presented here build on identified strengths while addressing systemic barriers. Implementation will require sustained commitment, adequate resources, cross-sector collaboration, and ongoing community engagement. Success depends on balancing immediate crisis response with prevention and early intervention, integrating services across silos, and ensuring that those most impacted by the system have a meaningful voice in shaping its evolution.

Appendix A – Community Program Planning Brief

As part of the BHSA Community Planning Process (CPP), HHSA engaged 514 community members through listening sessions, focus groups, interviews, and surveys. The Yolo County BHSA Community Planning Process Brief and Summary of Findings were distributed to the community on February 10, 2026 and available online at www.yolocounty.gov/mhsa.

Appendix B – Participants' Demographics

Age	Survey (N = 192)	CEWG (N= 22)	Focus Groups (N =24)	Listening Sessions (N = 53)
Under 15 years old	1%	0%	0%	0%
16 – 25 years old	3%	0%	8%	6%
26 – 59 years old	54%	82%	54%	81%
60+ years old	29%	18%	29%	13%
Prefer not to answer	14%	0%	8%	0%

*May not sum to 100% due to rounding

Sex Assigned at Birth	Survey	CEWG (N= 22)	Focus Groups (N = 25)	Listening Sessions (N = 54)
Female	N/A	82%	40%	83%
Male	N/A	18%	56%	17%
Prefer not to answer	N/A	0%	4%	0%

Gender Identity	Survey (N=199)	CEWG (N= 22)	Focus Groups (N =25)	Listening Session (N = 54)
Female	71%	77%	40%	76%
Genderqueer	1%	5%	0%	7%
Male	22%	18%	56%	17%
Questioning/unsure of gender identity	0%	0%	0%	0%
Transgender	0%	0%	0%	0%
A different identity	0%	0%	0%	0%
Prefer not to answer	7%	0%	4%	0%
Not applicable: I am a minor who is exempt from answering this question	0%*	0%	0%	0%

*Minors only received the options of *Female, Male,* or *Prefer Not to Answer* in the electronic survey platform.

Sexual Orientation	Survey (N = 200)	CEWG (N= 22)	Focus Groups (N = 24)	Listening Sessions (N = 54)
Bisexual	6%	5%	0%	2%
Gay or Lesbian	3%	14%	0%	6%
Hetero Sexual or Straight	77%	64%	88%	74%
Queer	3%	5%	0%	11%
Questioning or unsure of your sexual orientation	1%	0%	0%	0%
Another sexual orientation	1%	5%	0%	2%
Prefer not to answer	10%	5%	13%	4%
Not applicable: I am a minor who is exempt from answering this question	0%**	5%	0%	2%

*Individuals could select more than one option. Percentages may exceed 100%.
**Minors did not receive this survey item in the electronic survey platform

Primary Language Spoken at Home	Survey (N = 201)	CEWG (N= 22)	Focus Groups (N = 25)	Listening Sessions (N = 54)
English	87%	100%	96%	100%
Spanish	2%	0%	4%	0%
Russian	0%	0%	0%	0%
Both English and Spanish	11%	0%	0%	0%
English, Spanish and Portuguese	1%	0%	0%	0%

Primary Written Language	Survey	CEWG (N= 22)	Focus Groups (N = 25)	Listening Sessions (N = 54)
English	N/A	100%	96%	100%
Spanish	N/A	0%	4%	0%
Russian	N/A	0%	0%	0%
Both English and Spanish	N/A	0%	0%	0%

Ethnicity and Race	Survey (N = 230**)	CEWG (N=22)	Focus Groups (N = 25)	Listening Sessions (N =54)
American Indian or Alaska Native	4%	0%	8%	4%
Asian	6%	9%	4%	15%
Black or African American	4%	0%	4%	9%
Hispanic or Latinx	25%	9%	40%	17%
Native Hawaiian or Pacific Islander	1%	0%	4%	0%
White	62%	82%	52%	57%
Multiracial	5%	5%	8%	9%
Another race/ethnicity	2%	0%	8%	0%
Prefer not to answer	7%	0%	0%	0%

*Individuals could select more than one option. Percentages may exceed 100%.

Hispanic Identity	Survey	CEWG (N=2)	Focus Groups (N =10)	Listening Sessions (N =10)
Caribbean	N/A	0%	0%	10%
Central American	N/A	0%	0%	20%
Mexican/Chicano/Mexican-American	N/A	100%	70%	60%
Puerto Rican	N/A	0%	0%	0%
South American	N/A	0%	0%	20%
Other Hispanic Latino	N/A	0%	40%	0%
Prefer not to answer	N/A	0%	0%	0%

*Individuals could select more than one option. Percentages may exceed 100%.

Disability	Survey	CEWG (N= 22)	Focus Groups (N =24)	Listening Sessions (N = 54)
Yes	N/A	14%	46%	15%
No	N/A	86%	54%	83%
Prefer not to answer	N/A	0%	0%	2%

Veteran	Survey	CEWG (N= 21)	Focus Groups (N = 24)	Listening Sessions (N =54)
Yes	N/A	5%	4%	6%
No	N/A	95%	96%	93%
Prefer not to answer	N/A	0%	0%	2%

Additional Identities	Survey (N = 176)	CEWG (N= 21)	Focus Groups (N = 24)	Listening Sessions (N = 54)
I work at an organization that supports behavioral health, substance use, and/or homelessness	n/a	76%	4%	69%
I am a parent/caretaker of a child under 18	43%	43%	25%	28%
I am a veteran	5%	5%	4%	2%
I have a severe mental or emotional illness	13%	5%	42%	15%
I am a family member of someone with a serious mental or emotional illness	42%	33%	8%	30%
I have an alcohol or substance use disorder	6%	5%	33%	0%
I have a disability	13%	10%	21%	11%
I have a mental disability	6%	5%	29%	0%
I am a caregiver for an adult family member	17%	5%	0%	9%
I have unstable housing or am unhoused	8%	0%	42%	0%
I am part of the LGBTQ+ community	7%	19%	0%	15%
I am a survivor of domestic violence and/or sexual abuse	16%	5%	21%	11%
Other	17%	5%	8%	20%

*Individuals could select more than one option. Percentages may exceed 100%.

Organization Sector	Survey (N = 103)	CEWG (N= 16)	Focus Groups (N = 1)	Listening Sessions (N = 36)
Aging services	14%	19%	0%	17%
Developmental disability services	18%	0%	0%	8%
Disability insurance company	7%	0%	0%	0%
Early childhood services	23%	19%	0%	22%
Emergency medical services	12%	6%	0%	3%
Health insurance or managed care organization that provides behavioral health coverage	11%	0%	0%	3%
Healthcare organization that provides Medi-Cal behavioral health services	17%	38%	0%	42%
Higher education	7%	6%	0%	0%
Homeless services	19%	38%	100%	33%
Independent living center	5%	0%	0%	0%
K-12 education	22%	19%	0%	14%
Law enforcement, probation, or juvenile detention facilities	7%	0%	0%	3%
Organization serving youth with mental health/substance use needs	19%	0%	0%	42%
Organization serving adults with mental health/substance use needs	20%	81%	0%	33%
Public health on behavioral health initiatives	11%	13%	0%	14%
Social services/child welfare	15%	19%	0%	11%
Tribal or Indian health program	5%	0%	0%	0%
Veterans' organization	1%	6%	0%	3%
Other	7%	31%	0%	17%

*Individuals could select more than one option. Percentages may exceed 100%.

Residence	Survey	CEWG (N= 22)	Focus Groups (N =23)	Listening Sessions (N =53)
Brooks	N/A	0%	0%	0%
Clarksburg	N/A	0%	0%	0%
Davis	N/A	41%	22%	30%
Dunnigan	N/A	0%	0%	0%
Esparto	N/A	0%	0%	0%
Knights Landing	N/A	5%	0%	0%
Madison	N/A	0%	0%	4%
Sacramento (Board and Care)	N/A	0%	0%	0%
West Sacramento	N/A	5%	0%	9%
Winters	N/A	0%	0%	0%
Woodland	N/A	27%	74%	36%
Yolo	N/A	5%	0%	6%
Out of county	N/A	9%	0%	8%
Homeless	N/A	0%	4%	0%
Prefer not to answer	N/A	5%	0%	4%
Other	N/A	5%	0%	4%

*May not sum to 100% due to rounding

Community Behavioral Health Survey Key Populations	Valid %	% of Total	Yolo County (US Census)*	Compared to Valid %	Compared to % of Total
Gender/Sex Assigned at Birth (N = 199)					
Female	71%	53%	**51%**	20%	2%
Race/Ethnicity (N = 230)					
American Indian/Alaskan Native	4%	3%	**<1%**	4%	3%
African American	4%	3%	**3%**	1%	0%
Asian	6%	4%	**16%**	-10%	-12%
Hispanic/Latinx	25%	18%	**33%**	-8%	-15%
Native Hawaiian or Pacific Islander	1%	<1%	**<1%**	1%	0%
White	62%	46%	**41%**	21%	5%
Other	6%	5%	**7%**	-1%	-2%

Appendix C – Other Planning Processes

The Yolo County Health and Human Service Agency's (HHSA) Public Health Branch released the 2023-25 Community Health Assessment (CHA), which includes information about the overall health of residents in the county and identifies eleven significant health needs. Results from this assessment were incorporated into the 2023 Yolo County Community Health Improvement Plan (CHIP), which is a systematic, long-term, community-level effort to address Yolo County public health problems. Source: Healthy Yolo Community Health Publications.

Yolo County Draft BHSA Integrated Plan FY 2026-2029 Revised Public Comments Summary and Documentation of Public Hearing & Public Notices

30-Day Public Comment Period: April 1, 2026-April 30, 2026

YOLO COUNTY
Health & Human Services Agency

Behavioral Health Services Act (BHSA)

Draft Integrated Plan

2026-2029

Summary

The Yolo County Draft Behavioral Health Services Act (BHSA) Integrated Plan 2026-2029 30-day public comment period opened on April 1, 2026, and closed April 30, 2026. The county announced and disseminated the draft plan broadly through community stakeholders, general public, the Community Engagement Work Group, BHSA listservs, service providers, consumers and family members, Board of Supervisors, Local Behavioral Health Board, county staff, and requested and encouraged partners and community stakeholders to promote the review of the draft plan and participation by posting and sharing with others. Public Notices were also posted in the Davis Enterprise and the Daily Democrat newspapers for several dates. The draft plan was posted to the county's BHSA website and could be downloaded and/or viewed electronically along with hyperlinks to electronic public comment surveys, public notices, and previous planning materials and online resources. Hardcopies were also made available at HHSA locations in Woodland, Winters, Davis, West Sacramento, and a community location (Esparto) within Yolo County. Additionally, any interested party could request a copy of the draft by submitting a written or verbal request to the BHSA program staff. All Public Comments, and Statements, along with a summary are compiled within this document to date and were presented to the Local Behavioral Health Board. On Wednesday May 6th, 2026, at 6:00 PM, a public hearing was held by the Yolo County Local Behavioral Health Board in compliance with regulation. Public comments were provided to the LBHB in advance and the public hearing and an additional public comment from the public hearing was included in the summary below. The LBHB agenda and public notices are included for documentation.

Yolo County draft BHSA Integrated Plan FY 26-29

Summary of Feedback from 30-Day Public Comment Period (April 1-30th, 2026)

• Consideration to fund a range of evidence-based and community-informed approaches as part of implementation and future planning efforts (i.e. Village is Possible-Early Intervention; whole-family approach, complement FSP; complement Housing Interventions).

• Emphasis on directing resources to individuals in need of housing and behavioral health services (i.e. tighten county budget).

• Recommendation to capture more of the challenges provided by the data and the community plan within the Executive Summary.

• Community concern regarding individuals experiencing homelessness and serious mental illness with emphasis on identifying effective long-term solutions. (e.g. locked facility).

• Consideration to fund community partners with range to support rental subsidies, participant assistance, "housing shelter," and navigation services as important components of a comprehensive housing continuum (i.e. Davis Community Meals and Housing).

• Importance of the program services provided by National Alliance on Mental Illness (NAMI) in supporting individuals living with mental health conditions and their family members.

• Recommendation to provide additional details on funding allocations (i.e. amount allocated to individual contractors).

• Recommendations related to community engagement training and technical assistance models (e.g. University of the Pacific Transformational Change Partnership model).

• Opportunities to enhance data, outcomes measurement, and system improvement efforts, for Full-Service Partnership services (i.e. Third Sector Capital).

• Recommendation to provide at least $5 million in funding for rehabilitation of and improvements to existing homes in the continuum of care (i.e. annual $1m/$2m fund balance).

• Develop a prioritization and community engagement process for rehabilitation and improvement of existing housing and other residential care options (i.e. Physical needs assessment contractor funding, prioritize needs, RFP's).

• Fund a long-term study and funding strategy to define the need for additional housing and other residential care options (i.e. $250k).

• Encourage HHSA to develop community partnerships to raise funds to jointly invest in priority projects identified through above referenced recommendations.

• Personal statement from community member with lived experience on system failures.

• Recommendation to include a summary describing how HHSA will evaluate outcome measures and assess whether each program achieves its service goals and intended outcomes.

1.Village is Possible (Submitted Online; 04-02-26)
Shannon Scott
Community, faith, or cultural organization
703-819-7222 |shannon@ourlivedexperience.com
1275 4th St #371, Santa Rosa, CA 95404

To the Yolo County Behavioral Health Services Act Planning Team and Local Behavioral Health Board:

Thank you for the opportunity to submit public comment on the Yolo County BHSA Integrated Plan FY 2026-2029. We write on behalf of Village Is Possible (VIP), a Sacramento-area organization providing Family Centered Treatment (FCT) - a nationally recognized, evidence-based model designed to keep families together, address the root causes of family crisis, and prevent unnecessary entry into foster care and juvenile justice systems.

We strongly support Yolo County's commitment to prioritizing children and youth at risk of child welfare involvement, juvenile justice contact, and institutionalization under the new BHSA framework. These are the exact populations FCT is designed to serve - and the populations for whom early, intensive, family-preserving intervention produces the most durable outcomes.

Family Centered Treatment is a direct fit for multiple BHSA funding components:
Under Behavioral Health Services and Supports (BHSS), FCT functions as a high-fidelity Early Intervention model for children, youth, and families - particularly those ages 25 and under, consistent with BHSA's 51% EI set-aside priority.

FCT's whole-family, strength-based approach aligns closely with High Fidelity Wraparound, one of the BHSA's required evidence-based practices, and can complement Coordinated Specialty Care and FSP Intensive Case Management for families with co-occurring mental health and substance use needs.
For families experiencing or at risk of homelessness, another BHSA priority, FCT addresses the behavioral health and family stability factors that frequently drive housing instability, making it a natural complement to BHSA's Housing Interventions component.

Village Is Possible is currently providing FCT services in the greater Sacramento region and is well-positioned to serve Yolo County families. We respectfully ask that the Integrated Plan:
Explicitly name Family Centered Treatment as an eligible evidence-based model under BHSS Early Intervention programming.

Prioritize funding for family-preserving interventions that reduce child welfare involvement, juvenile justice contact, and out-of-home placement.
Create pathways for community-based providers like VIP to participate as contracted or subcontracted service partners under the new plan.

We believe that investing in families early, before crisis deepens, is both the most humane and most cost-effective use of BHSA resources. Village Is Possible is ready to be a partner in that work.

Thank you for your consideration. We welcome the opportunity to connect further.
Respectfully submitted,

The Village is Possible Team

2.Jeni Olstad (Submitted Online; 04-08-26)
Private Citizen
Jeniolstad@gmail.com

Take less money as the county, tighten your own budget and spend it on the actual people that need it by way of the shelter and other behavior health centers.

3.Valerie Olson (Submitted Online; 04-09-26)
Appointee Health Council; Retired Mental Health Provider
916-616-4601 | olsonmac@wavecable.com
718 Ashley Avenue, Woodland CA 95695

I applaud the effort involved in timely producing this very long draft BHSA Plan 2026-2029. The data provided highlighted some of the challenges in meeting the extensive requirements and the Community Plan more specifically addressed priority issues in Yolo County. I was somewhat surprised that the Executive Summary did not capture some of the challenges provided in the data and the Community Plan. Was this a missed opportunity to highlight not only the positive road ahead but to make some inroad into what will surely involve many bumps in the road?

4. Christian Serdahl, M.D. (Submitted Online; 04-17-26)
Healthcare or health plan provider
ccneye@sbcglobal.net

We need to build a locked facility to house homeless with mental illness. This will be the solution to the homeless problem in Yolo County

5. Davis Community Meals & Housing (Submitted Online; 04-20-26)
Diane Parro
Mental health, substance use, or social services provider; Housing;
Homeless shelter/resource center/permanent supportive housing
530-756-4008| dianeparro@gmail.com
1111 H Street, Davis, CA 95616

April 20, 2026

Monica Morales
Director, Health and Human Services Agency, County of Yolo

RE: Davis Community Meals and Housing Comments on the Draft BHSA Integrated Plan FY 2026-2029 for Yolo County

Dear Ms. Morales,
Davis Community Meals and Housing (DCMH) welcomes the opportunity to comment on the draft BHSA Integrated Plan FY 2026-2029 for Yolo County. Given our successful longstanding efforts to address the housing and other critical needs of the chronically homeless residing on the streets in Davis and local encampments, we appreciate the approach outlined in the section titled “BHSA Housing Interventions Implementation”.
We note that several of the specific housing interventions (HIs) that you have chosen to pursue in the

three-year timeframe are very much aligned with our own organizational priorities. The written proposal we presented to you on November 14, 2025, describes several HI projects that we urge you to consider for BHSA resources once you move forward with a formal request for proposals process. They are very much in sync with your descriptions of your priorities for action. We note these examples:

• A section of your plan describes your intent to provide individualized Rental Subsidies based on each person's unique needs, as one-time payments or multiple monthly payments, as well as non-time-limited rental subsidies in a variety of permanent housing settings to eligible individuals living with serious mental illness or co-occurring disorders. You rightly emphasize the importance of removing cost as a barrier to housing stability to promote recovery, independence, and long-term wellness.

Our November letter to you sought funding to establish a Safe and Sober Shelter involving exactly that approach. DCMH would operate a new short-term shelter at one of our facilities to create a safe haven for persons in dire need of substance abuse treatment, literally bringing in from the cold persons struggling to survive in local encampments who might otherwise be unwilling to accept treatment.

• Your plan describes your intent to allocate BHSA HI funds via Participant Assistance Funds, which may include assistance to chronically homeless individuals with funding for housing application fees, credit report fees, storage costs, security deposits and pet-related deposits and fees.

Our November 14, 2025, letter to you outlined our proposal for just such a Participant Assistance Fund to remove barriers that prevent at-risk and homeless individuals from meeting their immediate housing needs by providing assistance with such items as move-in costs, security and utility deposits, basic furniture, transportation, food and personal hygienic items.

• Your plan describes your intention to establish a Housing Transition Navigation Services and Tenancy Sustaining Services program that would be focused on verifying clients' eligibility status and supporting coordination by connecting individuals to the appropriate funding stream and revenue.

Our Peer Navigation Program would build upon our existing activities to recruit, train, and hire persons we have successfully supported as they moved from the streets to stability. Formerly homeless and at-risk individuals who complete our peer counseling program are overseen and guided by our professional staff as they use their training and lived experience to provide community outreach and help others to navigate to programs and services needed to overcome homelessness, mental health concerns, addiction and substance abuse.

With more than 30 years of success with homeless and at-risk populations, DCMH knows our nonprofit can be a valuable partner with Yolo County to fulfill the mandate in the new state law to increase access to proven housing interventions such as those presented in your plan. Accordingly, we support your plans to seek Board of Supervisors adoption of these HI strategies in your plan as proposed, and look forward to engaging with you further.

6. Alberto Acevedo
NAMI Client/Consumer
530-631-2046|lbrtacevedojedi@gmail.com

NAMI is an excellent program for people living with mental health disabilities and educational for those living with Family members with mental health issues.

7.NAMI Yolo County (Submitted Online; 04-30-26)

Lou Enge, Executive Director
Mental health, substance use, or social services provider
707-837-6511 | Lou@namiyolo.org
P.O. Box 477, Davis, CA. 95617

April 30th, 2026

Monica Morales
Director, Yolo County Health and Human Services
25 and 137 N. Cottonwood St.
Woodland, CA 95695

Supervisor Oscar Villegas
district1@yolocounty.gov

Supervisor Lucas Frerichs
Tara.Thronson@yolocounty.gov

Supervisor Mary Vixie Sandy
dotty.pritchard@yolocounty.gov

Supervisor Sheila Allen
Oliver.snow@yolocounty.gov

Supervisor Angel Barajas
Monica.Rivera@yolocounty.gov

Send via email: Monica.Morales@yolocounty.gov

RE: NAMI Yolo County Public Comment on the Behavioral Health Services Act Draft Plan

Dear Director Morales, Chair Allen, Supervisors Barajas, Frerichs, Vixie-Sandy, and Villegas:
We welcome this opportunity to comment on the draft Behavioral Health Services Act Plan for Fiscal Years 2026-29 (draft BHSA plan). In offering these comments we are acutely aware of the fiscal challenges that Yolo County is facing, as well as the added challenges of meeting the requirements of the Behavioral Health Services Act (BHSA) that become effective on July 1, 2026.

We offer these comments in the spirit of collaboration and our desire to be a strong partner with Yolo County as it fully transitions to BHSA.

Since 2020 NAMI has effectively provided peer support services throughout Yolo County under a contract with Yolo County. In all prior years Yolo County has provided the funding that supports our contract using Mental Health Services Act (now BHSA). Our understanding is that Yolo County proposes to use State realignment funding (Cal. Const. Art. XIII, Sec. 36 and implementing statutes) to support NAMI Yolo County in the 2026-27 fiscal year. We are very appreciative of this proposal, yet, there is no mention of this funding plan in the draft BHSA

plan. Related to that, one of the notable changes that Proposition 1 made is that the draft BHSA plan just identify, not only how it intends to use BHSA funds to support behavioral health, but must also identify other federal, state and local funding sources that it intends to use for behavioral health. In light of that, we respectfully ask that you include a clear indication of your intent to fund the services offered by NAMI Yolo County using state realignment funding.

We know that you have enormous challenges as you fully transition to Proposition 1 on July 1, 2026, so we have kept our comments brief.

We look forward to our continued partnership with you.

In partnership,
Lou Enge
Executive Director
NAMI Yolo County

8. Petrea Moyle Marchand (Submitted email; 04-30-26)
President, Consero Solutions
231 G Street, Suite 21
Davis, CA 95616
www.conserosolutions.com
o: 530-746-2083
c: 916-505-7191

April 30, 2026

Yolo County Board of Supervisors
625 Court Street, Suite 204
Woodland, CA 95695

Mónica Morales
Director, Yolo County Health and Human Services Agency
137 North Cottonwood Street
Woodland, CA 95659

Tony Kildare
Behavioral Health Director, Yolo County Health and Human Services Agency
137 North Cottonwood Street
Woodland, CA 95659

Dear Members of the Yolo County Board of Supervisors, Mónica Morales, and Tony Kildare:

Yolo County residents living with serious mental illness and substance use disorders depend on a fragile network of housing and services which urgently needs additional funding for rehabilitation and improvement.

We are writing as community advocates, philanthropic partners, and nonprofits responsible for providing housing and residential care options for people living with serious mental illness and substance use disorders. We have come together to coordinate comments on the Yolo County 2026-2029 Behavioral Health Integrated Plan ("2026-2029 Plan"), which will allocate almost $70 million available to Yolo County from a statewide tax on millionaires over the next three years for mental health and substance use disorder services, including housing.

We are working together because we strongly believe in the importance of providing people living with serious mental illness and substance use disorders with adequate shelter and support; this shared mission is larger than any of our individual organizations or philanthropic efforts.

We recommend the Yolo County Health and Human Services Agency (HHSA) include the following in the 2026-2029 Plan.

Recommendation #1: Provide at least $5 million in funding for rehabilitation of and improvements to existing homes in the continuum of care. Allocate $1 million annually of Housing Intervention funding annually at least $2 million in fund balance over the course of three years, for a total of $5 million, to rehabilitate or improve housing in the continuum of care for people living with serious mental illness and substance use disorders. (The continuum of care is the coordinated range of housing options to provide increasing or decreasing levels of assistance as needs change; see Attachment A for a list of facilities in the Yolo County continuum of care.) As presented at the March

3, 2026 Yolo County Board of Supervisors meeting, HHSA has $1 million annually in BHSA funding available for capital improvements over the next three years which HHSA can spend on rehabilitation of or improvement to existing homes, as well as a $5.4 million fund balance. One-time expenditures to rehabilitate or improve homes are an appropriate use of fund balance since the investment requires one-time expenditures versus ongoing expenditures; we therefore recommend allocating at least $2 million of the fund balance to this purpose. We also recognize HHSA is focusing on mandated expenditures; these improvements will directly benefit the people Yolo County is required by law to serve. We further recommend that if any of the $ 5 million remains after fulfilling all rehabilitation and improvement requests for existing homes and residential care options, HHSA should dedicate the remaining funds to new housing.

