



YOLO COUNTY

Health & Human Services Agency

Behavioral Health Services Act (BHSA)

Draft Integrated Plan

2026-2029





YOLO COUNTY

Health & Human Services Agency

Resource · Partner · Support System

Table of Contents

Executive Summary.....	1
2026-2029 Integrated Plan.....	2
General Information.....	2
County Behavioral Health System Overview.....	6
County Behavioral Health Technical Infrastructure.....	13
County Behavioral Health System Service Delivery Landscape.....	14
Statewide Behavioral Health Goals.....	22
Community Planning Process.....	52
Comment Period and Public Hearing.....	69
County Behavioral Health Services Care Continuum.....	71
County Provider Monitoring and Oversight.....	72
Behavioral Health Services Act/Fund Programs.....	78
Behavioral Health Services and Supports.....	78
Full Service Partnership Program.....	95
Housing Interventions.....	113
Workforce Strategy.....	144
Budget and Prudent Reserve.....	148
Plan Approval and Compliance.....	150
Requests.....	151
Community Planning Process Report.....	157
Draft Integrated Plan Budget.....	201



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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
<p>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</p>	<p><11*</p>
<p>Were chronically homeless or experiencing homelessness or at risk of homelessness</p>	<p>764</p>
<p>Were in the juvenile justice system</p>	<p>198</p>
<p>Have reentered the community from a youth correctional facility</p>	<p><11*</p>
<p>Were served by the Mental Health Plan and had an open child welfare case</p>	<p>104</p>
<p>Were served by the DMC County or DMC-ODS plan and had an open child welfare case</p>	<p>0</p>

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

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.

File Upload

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

BHSA Behavioral Health Services and Supports (BHSS)

BHSA Full Services Partnership (FSP)

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.

File Upload

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 Health 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.

File Upload

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

File Upload

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 using 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.

File Upload

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](#)

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 (HHS) 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

Link

Please provide the link to the public posting

[This section will be completed at end of posting period and included in the Final Plan.](#)

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

To be added after the close of the public comment period.

Summarize the substantive revisions recommended this stakeholder during the comment period

TBD

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

Substantive recommendations

To be added after the close of the public comment period. TBD

Confirm that the data is up to date and reflects the correct information for a Draft Plan

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)?

No

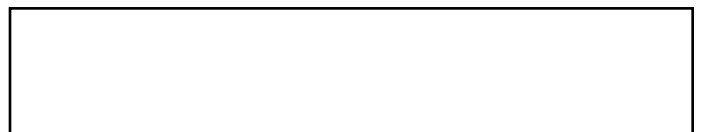
Contracted BHSA Provider Locations

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



Services Provided	Number of contracted BHA 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 BHA 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 BHA Provider Locations
SMHS only	11
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	1

All BHA Provider Locations

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

Among the county's BHA 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 BHA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

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](#).

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)

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

tbd

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

tbd- confirming numbers

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

Crisis Intervention Training

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

Outreach

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

No

Please describe intended outcomes of the program or service

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.

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
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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	150
FY 2027 – 2028	250
FY 2028 – 2029	300

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

Projections are based on consultation with program staff, including average attendance in training classes and number of classes offered per year. The CIT program projects and increase in average number of individuals served over this three-year plan because there is intention to expand the CIT program to more members of the community, specifically fire jurisdictions.

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
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
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 e

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.

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

Total Adult FSP Eligible Population	Estimates
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
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
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
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

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

N/A

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, HHS 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, HHS 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, HHS 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.

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. We will review 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 Health 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. HHS 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 BHS Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHS eligible individuals?

BHS 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 BHS-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 BHS 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 BHS 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 (HHS) 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 BHS 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 BHS 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 subsidies 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

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 BHS-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](#).

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

N/A

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.

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 BHSI 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](#)

9/30/2024

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

BHSS

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

Confirm that the data is up to date and reflects the correct information for a Draft Plan

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 BHSAs goals.

Across educational sessions, listening sessions, focus groups, key informant interviews, and community forums, stakeholders consistently emphasized the importance of early intervention 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 BHSAs_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*"

Yolo County BHTA 26-29 Community Planning Process Table of Contents

Acknowledgements	2
Introduction	3
Community Engagement.....	3
Community Behavioral Health Survey Findings.....	5
Behavioral Health Issues.....	6
Assessment of Service Availability.....	8
Barriers to Services.....	13
Improving Access to Drug Medi-Cal and Specialty Mental Health Services.....	17
Resources to Support Conservators or Individuals Considering Conservatorship.....	18
Youth Perspectives.....	18
Focus Groups Findings	19
Building Trust and Engagement.....	19
Peer Support	19
Quality of Care and Service Delivery.....	20
Crisis Response and Safety.....	21
Access and System Design.....	21
Vision and Priorities.....	22
Listening Sessions Findings.....	23
Addressing Barriers and Gaps.....	24
Identifying Strengths and Solutions.....	25
Key Informant Interview Findings.....	26
System Strengths.....	26
Subpopulations and Needs.....	27
Collaboration Opportunities.....	28
Funding Priorities.....	29
Behavioral Health Services Act Priority Goals.....	30
Conclusions and Recommendations	32
Key Cross-Cutting Themes.....	33
Service Delivery Insights.....	34
System-Level Considerations.....	34
Recommendations.....	35
Conclusion.....	36
Appendix A – Community Program Planning Brief	37
Appendix B – Participants’ Demographics.....	38
Appendix C – Other Planning Processes	44

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 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%.

