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Behavioral Health Integrated Plan FY 2026-2029

January 7, 2026

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CARE CONTINUUM AND FUNDING

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Behavioral Health Plan Care Continuum

Discrete Substance Use Disorder Service Categories	Primary Prevention Services	Early Intervention Services	Outpatient Services	Intensive Outpatient Services	Crisis and Field-Based Services	Residential Treatment Services	Inpatient Services	Housing Intervention Services
Discrete Mental Health Service Categories	Primary Prevention Services	Early Intervention Services	Outpatient & Intensive Outpatient Services	Crisis Services	Residential Treatment Services	Hospital/ Acute Services	Subacute/ Long-term Care Services	

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Behavioral Health Funding

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

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TRANSFORMATION of SERVICES ACT

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Historical Context of the Mental Health Services Act

- The Mental Health Services Act (MHSA) or Prop 63 was voted on by California voters and became law November 2024
- Taxes 1% of income over $1 million and provides additional funding to supplement and transform County's existing public behavioral health system
- The MHSA currently has 5 components:

    1. Community Services and Supports (CSS)
    2. Prevention and Early Intervention (PEI)
    3. Innovation (INN)
    4. Workforce Education and Training (WET)
    5. Capital Facilities/Technological Needs (CFTN)

Note: The 3-year MHSA Plan and Budget includes only initiatives funding by the MHSA

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Transformation of Mental Health Services Act to Behavioral Health Services Act

- MHSA transforms to **Behavioral Health Services Act (BHSA).** Most changes effective 7/1/2026.
- The BHSA funds both Mental Health (MH) and **Substance Use Disorder (SUD) treatment.**
- **The BHSA has 3 components:**

  1. Full-Service Partnerships (FSP)

  2. Housing Interventions (HI)

  3. Behavioral Health Services and Supports (BHSS)

- State's allocation of funds under BHSA is doubled (changes from 5% to 10%)
  - Shifts $140 million annually for population-based prevention programs, statewide BH workforce initiative and existing administrative costs.
- State commission, known as Mental Health Services Oversight and Accountability Commission (MHSOAC) becomes **Behavioral Health Services Overnight and Accountability Commission (BHSOAC)**

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Transformation of Mental Health Services Act to Behavioral Health Services Act

- MHSA Three Year Plan and Annual Updates become obsolete and replaced by **Integrated Plan (IP) and Annual Update Report**
  - IP and Annual Update are required to report out **on all local, state, and federal BH programming, funding, and outcomes provided by County public BH systems**
  - IP and Annual Update details to be determined by Department of Health Care Services (DHCS)
  - Reporting will be **electronic via reporting portal**. Information for all Counties will be posted online and available to the public.
  - Annual Revenue and Expenditure Report (ARER) becomes obsolete and replaced by **Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)**
- Community Program Planning Process (CPPP) is restructured significantly effective 7/1/25
  - **Must coordinate with managed care plans & local health jurisdictions**. In Contra Costa, this is Public Health and the Contra Costa Health Plan.
  - Other changes are to be determined.

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The Behavioral Health Integrated Plan (IP)

- The BHSA establishes the IP to serve as a three-year prospective global spending plan
- Describes how county behavioral health departments plan to use all available behavioral health funding
- Meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community
- IP provides a description of how counties plan expenditures across a range of behavioral health fund sources
- Data-informed local service planning process
- Provides transparency into county planning for expending BHSA funding and all other behavioral health funding sources
- Facilitate local and statewide data collection to provide baseline data on services and planned expenditures
- Supporting analysis of county goals and outcomes

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Components of the County Integrated Plan (IP)

Community Planning Process	• Stakeholder Outreach • Public Comment & Hearing • Response to Feedback
County Demographics and BH Needs	• Prevalence of SMI/SUD and gaps in care • Health Equity & Disparities
BH Care Continuum Capacity	• Service Delivery Landscape • Technical Infrastructure • Contracted Providers
Statewide & Local Goals	• Priority Goals (e.g., homelessness, JI) • Self-selected goals • Population-level measures
BH Services Fund (35/30/35)	• FSP – highest intensity (35%) • Housing Interventions (30%) • BHSS – includes EI (35%)
Workforce Strategy	• Lived Experience Integration (Peer Support Specialists) • Training & Retention – including training for EBPs
Budget & Prudent Reserve	• Projected Expenditures – 3-year budget for all funding (realignment, BHSA, Fed Grants, Medi-Cal) • Prudent Reserve Certification • Transfer Requests

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Data Used in the Implementation Plan – following Data Dictionary and Workbook

Stratified Analysis	• Age Groups • Race & Ethnicity • Gender Identity & Sexual Orientation • Primary Language
Population-Level Metrics	• Access to Care – Penetration rates • Homelessness – whether receiving BH services • Justice Involvement • Institutionalization • Child Welfare – Foster Care
Identification of Priority Populations	• Chronically Homeless • Re-entry Populations – from state prisons or Jails • Early Intervention Youth
Substance Use Disorder (SUD) Prevalence	• Overdose rates – stratified by Zip Code and demographic group • Unmet SUD need – estimates of the treatment gap

