2026–2029

Behavioral Health Services Act Integrated Plan

SANTA CRUZ COUNTY

County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division
Administration
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Salud Mental y
Tratamiento del Uso
de Sustancias

LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

To Our Community Members, Partners, and Colleagues,

It is my privilege to present the Santa Cruz County Behavioral Health Services Act Integrated Plan (BHSA IP) for the upcoming three-year cycle. We share this plan at a moment of significant fiscal uncertainty for behavioral health systems across California and the nation. While the plan has been developed using the best available revenue estimates, we anticipate the need to adjust—and potentially reduce—components of the plan as we learn more about the short- and long-term State and Federal fiscal impacts that will influence our local resources.

As we prepare for possible decreases in revenue, we also anticipate an increase in demand for behavioral health services. More Santa Cruz County residents will rely on publicly funded care as other avenues for services become less accessible or affordable. This creates a challenging landscape: fewer resources paired with greater need. We remain committed to responding thoughtfully, transparently, and in partnership with our community as we navigate these conditions.

The development of this BHSA Integrated Plan has been guided by the voices of the community we serve. I want to offer my sincere thanks to everyone who participated in our robust planning process. Your insights, your lived experience, and your ongoing engagement shaped this plan in meaningful ways. Across all discussion groups, surveys, and listening sessions, one theme resonated consistently: accessible, equitable care remains a top priority for Santa Cruz County. This plan reflects that priority.

I would also like to extend heartfelt appreciation to our Behavioral Health staff and contracted provider partners. Their commitment to serving this community—through workforce shortages, funding uncertainties, and growing demand—has remained steadfast. Their work ensures that residents continue to receive essential support, treatment, and connection during times of stability and during times of strain. This system relies on their expertise, compassion, adaptability, and dedication.

Looking ahead, we know that flexibility will be essential. As fiscal realities shift, we will revisit our priorities, maintain open communication, and work collaboratively to ensure that we continue to provide the highest level of care possible for our community.

Thank you again for your partnership, trust, and participation in shaping this plan. Together, we remain committed to building a healthier, more resilient Santa Cruz County.

With appreciation,
Dr. Marni R. Sandoval
Behavioral Health Director
County of Santa Cruz

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Introduction

As a result of California's voters passing Proposition 1 in March 2024, the Behavioral Health Services Act (BHSA) is replacing the Mental Health Services Act (MHSA), which has funded county mental health services since 2004. BHSA introduces significant changes in the allowable uses of Prop 1 funds as well as fundamental shifts in fund administration and distribution. These changes require counties to realign programs, budgets, and operations to meet new state-defined requirements.

This legislation's intention is to transform the County's Behavioral Health System. BHSA aims to improve California's behavioral health system by:
- Improving access to care, including timely services for people who need support.
- Supporting people with the greatest needs, including those who are unhoused or at risk of homelessness.
- Restructuring program priorities and increasing restrictions on how funding is used.
- Expanding the involvement of community voices, using feedback from people with lived experience, families, and partners to guide planning and funding decisions.

BHSA (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan (IP) for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029).

This report aims to amplify the voices of community members and partners of the County of Santa Cruz who participated in this community planning process.

The report was created by the Behavioral Health Division of the Santa Cruz County Health Services Agency. Community members and partners provided input by helping to identify the priority needs and potential solutions.

Description of Santa Cruz County

Santa Cruz County, located in the central coast of California, is known as the Gateway to the Monterey Bay Marine Sanctuary. It has twenty-nine miles of coastline and includes numerous state parks and beaches. It is located at the northern tip of Monterey Bay, approximately sixty-five miles south of San Francisco, thirty-five miles north of Monterey, and thirty-five miles southwest of Silicon Valley. It is a diverse community with a population of approximately 265,735. There are four incorporated cities in the county. The largest is the City of Santa Cruz, followed by Watsonville, Scotts Valley, and Capitola. To see the full demographics of Santa Cruz County please view this page on the DataShare Santa Cruz County Data for Action website

Population by Race	
White	57.40%
Black/African American	1.18%
American Indian/Alaskan Native	1.36%
Asian	4.88%
Native Hawaiian/Pacific Islander	0.15%
Some Other Race	19.97%
2+ Races	15.07%

Population by Ethnicity

Hispanic/Latino 36.4%

Non-Hispanic/Latino 63.6%
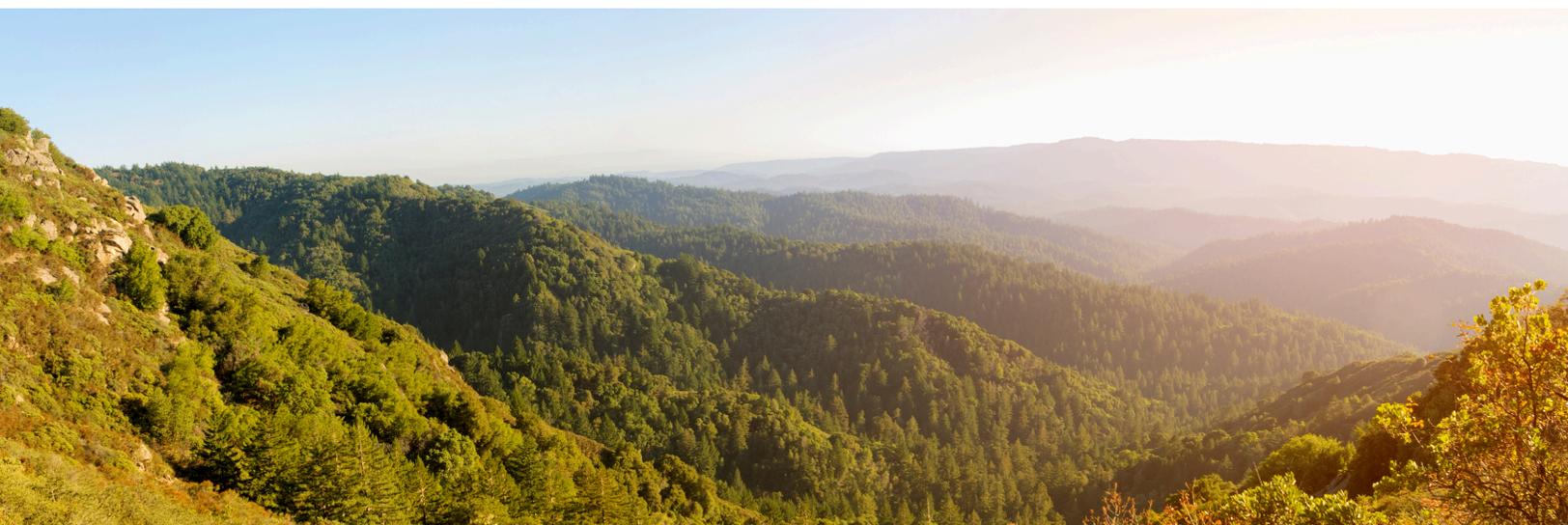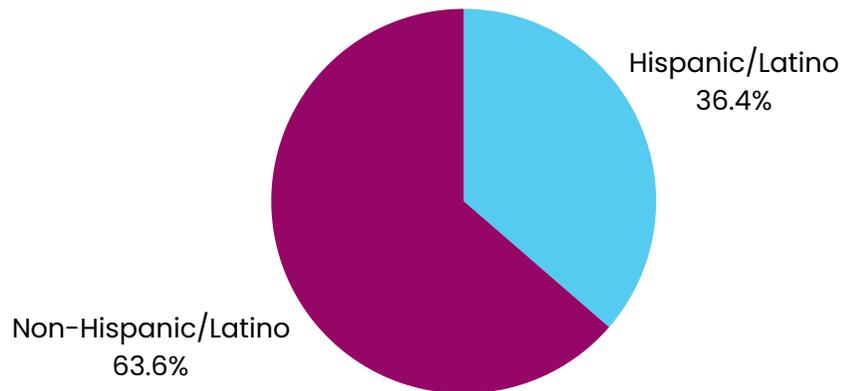
County Vision

Santa Cruz County is a healthy, safe and more affordable community that is culturally diverse, economically inclusive and environmentally vibrant.

County Equity Statement

Equity in action in Santa Cruz County is a transformative process that embraces individuals of every status, providing unwavering support, dignity, and compassion. Through this commitment, the County ensures intentional opportunities and access, fostering an environment where everyone can thrive and belong.

»» Who we are

The County of Santa Cruz Health Services Agency exists to enhance, protect and improve the health of the people in Santa Cruz County, California. To accomplish this, we provide a wide variety of health-related services in the areas of public health, environmental health, behavioral health and health center services.

»» Agency Misson

To promote and ensure a healthy community and environment by providing education, outreach and comprehensive health services in an inclusive and accessible manner.

»» Values

- Integrity
- Quality
- Compassion & Respect
- Equity & Justice
- Collective impact
- Capacity Building
- Positivity

Land Acknowledgment

The land on which we refer to as "Santa Cruz County" is the unceded territory of the Awaswas-speaking Uypi Tribe. The Amah Mutsun Tribal Band, comprised of the descendants of indigenous people taken to missions Santa Cruz and San Juan Bautista during Spanish colonization of the Central Coast, is today working hard to restore traditional stewardship practices on these lands and heal from historical trauma.

2026 - 2029 Integrated Plan
Santa Cruz 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
Santa Cruz County (SCC)

Behavioral Health Agency Name
Santa Cruz County Health Services Agency Behavioral Health Division (SCCBHD)

Behavioral Health Agency Mailing Address
P. O. Box 962 Santa Cruz, CA 95061

Primary Mental Health Contact

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Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

Name
Sube Robertson, LCSW

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Behavioral Health Services Act (BHSA) Coordinator

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Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

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Quality Assurance or Quality Improvement (QA/QI) lead

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Medical Director

Name	Email address
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| Dr. Hassan Dinakar | hassan.dinakar@santacruzcountyca.gov |

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)	1472
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	63
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	216
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	92

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	43
Were chronically homeless or experiencing homelessness or at risk of homelessness	12
Were in the juvenile justice system	60
Have reentered the community from a youth correctional facility	40
Were served by the Mental Health Plan and had an open child welfare case	99
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	<11*

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	325

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	<11*
Received Medi-Cal SMHS	3262
Received DMC or DMC-ODS services	1703
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	465
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	676

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	000
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	000
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	147
Were incarcerated (including state prison and jail)	76
Reentered the community from state prison or county jail	74
Received acute psychiatric services	610

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

Admitted or detained for 72-hour evaluation and treatment rate

1514

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

61

Admitted for 180-day post certification intensive treatment

0

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

44

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

000

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

Some of the data points in this section are not yet consistently available to report at this time. SCCBHD will continue working with partners and other departments to improve data sharing for cross-departmental reporting. As an example, while they County did collect data related to housing status and was able to report an aggregated number for the questions related to consumers who were chronically homeless, experiencing homelessness, or at-risk of homelessness, it should be noted that this number does not include consumers at-risk of homelessness as the county was not collecting that data in FY 2023/24. Additionally, the County was unable to provide data related to the number of consumers served experiencing unsheltered homelessness or for consumers who moved from unsheltered homelessness to permanent housing. Historically, SCCBHD has not collected data distinguishing unsheltered individuals from those who are homeless but sheltered. Therefore, specific data points requiring that level of distinction could not be fully completed. The County is in the process of improving data collection and reporting related to housing status for consumers served in order to understand client needs and report on required data points.

In order to provide data related to consumers involved with child welfare, on probation or parole; being incarcerated; and/or returning to the community from a carceral setting, County Behavioral Health worked with other County Departments to secure this data. This was possible due to the Health Services Agency Department having recently entered into a Data Sharing MOU with other County departments.

SCCBHD anticipates challenges with reporting data related to consumers returning to the community from prisons, including out of state facilities, as that data is not available at the county level. As a result, the incarcerated data field only reflects those who were in county jails.

It should be noted that local acute facilities submit information to the county Behavioral Health Plan (BHP) for LPS reporting based on admission and treatment data that is not specific to the host county. Therefore, data related to number of consumers admitted/detained for 72 hours, 14-days, 30-days or 180-days in local designated and approved facilities, the consumer counts will also include individuals placed from other counties who are not SCCBHD's beneficiaries/county residents. Similarly, SCCBHD's beneficiaries may be admitted/detained in facilities in other surrounding counties. For future reporting purposes ideally the plan template would provide some context for the public who may not be aware of the reporting mechanism for designated facilities and counties. For data points where information was unavailable, inaccessible, or could not be verified within the required reporting timeframe due to staff turnover, "000" was entered to indicate that the County does not currently have access to reliable data for those fields. In efforts to improve care coordination, data sharing and reporting for Behavioral Health and other county departments, Santa Cruz County will be investing in a data sharing technology Social Health Information Exchange (SHIE) in the Spring/Summer of 2026. This shared investment will include collaboration from all county departments and will be a phased project over five years. Initial use-case implementation will focus on care coordination and data integration of county departments that service the justice-involved population. Moving forward, SCCBHD is committed to strengthening internal coordination, centralizing data systems, and improving cross-department collaboration to enhance data quality and completeness.

Please describe the local data used during the planning process

Local data used during the planning process included multiple county and program-level sources. SCCBHD analyzed service utilization, demographics, diagnoses, and outcomes using AVATAR, SCCBHD's electronic health record (EHR), to understand who is being served, where gaps exist, and trends over time. We also incorporated program-specific data provided by behavioral health program managers and supervisors.

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

Yes

Please select which of the following EHRs the county uses
Netsmart
SmartCare

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

Please select which QHIO the county participates in
Manifest MedEx
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://santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/DeveloperAPIs.aspx

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?
Yes

Please describe these challenges and concerns
SCCBHD continues to collaborate with both our MCPs, Kaiser and Central California Alliance for Health (CCAH) to finalize MOUs. The current barriers to finalization are staff turn-over and cost sharing agreements. Data sharing conversations are also progressing with both MCPs and despite not yet finalizing current

MOUs, regular and ongoing meetings are occurring regarding care coordination of members, including admissions, discharges and transfers.

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?
Yes

Please select all services the county behavioral health system plans to provide under the PATH grant
Case Management Services
Outreach services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services

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

First Episode Psychosis Set-Aside
Discretionary/Base Allocation
Dual Diagnosis 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

Leadership, Planning, and Coordination

Prevent Misuse of Opioids

Research

Support People in Treatment and Recovery

Treat Opioid Use Disorder (OUD)

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?

ACT

CSC for FEP

FACT

IPS Supported Employment

Peer Support Services

Clubhouse 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
Board of State and Community Corrections (BSCC)
California Department of Health Care Services Contingency Incentives (Recovery Management)

Prop 47 and Cohort IV funds

Behavioral Health Bridge Housing (BHBH)

Mental Health Student Services Act (MHSSA) Grant

Behavioral Health Continuum Infrastructure Program (BHCIP)

Tabacco Settlement Revenue (TSR)

DOJ Opioid Prevention Grant

Crisis Care Mobile Unit (CCMU) Grant

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
Race or Ethnicity
Sex
Spoken Language

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

Spoken Language

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

Above

For children/youth

Above

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

Age

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

Specialty Mental Health Services (SMHS) penetration for both adults/older adults and children/youth was below statewide averages. Lower access is highest among young adults, males, Hispanic residents, and Spanish speakers, whose rates were near zero. Similar disparities were seen among youth ages 6–17, male youth, Hispanic youth, and Spanish-speaking youth, indicating ongoing linguistic, cultural, and engagement barriers.

Non-Specialty Mental Health Services (NSMHS) penetration exceeded statewide averages for adults and youth, reflecting strong prevention and early intervention reach. However, there is a lower utilization among older adults (69+), males, Asian Pacific Islander residents, Hispanic residents, Spanish speakers, and elementary-aged children, highlighting the need for continued culturally responsive outreach.