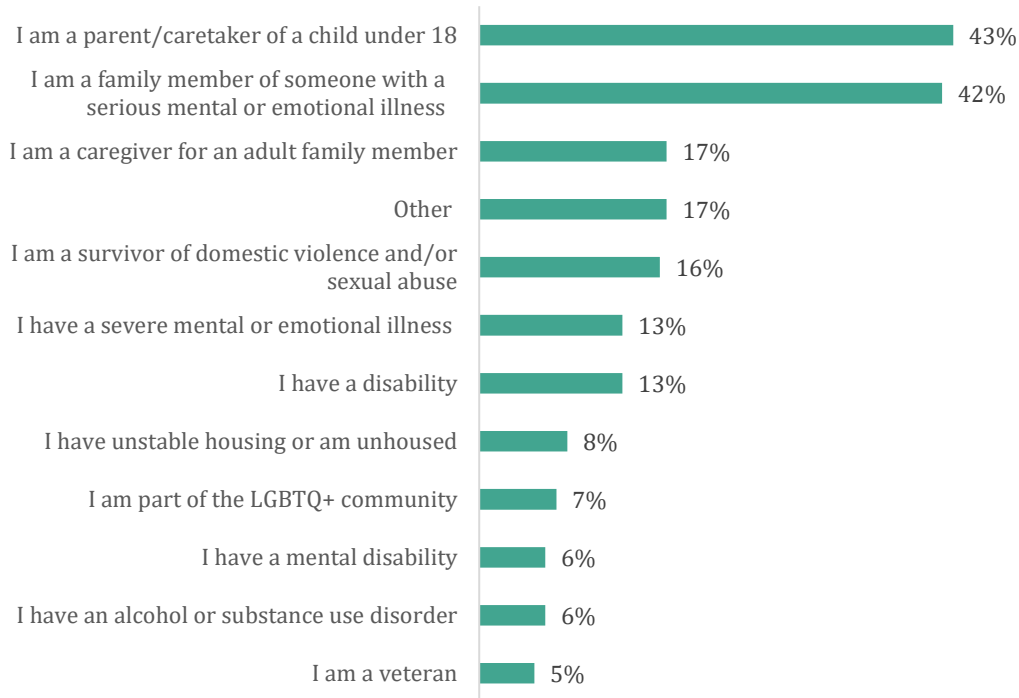
Additional Personal Identities

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

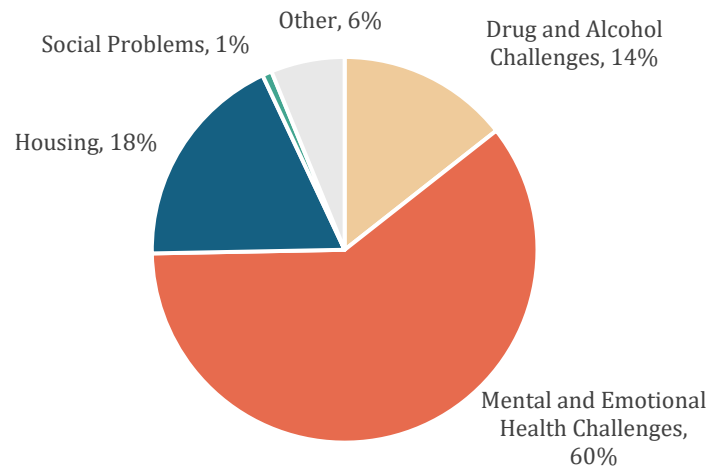
Understanding the behavioral health challenges most frequently cited by community members is essential for guiding responsive planning and resource allocation. Through the Community Health Survey, respondents shared their top concerns, highlighting specific issues they believed require greater attention 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



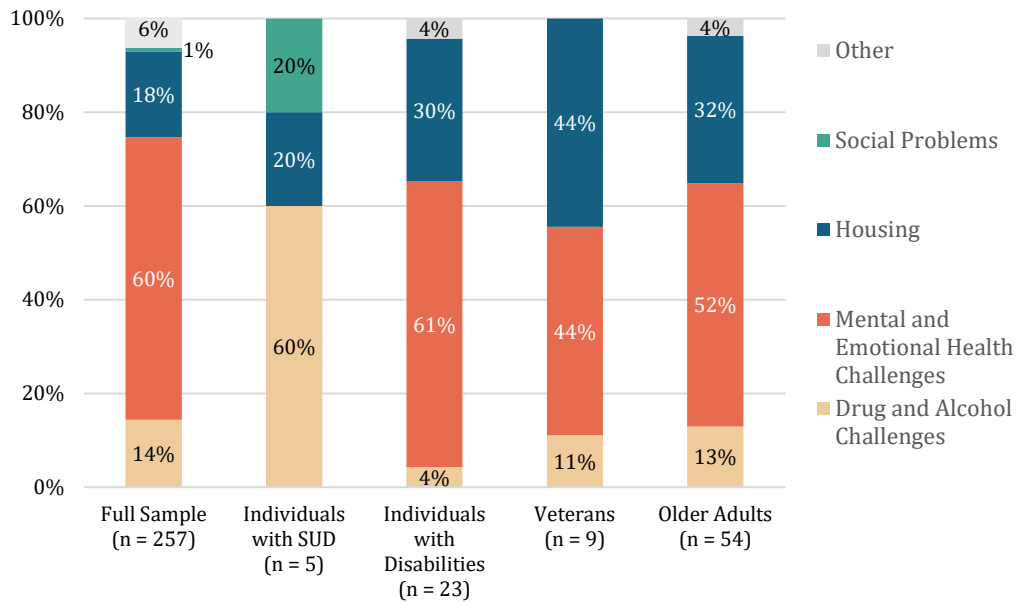
Note: the Social Problems option was only presented in the youth survey (n = 4 respondents)

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



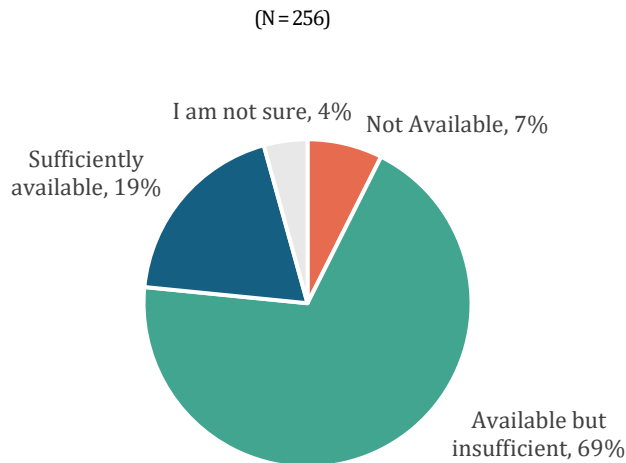
Note: Some subgroups have small sample sizes (n < 10); therefore, findings should be interpreted with caution.

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.