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Community Planning
Engaging the Community

61 Events *Apr-Jul 2025*

37 Community Conversations
10 Stakeholder-Focused Sessions
7 Town Hall Forums
7 Key Informant Interviews

741 Surveys

396 Online surveys (incl. 43 in Spanish)
263 Full paper surveys (44 Spanish)
81 Demographic-only w/ feedback
14 Jail detainee surveys
14 BHS intern surveys

Preliminary Analysis

- Data collection and cleaning continues
- **52 event notes + 353 surveys** pulled into one spreadsheet
- Thematic Analysis:
  1. Community Engagement Planning Workgroup facilitators reported themes & shared experiences from participants
  2. CPP committee combed through notes and surveys identifying key recurring themes & quotes
  3. AI tools identified patterns and representative quotes

Identified Needs

Access to Care
- **Systemic and Navigational Challenges**
- **Appointment Delays**
- **Lack of Information and Accessibility**
- **Cultural and Linguistic Barriers**
- **Stigma and Trust Issues**
- **Economic and Emotional Barriers to Care**
- **Insufficient Resources**
- **Comprehensive Behavioral Health Services Needed**
- **Administrative and Data Systems Challenges**

Quality and Effectiveness of Services
- **Under-resourced Services**
- **Equitable Access to Care**
- **Workforce and Training Challenges**
- **Lack of Coordination of Care**

Housing Supports and Services
- **Lack of Awareness**
- **Improved Support for Housed Individuals (frequent)**
- **Need for Navigation Support**
- **Increased Coordination with Behavioral Health Service Providers**
- **Limited Access to Housing Resources**
- **Tailored Housing Resources for Specific Populations**
- **Wider Range of Different Type of Housing & Support**

Additional Community Insights and Suggestions
- **Better Data Sharing and Coordination Among Providers**
- **Importance of Prevention and Early Intervention**
- **Recommendations for Resource Allocation**
- **Tailored Services to Diverse Populations**
- **Funding Reduction Concerns**
- **Providers should be Trained at Same Level as County Staff**

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Early Intervention: Focus Populations

Populations identified by the community for early intervention support include:

- **Culturally Diverse Communities** – outreach/services reflecting culture and language
- **LGBTQIA+** – culturally affirming care and support
- **Older Adults** – improving mental health and reducing isolation
- **Parents & Caregivers** – tools to reduce stress and strengthen relationships
- **Transition Age Youth** – building resilience, staying in school, avoiding crisis
- **Veterans** – early mental health and substance use support

Note: Populations are alphabetized, not ranked by priority.

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Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

Submit Behavioral Health Outcomes, Accountability, and Transparency Reports (BHOATRs) to the Department of Health Care Services (DHCS) on an annual basis

The BHOATR will provide California with greater transparency on how behavioral health dollars are spent and managed.

Report on Implementation of the county Integrated Plan (IP) and the related annual and intermittent updates.

County boards of supervisors are required to attest that the BHOATR is complete

Board of Supervisors are required to attest that the county is meeting its realignment obligations:

- Meet time and distance standards
- Appointment time standards
- Access to Care – No Waitlist
- Network adequacy

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BEHAVIORAL HEALTH SYSTEM TRANSFORMATION

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Behavioral Health Transformation Goals

Behavioral Health Transformation (BHT) Goals

- **Improve** access to care
- **Increase** accountability and transparency for publicly funded, county administered behavioral health services
- **Expand** capacity of behavioral health facilities across

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Priority Populations Under Behavioral Health Services Act

Eligible adults and older adults who are:

- Chronically homeless or experiencing homelessness or are at risk of homelessness
- In, or are at risk of being in, the justice system
- Reenting the community from prison or jail
- At risk of conservatorship
- At risk of institutionalization

Eligible children and youth who are:

- Chronically homeless or experiencing homelessness or are at risk of homelessness
- In, or are at risk of being in, the juvenile justice system
- Reenting the community from a youth correctional facility
- In the child welfare system
- At risk of institutionalization

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Statewide Behavioral Health Outcomes

To Improve

- Care Experience
- Access to Care
- Prevention and Treatment of co-occurring physical health conditions
- Quality of life
- Social Connection
- Engagement in school
- Engagement in work

To Reduce

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-Involvement
- Removal of children from home

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COMPONENT 1: BEHAVIORAL HEALTH SERVICES and SUPPORTS (BHSS)

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Transformation of Prevention and Early Intervention (PEI) to Early Intervention (EI)