DMC-ODS penetration exceeded statewide averages for both adults and youth, though disparities remain, with lower access among Hispanic residents and youth. SCCBHD also performed above the statewide average on initiation of substance use disorder treatment, reflecting timely connection to care. These findings reinforce the need for targeted, culturally and linguistically responsive strategies, stronger youth engagement, and expanded community-based outreach across the behavioral health continuum.

Data reported in the Access to Care section is from the California Mental Health Services Authority

(CalMHSA) reflecting Fiscal Year 2023-2024.

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

A key strategy is integrating SCCBHD's Access Teams, which serve as centralized points of entry for non-emergency mental health and substance use disorder (SUD) services for individuals not currently connected to care. An integrated Access program will ensure consistent, timely, access to care across the County. The bilingual team of mental health rehabilitation specialists, senior clinicians and psychiatrists conducts screenings, assessments, triage and de-escalate crises, and determines eligibility for Children's Mental Health, Adult Mental Health, and SUD services. This standardized access process addresses documented local barriers related to navigation, timeliness, and equity in access to care.

SCCBHD will continue to expand referral pathways into the Access Team through partnerships with Housing 4 Health, housing connectors, and Mobile Crisis Response. Mobile Crisis Response provides field-based crisis intervention regardless of insurance coverage and refers individuals directly into ongoing care, addressing unmet need among individuals experiencing crisis and housing instability.

Access for children and youth will significantly increase with the launch of new Youth Crisis Programs at Hope Forward/ Esperanza Adelante. These programs will fill critical gaps, as SCCBHD has lacked a children's Crisis Stabilization Unit and a children's Crisis Residential Program. This expansion responds to local data showing limited youth crisis capacity and delayed access to appropriate care.

In addition, Behavioral Health Student Services Act (BHSSA) funding will support Behavioral Health Navigators in schools to help students and families navigate access to services, informed by youth mental health and school-based data showing increasing need.

Together, these initiatives strengthen centralized access, expand youth crisis services, and improve cross-system coordination to increase equitable access to behavioral health care based on local needs and data.

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)
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Other
Substance Use Block Grant (SUBG)

Please describe other

Behavioral Health Student Services Act (BHSSA)

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?

Above

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?

Above

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

Age
Other
Sex
Race or Ethnicity
Spoken Language

Please describe other

Students with disabilities

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?

Above

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?
Race or Ethnicity
Age
Sex
Spoken Language

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**
Homelessness is a major driver of behavioral health needs in Santa Cruz County. Recent data indicated
rates above regional and statewide averages, with disparities across age, race/ethnicity, language, and
special populations. These trends inform BHSA priorities focused on outreach, engagement, coordinated
care, and strengthened partnership with the Continuum of Care (CoC).
Key findings show disproportionate homelessness among adults ages 35–44, males, American Indian,
Black/African American, and Hispanic residents. Student homelessness also exceeds the statewide average,
with higher rates among Hispanic students, migrant students, English Learners, students with disabilities,
and fourth-grade students.
Despite high need, access to Continuum of Care (CoC) services remains below the statewide average, with
lower utilization among Asian Americans, young adults (18–24), older adults (40+), and females, indicating
gaps in outreach and culturally responsive engagement.
Overall, the County faces high homelessness and significant inequities. BHSA strategies emphasize
strengthening equity-centered early intervention and outreach, expanding culturally and linguistically
responsive engagement, deepening coordination with the CoC, schools, and housing partners, and
increasing access to low-barrier mental health and substance use treatment for people experiencing
homelessness.
Data reported in the Homelessness section is from the California Mental Health Services Authority
(CalMHSA) reflecting the Point in Time count from 2024.

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)

Santa Cruz County's rate of homelessness continues to exceed the statewide average in California. In response, SCCBHD will strengthen targeted housing and engagement strategies to reduce homelessness among individuals experiencing severe mental illness, severe substance use disorder, or co-occurring conditions. Despite the high rates of homelessness, access to CoC services in Santa Cruz County is lower than the statewide average. This highlights the importance of stronger collaboration among SCCBHD and the CoC.

A primary initiative is the continued strengthening of the Integrated Housing and Recovery Team (IHART) Full-Service Partnership (FSP) program, delivered in collaboration with Front Street Partners, a local contracted community based organization. IHART currently serves Specialty Mental Health Services (SMHS) consumers with severe behavioral health conditions who are experiencing chronic homelessness. Transforming the IHART team into an FSP program will also strengthen care coordination and ensure individuals experiencing homelessness with substance use disorders are connected to needed treatment and services. Using an integrated, multidisciplinary approach, IHART combines intensive behavioral health treatment with housing navigation and stabilization supports to move individuals from homelessness into permanent housing and sustain engagement in care. This model directly addresses local gaps in housing stability and retention for individuals with the most complex clinical and housing needs. Staff from the IHART team will be trained in the required FSP evidence-based practice (EBP) models, serving as SCCBHD's FSP team for people experiencing homelessness. Restructuring and strengthening this team will help improve the county's homelessness response and address performance metrics that are currently worse than statewide averages.

SCCBHD will also continue to expand and refine its Focused Intervention Teams (FIT). FIT pairs law enforcement with behavioral health treatment professionals to provide intensive, coordinated outreach to individuals with severe behavioral health conditions who frequently come into contact with law enforcement and are often experiencing homelessness. Local data on high utilizers of emergency and public safety systems informed this approach. Community feedback highlighted the need for expanded behavioral health services and housing assistance to support individuals reentering the community after incarceration. FIT emphasizes relationship-building, trust development, and assertive engagement to connect individuals to behavioral health services, including mental health and substance use disorder (SUD) services, and the broader housing continuum, reducing repeat law enforcement contact and unsheltered homelessness.

Together, IHART and FIT are data-informed, targeted interventions designed to address populations with the poorest housing and behavioral health outcomes. By strengthening these partnerships and service models, the county aims to improve housing stability, reduce chronic homelessness, and move local outcomes closer to or above statewide medians for individuals with severe and co-occurring behavioral health conditions.

In addition, Santa Cruz County has built a strong cross-departmental partnership between the Human Services Department's Housing for Health Division and the Health Services Agency's Behavioral Health Division to advance housing stability for individuals with specialty behavioral health needs. Through

ongoing care and service coordination as well as shared data, both departments align resources and expertise to address clients' behavioral health needs that impact their housing stability and increase access to supportive housing.

File Upload

Please identify the category or categories of funding that the county is using to address the homelessness goal
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
Other
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Please describe other
SAMHSA INN

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

Above

For children/youth

Below

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

Age

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

Below

30-day involuntary detention rates per 10,000

Below

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

Above

Permanent Conservatorships

Below

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

Above

For children/youth

Below

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

Age

Race or Ethnicity

Spoken Language

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

The involuntary detention rates for 14- and 30-day holds in designated facilities located in Santa Cruz County are below statewide averages, suggesting fewer extended detentions and potential benefits from early intervention efforts, crisis alternatives, or local system capacity. As referenced previously, the data related to detention rates for 72 hours and 14-30 days in local designated facilities includes individuals placed from surrounding counties who are not SCCBHD's beneficiaries/county residents and conversely individuals who are SCCBHD's beneficiaries/county residents may be placed in facilities in other surrounding counties.

SCCBHD relies more heavily on temporary conservatorships than the state overall, while using permanent conservatorships less frequently. Crisis service utilization varies by service type and population. Adult crisis stabilization services are used at rates above the statewide average, showing strong reliance on short-term stabilization, while crisis intervention and crisis residential services are used less frequently than statewide, suggesting possible access, awareness, or capacity limitations. There was no data available related to crisis residential treatment services for children/youth due to the fact that SCCBHD has not historically had this type of program.

CalMHSA data shows that Hispanic and Spanish-speaking adults have high crisis service utilization, as well as adults ages 45–56 and male adults, highlighting the need for culturally and linguistically responsive services and targeted outreach. Youth utilization of crisis services is below statewide averages, but expected to increase as the county opens a new youth crisis center.

Overall, these patterns show the need to strengthen the crisis continuum by expanding culturally responsive services, enhancing youth crisis and stabilization options, improving early intervention pathways to reduce reliance on higher-acuity services, and continuing to examine conservatorship practices to ensure equitable and appropriate use. In 2023, the county implemented a 24/7/365 mobile crisis response team, to address crises early and stabilize in the community, as well as link to outpatient services, thereby reducing reliance on institutionalization for stabilization. SCCBHD will continue to provide

these services under BHSA.

Data reported in the Institutionalization section is from the California Mental Health Services Authority (CalMHSA) reflecting Fiscal Year 2023-2024.

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

File Upload

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)

As part of BHSA implementation, SCCBHD plans to implement a new adult/older adult Full-Service Partnership (FSP) program, expanding access to more intensive, field-based, and team-centered approach that includes comprehensive care coordination, individualized service planning, and flexible supports tailored to each consumer's needs. This expanded FSP capacity responds to local data showing higher rates of institutional placement among adults with serious mental illness and is designed to prevent avoidable admissions to institutional settings (CalMHSA. FY23-24). In addition to the local data available, community feedback from the Community Program Planning Process highlighted the need for increased services for older adults.

In addition, the Adult Mental Health (AMH) Community Re-Entry Support Team (CREST) team focuses on individuals with the most severe and persistent mental illness, many of whom are conserved and residing in institutional or locked care settings. CREST works closely with FSP programs and the Public Guardian to support consumers in achieving clinical stabilization, building functional skills, and advancing recovery goals. The primary objective of this team is to support safe step-down from locked or institutional settings into less restrictive, community-based placements. This model addresses local measures showing longer lengths of stay and limited step-down options for conserved individuals.

In addition, a new Youth Crisis Center is being developed to provide local stabilization through a Crisis Stabilization Unit and a short-term Crisis Residential Program, helping minimize the need for longer-term psychiatric hospitalization for youth. While the facility is not yet open, it is expected to begin serving youth

soon.

By strengthening intensive, recovery-oriented, and cross-system coordination with medical providers and the Public Guardian, Santa Cruz County aims to reduce institutionalization rates and improve alignment with statewide averages while meeting the complex needs of its most vulnerable residents.

File Upload

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

BHSA BHSS

1991 Realignment

2011 Realignment

BHSA FSP

Federal Financial Participation (SMHS, DMC/DMC-ODS)

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

Above

For juveniles

Above

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

Age

Sex

Race or Ethnicity

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?

No Disparities Data Available

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?

Above

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

County arrest data shows that both adult/older adult and juvenile arrest rates exceed statewide averages, showing higher levels of law enforcement contact and system involvement among county residents. Significant disparities persist across demographic groups. According to CalMHSA data, males, both adults and juveniles, experience substantially higher arrest rates than females, and adults ages 30–39 have the highest arrest rates of any age group. African American residents experience the highest arrest rates while only making up about 1% of the county population. These patterns highlight the disproportionate impact of justice-system involvement on specific communities and show the need for targeted prevention, diversion, and community-based stabilization and behavioral health supports.

The County's adult recidivism conviction rate is below the statewide average, suggesting that individuals released from incarceration are less likely to return to custody compared to the state. This may reflect effective local reentry, supervision, or stabilization efforts.

The County's rate of individuals found Incompetent to Stand Trial (IST) exceeds the statewide average, pointing to a higher rate of serious behavioral health needs within the criminal justice system. This trend

shows gaps in early identification, treatment, and diversion and reinforces the importance of expanding behavioral health–justice partnerships, crisis response alternatives, and timely access to stabilization services.

Data reported in the Justice-Involvement section is from the California Mental Health Services Authority (CalMHSA) reflecting Fiscal Year 2023-2024.

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)

SCCBHD will strengthen coordinated adult and youth behavioral health initiatives aimed at reducing justice involvement among individuals with significant behavioral health needs.

For adults, the Maintaining Ongoing Stability through Treatment (MOST) Full-Service Partnership (FSP) team will continue to provide intensive case management, psychiatry, psychotherapy, and employment skill development. The team also provides added supports for individuals involved in probation and court processes. As part of BHSA implementation, MOST staff will be trained in the required FSP evidence-based practices including the Forensic Assertive Community Treatment (FACT) model. MOST will serve as SCCBHD's designated FSP team for justice-involved adults, delivering comprehensive, field-based services with individualized care plans and flexible supports.

This work will align closely with the Children's Juvenile Justice Full-Service Partnership (FSP) team to ensure coordination and continuity of care across age groups. Referrals come directly from Juvenile Probation and the juvenile detention facility. The FSP team also provides outreach and discharge planning to ensure each youth is connected to services upon release. Services are delivered in multiple settings, including Juvenile Hall, the Evening Center, and outpatient clinics, to ensure access based on the youth's level of supervision and clinical need. The Juvenile Justice FSP team will include the required FSP High Fidelity Wraparound (HFW) evidenced-based practice model, serving as SCCBHD's designated FSP team for youth involved with the juvenile justice system. SCCBHD plans to contract with an external provider to implement the HFW model, working in close coordination with the County's internal team.

In addition, SCCBHD partners with law enforcement through Mental Health Liaisons (MHLs) assigned to the Santa Cruz Police Department, Watsonville Police Department, and Santa Cruz County Sheriff's Office. MHLs provide rapid crisis response, de-escalation, and linkage to treatment as alternatives to arrest, addressing frequent mental health–related calls for service.

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
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

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
Sex

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?
Above

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

Data highlights the strong collaboration between Santa Cruz County Behavioral Health and Child Welfare Services. This demonstrates that Santa Cruz County provides mental health services to youth in foster care at rates well above the state average, with Medi-cal penetration rates also exceeding statewide averages. Santa Cruz County is actively addressing identified disparities and adapting to emerging needs. For example, as the number of infants and children under age 2 entering foster care increased, Santa Cruz County has developed coordinated access to specialized infant mental health services. These efforts reflect the county's commitment to equity, timely care, and partnership-driven solutions for vulnerable children and families.

The County's foster care rate is lower than the statewide average, yet disparities remain. Children ages 1–2 experience the highest placement rates, and females are slightly more likely than males to enter foster care, highlighting the need for stronger early childhood and family-centered prevention supports. Among children with open child welfare cases, the Specialty Mental Health Services (SMHS) penetration is above the statewide rate but varies by demographic group. Hispanic and Black children, as well as children ages 0–2 and youth ages 12–17, have the lowest service engagement. Females access SMHS at higher rates than males, showing gaps in identification and referral for certain groups.

Maltreatment substantiation rates are below statewide levels, but infants under age one and Latino youth experience higher rates, underscoring the importance of prenatal, infant, and culturally responsive family support services.

Data reported in the Removal of Children from Home section is from the California Mental Health Services Authority (CalMHSA) reflecting Calendar Year 2024.

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

All Children's System of Care (CSOC) programs operate under the Santa Cruz County Comprehensive Prevention Plan (CPP) and provide coordinated behavioral health services to children and families to support stability at home. CSOC delivers services across multiple settings, including schools, homes, community sites, outpatient clinics, and Juvenile Hall, ensuring interventions are accessible where children and families live and learn. Services include mental health assessments, therapy, case management, crisis support, and family-centered interventions designed to address the behavioral health needs that can contribute to child welfare involvement. The CSOC Social Services Full-Service Partnership (FSP) program works closely with the County Child Welfare Services (CWS) Department to provide behavioral health services for children/youth in the foster care system. CWS social workers identify children/youth in need of behavioral health services and make referrals to SCCBHD. This FSP program will continue under BHSA and include a High Fidelity Wraparound (HFW) evidence-based practice model component from a contracted provider.

SCCBHD also partners with community-based organizations to expand prevention and early intervention supports, providing additional points of access for families who may face barriers such as transportation, language, or cultural differences. Programs emphasize family engagement, skill-building, and linkage to resources to strengthen parental capacity and reduce the likelihood of out-of-home placements. Referrals are coordinated through schools, probation, and community agencies to ensure timely connection to services.

SCCBHD will continue to partner with First 5 Santa Cruz County Early Intervention programming to provide the Positive Parenting Program (Triple P) evidenced-based parenting program to support parents and caretakers to learn healthy parenting skills, address behavioral problems in children with a goal to reduce incidences of child abuse.