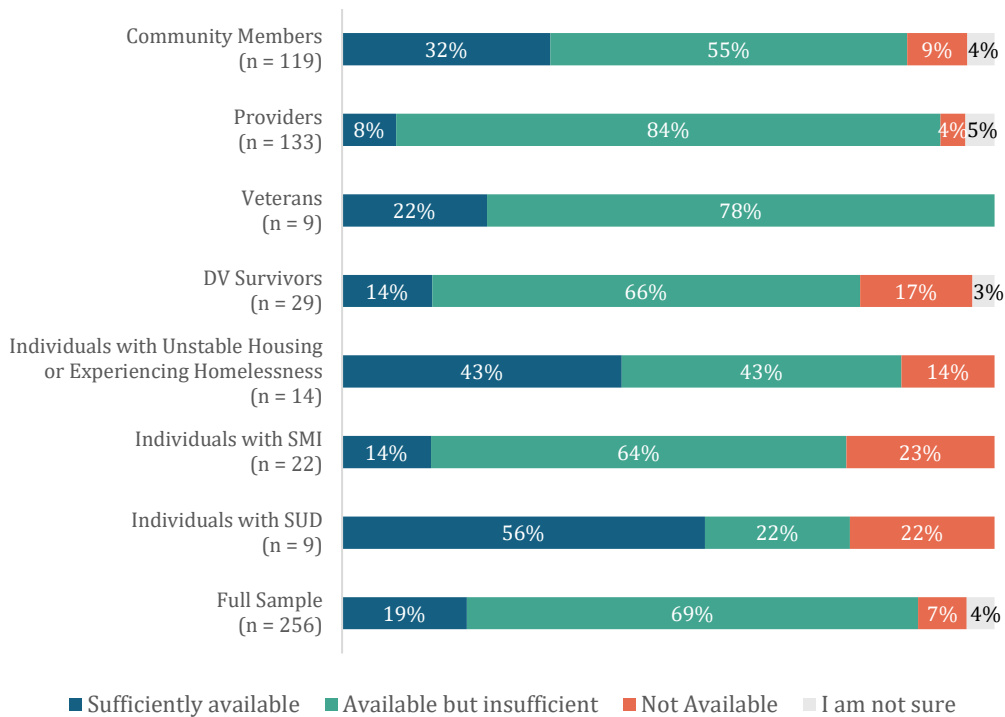
Figure 3 shows that more than two out of every three respondents perceived mental health services to be *available but insufficient to meet the needs*.

Figure 3. Overall Availability of Mental Health Services in the County as Identified by Survey Respondents



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)

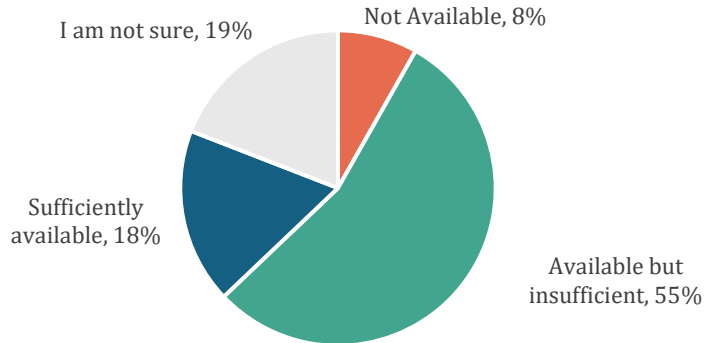
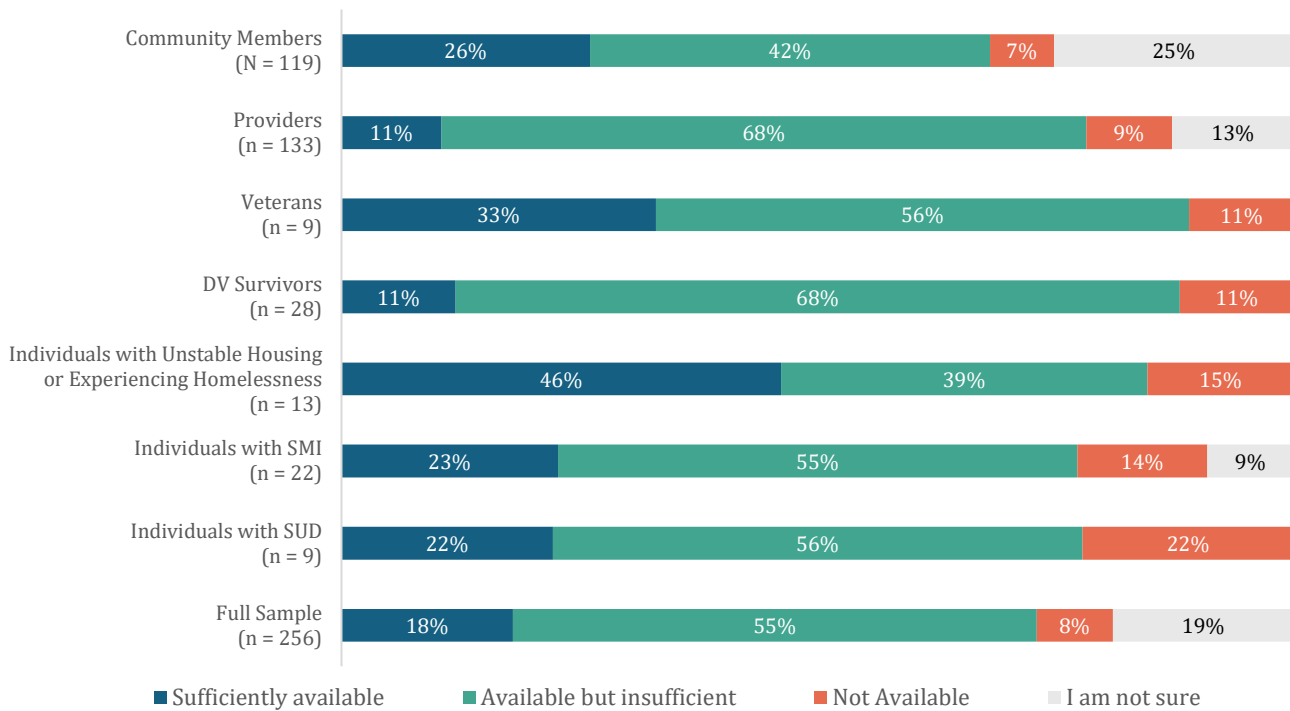


Figure 4b displays the variation in substance use availability seen across subgroups. Community members were again more likely to report that substance use services were *sufficiently available*, in comparison to providers. Along with DV survivors, providers were least likely of all subgroups to describe 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.

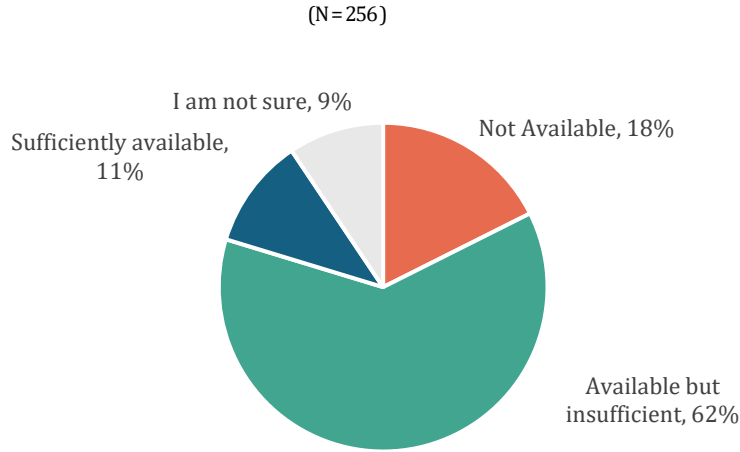
Figure 4b. Overall Availability of Substance Use Services in the County as Identified by Survey Respondents Across Subgroups



Note: Some subgroups have small sample sizes (n<10), and findings should be interpreted with caution.