- **Prevention category, currently under Prevention and Early Intervention (PEI)** component of MHSA is considered population-based programming and **no longer locally funded in BHSA.**
  - Prevention funding shifts to California Department of Public Health (CDPH). CDPH to be lead and will consult with DHCS and BHSOAC to administer funds through State initiatives
  - Programming may be provided via school-based prevention supports and programs. Services may be provided via schoolwide or classroom basis; or by a community-based organization off campus or on school grounds; AND (51%) of this programming must serve people ages 25 and younger.
- **Early Intervention (EI)** category remains under BHSA and funded through BHSS component. There are **significant changes** in EI compared to what has historically been known as PEI.
- Due to regulatory requirements under BHSA, service providers may need to restructure services to remain eligible for BHSA funding. This will likely affect EI contracts service providers significantly; as it may be necessary to provide **Medi-Cal billable services.**

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Early Intervention Goals

- EI funds **must prioritize childhood trauma & address root causes of Adverse Childhood Experiences (ACEs)** or other social determinants of health that contribute to early origins of MH and **SUD**, including strategies that focus on:
  - Youth experience homelessness
  - Justice-involved youth
  - Child welfare-involved youth with a history of trauma
  - Other populations at risk of developing serious emotional disturbance of **substance use disorders**
  - Children & youth in populations with identified disparities in behavioral health outcomes (WIC Sections 5840 and 5892)
- EI programs must focus on reducing likelihood of certain adverse outcomes (WIC Sections 5840(d)). **Bold** represents additional goals for counties under BHSA; including early childhood (ages 0-5), Transitional Kindergarten (TK) through 12th grade, and higher education
  - Suicide **and self harm**
  - Incarceration
  - School **suspension, expulsion, referral to an alternative or community school**, or failure to complete
  - Unemployment
  - Prolonged suffering
  - Homelessness
  - **Overdose**
  - Removal of children from homes
  - **Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood**

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Early Intervention Categories & Definitions

- EI programs are required to be "designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health" WIC Section 5840(a)(1)
- The three EI categories that may be funded are defined as:
  - **Access of Linkage to Care**
    - Focus on access and linkage to medically necessary care provided by County BH programs as early in the onset of these conditions as practicable
  - **Mental Health (MH) and Substance Use Disorder (SUD) Treatment Services and Supports**
    - MH and SUD treatment services and supports that are effective in preventing MH illness & SUD from becoming severe, and have become successful in reducing duration of untreated serious MH illness & SUD and assisting people in quickly regaining productive lives
  - **Outreach**
    - Inclusive of outreach to families, employers, primary care health care providers, BH urgent care, hospitals, inclusive of emergency departments, education, early care and learning, TK-12, higher education, and others to recognize early signs of potentially severe and disabling MH illness and SUD (WIC Section 5840 (b)(1))

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Coordinated Specialty Care

- CSC is a community-based service designed for members experiencing clinical high risk for psychosis or first episode psychosis.
  - By providing timely and integrated supports during the critical initial stages of psychosis, CSC reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness
- CSC is a person-centered, team-based service that helps members and their caregivers cope with the symptoms of their mental health condition and to function and remain integrated in the community
- Multidisciplinary CSC teams provide a wide range of individualized supports to members exhibiting initial signs of psychosis
- Bundled Rate (under BH-CONNECT)

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Other Initiatives Under BHSS

- **Children's, Adult, and Older Adult Systems of Care**
  - Activities may remain the same as what counties were funding under MHSA Community Services and Supports (General Systems Development), with addition of **SUD services and modified eligible priority populations**
- **Outreach and Engagement**
  - Reach, identify, and engage individuals and communities in the behavioral health system, include peers and families, and to reduce disparities
- **Workforce Education and Training (WET)**
  - Counties may fund in accordance with county needs to support employment in Public Behavioral Health System to include **SUD providers** such as: 1) Workforce recruitment, development, training, and retention; 2) Professional licensing and/or certification testing and fees; 3) Loan repayment; 4) Retention incentives and stipends; 5) Internship and apprenticeship programs; 6) Continuing education; 7) Efforts to increase racial, ethnic, and geographic diversity of public behavioral health workforce system
- **Capital Facilities/Technological Needs (CFTN)**
  - Counties may use CFTN funds as required match for Bond Behavioral Health Continuum Infrastructure Program (BHCIP) awards. Technological Needs projects should: 1) increase client and family empowerment and engagement by providing tools for secure access to health information and 2) modernize and transform clinical and administrative information systems.
- **Innovative Behavioral Health pilots and projects (INN)**
  - BHSOAC is lead. Counties may pilot innovative health models of care or innovative promising practices for programs in all funding components.