The County will also continue its longstanding partnership with the National Alliance on Mental Illness (NAMI) Santa Cruz County to provide early intervention services for youth and families. Through evidence-based education, outreach, and support programs, this collaboration helps identify mental health needs early and connect community members to appropriate care and resources.

File Upload

Comprehensive-Prevention-Plan-of-Santa-Cruz-County_2023-2025.pdf

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

BHSA BHSS

BHSA FSP

2011 Realignment

State General Fund

Federal Financial Participation (SMHS, DMC/DMC-ODS)

1991 Realignment

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?

Age

Sex

Race or Ethnicity

Spoken Language

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

Above

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

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
Sex
Race or Ethnicity

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
SCCBHD performs above statewide averages on emergency department follow-up measures, showing strong care coordination and linkage to services. However, supplemental data shows ongoing disparities in access and engagement.
According to CalMHSA data, follow-up after emergency department visits for both substance use and mental health conditions exceed statewide rates, yet gaps persist for certain groups. Adolescents, children, older adults, males, and Spanish-speaking individuals experience lower follow-up, pointing to age-specific, gender, and linguistic barriers during care transitions.
CalMHSA's data also shows a lower proportion of adults with unmet behavioral health needs compared to the statewide average, indicating relatively better access overall. Unmet needs remain higher among females, Latinos, individuals identifying with two or more races, and adults ages 25–65 with mental illness or substance use conditions.

These findings highlight the importance of strengthening targeted follow-up, culturally and linguistically responsive outreach, and age-appropriate engagement strategies to ensure timely connection to care for populations at higher risk of falling through gaps in the system.

Data reported in the Untreated Behavioral Health Conditions section is from the California Mental Health Services Authority (CalMHSA) reflecting Calendar Years 2021-2023.

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)

For children and youth, SCCBHD continues to support the use of the Adverse Childhood Experiences (ACEs) screening in primary care clinics to identify early behavioral health risks and connect families to services. Behavioral Health collaborates with primary care setting to ensure clear referral pathways into the Children's System of Care (CSOC), which provides outpatient and full service partnership (FSP) level of SMHS. The array of services include therapy, case management, crisis support, and community-based interventions through schools, homes, clinics, and other settings. CSOC also partners with community organizations to ensure families facing language, transportation, or cultural barriers can access timely care. For adults, SCCBHD will strengthen access to behavioral health services through the Access Team, which evaluates non-emergency requests for mental health and substance use services, conducts assessments, and connects individuals to Children's and Adult Mental Health Services as well as substance use disorder programs. Mobile Crisis Response and partnerships with Housing for Health expand outreach to individuals experiencing crises or housing instability, reducing barriers to treatment. The Adult System of Care provides outpatient and FSP level services as well including teams focused on individuals involved with the justice system and experiencing housing instability.

By integrating early identification through ACEs screening with these adult and youth services, and by leveraging cross-system partnerships, SCCBHD aims to reduce untreated behavioral health conditions, improve timely access to care, and address disparities in populations with historically poorer outcomes.

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Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG
SUBG

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
Same

For children/youth

Same

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

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

For adults/older adults

Same

For children/youth

Same

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?

Same

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?

Above

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Same

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?
Above

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
Above

For adults/older adults
Above

For children/youth
Above

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)

Same

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

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
Below

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?

Above

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured

Above

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

Below

For adults/older adults

Below

For children/youth

Below

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.

Suicides

Suicides

Please describe why this goal was selected

Reducing suicide rates was selected as the County's 7th goal because the county's overall suicide rate is substantially higher than the statewide average. The latest data from 2023 shows a rate of 15.5 per 100,000, compared with the statewide rate of 11.0 per 100,000. Suicide has a significant impact on families, communities, and the behavioral health system, making it a critical area for coordinated action. Establishing this goal aligns with broader efforts to improve mental health outcomes, reduce preventable deaths, and promote community well-being.

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

Analysis of Santa Cruz County's data shows disparities in suicide deaths, suicide attempts, and suicidal ideation among specific populations.

Suicide Ideation and Suicide Attempts (2017-2024 ESSENCE Surveillance Data):

• County residents that identify as Black, Native American and Multiracial experience disproportionately higher rates of suicidal ideation and suicide attempts compared to other racial groups in Santa Cruz County. In the 2022–2024 period, the prevalence rate for American Indian residents (0.47%) was nearly 7 times the county average (0.07%), while rates for Black (0.25%) and Multiracial (0.19%) residents were 3.6 and 2.7 times the county average, respectively.

• Girls under the age of 18 attempt suicide at a disproportionately higher rate compared to other age groups in Santa Cruz County. From 2017–2024, the rate for females under 18 was 84.93 per 100,000, which is more than 4.5 times the rate for males (18.82 per 100,000) in the same age group.

• Young people under the age of 25 experience higher rates of suicidal ideation compared to other age groups in Santa Cruz County. From 2017–2024, the ideation rate for the under 25 age group was 368.30 per 100,000, which is approximately 20% higher than the average rate for adults aged 26 and older (307.89 per 100,000).

According to 2023 data provided by CalMHSA, specific disparities exist in confirmed suicide deaths and non-fatal emergency department (ED) visits:

Suicide Death:

• Males: 27.1 per 100,000, nearly double the County average, indicating a high-risk gender group.

• Adults ages 65–84: 28.9 per 100,000, representing the highest age-related risk.

Non-Fatal Self Harm ED visits:

• Total non-fatal ED visits for the county: 80 per 100,000

• Female: 114.0 per 100,000

• Male: 61.0 per 100,000

• White: 84.7 per 100,000

• Hispanic: 64.3 per 100,000

• 10-14 year old: 341.1, more than 4 times higher compared to the county average.

• 15-19 year old: 291.5, more than 3.5 times higher compared to the county average

• 20-24: 120.6, 1.5 times more compared to the county average

While CalMHSA data reflects specific disparities in suicide deaths and non-fatal ED visits, local syndromic surveillance via ESSENCE highlights persistent disparities in suicidal ideation and suicide attempts for American Indian, Black, and Multiracial community members. While these populations represent a smaller number of Santa Cruz County residents, the disparity is stark: during 2020-2021, the rate for the American Indian residents was 8 times the county average and it remains nearly 7 times the county average in the 2022-2024 data.

Additionally, ESSENCE data on suicide is currently limited to biological sex and may not reflect the impact of suicide on the LGBTQ+ community. Despite this data limitation, the data shows that girls under the age of 18 have a higher rate of suicide attempts and young people (ages 25 and younger) of both sexes have higher rates of suicidal ideation and attempts. Additional analysis and prevention work will be done to understand the disparities across the entire suicide continuum (ideation, attempts, and deaths).

Santa Cruz County Behavioral Health and Public Health will be collaborating to ensure suicide prevention

efforts are culturally appropriate and gender-responsive, with specific strategies tailored to the populations experiencing the disparities and highest burden of suicide.

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 Suicides 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)

SCCBHD plans to build upon the existing countywide Suicide Prevention Plan to enhance evidence-based prevention and early intervention strategies. Local data indicates that Black, Native American, and Multiracial identifying residents experience disproportionally higher rates of suicidal ideation and attempts compared to other racial groups in Santa Cruz County. Additionally, girls under the age of 18 attempt suicide at a disproportionately higher rate compared to other age groups in Santa Cruz County. In response, the county will implement targeted outreach and engagement strategies for these high-risk groups, expand culturally and linguistically responsive services, and strengthen pathways to timely behavioral health care.

Suicide prevention efforts will continue to be closely coordinated with the Local Health Jurisdiction (LHJ) to ensure a unified, countywide public health and behavioral health approach. Through this partnership, SCCBHD and the LHJ will align data surveillance, prevention messaging, community education, and upstream risk-reduction strategies. This includes shared analysis of suicide data across the suicide continuum (ideation, attempt, and death), joint planning processes, and coordinated implementation of community-based prevention initiatives that address contributing factors.

Under the BHSA, the California Department of Public Health (CDPH) will administer the statewide population-based prevention BHSA funding of which a small portion will be allocated to county LHJs to support local suicide prevention efforts. SCCBHD will work closely with the LHJ to align these CDPH-administered funds with county behavioral health investments to ensure complementary, non-duplicative strategies. This coordination will support suicide prevention efforts across the full continuum.

Through this strengthened partnership and alignment of BHSA and CDPH resources, the County aims to improve suicide prevention outcomes across the entire population while continuing to focus on subpopulations with disproportionately higher rates of suicidal ideation, suicide attempts, and deaths. These collaborative efforts will promote a shared prevention approach to address the mental health needs as they relate to suicide for the most burdened populations in Santa Cruz County.

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

Other

Please describe other

CDPH Grants through BHSA prevention money

Community Planning Process

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

Stakeholder Engagement

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

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Please indicate the type of engagement used to obtain input on the planning process
County outreach through social media
County outreach through townhall meetings
County outreach through traditional media (e.g., television, radio, newspaper)
Focus group discussions
Key informant interviews with subject matter experts
Meeting(s) with county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

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

Type of engagement
Workgroups and committee meetings

Date
8/11/2025

Type of engagement
Workgroups and committee meetings

Date

8/21/2025

Type of engagement

County outreach through social media

Date

11/17/2025

Type of engagement

County outreach through social media

Date

11/10/2025

Type of engagement

County outreach through social media

Date

11/3/2025

Type of engagement

County outreach through townhall meetings

Date

11/17/2025

Type of engagement

County outreach through townhall meetings

Date

11/18/2025

Type of engagement

County outreach through townhall meetings

Date

11/20/2025

Type of engagement

Focus group discussions

Date

11/18/2025

Type of engagement

Focus group discussions

Date

11/19/2025

Type of engagement

Focus group discussions

Date

11/19/2025

Type of engagement

County outreach through townhall meetings

Date

12/1/2025

Type of engagement

Focus group discussions

Date

12/2/2025

Type of engagement

Focus group discussions

Date

12/2/2025

Type of engagement

Focus group discussions

Date

12/3/2025

Type of engagement

Focus group discussions

Date

12/17/2025

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

11/13/2025

Type of engagement

Key informant interviews with subject matter experts

Date

12/15/2025

Type of engagement

Workgroups and committee meetings

Date

12/18/2025

Type of engagement

Training, education, and outreach related to community planning

Date

12/2/2025

Type of engagement

Training, education, and outreach related to community planning

Date

12/8/2025

Type of engagement

Training, education, and outreach related to community planning

Date

12/10/2025

Type of engagement

Training, education, and outreach related to community planning

Date

12/18/2025

Type of engagement

Training, education, and outreach related to community planning

Date

12/16/2025

Type of engagement

Workgroups and committee meetings

Date

10/16/2025

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/5/2025

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/7/2025

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/12/2025

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/10/2025

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/17/2025

Type of engagement

Survey participation

Date

1/5/2026

Type of engagement

County outreach through traditional media (e.g., television, radio, newspaper)

Date

11/6/2025

Type of engagement

Public e-mail inbox submission

Date

12/15/2025

Type of engagement

Training, education, and outreach related to community planning

Date

3/12/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals

Youth Lived Expertise Board (YLEAB)
Behavioral Health Advisory Board
NAMI Santa Cruz
Pajaro Valley Prevention and Student Assistance (PVPSA)
Santa Cruz County Office of Education
Santa Cruz County Public Health
Santa Cruz County Housing for Health
Santa Cruz County Human Services Department
Santa Cruz County Behavioral Health Division
Housing Matters
Seniors Council of Santa Cruz
Family Service Agency of Central Coast
Encompass
Sobriety Works
Parents Center Santa Cruz County of Santa Cruz
Janus Santa Cruz
Applied Survey Research Santa Cruz
Psynergy
Pacific Clinics
First 5 Santa Cruz
Front St.
New Life Santa Cruz
Kaiser
Community Action Board of Santa Cruz
Nations First
Lived Experience Advisory Group (LEAG)
Community Bridges
Highland Behavioral Health
Diversity Center
Downtown Santa Cruz
Central CA Alliance for Health

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	Santa Cruz
2	Watsonville
3	Scotts Valley
4	Capitola
5	Aptos

Were you able to engage all required stakeholders/groups in the planning process?
No

If not, which required stakeholder/groups were you unable to engage in the planning process?
Higher education partners

Higher education partners
Attempted but did not receive a response

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
See attachments.

Upload File
Community Program Planning Summary.pdf
Focus Group Sign In Sheets.pdf
Forums & Education Sign In Sheets.pdf
Social Media Engagement - CPP 2025.pdf
Forums Promo Email.pdf
Contracted Providers Education and Focus Group Email.pdf

Community Survey Email1.pdf
Staff BHSA Education.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.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans **(MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities**

SCCBHD engaged with the LHJ and Medi-Cal managed care plans (MCPs) through collaboration, data-sharing, and stakeholder activities in several ways. The BHSA Coordinator actively participated in multiple community collaborative meetings led by the LHJ, providing input on CHIP priorities while building relationships with partners across sectors. Both MCPs, Central California Alliance for Health and Kaiser Permanente have contributed funds to the CHIP. Additionally, representatives from both MCPs also participated in the development of CHIP priorities.

To prevent duplication, the BHSA Coordinator conducted a gap analysis of the CHA data collection process, which helped identify additional partners for engagement in the BHSA community program planning (CPP) process. CHA data has been incorporated into the county's Behavioral Health Integrated Plan and has directly informed the identification of BHSA priorities. Ongoing collaboration is also maintained through regular meetings with the LHJ and MCPs to ensure alignment across all county needs assessments and plans, supporting further integration of behavioral health within the broader public health framework. The next community health assessment will be done in collaboration with all four entities, covering each department's unique and overlapping requirements. This will help streamline planning, reduce duplication, lower administrative and community burden, and support better alignment of programs and funding.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?

No

Collaboration

Please select how the county collaborated with the LHJ

Attended key CHA and CHIP meetings as requested.

Served on CHA and CHIP governance structures and/or subcommittees as requested.

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

Homelessness

Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Suicides

Overdoses

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

Homelessness

Suicides

Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Overdoses

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)

Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process. Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.

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

Behavioral Health leadership and staff participated in cross-departmental meetings and community forums led by the LHJ's CHA/CHIP team, including regular coordination with the CHA/CHIP lead, to review assessment findings, discuss emerging needs, and identify opportunities for alignment.

Key CHA priority areas, including mental health, housing stability, and access to care, directly align with the Behavioral Health Integrated Plan (BHIP) priorities and strategies. CHA data highlighted unmet mental health needs and disparities reinforcing the BHSA focus on early intervention and treatment expansion. Housing instability identified in the CHA aligns with BHSA strategies targeting individuals who are chronically homeless, experiencing homelessness and/or at risk of homelessness. CHA findings related to barriers to access to care informed BHSA strategies to strengthen care coordination, expand service availability, and improve navigation across behavioral health, public health, and healthcare systems. Ongoing collaboration with the LHJ includes aligning planning timelines and implementation efforts to ensure consistency across county initiatives, with a focus on advancing shared goals related to access to care and suicide prevention. Behavioral Health will partner closely with the LHJ related to the BHSA state

administered population-based prevention funding that will support the local Suicide Prevention Coalition and countywide Suicide Prevention Plan. This overall coordinated approach supports complementary investments, reduces duplication, and strengthens the county's ability to address priority behavioral health needs through an integrated, countywide strategy.

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

Central CA Alliance for Health

Kaiser Permanente

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?

Central California Alliance for Health (the Alliance) Community Reinvestment planning is aligned with the Alliance's Medi-Cal Capacity Grant Program (MCGP) annual investment planning process, which incorporates stakeholder input from county behavioral health departments across the Alliance's service area. This structure positions the Alliance to align future community investments with SCCBHD's BHIP in future years.

