Yolo County Health & Human Services Agency

Behavioral Health Services Act (BHSA) 2026-2029 Community Planning Process (CPP) Brief & Summary of Findings

What is the Community Planning Process (CPP)?

The Behavioral Health Services Act (BHSA) requires counties to engage the community in the development of a Three-Year Behavioral Health Integrated Plan. To meet this requirement, Yolo County implemented a Community Planning Process (CPP) with three main goals:

1. Gather Community Input: Collect meaningful input from community members about behavioral health services and funding priorities through honest conversations about what's working and what isn't.

2. Examine Service Gaps: Explore the relationship between available services and community needs to identify potential improvements.

3. Build on Existing Work: Create a formal structure around community conversations that may already be happening.

How it Works: **Building Trust:** The CPP creates stronger relationships between community members and the behavioral health system by showing how community input influences decisions. **Required Voices:** The state has identified specific community groups that must have a voice in program and funding decisions.

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Required BHSA Stakeholders

People with Lived Experience
•Eligible adults and older adults (individuals with lived experience)
•Families of eligible children and youth, eligible adults, and eligible older adults (with lived experience)
•Individuals with behavioral health experience, including peers and families
•Youths (individuals with lived experience), youth mental health/
•Substance use disorder organizations
•Veterans & Representatives from veterans' organizations
•People with lived experience of homelessness

Healthcare & Treatment Providers
•Providers of mental health services
•Providers of substance use disorder treatment services
•Health care organizations, including hospitals
•Health care service plans, including Medi-Cal managed care plans
•Disability insurers
•Emergency medical services

Government & Public Systems
•Public safety partners, including county juvenile justice agencies
•Local public health jurisdictions
•County social services and child welfare agencies
•Representatives from the five most populous cities in counties

Education & Development
•Local education agencies
•Higher education partners
•Early childhood organizations

Specialized Services & Support
•Area agencies on aging
•Independent living centers
•Regional centers
•Continuums of care, including representatives from the homeless service provider community
•Labor representative organizations

Cultural & Community Organizations
•Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
•Community-based organizations serving culturally and linguistically diverse constituents
•Youth from historically marginalized communities
•Organizations specializing in working with underserved, racially and ethnically diverse communities
•Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities
Victims of domestic violence and sexual abuse

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Community Engagement Activities

Here's how we collected input from the community

Engagement Method	Number of Activities	Number of Participants
Community Engagement Work Group (CEWG) Engagement workgroup designed to support Behavioral Health Services Act Planning, open to all Yolo County community members	1	41
Community Behavioral Health Survey A broad survey about behavioral health and housing needs available online and on paper in English, Spanish, Russian and Farsi. Tailored versions for youth, caregivers, and system partners.	1	268
Community Listening Sessions Four online sessions covering Full Service Partnership (September 24th), Behavioral Health Services (September 30th), and Housing Initiatives (October 2nd; October 16th). We shared county performance outcomes and gathered feedback on funding and service priorities.	4	144
Focus Groups Special sessions designed for people with lived experience, offered online, in-person, or hybrid so people could participate in whatever way felt most comfortable.	6	26
Key Informant Interviews On-on-one conversations with system partners conducted online to understand system-level perspectives and identify collaboration opportunities.	29	35

In total, the CPP engaged 514 community members through a combination of data collection efforts, informational sessions, and interviews.

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TIMELINE

May-July 2025: The process began with foundational work - reviewing regulations, analyzing data, and planning the approach. This included reviewing state policy guidance and analyzing county behavioral health performance.

August 2025: The county mapped stakeholders and developed the engagement strategy, identifying community groups and determining the best ways to reach and involve them.

September-November 2025: The county shared behavioral health information and county outcomes while gathering community input through multiple engagement activities.

November-December 2025: All community input was analyzed and compiled into a findings report. The draft Integrated Plan development process began.

January-March 2026: The draft Integrated Plan development & review process continued. The first draft is due to the State by March 31, 2026.

April-June 2026: A required 30-day public posting period for the plan, followed by a public hearing, implementation planning, and submission of the first draft Integrated Plan to the State by June 30, 2026.

Community participation in engagement activities directly influences this planning work.

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Community Engagement Summary of Findings

What We Heard: Key Themes Across All Stakeholders

Fragmentation & Coordination

Information about services is scattered across multiple locations with no central access point. Communication gaps exist between organizations and within county departments. Even providers report difficulty knowing where to refer clients, leading to duplicated efforts and missed opportunities to serve individuals.

Housing as a Foundation

Participants emphasized that addressing behavioral health is difficult when individuals lack stable housing. Housing instability intersects with serious mental illness, substance use disorders, and justice involvement. The absence of transitional housing limits progression through care levels, and affordable housing shortages particularly affect communities with fixed incomes.

Early Intervention Need

Families described feeling helpless while waiting for situations to escalate to crisis levels before accessing resources. The shift from MHSA's prevention focus raised concerns about losing early intervention capacity, particularly in underserved areas. Participants emphasized proactive approaches that respond to warning signs rather than waiting for crisis thresholds.

Cultural Responsiveness Enhancement

Non-English-speaking communities face 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 with cultural input are better positioned to effectively reach and serve diverse communities.

Resource Constraints & Workforce Capacity

Provider shortages make it difficult to sustain services like 24/7 crisis access. Budget deficits prevent adequate staffing to meet caseload demands. Grant-funded structures create instability when funding cycles end.