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BEHAVIORAL HEALTH SUPPORT and SERVICES EVIDENCE BASED PRACTICES

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Functional Family Therapy

- Functional Family Therapy (FFT) is an effective, short-term, family-based, proprietary counseling service which seeks **to empower familied to solve their own problems** through growth and change
  - FFT is designed for young people (ages 10-18) who are at risk of, or have been referred for, behavioral or emotional problems (e.g., delinquency, substance use)
  - **Status in Contra Costa**: Contracted program with EMBRACE Mental Health

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Multi-Systemic Therapy

- Multi-Systemic Therapy (MST) is an intensive, evidence-based, family-driven, proprietary treatment model for youth (ages 12-17 years old) who are **involved in the juvenile justice system** who are **at risk of out-of-home placement** due to a history of delinquent behavior.
  - MST emphasizes cultural responsiveness and the centering of home and communal settings, as well as partnership with law enforcement and the juvenile justice system
  - **Status in Contra Costa**: Contracted program with EMBRACE Mental Health

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Parent Child Interactive Therapy

- Parent-Child Interactive Therapy (PCIT) is an evidence-based, short-term treatment designed to foster the well-being of children and families of all cultures by teaching parents strategies that will promote positive behaviors in children and youth (ages 2-7) who exhibit challenging behaviors such as defiance and aggression
  - **Status in Contra Costa**: Currently not implemented

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COMPONENT 2:
FULL-SERVICE PARTNERSHIP

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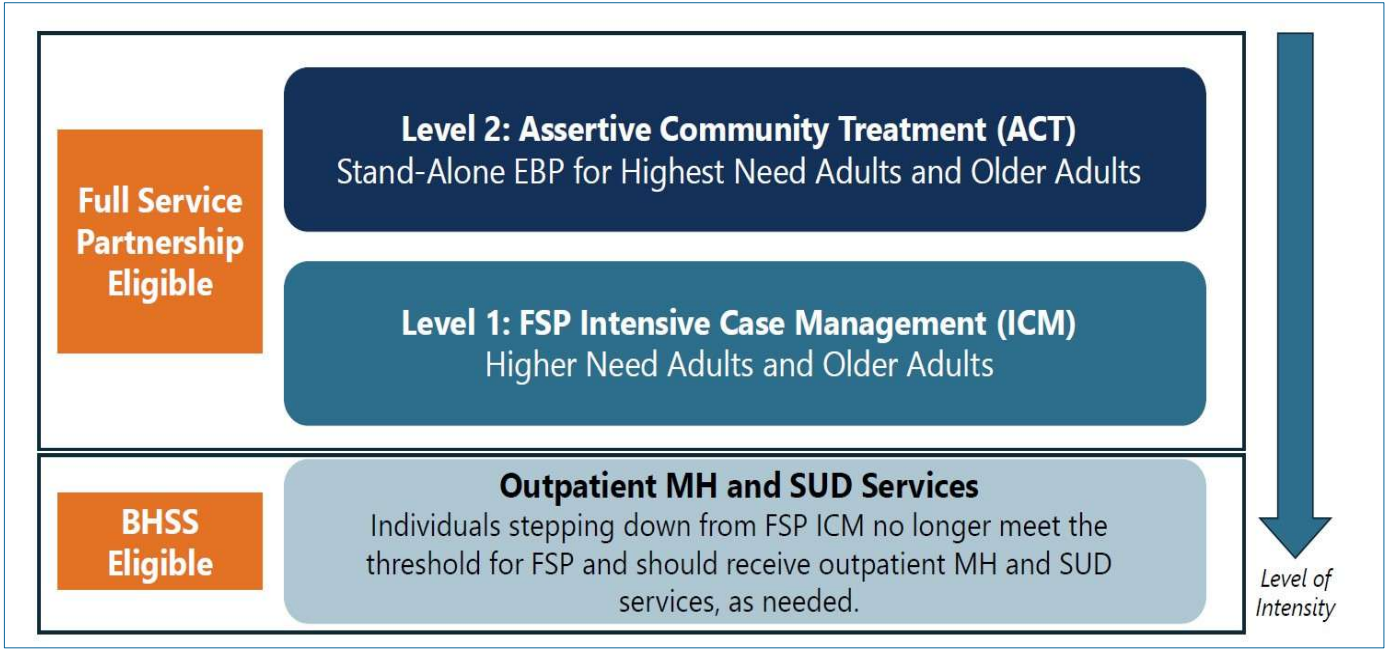
Adult FSP Levels of Care Framework

- The framework includes two levels of coordinated care for adults and older adults with ACT/FACT as the highest level and a step-down level from ACT/FACT, called FSP Intensive Case Management (ICM)
  - **ACT**: Assertive Community Treatment
  - **FACT**: Forensic Assertive Community Treatment, ACT-level services for justice involved individuals



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Assertive Community Treatment Specialty Models

(Both adaptions can be part of an ACT program)

FACT (Forensic ACT)
Tailored to justice involved individuals. The goal is to reduce recidivism
Includes intensive coordination with justice partners (courts, probation)
Use risk/needs assessments to inform joint treatment planning with justice partners to promote wellness and public safety, with a focus on criminogenic risks
The Rochester Forensic Assertive Community Treatment Scale (R-FACT) must be used to monitor fidelity
FACT teams are multidisciplinary and must include members with lived experience in the justice system
All members have FACT training

ACT-SUD
Assertive field-based MAT initiation for SUD treatment using harm reduction principles
No wrong door to Medication Assisted Treatment (MAT) for individuals with opioid use and alcohol use disorders
Outreach and engagement to individuals wherever they are, (e.g., on the street, Eds, in syringe exchange programs, in homeless encampments)
Expands low-barrier, rapid access to all forms of MAT (buprenorphine, methadone, naltrexone, naloxone, sublocade, etc.)