Recommendation #2: Develop a prioritization process through a robust community engagement effort. HHSA should develop a prioritization and community engagement process for rehabilitation and improvement of existing housing and other residential care options in coordination with the community with the following elements:

- ***Set aside funding to complete physical need assessments (PNAs)***. HHSA should hire a consultant with physical needs assessment expertise to complete this work; these assessments will result in an independent, detailed assessment of the needs. HHSA could fund this work out of the $5 million recommended in Recommendation #1.
- ***Prioritize needs.*** The PNAs should identify critical infrastructure needs at existing homes and other residential care options within six months and release an RFP to fund these critical needs in early 2027. (HHSA has already publicly discussed potentially releasing a Request for Proposals in 2026-27 to allocate $ 1 million in capital improvement funds, so this is consistent with that direction.) For the remaining needs, HHSA should work with the community to develop a process to evaluate and prioritize needs, including criteria to rank needs. Criteria could include the number of people the improvement will serve, the severity of the need (e.g. critical plumbing repair or roof replacement), and other factors. This effort should result in a prioritized list of projects. This list will consider the ranking in the PNAs but other factors identified with the community as well. This community engagement to prioritize needs should also occur in the 2026-27 fiscal year.
- ***Release RFPs.*** In addition to the 2027 RFP mentioned above for critical infrastructure needs, HHSA should release RFPs for rehabilitation and improvements in 2027-28 and 2028-29. HHSA should provide significant points to projects which rank high on HHSA's list (prioritized based on a process developed with community engagement), but HHSA may also consider other factors such as the availability of matching funds.

Independent assessments and community engagement as described above will ensure the limited funding addresses the highest needs.

Recommendation #3: Fund a long-term study and funding strategy to define the need for additional housing and other residential care options. HHSA should include $250,000 in the 2026-2029 Plan to fund community engagement, research, and analysis of the unmet housing and residential care options (including crisis care and emergency shelters) for individuals served by Yolo County living with serious mental illness and substance use disorders. We know many Yolo County residents living with serious mental illness or substance use disorders cannot live near family and friends because of insufficient housing and facilities. This recommendation will supply crucial information for assessing the level of need—including the quantity and types of required housing, such as crisis, recuperative, 18-month housing, and adult residential facilities—for this population. The study should build on the 2019 Board and Care Study funded by HHSA (Attachment B), which included the following recommendations:

- **Support.** The study recommends helping existing Board and Care home operations stay in business while looking to new, innovative models to meet the growing need for adult residential care systems.
- **Innovate.** The study recommends adapting innovative models to meet the unique needs of Yolo County.
- **Improve.** The study recommends improving data collection capacity to track needs of Yolo County consumers and instituting a continuous quality improvement process that uses housing data to assess community needs on a semi-regular basis.

Recommendation #3 would ensure the 2026-2029 Plan includes funding for a three-year process to engage the community, conduct research, analyze the data, and develop a comprehensive plan and funding strategy to inform the next 3-year BHSA Integrated Plan.

Recommendation #4: Encourage HHSA to develop community partnerships to raise funds to jointly invest in priority projects identified in Recommendation #1 and #2. HHSA should develop partnerships with housing nonprofits and community members to increase funding for priority rehabilitation and improvement projects for housing and other residential care options in the continuum of care. The newly created Thomson-Williams Mental Health Committee opened the Thomson-Williams Mental Health Fund at the Yolo Community Foundation, for example, to help raise funds to support people living with serious mental illness. The Homeless and Poverty Action Coalition (HPAC) serves as Yolo County's Federal Homeless Continuum of Care (CoC) and is comprised of a 15-member Board. HPAC aims to provide leadership and coordination on the issues of homelessness and poverty in Yolo County. HHSA should consider developing a formal partnership with the HPAC, the Thomson-Williams Mental Health Committee, and other community members or organizations to raise funds to leverage Yolo County funds for rehabilitation of and improvements for homes and

other facilities in the continuum of care. These partnerships are powerful; Yolo County recently worked with community advocates and philanthropic partners to raise millions of dollars to save Pine Tree Gardens East and West, two adult residential facilities in the continuum of care, as described in this story.[1]

The nonprofits which provide housing and other facilities, as well as services, in the continuum of care require significant local government and community support. The continuum of care serves people Yolo County is required to serve, although the nonprofits which own these homes must raise funds from the community for facility rehabilitation, improvements, supportive services, or new housing. These donations are insufficient to meet the needs, so additional funding is needed to sustain the continuum of care.

Petrea Marchand, President of Consero Solutions and a member of the Thomson-Williams Mental Health Committee, is volunteering her firm's pro bono time to coordinate this group of nonprofits and individuals working to support these recommendations. Please feel free to contact any of the undersigned independently or to ask Ms. Marchand to coordinate a phone call or meeting with representatives of this group for more information or assistance. You can reach Petrea Marchand at 916-505-7191 or petrea@conserosolutions.com.

Sincerely,

Terri Smyth Canillo, MSW

Vice President Community Impact

Community Housing Opportunities Corporation

Maria Grijalva

Director and Founder

Latino Information and Resource Center

[1] https://www.conserosolutions.com/post/pine-tree-gardens-east-and-west

Victor Lagunes

Executive Director

Davis Community Action Network

Ian Evans

President / CEO

New Hope Development Corporation

Samantha Toure, MPH, CCM

Executive Director

Yolo Community Care Continuum

Doug Zeck

Executive Director

Fourth & Hope

Erica Plumb

Regional Vice President of Resident Services

Mercy Housing

	Individuals	City/State
1	Nancy Temple	Davis, CA
2	Connie Saint	Davis, CA
3	David Dickson	Carmichael, CA

4	Linda Wight	Woodland, CA
5	Marilyn Moyle	Davis, CA
6	Anya McCann	Davis, CA
7	Jeni Price	Davis, CA
8	Petrea Marchand	Davis, CA
9	Helen Thomson	Davis, CA
10	Lauren Arneson	New York, NY
11	Brett Lee	Davis, CA
12	Judy Ennis	Davis, CA
13	Jane Presto	Davis, CA
14	Nicki King	Davis, CA
15	Kathy Williams-Fossdahl	Davis, CA
16	Craig Reynolds	Davis, CA
17	Cass Sylvia	Davis, CA
18	Jim Gray	Davis, CA
19	Woody Fridae	Winters, CA
20	Rebecca Fridae	Winters, CA
21	Nahz Avary	Davis, CA
22	Mary Kimball	Woodland, CA
23	Sue DiTomaso	Woodland, CA
24	Erika Arneson	Portland, OR
25	Peter Moyle	Davis, CA
26	Kim Bullman	Sacramento, CA
27	Lindsay Weston	Davis, CA
28	Diane Sommers	Davis, CA
29	Christy Correa	Sacramento, CA
30	Lill Birdsall	Woodland, CA
31	Dian Vorters	Davis, CA
32	Hilda Bartlett	Davis, CA
33	Dr. Shelly Gilbride	Davis, CA
34	Diana Fallbeck	Woodland, CA
35	Sally Mandujan	West Sacramento, CA
36	Serena Durand	Woodland, CA
37	John Durand	Woodland, CA
38	Jim Provenza	Davis, CA
39	Tensy Maria Torres	Davis, CA
40	Antonia Tsobanoudis	Palo Alto, CA
41	Joan Planell	Woodland, CA
42	Tyler Pehlke	Sacramento, CA

43	Eric Roe	Davis, CA
44	David Segal	Davis, CA
45	Marilyn Schwartz	Woodland, CA
46	Mike Blankinship	Davis, CA
47	Gary Wright	Davis, CA
48	Tom Wright	Davis, CA
49	Noral Oldwin	Davis, CA
50	Dean Johansson	Davis, CA
51	Maria Grijalva	West Sacramento, CA
52	Richard J. Bellows	Davis, CA
53	Bill Pride	Woodland, CA
54	Ellen Kolarik	Davis, CA

Attachment A

Housing and Residential Care Options in the Continuum of Care for People Living with Serious Mental Illness and Substance Use Disorders

Name	Capacity	Location	Owner	Operator / Services	Category
Emergency Shelter					
Paul's Place	8 beds	Davis	Davis Community Meals and Housing	Davis Community Meals and Housing	Emergency Shelter
East Beamer Way	100 beds	Woodland	Friends of the Mission	Fourth and Hope	Emergency Shelter
Rodeway	40 rooms	West Sacramento	City of West Sacramento	City of West Sacramento	Emergency Shelter
Flamingo Motel	25 beds	West Sacramento	City of West Sacramento	City of West Sacramento	Emergency Shelter
Westwood Motel	20 rooms	West Sacramento	City of West Sacramento	City of West Sacramento	Emergency Shelter
Empower Yolo Domestic Violence Shelters	—	County-wide	Empower Yolo	Empower Yolo	Emergency Shelter
Transitional / Interim Housing					
Trinity House	5 beds	Woodland	Yolo County Housing (on behalf of HHSA)	HHSA	Transitional/Interim
IGT House	5 beds	Woodland	Yolo County Housing (on behalf of Probation)	Multiple service providers Probation provides oversight	Transitional/Interim

Name	Capacity	Location	Owner	Operator / Services	Category
Fourth and Hope Substance Use Recovery/Transitional Housing	34 beds	Woodland	Fourth and Hope	Fourth and Hope	Transitional/interim housing
Fourth and Hope Behavioral Health Bridge Housing	12 beds	Woodland	Fourth and Hope	Fourth and Hope	
Fourth and Hope Transitional Housing/CalWorks	11 units	Woodland	Fourth & Hope	Fourth & Hope/Yolo County	Transitional/interim housing/Yolo County CalWorks (families)
Cache Creek Lodge Substance Use Recovery/Transitional Housing	-	Woodland	Cache Creek Lodge	Cache Creek Lodge	Transitional/interim housing
Haven House – Medical Respite Care	4 beds	Woodland	Yolo Community Care Continuum	Yolo Community Care Continuum	Transitional/interim housing
Residential Treatment / Supported Living Environments					
Pine Tree Gardens East & West House (Adults	27 beds	Davis	New Hope Community Development Corporation	North Valley Behavioral Health (funded by HHSA)	Residential treatment for adults living with Serious Mental Illness

Name	Capacity	Location	Owner	Operator / Services	Category
Residential Facilities)			(on behalf of HHSA)		
Farmhouse – Augmented Board and Care	10 beds	Davis	Yolo Community Care Continuum	Yolo Community Care Continuum	Residential treatment for adults living with Serious Mental Illness
Walters House – Residential Substance Use Treatment	60 beds	Woodland	Fourth and Hope	Fourth and Hope	Residential treatment for adults living with Substance Use Disorders
Cache Creek Lodge – Residential Substance Use Treatment	—	Woodland	Cache Creek Lodge	Cache Creek Lodge	Residential treatment for adults living with Substance Use Disorders
Safe Harbor Short-Term Crisis Residential*	14 beds	Woodland	Yolo Community Care Continuum	Yolo Community Care Continuum	Residential treatment for adults living with Serious Mental Illness
Be House	5 beds	Woodland	Yolo Community Care Continuum	Yolo Community Care Continuum	Residential treatment for adults living with Serious Mental Illness
Permanent Supportive Housing					

Name	Capacity	Location	Owner	Operator / Services	Category
Homestead	21 beds	Davis	Community Housing Opportunities Corporation	Yolo Community Care Continuum	Permanent Supportive Housing for adults living with Serious Mental Illness
Cesar Chavez	52 total units, 19 for individuals with mental health needs - 10 Project-Based Vouchers	Davis	New Hope CDC, Davis Community Meals and Housing + partners	Davis Community Meals and Housing	Permanent Supportive Housing for adults living with Serious Mental Illness
Creekside	90 total units 19 units for chronically homeless	Davis	Davis Community Meals and Housing + partners	Davis Community Meals and Housing	Permanent Supportive Housing for adults living with Serious Mental Illness
Paul's Place	18 total units - 5 Project-Based Vouchers	Davis		Davis Community Meals and Housing	Permanent Housing with supports
New Dimensions	15 units	Woodland	Community Housing Opportunities Corporation	Yolo Community Care Continuum	Permanent Supportive Housing for adults living with Serious Mental Illness
Hotel Woodland	15 units for Veterans Affairs Supportive Housing	Woodland	Synergy Community Development Corporation	Veterans Affairs	Permanent Supportive Housing for adults living with Serious Mental Illness

Name	Capacity	Location	Owner	Operator / Services	Category
	Project-Based Vouchers				
West Beamer Place	80 units (32 Permanent Supportive Housing: 12 CalWORKs & 20 Full Service Partnership units); 20 Project-Based Vouchers	Woodland	Mercy Housing & New Hope CDC	County/County-contracted provider (2 FTE onsite; 30-yr commitment)	Permanent Supportive Housing for adults living with Serious Mental Illness
East Beamer Way	60 units (29 Permanent Supportive Housing); 25 Project-Based Vouchers	Woodland	Friends of the Mission	County/County-contracted provider (3 FTE onsite; 20-yr commitment)	Permanent Supportive Housing for adults living with Serious Mental Illness
1801 West Capitol	85 Permanent Supportive Housing units (41 NPLH Full Service Partnership + 44); 85 Project-Based Vouchers	West Sacramento	Mercy Housing & New Hope Community Development Corporation	County/County-contracted provider (3 FTE onsite; 20-yr commitment)	Permanent Supportive Housing for adults living with Serious Mental Illness
East Oak Apartments	8 two-bedroom units	Woodland	Fourth & Hope	Fourth & Hope	Permanent Supportive Housing for adults living with Serious Mental Illness
Freeman Garden Court	12 units/Project-	Woodland	Friends of the Mission & Woodland	Fourth & Hope	Permanent Supportive Housing for

Name	Capacity	Location	Owner	Operator / Services	Category
	Based Vouchers		Opportunity Village		adults living with Serious Mental Illness
Paul's Place	10 beds	Davis	Davis Community Meals and Housing	Davis Community Meals and Housing	Transitional

Attachment B

Yolo County Board & Care Study

Yolo County MHSA FY 2017-2020 Innovation Program Plan

Prepared by:

Resource Development Associates

April 2019

Introduction

The Yolo County Health and Human Services Agency (HHSA) partnered with Resource Development Associates (RDA) to conduct a Board and Care Study to assess and address the need for more Board and Care homes in the County. Board and Care homes, including adult residential facilities, provide 24-hour supervision and services such as healthy meals, laundry, social activities, personal care assistance, support with medical and psychiatric needs and appointments, and dispensation of medications, for consumers living with serious mental illness (SMI) and others in need of similar care.

Yolo County lacks an overall continuum of housing options for people with the most intense service needs, including a shortage of Board and Care homes. This shortage of Board and Care homes has led to adults with SMI being placed in Board and Care homes outside of the County, living with aging parents or other family, living in other arrangements that do not provide needed support (e.g., room and board), or homeless.

Yolo County, in partnership with their stakeholders, developed this innovation project with the intention of engaging in a study to develop a more thorough and accurate understanding of the problem and work together to develop creative solutions and long-term strategies to address the issues identified.

While the focus of this study was not on finding ways to support existing Board and Care homes to stay in business, one of the few remaining Board and Care homes in Yolo County, Pine Tree Gardens, became at risk of closing during the course of this study due to financial operating constraints. The focus of this study is to examine new models to support an increase in Board and Care placements, and therefore did not specifically address sustainability planning for Pine Tree Gardens.

Background

While Yolo County is considered to be mid-sized with a population of approximately 219,000, it spans a significant geographic area of over 1,000 square miles.[1] The County, with its distinct geographic, cultural, and socio-economic characteristics, has the unique challenge of providing services to diverse groups and communities that are also geographically varied, and must contend with the need for flexible service delivery, cultural competency across groups, transportation, and access to services across a vast territory.

High levels of poverty, rural, and cultural isolation affect many residents of the County, where over 17% of the population lives below the poverty line.[2] The demographics of behavioral health consumers and those in need of behavioral health services mirror those of the County's population. Yolo County has high

[1] US Census Bureau, 2018, http://www.census.gov/quickfacts/table/PST045215/06113
[2] US Census Bureau, 2018, http://www.census.gov/quickfacts/table/PST045215/06113

rates of poverty and 25% of the population receive Medi-Cal. Additionally, one in four residents experienced severe housing problems in 2016.[3] Furthermore, the rate of hospitalizations for mental health diagnoses in Yolo County has been increasing since 2008, particularly for hospitalizations for psychoses.[4] During the MHSA community planning process in Yolo County, stakeholders connected the challenge of meeting the behavioral health needs of the County's diverse and scattered population to multiple factors, including the need for increased coordination across providers, narrow transportation options, limited specialized crisis service hours, and the need for expanded consumer access to health and wellness service coordination.

Yolo County has employed considerable efforts to strengthen crisis services and reduce psychiatric hospitalizations, incarcerations, and homelessness. The County provides multiple service programs for adults with SMI, including: a community-based navigation center that provides both recovery-based mental health and social services; a 7-day/week Mental Health Urgent Care; field-based case management services for Full Service Partnership consumers to maintain linkage to psychiatric care and community resources; Specialty Mental Health and Addiction Intervention Courts, Misdemeanant Competency Restoration Services; short-term Cognitive Behavioral Therapy and a myriad of homeless intervention services and programs. Teams work collaboratively with multiple community-based organizations as well as other County partners, including the Public Defender, District Attorney, Sheriff, Law Enforcement and local custody setting staff, with the goal of assuring timely and early intervention in crisis situations. Yolo County implemented the Drug Medi-Cal Organized Delivery System and contracted with a new provider for 24/7 telephone response to individuals requesting substance use treatment. This same 24/7 telephone line serves as the County's Mental Health Crisis line, for a warm connection and in-person response to the two local Emergency Departments for all Yolo Medi-Cal beneficiary mental health hold evaluations. HHSA provides Full Service Partnership (FSP) services through Care Teams focused on children, Transition Age Youth, Adults, Older Adults and Adults with high forensic system involvement. Each team supports individuals with severe and persistent mental health conditions, substance use disorders, chronic homelessness, and/or forensic or behavioral health involvement. These efforts reflect the deep commitment of Yolo County HHSA leadership, staff, providers, consumers, family members, and other stakeholders to the meaningful participation of the community as a whole in designing mental health programs that are wellness and recovery-focused, consumer and family-driven, culturally competent, integrated, and collaborative.

Adults with SMI typically require comprehensive wraparound supportive engagement in services, including 24/7 housing support. While funding for emergent housing needs is increasing as California experiences a statewide crisis in the area of homelessness, there continues to be limited housing stock

[3] http://www.countyhealthrankings.org/app/california/2016/rankings/yolo/county/outcomes/overall/snapshot
[4] Yolo County Health Department. (2014). Community Health Status Assessment. Accessed on March 24, 2017 from http://www.yolocounty.org/Home/ShowDocument?id=25983.

overall, and a corresponding limited array of supervised environments for those with higher support needs.

Board and Care homes offer a safe and dignified housing option for adults with SMI, while providing an environment to receive behavioral health services and resources. Board and Care homes operate under the supervision of Community Care Licensing (CCL), a sub-agency of the California Department of Social Services (DSS), and are licensed as Adult Residential Facilities (ARF). In the early 1970's, California established a residential care system to provide non-institutional home-based services to dependent care groups such as the elderly, intellectually and/or developmentally disabled, and those with a mental health diagnosis. At that time, Residential Care Facilities for the Elderly (RCFE) were known as Board and Care homes and the name still persists as a common term to describe both ARF and RCFE.

Board and Care homes provide housekeeping services, social and recreational activities, meals and meal supervision, assistance with activities of daily living (e.g., bathing, dressing, eating) and independent adult living services (e.g., budgeting, transportation, communication). Facilities also offer assistance to medical appointments and provide updates on consumer's status to mental health providers. In addition, Board and Care homes are able to store and monitor medication on an appropriate schedule, which is critically important for individuals with SMI.

Overall, Board and Care homes house consumers who would otherwise be at risk of being placed in a skilled nursing facility or other institutional environment, thereby resulting in cost savings to the community[5] and playing a critical role in the mental health system by supporting individuals with SMI to live in the community.

As mentioned above, a Board and Care home is licensed as an **Adult Residential Care Facility (ARF)** - a residential home for adults ages 18 through 59 with mental health care needs or who have physical and/or developmental disabilities and require or prefer assistance with care and supervision. Other adult facility types licensed by DSS-CCL include:

- **Adult Day Program** - Any community-based facility or program that provides care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of these individuals on less than a 24-hour basis.
- **Adult Residential Facility for Persons with Special Health Needs** - A residential home that provides 24-hour services for up to five adults with developmental disabilities who have special health care and intensive support needs and who would otherwise need to reside in an institution.

[5] Doty, P. (2000). *Cost-Effectiveness of Home and Community-Based Long-Term Care Services*. USHHS/ASPE Office of Disability, Aging and Long Term Care Policy. U.S. Department of Health and Human Services.

- **Residential Care Facility for the Elderly** - A residential home for seniors aged 60 and over who require or prefer assistance with care and supervision. Residential Care Facilities for the Elderly may also be known as assisted living facilities, retirement homes and Board and Care homes.
- **Residential Care Facility for the Chronically Ill** - A facility that provides care and supervision to adults who have a terminal illness, Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus (HIV).
- **Social Rehabilitation Facility** - A facility that provides 24-hour non-medical care and supervision in a group setting to adults recovering from mental illnesses who temporarily need assistance, guidance, or counseling. These facilities are able to offer psychiatric and mental health treatment as part of their residential program services, beyond what an Adult Residential Facility is allowed to provide. Social Rehabilitation Facilities include:
    - Short-Term Crisis Residential Programs
    - Transitional Residential Treatment Programs
    - Mental Health Rehabilitation Centers (acute in-patient programs)

The above types of residential care and services are part of a continuum of care that is critical to serve individuals with significant mental health challenges in the community (Figure 1).

Figure 1. Residential Facility Continuum of Service

Crisis Residential Treatment	Transitional Residential Treatment	Mental Health Rehabilitation Center	Board and Care Homes	Supportive Living Services
Short-term 24/7 On-site treatment providing stabilization for three months maximum	Long-term 24/7 Residential treatment encouraging utilization of community resources for 18 months maximum	Long-term 24/7 Services for the chronically mentally ill to develop independent living skills for three years maximum	Long-term 24/7 Residential on-site support with medication and daily living Offsite treatment	Long-term 24/7 Oversight Independent living support services providing assistance in a minimally restrictive setting; no medication administration
Licensed	**Licensed**	**Licensed**	**Licensed**	**Unlicensed**

Due to statewide Board and Care home closures and the lack of new facilities and/or adequate supportive housing options available, many individuals with mental illness are unable to obtain appropriate and sustainable treatment care options after they are discharged or released from acute inpatient treatment programs, hospitals, short-term crisis and transitional residential treatment programs, etc. This creates a "revolving door scenario" where the newly released individual cannot find appropriate residential care or housing; when another mental health crisis occurs the individual returns to high-level crisis program services and facilities, hospitals, jails/prisons or homelessness.

Historically, many Board and Care homes have closed down in Yolo County. As of March 2017, there were eight adult residential facilities serving Yolo County residents, and only two that focus on individuals with SMI (Table 1).

Table 1. Board and Care Homes in Yolo County[6]

Home	Population Served	Capacity	Years in Operation
Pine Tree Gardens West	Individuals with SMI	15	7
Pine Tree Gardens East	Individuals with SMI	13	7
Davis Summer House	Individuals with Developmental Disabilities	14	24
Summer House Inc.	Individuals with Developmental Disabilities	12	42
E & J Griffin Family Care Home	Individuals with Developmental Disabilities	6	20
E & J Griffin Family Care Home II	Individuals with Developmental Disabilities	6	12
Tropical Villa-ARF	Individuals with Developmental Disabilities	6	12
V & P Truong Care Home, LLC	Individuals with Developmental Disabilities	4	6
Total and Range		76	6 – 42

The need for a robust continuum of community-based housing, including facilities for adults with SMI, is critical. Board and Care homes are an essential component of this housing continuum, providing services and support to meet the complex behavioral health needs of Yolo County residents.

[6] California Department of Social Services. Licensed Facility Search. Accessed on March 21, 2017 from https://secure.dss.ca.gov/CareFacilitySearch/.

Other Challenges and Considerations

Due to the limited amount of Board and Care Homes, providers may be less likely to accept individuals with more intensive needs.

Several issues may contribute to the likelihood for existing Board and Care homes to decline service to individuals with SMI who have more intensive needs, such as:

- Availability of individuals with less intensive needs who are relatively easier to serve, require less support to adapt to a group living situation, and who will follow Board and Care home rules with minimal difficulty
- Lack of staff training to effectively and appropriately serve consumers with significant behavioral challenges
- Lack of incentives or sufficient funding to adequately staff 24/7 support for consumers with round-the-clock needs

Mental health consumers with the highest needs are often placed out of county and away from their homes and families and/or support system.