For the initial Community Reinvestment Plan tied to CY 2024 net income only, DHCS will allow MCPs to claim current voluntary investments (i.e., grants awarded through the MCGP) toward their CY 2024 Community Reinvestment obligation. These activities that will be included in the initial Community Investment Plan due to DHCS in Q3 2026 for CY 2024 and will meet all requirements established in the APL for categories of investments. The Alliance awarded approximately $19 million between in CY 2024 and CY 2025 to expand access to health care and supportive services for Medi-Cal members in the County and to address social drivers of health. Of these investments, 29% supports behavioral health service delivery in the county, including behavioral health workforce recruitment, community-based health programs, and permanent supportive housing. The Alliance is awaiting confirmation from DHCS of the total dollar amount of the CY 2024 Base Obligation that will be included in the Community Reinvestment Plan. This amount is anticipated to be approximately 6% of investments already made in SCC in CY 2024 and 2025 through the MCGP.

Consistent with APL 25-004, the Alliance will include SCC in a future Community Reinvestment Plan for any

calendar year in which the Alliance generates net positive income and is required to meet Community Reinvestment activity requirements.

Kaiser Permanente has participated in stakeholder discussions and supported alignment around identified behavioral health, housing, and access-to-care priorities.
In California, Kaiser Foundation Health Plan's Medi-Cal line of business does not meet the financial threshold for Community Reinvestment as set by DHCS. Kaiser Permanente will continue to support community- and county-identified needs. Through its broader integrated model, including Kaiser Foundation Hospital's community benefit investments, Kaiser Permanente will continue investing in nonprofit and community-based partners across Santa Cruz County. Kaiser Permanente will also continue collaborating with the County, community-based organizations, and other stakeholders to ensure alignment with BHSA priorities and to inform future planning efforts, including any applicable Community Reinvestment planning cycles.

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
3/18/2026

Date the stakeholder comment period closed
4/16/2026

Date of behavioral health board public hearing on draft IP
4/16/2026

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

Please upload the PDF, image, or other file documenting the public posting

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
santacruzhealth.org/BHSA

File Upload

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

Public posting
Email outreach
Other

Attach email

Please specify the other process the draft plan was circulated to stakeholders

A hard copy of the draft plan was placed in county and contractor operated clinic lobbies with information about how to submit a public comment. Additionally, the County used social media platforms to notify the public that the IP had been posted for 30-day public comment.

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

Summarize the substantive revisions recommended this stakeholder during the comment period

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

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

FY25 -26 QI Work Plan Goals and Exec Summary_FINAL_10.2025.pdf

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

Yes

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

FY25 -26 QI Work Plan Goals and Exec Summary_FINAL_10.2025.pdf

Contracted BHSA Provider Locations

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

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	43
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	23
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

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

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?
22

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
SCCBHD will collaborate with MCP partners to support alignment, improve communication, and reduce barriers to contracting. SCCBHD plans to share relevant MCP training and informational opportunities with BHSA providers and community partners and will connect providers directly to MCP representatives when technical assistance or contracting support is needed. These efforts will help strengthen provider readiness and expand participation in MCP networks.

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?
Yes

Please describe any implementation challenges or concerns with the requirements for BHSA providers

Requiring providers to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial insurers will be a significant change for many local providers. In particular for the smaller community-based organizations (CBOs) that have not already entered into contracts with MCPs to provide enhanced care management (ECM) or Community Supports (CS) benefits, this requirement may present barriers and challenges. Many CBOs lack the infrastructure to bill (e.g., certified billing staff, EHRs, compliance systems) or the capacity to contract with health plans, making these requirements costly and sometimes infeasible. Even when billing is possible, claims denials, long payment timelines, and limited coverage of community-based services may create financial risk and administrative burden. Without significant investment to support county oversight and develop CBO infrastructure for billing and contracting capacity, these requirements may unintentionally disadvantage the providers BHSA is intended to support.

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

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

Yes

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

Yes

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

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General

Please select the specific Behavioral Health Services and Supports (BHSS) **that are included in your plan**
Early Intervention Programs (EIP)
Children's System of Care (non-Full Service Partnership (FSP))
Capital Facilities and Technological Needs (CFTN)

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on 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
Supportive services

Please describe the specific services provided

The Hope Forward | Esperanza Adelante Youth Crisis Center - Crisis Residential Program

The Santa Cruz County Hope Forward | Esperanza Adelante Youth Crisis Center is a safe, inclusive space where children and youth experiencing a mental health crisis can begin healing close to home. The center is committed to providing culturally-responsive services focused in equity, family involvement, and community connection—honoring each young person's identity, culture, and lived experience.

This crisis center will offer both crisis residential program (CRP) and crisis stabilization unit (CSU) services for children and youth. The CRP program component will be funded using BHSS Other funding, while the CSU program component will be funded using BHSS Early Intervention funding. The 16-bed CRP program serves youth ages 12-17 and offers 24-hour supervision, therapeutic support, care coordination, and recovery-focused treatment. A typical stay ranges from 2-10 days. Services include psychiatric evaluation, medication monitoring, therapeutic support including individual and group therapy as indicated, rehabilitative services, case management and peer support. This program will serve youth with Medi-Cal or private insurance (with prior authorization) and will serve youth from other counties when capacity allows. The private insurance carrier and/or other county will be financially responsible for services rendered.

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	150
FY 2027 – 2028	250
FY 2028 – 2029	350

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

To project the number of individuals served in the new Youth Crisis Center CPR program, SCCBHD analyzed three years of local behavioral health utilization data, including youth crisis evaluations, mobile crisis dispatches, and inpatient psychiatric admissions. SCCBHD considered anticipated diversion rates from higher levels of care, projected referral pathways from schools, law enforcement, and the Access line, and mobile crisis response. These data points were adjusted to reflect staffing capacity, hours of operation, and planned bed availability to ensure projections were both data-informed and operationally feasible for the program's first year. It should be noted that the projected number of individuals served represents the total projected number to be served including both Medi-Cal and privately insured individuals as well as youth from other counties.

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
The Hope Forward | Esperanza Adelante Youth Crisis Center – Crisis Stabilization Unit

Please select which of the three EI components are included as part of the program or service
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Access and Linkage: Assessments
Access and Linkage: Referrals

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 Santa Cruz County Hope Forward | Esperanza Adelante Youth Crisis Center is a safe, inclusive space where children and youth experiencing a mental health crisis can begin healing close to home. The center is committed to providing culturally-responsive services focused on equity, family involvement, and community connection—honoring each young person's identity, culture, and lived experience. This crisis center will offer both crisis stabilization unit (CSU) services and crisis residential program (CRP) services for children and youth. The CSU program component of the program will be funded with BHSS Early Intervention funding, while the CRP component of the program will be funded with BHSS Other funding as indicated previously. The 8-chair CSU program offers 24-hour supervision and short-term crisis stabilization services for children ages 5-17 via voluntary placement or involuntary 5585 holds. Services include crisis assessment, psychiatric evaluation and medication monitoring as needed, crisis stabilization services and supports, discharge planning and linkage. The average stay is under 24 hours. In the event that the child/youth cannot be stabilized, the program will secure placement in the most appropriate level of care which can include the CRP or an inpatient psychiatric facility. This program will serve youth with Medi-Cal or private insurance (with prior authorization) and will serve youth from other counties when capacity allows.

The private insurance carrier and/or other county will be financially responsible for services rendered.

The intended outcomes of this program include:
• Provide immediate safety and crisis stabilization reducing acute risk of harm to self or others.
• Decreased use of higher levels of care including unnecessary psychiatric hospitalizations and emergency department utilization.
• Timely connection to ongoing care and reduction in gaps in care following discharge.
• Equitable access to crisis care to reduce disparities in access to behavioral health crisis stabilization.
• Reduced recidivism by lowering rates of repeat crisis episodes and readmissions within 30–90 days.
• Reduce impacts of suicide.

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	500
FY 2027 – 2028	600
FY 2028 – 2029	700

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
To project the number of individuals served in the new Youth Crisis Center CSU program, SCCBHD analyzed three years of local behavioral health utilization data, including youth crisis evaluations, mobile crisis dispatches, and inpatient psychiatric admissions. SCCBHD considered anticipated diversion rates from higher levels of care, projected referral pathways from schools, law enforcement, and the Access line, and mobile crisis response. These data points were adjusted to reflect staffing capacity, hours of operation, and planned bed availability to ensure projections were both data-informed and operationally feasible for the program's first year. It should be noted that the projected number of individuals served represents the total projected number to be served including both Medi-Cal and privately insured individuals as well as youth from other counties.

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
MCRT: Mobile Crisis Response Team

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

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 Mobile Crisis Response Team provides 24/7 rapid behavioral health crisis intervention for individuals of all ages experiencing a mental health or substance use crisis in Santa Cruz County. Services include screening and support through the mobile crisis line, dispatching of the mobile crisis response team as needed, on-site crisis evaluation to determine the appropriate level of care and intervention, crisis de-escalation and stabilization services and supports, safety planning, and linkage to community resources including further crisis stabilization, mental health and substance use disorder treatment services, housing and medical care. A goal of the program is to maintain individuals in the least restrictive, safest community-based setting whenever possible. The program is available to all Santa Cruz County residents regardless of insurance coverage.

The intended outcomes of this program include:
• Provide immediate safety and crisis stabilization, reducing acute risk of harm to self or others.

• Reduce unnecessary utilization of law enforcement to address behavioral health crises.
• Decrease use of higher levels of care including unnecessary psychiatric hospitalizations and emergency department utilization.
• Reduce impacts of suicide.

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	1500
FY 2027 – 2028	1800
FY 2028 – 2029	2250

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
SCCBHD used historical Mobile Crisis and crisis call volume data from the past three years to project the number of individuals to be served through this Early Intervention (EI) program. Trends in dispatches, unique individuals served, repeat encounters, and referrals law enforcement, emergency departments, and Access line calls were analyzed to estimate future demand. These trends were projected forward over the next three years, assuming continued growth in community-based crisis response, increased 988 utilization, and expanded diversion from emergency departments and law enforcement.

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

Family Services Agency of the Central Coast– Senior Program

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

Outreach

Access and Linkage: Referrals

Access and Linkage: Screenings

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 Senior Outreach Counseling Program provides in-home counseling services to adults age 60 and older residing in Santa Cruz County. Services are designed to increase access to behavioral health support for older adults who may face mobility, language, or cultural barriers to care. In addition to in-home services, the program offers ongoing drop-in and scheduled bilingual, bicultural peer counseling at the Watsonville Senior Center to ensure culturally responsive and accessible support.

The program also conducts outreach to community agencies, congregate living sites, and senior centers to increase awareness of services and connect older adults to needed behavioral health and supportive resources.

The intended outcomes for this program are:

• Increased access to behavioral health services for older adults

• Reduced social isolation among seniors

• Improved emotional well-being and coping skills

• Increased utilization of culturally and linguistically appropriate services

• Strengthened connections between seniors and community-based supports

• Early identification and intervention for behavioral health concerns

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	150
FY 2027 – 2028	150
FY 2028 – 2029	200

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

SCCBHD used performance measure reports from the Family Service Agency over the last two fiscal years and projected estimates based on performance, staffing and available resources.

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

County Office of Education – School Based Early Intervention

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

Please specify "other" type of Treatment Services and Supports
• Onsite Cognitive Behavioral Therapy services for youth and their families.
• Targeted Tier 2 early intervention behavioral supports within a Multi-Tiered System of Supports (MTSS) framework

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
Cognitive Behavioral Therapy (CBT) for Psychosis
Triple P - Positive Parenting Program (Triple P)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
The Protective Factors Framework

Please describe intended outcomes of the program or service
The Santa Cruz County Office of Education (COE) School-Based Early Intervention program focuses on outreach, early identification, referral, and supportive interventions for children, youth, and families across multiple districts. To ensure culturally responsive and community-based services, the COE partners with local community-based organizations, including Live Oak Community Resources, The Diversity Center, and providers implementing Positive Behavioral Interventions and Supports (PBIS). These partnerships expand the County's reach and strengthen coordination between schools and trusted community organizations. Through PBIS, the program promotes a positive school climate and includes targeted behavioral assessment and function-based supports for students demonstrating early signs of distress. Community partners conduct proactive outreach through parent education, community presentations, LGBTQ+ awareness initiatives, and school partnerships. Students and families are connected to appropriate counseling, advocacy, and community resources through structured referral pathways, including identification and referral services for youth showing early indicators of behavioral health concerns. Overall, the program emphasizes early intervention, timely referrals, coordinated care, and strong school-community partnerships to reduce risk factors and strengthen protective factors.

The intended outcomes of this program include:
• Increase early identification and intervention for students showing signs of behavioral health concerns through school-based behavioral assessment and structured support systems.

• Strengthen outreach and engagement with students, families, and school communities to raise awareness, and build protective factors.

• Improve access to appropriate services by providing timely referrals, coordination, and linkage to counseling, advocacy, and community-based resources.

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	5303
FY 2027 – 2028	5303
FY 2028 – 2029	5303

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

The total projected number of individuals served through Early Intervention (EI) services provided by The Diversity Center during each plan period is 5,203 students.

This estimate is based on the Positive Behavior Intervention and Supports (PBIS) and Multi-Tiered System of Supports (MTSS) framework, which identifies approximately 10–15% of the total student population as likely to require Tier 2 targeted early intervention supports beyond universal (Tier 1) prevention strategies. While 100% of students enrolled at participating school sites will benefit from Tier 1 universal prevention practices, Tier 2 services are designed to support students demonstrating early indicators of behavioral, emotional, or social risk. Based on total enrollment across participating schools and Districts (total of 34,685 students across six Districts), approximately 15% of students are projected to require structured, small-group or targeted interventions (e.g., Check-In/Check-Out and other data-informed supports), resulting in an estimated 5,203 students served through EI during the plan period.

This projection reflects anticipated need and aligns with national PBIS implementation data regarding Tier 2 service utilization rates.

Live Oak Community Resources projects to serve 100 individuals per year based on past performance measure reports, staffing and available resources.

This makes a total of 5,303 individuals serve per year for this program.

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
First 5 Santa Cruz County: Positive Parenting Program (Triple P)

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

Please specify "other" type of Treatment Services and Supports
• Reduce the likelihood of removal of children from their homes.
• Reduce mental illness in children and youth through social, emotional and behavioral services and supports in early childhood.

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
Triple P - Positive Parenting Program (Triple P)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Triple P – Positive Parenting Program System, Positive Parenting Program Level 2 Selected Seminar Series, Level 3 Primary Care & Discussion Group, Level 4 Standard & Group Triple P Online (Level 4)

Please describe intended outcomes of the program or service

Triple P (Positive Parenting Program) is a comprehensive, evidence-based parenting and family support system designed to reduce behavioral and emotional challenges in children and adolescents and prevent child abuse and neglect. Triple P emphasizes proactive community outreach and accessible service pathways to ensure families can easily connect to the level of support that best meets their needs. Outreach efforts include community education, collaboration with schools and community-based organizations, and targeted engagement of priority populations. Families are connected through coordinated referral systems, including referrals from behavioral health providers, schools, pediatricians, child welfare, and other community partners.
Triple P has been shown to strengthen both risk and protective factors, including reductions in family conflict and parent stress, and improvements in family cohesion and parent self-efficacy.

Intended outcomes include:
• Improved child behavior and emotional regulation
• Increased use of positive, evidence-based parenting strategies
• Improved parental emotional well-being and stronger family relationships
• Increased parental confidence and self-efficacy
• Increased awareness of and access to supportive services through coordinated outreach and referral networks

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	3454
FY 2027 – 2028	3557
FY 2028 – 2029	3664

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

Projections are based on 2024–2025 unduplicated utilization data and historical participation trends for First Five – Triple P. The projected number of individuals served includes both early intervention services (e.g., seminars, workshops, and one-time consultations) and more in-depth interventions (e.g., Level 3 Primary Care, Discussion/Brief Groups, Level 4, and Level 5 services), reflecting the full continuum of the Triple P multi-level system. A 3% annual growth rate was applied based on stable staffing levels, sustained community demand, expanded and strengthened partnerships with community-based organizations, and continued outreach efforts, while maintaining realistic service capacity assumptions.