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Intensive Case Management

- Intensive Case Management (ICM) is a well-known services and documented in the literature
- ICM includes a **comprehensive set of community-based services** for individuals with significant behavioral health conditions
- Compared to standard care, ICM has been shown to improve **general functioning, employment and housing outcomes, and reduce length of hospital stays**
- ICM does not have set fidelity criteria like ACT but generally combines the principles of case management (assessment, planning, linkages) with **low staff to client ratios, assertive outreach**, and **direct service delivery**

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Individual Placement and Support Employment Eligibility Criteria

- Individual Placement and Support (IPS) proposed eligibility criteria aligns with best practices, prioritizing inclusivity and client choice

Proposed Eligibility Criteria

To be eligible for Supported Employment services, an individual must:

a. Meet FSP eligibility criteria; **AND**
b. Express interest in receiving Supported Employment Services

- This approach is grounded in national best practices including "zero exclusion criteria" from the official IPS fidelity scale and "eligibility is based on consumer choice" from SAMHSA's Supported Employment toolkit

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High Fidelity Wraparound Overview

- High Fidelity Wraparound is a **team-based** and **family centered evidence-based practice** that includes an **"anything necessary"** approach for children/youth living with the **most intensive mental health or behavioral health challenges.**
  - HFW is regarded as an **alternative to out-of-home placement for children with complex needs**, by providing intensive services in the family's home and community

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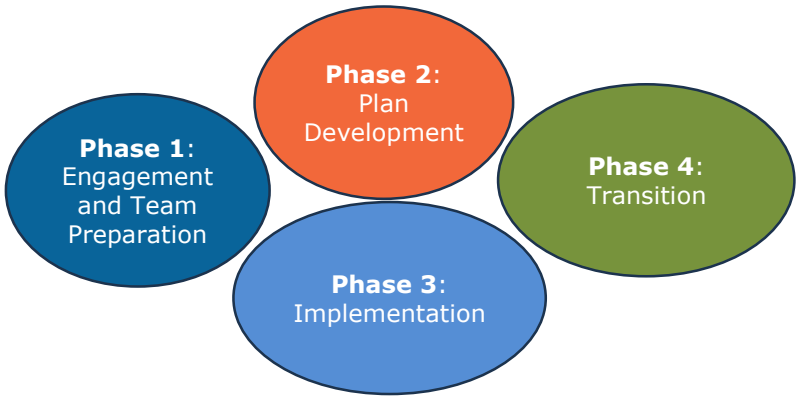
High Fidelity Wraparound Overview (cont.)

High Fidelity Wraparound (HFW) centers **family voice** and decision making in developing a **care plan** to reach desired family outcomes by providing a structured, creative, and **individualized** set of strategies that result in plans/services that are effective and relevant to the child, youth and family

HFW is delivered by a HFW facilitator who leads a **team** through a prescribed process, which is both flexible and responsive to child and family-identified strengths and needs

At its core, high fidelity is defined as adherence to the four phases of the MHW model



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COMPONENT 3: HOUSING

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What Types of "Housing" Behavioral Health Services Does Now

TEMPORARY BEDS	TREATMENT BEDS		INTERIM/PERMANENT HOUSING
ACUTE	SUB-ACUTE	RESIDENTIAL	1. Board and Care (non-enhanced) 2. Room and Board
1. State Hospital Beds 2. Acute Psychiatric 3. General Acute Care Hospital with Psychiatric Ward 4. Psychiatric Health Facility (PHF) 5. Crisis Stabilization Unit (CSU) 6. ASAM Medically Managed Inpatient (ASAM 4)	1. Sub-Acute State Hospital beds 2. Special Treatment Program/Skilled Nursing Facility (STP/SNF) 3. ASAM Medically Managed Residential (3.7) 4. Mental Health Rehab Center (MHRC) 5. Recuperative Care	1. Crisis Residential 2. Peer Respite (29 days-tenancy 3. ASAM 3.1-3.5 4. Transitional Adult Residential Treatment Facilities 5. Enhance Board and Care (patched)	3. Peer Supported Housing & Peer Run Recovery Residence (ASAM Type P) 4. Recovery Residences Supervised (ASAM Type S) 5. Recovery Residences Monitored (ASAM Type M) 6. Transitional /Bridge Housing 7. Permanent Supportive Housing -Individual Units 8. Permanent Supportive Housing – Shared Units 9. Permanent Supportive Housing –SRO Motel Conversion 10. Master Lease Housing 11. Affordable Senior Housing 12. Affordable rental/ Affordable Homeowner 13. Unsubsidized Rental/ Standard Homeowner