The Board and Care home shortages tend to disproportionately impact those with the highest level of need. Without adequate options within the County, Yolo residents who require this level of support to remain integrated in community-based settings are often placed in out-of-county Board and Care homes. This creates a variety of challenges, including:

- Consumers are farther away from their families, other natural supports, and health and mental health services, creating barriers to their recovery and support.
- County staff have to travel further distances to meet with the consumers, making it more difficult to monitor support quality as well as provide support to the consumer and Board and Care home staff.
- Medi-Cal and other benefits connected to the consumer's county of residence may be moved to the new county, creating unnecessary challenges for the consumer as well as administrative burdens on the staff.
- Consumers who are unable to successfully live in their home county or in a nearby community-based setting are at an increased risk of being placed in higher level/locked institutional settings, and may subsequently experience a longer length of stay due to the lack of supported step-down housing options.

Collectively these dilemmas support a need for increasing locally available structured community-based living settings for adults with SMI. The small group setting can foster social connections, while the independent living skills training and 24/7 staff allow consumers to strive towards their best potential in

their home community. However, the significant financial barriers for providers to sustain and grow the inventory of Board and Care homes, as well as the complexities of serving a population with intensive support needs, contribute to the current challenges of increasing community-based residential care homes for individuals living with SMI.

Methodology

RDA staff, in collaboration with HHSA, conducted a set of community meetings and information-gathering activities to inform this study.

Quantitative Data: At the onset of the project, available data on the number of consumers in or outside of the County that may be in need of a Board and Care home was collected. Despite encountering some data limitations, the available data provided a conservative estimate of the number of Board and Care home beds needed in the County.

Key Informant Interviews: RDA staff conducted phone interviews with key leadership staff from the County, other key stakeholders, and both current and former Board and Care home providers. The interviews were used to explore the strengths and challenges of opening and sustaining Board and Care homes in Yolo County, gather feedback and recommendations for addressing gaps and increasing consumer access to the homes, as well as feedback and recommendations on increasing the inventory of Board and Care homes in the county. In addition to the key informant telephone interviews, RDA also conducted an in-person meeting with HHSA staff and the Housing Authority of Yolo County (YCH) to gather information about local options available to Yolo County.

Benchmarking and Best Practices Research: In addition to interviewing key informants within Yolo County, RDA conducted benchmarking interviews with other counties and reviewed literature to explore promising models emerging within other jurisdictions across the state. This best practices and benchmarking research helped increase our understanding of effective strategies as well as what models are emerging from other jurisdictions that may be useful for the County's consideration.

Community Meetings: At select key points during the study, RDA conducted community meetings to receive feedback from local experts about the study and gather recommendations for increasing Board and Care home options for residents of the County. RDA presented preliminary findings at a community meeting in October 2018 to gather additional feedback and refine and vet the study recommendations.

Findings

Many of the concerns that emerged from the data gathering phase were also reflected in feedback collected during the community meeting held in October 2018. The following findings highlight the concerns presented by the community and the challenges that the stakeholders are experiencing.

There are not enough residential facilities to serve the number of consumers in need, especially for those with limited Social Security benefits.

RDA used existing data to gather a sense of the magnitude of need in the County. As shown in Table 2, there are approximately 23 consumers who are currently living in a Board and Care home outside of the County; we estimate that most of these consumers would benefit more by receiving Board and Care home services in Yolo County, allowing them to be closer to home. Additionally, there are approximately 59 consumers who are currently living in higher levels of care with limited local step-down housing options available in Yolo County. Of these consumers, it is unclear who would be able to move to a Board and Care home should a local bed become available. There are also an unknown number of individuals who are currently living at home with aging parents, living in substandard unlicensed facilities, or who are living without secure housing (e.g., shelters, homeless, etc.). While it is a challenge to estimate the number of individuals who would benefit from new Board and Care home options, this study indicates that 50-75 beds would likely result in a substantial reduction of individuals living in insecure or substandard housing situations.

Table 2. Estimate of the Number of Individuals Who May Benefit from a Board and Care Home

Board and Care Homes	Consumers	Capacity
Local Homes		
Residential Care for Elderly	8	14
Adult Residential Facility	24	28
Total Local Consumers	**32**	**42**
Out of County Homes		
Augmented Board and Care Home Placements	8	N/A
Sacramento Board and Care Homes	15	N/A
Total Out of County Consumers	**23**	**-**

Statewide, existing Board and Care homes are either closing or at risk of closing for the same reasons as in Yolo County.

The shortage of Board and Care homes is not unique to Yolo County. RDA could not identify any models in the state where a county is successfully sustaining the current owner-operator Board and Care home model. There are numerous challenges that Board and Care home operators face, with the most prominent being financial. Due to the low-income level of consumers living in Board and Care homes, they are unable to pay enough to cover the operating costs. Adult residential facilities for adults with SMI cannot survive financially on a small scale (under 15 beds) without substantial financial subsidies. For the most part, monthly rates charged by Board and Care home operators are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) paid to Californians with disabilities who are unable to work. The SSI/SSP payment, as the sole source of payment for the consumer residing in a Board and Care home, is not sufficient to provide adequate income for the operation of a licensed facility, especially when some amount of the SSI/SSP payment is set aside for the consumer's personal needs. Therefore, subsidies, often called "patches" are necessary. However, in higher cost counties, the "patch" required may be prohibitively high for a county agency to provide the Board and Care home on an ongoing basis.

Table 3. Key Factors in Board and Care Home Instability

Existing Board and Care homes are closing or at risk of closing for a variety of reasons:	
Property Value & Upkeep	• Aging properties are too expensive to repair and maintain • High real estate values have enticed owners to sell their property and close their business
Low Revenue	• Operators have fixed expenses yet are not guaranteed enough revenue to cover the expenses
Regulatory Requirements	• Operators face increasing compliance monitoring and subsequent fines from regulatory agencies
Operational Challenges	• Board and Care homes serve a difficult population; consumers are experiencing increasingly challenging behaviors and operators sometimes get referrals for individuals who are not appropriate for the level of care that the Board and Care home is equipped to serve • Finding, training, and retaining reliable staff; Board and Care home staff positions can be stressful and challenging yet their wages are low

There are significant barriers to opening new Board and Care homes.

The barriers to opening new Board and Care homes are similar to those facing existing operators.

Financial: As mentioned above, due to the low-income level of consumers living in Board and Care homes, they are unable to pay enough to cover operator costs. On a larger scale, some residential care homes can be financially viable, but that is dependent on the level of care provided to the residents. Residents requiring higher levels of care and support will necessitate additional care providers and/or equipment resulting in increased operational costs. The SSI/SSP amount that consumers receive is rarely sufficient to cover the operating costs.

Community Resistance/Opposition: In order to open a Board and Care home with more than six beds, operators are required to obtain a use permit and are frequently confronted with "Not in My Backyard" (NIMBY) opposition from the community residents. The resistance is often successful, preventing new operators from obtaining the required land use approvals and permits.

Staffing: Recruiting, training, and retaining experienced staff requires proper management, competitive salaries, and ongoing training, which adds to operators' financial challenges. In addition, there are strict staffing regulations that must be followed.

Cost of Property: The ability to purchase or rent property is becoming increasingly difficult in the current real estate market. In addition, most properties will require modifications (construction/renovations) to bring the property up to code and to meet DSS-CCL regulations. In most cases, larger facilities need to be newly constructed since most community residential homes do not have the capacity required to house more than six consumers, which raises the overall cost.

Table 4. Key Barriers in Opening New Board and Care Homes

There are significant barriers to opening new Board and Care homes.	
Financial Hardship and Startup Costs	• Not a profitable business; revenue is not enough to sustain business operations • High real estate prices make it difficult to acquire property sites • Zoning and permitting challenges: obtaining a use permit can be very difficult, time consuming and costly

Risks	• Licensing challenges: it can be difficult to obtain a facility license and keep up with ever-changing regulations; operators face fines if they are found to be out of compliance • Recruiting and hiring reliable staff and keeping up with training requirements (licensing regulations require ongoing staff training); high staff turnover due to burnout and low wages • There is substantial risk involved working with vulnerable populations such as individuals with SMI
Community Backlash	• Operators face neighborhood opposition and NIMBY-ism (not in my backyard)

Conclusion

A continuum of care for adults with SMI is critically needed. Adult residential facilities are an essential component of this housing continuum, providing services and supports to meet their consumers' complex set of behavioral, medical and physical needs.

However, all evidence from this study suggests that **the traditional owner-operated Board and Care home is no longer a viable option**, primarily because it is not financially profitable with today's real estate market, especially considering the numerous challenges and risks involved. **RDA could not identify any models statewide where a county is successfully sustaining the current owner-operator model for Board and Care homes.**

Despite the local statewide housing challenges, there are some models that have promising results.

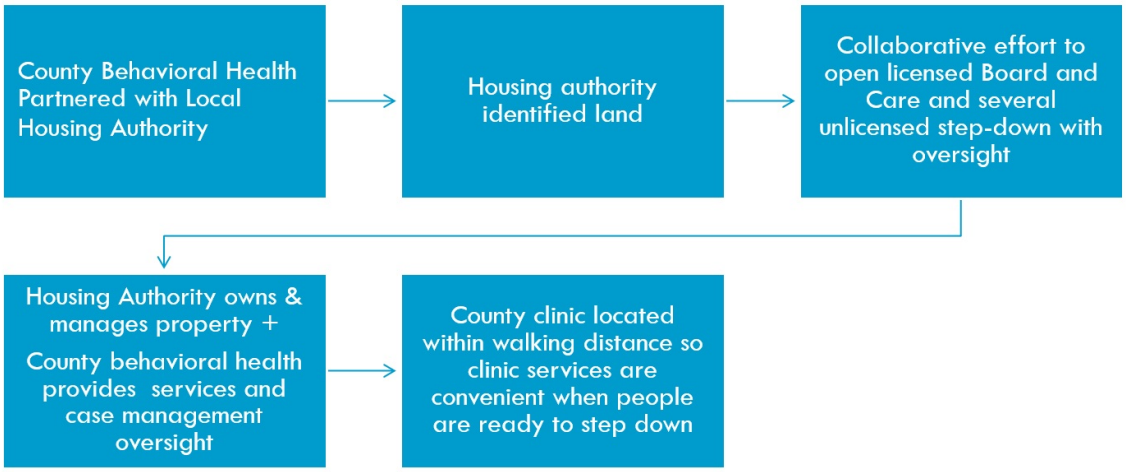
Promising Models

RDA examined several alternative models across the state of California that are currently in operation and are experiencing positive results. These models suggest innovative system opportunities that have a larger impact on increasing housing that could be considered in Yolo County. By collaborating with non-profit and affordable housing providers, public housing and community development agencies, and mental health agencies, new options can be created. Below are some examples of new models being implemented to serve this growing need.

Tulare County Model

As shown in Figure 2, Tulare County created a series of local step-down housing options for their consumers through a collaboration with their local Housing Authority (HATC). This collaborative model limits risk for the Tulare County Behavioral Health Services (BHS) because HATC provides the oversight and responsibility for the properties. Additionally, by creating a series of local step-down housing options, BHS is able to reserve the Board and Care home beds for consumers who need that level of care. When consumers are ready to step-down to a lower level housing option, they are still in close proximity to oversight and services. A variation of this model is in place in other areas where the county contracts behavioral health services to a non-profit provider but retains responsibility for the property.

Figure 2. Tulare County Model



Los Angeles County Model

In Los Angeles County, the Department of Health Services (DHS) created a supportive housing rental subsidy program to secure housing for DHS patients. In this model, DHS partnered with a nonprofit community housing organization to secure housing options which can include single family homes, individual apartments, blocks of units, or entire buildings.

The community housing organization provides move-in assistance and rental subsidy disbursement, coordinates with case managers, and assists with landlord and neighborhood relations. All consumers housed through the program are linked to intensive case management and wraparound services for support.

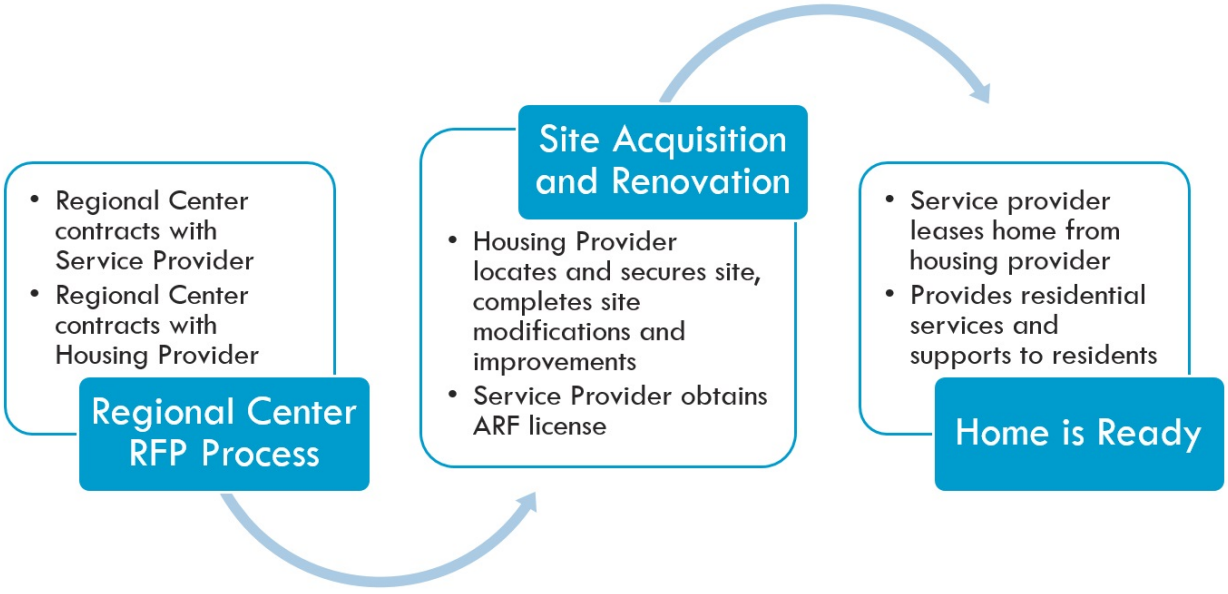
Figure 3. Los Angeles County Model

California Regional Center Model

California regional centers, who provide services to individuals with intellectual and developmental disabilities, have historically had the same challenges in providing residential care to their consumers as experienced in the mental health system. It has become increasingly difficult for program operators to find and secure property, obtain licenses and permits, and operate their facilities with limited income. In an effort to address the issue, The Department of Developmental Services (DDS) designed the Community Placement Plan (CPP) and Community Resource Development Plan (CRDP) to provide funding for the development of a variety of resources within the communities, including residential development, transportation, day services, mental health and crisis services, etc.

The regional centers can use CPP funds to develop safe, affordable, and sustainable homes as a residential option through the "Buy It Once" model where a housing developer organization (HDO) owns the property for the restricted use by regional center consumers. The HDO develops the property to meet the needs of the consumers (e.g., modifications for individual needs such as wheelchair ramps, widened hallways, soft walls, etc.) and then leases the home/facility to the service provider. This de-couples the property owner and operator so that the operator is not responsible for property acquisition, repairs, or ongoing maintenance.

Figure 4. Regional Center Model



Summary and Recommendations

RDA's study results indicate the following key findings:

- A continuum of care for adults with SMI is critically needed in Yolo County. Adult residential facilities are an essential component of this housing continuum, providing services and supports to meet their consumers' complex set of behavioral, medical and physical needs.
- Despite data limitations, all indications suggest Yolo County has a severe shortage of necessary Board and Care homes.
- Traditional owner-operated Board and Care homes as a model is no longer a viable option, primarily because it is not financially profitable with today's real estate market and risks involved. RDA could not identify any models in the state where a county is successfully sustaining the current owner-operator model.
- Across the state there are new and innovative models that are showing success in meeting housing needs for similar populations.
- Despite being different, the models we researched contained many of the same key components that appear to contribute to the models' successes. The following concepts were common across all of the models:
  - De-couple owner and operator
  - Collaborate within county (e.g., with housing authority) or outside investors
  - Creatively fund services to surround consumers in Board and Care homes and step-down housing
  - Develop a full continuum of care that allows for step-down housing and reserves the higher levels for consumers who need them

Based on our findings, we recommend Yolo County consider the following recommendations:

1. **Support existing Board and Care home operations to stay in business while looking to new, innovative models to meet the growing need for adult residential care systems.** As mentioned in the introduction, the focus of this study was not on finding ways to support the sustainability of the few remaining Board and Care homes. However, closing these homes would cause instability and further exacerbate the housing problem for this population. Thus, we suggest that when feasible, the County look to provide stability for existing operations while exploring new opportunities that expand beyond the traditional owner-operator model.
2. **Consider adapting innovative models to meet the unique needs of Yolo County.** It is unlikely that any one model that has been successful in another region will exactly fit the needs and opportunities in Yolo County. However, we suggest looking at models in other counties, meeting with key stakeholders involved in these models, and working within the community to identify local opportunities to adapt some aspects of the key models to test in the County.

3. **Improve data collection capacity to track the needs of Yolo County consumers.** Moving forward, Yolo HHSA may want to look for options to capture data on the housing status of behavioral health consumers that is more robust and supports gaining an accurate picture of the magnitude of need in the County for various housing options. Specifically, the County may benefit from data on the number of consumers who are receiving full service partnership services and are homeless or in insecure housing settings; the number of consumers on waitlists for the County's mental health transitional homes; and hospitalization data with the numbers of high utilizers who subsequently end up on conservatorship following multiple community-based placement efforts.
4. **Institute a continuous quality improvement process that uses housing data to assess community needs on a semi-regular basis.** As a component of a more robust data system, we recommend keeping track of the County's efforts to increase the supply of housing and continually reassess the need. This will allow the County to gauge whether new housing options are having a positive impact for their consumers, and will provide an ongoing mechanism to reassess the need for new or additional housing options.

9. Petrea Moyle Marchand (Submitted email; 04-30-26)
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April 30, 2026

Yolo County Board of Supervisors
625 Court Street, Suite 204
Woodland, CA 95695

Mónica Morales
Director, Yolo County Health and Human Services Agency
137 North Cottonwood Street
Woodland, CA 95659

Tony Kildare
Behavioral Health Director, Yolo County Health and Human Services Agency
137 North Cottonwood Street
Woodland, CA 95659

Dear Members of the Yolo County Board of Supervisors, Mónica Morales, and Tony Kildare:

I am writing as community advocate, philanthropic partner, former NAMI Yolo County Board President, and members of the Thomson-Williams Mental Health Committee to provide comments on the Yolo County 2026-2029 Behavioral Health Integrated Plan ("2026-2029 Plan"), which will allocate almost $70 million available to Yolo County from a statewide tax on millionaires over the next three years for mental health and substance use disorder services, including housing. I am deeply grateful to the Yolo County Health and Human Services Agency (HHSA) staff for their work to improve the community engagement process and look forward to further improvements in the future.

I also am grateful for the opportunity to comment on this important plan, which will shape the support people living with serious mental illness and substance use disorders receive in Yolo County for years to come.

I recommend the following:

Recommendation #1: Update the 2026-2029 Plan to clearly describe the allocation of the $70 million over three years. The plan does not clearly state how the funds will be spent. The plan includes $1.1 million annually for North Valley Behavioral Health to continue operations of Pine Tree Gardens, for example, but Pine Tree Gardens is not mentioned in the plan. HHSA should update the plan to clearly describe the allocation of funds in common-sense language, including the amount allocated to HHSA staff and the amount allocated to individual outside contractors.

Recommendation #2: Hire the University of the Pacific to train HHSA staff to engage the community based on the University's Transformational Change Partnership (TCP) model. According to the Transformational Change Partnership website, TCP provides county health and human services teams and their partners with knowledge, learning experiences, and implementation support to achieve

transformative systems change. TCP is designed to help county agencies successfully implement the numerous current state initiatives and reforms in ways to improve operations, relationships with community partners, and client and community results.

Recommendation #3: Work with the nonprofit Third Sector Capital to develop outcome-based measurement for delivery of Full Service Partnership services. Third Sector Capital recently received a grant from the California Behavioral Health Commission to offer a two-year opportunity for up to 20 county behavioral health departments and 40 Full Service Partnership providers. The grant will provide dedicated technical assistance and training to collaboratively design, implement, and monitor performance for county Full Service Partnership programs. Third Sector Capital will provide $80,000 in incentives per participating county to help fund two years of dedicated training.

Thank you for the opportunity to comment.

Petrea Marchand
President, Consero Solutions

10. Anonymous-(Submitted by email; 5-1-26) Personal Statement

Dear Yolo County BHSA Team,

I am submitting this public comment as part of the BHSA community engagement process. Our family moved to Davis in 1997, when I was seven and my brother was five. I often regret our parents didn't choose a more normal place. Davis is an elitist, neoliberal community—one that speaks the language of inclusion and sustainability while measuring human worth by high achievement, economic productivity, and the ability to compete. My family was more average. We never belonged in this highly privileged community.

My brother graduated Davis High School in 2010, directly into the wreckage of the Great Recession. The opportunities promised to him as a millennial child growing up in the 1990s and 2000s never materialized. He was born with spina bifida, had a lazy eye, and showed traits of autism, including slower processing speed, a speech delay, and a speech impediment. He was artistic, athletic, intellectually curious, sensitive, kind, and deeply spiritual. These gifts were overlooked in a school system that prioritized high-performing students and abandoned those who could not keep pace. He was neglected at home, at school, and by every institution that should have protected him.

These outcomes are not just personal tragedies. They are the result of system failures that the 2023 *Report on Improving Mental Health Outcomes* (Gottstein, Gøtzsche, Cohen, Ruby & Myers; **linked**) describes as "colossally counter-productive and harmful." That report documents that an over-reliance on psychiatric drugs reduces recovery rates from a possible 80% to just 5%, and that forced interventions add to trauma without improving outcomes.

My Story

In March 2020, a prescribing cascade left me with permanent brain damage. I was a student at UC Santa Cruz and had a manic reaction to Adderall, which I took exactly as prescribed. I stopped the Adderall. I was then wrongly prescribed the antipsychotic Abilify, and I developed total insomnia and severe akathisia—a state of unbearable inner torment that neither I nor the staff at Woodland Memorial Hospital recognized.

Instead of identifying the offending drug and withdrawing it, the hospital detained me. When my mother arrived at the ER and tried to take me home, she was told it was too late. I was placed on a 5150 hold, later extended to a 5250, and held at Woodland Memorial Hospital on Cottonwood Street for two weeks. During that time, I was isolated from outside contact and given a cascade of drugs—olanzapine, Risperdal, Seroquel, benzodiazepines, and many others—without ever being diagnosed with a psychotic disorder or being given informed consent. A nurse named [redacted] coerced me into injections of Invega Sustenna, rolling her eyes when I said I did not want to be injected. I later found out I had been given the highest FDA-approved dose: 234 mg. All of this happened within a month.

When my mother picked me up, I was so heavily drugged I could not speak in full sentences. I later discovered my signature had been forged on discharge paperwork. I have since been diagnosed with a permanent neurocognitive disorder. I had to drop out of university; I cannot read a book, watch television, hold a conversation, work, or secure SSI benefits despite a Sutter neuropsychologist's recommendation.

My Brother's Story

My brother carried unrecognized trauma and neglect into adulthood. He was the family scapegoat, but those who knew him remember him as honest, funny, intellectual, generous, and edgy in the best way—he loved going to raves like Electric Daisy Carnival, had deep knowledge of music, and wanted to produce

it. He was fun-loving and adventurous, philosophical, playful, imaginative, caring, and deeply interested in geopolitics. He loved Philip K. Dick, Jordan B. Peterson, mythology, and sacred texts. He loved Jesus and America too. He attended community college screenwriting classes and hoped to earn a degree. He worked low-wage jobs in Davis and was fired.

He was sent to a wilderness program and boarding school during high school. The troubled-teen industry of the 2000s exploited our family. After a toxic relationship in his early twenties that I believe left him with PTSD, a different woman introduced him to heroin in 2019.

In late 2021, he was staying in a hotel through Project Roomkey, near the I-5/Richards Boulevard overpass. There he met [redacted] from the Davis Community Clinic. At that time, their relationship was good; my mom said [redacted] would spend hours talking to him.

By fall 2021, my brother was in profound spiritual distress. He posted videos and messages that showed a person in extreme crisis, grappling with experiences he believed were cosmic, interdimensional, and demonic. In October 2021, he tried to jump from the highway overpass near his hotel; the *Davis Enterprise* referred to him as a "man in distress." While he was on the overpass, a police officer called me and said, "Your mom gave us your number and told us you are the closest to him. What can we say to him to get him to come down?" I was already brain-damaged. I felt numb and had nothing to say. The trained professionals had so little to offer him that they turned to his disabled sibling for answers.