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

National Alliance on Mental Illness Santa Cruz County (NAMI) - Early Intervention Mental Health Peer Support for Youth <25

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

Outreach

Access and Linkage: Other

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

Please specify "other" type of Access and Linkage

Resource Navigation Support

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

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
NAMI Basics Class/ Bases

NAMI Peer-to-Peer Class/ Persona-a-Persona

NAMI Ending the Silence

NAMI In Your Own Voice/ Ambassadors

Peer Support Groups (in Spanish & English)

Family Support Groups (in Spanish & English)

Please describe intended outcomes of the program or service

NAMI Santa Cruz County (NAMISCC) delivers a comprehensive continuum of evidence-based and peer-led behavioral health programs designed to promote early intervention, reduce stigma, and improve recovery outcomes for youth, young adults, and families impacted by mental health conditions and serious emotional disturbances (SED). Services span school-based prevention education, peer recovery programs, caregiver education, support groups, community outreach, and bilingual resource navigation. Programs are grounded in lived experience and emphasize culturally responsive, trauma-informed approaches that reduce isolation, strengthen protective factors, and connect participants to appropriate care and community-based supports.

NAMISCC's youth-focused prevention programs include National Alliance on Mental Illness (NAMI) Ending the Silence, a school-based mental health education and suicide prevention presentation for middle and high school students, and bilingual outreach teams that provide on-campus engagement, early identification of behavioral health concerns, and resource linkage. For young adults experiencing mental health challenges, services include peer-led education and recovery programs such as NAMI Peer-to-Peer, NAMI In Our Own Voice, ongoing peer support groups, and structured social connection opportunities that foster belonging and reduce social isolation—key protective factors against crisis and deterioration. NAMISCC also provides intensive support for families and caregivers through evidence-based education courses, peer-led support groups, and bilingual Family Navigator/HelpLine services that offer compassionate guidance, system navigation, and early intervention support. These programs strengthen caregiver capacity to recognize early warning signs, advocate for services, and effectively support youth and young adults experiencing mental health challenges. All services are free, low-barrier, and offered in English

and Spanish to ensure equitable access for historically underserved communities, aligning with Behavioral Health Services Act priorities for culturally responsive care and disparity reduction.

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	4201
FY 2027 – 2028	4453
FY 2028 – 2029	4720

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected number of individuals served are based on current programs and staffing capacity for fiscal year 25/26. Projections for the next fiscal years reflect a conservative estimate focused on sustaining core services and maintaining program quality with the goal of increasing the number served by 6% each year through expanded, targeted outreach efforts.

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
Clubhouse Early Intervention Service

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

Please specify "other" type of Treatment Services and Supports
Recovery support and community integration

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

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Clubhouse Model

Please describe intended outcomes of the program or service
Currently Santa Cruz County does not have any Clubhouse Model programs. The community planning process input in combination with SCCBHD service data indicates that the lack of this type of programming in the County is a gap. We have built funding into the plan to support the provision of services within a Clubhouse Model program and will work in partnership with community providers to bring this model to Santa Cruz County.
The Clubhouse Early Intervention model will provide outreach, engagement, and supportive services for individuals experiencing early signs of behavioral health challenges. The program aims to increase early identification of behavioral health needs, improve timely access to services, and reduce the progression of symptoms. Through peer support, skill development, and community integration, this service will promote recovery, social connectedness, and improved functioning in work, education, and daily life. The program will also seek to reduce isolation, prevent crises, and connect participants to appropriate treatment and community resources.

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	50
FY 2027 – 2028	50
FY 2028 – 2029	50

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

Projections are based on identified community need, partner input, and analysis of service gaps within the county's behavioral health system. This will be a new service being implemented so estimated participation levels were informed by feedback from community engagement activities and utilization patterns observed in similar programs that were previously available but have since ended. These projections also consider anticipated program capacity and planned outreach efforts to connect individuals to early intervention 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
Volunteer Center Community Connections Wellness Connect Program

CSC program description

The Volunteer Center of Santa Cruz operates Community Connection in partnership with SCCBHD to support youth and adults experiencing early onset and serious mental health conditions. The program delivers treatment and supportive services grounded in evidence-based practices that promote meaningful daily activities, pre-employment and employment skills, education, and overall wellness. Services are designed to help individuals build independence, strengthen functioning, and improve quality of life while increasing their connection to the community.

Through this Wellness Connect program, Community Connection serves transition-age youth (ages 14–25) experiencing first-episode psychosis using the NAVIGATE evidence-based model. Services include psychiatric evaluation, medication monitoring, therapeutic support including individual, group and family therapy as indicated, rehabilitative services, case management case management and resiliency support, family education, supported employment and education, and co-occurring substance use disorder services. The contractor collaborates closely with SCCBHD on referrals, including those from the Behavioral Health Access Team and community partners, and coordinates with the County's Jail Discharge Planner to support successful reentry. The program aims to improve functioning and quality of life, reduce crisis service and inpatient utilization, and decrease long-term reliance on the system of care through prevention and early intervention. The program will be implementing the required Coordinated Specialty Care (CSC) evidenced-based practice model.

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	35
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	5	5	5
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)

SCCBHD will leverage the Community Mental Health Block Grant (MHBG) First Episode Psychosis (FEP) Set-Aside funds to support this program.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name

Annual cost of EHR system

Please select the type of project

Technological needs project

If Technological Needs Project, please select the focus area(s) of the project

Electronic health record system

System maintenance costs

Please describe the project

SCCBHD is upgrading and enhancing our Electronic Health Record (EHR) system to better support access to care, service coordination, and fiscal accountability under the new funding and reporting requirements. These upgrades will reduce administrative burden on providers, improve SCCBHD's ability to capture and bill for reimbursable services, and strengthen data quality across the system. BHSA funds will be used to pay the annual cost of the EHR system.

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

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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	637
Number of Uninsured Individuals	84
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	278

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	97
Number of Uninsured Individuals	13

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	48
Number of Uninsured Individuals	6

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	20
Number of Teams Needed to Serve Total Eligible Population	<11*

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	23	23	23
Total Number of Teams	3	3	3

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	492
Number of Uninsured Individuals	65

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	25

FSP ICM Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	5

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	38	38	38
Total Number of Teams	6	6	6

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	221

HFW Eligible Population	Estimates
Number of Uninsured Individuals	25

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	83
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 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	5	5	5
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	1011
Number of Uninsured Individuals	133

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	73
Number of Teams Needed to Serve Total Eligible Population	29

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	5	5	5

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

Full Service Partnership (FSP) Program Overview

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

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

Yes

Please describe how the estimated practitioners will provide more than one EBP

The estimated practitioners will be trained and supported to deliver more than one evidence-based practice (EBP) in order to maximize flexibility, access, and continuity of care. Given current staffing shortages, budget cuts, and increasing demand for services, SCCBHD is intentionally cross-training clinicians so they can competently provide multiple EBPs aligned with consumer needs and program requirements. Specifically adult/older adult FSP program practitioners will be cross trained in ACT/FACT and ICM EBPs. Child/youth FSP program practitioners will be trained in ICM. The County will utilize a contractor to provide the HFW and IPS EBPs, and those practitioners will work closely with the FSP teams to ensure seamless coordinated care and access to employment services.

The state estimates that the county was given account for all potential consumers, however it does not account for the possibility of consumers would be appropriate for a lower level of care or may deny this higher level of service, which is something SCCBHD often sees. The County does not have sufficient financial resources to hire additional staff dedicated to a single EBP model. As a result, cross-training existing staff is necessary to sustain service delivery and meet BHSA requirements within current funding constraints.

To ensure fidelity and quality, SCCBHD is partnering with the appropriate Centers of Excellence (COEs) to receive formal training, technical assistance, and ongoing consultation in each EBP. Practitioners will participate in required initial trainings as well as ongoing learning collaboratives and fidelity monitoring as recommended by the COEs. The BHSA Coordinator will be responsible for monitoring compliance with training requirements, tracking completion of required EBP trainings, and conducting follow-up with practitioners, supervisors, and program directors to ensure timelines and documentation standards are met. This structured oversight ensures staff are properly trained, supported, and implementing EBPs with fidelity while responding to evolving community needs.

SCCBHD would like to take the opportunity to reflect that the estimated number of eligible FSP consumers, number of practitioners and teams needed for the IPS model appears to be high and potentially inaccurate. Based on the estimates provided by the state an estimated 999 individuals would be eligible for FSP services, yet the estimate for IPS eligible individuals is 1,144. As previously referenced SCCBHD has concerns related to consumers declining FSP level services and anticipates that of the FSP consumers that will be served not all of them will be appropriate for, or want employment support. The County currently contracts out IPS supported employment services and will be working with our partner to try to increase the number of practitioners and teams they have, and will continue to evaluate how many IPS practitioners and teams are truly required to meet the needs of consumers.

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

SCCBHD employs a whole-person, trauma-informed approach that addresses behavioral, physical, and social determinants impacting an individual's mental health and substance use needs. Services are person-centered, culturally responsive, and grounded in principles of safety, trust, empowerment, and choice. The department integrates an understanding of trauma and adverse experiences into screening, assessment, treatment planning, and service delivery to promote healing and avoid re-traumatization across all levels of care.

This approach is implemented through the use of evidence-based and evidence-informed behavioral health models, including trauma-informed care frameworks, recovery-oriented systems of care, integrated behavioral health, and family-centered and peer-supported practices. SCCBHD staff and contracted providers receive ongoing training in trauma-informed practices, cultural humility, motivational interviewing, crisis intervention, and de-escalation to ensure consistent, high-quality care. In partnership with families and an individual's natural supports, the department actively promotes shared decision-making and family-inclusive treatment planning, when clinically appropriate and desired by the individual. Collaboration with community-based organizations and cross-system partners, such as primary care, housing, child welfare, and social services, supports coordinated care, continuity of services, and improved behavioral health outcomes for individuals and families.

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

SCCBHD is committed to reducing disparities for all consumers served including Full Service Partnership (FSP) participants by ensuring services are accessible, equitable, and responsive to individuals with the highest levels of behavioral health needs. SCCBHD prioritizes outreach and engagement for populations that have been historically underserved or disproportionately impacted by behavioral health inequities, including individuals who are justice-involved, involved in the child welfare system, and those experiencing chronic homelessness. Services are delivered in culturally and linguistically appropriate ways and are informed by ongoing community engagement to reduce barriers related to stigma, transportation, documentation, and system navigation.

SCCBHD FSP teams operate under a "whatever it takes" philosophy, providing intensive, flexible, and

individualized support to promote recovery and stability. Multidisciplinary teams include staff with specialized expertise in serving high-need populations, such as individuals who are justice involved, reentering from correctional facilities, families involved with child welfare, and people experiencing homelessness. These specialized team members support system navigation, cross-agency coordination, and engagement strategies tailored to each population's unique needs. By meeting consumers where they are, offering 24/7 support, and addressing behavioral health, housing, physical health, and social needs in a coordinated manner, FSP programs reduce disparities in access and outcomes and support sustained recovery and wellness for SCC's most vulnerable residents.

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
Removal of children from home
Untreated behavioral health conditions
Suicides

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

SCCBHD FSP teams provide services through a client-centered, trauma-informed approach that emphasizes trust, collaboration, cultural responsiveness, and individualized care. Services are tailored to each consumer's strengths and goals, with care plans developed in partnership with the consumer and, when appropriate, their family or identified supports. Teams conduct regular check-ins in homes and community settings, provide intensive case management, and coordinate behavioral health treatment, primary care, substance use services, housing support, and benefits advocacy. Ongoing case management meetings with the consumer's care team ensure services remain aligned with evolving needs. FSP teams will coordinate with housing providers when FSP participants are in need of housing supports.
Strong relationship-building is central to the FSP model. Staff use consistent outreach, strengths-based engagement strategies, and peer support to foster trust and sustained participation in services. FSP teams provide field-based services, flexible scheduling, and appointment accompaniment to reduce barriers to care, and they intensify support during key transitions such as hospital discharge or release from incarceration. This coordinated approach promotes stability, reduces crises and hospitalizations, and supports long-term recovery and community integration.

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.)

SCCBHD will comply with required Full Service Partnership (FSP) levels of care by aligning program design, staffing, and service delivery with state-defined levels of care, including FSP Level 2 utilizing required evidence-based practices (EBPs) to include Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), High Fidelity Wraparound (HFW), and FSP Level 1 Intensive Case Management (ICM). Additionally the Individual Placements and Supports (IPS) supported employment model will be available for eligible FSP consumers across both FSP Level 2 and Level 1. SCCBHD is actively planning for the appropriate transition of existing FSP ICM teams to ACT/FACT where indicated, while also standing up new ACT/FACT teams and/or new FSP ICM teams to ensure sufficient capacity across the full continuum of care. These efforts are guided by an assessment of community need, acuity levels, and service gaps to ensure individuals receive the right level of support at the right time.

To support fidelity to each model, SCCBHD is working closely with the Centers of Excellence to provide ongoing training, technical assistance, and coaching for county and contracted provider staff. This partnership ensures teams have a clear and shared understanding of FSP EBP models, including eligibility criteria, staffing requirements, service intensity, and expected outcomes. FSP teams will work collaboratively across programs to regularly assess consumer needs, meet individuals where they are, and support timely and clinically appropriate transitions across levels of care. By following evidence-based models and maintaining strong coordination between teams, SCCBHD will ensure continuity of care, model fidelity, and individualized, recovery-oriented services for FSP participants.

SCCBHD will develop FSP criteria per direction and guidance from the state and will develop a referral process to ensure that consumers can move between both FSP levels of care and the outpatient level of care. FSP program supervisors and managers will be responsible to monitor that the FSP criteria is utilized appropriately and that the referral pathway promotes the seamless transition of consumers to the most appropriate level of care based on each individual consumer's need.

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

Yes

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)

Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program

The Integrated Housing and Recovery Team (IHART) adult/older adult full service partnership (FSP) program, delivered in partnership between SCCBHD and a contractor serves consumers with severe behavioral health conditions who are experiencing chronic homelessness. IHART staff engage consumers who are chronically homeless and/or experiencing homelessness. The outreach activities will be expanded to ensure adequate outreach and engagement services are provided in encampments and where the chronically homeless population congregates. The Maintaining Ongoing Stability through Treatment (MOST) adult/older adult FSP team will conduct outreach for individuals involved with the justice system including individuals on probation and/or engaged in an active court process.

In addition to targeted outreach with the homeless and justice-involved populations, SCCBHD FSP programs will utilize an existing adult/older adult program called the Community Re-Entry Support Team (CREST) to identify and outreach to consumers who are transitioning from subacute/acute facilities back to the community. This will ensure that these individuals receive an appropriate level of care upon discharge from subacute/acute facilities.

SCCBHD Children's System of Care (CSOC) currently operates two children/youth FSP programs that are specifically coordinating care for child welfare and justice involved children and youth. The Children's Social Services FSP program works closely with the County Child Welfare Services (CWS) Department to provide behavioral health services for children/youth in the foster care system. CWS social workers identify children/youth in need of behavioral health services and make referrals to SCCBHD. The Juvenile Justice FSP program receives referrals directly from juvenile probation and the juvenile detention facility. Both of these FSP teams screen and assess all of the children/youth referred and link them to the most appropriate level of care including identifying those that meet the FSP level of care criteria.

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

SCCBHD reviewed local data on youth probation involvement, diversion participation, and behavioral health utilization among justice-involved youth to identify service gaps and disparities. Additionally, SCCBHD incorporated input gathered through the community program planning (CPP) process which included BHSA educational sessions, community forums, key informant interviews, targeted focus groups, and a community needs survey to identify strengths, gaps, and priority needs across diverse communities—including the LGBTQ+ community—and BHSA priority populations. Feedback was gathered through structured protocols and community-defined activities designed to elevate lived experience perspectives and reduce disparities.