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Refocus of Behavioral Health Housing and Supports

PROGRAM GOALS

- Reduce homelessness among BHSA eligible individuals.
- To the extent possible – provide permanent supportive housing (PSH) including supports such as ACT and ICM. (Intersection with FSP Group)
- Support low-barrier, harm reduction and housing first principals.
- Complement other ongoing initiatives including State and Continuum of Care

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Housing Interventions Allowable Under BHSA

Non-Time Limited Permanent Settings	Time-Limited Interim Settings	Other Housing Supports
Supportive Housing	Hotel and motel stays	Housing Flex Pool Expenditures (start-up expenditures)
Apartments, including master-lease apartments	Non-congregate interim housing models	Rental Subsidies
Single and multi-family homes	Congregate setting	% administered through Flex Pools
Single room occupancy units	Recuperative care	Operating Subsidies
Accessory dwelling units, including Junior Accessory Dwelling Units	Short-term post hospitalization housing	Other Housing Supports: Landlord Outreach and Mitigation
Shared Housing	Tiny homes, emergency sleeping cabins, emergency stabilization units	Other Housing Supports: Participant Assistance Funds
Recovery/Sober living housing	Peer respite	Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services
Assisted Living (ARF, RCFE and licensed board and care)	Other settings defined under Transitional Rent	Capital Development Projects
Unlicensed room and board		
Other settings defined under transitional rent benefit		

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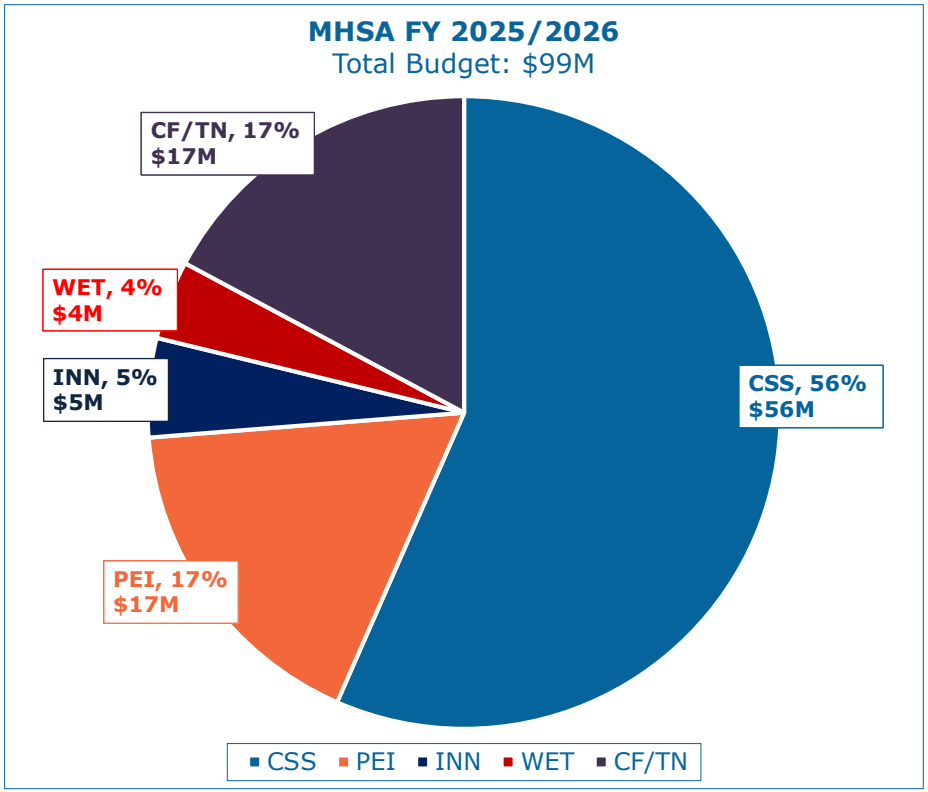
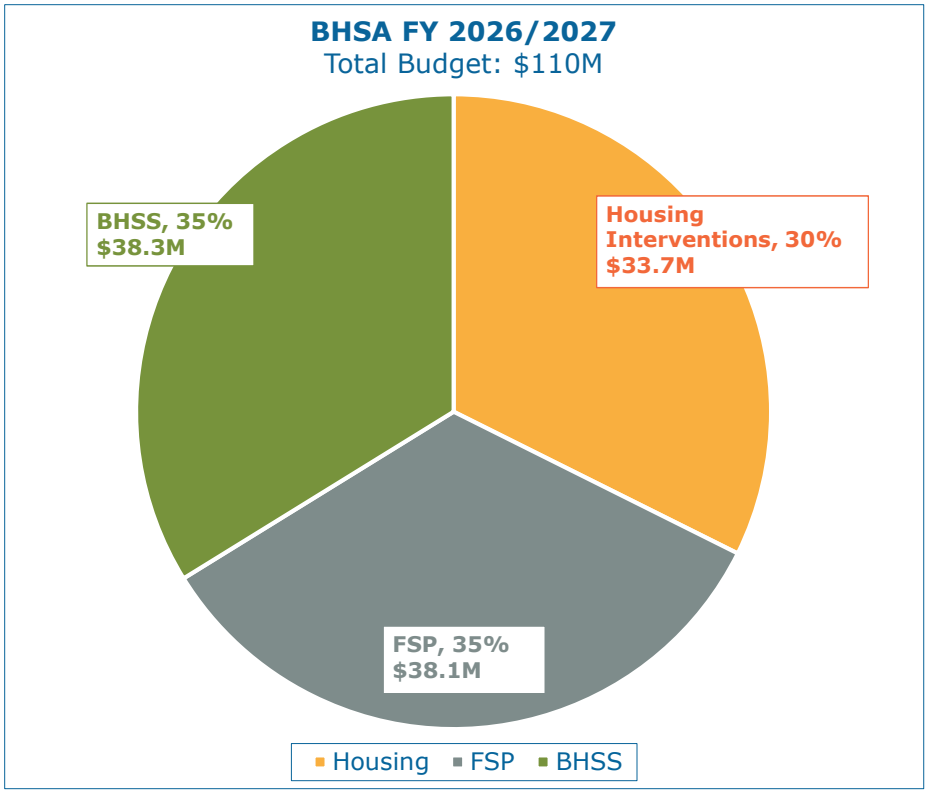
MHSA FY25/26 and BHSA FY26/27