The following month, after being discharged from the Sutter Davis Hospital emergency room without a psychiatric hold, he climbed a water tower on the UC Davis campus hours later. He was manic and half-naked. People on a nearby tennis court saw him and shouted at him to jump. UC Davis police arrived but left him there. The university later denied any record of police responding to the water tower. He always insisted they came and abandoned him up there. He later described the experience in biblical terms: a test like Abraham and Isaac, a voice telling him to jump in a certain direction, and a tree that broke his fall.

He survived with life-changing injuries to his pelvis, nerves, and feet. He walked with a limp and used a cane, and he lived with constant, severe pain.

Even with a visible physical disability, he was denied sympathy because he carried the labels of "addict" and "mentally ill." His application to Yolo County Housing—filed as a recognized disabled person with physical and psychosocial disabilities—went unanswered; the waitlists were impossibly long.

[redacted] initially prescribed Norco for his pain, but later withdrew the prescription, labeled my brother an addict, and cut off all pain management. When my brother, in agony, tried to advocate for himself, his behavior was framed as harassment. He believed [redacted] had abandoned him to protect himself professionally. In 2023, [redacted] obtained a restraining order that barred him from the clinic entirely. I did not even know it was possible for a medical clinic to close its doors that completely to a person in desperate need. He was cut off from the only legitimate pain treatment he had.

With no legitimate way to treat his pain, he turned to smoking heroin and fentanyl.

Even after everything, my brother remained engaged with the world. In May 2024, he participated in the Palestine protest encampment on the UC Berkeley campus. But his quality of life was devastatingly low, and he seemed to regress. He carried a heavy, unspoken shame about his lack of conventional success.

Homeless along Putah Creek and suffering repeated infections, he finally left for Oregon. A couple of weeks after escaping Davis, he died in a house fire on March 11, 2025, aged 33.

What happened to my brother is part of a well-documented pattern. Research confirms that forced opioid tapering causes measurable harm: a 2023 UC Davis study of over 110,000 stable long-term opioid patients linked tapering to more emergency department visits, hospitalizations, and poorer health outcomes. Human Rights Watch, the American Medical Association, and pain medicine societies have described a "silent public health crisis of untreated chronic pain," with rapid tapers tied to tripled overdose risk, increased suicides, and eroded trust in health care. Anne Fuqua, a patient advocate and nurse who uses a wheelchair due to severe chronic pain, has written about her own reliance on prescription opioids and co-authored a pilot study documenting families who lost loved ones after prescription changes. While my brother's death was ultimately accidental—a death of despair, but not a suicide—his trajectory followed this same documented pattern: a person in pain, cut off from prescribed treatment, left with no options but the street supply.

His ashes were buried in Davis Cemetery—a place he kept trying to leave. He did escape, in the end. He got out, he went to stay with friends in Winston, Oregon. But his ashes are in Davis, in a community where he was never welcome. That is not a feeling; it is the truth. There is a colorful lawn sign I see all over town: "Davis is for everyone," by the Davis Phoenix Coalition with the LGBT flag. It is hollow virtue signaling. It is not true. My brother is proof that it is not true. A few months later, in May 2025, I learned that another childhood friend of his from Davis—someone who had slept over at our house as a child—also died of an overdose. These are not isolated tragedies. They are outcomes produced by a system that discards people.

My Message to Yolo County

I was permanently disabled by a drug I never needed, and because of this preventable injury, I was unable to be the sister my brother needed. He was marginalized, dehumanized, criminalized, and abandoned. The systems responsible for protecting him instead shut their doors. What he needed was dignity—and that was denied to him at every turn.

The evidence is clear—from the Gottstein report, the AMA's guidance, and the patient advocacy of Anne Fuqua—that a different approach is possible: voluntary, non-coercive supports built around real housing access, meaningful pain management that does not abandon patients, and authentic human connection. I also draw attention to the WJW Mental Health Legal Fund, founded in honor of William Jeffrey Welton—an artistic man who, like my brother, was failed by decades of criminalization and psychiatric cycling. His family now advocates "for all the Jeffs." My brother was one of them.

I miss my brother. I will never know what he would have thought about the world as it is now. My sweet, silly brother did not need to die a junkie's death. He deserved better. Until Yolo County invests in these alternatives, more people will be lost.

I believe these are all symptoms of a collapsing stage of a civilization, a failing empire and ecological overshoot: moral decay, high wealth and income inequality, high inflation, no opportunity.

Thank you for reading.

REPORT
ON
IMPROVING MENTAL HEALTH OUTCOMES

James B. (Jim) Gottstein, Esq.; Peter C. Gøtzsche, MD;
David Cohen, PhD; Chuck Ruby, PhD; Faith Myers

September 18, 2023

I. EXECUTIVE SUMMARY

The mental health system's standard treatments are colossally counter-productive and harmful, often forced on unwilling patients. The overreliance on psychiatric drugs is reducing the recovery rate of people diagnosed with serious mental illness from a possible 80% to 5% and reducing their life spans by 20 years or so. Psychiatric incarceration, euphemistically called "involuntary commitment," is similarly counterproductive and harmful, adding to patients' trauma and massively associated with suicides. Harmful psychiatric interventions are being imposed on people without consideration of the facts about treatments and their harms, and are a violation of International Law.

The most important elements for improving patients' lives are People, Place and Purpose. People—even psychiatric patients—need to have relationships (People), a safe place to live (Place), and activity that is meaningful to them, usually school or work (Purpose). People need to be given hope these are possible. Voluntary approaches that improve people's lives should be made broadly available instead of the currently prevailing counterproductive and harmful psychiatric drugs for everyone, forever, regime often forced on people. These approaches include Peer Respites, Soteria Houses, Open Dialogue, Drug-Free Hospitals, Housing First, Employment, Warm Lines, Hearing Voices Network, Non-Police Community Response Teams, and emotional CPR (eCPR).

By implementing these approaches, mental health systems can move towards, and even achieve, the 80% possible recovery rate.

As bad as it is for adults, the psychiatric incarceration and psychiatric drugging of children and youth is even more tragic and should cease. Instead, children and youth should be helped to manage their emotions and become successful, and their parents should be given support and assistance to achieve this.

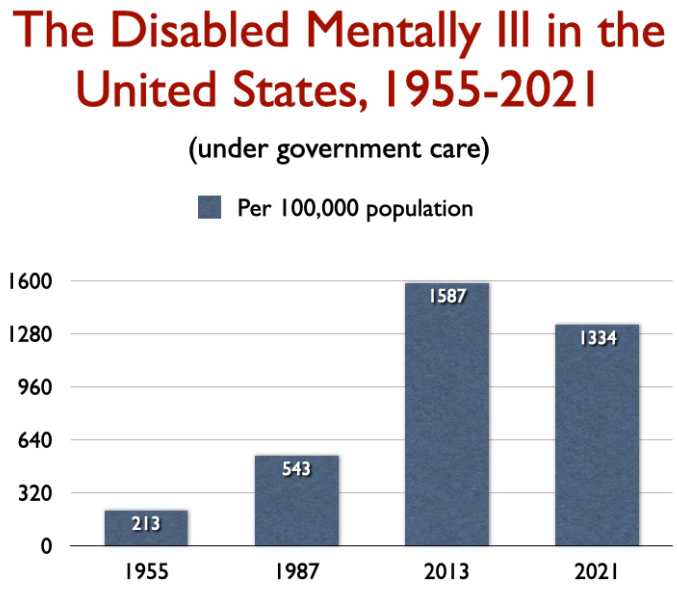
II. TABLE OF CONTENTS

III. THE CURRENT MENTAL HEALTH SYSTEM IS EXTREMELY COUNTERPRODUCTIVE AND HARMFUL

The Overuse of Psychiatric Drugs

It is fairly universally accepted that the mental health system is a failure, especially regarding what has been accomplished with the most noteworthy feature of psychiatric treatment since the 1950s and exponentially so since the early 1980s, psychiatric drugs. At great public expense, the system's ubiquitous deployment of psychiatric drugs, including being forced upon unwilling patients, often by holding them down and injecting them against their will, or threatening to do so to obtain "compliance," dramatically worsens outcomes and suffering.

Since the introduction of the so-called miracle drug Thorazine (chlorpromazine) in the mid-1950s, the disability rate of people diagnosed with serious mental illness has increased more than six-fold.[1]



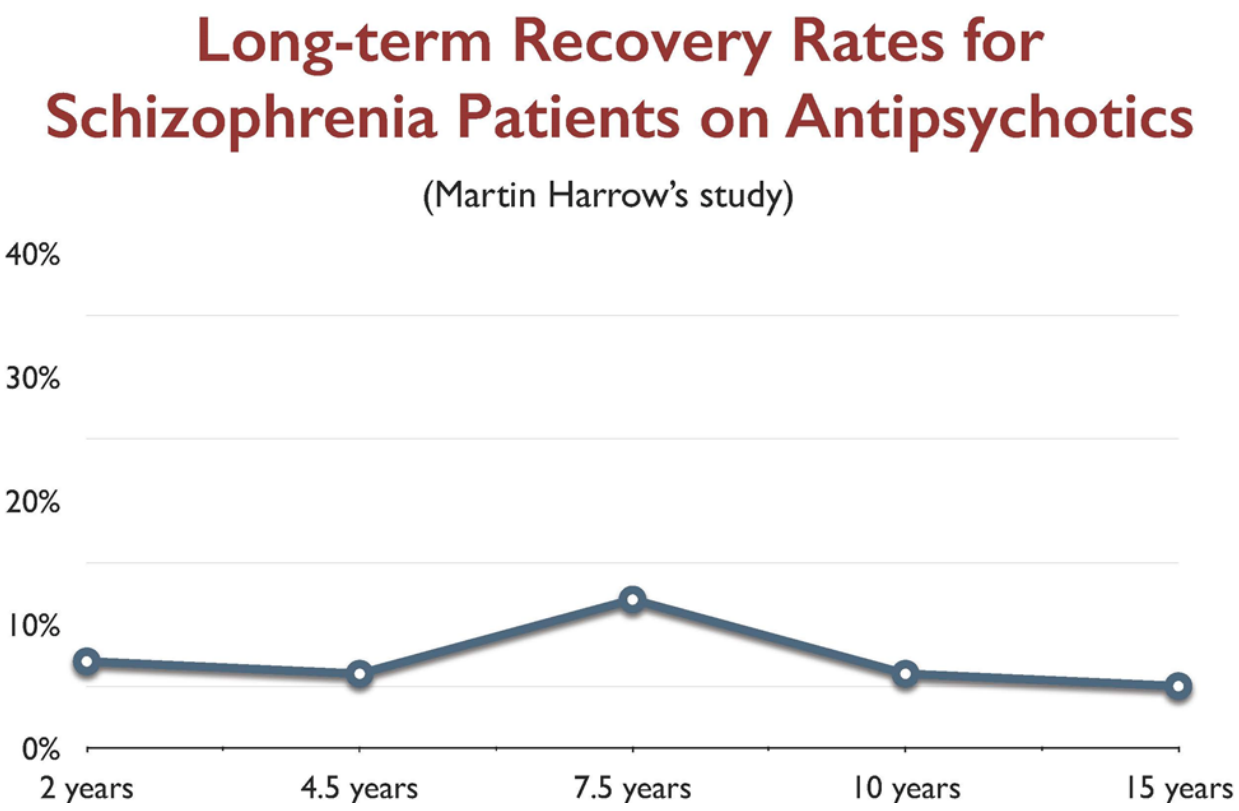
Source: Silverman, C. *The Epidemiology of Depression* (1968): 139. U.S. Social Security Administration Reports, 1987-2021.

[1] The charts in this section are from award winning journalist Robert Whitaker, author of *Anatomy of an Epidemic* (2010) and *Mad in America* (2002) including his highly recommended July 16, 2021, talk to the Soteria Network in the UK, "Soteria Past, Present, and Future: The Evidence For This Model of Care."

It is likely at least some of the increase after 1987 was because people were thrown off welfare under the "welfare to work" legislation passed in 1996,[2] and had to be certified as disabled to continue to receive financial assistance. The decrease since 2013 is in large part due to the government making it harder to qualify for such disability payments. This in turn may very well have increased the number of homeless people.

Thomas Insel, who for 12 years was Director of the National Institute of Mental Health (NIMH) frankly stated in 2009 and repeatedly thereafter that, "despite five decades of antipsychotic medication and deinstitutionalization, there is little evidence that the prospects for recovery have changed substantially in the past century."[3]

We now have a recovery rate of only 5% for people diagnosed with schizophrenia who are maintained on neuroleptics.[4,5]



[2] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. Law. 104–193, August. 22, 1996; 110 Stat. 2105.

[3] Insel, Thomas R. (2009). "Translating Scientific Opportunity Into Public Health Impact: A Strategic Plan for Research on Mental Illness." *Archives of General Psychiatry* 66(2): 128–133.

[4] Harrow, Martin; & Jobe, Thomas H. (2007). "Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study." *Journal of Nervous and Mental Disease* 195(5): 406–414.

[5] Neuroleptics are marketed as "antipsychotics" even though they don't have specific anti-psychotic effects for most people.

This is far worse than anything seen before the advent of the neuroleptics in the mid-1950s.

Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

Study	Time	Good Outcome*
York Retreat	1796-1811	70%
Worcester Asylum	1833-1846	65%
Pennsylvania Hospital	1841-1882	45% to 70%
Warren State Hospital	1946-1950	73%
Delaware Hospital	1948-1950	70%
Boston Psychopathic Hospital	1947-1952	76%
Norway	1948-1952	63%
California FEP study	1956 (no neuroleptics)	88%

* Good outcome = discharge from hospital, or living in community at end of study period

Yet if we try to avoid the use of neuroleptics when people experience their first psychotic break, a nearly 80% recovery rate can be achieved. The following chart shows results from the "Open Dialogue" program in Northern Finland in which the use of neuroleptics is avoided if possible.[6]

Five-Year Outcomes for First-Episode Psychotic Patients in Finnish Western Lapland Treated with Open-Dialogue Therapy

Patients (N=75)	
Schizophrenia (N=30)	
Other psychotic disorders (N=45)	
Antipsychotic use	
Never exposed to antipsychotics	67%
Occasional use during five years	33%
Ongoing use at end of five years	20%
Psychotic symptoms	
Never relapsed during five years	67%
Asymptomatic at five-year followup	79%
Functional outcomes at five years	
Working or in school	73%
Unemployed	7%
On disability	20%

Source: Seikkula, J. "Five-year experience of first-episode nonaffective psychosis in open-dialogue approach." *Psychotherapy Research* 16 (2006):214-28.

[6] Seikkula, Jaakko, et al. (2006). "Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies." *Psychotherapy Research* 16(2): 214–228.

Similar results were achieved during the Soteria-House study in the 1970s conducted by Loren Mosher, MD, then Chief of Schizophrenia Research at the NIMH:

Soteria-House Study

At six weeks, psychopathology reduced comparably in both groups.

At two years:

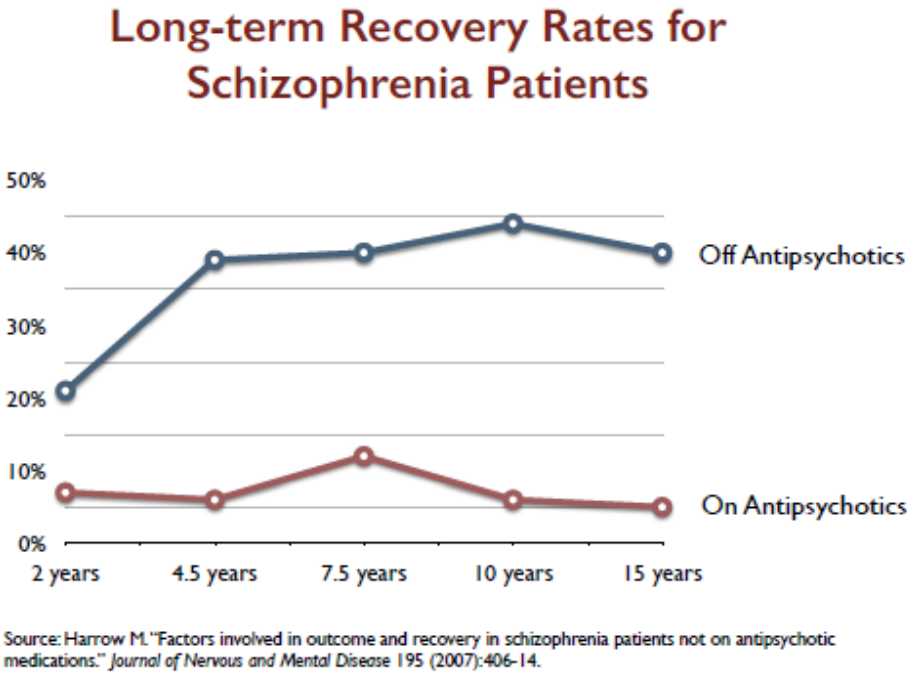
- Soteria patients had better psychopathology scores
- Soteria patients had fewer hospital readmissions
- Soteria patients had higher occupational levels
- Soteria patients were more often living independently or with peers

Neuroleptic use in Soteria patients:

- 76% did not use antipsychotic drugs during first six weeks
- 42% did not use any antipsychotic during two-year study
- Only 19% regularly maintained on drugs during follow-up period

Mosher (1999). *J Nerv Ment Dis* 187(3):142–149
Bola & Mosher (2003). *J Nerv Ment Dis* 191(4): 219–229

The recovery rate of people who get off neuroleptics after they have been on them goes from 5% to 40%.[7]



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

[7] Harrow, Martin; & Jobe, Thomas H. (2007). "Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study." *Journal of Nervous and Mental Disease* 195(5): 406–414.

While this is 8 times better than staying on them (40% vs. 5%), it is half of what can be achieved by avoiding the use of neuroleptics in the first place (80%), as established by the Open Dialogue and Soteria House studies.[8] **This demonstrates the importance of avoiding the use of neuroleptics in the first place.** In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be receiving life-long publicly paid services and transfer payments into productive, taxpaying citizens.[9]

The Harrow and Jobe results were so unexpected and contrary to mainstream psychiatry's beliefs that other explanations were proposed, such as it was the people with the best prognosis in the first place who got off the drugs and therefore had better outcomes, that additional analysis was undertaken. None of the alternate explanations proved correct.[10]

In addition to dramatically reducing the recovery rate, **the ubiquitous use of psychiatric drugs is extremely harmful physically, reducing lifespans by 20 years or so**.[11] In a given time period, the relative risk of dying increases markedly with the number of neuroleptics the person takes.[12] Neuroleptic users have an increased risk of cardiac mortality, all-cause mortality, and sudden cardiac death compared to psychiatric patients

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[8] While there might not be a 100% overlap between the 80% who recovered and the 80% who were not taking the neuroleptics long term, clearly minimizing the use of the neuroleptics produces dramatically better outcomes.

[9] The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (2010) by Robert Whitaker, from whose work this section is largely drawn.

[10] Harrow, Martin; Jobe, Thomas H.; & Faull, Robert N. (2012). "Do All Schizophrenia Patients Need Antipsychotic Treatment Continuously Throughout Their Lifetime? A 20-Year Longitudinal Study." *Psychological Medicine* 42(10): 2145–2155; Harrow, Martin; & Jobe, Thomas H. (2013). "Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery?" *Schizophrenia Bulletin* 39(5): 962–965; Harrow, M.; Jobe, T. H.; & Faull, R. N. (2014). "Does Treatment of Schizophrenia With Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-up Study." *Psychological Medicine* 44(14): 3007–3016; Harrow, Martin, et al. (2017). "A 20-Year Multi-Followup Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia." *Psychiatry Research* 256: 267–274; and Harrow, Martin; & Jobe, Thomas H. (2018). "Long-Term Antipsychotic Treatment of Schizophrenia: Does it Help or Hurt Over a 20-Year Period?" *World Psychiatry* 17(2): 162–163; Harrow, Martin; Jobe, Thomas H; & Tong, Liping. (2022). "Twenty-Year Effects of Antipsychotics in Schizophrenia and Affective Psychotic Disorders." *Psychological Medicine* 52(13): 2681–2691.

[11] Gøtzsche, Peter C. (2015), *Deadly Psychiatry and Organized Denial*, p. 165, *et. seq*. (Copenhagen: People's Press). See also Parks, Joe, et al. (2006), *Morbidity and Mortality in People With Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors). The report documents mortality in people diagnosed with serious mental illness in the public mental health system has accelerated to the point where they are now dying 25 years earlier than the general population. The report does not attribute this to psychiatric drugs, but it is clear the major change is the advent of the second generation neuroleptics, and the great increase in polypharmacy.

[12] Joukamaa, Matti, et al. (2006). "Schizophrenia, Neuroleptic Medication and Mortality." *British Journal of Psychiatry* 188(2): 122–127.

not taking them.[13] People prescribed even moderate doses of neuroleptics have large relative and absolute increases in the risk of sudden cardiac death.[14]

Citing Robert Whitaker's 2002 book, *Mad in America*, Gøtzsche, recently wrote about the drug companies hiding large numbers of deaths in their clinical trials of neuroleptics:

> One in every 138 [initial number, later updated to 145] patients who entered the trials for newer neuroleptics died, but none of these deaths were mentioned in the scientific literature, and the FDA didn't require them to be mentioned. Many patients killed themselves, and the suicide rate was two to five times the usual rate for patients with schizophrenia. A major reason was drug-withdrawal akathisia.[15]

The result of introducing more and more psychiatric drugs is the standard mortality rates of schizophrenia patients worsen over time, which Robert Whitaker of *Mad in America* recently summarized:[16]

> Standard mortality rates (SMRs) tell of the higher mortality rates for patient groups compared to the general population. For instance, a standard mortality rate of 2 for schizophrenia patients means that they are twice as likely to die over a set period than the general population. SMRs for schizophrenia and bipolar patients have *worsened* over the last 50 years.
>
> In 2007, Australian researchers conducted a systematic review of published reports of mortality rates of schizophrenia patients in 25 nations. They found that the SMRs for "all-cause mortality" rose from 1.84 in the 1970s to 2.98 in the 1980s to 3.20 in the 1990s.
>
> Here is a summary of the increase in SMRs for the seriously mentally ill from various studies:

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[13] Murray-Thomas, Tarita, et al. (2013). "Risk of Mortality (Including Sudden Cardiac Death) and Major Cardiovascular Events in Atypical and Typical Antipsychotic Users: A Study With the General Practice Research Database." *Cardiovascular Psychiatry and Neurology* 2013: 247486.

[14] Ray, Wayne A., et al. (2001). "Antipsychotics and the Risk of Sudden Cardiac Death." *Archives of General Psychiatry* 58(12): 1161–1167.

[15] Gøtzsche, Peter C. (25 Feb 2023). "A New Paradigm for Testing Psychiatric Drugs is Needed." *Mad in America*.

[16] Whitaker, Robert. (6 Apr 2023). "Answering Awais Aftab: When it Comes to Misleading the Public, Who is the Culprit?" *Mad in America*, citing Saha, Sukanta; Chant, David; & McGrath, John. (2007). "A Systematic Review of Mortality in Schizophrenia: Is the Differential Mortality Gap Worsening Over Time?" *Archives of General Psychiatry* 64(10): 1123–1131; Hayes, Joseph F., et al. (2017). "Mortality Gap for People With Bipolar Disorder and Schizophrenia: UK-Based Cohort Study 2000–2014." *British Journal of Psychiatry* 211(3): 175–181; Lilly, Samantha (6 Oct 2022). "Long Term Antidepressant Use Associated With Increased Morbidity and Mortality." *Mad in America*.

All-Cause Mortality Among The Seriously Mentally Ill

Investigator	Patient Population	Country	Time Period	Standardized Mortality Rate
Saha	Schizophrenia	Global	1970s-1990s	2.98
Joukamaa	Schizophrenia	Ireland	1978-1995	1 antipsychotic = 2.97 2 antipsychotics = 3.21 3 antipsychotics = 6.83
Tiihonen	Schizophrenia/ Schizoaffective	Finland	1995-2004	4.5
Olson	Schizophrenia	United States	2001-2007	3.7
Torniainen	Schizophrenia	Sweden	2006-2010	4.8

> In 2017, UK investigators reported that the SMR for bipolar patients had risen steadily from 2000 to 2014, increasing by 0.14 per year, while the SMR for schizophrenia patients had increased gradually from 2000 to 2010 (0.11 per year) and then more rapidly from 2010 to 2014 (0.34 per year.) "The mortality gap between individuals with bipolar disorders and schizophrenia, and the general population, is widening," they wrote.
>
> Long-term use of antidepressants has also been found to be associated with increased morbidity and mortality.