SCCBHD conducted targeted outreach to youth with lived experience and juvenile justice partners, including Probation and community-based providers, to participate in the aforementioned focus groups, key informant interviews, the community needs survey, and community forums. Representatives from this population participated in at least one engagement session, and organizations serving justice-involved youth were also represented in the broader community engagement process. Feedback gathered directly informed FSP program design, including service intensity, care coordination, and reentry supports. SCCBHD's Children's System of Care currently has a Juvenile Justice Full Service Partnership (FSP) program which receives referrals directly from juvenile probation and the juvenile detention facility. This FSP program will continue under BHSA and will incorporate the High Fidelity Wraproud evidenced-based practice model.

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

SCCBHD engaged in a comprehensive CPP process which included representatives from the LGBTQ+ community. Seven percent of the CPP participants identified as representatives from the LGBTQ+ community. Additionally, SCCBHD analyzed available data and community feedback related to disparities in behavioral health outcomes and service access for LGBTQ+ youth. We strategically conducted outreach to LGBTQ+ populations and affirming community-based organizations to ensure participation in CPP focus groups, key informant interviews, the community needs survey, and community forums. Representatives from this population engaged in at least one feedback session, and organizations serving LGBTQ+ youth, including the Diversity Center, were present throughout the community engagement process. Input received informed culturally responsive service approaches and inclusive FSP service delivery models.

Children/Youth FSP programs will be trained in the High Fidelity Wrapround evidenced-based practice model and efforts will be made across the SCCBHD system of care, including FSP programs, to provide training in culturally responsive care including gender-affirming care.

In the child welfare system

SCCBHD engaged in a comprehensive CPP process which included representatives with experience with the child welfare system including transitional age youth. Additionally, SCCBHD reviewed child welfare and behavioral health crossover data, including placement disruptions and crisis utilization, to better understand the needs of youth involved in the child welfare system. 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. Their feedback helped shape FSP planning related to trauma-informed care, caregiver involvement, and cross-system coordination. SCCBHD's Children's System of Care currently has the Children's Social Services Full Service Partnership (FSP) program which receives referrals directly from Child Welfare. This FSP program will continue under BHSA, and team members will be trained in the High Fidelity Wrapround evidenced-based practice model.

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

SCCBHD engaged in a comprehensive CPP process of which 16% of the participants were older adults. SCCBHD reviewed required population health measures and local utilization data, including crisis contacts, inpatient admissions, and service penetration rates among older adults, to identify disparities and service gaps. Older adults and organizations serving this population were engaged through community forums, key informant interviews, the community needs survey, and focus groups, where feedback was collected to inform FSP program design, including accessibility, care coordination, and age-responsive service approaches. Input gathered through the community engagement process directly shaped program planning to ensure FSP services are responsive to the unique needs of older adults. Currently SCCBH has a dedicated team specializing in supporting the older adult population. Members of this team will be embedded in the adult FSP programs.

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

SCCBHD engaged in a comprehensive CPP process which included representatives from the LGBTQ+ community. Seven percent of the CPP participants identified as representatives from the LGBTQ+ community. Additionally, SCCBHD conducted targeted outreach to LGBTQ+ community members and affirming organizations to ensure representation in community forums and engagement activities.

Feedback collected through these sessions informed culturally responsive service delivery, staff training priorities, and inclusive FSP practices. Organizations serving LGBTQ+ individuals, including The Diversity Center, were also represented in the community engagement process to help guide program planning. Efforts will be made across the SCCBHD 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

SCCBHD's comprehensive CPP process included representatives with experience with the justice system. One focus group was held with adult consumers involved with the justice system. SCCBHD reviewed data on justice involvement alongside required population health measures. We engaged individuals with lived experience and justice system partners through community forums, key informant interviews, the community needs survey, and targeted outreach to gather feedback that informed FSP development. SCCBHD's Adult System of Care currently has the Maintaining Ongoing Stability through Treatment (MOST) full service partnership (FSP) designed to serve justice-involved individuals. This FSP program will continue under BHSA. In addition to the MOST FSP, the County will continue a standalone FSP focused on individuals experiencing homelessness called Integrated Housing and Recovery Team (IHART) and a general adult FSP program to ensure broad access for eligible individuals with serious mental illness who are not justice-involved or experiencing homelessness. All adult FSP team members will be trained in both the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) evidenced-based practice models.

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

Targeted outreach through Homeless Persons Health Project (HPHP)

Program descriptions

HPHP provides targeted outreach to unsheltered individuals experiencing co-occurring disorders and physical health issues.

Current funding source

Medi-Cal FFP

BHSA changes to existing programs to meet BHSA requirements

Existing programs currently meet BHSA requirement

Expected timeline of operation

Currently in operation, expansion plans in place for FY26/27

Mobile-field based programs

Existing programs

Street medicine program through HPHP

Program descriptions

The primary interventions will be provided through street medicine programs that include multidisciplinary teams of health care providers conducting services at pop-up sites (encampments, shelters, etc.), with the mobile clinic, and through back-pack outreach. The services will include general medicine, medication-assisted treatment, medical (MAT) case management, Enhanced Care Management (ECM), housing navigation, behavioral health, STI testing and treatment, and other support services (addressing food insecurity, benefits, etc.).

Current funding source

Medi-Cal FFP

BHSA changes to existing programs to meet BHSA requirements

Currently meets BHSA requirements

Expected timeline of operation

Currently in operation, plans to expand in FY26/27

Open-access clinics

Existing programs

Janus NTP/MAT

Program descriptions

Contractor (Janus) operates

Current funding source

DMC-ODS FFP

BHSA changes to existing programs to meet BHSA requirements

Currently meets BHSA requirements

Expected timeline of operation

Currently operating. Will continue into next fiscal year

New Programs for Assertive Field-Based SUD Treatment Services
Targeted outreach

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Mobile-field based programs

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Open-access clinics

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

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

SCCBHD will utilize Medi-Cal expected utilization numbers from the Medi-Cal eligible population to determine community need and evaluate the capacity of all current MAT providers to assess potential gaps. If gaps exist, SCCBHD will identify strategies to expand access at various MAT entry points in the community. In addition, SCCBHD will increase access to substance use disorder (SUD) services through greater integration and coordination with Children's and Adult Mental Health divisions, strengthening cross-referral pathways, co-located services, and shared care planning to ensure timely identification, engagement, and treatment for individuals with co-occurring behavioral health needs.

Select the following practices the county will implement to ensure same day access to MAT

Contract directly with MAT providers in the County

Operate MAT clinics directly

Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal

Leverage telehealth model(s)

Partner with neighboring counties

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

SCCBHD partners with Alameda County for SUD treatment level of care 3.3, which is residential treatment for persons with traumatic brain injury and cognitive impairments. Santa Cruz County does not have any local providers licensed to provide this level of care, which is why the county partners with neighboring counties. SCCBHD also partners with Monterey County for residential treatment 3.1, 3.2 and 3.5.

What forms of MAT will the county provide utilizing the strategies selected above?

Buprenorphine
Methadone
Other

Please specify other forms of MAT

Brixadi and Vivatrol

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

Medium gap

Apartments, including master-lease apartments

Medium gap

Single and multi-family homes

Medium gap

Housing in mobile home communities

Large gap

(Permanent) Single room occupancy units

Medium gap

(Interim) Single room occupancy units

Not applicable

Accessory dwelling units, including junior accessory dwelling units

Large gap

(Permanent) Tiny homes

Small gap

Shared housing

Medium gap

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

Medium gap

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

Medium gap

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

Medium gap

License-exempt room and board

Small gap

Hotel and Motel stays

Medium gap

Non-congregate interim housing models

Medium 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)

Medium gap

Recuperative Care

Medium gap

Short-Term Post-Hospitalization housing

Medium gap

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

Medium gap

Peer Respite

Medium gap

Permanent rental subsidies

Large gap

Housing supportive services

Medium 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 **?**

SCCBHD will utilize several non-BHSA resources to expand housing access for BHSA-eligible individuals, including:

• United States Department of Housing and Urban Development (HUD) vouchers – federal

• Medi-Cal Managed Care Plan (MCP) Transitional Rent (TR) programs – state

• HUD Continuum of Care (CoC) and Emergency Solutions Grant (ESG) – federal

• Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in

Transition from Homelessness (PATH) Grant – federal
• Housing Authority – local
• Encampment Resolution Funding (ERF) Program - state
• Homeless Housing Assistance and Prevention (HHAP) – state
• Permanent Local Housing Allocation (PLHA) – state
• Community Care Expansion – Preservation – state
• Transitional Housing Program (THP) & Housing Navigation & Maintenance Program (HNMP) - state
• AB109, Prop. 47 - state
• California Department of Social Services Housing and Homelessness programs – state
• California Department of Housing and Community Development (HCD) programs -   Homekey, No Place Like Home, MHP, and others – state
• County and city general funds – local
• Behavioral Health Bridge Housing (BHBH) funding – available through June 30, 2027, supporting rental assistance, housing navigation, and low-barrier navigation sites – state

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions will strategically intersect with other county and community resources to strengthen the continuum of housing supports for BHSA-eligible individuals. SCCBHD will be updating an MOU with our County Housing for Health Division (H4H) to articulate new ways of partnering and leveraging resources including BHSA Housing Interventions funding, Medi-Cal Managed Care Plan (MCP) Community Supports transitional rent benefit, and other new collaborative opportunities. H4H is a Division of the County's Human Services Department that was established in November 2020 to help coordinate countywide efforts to ensure all residents have stable, healthy, safe places to live. Some examples of current collaborations we intend to build upon are: two new interim housing sites for behavioral health consumers, No Place Like Home (NPLH) permanent supportive housing units, Medi-Cal MCP Community Supports transitional rent and the establishment of a flexible housing subsidy pool, MDT outreach to unsheltered individuals with behavioral health conditions, and a data sharing collaborative to improve care for individuals that interact with the housing, behavioral health, and criminal justice systems. BHSA Housing Interventions are designed to complement existing programs such as HUD vouchers, CoC services, and BHBH funding, creating a seamless pathway from temporary to permanent housing. By aligning these resources and maintaining sustainability through diversified funding streams, the county can expand housing capacity, improve stability for individuals with behavioral health needs, and ensure long-term support across the housing and services continuum.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?

The SCCBHD system promotes permanent housing placement and retention for BHSA-eligible individuals through a Housing First model, providing immediate access to housing without preconditions and pairing it with comprehensive supportive services, including case management, behavioral health care, and connection to community resources. SCCBHD is actively working toward ensuring all housing providers adhere to the core components of the Housing First model, ensuring that interventions are client-centered, and designed to support long-term housing stability and improved quality of life for individuals with behavioral health needs. SCCBH currently has a technical assistance contract with the Pathways Housing First Institute to support our local efforts in this area. As indicated previously the County is in the process of implementing a new NPLH permanent supportive housing units scheduled to be available in the Spring of 2026. Additionally, SCCBH will be providing training and support for practitioners from full service partnership (FSP) programs, outpatient programs and other case management programs to strengthen efforts to identify permanent housing options available via consumers' natural supports. Additionally, FSP consumers will be linked to the Individual Placement and Support (IPS) supported employment model which will provide an opportunity for behavioral health consumers to secure an income that could support consumers in securing permanent housing.

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)?

SCCBHD behavioral health system is actively connecting BHSA-eligible individuals to permanent supportive housing (PSH) through partnerships with the Continuum of Care (CoC) and SCC Human Services Department (HSD) Housing for Health (H4H) initiatives. These collaborations support access to rental subsidies, operating subsidies, and supportive services within PSH projects, as well as assistance for individuals residing in other permanent housing settings. SCCBHD is working with H4H to create a flexible housing subsidy pool that combines rental assistance funding from multiple sources. The funding pool will initially focus on serving BHSA-eligible individuals. By coordinating resources and leveraging these partnerships, SCCBHD strengthens the housing continuum and ensures that BHSA-eligible individuals receive the services and supports needed to maintain long-term housing stability.

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

SCCBHD ensures that all BHSA Housing Intervention settings provide access to clinical and supportive behavioral health care through referrals to mental health (MH) and substance use disorder (SUD) case management and treatment services including both MH and SUD outpatient and intensive outpatient, full

service partnership (FSP) levels of care, and assertive field-based SUD interventions. Many of these programs are delivered by multidisciplinary teams, and services will include psychiatry, counseling, case management, and peer support. Housing supports are integrated across the continuum of services, leveraging H4H contracts and coordination with Medi-Cal Managed Care Plans (MCPs) through Enhanced Care Management (ECM) and Community Supports (CS) services. This approach ensures that individuals in all housing settings receive comprehensive, client-centered care that addresses both behavioral health needs and housing stability.

Eligible Populations

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

SCCBHD will identify, screen, and refer individuals eligible for BHSA Housing Interventions through a coordinated, system-wide approach embedded within routine behavioral health service delivery. Individuals will be identified at multiple entry points, including outpatient providers, Full Service Partnership programs, crisis services, inpatient and residential discharge planning, justice reentry programs, and outreach teams. Housing instability will be screened at intake and reassessment using standardized tools aligned with HUD definitions, alongside confirmation of specialty mental health eligibility and functional impairment. Multidisciplinary case conferencing will support appropriate matching to BHSA Housing, Behavioral Health Bridge Housing (BHBH), and other local housing resources. SCCBHD will also partner closely with the local Continuum of Care (CoC) to support data-informed identification and referral. Through formal data-sharing agreements and regular, HIPAA-compliant data matching between behavioral health records and HMIS, the County will identify individuals served in both systems who may qualify for BHSA or BHBH resources, as well as individuals engaged in one system who would benefit from connection to the other. Joint case conferencing, Coordinated Entry collaboration, and shared outcome monitoring will ensure individuals with serious behavioral health conditions and housing instability are prioritized, efficiently referred, and supported toward stable housing and sustained service engagement.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only ?
No

Please indicate why the county behavioral health system will not provide BHSA funded Housing Interventions to individuals living with a SUD only and include data to support
Insufficient resources
Other

Please explain why there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with an SUD only

Currently, there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only due to a lack of available housing and limited funding. Current BHSA funding is insufficient to sustain existing housing intervention programs.. While the long-term goal is to expand access to housing for individuals with SUD only, achieving this will require additional funding and housing resources to ensure adequate capacity and support.

However, SCCBHD is able to meet housing intervention needs for many individuals living with a substance use disorder through sober living facilities and recovery residences maintained through other funding streams.

Other than insufficient need or insufficient resources, please explain why the county is not providing BHSA-funded Housing Interventions to individuals living with a SUD only

This work is currently funded through other funding streams.

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

SCCBHD gathered input through the community program planning (CPP) process which included BHSA educational sessions, community forums, key informant interviews, targeted focus groups, and a community needs survey to identify strengths, gaps, and priority needs across diverse communities—including the LGBTQ+ community—and BHSA priority populations. Feedback was gathered through structured protocols and community-defined activities designed to elevate lived experience perspectives and reduce disparities. Two targeted focus groups were held with individuals with lived experience of homelessness. It should be noted that 13% of the total CPP participants identified as having lived experience with homelessness. Targeted outreach was conducted with youth with lived experience and juvenile justice partners, including Probation, our BH forensics team, and our Youth with Lived Experience Advisory Board (YLEAB), to participate in focus groups, key informant interviews, the community needs survey, and community forums. Representatives from this population engaged in at least one feedback session, and organizations serving justice-involved youth were included in the broader housing planning discussions. Feedback directly informed housing intervention planning.

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

Seven percent of the CPP participants identified as representatives from the LGBTQ+ community. SCCBHD conducted targeted outreach to LGBTQ+ individuals and affirming community-based organizations to ensure meaningful participation in housing-focused engagement sessions. Organizations serving LGBTQ+

youth, including the Diversity Center, participated throughout the CPP process. Input received informed the development of culturally responsive housing interventions, including affirming housing placements, landlord engagement strategies, and supportive services. Efforts will be made across the SCCBHD system of care to provide training in culturally responsive care including gender-affirming care and this training should be extended to housing providers.