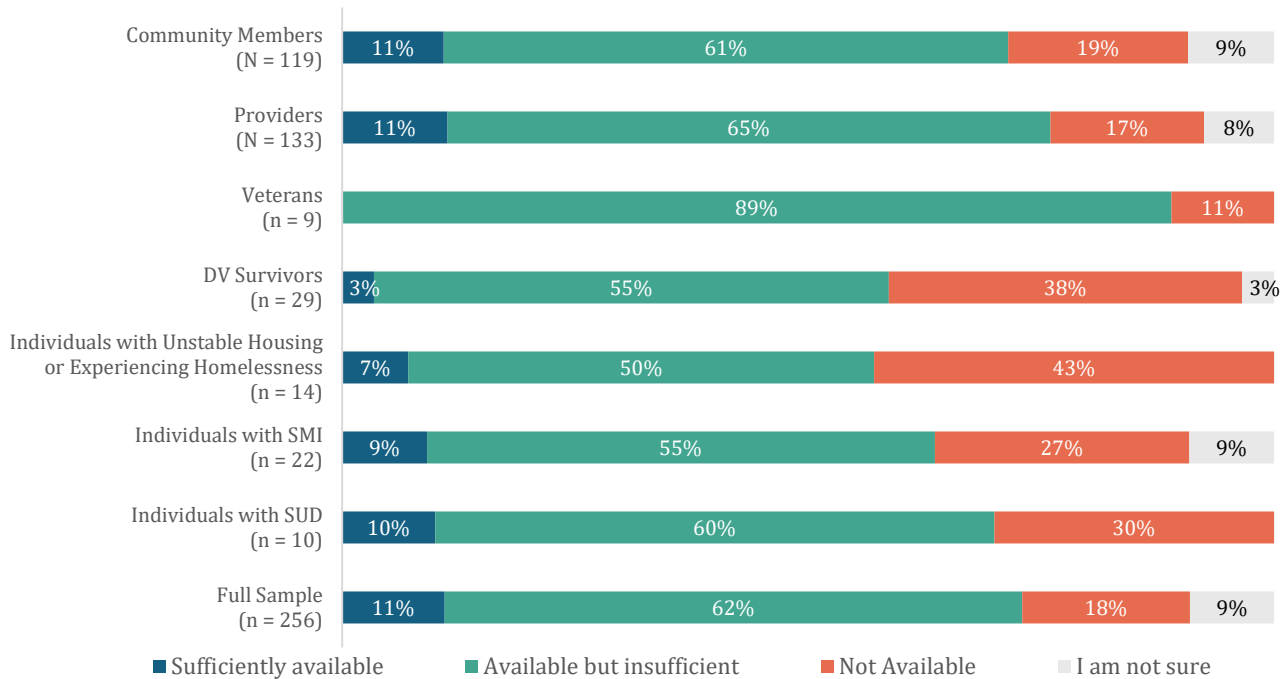
Figure 5 illustrates that only one in every ten respondents perceived housing services in the county as being *sufficiently available*. Again, the majority (three out of every five) of respondents found services to be available but insufficient to meet their *needs*.

Figure 5. Overall Availability of Housing Services in the County as Identified by Survey Respondents



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



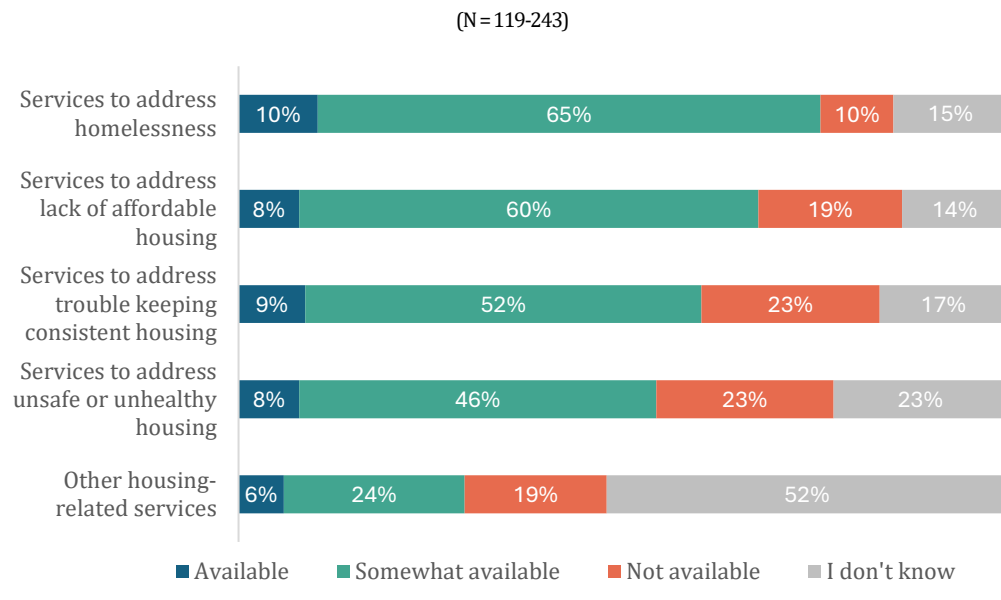
Note: Some subgroups have small sample sizes (n < 10); therefore, findings should be interpreted with caution.

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*



*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.