In addition to the neuroleptics killing people due to direct physical harm, such as cardiac arrest and diabetes, they dramatically increase the suicide rate,[17] as do the so-called antidepressants,[18] anti-seizure/anti-epileptic drugs marketed as "mood stabilizers,[19]

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[17] Lehmann, Peter. (2012). "About the Intrinsic Suicidal Effects of Neuroleptics: Towards Breaking the Taboo and Fighting Therapeutic Recklessness." *International Journal of Psychotherapy* 16(1): 30–49; Whitaker, Robert. (2 May 2020). "Do Antipsychotics Protect Against Early Death? A Review of the Evidence." *Mad in America*; Healy, David, et al. (2006). "Lifetime Suicide Rates in Treated Schizophrenia: 1875–1924 and 1994–1998 Cohorts Compared." *British Journal of Psychiatry* 188(3): 223–228.

[18] Healy, David; & Aldred, Graham. (2005). "Antidepressant Drug Use & the Risk of Suicide." *International Review of Psychiatry* 17(3): 163–172; Hengartner, Michael P.; & Plöderl, Martin. (2019). "Newer-Generation Antidepressants and Suicide Risk in Randomized Controlled Trials: A Re-Analysis of the FDA Database." *Psychotherapy and Psychosomatics* 88(4): 247–248; Hengartner, Michael P.; & Plöderl, Martin. (2019). "Reply to the Letter to the Editor: 'Newer–Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl's Re-Analysis'." *Psychotherapy and Psychosomatics* 88(6): 373–374; Fergusson, Dean, et al. (2005). "Association Between Suicide Attempts and Selective Serotonin Reuptake Inhibitors: Systematic Review of Randomised Controlled Trials." *BMJ* 330,7488: 396.

[19] Britton, Jeffery W.; & Shih, Jerry J. (2010). "Antiepileptic Drugs and Suicidality." *Drug, Healthcare and Patient Safety* 2: 181–189; Food and Drug Administration, Center for Drug Evaluation and Research. (2008). *Statistical Review and Evaluation: Antiepileptic Drugs and Suicidality*. As a result, the FDA requires the labels for these drugs to carry the warning "Antiepileptic drugs, including increase the risk of suicidal thoughts or behavior." See the FDA labels for Neurontin (gabapentin), and Lyrica (pregabalin).

and benzodiazapines.[20] Also, as discussed in the next section, psychiatric incarceration itself is associated with a massive increase in suicides.

While some people find these drugs helpful, on the whole, they are harmful and counterproductive, dramatically reducing recovery rates and life spans. **Forcing psychiatric drugs into people is an atrocity**.

The Clinical Trial Literature on Psychiatric Drugs is Unreliable

Since psychiatric drugs are so harmful and counterproductive the question naturally arises as to why they are so predominant. One reason, as Marcia Angell, MD, former editor of *The New England Journal of Medicine* points out, is the unreliability of the clinical drug trial literature.

> It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine*.[21]

Dr. Angell states psychiatry is the worst (the problems with psychiatry reach "their most florid form").

As a general matter this is because the studies are designed and reported in ways to promote drug sales, rather than reveal the truth. This is often accomplished by misleading or even outright dishonest statistical manipulations.[22] Drug companies publish as positive trials the FDA has classified as negative,[23] and much of the clinical drug trial literature is ghost written.[24] "Study 329" of paroxetine (Paxil) in teenagers and the two pivotal studies of fluoxetine (Prozac) in children and adolescents diagnosed with depression are examples

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[20] Dodds, Tyler J. (2017). "Prescribed Benzodiazepines and Suicide Risk: A Review of the Literature." *Primary Care Companion for CNS Disorders* 19(2): 16r02037.

[21] Angell, Marcia (19 Jan 2009). "Drug Companies & Doctors: A Story of Corruption." *The New York Review*.

[22] *Ibid*. and Gøtzsche, Peter C. (2013). *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare*. London: CRC Press.

[23] Turner, Erick H., et al. (2008). "Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy." *New England Journal of Medicine* 358(3): 252–260; Gøtzsche, Peter C.; & Healy, David. (2022). "Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression." *International Journal of Risk & Safety in Medicine* 33(4): 385–408.

[24] PLoS Medicine Editors. (2009). "Ghostwriting: The Dirty Little Secret of Medical Publishing That Just Got Bigger." *PLOS Medicine* 6(9): e1000156; Gøtzsche, Peter C., et al. (2007). "Ghost Authorship in Industry-Initiated Randomised Trials." *PLOS Medicine* 4(1): e19.

of negative studies that were published as positive and of omission of serious harms in the publications.[25]

The truth is hard to ferret out because drug companies claim the clinical data are trade secrets and deny even the listed authors, let alone peer reviewers, and other potential reviewers access to the trial data.[26] The validity of clinical trials cannot be assessed without access to the underlying data. When this has been investigated, usually when data has been revealed through litigation, some serious harms – including suicidal events – have often occurred in the clinical trials but have been omitted in the published results. Companies state their drugs have no known serious side effects to be concerned about when they know the opposite is true.[27]

The claimed benefit in psychiatric drug trials typically involves a minor change in a rating scale score, which is not clinically relevant, while at the same time more people die from the active treatment than die on placebo.[28] Many of these deaths are hidden in the published studies. About half of the deaths including half of the suicides occurring in trials of psychiatric drugs have been left out of published trial reports.[29]

One of the ways drug companies make neuroleptics look beneficial is to have a so-called placebo arm consisting of people abruptly withdrawn from a neuroleptic, which is known to cause many people to become psychotic, thereby making the drug company drug look good by comparison. These trials are highly unethical as well as flawed because they harm patients in the placebo group in order to make the company's drug look better.[30]

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[25] Le Noury, Joanna, et al. (2015). "Restoring Study 329: Efficacy and Harms of Paroxetine and Imipramine in Treatment of Major Depression in Adolescence." *BMJ* 351: h4320; Gøtzsche, Peter C.; & Healy, David. (2022). "Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression." *International Journal of Risk & Safety in Medicine* 33(4): 385–408; Gøtzsche, Peter C. (2015). *Deadly Psychiatry and Organised Denial*. Copenhagen: People's Press; Healy, David; Le Noury, Joanna; & Jureidini, Jon. (2019). "Paediatric Antidepressants: Benefits and Risks." *International Journal of Risk & Safety in Medicine* 30(1): 1–7.

[26] Gøtzsche, Peter C., et al. (2006). "Constraints on Publication Rights in Industry-Initiated Clinical Trials." *JAMA* 295(14): 1641–1646.

[27] Gøtzsche, Peter C. (2013). *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare*. London: CRC Press; Hudson, Ian. (2000). "Video Deposition of Ian R. B. Hudson, M.R.C.P., M.D." *Tobin v SmithKline Beecham*. In the United States District Court for the Eastern District of Pennsylvania, Case No. 00CV0025; Healy, David; Germán Roux, Augusto; & Dressen, Brianne. (2023). "The Coverage of Medical Injuries in Company Trial Informed Consent Forms." *International Journal of Risk & Safety in Medicine*: 1–8; Healy, David. (2023). "Diagnosis, Verdict, Conclusion, and Causality." *Ethical Human Psychology and Psychiatry*.

[28] Gøtzsche, Peter C. (2015). *Deadly Psychiatry and Organized Denial*. Copenhagen: People's Press.

[29] Hughes, Shannon; Cohen, David; & Jaggi, Rachel. (2014). "Differences in Reporting Serious Adverse Events in Industry Sponsored Clinical Trial Registries and Journal Articles on Antidepressant and Antipsychotic Drugs: A Cross-Sectional Study." *BMJ Open* 4(7): e005535.

[30] Gøtzsche, Peter C. (2022). *Critical Psychiatry Textbook*. Copenhagen: Institute for Scientific Freedom (freely available); Gottstein, Jim (2021). *The Zyprexa Papers*. Toronto: Samizdat Health Writer's Co-operative, Jackson, Grace E. (2003). "An Analysis of the Olanzapine Clinical Trials— Dangerous Drug, Dubious Efficacy" [affidavit]. *In the Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

Because people in the so-called placebo group were unethically withdrawn abruptly from the neuroleptic they were taking, causing additional deaths, it is not possible to accurately estimate the effect on mortality, but we do know that "One in every 145 patients who entered the trials—for risperidone, olanzapine, quetiapine, and a fourth atypical called sertindole—died, and yet those deaths were never mentioned in the scientific literature."[31]

In sum, the ubiquitous use of psychiatric drugs for treating people diagnosed with serious mental illness, including forcing them into people, is driven in part by unreliable and often fraudulent clinical trial literature.

Inpatient Hospitalizations Associated with Astronomically Higher Suicide Rates

Similarly, the notion people need to be psychiatrically incarcerated to keep them from harming themselves is directly contradicted by suicides dramatically increasing following hospitalization. For example, a 2019 study concluded: "Among patients recently discharged from psychiatric hospitalization, rates of suicide deaths and attempts were far higher than…in unselected clinical samples of comparable patients."[32]

Another study of all suicides in Denmark between 1981 and 1997 found the risk of suicide 102 times higher for men and 246 times higher for women in the first week after discharge (compared to hundreds of thousands of control subjects matched for age, sex, and calendar time of suicide). These rates decline the longer someone is hospitalized and after discharge, but still greatly exceed what would otherwise be expected.[33]

Gøtzsche describes another Danish study in his 2015 book, *Deadly Psychiatry and Organised Denial*:[34]

> The fact that forced treatment can be fatal was recently underlined in a Danish register study of 2,429 suicides.[35] It showed that the closer the contact with psychiatric staff — which often involves forced treatment — the worse the outcome. Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was six for people receiving only psychiatric medication, eight for people with psychiatric outpatient contact, 28 for people with psychiatric emergency room contacts, and 44 for people who had been admitted to a

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[31] Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books; Whitaker, Robert (17 Nov 1998). "Lure of Riches Fuels Testing." *Boston Globe*, p. A01.

[32] Forte, Alberto, et al. (2019). "Suicidal Risk Following Hospital Discharge: A Review." *Harvard Review of Psychiatry* 27(4): 209–216.

[33] Qin, Ping; & Nordentoft, Merete. (2005). "Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers." *Archives of General Psychiatry* 62(4): 427–432.

[34] Gøtzsche, Peter C. (2015). *Deadly Psychiatry and Organized Denial*. Copenhagen: People's Press.

[35] Hjorthøj, Carsten Rygaard, et al. (2014). "Risk of Suicide According to Level of Psychiatric Treatment: A Nationwide Nested Case–Control Study." *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1357–1365.

> psychiatric hospital. Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they were more ill than the others (confounding by indication), but the findings were robust and most of the potential biases in the study were actually conservative, i.e. favoured the null hypothesis of there being no relationship. An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment — particularly if involuntary — might cause suicide.[36] The editorialists believed that a proportion of people who commit suicide during or after an admission to hospital do so because of conditions inherent in that hospitalisation.

Thus, the justification that someone should be psychiatrically incarcerated to prevent suicide is fallacious, even absurd.[37] If the best society has to offer someone grappling with a life-and-death decision is to remove their agency and lock them up until they say what others want to hear, then it is easy to imagine why people would lose faith in society's ability to help them, and be more likely to commit suicide as soon as they are released.

Treatment Should Be Voluntary

All of this makes clear psychiatric incarceration and forced drugging should be abolished.[38] Unwanted psychiatric interventions are violence perpetrated against the patient. Restraining psychiatric patients, pulling down their pants and injecting them with psychiatric drugs they do not want is violence, justified on the grounds patients don't know what is good for them. Patients protesting and saying what is true—that the drugs hurt them and do not help—are said to be delusional, and their statements prove they "lack insight" and should be drugged against their will.[39] That this occurs every day does not make it right.

Forced psychiatric interventions are not for the benefit of patients; they are used to manage troublesome people thereby benefiting the staff.

> [The] coercive function is what society and most people actually appreciate most about psychiatry. That families and other people in crisis can call upon

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[36] Large, Matthew M.; & Ryan, Christopher J. (2014). "Disturbing Findings About the Risk of Suicide and Psychiatric Hospitals." *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1353–1355.

[37] See, e.g., Harris, Leah. (14 Jan 2023). "You Can't Coerce Someone Into Wanting to be Alive: The Carceral Heart of the 988 Lifeline." *Mad in America*.

[38] The same is true of electroshock. See Andre, Linda. (2009). *Doctors of Deception: What the Doctors Don't Want You to Know About Shock Treatment*. New Brunswick, NJ: Rutgers University Press.

[39] Tasch, Gail; & Gøtzsche, Peter C. (2023). "Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska." *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). "Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients." *Indian Journal of Medical Ethics* 5(4): 312–318.

> the police to restrain someone acting in a seemingly incomprehensible or dangerous way and have that person taken by force to a place run by psychiatrists is truly where psychiatry as a profession distinguishes itself.[40]

Many effective and non-coercive services exist for the treatment of psychiatric patients. They are psychosocially focused rather than medically focused, and always voluntary. While they differ because they have been developed within different geographical and cultural contexts, they share the following values:

1. Voluntariness and informed choice.
2. Relationships as the first line of treatment.
3. Respect for the individual and their life experience.
4. Emphasizing community inclusion (continuing to participate as student, worker, family member).

When Dr. Loren Mosher testified as a court-qualified expert witness at the trial in *Myers v. Alaska Psychiatric Institute*[41] he stated involuntary treatment should be difficult to implement and should be used only in the direst of circumstances, and then:

> [I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing … Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to … In my career I have never committed anyone … I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a[n] ongoing treatment plan that is acceptable to both of us.[42]

In addition to the other state-sanctioned violence inflicted on psychiatric inmates, forcing unwanted psychiatric drugs into a patient, especially when the patient is knowledgeable about their counterproductive and harmful effects, is traumatic, often extremely so. Even when a patient agrees to take the drug(s), they are not giving informed consent because they are not told about the likely or common outcomes, or the agreement is not a true agreement because the patients know that if they disagree, they will be forced to take the drug anyway. While some states have changed this, at common law, failure to

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[40] Cohen, David. (21 Oct 2014). "It's the Coercion, Stupid!" *Mad in America*. See also Kirk, Stuart A.; Gomory, Tomi; & Cohen, David. (2017). *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs*. New York: Routledge.

[41] *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

[42] *In the Matter of F.M.* Transcript of proceedings (March 5 and March 10, 2003), p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI.

obtain informed consent constitutes a battery.[43] This is also a recognition that forced drugging is violence perpetrated against the patient.

If it is not voluntary it is not treatment. In short, unwanted psychiatric interventions are traumatic, counterproductive and harmful, and should be abolished. They are also violations of International Law.

Unwanted Psychiatric Interventions Violate International Law and Can Constitute Torture

Under Articles 12 and 14 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD),[44] governments are prohibited from denying people decision-making authority, from confining people, or administering any unwanted psychiatric intervention on the basis of a disability, including being diagnosed with a mental illness. Because there was a general misunderstanding of the scope of Article 12 of the CRPD, the United Nations Committee on the Rights of Persons with Disabilities issued General Comment No. 1 (2014) to clarify that taking away someone's decision making rights and forced psychiatric interventions are prohibited.[45] See also Guidelines on the right to liberty and security of persons with disabilities (the practice of detaining people on the grounds of actual or perceived impairment provided there are other reasons including that they are deemed dangerous to themselves or others is incompatible with article 14).[46]

The UN has also repeatedly stated such **unwanted psychiatric interventions can amount to torture**.[47]

Patients' Rights Are Uniformly Violated

While the United States has not ratified the CRPD there are constitutional and statutory rights and procedures in the United States that are uniformly violated to the great

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[43] Gottstein, James B. (2007). "Psychiatrists' Failure to Inform: Is There Substantial Financial Exposure?" *Ethical Human Psychology and Psychiatry* 9(2): 117–125.

[44] United Nations General Assembly. (2006). *Convention on the Rights of Persons With Disabilities (CRPD)*. A/RES/61/106. New York: United Nations.

[45] UN Committee on the Rights of Persons with Disabilities (11th Session). (2014). "General Comment No. 1 (2014): Article 12, Equal Recognition Before the Law." CRPD/C/GC/1. Geneva: United Nations.

[46] UN Committee on the Rights of Persons with Disabilities. (2017). "Guidelines on the Right to Liberty and Security of Persons With Disabilities." In *Report of the Committee on the Rights of Persons With Disabilities (13th Through 16th Sessions (2015–2016)*, pp. 16–21. A/72/55. Geneva: United Nations.

[47] UN Human Rights Council. (19 June 2020). "Mental Health and Human Rights: Resolution 43/13 Adopted 19 June 2020." A/HRC/RES/43/13. Geneva: United Nations; UN Human Rights Council. (20 Mar 2020). *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Report of the Special Rapporteur*. A/HRC/43/49. Geneva: United Nations; Méndez, Juan E. (4 Mar 2013). "Statement By Mr. Juan E Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council of the United Nations." Geneva: United Nations. See also the related *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez* (2013), A/HRC/22/53. Geneva: United Nations.

detriment of people ensnared by the coercive psychiatric system. As a general rule, people cannot be constitutional confined for being mentally ill in the United States unless the government proves by clear and convincing evidence that

1. as a result of being mentally ill they are a danger to themselves or others, or
2. so disabled by mental illness they cannot survive safely in freedom without the help of willing friends and family,
3. and there is no less restrictive alternative.[48]

"Clear and convincing evidence" is more than the "preponderance of the evidence" standard used in civil cases, meaning "more likely than not" or just over 50%, but less than the "beyond a reasonable doubt" standard used in criminal cases where defendants also face incarceration. In holding beyond a reasonable doubt was not required, the U.S. Supreme Court noted that meeting commitment criteria could never be proven beyond a reasonable doubt.[49]

People diagnosed with mental illness are not significantly more violent than the general population,[50] and psychiatrists are notoriously bad at predicting violence, being no better than chance.[51] This has been known for a long time. In fact, in the 1983 United States Supreme Court case of *Barefoot v. Estelle*,[52] the American Psychiatric Association filed an *amicus* brief in which they stated psychiatrists cannot accurately predict violence. (See also *Reign of Error* by Lee Coleman, MD.)[53] Psychiatrists are no more able to accurately predict suicidality.[54]

A related problem is the treatment patients universally get while psychiatrically incarcerated—psychiatric drugs—often against the person's wishes, are known to cause both violence and suicidality, including in people who have never exhibited these previously to being administered these drugs.

> Before 1955, four studies found that patients discharged from mental hospitals committed crimes at either the same or a lower rate than the general population. However, eight studies conducted from 1965 to 1979 determined that discharged patients were being arrested at rates that exceeded those of the general population. And while there may have been

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[48] *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486 (1975).

[49] *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804 (1979).

[50] Teplin, Linda A. (1985). "The Criminality of the Mentally Ill: A Dangerous Misconception." *American Journal of Psychiatry* 142(5): 593–599; Fazel, Seena, et al. (2009). "Schizophrenia and Violence: Systematic Review and Meta-Analysis." *PLoS Medicine* 6(8): e1000120; Elbogen, Eric B.; & Johnson, Sally C. (2009). "The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions." *Archives of General Psychiatry* 66(2): 152–161.

[51] Garrett, Brandon L.; & Monahan, John. (2020). "Judging Risk." *California Law Review* 108(2): 439–493.

[52] *Barefoot v. Estelle*. 463 U.S. 880, 103 S. Ct. 3383, 77 L. Ed. 2d 1090 (1983).

[53] Coleman, Lee. (1984). *Reign of Error: Psychiatry, Authority and Law*. Boston: Beacon Press. (Now a free download.)

[54] Franklin, Joseph C., et al. (2017). "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research." *Psychological Bulletin* 143(2): 187–232.

> many social causes for this change in relative arrest rates (homelessness among the mentally ill is an obvious cause), akathisia was also clearly a contributing factor.[55]

Since then, there has been increasing evidence that diminished metabolism of psychiatric drugs due to cytochrome P450 gene variations is associated with an increase in violence.[56]

As explained above, psychiatric incarceration dramatically increases suicides, so preventing self-harm cannot be a legitimate basis for locking someone up.

The United States Supreme Court has not specifically ruled on the constitutional limits for psychiatrically drugging someone against their will in the civil commitment context, but has in the competence to stand trial context, holding such drugging is constitutional only if,

1. Important governmental interests are at stake,
2. It will significantly further those state interests - substantially unlikely to have side effects that will interfere significantly (with achieving state interest),
3. It is necessary to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results, and
4. It is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition, considered on drug-by-drug basis.[57]

Civil forced drugging proceedings are usually prosecuted under state law and different state supreme courts considering the issue can take different positions, but many are consistent with *Sell*, holding forced drugging is only constitutional if it is proven by clear and convincing evidence the forced drugging is in the person's best interest and there is no less intrusive alternative.[58]

While some people find psychiatric drugs helpful and adults at least should have access to them if so, as set forth above, on the whole psychiatric drugs are massively counter-productive and harmful. There are no studies showing psychiatric treatment improves patient outcomes.[59] Thus, **forced psychiatric drugging on the grounds it is in people's best interest can never be legally justified**.

Unfortunately, the inability to accurately predict violence or self-harm and the massively counterproductive and harmful nature of psychiatric drugs has proven to be no

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[55] Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books, citing Rabkin, Judith Godwin. (1979). "Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research." *Psychological Bulletin* 86(1): 1–27.

[56] Clarke, Catherine; Evans, Jan; & Brogan, Kelly. (2019). "Treatment Emergent Violence to Self and Others: A Literature Review of Neuropsychiatric Adverse Reactions for Antidepressant and Neuroleptic Psychiatric Drugs and General Medications." *Advances in Mind-Body Medicine* 33(1): 4–21.

[57] *Sell v. United States*, 539 U.S. 166, 177-8, 123 S.Ct. 2174, 2183 (2003).

[58] *See*, e.g., *Rivers v. Katz* 495 N.E.2d 337 (New York, 1986); *Steele v. Hamilton County Community Mental Health Board*, 736 N.E.2d 10 (Ohio 2000); *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

[59] See chapter 22 of Wipond, Rob. (2023). *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships*. Dallas, TX: BenBella Books.

impediment keeping courts from psychiatrically incarcerating people and drugging them against their will:

> [C]ourts accept…testimonial dishonesty…, specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." …
>
> Experts frequently…and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment….
>
> This combination…helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to ensure that the allegedly "therapeutically correct" social end is met…. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.[60]

As a result, it has been estimated no more than 10% of the people psychiatrically incarcerated actually meet commitment criteria.[61]

The legal representation of people facing psychiatric incarceration and forced drugging is supposed to prevent this, but the assigned lawyers are almost universally ineffective or worse by taking the attitude "if my client wasn't crazy they'd know locking them up and drugging them against their will is good for them."[62] The information in this Report is not presented to the courts. This ineffective representation is not completely the assigned lawyers' fault as they are not allowed the time, nor given the resources, such as expert witness testimony, to present an adequate defense. The result is these proceedings can fairly be characterized as shams.[63] That people are being locked up and drugged against their will when there is such overwhelming proof the legal prerequisites for doing so do not exist is a failure of effective legal representation and the legal system as a whole, resulting in immense harm.

> By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defense and are

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[60] Perlin, Michael L. (1993). "The ADA and Persons With Mental Disabilities: Can Sanist Attitudes be Undone." *Journal of Law and Health* 8(1): 15–45.

[61] Gottstein, James B. (28 Oct 2005). "How the Legal System Can Help Create a Recovery Culture in Mental Health Systems." Paper presented at Alternatives 2005: Leading the Transformation to Recovery, Phoenix, AZ.

[62] Gottstein, James B. (2008). "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course." *Alaska Law Review* 25(1): 51–106.

[63] Tasch, Gail; & Gøtzsche, Peter C. (2023). "Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska." *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). "Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients." *Indian Journal of Medical Ethics* 5(4): 312–318.

not discovering and presenting to judges the evidence of the harm to their clients. By abandoning their core principle of being faithful to the law, judges have become instruments of oppression, rather than protectors of the rights of the downtrodden.[64]

Children and Youth Should Not be Given Psychiatric Drugs

The psychiatric drugging of children and youth, especially those on Medicaid and in foster care, is the most heartbreaking and tragic example of the misuse of psychiatric drugs. They are told there is something incurably wrong with their brain, their unacceptable behavior is the result of this defect and not their responsibility, they need to take debilitating psychiatric drugs for the rest of their lives, and the best they can hope for is to minimize psychiatric hospitalizations. These are exactly the wrong messages to give children and youth.

One of the most important things children and youth should learn is how to cope with their emotions without engaging in unacceptable behavior. In other words, take responsibility for their behavior. We should not be telling children and youth they are defective and unable to control themselves. Rather than take children and youth away from their parents, parents should be helped to raise their children to be successful, which is often a viable avenue.

One of the terms of the multi-state settlement of consumer fraud claims regarding the illegal marketing of the prescription drug Neurontin® was funding a rigorous review of psychiatric drugs administered to children and youth. This resulted in the *CriticalThinkRx* curriculum as a series of eight modules:[65]

- Module One: Why a Critical Skills Curriculum on Psychotropic Medications?
- Module Two: Increasing Use of Psychotropics: Public Health Concerns.
- Module Three: The Drug Approval Process.
- Module Four: Pharmaceutical Industry Influences on Prescribing.
- Module Five: Specific Drug Classes: Use, Efficacy, Safety.
- Module Six: Non-Medical Professionals and Psychotropic Medications: Legal, Ethical and Training Issues.
- Module Seven: Medication Management: Professional Roles and Best Practices.