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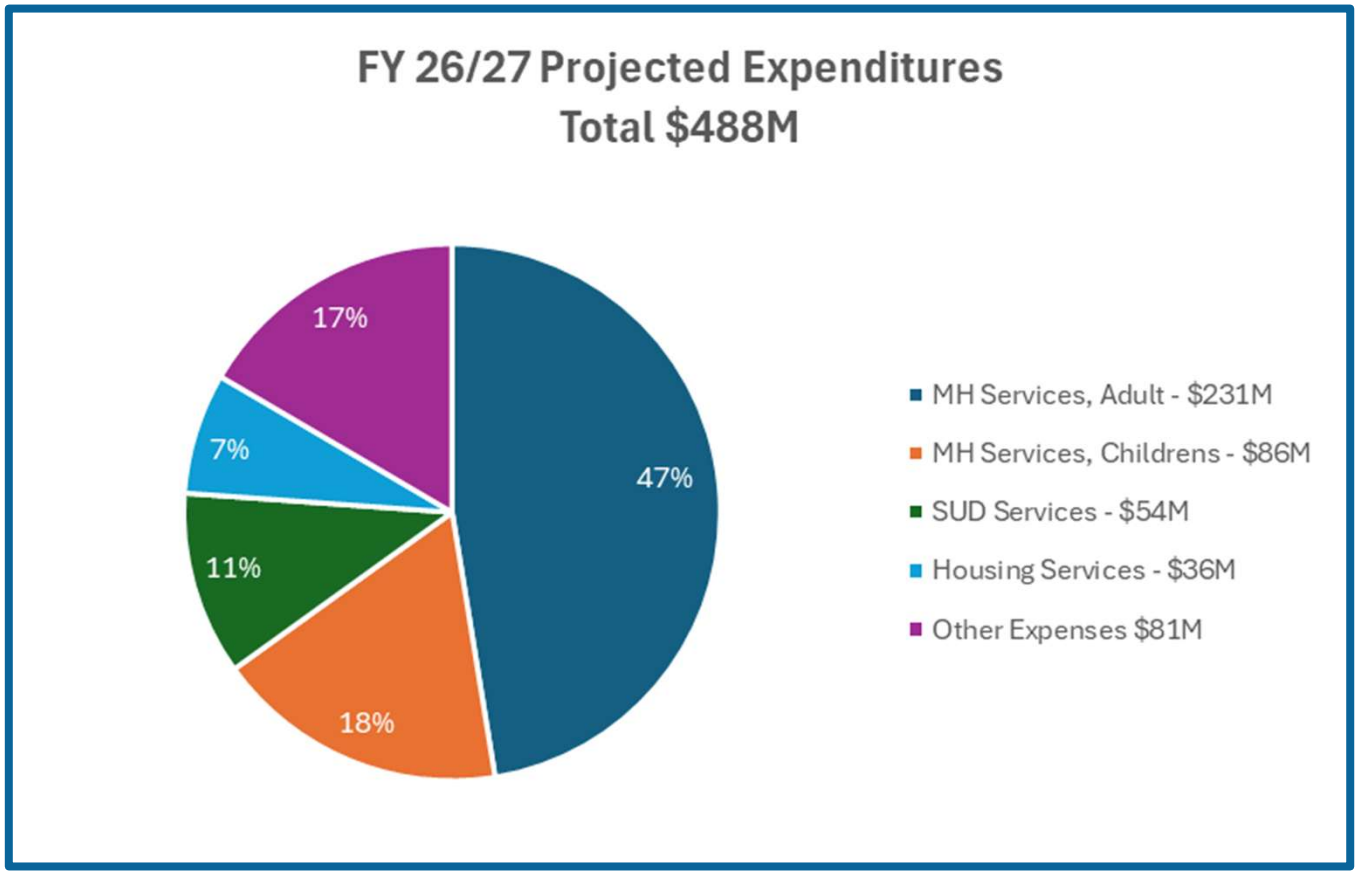
Care Continuum Projected Expenses