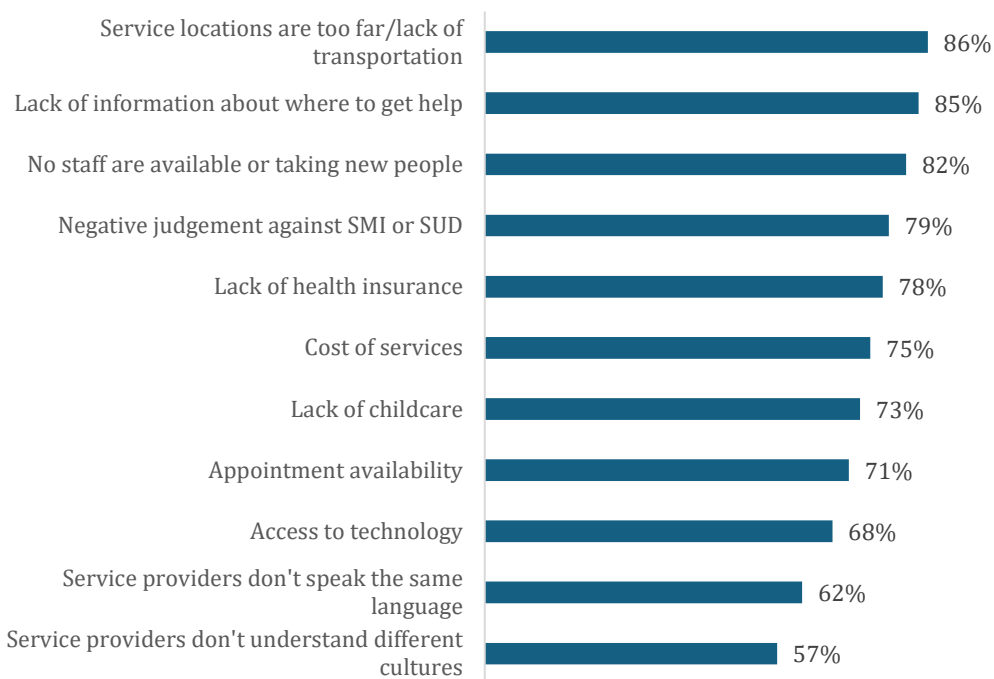
In comparison to the full sample, individuals with substance use disorder were more likely to report availability of *services to address homelessness* and *lack of affordable housing*. Individuals with unstable housing or experiencing homelessness had higher ratings of availability for *services to 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)

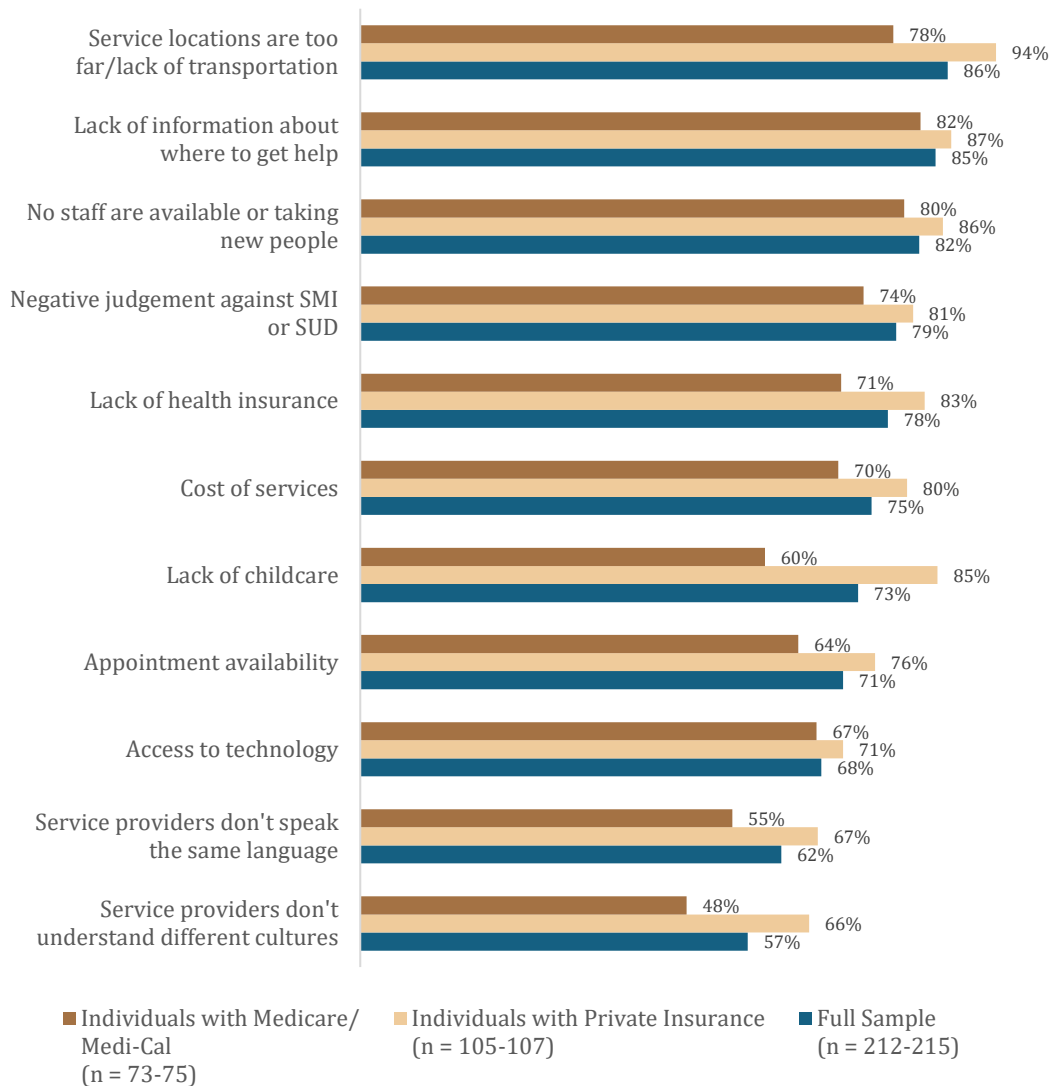


*Barriers represent the percentage of respondents who indicated an issue gets in the way of mental health or substance use resources a lot or a little

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:

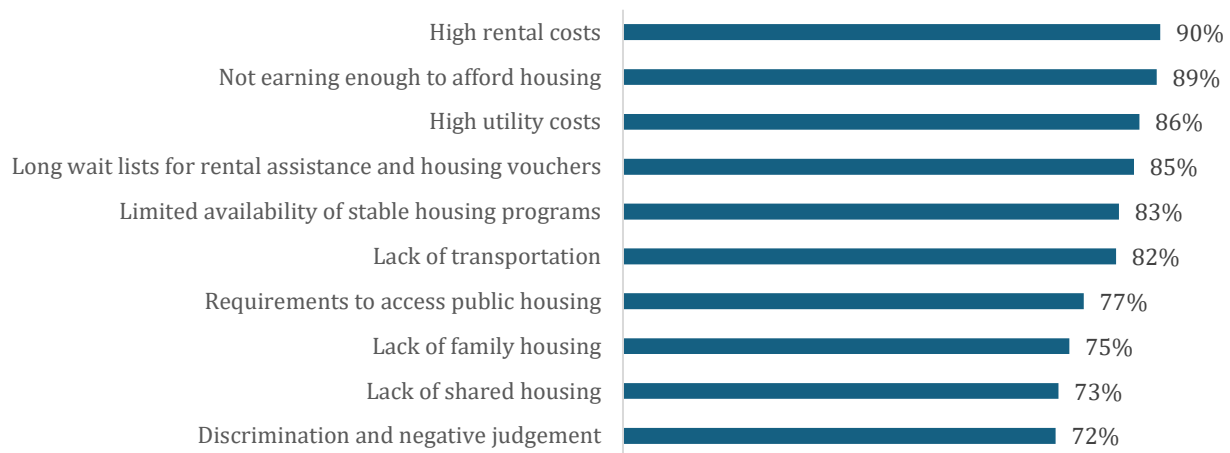
- System Structure & Crisis Response:* Mental health system criteria require individuals with SMI to meet crisis levels (danger to self/others or grave disability) before accessing highest level of care, often resulting in significant deterioration before intervention; lack of accessible crisis response 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 constraints; 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