In the child welfare system

SCCBHD's comprehensive CPP process included representatives with experience with the child welfare system including transitional age youth. In partnership with Child Welfare Services and community-based providers, SCCBHD conducted targeted outreach to youth and caregivers with lived experience to participate in housing-focused discussions, targeted focus groups, key informant interviews, the community needs survey, and community forums. Representatives from Child Welfare Services and organizations serving foster youth contributed to at least one engagement activity. Their feedback was incorporated into our planning process and helped identify housing strategies for families

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

The CPP process included 2 targeted focus groups with individuals with lived experience of homelessness. Regarding the older adult population, it should be noted that 16% of the CPP participants were older adults. Representatives and individuals with lived experience, including older adults and behavioral health providers serving older adults, participated in SCCBHD's CPP process including in focus groups, key informant interviews, the community needs survey, and community forums. Participants provided input on barriers to housing access, accessibility needs, and supportive service gaps specific to older adults. Their feedback informed prioritization strategies within Housing Interventions.

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

Representatives with experience with the justice system participated in the local CPP process. SCCBHD held one focus group with adult consumers involved with the justice system. In addition, targeted outreach was conducted with people with lived experience and justice partners, including Probation, our BH forensics team, and our Lived Experience Advisory Board (LEAB), to participate in focus groups, key informant interviews, the community needs survey, and community forums. Representatives from this population engaged in at least one feedback session, and organizations serving justice-involved adults/older adults were included in the broader housing planning discuss.

In underserved communities

SCCBHD intentionally engaged underserved communities in the development of Housing Interventions through partnerships with Community Health Workers (CHWs) at the Community Action Board (CAB), NAACP, NAMI, and other community-based organizations that serve historically marginalized populations throughout the county. These partners played a key role in sharing information, gathering feedback, and ensuring housing planning efforts reflected the lived realities of individuals experiencing homelessness, housing instability, language barriers, and limited access to services.

SCCBHD staff conducted field-based outreach to advertise CPP process and community engagement opportunities, including distributing and posting flyers in community locations across the county, sharing information through trusted service providers, and conducting direct outreach in areas with high concentrations of unsheltered individuals. As a result of these efforts, individuals from underserved communities actively participated in the CPP and provided direct input on housing access barriers.

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?

SCCBHD coordinates with the Continuum of Care (CoC) through participation on the CoC Policy Board, regular coordination meetings, data sharing, and collaborative planning to ensure alignment of Housing Interventions services with local homeless system priorities. Referrals are received through data sharing efforts (HMIS and Avatar) across both teams. BH has close and frequent collaboration with our housing connectors and housing continuum to identify individuals with long histories of homelessness. BH has regular coordination meetings with CoC to prioritize referrals for shelter sites and available NPLH units.

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

SCCBHD maintains active collaboration with the local Continuum of Care (CoC) through HMIS access, regular data sharing, and participation in stakeholder council meetings. Behavioral health administration staff attend CoC meetings to coordinate housing interventions, align services with system-wide priorities, and ensure timely referrals for individuals experiencing homelessness. CoC partners were included in County email distribution lists and actively participated in the Community Planning Process (CPP), providing input on system needs, priorities, and service design.

Public Housing Agency

SCCBHD partners with the Housing Authority to support Permanent Supportive Housing (PSH) development and implement the No Place Like Home (NPLH) program. This collaboration facilitates access to affordable housing, coordinates referrals, and ensures behavioral health clients are prioritized for housing resources when eligible. Housing Authority staff were included in County email distribution lists and engaged in the CPP, contributing perspectives on housing availability, eligibility criteria, and program planning.

MCPs

SCCBHD works closely with our two MCPs to coordinate transitional rental assistance, establish referral pathways, and integrate housing services into care planning. Memorandums of understanding and policies are under development to formalize these processes. MCP representatives were included in County email distribution lists and participated in the CPP, offering input on care coordination, housing referrals, and integration with managed care services.

ECM and Community Supports Providers

Behavioral health staff actively participate in the Santa Cruz County PATH CPI meeting, which brings together Enhanced Care Management (ECM) and Community Supports providers. This collaboration ensures alignment of housing interventions with individualized care plans, facilitates referrals, and promotes integrated service delivery for vulnerable clients. ECM and Community Supports providers were included in County email distribution lists and participated in the CPP, sharing feedback on service needs, coordination strategies, and best practices.

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

SCCBHD engages other housing partners, including CalWORKS/TANF housing programs, child welfare housing programs, and existing or prospective PSH developers and providers. Collaboration includes coordinated planning, referral pathways, and joint problem-solving to expand housing capacity, reduce service gaps, and ensure that housing interventions meet the needs of the county's most vulnerable populations. These partners were included in County email distribution lists and participated in the CPP, providing guidance on program design, capacity building, and strategies for equitable access to housing.

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?

SCCBHD will work in close partnership with Homekey+ developments, the local Continuum of Care (CoC), and supportive housing providers to ensure BHSA-eligible individuals are appropriately referred, housed, and supported. Through coordinated planning with the CoC, participation in joint prioritization and case

conferencing, and alignment with Coordinated Entry processes, the County will help match individuals enrolled in specialty mental health services who meet medical necessity criteria to available Homekey+ and permanent supportive housing units. Front Street Inc., under contract with the County to provide supportive housing services, will serve as a key implementation partner—supporting referrals, housing navigation, and tenancy transition coordination to ensure seamless placement and engagement. SCCBHD will provide and/or contract specialty mental health services within Homekey+ and other supportive housing sites, including Full Service Partnership (FSP), outpatient treatment, psychiatry, case management, and field-based services. BHSA funding will be braided with other federal, state, and local resources to sustain services and promote long-term housing stability. The County will maintain ongoing collaboration with housing operators, the CoC, and Front Street through data sharing (as permitted by law), shared access to HMIS and behavioral health systems for key staff, and routine cross-system meetings to monitor outcomes, address tenancy challenges early, prevent evictions, and reduce returns to homelessness.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

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?

260

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

160

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

100

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?

SCCBHD analyzed the number of available permanent and interim beds across housing providers, aggregated total capacity, and reviewed turnover trends to estimate the number of individuals who could be served annually.

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: Shared 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

Time Limited Interim Settings: Hotel and motel stays

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

SCCBHD will utilize BHSA Housing Interventions funding to provide rental subsidies for allowable settings, operating subsidies, and other housing supports to include participant assistance funds, for BHSA- eligible individuals who are enrolled in County Behavioral Health services who are experiencing homelessness or

at-risk of homelessness and/or individuals experiencing more serious behavioral health conditions who have been identified by SCCBHD.

BHSA Housing Interventions funding will be used to provide rental assistance for permanent supportive housing as well as interim housing settings with a goal to transition individuals to permanent housing situations. This will include covering the difference between tenant rent contributions and the full rent amount. SCCBHD will fund rental subsidies for licensed board and cares (B&Cs), adult residential facilities (ARFs), residential care facilities for the elderly (RCFE), unlicensed room and boards (R&Bs), peer respite housing, and scattered sites across the county including expenses related to hotel/motel stays for consumers that need short-term urgent housing. SCCBHD will continue to utilize master leasing and property management strategies to secure units dedicated to behavioral health consumers.

The County will work closely with the local Medi-Cal Managed Care Plans (MCPs) to leverage the Community Supports (CS) Transitional Rent benefit to prevent housing loss, facilitate discharges from correctional facilities and institutional settings serving as a bridge to a more permanent housing situation. Housing supports will be paired with voluntary recovery-focused care coordination and treatment funded by other SCCBHD funding sources.

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?
Project-based
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
During the community program planning (CPP) process SCCBHD engaged in system mapping and gap analysis activities which included mapping current housing units available. SCCBHD will   continue to maintain a portfolio of available housing units for BHSA-eligible individuals by leveraging and expanding existing housing partnerships and infrastructure.

As an example, the Health Services Agency's Behavioral Health Division collaborates closely with the Human Services Department's Housing for Health Division in the planning for countywide housing supports. The Housing for Health Division received funding to support landlord engagement and risk mitigation activities and will make these resources available to eligible behavioral health consumers in coordination with SCCBHD. This coordinated approach ensures that behavioral health consumers can access landlord incentives and mitigation resources without duplicating funding streams. By partnering with Housing for Health, the County can continue to reduce landlord risk, expand access to private-market units, and shorten the time from referral to placement. When paired with ongoing specialty mental health services and tenancy-sustaining supports provided or coordinated by SCCBHD, this strategy strengthens housing stability outcomes and enhances the County's capacity to serve individuals with the highest levels

of vulnerability and service need.

The Housing Interventions will be implemented in partnership with the Continuum of Care's (CoC) Coordinated Entry System (CES) and the Homeless Management Information System (HMIS) in partnership with MCPs including Enhanced Care Management (ECM) and CS providers.

SCCBHD will also coordinate placements in No Place Like Home (NPLH) Program units and collaborate with the local Continuum of Care (CoC) to access CoC-funded housing resources. In addition, SCCBHD is in the process of developing a flex pool with other county partners.

Total number of units funded with BHSA Housing Interventions per year

260

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

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

156

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

BHSA Housing Interventions funding will be used to support a range of eligible operating costs, including:

• Utilities: Payment of basic utilities such as electricity, water, gas, and trash tied to housing operations.

• Property operations and maintenance: Routine maintenance, repairs, janitorial services, pest control, and upkeep necessary to keep units habitable.

• Property management expenses: Costs associated with managing housing units, including leasing administration and occupancy coordination.

• Insurance and operating reserves: Building insurance and limited reserves needed to sustain ongoing housing operations.

• Office supplies and expenses.

• Legal and accounting services as needed.

• Security and/or site monitors.

• Housing incidentals, e.g., appliances, water heater, transportation, food, hygiene products, etc.
• Furnishings and basic household needs: Essential furnishings or replacements that support unit functionality and housing stability.

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: Shared 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
Time Limited Interim Settings: Peer respite

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

200

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

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

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

SCCBHD will not implement a Landlord Outreach and Mitigation Funds intervention under BHSA Housing Interventions. However, Santa Cruz County Housing for Health did receive funding to support landlord engagement and risk mitigation activities and will make these resources available to eligible behavioral health clients in coordination with SCCBHD. Through Housing for Health, landlord recruitment and engagement efforts, signing incentives, risk mitigation funds (to cover potential damages or unpaid rent beyond standard deposits), and flexible financial supports to address barriers to tenancy will be available to support housing placements, including for individuals with serious behavioral health conditions

experiencing chronic homelessness.

This coordinated approach ensures that behavioral health clients can access landlord incentives and mitigation resources without duplicating funding streams. By partnering with Housing for Health, the County can continue to reduce landlord risk, expand access to private-market units, and shorten the time from referral to placement. When paired with ongoing specialty mental health services and tenancy-sustaining supports provided or coordinated by SCCBHD, this strategy strengthens housing stability outcomes and enhances the County's capacity to serve individuals with the highest levels of vulnerability and service need.

Anticipated number of individuals served per year

000

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

N/A

Total number of units funded with BHSA Housing Interventions per year

000

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

N/A

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

150

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

Specific uses of Participant Assistance Funds may include:
• Costs associated with obtaining government-issued identification and other vital documents
• Housing application fees
• Fees for credit reports
• Security and utility deposits
• Storage fees
• Pet deposits and other pet fees
• Move-in costs (see BHSA Policy Manual for examples)
• Rent and utility arrears

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?
No

Please explain why the county is not providing this intervention
SCCBHD is not directly providing Housing Transition Navigation Services and Tenancy Sustaining Services (HTSS) under BHSA because these services are already administered countywide through the Human Services Department (HSD) as part of CalAIM Community Supports for eligible Medi-Cal members. HSD oversees and coordinates Housing Transition Navigation and Tenancy Sustaining Services through contracted community-based providers, ensuring standardized eligibility determination, service delivery, billing compliance, and system alignment across populations. This structure avoids duplication of services and leverages Medi-Cal reimbursement to sustain housing-related supports.
SCCBHD works in close partnership with HSD and contracted agencies who play a key role in housing navigation and supportive housing services—to ensure BHSA-eligible individuals are referred and connected to available HTSS resources. Through shared case conferencing, coordinated entry processes, and cross-system collaboration, Behavioral Health consumers receive access to housing navigation and tenancy supports while Behavioral Health focuses BHSA funding on specialty mental health services and other Housing Interventions that complement, rather than duplicate, existing CalAIM-funded infrastructure.

Housing Interventions Outreach and Engagement

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
This service is provided through other funding sources – not BHSA.

Capital Development Projects

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?
No

Please explain why the county is not providing this intervention
SCCBHD is not providing this resource because funds are being prioritized to sustain and strengthen existing housing resources and treatment services that address the most urgent behavioral health needs identified by the community. Resources are being allocated to maintain service continuity, housing stability, and critical treatment capacity.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
No

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year

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)
N/A

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?
None of the Above

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
No

Recuperative Care
No

Day Habilitation
No

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)?
SCCBHD identifies members who may benefit from housing-related MCP Community Supports through
routine clinical assessments, housing status screenings, enrollment processes, and ongoing case
management. Housing instability, risk of homelessness, or recent homelessness are documented in the
consumer record and discussed during interdisciplinary case reviews.
Referrals are submitted directly to the appropriate MCP via secure email in accordance with established
referral protocols. SCCBHD staff maintain communication with MCP care managers to track referral status,
respond to requests for additional information, and coordinate next steps.
SCCBHD is currently working with MCPs to finalize formal agreements and detailed workflows specific to
Transitional Rent. These processes are being refined with the intent of aligning Transitional Rent referrals
with the already established referral pathways and care coordination workflows currently used for other
Community Supports.

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
SCCBHD has standing meetings with the MCPs to discuss BHSA efforts and ensure everyone is aligned and
aware of Housing Interventions. In addition, representatives from each MCP will be invited to review this
plan, with the opportunity to provide public comment, not only for the Housing Intervention section, but
also other areas of the integrated plan. In addition, we are working on new MOU agreements with each
MCP, which will detail our processes for housing interventions.

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
SCCBHD tracks which of its contracted housing providers also deliver MCP-funded housing-related
Community Supports by cross-referencing County contracts with the publicly posted provider network
from the Central California Alliance for Health and Kaiser. This allows the County to identify overlap,
partnership opportunities, and potential service gaps. Behavioral Health is also exploring enhanced
data-sharing with MCPs to better identify specialty mental health consumers enrolled in MCP housing
services, which would support coordinated care planning and reduce service duplication.
To align network development, SCCBH coordinates with MCPs, the Human Services Department, the CoC,

and contracted housing providers through regular planning meetings, shared data review, and system-wide collaboration. This ensures BHSA funding will be focused on specialty mental health services and intensive supportive housing interventions, while MCP-funded Community Supports provide housing navigation and tenancy services. Collaboration with providers serving multiple systems streamlines referrals, clarifies roles and funding, and strengthens integrated service delivery for individuals with serious behavioral health conditions who are experiencing homelessness.

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?
When MCP housing services are exhausted, members can be referred to our county Housing Intervention programs. Referrals will be processed in the order they are received, with multiple teams working to adequately serve the community.

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?
Yes

What role does the county behavioral health system plan to have in the Flex Pool?
Funder

Have you identified an Operator of the Flex Pool?
Yes

What organization is serving as the Operator?
Front St. Inc.