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[64] Gottstein, James B. (2008). "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course." *Alaska Law Review* 25(1): 51–106.

[65] Cohen, David; & Sengelmann, Inge; et al. (Jun 2008). "A Critical Curriculum on Psychotropic Medications." *CriticalThinkRx*.

- Module Eight: Alternatives to Medication: Evidence-Based Psychosocial Interventions

There are also 10–20 minute videos on each on these modules.

In Chapter Seven of *Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It*, child psychiatrist Tony Stanton describes Seneca, the extremely successful non-drug residential program where the most difficult youth were sent.[66] It turned out that whether the success achieved at Seneca lasted depended upon the environment to which the youth was returned. This illustrates that rather than blaming parents, we should be helping them raise their children to be resilient and successful. While there are some parents who deliberately abuse their children, almost all want the best for them and do the best they can. We should invest in parents' and children's and youths' success, not abusive children and youth-drugging prisons.[67]

So-called residential treatment facilities for children and youth have been exposed as abusive.[68] **Children and youth should not be psychiatrically incarcerated or drugged**.

[66] Stanton, Tony. (2012). "Drug-Free Mental Health Care for Children and Youth: Lessons From Residential Treatment." In Sharna Olfman & Brent Dean Robbins (eds.), *Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It*, pp. 119–138. Santa Barbara, CA: Praeger.

[67] The very profitable abuse by what is called the Troubled Teen Industry has been the subject of recent exposés. See, e.g., Stockton, Alexander (11 Oct 2022). "Can You Punish a Child's Mental Health Problems Away?" *New York Times*.

[68] See, e.g., The National Youth Rights Association on "The 'Troubled Teen' Industry" (2023) and the American Bar Association's "Five Facts About the Troubled Teen Industry" (2021).

IV. VOLUNTARY, EFFECTIVE, SAFE AND HUMANE APPROACHES

In stark contrast to mainstream professionals driven psychiatric practices which are horrendously harmful and counterproductive, there are a number of very successful, **voluntary** programs that help people get through what they are going through and back on track. Many of these have been developed by people with lived experience of the coercive mental health system who know what is helpful, often called "peers."

The Power of Peer Support

Peer Support is one such proven approach for recovery, i.e., much better outcomes for people diagnosed with serious mental illness such as schizophrenia and bipolar disorder.[69] Peer Support arose from the Mental Health Consumer/Psychiatric Survivor Movement and is steeped in the use of relationship and support to help people get through a crisis or difficult time that is otherwise likely to result in hospitalization or some other form of hospital emergency services.[70]

> Peer-developed peer support is a non-hierarchical approach with origins in informal self-help and consciousness-raising groups organized in the 1970s by people in the ex-patients' movement. It arose in reaction to negative experiences with mental health treatment and dissatisfaction with the limits of the mental patient role. Peer support among people with psychiatric histories is closely intertwined with experiences of powerlessness within the mental health system and with activism promoting human rights and alternatives to the medical model.[71]

It is defined by the use of people who have experienced extreme states and/or the behavioral health system. Most have been subjected to psychiatric incarceration and forced drugging and/or electroshock.

The magic of peers is (1) their ability to relate and connect to people currently ensnared in the mental health system through shared experience and (2) they belie the mental health system's message of hopelessness by their example of recovery. True Peer Support is egalitarian and based on respect, reciprocity, validation, self-help and mutual aid. Peer Support is always voluntary. If it is not voluntary it is not Peer Support.

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[69] See National Empowerment Center, "Evidence for Peer-Run Crisis Alternatives" (website). Accessed 18 Sep 2023.

[70] Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (National Empowerment Center), originally published in 1978, is considered to have started this approach in the modern era.

[71] Penney, Darby. (10 Feb 2018). "Who Gets to Define 'Peer Support?'" *Mad in America*.

The dramatic success of peer support has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to designate it as an evidence based practice[72] and it is now a Medicaid reimbursable service. This has also unfortunately led to the co-optation of peer support, especially when incorporated into traditional mental health programs.[73] It is not just the lived experience that works its magic; it must be combined with true Peer Support Principles. SAMHSA articulates the following core competencies for behavioral health peer workers.[74]

1. Recovery oriented
2. Person centered
3. Voluntary
4. Relationship focused
5. Trauma informed

A peer specialist who is tasked with medication compliance, for example, is not engaging in true peer support and is not likely to achieve any more success than traditional mental health services. Thus, it is especially important to maintain fidelity to Peer Support Principles.[75] **It is pointless and counterproductive to deploy peers in violation of Peer Support Principles**.

World Health Organization Recommendations

In 2021, the World Health Organization published *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*, (WHO Guidelines) identifying these key messages:

- Many people with mental health conditions and psychosocial disabilities face poor quality care and violations of their human rights, which demand profound changes in mental health systems and service delivery.
- In many parts of the world examples exist of good practice, community-based mental health services that are person-centered, recovery-oriented and adhere to human rights standards.
- In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.

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[72] See, e.g., "Peer Support Services in Crisis Care." *SAMHSA Advisory*, June 2022.

[73] Alberta, Anthony J.; & Ploski, Richard R. (2014). "Cooptation of Peer Support Staff: Quantitative Evidence." *Rehabilitation Process and Outcome* 2014(3): 25–29.

[74] SAMHSA. (2015). "Core Competencies for Peer Workers in Behavioral Health Services." *Bringing Recovery Supports to Scale — Technical Assistance Center Strategy (BRSS TACS)*.

[75] The International Peer Respite/Soteria Summit (Summit) has posted a 35 minute video of one of its Mentoring Circle's meetings discussing this, Navigating a Misguided System (2022).

- Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.
- It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.[76]

Recognizing the requirements of the CRPD, the WHO Guidelines join the call for "eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion and tackling the power imbalances that exist between health staff and people using the services." In doing so the WHO acknowledges that complying with the CRPD "will require considerable changes in practice. " And then states:

> This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done. . . .
>
> [C]ritical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice.

The WHO Guidelines include seven "technical packages" on specific mental health categories and

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;
- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;
- outline the positive outcomes that can be achieved for people using good practice mental health services;
- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;

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[76] World Health Organization. (9 Jun 2021). *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*. Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization.

- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and
- present a series of action steps towards the development of a good practice service that is person centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

Peer Respites

Peer Respites are voluntary, short-term, overnight programs providing community-based, non-clinical crisis support to help people find new understanding and ways to move forward. They operate 24 hours a day in a homelike environment and are designed as psychiatric hospital diversion programs to support individuals experiencing or at risk of a psychiatric crisis. Typically, people can stay for 7–10 days at Peer Respites. The WHO Guidelines support them.

The premise behind Peer Respites is psychiatric emergency services can be avoided if non-coercive supports are available in the community. They are 100% staffed and operated by people who have lived experience of extreme states and/or the behavioral health system, normally psychiatric incarceration and/or forced drugging, and are either operated by a peer-run organization, or has an advisory group with over 50% or more of members having lived experience.[77]

Since the first completely peer operated respite house was developed in 1997 in New Hampshire by Shery Mead (the originator of Intentional Peer Support — the approach implemented as a foundation of the house)[78] — they have proliferated around the country because of their outstanding success.[79] Three prominent Consumer Operated Service Programs (COSPs) that operate Peer Respites are People USA's Rose Houses in New York State, Wildflower Alliance in Massachusetts, formerly known as the Western Massachusetts Recovery Learning Community, and the Promise Resource Network in Mecklenburg, North Carolina. All three have a great deal of information about how these kinds of programs should be operated.[80]

The International Peer Respite/Soteria Summit has posted a five minute video on YouTube, "How Afiya House Helped Me," pulled from the December 5, 2021, follow-up day that provides a good picture of how a Peer Respite approaches people who would otherwise be locked up in a psychiatric hospital and the tremendously beneficial effects of such an approach.

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[77] This description of Peer Respites was pulled from Live & Learn, Inc. "Peer Respites: Action + Evaluation" (website).

[78] Intentional Peer Support. (website). Accessed 18 Sep 2023. See also Mead, Shery; Kuno, Eri; & Knutson, Sarah. (2013). "Intentional Peer Support." *Vertex* (Buenos Aires, Argentina) 24(112): 426-433.

[79] There is a somewhat outdated list at the National Empowerment Center website.

[80] People USA's Rose Houses; Wildflower Alliance; Promise Resource Network. Websites Accessed 18 Sep 2023.

Housing First

"Without adequate housing, mental health 'treatment' is mostly a waste of time and money."[81] The CRPD promotes the right to housing for persons with disabilities including the right to a secure home and community. Housing is an important determinant of mental health and an essential part of recovery. Addressing adequate housing is not only a human right but should also be a public health priority.

The Housing First approach was pioneered in the 1990s by two organizations, Pathways to Housing in New York City (now Pathways Housing First Institute), and by what was then called the Downtown Emergency Service Center in Seattle, Washington (DESC).[82] Its underpinnings were person-centered—asking people on the street "what do you need or how can I help you?" They didn't say counselling. They didn't say medication—they said "a home" and to not have strings attached. There is evidence to support the beneficial effects of the Housing First approach on people's quality of life, including dimensions such as community adjustment and social integration, and some aspects of health.[83] As the research base is growing in favor of this approach, the Housing First model is now expanding across European countries and has even become national policy in Finland. Housing First is money well spent, reducing other costs, likely by multiples.

Employment

Behind housing, employment is perhaps the most important therapeutic element for people diagnosed with serious mental illness. In a 30-year longitudinal research study involving 269 subjects who were discharged from the backwards of public institutions, it was found the strongest link to successful recovery and integration into community roles was involvement in community based rehabilitation, particularly vocational rehabilitation leading to employment.[84]

In "Employment is a Critical Mental Health Intervention," Robert E. Drake and Michael A. Wallach, state, "[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life,

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[81] Mosher, Loren R. (5 Mar 2003). Affidavit of Loren R. Mosher, M.D. *In The Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

[82] See Downtown Emergency Service Center (DESC). "What is Housing First?" (website). Accessed 18 Sep 2023.

[83] National Low Income Housing Coalition; & National Alliance to End Homelessness. (2020). *The Case for Housing First*; Mackelprang, Jessica L.; Collins, Susan E.; & Clifasefi, Seema L. (2014). "Housing First is Associated With Reduced Use of Emergency Medical Services." *Prehospital Emergency Care* 18(4): 476–482.

[84] DeSisto, Michael J., et al. (1995). "The Maine and Vermont Three-Decade Studies of Serious Mental Illness: I. Matched Comparison of Cross-Sectional Outcome." *British Journal of Psychiatry* 167(3): 331–338.

social relationships and community integration, without harmful side effects."[85] Drake and Wallach summarize the data on employment:

> "The great majority of people with serious mental disorders desire employment as a primary treatment goal (Wescott et al., 2015)."
>
> "[P]eople with mental disorders view 'recovery' as a meaningful, active, functional life, not as a complete absence of symptoms (Deegan, 1988). People can learn to tolerate and cope with symptoms if they have a life that they consider valuable."
>
> "They want a safe apartment; a part-time job; and the chance to meet people, have friends, contribute to society and participate in community life that comes with a job and a modest income. They also value the secondary benefits — a positive identity, structure to the day, enhanced self-esteem, friends at work, less interaction with the mental health system and reduced personal and social stigma — gains that do not usually follow hospitalisation, polypharmacy or involuntary treatment."
>
> "[E]mployment is both a critical health intervention and a meaningful outcome for people with serious mental disorders such as schizophrenia, bipolar disorder and depression (Knapp and Wong, 2020). This recognition follows patients' own expressed goals as well as actual work outcomes. People with even the most serious mental disorders report a higher quality of life, greater self-esteem and fewer psychiatric symptoms when they are employed (Luciano et al., 2014)."
>
> "[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life, social relationships and community integration, without harmful side effects (Drake et al., 2013)."
>
> "Supported employment is a relatively inexpensive intervention (Latimer et al., 2004) and employment leads to steady reductions in mental healthcare costs over at least 10 years (Bush et al., 2009)."
>
> "**[H]elping people with employment should be a standard mental health intervention**."

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[85] Drake, Robert E.; & Wallach, Michael A. (2020). "Employment is a Critical Mental Health Intervention." *Epidemiology and Psychiatric Sciences* 29: e178 — citing Drake, Robert E., et al. (2013). "Assisting Social Security Disability Insurance Beneficiaries With Schizophrenia, Bipolar Disorder, or Major Depression in Returning to Work." *American Journal of Psychiatry* 170(12): 1433–1441.

Soteria Houses

Soteria House, whose outstanding outcomes are set forth above, was established in San Jose, California by Loren Mosher, MD, a psychiatrist and schizophrenia expert who was at the time the Chief of Schizophrenia Studies for the National Institute of Mental Health.[86] The original Soteria House was a research project for more than 10 years to answer the question: *Can people newly diagnosed with schizophrenia recover in the community without the conventional treatment of hospitalization and debilitating neuroleptic medications?* The answer was a resounding yes. Soteria is a home-like environment focusing on psychological and physical safety through compassionate relationships between staff and residents. The mantra of Soteria House is "being with, rather than doing to."

A colleague of Dr. Mosher, Luc Ciompi, MD, opened a Soteria House in Berne, Switzerland in 1984 and ran it for decades. In 2004 or thereabouts, Dr. Ciompi and Dr. Mosher published the following Soteria Critical Elements: [87]

SOTERIA CRITICAL ELEMENTS

Luc Ciompi, Loren Mosher

1. **FACILITY:**
   a. Small, community based
   b. Open, voluntary home-like
   c. sleeping no more than 10 persons including two staff (1 man & 1 woman) on duty
   d. preferably 24 – 48 hour shifts to allow prolonged intensive 1:1 contact as needed
2. **SOCIAL ENVIRONMENT:**
   a. respectful, consistent, clear and predictable with the ability to provide asylum, safety, protection, containment, control of stimulation, support and socialization as determined by individual needs
   b. over time it will come to be experienced as a surrogate family
3. **SOCIAL STRUCTURE:**
   a. preservation of personal power to maintain autonomy, diminish the hierarchy, prevent the development of unnecessary dependency and encourage reciprocal relationships
   b. minimal role differentiation (between staff and clients) to encourage flexibility of roles, relationships and responses
   c. daily running of house shared to the extent possible; "usual" activities carried out to maintain attachments to ordinary life – e.g. cooking, cleaning, shopping, art, excursions etc.

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[86] Mosher, Loren R. (1999). "Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review." *The Journal of Nervous and Mental Disease* 187(3): 142–149.

[87] Ciompi, Luc, & Mosher, Loren, R. (ca. 2004). Soteria Critical Elements. Accessed 18 Sep 2023 (psychiatrized.org).

4. **STAFF:**
   a. may be mental health trained professionals, specifically trained and selected non- professionals, former clients, especially those who were treated in the program or a combination of the three types
   b. on the job training via supervision of work with clients, including family interventions, should be available to all staff as needed
5. **RELATIONSHIPS: these are central to the program's work**
   a. facilitated by staff being ideologically uncommitted (i.e. to approach psychosis with an open mind)
   b. convey positive expectations of recovery
   c. validate the psychotic person's subjective experience of psychosis as real by developing an understanding of it by "being with" and "doing with" the clients
   d. no psychiatric jargon is used in interactions with these clients
6. **THERAPY:**
   a. all activities viewed as potentially "therapeutic" but without formal therapy sessions with the exception of work with families of those in residence
   b. in-house problems dealt with immediately by convening those involved in problem solving sessions
7. **MEDICATIONS:**
   a. no or low dose neuroleptic drug use to avoid their acute "dumbing down" effects and their suppression of affective expression, also avoids risk of long term toxicities
   b. benzodiazepines may be used short term to restore the sleep/wake cycles
8. **LENGTH OF STAY:**
   a. sufficient time spent in program for relationships to develop that allow precipitating events to be acknowledged, usually disavowed painful emotions to be experienced and expressed and put into perspective by fitting them into the continuity of a person's life
9. **AFTER CARE:**
   a. post discharge relationships encouraged (with staff and peers) to allow easy return (if necessary) and foster development of peer based problem solving community based social networks
   b. the availability of these networks is critical to long term outcome as they promote community integration of former clients and the program itself

The research demonstrated the typical Soteria resident became stabilized in about six weeks with an average stay of three months. At six weeks, when compared to hospitalized, medicated patients, persons served at Soteria House had similar outcomes. After one and two-year follow-ups the patients treated at Soteria House were doing significantly better than conventionally treated patients in terms of symptoms, rehospitalization, social functioning and employment, thus averting a trajectory of chronic mental illness.[88]

[88] Bola, John R.; & Mosher, Loren R. (2003). "Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes From the Soteria Project." *Journal of Nervous and Mental Disease* 191(4): 219–229.

With respect to cost:

> In the first cohort, despite the large differences in lengths of stay during the initial admissions (about 1 month versus 5 months), the cost of the first 6 months of care for both groups was approximately $4000. Costs were similar despite 5-month Soteria and 1-month hospital initial lengths of stay because of Soteria's low per diem cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients.[89]

The original Soteria House closed after its study funding ended. Its extremely good results challenged bio-psychiatry and was largely buried by the psychiatric establishment until Robert Whitaker wrote about it in his influential 2002 book, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*.[90] Since then the approach has seen increased interest, directly leading to the establishment of Soteria Houses in Alaska, Vermont and Israel.

The Burlington, Vermont Soteria House is funded by the state of Vermont and operated by Pathways Vermont.[91] In Israel, there are several Soteria Houses and other similar programs incorporated into the mental health system to the point where they are not considered alternatives, but part of Israel's mainstream mental health system.[92]

Despite its success, Soteria-Alaska closed due to a change in leadership and direction by the organization operating it, impacted by several factors including, but not limited to the fatigue of securing sufficient funding in the face of chronic inadequate governmental financial support. This is a cautionary tale — sustainability is impacted, not just by funding but by commitment and fidelity to a vision and historical purpose.[93]

Similarly, Soteria Berne operated successfully for decades by Dr. Ciompi under the Soteria Critical Elements principles they developed. However, since Dr. Ciompi retired, Soteria Berne has drifted away from these elements. This demonstrates the danger of backsliding when the visionary founder leaves. This was also a key factor in Soteria-Alaska's closure. It is thus extremely important to develop a critical mass of people who understand and support Soteria principles. There are also other programs that claim to be Soteria programs even though they do not comply with the Soteria Critical Elements and may even be involved in psychiatric incarceration and forced drugging.

As demonstrated above, it is critically important to prevent people from being put on neuroleptics and Soteria Houses should be the first option for people who experience a first episode of psychosis who would otherwise be psychiatrically hospitalized and drugged

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[89] Mosher, Loren R. (1999). "Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review." *Journal of Nervous and Mental Disease* 187(3): 142–149.

[90] Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books.

[91] Pathways Vermont Soteria House. Accessed 18 Sep 2023.

[92] Friedlander, Avraham; Tzur Bitan, Dana; & Lichtenberg, Pesach. (2022). "The Soteria Model: Implementing an Alternative to Acute Psychiatric Hospitalization in Israel." *Psychosis* 14(2): 99–108.

[93] Gottstein, Jim. (29 Jun 2015). "Lessons From Soteria-Alaska." *Mad in America*.

under the current system. They have been proven to be successful with people already drugged, but their best use is to help people from being put on the neuroleptics in the first place.

Drug Free Hospitals

Psychiatric inpatients should be given the option of no drugs. In 2010, at the urging of patient organizations, the Norwegian parliament mandated patients be allowed to choose a drug-free psychiatric hospital. As a result, the private Hurdalsjøen Recovery Center was opened and operated with extreme success.[94] Unfortunately, more recently the Norwegian government decided not to continue financially supporting private hospitals, forcing its closure.[95] Drug free hospitals should be made generally available for inpatients who choose not to take the drugs.

Open Dialogue

The Open Dialogue approach, as set forth above, can also achieve remarkable results in the 80% recovery range.[96] There are Seven Principles of the Open Dialogue Approach:

1. Immediate help
2. Social network perspective
3. Flexibility and mobility
4. Responsibility
5. Psychological continuity
6. Tolerance of uncertainty
7. Dialogue (& polyphony).[97]

As stated on the Developing Open Dialogue website:

> The principles and values of Open Dialogue are simple. People are met in crisis within 24 hours of contact and daily until the crisis is resolved. Hospitalisation is avoided and its consequential stigma, preferring to meet in the homes of those seeking their services. They avoid the use of anti-psychotic medication wherever possible. All those who have something to say are invited including the networks of the person and mental health services. The latter are integrated into a comprehensive service and the same

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[94] Whitaker, Robert. (8 Dec 2019). "Medication-Free Treatment in Norway: A Private Hospital Takes Center Stage." *Mad in America*.

[95] Whitaker, Robert. (11 Jan 2023). "A Revolution Wobbles: Will Norway's 'Medication-Free' Hospital Survive? Politics, Mainstream Psychiatry May Shutter Lake Hurdal Recovery Center." *Mad in America*.

[96] Seikkula, Jaakko, et al. (2006). "Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies." *Psychotherapy Research* 16(2): 214–228.

[97] Olson, Mary; Seikkula, Jaakko; & Ziedonis, Douglas. (2014). "The Key Elements of Dialogic Practice in Open Dialogue." Worcester, MA: University of Massachusetts Medical School.

> Open Dialogue team work with the client and their social network throughout the life of the problem. In addition people are offered other therapies as required e.g. employment support, individual therapy, occupational therapy etc.[98]

Open Dialogue, or the dialogic approach as it is sometimes called, with variations, is being deployed as an alternative to the traditional psychiatric drug and coercion system around the world.[99] It needs to become part of the mainstream system as it has in Lappland, where it reduced schizophrenia diagnoses by 90% because they were getting people through what they were going through and their lives back on track before the six months of symptoms required for a schizophrenia diagnosis to properly be made.[100] This was possible because the Open Dialogue Approach was the first and preferred treatment.

Hearing Voices Network

Hearing Voices Groups bring together people who hear voices, in peer-supported group meetings that seek to help those with similar experiences explore the nature of their voices, meanings and ultimately, acceptance. Hearing Voices Groups have grown in popularity in no small part because suppressing voices using medication and other interventions are often ineffective or worse. Hearing Voices groups ask not what is wrong with you, but what happened to you? The *WHO Guidance* endorses the Hearing Voices Network.[101]

The Hearing Voices Movement began in the Netherlands in the late 1980s. It now has national networks in 30 countries. Some groups are co-founded by professionals and closely aligned with mental health services while others are initiated independently by voice hearers. Due to the independent nature of these groups, it is challenging to research outcomes. In spite of limited research, some reported outcomes include: decrease in hospital admissions, voice frequency and use of medication, increase in support that is often otherwise unavailable and better understanding of voice experiences.[102] Most importantly, the participants value Hearing Voices groups and they should be encouraged and supported.

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[98] Developing Open Dialogue. "Open Dialogue Finland" (web page). Accessed 18 Sep 2023.

[99] Mosse, David, et al. (2023). "Introduction: Open Dialogue Around the World – Implementation, Outcomes, Experiences and Perspectives." *Frontiers in Psychology* 13.

[100] Seikkula, Jaakko, et al. (2006). "Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies." *Psychotherapy Research* 16(2): 214–228.

[101] World Health Organization. (9 Jun 2021). *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*. Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization. See also the Hearing Voices Network website.

[102] Branitsky, Alison. (2017). "Commentary: Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups." *Frontiers in Psychology* 8; Beavan, Vanessa; de Jager, Adele; & dos Santos, Bianca. (2017). "Do Peer-Support Groups for Voice-Hearers Work? A Small Scale Study of Hearing Voices Network Support Groups in Australia." *Psychosis* 9(1): 57–66.

Minimal costs are involved, usually only rent for a weekly meeting space and a possible fee for the facilitator, if even that. **The very low cost Hearing Voices Network approach should be encouraged and facilitated**.

Warmlines

Warmlines are different than crisis/suicide lines, also called "hot lines," which often betray callers by having the police dispatched to haul them off to the psychiatric hospital in handcuffs even though they advertise themselves as confidential and/or anonymous.[103] This betrayal went national with the rollout of the 988 line in the United States, which is often linked with mental health crisis response programs, such as Crisis Now.[104] The rationale for the betrayal is they only call for the apprehension of people who are at risk of suicide so they can be incarcerated safely in a psychiatric ward. Not only does this make people unwilling to call the hotline, but as set forth above, increases suicides.

A fundamental principle of warmlines is to only do what the person wants. If they want to go to the hospital—fine. If they don't, that is respected. Confidentiality is never breached. In order to achieve this, people staffing warmlines cannot be mandatory reporters. The purpose of a warmline is connection to combat isolation, support through distress, troubleshoot life challenges, and provide information on resources if desired by the caller. They focus on crisis prevention and diversion from hospitals, 911, and mobile crisis.