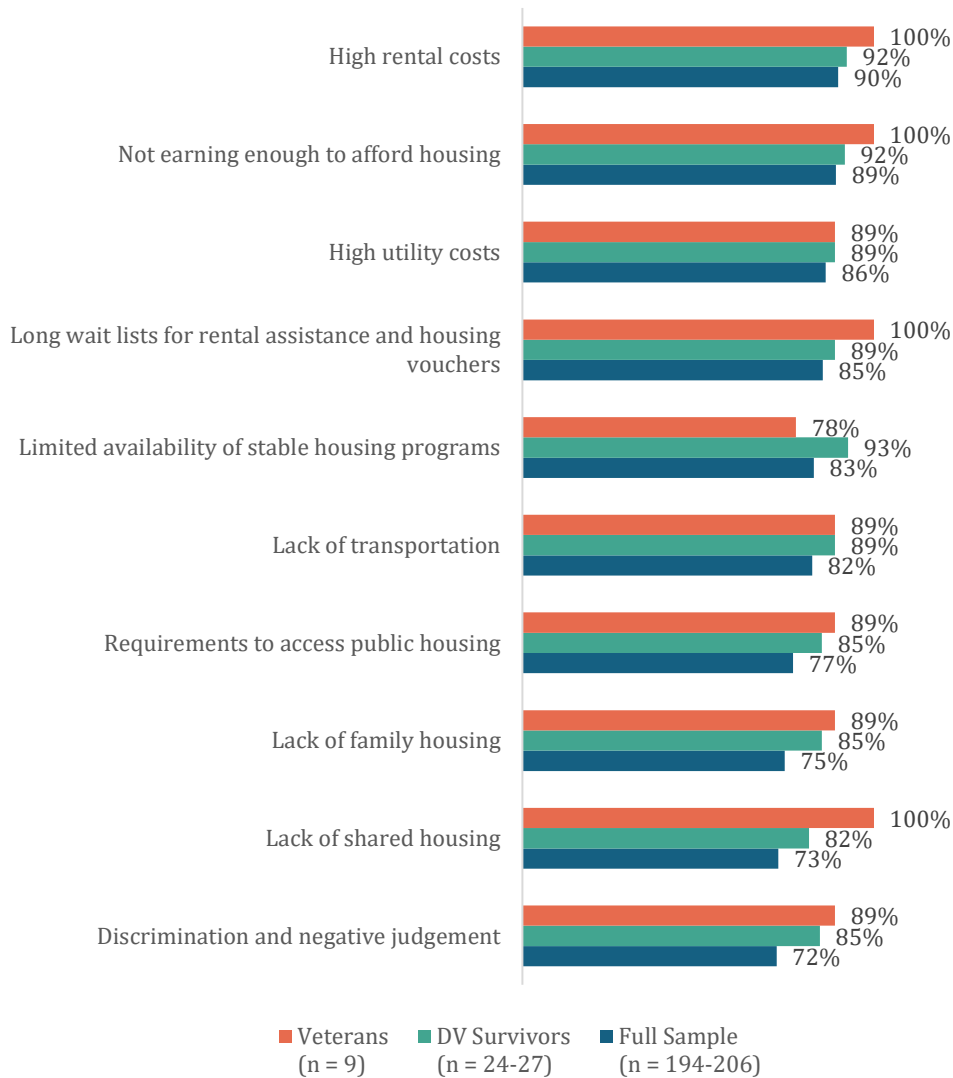
(N = 194-206)



*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.

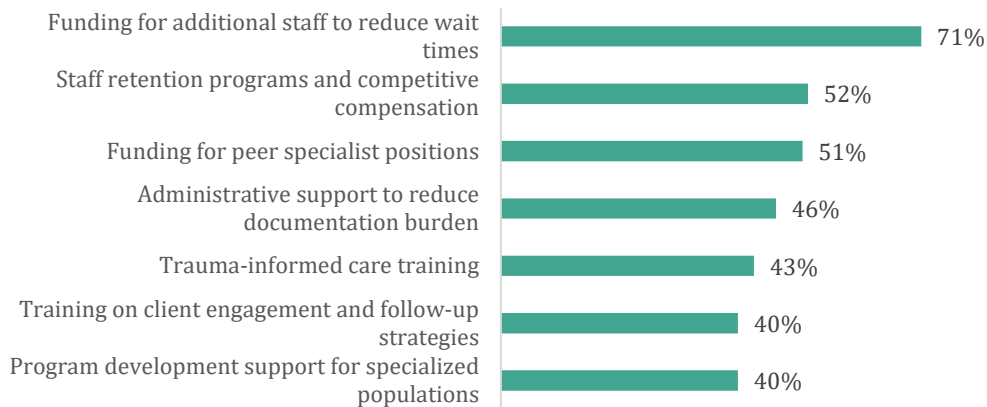
- *Support & Advocacy Gaps:* Lack of advocacy support; absence of personal support systems; closed waitlists for subsidized housing preventing individuals from knowing scope of needs or their place in queue.
- *Housing Quality & Service Continuity:* Housing offered to people with mental illness does 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:

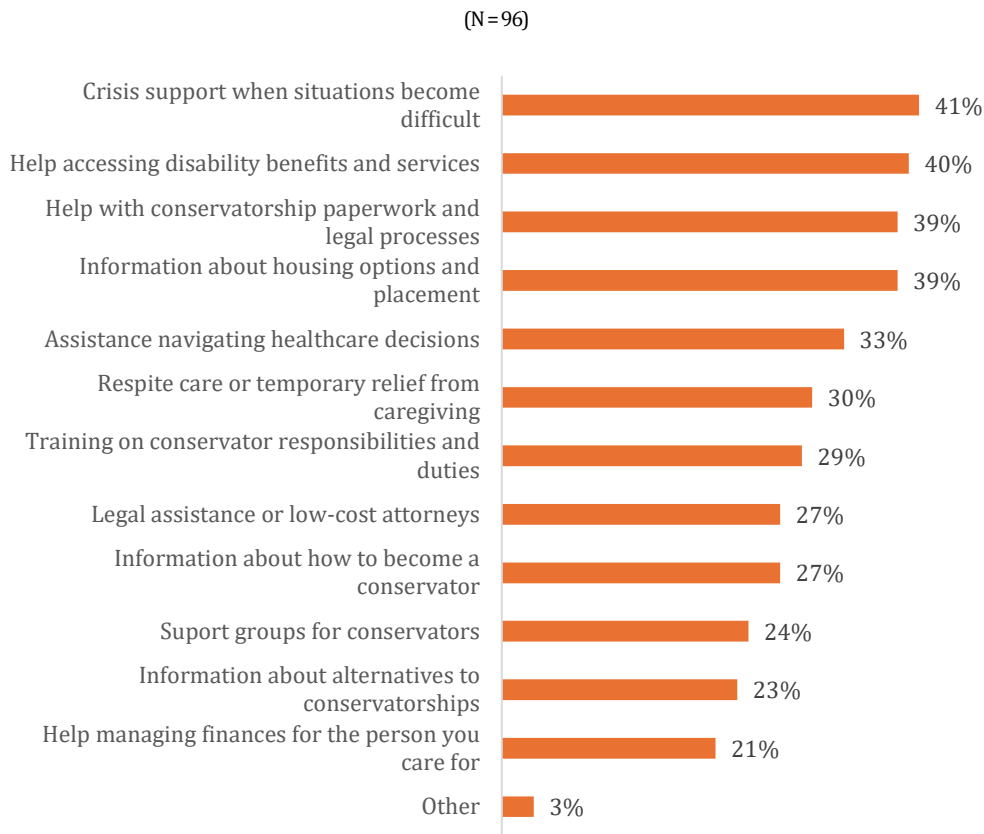
- *Staffing & Workforce Development:* Increase funding for adequate staffing levels, recruit more qualified case managers and psychiatrists, and provide mental health supports for educators from daycare providers through high school teachers to address workforce shortages.
- *Service Delivery & Access 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*



*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)

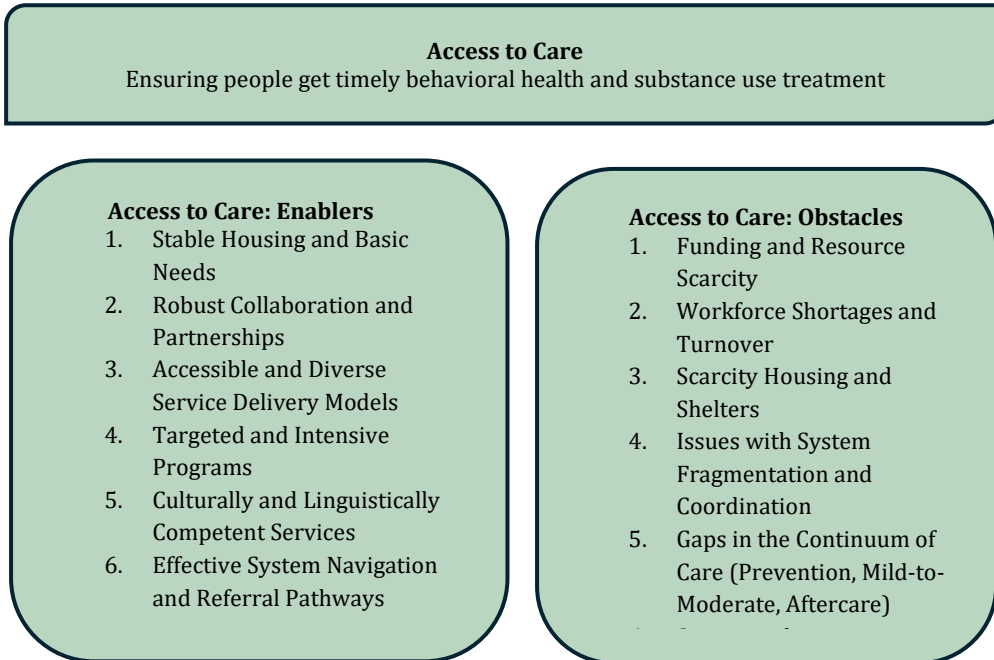
Other interviewees identified FSPs as their top priority due to the intensive, comprehensive support this component provides for individuals with serious mental illness. One interviewee explained their rationale: "I would probably put that [FSP] as my highest because we also see that [it] also tends 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.



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 BHS 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 (HHS) 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](#).

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	<input checked="" type="checkbox"/>	\$ -	\$ -	\$ -	\$ 642,323.00	\$ 674,439.00	\$ 708,161.00	#	#
Early Intervention Services	<input type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	#	#
Outpatient Services	<input checked="" type="checkbox"/>	\$ 3,454,146.00	\$ 3,626,853.00	\$ 3,808,196.00	\$ -	\$ -	\$ -	#	#
Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 2,000,000.00	\$ 2,100,000.00	\$ 2,205,000.00	\$ 205,900.00	\$ 216,195.00	\$ 227,005.00	#	#
Crisis and Field-Based Services	<input type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	#	#
Residential Treatment Services	<input type="checkbox"/>	\$ 2,775,000.00	\$ 2,913,750.00	\$ 3,059,438.00	\$ 50,000.00	\$ 52,500.00	\$ 55,125.00	#	#
Inpatient Services	<input checked="" type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	<input type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	#	#
Early Intervention Services	<input checked="" type="checkbox"/>	\$ 1,408,336.00	\$ 1,478,753.00	\$ 1,552,691.00	\$ 10,500,372.00	\$ 11,025,391.00	\$ 11,576,661.00	#	#
Outpatient and Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 17,197,487.00	\$ 18,057,361.00	\$ 18,960,229.00	\$ 3,900,284.00	\$ 4,095,298.00	\$ 4,300,063.00	#	#
Crisis Services	<input checked="" type="checkbox"/>	\$ 5,415,423.00	\$ 5,686,194.00	\$ 5,970,504.00	\$ -	\$ -	\$ -	#	#
Residential Treatment Services	<input checked="" type="checkbox"/>	\$ 800,959.00	\$ 841,007.00	\$ 883,057.00	\$ -	\$ -	\$ -	#	#
Hospital and Acute Services	<input checked="" type="checkbox"/>	\$ 8,574,061.00	\$ 9,002,764.00	\$ 9,452,902.00	\$ 110,000.00	\$ 115,500.00	\$ 121,275.00	#	#
Subacute and Long-Term Care Services	<input checked="" type="checkbox"/>	\$ 11,078,687.00	\$ 11,632,621.00	\$ 12,214,252.00	\$ 664,000.00	\$ 697,200.00	\$ 732,060.00	#	#
Housing Services (MH + SUD)									
Housing Services	<input checked="" type="checkbox"/>	\$ 8,424,779.00	\$ 8,846,018.00	\$ 9,288,319.00	\$ -	\$ -	\$ -	#	#
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		\$ 61,128,878.00	\$ 64,185,321.00	\$ 67,394,588.00	\$ 16,072,879.00	\$ 16,876,523.00	\$ 17,720,350.00	0	0