- Care Continuum Expenses are inclusive of all Behavioral Health services, regardless of funding.
- SUD Services largely reflect AOD existing service levels for adult ($47M) and children ($7M) SUD services.
- Implementation of BHSA has primarily impacted MH and Housing services.
- Other Expenses include Capital Infrastructure ($27M), Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities ($31M)

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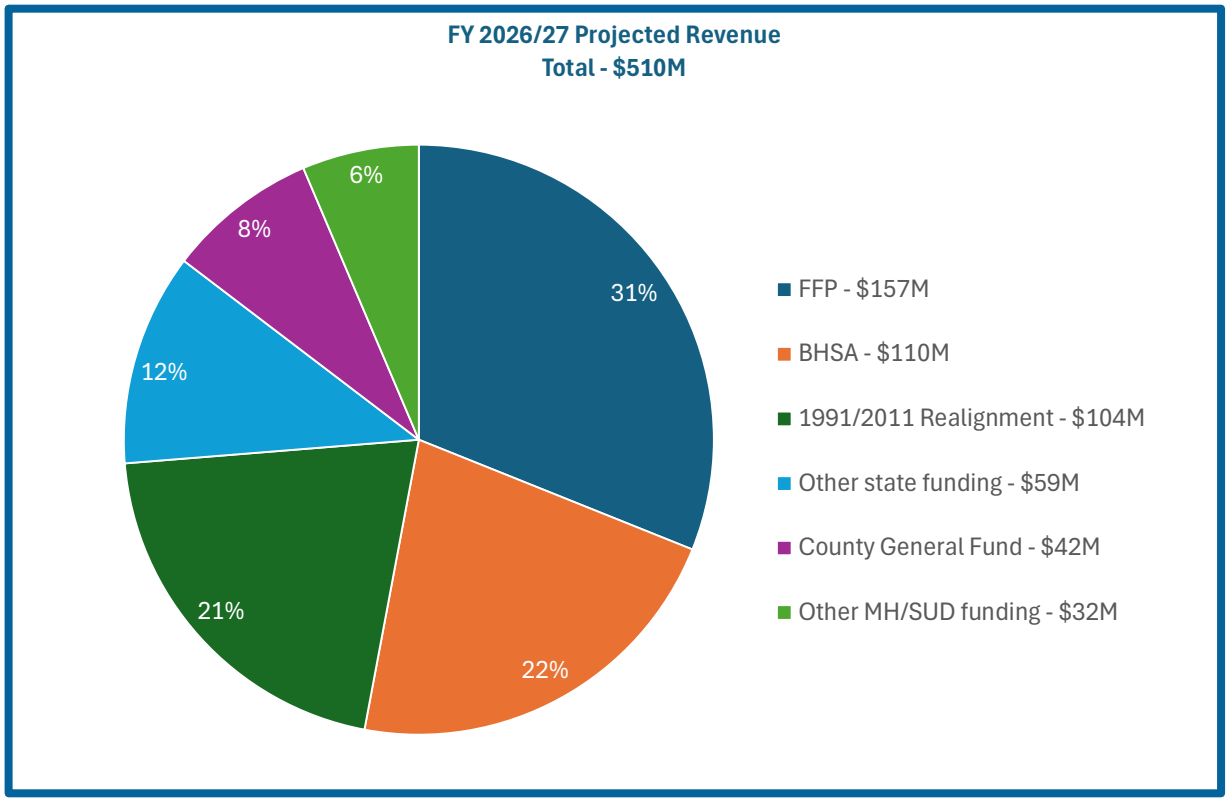
Care Continuum FY26/27 Funding



- County General Fund kept at FY25/26 levels and is inclusive of $23M in Measure X for A3 and youth/LGBTQ+ services.
- $110M in BHSA funding includes planned use of $13M in MHSA/BHSA fund balance.
- Other state funding includes $17.9M in State General Fund and includes a reduction of $4.8M for anticipated Medi-Cal revenue reduction for the UIS population.

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Thank you!