"Standalone peer-run warm lines are garnering national attention as a part of states' responses since they are cost effective, highly utilized and are the most accessible way for people, regardless of age, gender, sexual orientation, race, ethnicity, geography, insurance/no insurance and financial circumstances to get support and prevent emergency department, 911 and involuntary hospital stays."[105] Forty states have warmlines. [106]

Emotional CPR (eCPR)

Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis[107] by three simple steps:

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[103] Chapter 10 of the comprehensive and authoritative book on forced psychiatric interventions, *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships* (2023) by investigative reporter Rob Wipond, documents the tracing of promised confidential and/or anonymous calls and dispatching of police to take people into custody.

[104] National Association of State Mental Health Program Directors (NASMHP). "Crisis Now: Transforming Crisis Services" (website). Accessed 18 Sep 2023.

[105] From a presentation by Cherene Caraco, Warm Lines, part of her series of webinars on Peer Run Crisis Alternatives, presented by the Café TA Center, Tallahassee, FL.

[106] warmline.org maintains a directory of known warmlines in the U.S.

[107] The terrific book *Heartbeats of Hope: the Empowerment Way to Recover Your Life* (2018) by psychiatric survivor and psychiatrist Daniel Fisher includes a description eCPR and its development.

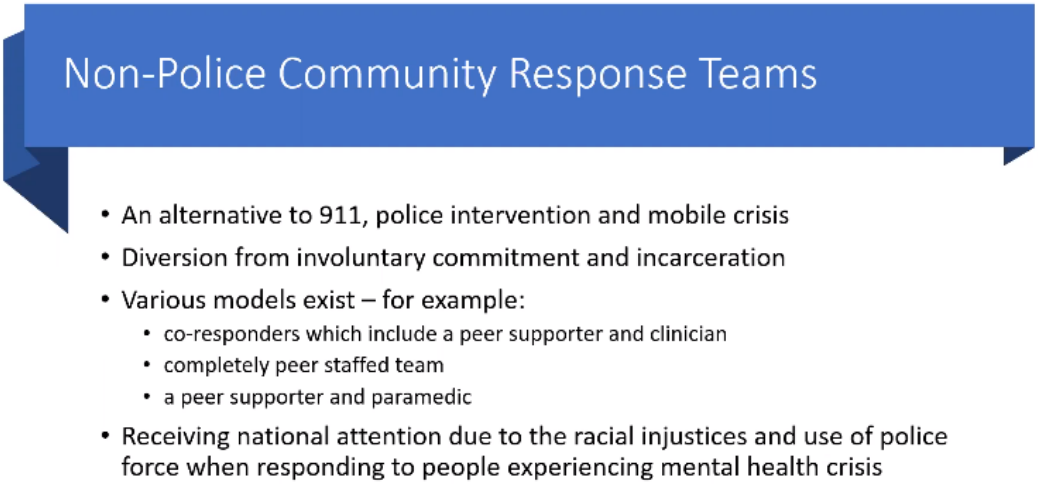
C = Connecting
P = emPowering, and
R = Revitalizing

The Connecting process of eCPR involves deepening listening skills, practicing presence, and creating a sense of safety for the person experiencing a crisis. The emPowering process helps people better understand how to feel empowered themselves as well as to assist others to feel more hopeful and engaged in life. In the Revitalizing process, people re-engage in relationships with their loved ones or their support system, and they resume or begin routines that support health and wellness which reinforces the person's sense of mastery and accomplishment, further energizing the healing process. eCPR is based on the principles found to be shared by a number of support approaches: trauma-informed, counseling after disasters, peer support to avoid continuing emotional despair, emotional intelligence, suicide prevention, and cultural attunement. It was developed with input from a diverse cadre of recognized leaders from across the U.S., who themselves have learned how to recover and grow from emotional crises. **eCPR Training should be made widely available**.

eCPR is to be contrasted with Mental Health First Aid, which funnels people into the traditional mental health system with its message of hopelessness and psychiatric drugging.

Non-Police Community Response Teams

It is being recognized more and more that the police should not be involved in responding to what are termed mental health crises. So many of these police encounters end in tragedy in the United States with the police shooting and killing people for whom they were asked to check on. Mobile Crisis Teams are meant to address the problem of police being first responders, but they are set up to psychiatrically incarcerate people which, as set forth above, is counterproductive and cause people to avoid contact with the system no matter what problems they may be having. Instead, non-coercive non-police community response teams should be utilized.



Open Dialogue teams could be viewed as community response teams that continue the engagement with the person and the person's close community. They are often used in situations where mobile crisis teams would be deployed, but with the outstanding outcomes set forth above.

Psychotherapy

Psychotherapy is often overlooked, or even dismissed, as an effective approach for people diagnosed with serious mental illness, but much of what works in the approaches discussed above could be considered psychotherapy in a broad sense, and good psychotherapy is provided in a way that is consistent with these voluntary, relationship-based approaches. As set forth above, Dr. Mosher testified as a qualified expert witness in the *Myers* case, that "in the field of psychiatry, it is the therapeutic relationship which is the single most important thing."[109]

Many patients desire psychotherapy and it has been shown to be very effective.[110] The 1966–1971 Michigan Psychotherapy Project found that psychotherapy was significantly more effective than neuroleptic treatment for people diagnosed with schizophrenia.[111]

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[108] "Peer Run Crisis Alternatives: Community Response Teams" (video) by Cherene Caraco, 16 Jun 2021, from the CAFE TAC Peer-Run Crisis Alternatives Webinar Series. These are really worth watching.

[109] *In the Matter of F.M.* Transcript of proceedings (March 5 and March 10, 2003), p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI; See also Duncan, Barry L. (2015). "The Person of the Therapist: One Therapist's Journey to Relationship." In Kirk J. Schneider, J. Fraser Pierson, & James F. T. Bugental (eds.), *The Handbook of Humanistic Psychology: Theory, Research, and Practice*, 2nd ed., pp. 457–472. Thousand Oaks, CA: Sage Publications.

[110] Gøtzsche, Peter C. (22 Dec 2022). "Psychotherapy: Less Expensive and Better Than Pills, it's What the Patients Want But Don't Get." *Mad in America*; Irwin, Matt. (Jan 2004). "Treatment of Schizophrenia Without Neuroleptics: Psychosocial Interventions Versus Neuroleptic Treatment." *Ethical Human Sciences and Services* 6(2): 99–110.

[111] Karon, Bertram P.; & VandenBos, Gary R. (1972). "The Consequences of Psychotherapy for Schizophrenic Patients." Psychotherapy: Theory, Research & Practice 9(2): 111-119; Karon, Bertram P.; & VandenBos, Gary R. (1981). *Psychotherapy of Schizophrenia: The Treatment of Choice*. New York: Roman &

Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms psychiatric drugs.[112]

Other Person-Centered and Rights-Based Approaches

In addition to the programs described above endorsed by the WHO Guidelines, a number of other effective, humane, person-centered and rights-based programs are identified.[113] Similarly, the Compendium Report: Good Practices In The Council Of Europe To Promote Voluntary Measures In Mental Health (Good Practices Compendium), was published to assist member States by developing a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on examples in Council of Europe countries.[114]

One of programs described in the WHO Guidelines is the Friendship Bench program in Zimbabwe:

> The name Friendship Bench derives from the shona term, chigaro chekupanamazano, which translates literally as, "bench to sit on to exchange ideas". It provides a short-term form of problem-solving therapy to people with common mental health conditions, known in shona as kufungisisa, which translates literally as "thinking too much." The free service is linked to the local primary health care centre and is usually delivered outside the centre on a wooden bench. People can self-refer or be referred by schools, police stations or the primary care clinic.

This seems somewhat similar to the tōjisha-kenkyū program in Japan, which roughly translates as "the science of the self" or "self-supported research", where people with disabilities and/or mental illness learn to study their own experiences.[115]

Both of these are examples of a community developing solutions that work for them. There should be room in the mental health system to support approaches the people themselves develop and want to implement. When a community comes up with a solution

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Littlefield; Morrison, Anthony P, et al. (2014). "Cognitive Therapy for People With Schizophrenia Spectrum Disorders Not Taking Antipsychotic Drugs: A Single-Blind Randomised Controlled Trial." *The Lancet* 383(9926): 1395–1403.

[112] Cuijpers, Pim, et al. (2013). "Does Cognitive Behaviour Therapy Have an Enduring Effect That is Superior to Keeping Patients on Continuation Pharmacotherapy? A Meta-Analysis." *BMJ Open* 3(4): e002542; Shedler, Jonathan. (2010). "The Efficacy of Psychodynamic Psychotherapy." *American Psychologist* 65(2): 98-109; Bighelli, Irene, et al. (2021). "Psychosocial and Psychological Interventions for Relapse Prevention in Schizophrenia: A Systematic Review and Network Meta-Analysis." *The Lancet Psychiatry* 8(11): 969–980.

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they want to pursue, there is "buy-in" which succeeds because the community makes it succeed. Such programs are not necessarily susceptible to being replicated because the buy-in is such a critical component. This does not diminish its effectiveness for that community.

An example is **Ionia** in Alaska.[116] Five refugee couples from the psychiatric system on the East Coast settled in Kasilof after trying out a number of other locales. They pooled their individually meager assets to purchase land. Starting out in yurts the first winter, they then built cabins with wood stoves. They have a macrobiotic diet, growing as much of their own food as they can, and gathering other food such as seaweed. They have a community meeting every day to work out conflicts and they consider their simple but hard, close to the earth work to be therapy. These couples, at least one of which in each was written off as hopelessly mentally ill, have created a life that works for them. A whole generation of their children grew up there and there is a blossoming third generation. The point is not that Ionia is a model program that should be replicated, but an example of people finding their own solutions.

One of the programs identified by the Good Practices Compendium is **TANDEMplus** in Belgium, a mobile crisis service involving interdisciplinary teams that support people during and shortly after a mental health crisis. The crisis teams help a person to (re)activate her/his local support network, including connecting to both formal and informal sources of support. Emphasis is placed on the person defining the kind of support she/he would like to receive.

Another program identified by the Good Practices Compendium is "**Citizen Psychiatry**," in the French City of Lille. "Over the past three decades, the city of Lille has progressively developed a program of 'citizen psychiatry' in which mental health services' aim to avoid resorting to traditional hospitalisation, and instead 'integrate the entire health system' into the city, via a network involving all interested partners: service users, carers, families and elected representatives. Within this broad approach to mental health services, there are several specific practices detailed in the report."

Another is the **Trieste, Italy model** "described as an 'open door—no restraint' initiative which aims to 'de-hospitalise' responses to mental health across the city of Trieste. The core of the program involves a network of 'Community Mental Health Centres' with relatively few beds, one general hospital psychiatric unit, a network of supported housing facilities, and several social enterprises/cooperative businesses."

Healing Homes operated by the Family Care Foundation in Gothenburg, Sweden,[117] backed by over twenty years of experience, places people who have been failed by traditional psychiatry with host families — predominately farm families in the Swedish

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countryside — as a start for a whole new life journey without psychiatric drugs. Host families are chosen not for any psychiatric expertise, but for their compassion, stability, and desire to give back. People live with these families for upwards of a year or two and become an integral part of a functioning family system.

Staff members offer clients intensive psychotherapy and provide host families with intensive supervision. The Family Care Foundation eschews the use of diagnosis, works within a framework of striving to help people come safely off psychiatric drugs, and provides their services, which operate within the context of the Swedish national health service, for free. There is a movie, *Healing Homes*, by Daniel Mackler, now a free download, about this program that has been translated into 20 languages and viewed over 66,000 times.[118] Like Soteria Houses and Peer Respites, Healing Homes provide a home or home-like environment with the expectation people can get through their experiences and come out the other side able to have meaning, purpose and connection in their lives.

Healing Homes is similar to the more well-known city of Geel in Belgium, which has a centuries-long tradition of taking people into their homes and making them part of their families.

Warfighter Advance is another example of a community fashioning a solution.[119] In this case, the community are people who have been deployed to wars overseas and come home with psychiatric diagnoses, put on psychiatric drugs and told there is something wrong with their brain and they essentially have no future. Warfighter Advance changes the trajectory of the warfighter's post-deployment life, so that rather than an existence characterized by an endless cycle of mental illness diagnoses, drugs, medical appointments and disappointments, the warfighter has a life characterized by pride, productivity, healthy relationships, continued service, and advocacy for the same outcomes for their fellow service members. Warfighter Advance eschews psychiatric drugs and force, instead encouraging informed consent. It has outstanding results in helping traumatized veterans live fulfilling lives. This program and two of its participants are featured in the award winning documentary film, *Medicating Normal*.[120]

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V. ACKNOWLEDGMENTS

The authors give great thanks to Melissa S. Green for editing and formatting assistance and to Susan Musante, LPCC, for her input. Melissa was the publication specialist at the University of Alaska Anchorage's Justice Center for 29 years. Among many other things, Susan was the founding director of Soteria-Alaska and thus has personal experience successfully implementing the types of programs recommended in this Report.

VI. AUTHORS

James B. (Jim) Gottstein, Esq.

James B. (Jim) Gottstein, Esq., author of *The Zyprexa Papers* (2021) is an Alaskan lawyer who in 1982, at the age twenty-nine, experienced a manic episode as a result of sleep deprivation and was held at the Alaska Psychiatric Institute (API) for 30 days. He was told he would never practice law again and the best he could hope for was to minimize his hospitalizations by taking one or more neuroleptics for the rest of his life. Instead, with one other brief hospitalization in 1985, Mr. Gottstein learned how to manage his life to avoid getting into trouble again.

Mr. Gottstein was one of the plaintiffs' lawyers in the Alaska Mental Health Trust Lands Litigation over the State of Alaska's illegal 1978 redesignation (theft) of Alaska Mental Health Trust Lands as General Grant Land, resulting in a 1994 settlement, reconstituting the trust and creating the Alaska Mental Health Trust Authority. From 1998 to 2004, Mr. Gottstein was a member of the Alaska Mental Health Board, the state agency charged with planning and coordinating mental health services in the State of Alaska.

In 2002, Mr. Gottstein founded the Law Project for Psychiatric Rights (PsychRights) to mount a strategic litigation campaign against forced psychiatric drugging and electroshock, winning five Alaska Supreme Court Cases, three on constitutional grounds, and one in the Seventh United States Circuit Court of Appeals.

- *Myers v. Alaska Psychiatric Institute*, 138 P3d. 238 (Alaska 2006)
- *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371 (Alaska 2007)
- *Wayne B. v. Alaska Psychiatric Institute*, 192 P.3d 989 (Alaska 2008)
- *Bigley v. Alaska Psychiatric Institute*, 208 P.3d 168 (Alaska 2009)
- *In the Matter of Heather R.*, 366 P.3d 530 (Alaska 2016)
- *United States v. King-Vassel*, 728 F.3d 707 (7th Cir. 2013)

PsychRights' Mission also includes informing the public about the counterproductive and harmful nature of the drugs and electroshock.

In addition, Mr. Gottstein co-founded a number of organizations to help psychiatric patients, all but one of which were peer-run:

- Mental Health Consumers of Alaska
- Alaska Mental Health Consumer Web
- Peer Properties
- CHOICES, Inc.
- Soteria-Alaska

See *Multifaceted Grassroots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program* (2012).

Peter C. Gøtzsche, MD

Peter C. Gøtzsche is a specialist in internal medicine but has a special interest in psychiatry; has published numerous scientific articles and several books about psychiatric drugs and the harms of forced treatment; and has had five PhD students who worked with psychiatric drugs.

Gøtzsche is an internationally recognized expert in research methodology, which resulted in a professorship at the University of Copenhagen in Clinical Research Design and Analysis in 2010. Co-founded the Cochrane Collaboration and established the Nordic Cochrane Centre in 1993. Co-founded Council for Evidence-based Psychiatry in the UK in 2014 and International Institute for Psychiatric Drug Withdrawal in Sweden in 2016. Founded the Institute for Scientific Freedom in 2019.

Gøtzsche's greatest contribution to public health was when he, in 2010, opened the archives of clinical study reports in the European Medicines Agency (EMA) after a 3-year long battle that involved a complaint to the European Ombudsman. EMA was solely concerned with protecting the drug industry's interests while ignoring those of the patients. The Ombudsman ruled there was no commercially confidential information in the study reports.

Gøtzsche has published over 100 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and his scientific works have been cited over 190,000 times (his H-index is 91 according to Web of Science, June 2022, which means that 91 papers have been cited at least 91 times). Gøtzsche is the author of several books. The ones most relevant for psychiatry are:

- *Critical psychiatry textbook* (2022) (freely available)
- *Mental health survival kit and withdrawal from psychiatric drugs: A user's guide* (2022, exists in 8 languages).
- *Deadly psychiatry and organised denial* (2015, in 9 languages).
- *Deadly medicines and organised crime: How big pharma has corrupted health care* (2013, in 16 languages). Winner, British Medical Association's Annual Book Award, Basis of Medicine in 2014.

Gøtzsche has given numerous interviews, one of which — about organised crime in the drug industry — has been seen by half a million on YouTube. Gøtzsche was in The Daily Show in New York on 16 Sept 2014 where he played the role of Deep Throat revealing secrets about big pharma. A documentary film about Peter's reform work, *Diagnosing Psychiatry*, appeared in 2017, and another one is in the making, *The honest professor and the fall of the Cochrane empire*.

Peter has an interest in statistics and research methodology. He has co-authored guidelines for good reporting: CONSORT for randomised trials, STROBE for observational studies, PRISMA for systematic reviews and meta-analyses, and SPIRIT for trial protocols. Peter was an editor in the Cochrane Methodology Review Group 1997–2014.

David Cohen, PhD

David Cohen is a Professor and Associate Dean for Research and Faculty Development at UCLA's Luskin School of Public Affairs. He looks at psychoactive drugs (prescribed, licit, and illicit) and their desirable and undesirable effects as socio-cultural phenomena "constructed" through language, policy, attitudes, and social interactions. He also documents treatment-induced harms (iatrogenesis), and pursues international comparative research on mental health trends, especially involving alternatives to coercion. Public and private institutions in the U.S., Canada, and France have funded him to conduct clinical-neuropsychological studies, qualitative investigations, and epidemiological surveys of patients, professionals, and the general population.

In his clinical work for over two decades, Cohen has developed person-centered methods to withdraw from psychiatric drugs and given workshops on this topic around the world. He designed and launched the CriticalThinkRx web-based Critical Curriculum on Psychotropic Medications for child welfare professionals in 2009, since taken by thousands of practitioners and updated in 2018. Tested in a 16-month longitudinal controlled study, CriticalThinkRx was shown to reduce psychiatric prescribing to children in foster care.

He has authored or co-authored over 120 articles and book chapters. His edited books include *Challenging the Therapeutic State* (1990), *Médicalisation et contrôle social* (1996), and *Critical New Perspectives on ADHD* (2006). His co-authored books include *Guide critique des médicaments de l'âme* (1995), *Your Drug May Be Your Problem* (1999/2007), and *Mad Science* (2013).

Dr. Cohen previously taught at Université de Montréal and Florida International University. In Montreal, he directed the Health & Prevention Social Research Group, and at Florida International University where he was PhD Program Director and Interim Director of the School of Social Work. He held the Fulbright-Tocqueville Chair to France in 2012.

Chuck Ruby, PhD

Chuck Ruby, author of Smoke and Mirrors: How You Are Being Fooled About Mental Illness - An Insider's Warning to Consumers, is a licensed psychologist in private practice in southern Maryland. He is the Executive Director of the International Society for Ethical Psychology and Psychiatry (ISEPP), a non-profit research and public education organization that rejects the traditional medical notion of "mental illness" and calls for humane ways of helping people who suffer from significant life distress. Dr. Ruby was trained in clinical psychology at the Florida State University, earning his Ph.D. in 1995. He is also a retired U.S. Air Force Lieutenant Colonel who served in counterespionage, counterintelligence, and criminal investigative assignments across the globe.

Faith J. Myers

Faith J. Myers is the author of the book *Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients* (2020). For approximately 5 years, from 1999 to 2003, Faith was in and out of acute care psychiatric facilities or units and at times, homeless. She is the Myers in *Myers v. Alaska Psychiatric Institute*, declaring Alaska's forced drugging regime unconstitutional.

On seven occasions, Faith ended up in a psychiatric facility, four times in a psychiatric evaluation unit and six times she was escorted to those facilities by the police in handcuffs. She was in crisis treatment centers three times. Faith stated, "It was the indifference of my treatment and mistreatment that led me to become a mental health psychiatric patient rights activist."

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Yolo BHSA Documentation of Public Hearing and Public Notices

COUNTY OF YOLO

Local Behavioral Health Board

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Behavioral Health Board Meeting and Public Hearing

Date: Wednesday, May 6, 2026, 6:00 PM–8:00 PM

Location: 25 N Cottonwood Street, Woodland CA

Hybrid Option through ZOOM:
https://yolocounty.zoom.us/j/88418721448

(Public meetings are recorded and posted for public access)

All items on this agenda may be considered for action.

LMHB CALL TO ORDER----------6:00 PM – 6:30 PM

1. PUBLIC COMMENT: Members of the public are welcome to speak, either in person or over Zoom. Speakers are not required to identify themselves. In compliance with the Brown Act, no action or discussion will be undertaken on any item raised during the public comment period. Board members may ask for clarification, refer concerns to staff, and/or request that an item be placed on a future agenda. There will be multiple opportunities for public comment throughout this meeting.
2. Approval of Agenda
3. Approval of minutes from April 1, 2026
4. Chair Report
   - Adapt board recess date (July/August)
   - Letter to BOS-Mobile Crisis
5. Member Announcements
6. Correspondence-
7. Board of Supervisors Report: Oscar Villegas & Lucas Frerichs or Representative

PUBLIC HEARING CALL TO ORDER ----------6:30 PM – 7:15PM

8. Yolo draft BHSA Integrated Plan for FY 2026-2029
   - Board Comment
   - Public Comment

   **PUBLIC HEARING ADJOURNED*

TIME SET AGENDA ----------7:15 PM – 7:30PM

9. Housing Recommendation-Petrea Marchand, Consero Solutions President
   - Letter to BOS Housing Recommendation

- Letter to BOS PMM

REGULAR AGENDA----------7:30 PM – 7:55 PM

10. PUBLIC COMMENT
11. Behavioral Health Director's Report: Tony Kildare
12. Ad Hoc Committee Reports
    - 2026 Site Visit Planning Ad Hoc Committee: Melanie Klinkamon, Chair
      Safe Harbor-Melanie Klinkamon
      Jail-Chris Bulkeley, Chair
      Pine Tree Gardens-Melanie Kilnkamon, Chair
    - 2026 Communications and Education Ad Hoc: Dee Olivarez, Chair
    - Care Court-Dee Olivarez, Chair

PLANNING AND ADJOURNMENT ---------- 7:55PM – 8:00 PM

13. PUBLIC COMMENT
14. Future Meeting Planning and Adjournment

Next Meeting Date and Location

June

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, May 1, 2026. Christina Grandison Local Behavioral Health Board Administrative Support Liaison Yolo County Health and Human Services

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

COUNTY OF YOLO

Health and Human Services Agency

BEHAVIORAL HEALTH SERVICES ACT(BHSA):
NOTICE OF 30-DAY PUBLIC COMMENT PERIOD and NOTICE OF PUBLIC HEARING

BHSA INTEGRATED PLAN FY 2026-2029

To all interested stakeholders, Yolo County Health and Human Services Agency (HHSA), in accordance with the Behavioral Health Services Act (BHSA), is publishing this **Notice of 30-Day Public Comment Period and Notice of Public Hearing** regarding the above-entitled document.

I. **THE PUBLIC REVIEW AND COMMENT PERIOD begins Wednesday April 1, 2026 and ends at 5:00 p.m. on Thursday April 30, 2026.** Interested persons may provide comments during this timeline either online https://forms.office.com/g/Y8VttiAt34 or by mail. Written comments should be addressed to HHSA, Attn: BHSA Coordinator, 25 N. Cottonwood Street, Courier #16CH, Woodland, CA 95695. Please use the Public comment form provided for the BHSA Integrated Plan FY 2026-2029.

II. **BHSA COMMUNITY MEETINGS**-Join us to discuss and learn more about the BHSA Draft Plan:

- **Thursday April 16th, 2026 (5:30pm-7:00pm)-Virtual**
  Zoom Link: https://yolocounty.zoom.us/j/86974865232

- **Wednesday April 22nd, 2026 (1:30pm-3:00pm)-Hybrid (In-Person & Virtual Option)**
  Address: HHSA (Gonzales Building-Community Room)
  25 North Cottonwood Street, Woodland, CA 95695
  Zoom Link: https://yolocounty.zoom.us/j/81153459049

III. **A PUBLIC HEARING will be held by the Yolo County Local Behavioral Health Board on Wednesday, May 6, 2026, at 6:00 PM.** Information will be published in advance of the meeting and listed on the Local Behavioral Health Board event listing www.yolocounty.gov/lmhb.