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	\$ -	\$ -	\$ -
Workforce Investment Activities	\$ 221,254.00	\$ 232,317.00	\$ 243,933.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	\$ 10,793,527.00	\$ 11,333,203.00	\$ 11,899,863.00
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)	\$ 11,483,990.00	\$ 12,058,189.00	\$ 12,661,098.00

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	\$ 22,453,673.00	\$ 24,174,023.00	\$ 25,392,917.00
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	\$ 2,987,591.00	\$ 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)	\$ 88,685,747.00	\$ 93,120,033.00	\$ 97,776,036.00
Total Projected Expenditure Variance	\$ -	\$ -	\$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	\$ 77,201,757.00	\$ 81,061,844.00	\$ 85,114,938.00
Auto-validation: Table 2: Other County Expenditures	\$ 11,483,990.00	\$ 12,058,189.00	\$ 12,661,098.00

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.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers				
	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 (BHSA) 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 (BHSA) 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 (BHSP) 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)	\$ 3,468,916.00			
Excess Prudent Reserve Funding that must be transferred	\$ (744,847.00)			
Housing Intervention (3)	\$ -			
FSP	\$ -			
BHSS (4)	\$ -			
Total Transferred Excess Prudent Reserve (auto-populated)	\$ -			
References				
1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.				

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the 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 MSHA 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 MSHA 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 MSHA 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	\$ -	\$ -	\$ -
Total Housing Interventions Expenditures (auto-populated)	\$ 3,252,270.00	\$ 3,612,548.00	\$ 3,793,177.00
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)	\$ -	\$ -	\$ -
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 MHS-A-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year One	Year Two	Year Three
MHS-A "Encumbered" INN	\$ -	\$ -	\$ -
References			
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHS-A 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 BHS-A-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 8.8.2 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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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	\$ 111,408.00	\$ 116,978.00	\$ 122,827.00
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)	30	30	30						
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 MHSAs 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 MHSAs 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 6.8.2 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: MHSAs 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 MHSAs 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 (MHSAs - Unspent Carryover Funds)	\$ 3,250,000.00	\$ 3,250,000.00	\$ 3,234,000.00						
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSAs Funds)	\$ 11,418,234.00	\$ 11,317,819.00	\$ 11,324,455.00						
Type of Service	Projected Expenditures - Unspent MHSAs and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSAs and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSAs 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	\$ 2,962,012.00	\$ 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	\$ 4,948,651.00	\$ 5,196,084.00	\$ 5,455,888.00	\$ 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	\$ 4,648,651.00	\$ 4,881,084.00	\$ 5,125,138.00	\$ 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)	\$ 221,254.00	\$ 232,317.00	\$ 243,933.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated BHSA WET funds	\$ 221,254.00	\$ 232,317.00	\$ 243,933.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated MHSAs WET funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Facilities and Technological Needs (CF/TN)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated BHSA CF/TN funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dedicated MHSAs CF/TN funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
BHSA Innovative BHSS Pilots and Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MHSAs INN Projects	\$ 1,306,808.00	\$ 1,772,148.00	\$ 1,870,946.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 9,163,345.00	\$ 10,021,513.00	\$ 10,532,779.00	\$ 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	\$ 11,660,567.00	\$ 12,253,786.00						
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)	76.5%	67.7%	57.7%						
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	74.9%	74.9%	74.9%						
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	\$ -	\$ -	\$ -						
BHSS transfer to CF/TN	\$ -	\$ -	\$ -						
Projected MHSAs-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	Year One	Year Two	Year Three						
Estimated MHSAs WET Funds	\$ -	\$ -	\$ -						
Estimated MHSAs CF/TN Funds	\$ -	\$ -	\$ -						
MHSAs "Encumbered" INN	\$ 4,949,902.00	\$ 3,643,094.00	\$ 1,870,946.00						
References									

<p>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).</p>
<p>2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs</p>
<p>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.</p>
<p>4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHS 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.</p>
<p>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.</p>

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	\$ 1,684,358.00	\$ 1,768,576.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 311,197.00	\$ 326,757.00	\$ 343,095.00
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	\$ 43,141,063.00	\$ 93,120,033.00	\$ 97,776,036.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.9%	1.8%	1.8%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.7%	0.4%	0.4%
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)	\$ 3,468,916.00
Excess Prudent Reserve Funds (auto-populated)	\$ (744,847.00)
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	\$ 3,250,000.00	\$ 4,870,000.00
Estimated Total Available Funding for Year One	\$ 4,473,080.00	\$ 8,426,862.00	\$ 11,418,234.00	\$ 24,318,176.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year One Expenditures	\$ 3,252,270.00	\$ 6,556,471.00	\$ 10,724,349.00	\$ 20,533,090.00
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)	\$ 1,220,810.00	\$ 3,490,391.00	\$ 3,943,885.00	\$ 8,655,086.00
Estimated Total Available Funding for Year Two	\$ 5,638,901.00	\$ 10,213,574.00	\$ 12,011,704.00	\$ 27,864,179.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Two Expenditures	\$ 3,612,548.00	\$ 6,884,295.00	\$ 11,660,567.00	\$ 22,157,410.00
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)	\$ 2,026,353.00	\$ 4,939,279.00	\$ 3,585,137.00	\$ 10,550,769.00
Estimated Total Available Funding for Year Three	\$ 6,456,840.00	\$ 11,681,325.00	\$ 11,675,592.00	\$ 29,813,757.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Three Expenditures	\$ 3,793,177.00	\$ 7,228,511.00	\$ 12,253,786.00	\$ 23,275,474.00
BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	\$ 800,000.00	\$ 1,684,358.00	\$ 1,768,576.00	\$ 4,252,934.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 311,197.00	\$ 326,757.00	\$ 343,095.00	\$ 981,049.00
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 MHSAs unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSAs 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 BHSA". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Components): Added unspent MHSAs funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSAs 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 MHSAs "Encumbered" INN Funds and unspent MHSAs "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 MHSAs "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSAs 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 MHSAs 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