Relationships and Collaboration as Strengths

Strong collaborative relationships and dedicated staff emerged as foundational system strengths. Yolo County's manageable size facilitates relationship-building across sectors, creating an environment conducive to cross-sector collaboration. Staff demonstrate genuine care and commitment across all levels, from leadership to frontline positions. This collaborative spirit and willingness to partner distinguishes Yolo County from larger systems. Participants emphasized that these established relationships, trust, and shared commitment to community wellbeing create opportunities to address fragmentation and build more integrated approaches to care.

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Community Engagement Summary of Findings

Survey participants were asked to rate priorities among the following behavioral health issues. Mental and emotional health was the top priority among respondents. It's also essential to note that priorities varied by population as displayed.

Priority Behavioral Health Issues

Issue	Percent
Mental & Emotional Health	60%
Housing	18%
Drugs & Alcohol	14%

Population Variations

SUD Individuals: substance use (60%)

Veterans: housing (44%)

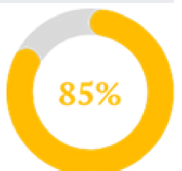
Older Adults: housing (32%)

Individuals with disabilities: housing (30%)

Participants rated how much each issue gets in the way of accessing services. The top barriers are presented below:

Barriers to Accessing Mental Health and Substance Use Resources

Service Locations Are Too Far or Lack of Transportation
Rural residents face acute transportation barriers when services are concentrated in distant urban centers.

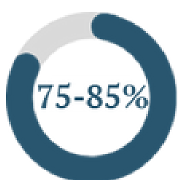


Lack of Information about Where to Get Help
Information about available services is scattered with no centralized access point, making it difficult for people to know where to turn.

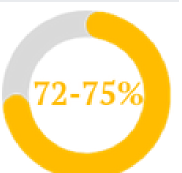
Limited Staff Availability and Closed Caseloads
Staffing shortages and closed caseloads create barriers to access, affecting underserved communities.

Barriers to Accessing Housing Services for Individuals with SUD and/or SMI

Affordability Crisis (Rental and Utility Costs, Insufficient Income)
Housing and utility costs outpace income — particularly for SSI/SSDI recipients whose benefits have not kept up with local cost of living.



System Capacity & Access Gaps (Waitlists, Requirements, and Scarcity)
Long waitlists, limited programs, and complex requirements restrict access —with some individuals giving up due to overwhelming paperwork.



Limited Housing Options and Discrimination
Few family and shared housing options exist, and discrimination against people with criminal justice histories, behavioral health conditions, or experiences of homelessness further limits access.

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Community Engagement Summary of Findings

Beyond identifying barriers, stakeholders shared insights on how behavioral health services could better meet community needs. Four clear priorities emerged.

Trust & Empathy in Service Delivery

Participants emphasized the importance of how people are treated when seeking services. They highlighted active listening, staff with lived experience, community outreach, and crisis-trained first responders as essential elements.

Integrated & Individualized Care

Participants expressed the need for seamless coordination across mental health, substance use treatment, and housing services rather than navigating separate silos. They emphasized personalized attention that recognizes individual differences and circumstances.

"The support we need is just for them to listen to us and then go from there."

Provider Network & Information Systems

Centralized resource directories and better communication infrastructure across systems were identified as key needs. These priorities came from providers themselves — underscoring that even those working within the system face challenges connecting people to appropriate services.

Equity-Centered, Stigma-Free Care

Participants described experiencing stigma and discrimination across multiple dimensions — housing status, criminal history, substance use, and behavioral health conditions — and emphasized the need for non-judgmental care.

"There's a lack of knowledge about where to refer… clear guidelines about access will be really helpful…"

This vision reflects what CPP participants are asking for: compassionate treatment, coordinated services, clear information, and freedom from discrimination. BHSA funding provides an opportunity to advance care coordination, peer support, culturally responsive services, and early intervention.

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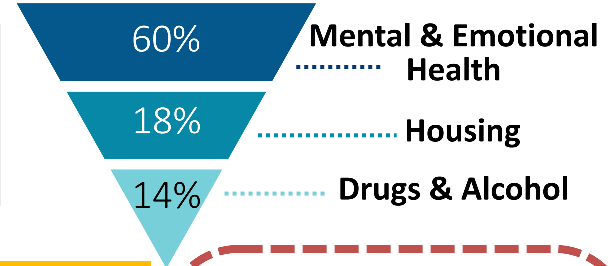
BHSA Community Planning Process Findings

Yolo County HHSA engaged 514 community members through focus groups, listening sessions, interviews, a community engagement workgroup, and a community survey between September and November 2025.

Survey participants rated behavioral health priorities, with mental and emotional health ranking highest



6 Key Findings from What We Heard:

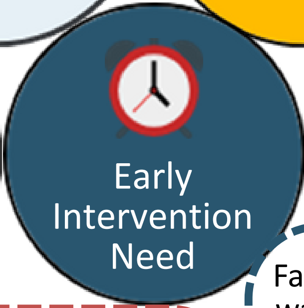
Strong collaborative relationships and dedicated staff emerged as foundational strengths. Participants noted that this existing trust and shared commitment creates opportunities to address fragmentation and build more integrated approaches.

Participants called for seamless coordination across mental health, substance use, and housing services — not separate silos — along with personalized care that recognizes individual circumstances.

Participants described experiencing stigma and discrimination across multiple dimensions, and called for services that treat people with dignity regardless of history or circumstances.

Participants stressed that behavioral health needs cannot be effectively addressed without stable housing — a challenge compounded by its intersection with serious mental illness, substance use, and justice involvement.

Non-English-speaking communities face difficulty accessing therapeutic services due to limited multilingual provider capacity, and called for services designed with cultural input.



Families described feeling helpless waiting for crises before accessing resources, and emphasized proactive approaches that respond to early warning signs.