IV. **To review the BHSA Draft Plan for FY 2026-2029**, or other MHSA documents via Internet, follow this link to the Yolo County website: http://www.yolocounty.gov/bhsa.

Scan QR code to view posted plan and survey on the BHSA website

www.yolocounty.gov/bhsa

V. **Printed copies** of the BHSA Plan Draft for FY 2026-2029, are available. To obtain copies by mail, or to request an accommodation or translation of the document into other languages or formats, call HHSA's BHSA Office at (530) 666-8536 or email bhsa@yolocounty.gov by Friday April 17, 2026.

CONDADO DE YOLO

Agencia de Salud y Servicios Humanos

LEY DE SERVICIOS DE SALUD CONDUCTUAL (BHSA):
AVISO DE PERÍODO DE COMENTARIOS PÚBLICOS DE 30 DÍAS
Y AVISO DE AUDIENCIA PÚBLICA
PLAN INTEGRADO BHSA AÑO FISCAL 2026-2029

A todas las partes interesadas: La Agencia de Salud y Servicios Humanos del Condado de Yolo (HHSA), de conformidad con la Ley de Servicios de Salud Conductual (BHSA), publica este **Aviso de Período de Comentarios Públicos de 30 días y Aviso de Audiencia Pública** con respecto al documento mencionado anteriormente.

I. PERÍODO DE REVISIÓN Y COMENTARIOS PÚBLICOS
Comienza el miércoles 1 de abril de 2026 y finaliza a las 5:00 p.m. el jueves 30 de abril de 2026. Las personas interesadas pueden enviar comentarios durante este período en línea en https://forms.office.com/g/Y8VttiAt34 o por correo. Los comentarios escritos deben enviarse a: HHSA, Attn: BHSA Coordinator, 25 N. Cottonwood Street, Courier #16CH, Woodland, CA 95695. Utilice el formulario de comentarios públicos proporcionado para el Plan Integrado BHSA FY 2026-2029.

II. REUNIONES COMUNITARIAS DE BHSA – Únase para discutir y aprender más sobre el borrador del plan BHSA:

• **Jueves 16 de abril de 2026 (5:30pm–7:00pm) – Virtual**
Enlace Zoom: https://yolocounty.zoom.us/j/86974865232

• **Miércoles 22 de abril de 2026 (1:30pm–3:00pm) – Híbrido (En Persona y Virtual)**
Dirección: HHSA (Edificio Gonzales – Sala Comunitaria), 25 North Cottonwood Street, Woodland, CA 95695
Enlace Zoom: https://yolocounty.zoom.us/j/81153459049

III. AUDIENCIA PÚBLICA
Se llevará a cabo por la Junta Local de Salud Conductual del Condado de Yolo el miércoles 6 de mayo de 2026 a las 6:00 PM. La información se publicará con anticipación y estará disponible en: www.yolocounty.gov/lmhb

IV. REVISIÓN DEL PLAN
Para revisar el borrador del Plan BHSA FY 2026-2029 u otros documentos MHSA en línea, visite: http://www.yolocounty.gov/bhsa

Escanee el código QR para ver el plan publicado y la encuesta en el sitio web de BHSA:

www.yolocounty.gov/bhsa

V. COPIAS IMPRESAS
Hay copias impresas disponibles del borrador del Plan BHSA FY 2026-2029. Para solicitar copias por correo, adaptaciones o traducciones a otros idiomas o formatos, llame a la Oficina BHSA de HHSA al (530) 666-8536 o envíe un correo electrónico a bhsa@yolocounty.gov antes del viernes 17 de abril de 2026.

THE DAVIS enterprise

PROOF OF PUBLICATION
(2015.5 C.C.P.)

Proof of Publication

Notice is hereby given: the 30-Day Public Review and Comment Period pertaining to the Draft Behavioral Health Services Act (BHSA) Integrated Plan FY 2026-2029 began Wednesday April 1, 2026; the draft plan, electronic comment survey link, and public notices are posted on the BHSA page of the Yolo County Website at www.yolocounty.gov/bhsa. The Draft Plan is available for public comment and review until 5:00 PM on Thursday April 30, 2026; all interested stakeholders are encouraged to submit comments. A public hearing will be held by the Yolo County Local Behavioral Health Board on Wednesday, May 6, 2026, at 6:00 PM. Information will be published in advance of the meeting and listed on the Local Behavioral Health Board event listing at www.yolocounty.gov/lmhb. After final revisions, the BHSA Plan will be presented to the Yolo County Board of Supervisors by June 30, 2026. Questions? Email BHSA@yolocounty.gov
4/12, 4/15/26 #88711

STATE OF CALIFORNIA
County of Yolo

I am a citizen of the United States and a resident of the County aforesaid; I'm over the age of eighteen years, and not a party to or interested in the above-entitled matter. I am principal clerk of the printer at the Davis Enterprise, 315 G Street, a newspaper of general circulation, printed and published Sunday, and Wednesday, in the City of Davis, County of Yolo, and which newspaper has been adjudged a newspaper of general circulation by the Superior Court to the County of Yolo, State of California, under the date of July 14, 1952, Case Number 12680; that the notice, of which the annexed is a printed copy (set in type no smaller than non-pareil), has been published in each regular and entire issue of said newspaper and not in any supplement thereof on the following dates, to-wit:

4/12, 4/15, **2026**

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Dated at Davis, California, this 15 **day** of April, **2026**

M. Gracie Solano

M. Gracie Solano
Legal Advertising Clerk

Woodland Daily Democrat
c/o Legals 57 Commerce Place, Suite A
Vacaville, CA 95687
530-406-6223
legals@dailydemocrat.com

3827661

YOLO COUNTY HEALTH & HUMAN SERVICES AGENCY (HHSA)
137 N COTTONWOOD ST.
WOODLAND, CA 95695

PROOF OF PUBLICATION
(2015.5 C.C.P.)

STATE OF CALIFORNIA
COUNTY OF YOLO

I am a citizen of the United States. I am over the age of eighteen years and not a party to or interested in the above-entitled matter. I am the Legal Advertising Clerk of the printer and publisher of The Daily Democrat, a newspaper published in the English language in the City of Woodland, County of Yolo, State of California.

I declare that the Daily Democrat is a newspaper of general circulation as defined by the laws of the State of California as determined by this court's order dated June 30, 1952 in the action entitled In the Matter of the Ascertainment and Establishment of the Standing of The Daily Democrat as a Newspaper of General Circulation, Case Number 12659. Said order states "The Daily Democrat" has been established, printed and published in the City of Woodland, County of Yolo, State of California; That it is a newspaper published daily for the dissemination of local and telegraphic news and intelligence of general character and has a bona fide subscription list of paying subscribers; and...THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED:...That "The Daily Democrat" is a newspaper of general circulation for the City of Woodland, County of Yolo, California. Said order has not been revoked.

I declare that this notice, of which the annexed is a printed copy, has been published in each regular and entire issue of said newspaper and not in any supplement thereof on the following dates, to wit:

04/15/2026, 04/18/2026

I certify (or declare) under penalty of perjury that the foregoing is true and correct.

Dated at Woodland, California, this
20th day of April 2026

(Signature) Melanie Irmer

Legal No. **0006961194**

Notice is hereby given: the 30-Day Public Review and Comment Period pertaining to the Draft Behavioral Health Services Act (BHSA) Integrated Plan FY 2026-2029 began Wednesday April 1, 2026; the draft plan, electronic comment survey link, and public notices are posted on the BHSA page of the Yolo County Website at www.yolocounty.gov/bhsa. The Draft Plan is available for public comment and review until 5:00 PM on Thursday April 30, 2026; all interested stakeholders are encouraged to submit comments. A public hearing will be held by the Yolo County Local Behavioral Health Board on Wednesday, May 6, 2026, at 6:00 PM. Information will be published in advance of the meeting and listed on the Local Behavioral Health Board event listing at www.yolocounty.gov/lmhb. After final revisions, the BHSA Plan will be presented to the Yolo County Board of Supervisors by June 30, 2026. Questions? Email BHSA@yolocounty.gov.

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ -	$ -	$ -	$ 642,323.00	$ 674,439.00	$ 708,161.00	0.00	673.00
Early Intervention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Outpatient Services	☑	$ 3,454,146.00	$ 3,626,853.00	$ 3,808,196.00	$ -	$ -	$ -	800	120.00
Intensive Outpatient Services	☑	$ 2,000,000.00	$ 2,100,000.00	$ 2,205,000.00	$ 205,900.00	$ 216,195.00	$ 227,005.00	125	5.00
Crisis and Field-Based Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Residential Treatment Services	☑	$ 2,775,000.00	$ 2,913,750.00	$ 3,059,438.00	$ 50,000.00	$ 52,500.00	$ 55,125.00	700	3.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Early Intervention Services	☑	$ 1,274,510.00	$ 1,338,236.00	$ 1,405,148.00	$ 10,500,372.00	$ 11,025,391.00	$ 11,576,661.00	2400	2557
Outpatient and Intensive Outpatient Services	☑	$ 17,197,487.00	$ 18,057,361.00	$ 18,960,229.00	$ 3,900,284.00	$ 4,095,298.00	$ 4,300,063.00	715	625
Crisis Services	☑	$ 5,415,423.00	$ 5,686,194.00	$ 5,970,504.00	$ -	$ -	$ -	844	177
Residential Treatment Services	☐	$ 800,959.00	$ 841,007.00	$ 883,057.00	$ -	$ -	$ -	116	1
Hospital and Acute Services	☑	$ 8,574,061.00	$ 9,002,764.00	$ 9,452,902.00	$ 110,000.00	$ 115,500.00	$ 121,275.00	594	137
Subacute and Long-Term Care Services	☑	$ 11,078,687.00	$ 11,632,621.00	$ 12,214,252.00	$ 664,000.00	$ 697,200.00	$ 732,060.00	83	15
Housing Services (MH + SUD)									
Housing Services	☑	$ 7,306,509.00	$ 8,846,018.00	$ 9,288,319.00	$ -	$ -	$ -	300	20
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 59,876,782.00	$ 64,044,804.00	$ 67,247,045.00	$ 16,072,879.00	$ 16,876,523.00	$ 17,720,350.00	6677	4333

Instructions

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

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures

Other Expenditures	Total Projected Expenditures (Year One)	Total Projected Expenditures (Year Two)	Total Projected Expenditures (Year Three)
Capital Infrastructure Activities	$ 1,118,270.00	$ -	$ -
Workforce Investment Activities	$ 355,080.00	$ 372,834.00	$ 391,476.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 11,750,731.00	$ 12,695,582.00	$ 13,282,502.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 469,209.00	$ 492,669.00	$ 517,302.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 13,693,290.00	$ 13,561,085.00	$ 14,191,280.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source

	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
BHSA	$ 23,796,760.00	$ 25,536,402.00	$ 26,775,556.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 9,225,360.00	$ 9,686,628.00	$ 10,170,959.00
2011 Realignment (Public Safety Realignment)	$ 11,462,030.00	$ 9,901,503.00	$ 9,981,537.00
State General Fund	$ 2,463,072.00	$ 2,586,226.00	$ 2,715,537.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 22,696,213.00	$ 24,511,910.00	$ 26,472,863.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 473,727.00	$ 497,413.00	$ 522,284.00
Substance Use Block Grant (SUBG)	$ 1,113,893.00	$ 1,169,588.00	$ 1,228,067.00
Commercial Insurance	$ -	$ -	$ -
County General Fund	$ 2,306,105.00	$ 2,306,105.00	$ 2,306,105.00
Opioid Settlement Funds	$ 642,926.00	$ 675,072.00	$ 708,826.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 868,480.00	$ 911,904.00	$ 957,499.00
Other state funding (including DSH funding)	$ 9,800,057.00	$ 10,690,060.00	$ 11,224,563.00
Other county mental health or SUD funding	$ 2,192,620.00	$ 2,302,251.00	$ 2,417,364.00
Other foundation funding	$ 2,601,708.00	$ 3,707,350.00	$ 3,677,515.00
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 89,642,951.00	$ 94,482,412.00	$ 99,158,675.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 75,949,661.00	$ 80,921,327.00	$ 84,967,395.00
Auto-validation: Table 2: Other County Expenditures	$ 13,693,290.00	$ 13,561,085.00	$ 14,191,280.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

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Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 5,834,453.00	$ 6,806,862.00	$ 6,806,862.00	$ 19,448,177.00
Year Two Component Allocation (dollars)	$ 5,762,728.00	$ 6,723,183.00	$ 6,723,183.00	$ 19,209,094.00
Year Three Component Allocation (dollars)	$ 5,778,897.00	$ 6,742,046.00	$ 6,742,046.00	$ 19,262,989.00

BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 4,473,080.63	$ 6,806,862.00	$ 8,168,234.40	$ 19,448,177.03
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 4,850,000.00	$ 14,683,902.00	$ 19,533,902.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 4,418,091.47	$ 6,723,183.00	$ 8,067,819.60	$ 19,209,094.07

BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	35%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 4,430,487.70	$ 6,742,046.00	$ 8,090,455.20	$ 19,262,988.90

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**
Base Percentage and Funding	30%	$ 5,834,453.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,834,453.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 6,806,862.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,806,862.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 6,806,862.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,806,862.00

Funding Transfers (Year One)				
	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	7%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)

Base Component (Year Two)	Housing Intervention Percentage (Year Two)	Housing Intervention Funds (Year Two)
Base Percentage and Funding	30%	$ 5,762,728.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,762,728.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 6,723,183.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,723,183.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 6,723,183.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,723,183.00

Funding Transfers (Year Two)

	Housing Intervention (Year Two) (1)	Full-Service Partnership (Year Two)	Behavioral Health Services and Support (Year Two)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-7%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)

Base Component	Housing Intervention Percentage (Year Three)	Housing Intervention Funds (Year Three)
Base Percentage and Funding	30%	$ 5,778,897.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,778,897.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 6,742,046.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 6,742,046.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$ 6,742,046.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 6,742,046.00

Funding Transfers (Year Three)

	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	-7%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	-7%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	23%	35%	42%	Row Equals 100%

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 10,500,000.00	$ -	$ 4,500,000.00	$ 6,000,000.00
PEI	$ 4,084,000.00	$ -	$ 350,000.00	$ 3,734,000.00
Encumbered INN	$ 4,949,902.00	$ -	$ -	$ 4,949,902.00
Unencumbered INN	$ -	$ -	$ -	$ -
WET	$ -			$ -
CFTN	$ -			$ -
Total (auto-populated)	$ 19,533,902.00	$ -	$ 4,850,000.00	$ 14,683,902.00

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 2,724,069.00
Local Prudent Reserve Maximum (2)	$ 3,475,967.12
Excess Prudent Reserve Funding that must be transferred	**$ (751,898.12)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

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

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated**.**

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 4,473,080.00	$ 4,418,091.00	$ 4,430,487.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 4,473,080.00	$ 4,418,091.00	$ 4,430,487.00

Housing Interventions Category

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 256,000.00	$ 268,800.00	$ 282,240.00	$ -	$ -	$ -
Operating Subsidies	$ 727,000.00	$ 763,350.00	$ 801,518.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 384,000.00	$ 403,200.00	$ 423,360.00	$ -	$ -	$ -
Operating Subsidies	$ 727,000.00	$ 2,135,198.00	$ 2,241,958.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 13,000.00	$ 13,650.00	$ 14,333.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 14,000.00	$ 14,700.00	$ 15,435.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 13,000.00	$ 13,650.00	$ 14,333.00	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ 1,118,270.00	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 3,252,270.00	$ 3,612,548.00	$ 3,793,177.00	$ -	$ -	$ -
Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**			

Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 957,204.00	$ 957,204.00	$ 957,204.00
Total Housing Interventions Expenditures (auto-populated)	$ 4,209,474.00	$ 4,569,752.00	$ 4,750,381.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 2,236,540.00	$ 2,209,045.50	$ 2,215,243.50
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 84,189.00	$ 88,398.00	$ 92,818.00
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	25.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.0%	50.0%	50.0%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	14	29	30
Eligible Adults/Older Adults	185	235	235
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions
Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.
Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.
Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.
Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.
Rows 31-40: input the projected expenditures for each FSP service category or program for each year.
Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.
Row 39: input expenditures for BHSA-funded innovation pilots or projects.
Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.
Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.
Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.
Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.
Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 6,806,862.00	$ 6,723,183.00	$ 6,742,046.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 1,620,000.00	$ 1,620,000.00	$ 1,610,000.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 8,426,862.00	$ 8,343,183.00	$ 8,352,046.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 517,334.00	$ 543,201.00	$ 570,361.00	$ 389,660.00	$ 409,143.00	$ 429,600.00	$ 67,065.00	$ 70,418.00	$ 73,939.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 254,181.00	$ 266,890.00	$ 280,235.00	$ -	$ -	$ -	$ -	$ -	$ -
FSP Intensive Case Management	$ 2,287,632.00	$ 2,402,014.00	$ 2,522,115.00	$ 677,559.00	$ 711,437.00	$ 747,009.00	$ 43,043.00	$ 45,195.00	$ 47,455.00
High Fidelity Wraparound	$ 1,000,000.00	$ 1,050,000.00	$ 1,102,500.00	$ 667,000.00	$ 700,350.00	$ 735,368.00	$ 1,300.00	$ 1,365.00	$ 1,433.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 300,000.00	$ 315,000.00	$ 330,750.00	$ -	$ -	$ -	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,000.00	$ 37,800.00	$ 39,690.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 1,000,000.00	$ 1,050,000.00	$ 1,102,500.00	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 5,359,147.00	$ 5,627,105.00	$ 5,908,461.00	$ 1,734,219.00	$ 1,820,930.00	$ 1,911,977.00	$ 147,408.00	$ 154,778.00	$ 162,517.00
FSP Transfer Information	**Year One**	**Year Two**	**Year Three**						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**						
FSP Component Admin Expenses	$ 1,197,324.00	$ 1,257,190.00	$ 1,320,050.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 6,556,471.00	$ 6,884,295.00	$ 7,228,511.00						
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**						
Eligible Children/TAY (25 years and younger)	40	40	40						
Eligible Adults/Older Adults	130	130	130						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**						
MHSA "Encumbered" INN	$ -	$ -	$ -						

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions
Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.
Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.
Row 45: input expenditures for BHSA-funded innovation pilots or projects.
Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 8,168,234.00	$ 8,067,819.00	$ 8,090,455.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 4,556,808.00	$ 5,022,148.00	$ 5,104,946.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 12,725,042.00	$ 13,089,967.00	$ 13,195,401.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 2,686,632.00	$ 2,820,964.00	$ 2,487,012.00	$ 2,592,379.00	$ 2,721,998.00	$ 2,858,098.00	$ 2,553,522.00	$ 2,681,198.00	$ 2,815,258.00
Early Intervention Expenditures	$ 4,814,825.00	$ 5,055,566.00	$ 5,783,344.00	$ 4,086,635.00	$ 4,290,967.00	$ 4,505,515.00	$ 1,793,400.00	$ 1,883,070.00	$ 1,977,224.00
Coordinated Specialty Care for First Episode Psychosis	$ 300,000.00	$ 315,000.00	$ 330,750.00	$ -	$ -	$ -	$ 200,757.00	$ 210,795.00	$ 221,335.00
All Other EI Expenditures	$ 4,514,825.00	$ 4,740,566.00	$ 5,452,594.00	$ 4,086,635.00	$ 4,290,967.00	$ 4,505,515.00	$ 1,592,643.00	$ 1,672,275.00	$ 1,755,889.00
Outreach and Engagement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 355,080.00	$ 372,834.00	$ 391,476.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ 355,080.00	$ 372,834.00	$ 391,476.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 1,306,808.00	$ 1,772,148.00	$ 1,870,946.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 9,163,345.00	$ 10,021,512.00	$ 10,532,778.00	$ 6,679,014.00	$ 7,012,965.00	$ 7,363,613.00	$ 4,346,922.00	$ 4,564,268.00	$ 4,792,482.00

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 1,561,004.00	$ 1,639,054.00	$ 1,721,007.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 10,724,349.00	$ 11,660,566.00	$ 12,253,785.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 3,706,102.00	$ 3,891,407.00	$ 4,085,977.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	61.9%	53.5%	51.1%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	77.0%	77.0%	70.7%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	2560	2560	2560
Eligible Adults/Older Adults	5100	5200	5250
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ 355,080.00	$ 372,834.00	$ 391,476.00
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ -	$ -	$ -
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ 4,949,902.00	$ 3,643,094.00	$ 1,870,946.00

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

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

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 800,000.00	$ 840,000.00	$ 882,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 697,080.00	$ 731,934.00	$ 768,531.00
New and Ongoing Administrative Costs	$ 809,386.00	$ 849,855.00	$ 892,348.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 44,098,267.00	$ 45,124,533.00	$ 46,928,052.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.8%	1.9%	1.9%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	1.6%	1.6%	1.6%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

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

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

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

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

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

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 2,724,069.00
Local Prudent Reserve Maximum (1)	$ 3,475,967.12
Excess Prudent Reserve Funds (auto-populated)	$ (751,898.12)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 4,473,080.00	$ 6,806,862.00	$ 8,168,234.00	$ 19,448,176.00
Year Two				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 4,418,091.00	$ 6,723,183.00	$ 8,067,819.00	$ 19,209,093.00
Year Three				
Allocation Percentage, with Transfers	23%	35%	42%	100%
Component Allocations	$ 4,430,487.00	$ 6,742,046.00	$ 8,090,455.00	$ 19,262,988.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	**Full Service Partnerships (Year One)**	**Behavioral Health Services and Supports (Year One)**	**Year One Totals**
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 4,473,080.00	$ 6,806,862.00	$ 8,168,234.00	$ 19,448,176.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 1,620,000.00	$ 4,556,808.00	$ 6,176,808.00
Estimated Total Available Funding for Year One	$ 4,473,080.00	$ 8,426,862.00	$ 12,725,042.00	$ 25,624,984.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 4,209,474.00	$ 6,556,471.00	$ 10,724,349.00	$ 21,490,294.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	**Full Service Partnerships (Year Two)**	**Behavioral Health Services and Supports (Year Two)**	**Year Two Totals**
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 4,418,091.00	$ 6,723,183.00	$ 8,067,819.00	$ 19,209,093.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 263,606.00	$ 3,490,391.00	$ 7,022,841.00	$ 10,776,838.00
Estimated Total Available Funding for Year Two	$ 4,681,697.00	$ 10,213,574.00	$ 15,090,660.00	$ 29,985,931.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 4,569,752.00	$ 6,884,295.00	$ 11,660,566.00	$ 23,114,613.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	**Full Service Partnerships (Year Three)**	**Behavioral Health Services and Supports (Year Three)**	**Year Three Totals**
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 4,430,487.00	$ 6,742,046.00	$ 8,090,455.00	$ 19,262,988.00

Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 111,945.00	$ 4,939,279.00	$ 8,535,040.00	$ 13,586,264.00
Estimated Total Available Funding for Year Three	$ 4,542,432.00	$ 11,681,325.00	$ 16,625,495.00	$ 32,849,252.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 4,750,381.00	$ 7,228,511.00	$ 12,253,785.00	$ 24,232,677.00

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 800,000.00	$ 840,000.00	$ 882,000.00	$ 2,522,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 697,080.00	$ 731,934.00	$ 768,531.00	$ 2,197,545.00
Total Projected New and Ongoing Administrative Expenditures	$ 809,386.00	$ 849,855.00	$ 892,348.00	$ 2,551,589.00

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA “Encumbered” INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for “Improvement and Monitoring” (2% or 4%) and “Planning” (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to “No Excess” or “Reduce Excess”	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

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Behavioral Health Director Certification

Certification

1. I hereby certify that Yolo County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - [x] The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - [x] I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - [x] The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - [x] Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - [x] BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - [ ] The IP was submitted to the local behavioral health board

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   - ( ) Yes
   - (•) No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

n/a

County Behavioral Health Agency Director contact information

3. County Name

Yolo County

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Tony Kildare

6. County Behavioral Health Agency Director phone number

530-661-2929

7. County Behavioral Health Agency Director email

tony.kildare@yolocounty.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

n/a

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name

Tony Kildare

13. Title

Behavioral Health Director

14. Date

March 30, 2026

15. Signature

Tony Kildare, LCSW

Digitally signed by Tony Kildare, LCSW
Date: 2026.03.30 10:23:03 -07'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

n/a

17. Title

18. Date

19. Signature

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County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

Signature

3. Print name

Michael Webb

4. Date

03/27/2026

5. Signature

Contact information

6. County Name

Yolo

7. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (•) Draft

8. County Chief Administration Officer Name

Michael Webb

9. County Chief Administration Officer Phone number

530-666-8150

10. County Chief Administration Officer Email

michael.webb@yolocounty.gov