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
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
SCCBHD will serve as a funder and collaborative partner in the development and implementation of the Flex Pool. SCCBHD will participate in planning meetings, governance discussions, and cross-system coordination efforts to support the successful launch and scaling of the Flex Pool. The County Human Services Department Housing for Health Division will serve as the Lead Entity. SCCBHD will work closely with Housing for Health, and community partners to align funding, establish clear eligibility and referral pathways, and ensure integration with existing behavioral health and housing resources. Through ongoing collaboration, the County will help support operational planning, data sharing, and continuous quality improvement to maximize the Flex Pool's impact in addressing housing instability among individuals with behavioral health needs.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

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

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

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

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

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

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

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

Build Workforce to Address Statewide Behavioral Health Goals

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

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
13

Upload any data source(s) used to determine vacancy rate
Workforce Vacancy Rates (1).docx

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Licensed Clinical Social Worker
Licensed Psychologist
Medical assistant
Substance Use Disorder Counselor
Licensed Professional Clinical Counselor

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 existing staff. SCCBHD does not anticipate additional funding to hire staff to support implementation, meaning current employees will be required to absorb this work. As a result, SCCBHD expects increased vacancies due to burnout, higher turnover, and ongoing challenges with recruitment and retention stemming from limited resources and increased requirements.

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
SCCBHD plans to leverage the BH-CONNECT workforce initiative by actively supporting staff participation in the Behavioral Health Student Loan Payment Program. While individual eligible staff apply directly to the state-administered program, SCCBHD will serve as an eligible public employer and promote loan repayment opportunities as part of its recruitment, onboarding, and retention strategies. SCCBHD will provide required employment verification and administrative support to facilitate staff participation and will integrate student loan repayment opportunities into broader workforce development efforts aligned with Behavioral Health Transformation and BH-CONNECT goals.
SCCBHD's Behavioral Health Senior Trainer ensured that all Behavioral Health staff were made aware of this opportunity by sharing the California Department of Health Care Access and Information (HCAI) notice with all staff so they can apply & take action if they meet the requirements.

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

No

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?

No

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 budgetary constraints all County Departments are currently subject to a hiring freeze. Ongoing workforce shortages coupled with budget constraints have necessitated the reduction of longstanding vacant positions within the past 2 years. These challenges are not unique to Santa Cruz County. The current complex and competing realities of high and increasing demands for services, reductions in both state and federal funding, a statewide workforce crisis, and an existing service delivery system that is overtaxed, combined with new and emerging State mandates are placing behavioral health plans across the state in an untenable position. SCCBHD executive leadership are actively working to restructure the system of care in order to ensure the County meets our mandates, staff are supported, and we continue to provide high quality services to vulnerable behavioral health consumers. Active and ongoing efforts have been made to improve communication with staff, engage in morale and team building activities to support the current staff, and include staff in program evaluation and transformation. We are striving for a trauma informed organization where staff feel valued, we all work smarter not harder, and the community experiences welcoming quality mental health and substance use care.

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
2026-03-11 BHD DRAFT BHSA IP Budget Template V3 for Review.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. SCCBHD is not over the maximum allowed prudent reserve.

Full Service Partnership (FSP)
N/A. SCCBHD is not over the maximum allowed prudent reserve.

Housing Interventions
N/A. SCCBHD is not over the maximum allowed prudent reserve.

 Enter date of last prudent reserve assessment
1/15/2026

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

BHSS

N/A. SCCBHD is not over the maximum allowed prudent reserve.

FSP

N/A. SCCBHD is not over the maximum allowed prudent reserve.

Housing Interventions

N/A. SCCBHD is not over the maximum allowed prudent reserve.

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%)	28	28	28
Housing Intervention (Base 30%)	30	30	30
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	1849131	1849131	1849131
Dollars transferred from Housing Intervention	0	0	0
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

SCCBHD is requesting a transfer of funds from Full-Service Partnership (FSP) to Behavioral Health Services and Supports (BHSS) to sustain critical treatment services and programs serving Behavioral Health Services Act (BHSA) priority populations. 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, 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. 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	1849131	1849131	1849131
Dollars transferred into Housing Intervention	0	0	0

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

As previously indicated, SCCBHD is requesting a transfer of funds from Full-Service Partnership (FSP) to Behavioral Health Services and Supports (BHSS) to sustain critical treatment services and programs serving

Behavioral Health Services Act (BHSA) priority populations. This transfer ensures continuity of care and maintains access to local essential outpatient, rehabilitative, and supportive services that address the needs of individuals with serious mental illness, substance use disorders, 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 CPP process. SCCBHD has ensured that the budget allocated to Full-Service Partnership (FSP) programming is more than adequate to support the continued delivery of FSP services and supports including the implementation of evidence-based practices and FSP levels of care. The transfer of FSP funding to Behavioral Health Services and Supports will address identified funding shortfalls and will further support SCCBHD in ensuring that there is adequate outpatient level treatment available for FSP consumers that are identified to be eligible to step down and transitioned to outpatient services.

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	0	0	0
Dollars transferred into Full Service Partnerships	0	0	0

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

N/A

Supporting Information and Data

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

Financial and utilization data were also reviewed to evaluate available funding and support development of an updated financial model that maximizes sustainability through blended and braided financing approaches. This included consideration of how Medi-Cal reimbursement and other funding sources can support ongoing service delivery in combination with BHSA service expansion resources. The request to transfer funding from Full-Service Partnership to Behavioral Health Services and Supports aligns available funding with current service demand, program utilization trends, and data collected through the County's community program planning (CPP) process. 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, SCCBHD utilized data to guide program design, funding strategy, and system transformation priorities, ensuring that the Integrated Plan is community-informed, equitable, and aligned with BHSA goals.

Feedback from consumers, family members, providers, and community partners identified the need to preserve and strengthen core treatment services across the behavioral health continuum. Within the CPP identified top five system gaps and needs, mental health services and supports was found as the second most significant gap ranging from the need for more crisis/field-based services, outpatient services for

children/youth and adults/older adults, peer services, and services and support specific to special populations. This funding transfer request supports system stability, prevents service disruptions, and ensures ongoing compliance with BHSA requirements to prioritize high-need populations.

Please include local data supporting the funding transfer request

Community Program Planning Summary.pdf

Data Suppression Notice:

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

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

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

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
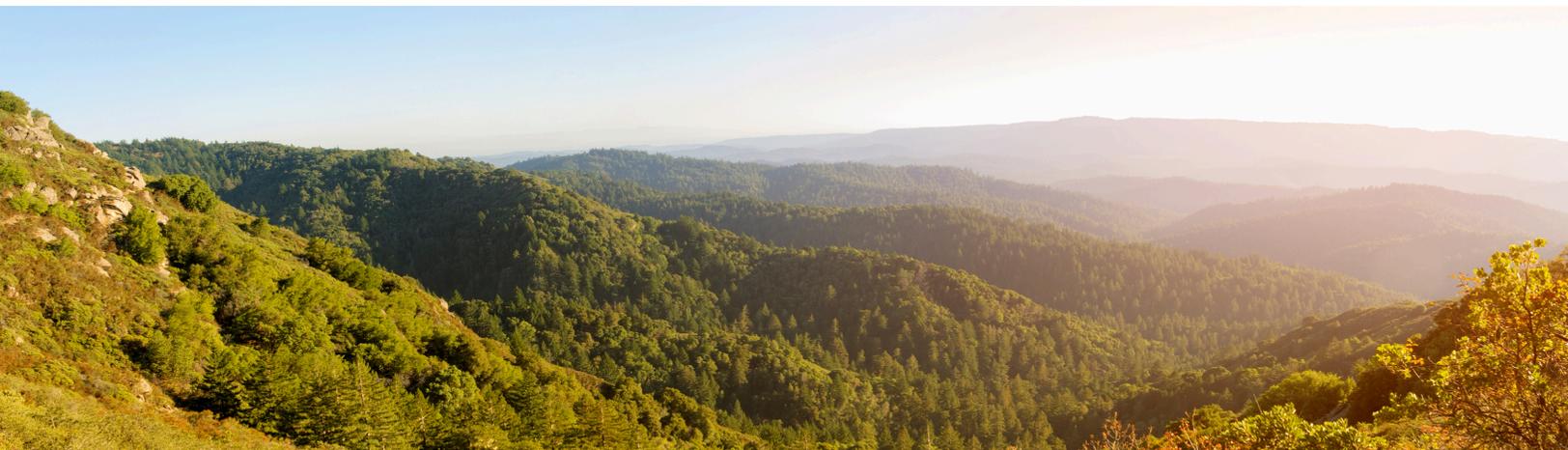
Appendices

Appendix 1 - Draft Budget

Appendix 2 - Community Program Planning Process Supporting Documentation

Appendix 3 - Quality Improvement Work Plan FY 2025-2026

Appendix 4 - How to Submit Public Comment

Appendix 1
Draft Budget

Please note: This budget is posted in **draft** form and is subject to change. Final allocations may be adjusted before implementation.

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
Table One: Behavioral Health Care Continuum Projected Expenditures									
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older Adults	Eligible Children/Youth
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 306,365.00	$ 306,365.00	$ 306,365.00	$ 2,012,986.00	$ 2,012,986.00	$ 2,012,986.00	350	3500
Early Intervention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	79
Outpatient Services	☑	$ 6,195,869.00	$ 6,195,869.00	$ 6,195,869.00	$ 66,223.00	$ 66,223.00	$ 66,223.00	1548	126
Intensive Outpatient Services	☑	$ 2,938,373.00	$ 2,938,373.00	$ 2,938,373.00	$ -	$ -	$ -	189	#
Crisis and Field-Based Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Residential Treatment Services	☑	$ 39,145,559.00	$ 39,145,559.00	$ 39,145,559.00	$ 100,000.00	$ 100,000.00	$ 100,000.00	687	11
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	☑	$ -	$ -	$ -	$ 1,492,405.00	$ 1,492,405.00	$ 1,492,405.00	0	55
Early Intervention Services	☑	$ 27,774.00	$ 27,774.00	$ 27,774.00	$ 102,108.00	$ 102,108.00	$ 102,108.00	8144	14189
Outpatient and Intensive Outpatient Services	☑	$ 16,515,083.00	$ 16,515,083.00	$ 16,515,083.00	$ 13,825,909.00	$ 13,825,909.00	$ 13,825,909.00	2818	1431
Crisis Services	☑	$ 3,685,646.00	$ 3,685,646.00	$ 3,685,646.00	$ 7,547,546.00	$ 7,547,546.00	$ 7,547,546.00	900	750
Residential Treatment Services	☑	$ 7,277,194.00	$ 7,277,194.00	$ 7,277,194.00	$ 50,000.00	$ 50,000.00	$ 50,000.00	229	1
Hospital and Acute Services	☑	$ 24,611,537.00	$ 24,611,537.00	$ 24,611,537.00	$ -	$ -	$ -	156	78
Subacute and Long-Term Care Services	☑	$ 8,386,858.00	$ 8,386,858.00	$ 8,386,858.00	$ -	$ -	$ -	50	#
Housing Services (MH + SUD)									
Housing Services	☑	$ 14,751,359.00	$ 14,751,359.00	$ 14,751,359.00	$ -	$ -	$ -	260	5
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 123,841,617.00	$ 123,841,617.00	$ 123,841,617.00	$ 25,197,177.00	$ 25,197,177.00	$ 25,197,177.00	15331	20225

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ -	$ -	$ -
Workforce Investment Activities	$ -	$ -	$ -
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 34,693,977.00	$ 34,693,977.00	$ 34,693,977.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 25,687,026.00	$ 25,687,026.00	$ 25,687,026.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 60,381,003.00	$ 60,381,003.00	$ 60,381,003.00

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	$ 26,416,166.00	$ 26,416,166.00	$ 26,416,166.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 9,903,544.00	$ 9,903,544.00	$ 9,903,544.00
2011 Realignment (Public Safety Realignment)	$ 18,476,671.00	$ 18,476,671.00	$ 18,476,671.00
State General Fund	$ 7,423,951.00	$ 7,423,951.00	$ 7,423,951.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 77,154,578.00	$ 77,154,578.00	$ 77,154,578.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 42,829.00	$ 42,829.00	$ 42,829.00
Community Mental Health Block Grant (MHBG)	$ 534,206.00	$ 534,206.00	$ 534,206.00
Substance Use Block Grant (SUBG)	$ 1,928,021.00	$ 1,928,021.00	$ 1,928,021.00
Commercial Insurance	$ -	$ -	$ -
County General Fund	$ 18,532,646.00	$ 18,532,646.00	$ 18,532,646.00
Opioid Settlement Funds	$ 6,466,452.00	$ 6,466,452.00	$ 6,466,452.00
Other Funding Sources	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
Other federal grants	$ 140,674.00	$ 140,674.00	$ 140,674.00
Other state funding (including DSH funding)	$ 11,035,063.00	$ 11,035,063.00	$ 11,035,063.00
Other county mental health or SUD funding	$ 30,710,373.00	$ 30,710,373.00	$ 30,710,373.00
Other foundation funding	$ 654,623.00	$ 654,623.00	$ 654,623.00
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)	$ 209,419,797.00	$ 209,419,797.00	$ 209,419,797.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 149,038,794.00	$ 149,038,794.00	$ 149,038,794.00
Auto-validation: Table 2: Other County Expenditures	$ 60,381,003.00	$ 60,381,003.00	$ 60,381,003.00

Table Four: BHSA Transfers			
County Base BHSA Funding Allocations			
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Total**
Year 1 Component Allocation (dollars)	$ 7,332,582.00	$ 8,554,679.00	$ 8,554,679.00	$ 24,441,940.00
Year 2 Component Allocation (dollars)	$ 8,371,940.00	$ 9,617,664.00	$ 9,617,664.00	$ 27,607,268.00
Year 3 Component Allocation (dollars)	$ 8,631,470.00	$ 9,915,812.00	$ 9,915,812.00	$ 28,463,094.00

Summary (auto-populated)			
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	30%	40%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 7,332,582.00	$ 7,428,330.05	$ 9,681,027.95	$ 24,441,940.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 935,153.00	$ -	$ 1,952,826.00	$ 2,887,979.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	28%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 8,371,940.00	$ 7,694,131.20	$ 11,541,196.80	$ 27,607,268.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	28%	42%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 8,631,470.00	$ 7,932,649.60	$ 11,898,974.40	$ 28,463,094.00

Funding Transfer Request Allocations		
Year 1		
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 7,332,582.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 7,332,582.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 8,554,679.00
Percentage Reduced	-4.61%	$ 1,126,349.00
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	30%	$ 7,428,330.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 8,554,679.00
Percentage Reduced	0%	$ -
Percentage Added	4.61%	$ 1,126,349.00
New BHSS Base Percentage (auto-populated)	40%	$ 9,681,028.00

Transfers			
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	30%	40%	Row Equals 100%

159

Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	30%	40%	Row Equals 100%

Year 2

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 8,371,940.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 8,371,940.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 9,617,664.00
Percentage Reduced	-7%	$ 1,923,533.00
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	28%	$ 7,694,131.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 9,617,664.00
Percentage Reduced	0%	$ -
Percentage Added	7%	$ 1,923,533.00
New BHSS Base Percentage (auto-populated)	42%	$ 11,541,197.00

Transfers			
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	28%	42%	Row Equals 100%
Amount Transferring Out	0%		0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%		Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	28%	42%	Row Equals 100%

Year 3

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 8,631,470.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 8,631,470.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 9,915,812.00
Percentage Reduced	-7%	$ 1,983,162.00
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	28%	$ 7,932,650.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 9,915,812.00
Percentage Reduced	0%	$ -
Percentage Added	7%	$ 160 1,983,162.00
New BHSS Base Percentage (auto-populated)	42%	$ 11,898,974.00

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	28%	42%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	28%	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	$ -	$ -	$ -	$ -
PEI	$ 1,610,989.00			$ 1,610,989.00
Encumbered INN	$ -	$ -	$ -	$ -
Unencumbered INN	$ 1,276,990.00	$ 935,153.00		$ 341,837.00
WET	$ -			$ -
CFTN	$ -			$ -
Total (auto-populated)	$ 2,887,979.00	$ 935,153.00	$ -	$ 1,952,826.00 $ -

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	$ 2,997,357.00
Local Prudent Reserve Maximum (2)	$ 3,916,761.98
Excess Prudent Reserve Funding that must be transferred	$ (919,404.98)
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.

4. W&I Code § 5892, subdivision (b)(6)(A) states counties must spend prudent reserve funds on Housing Intervention, FSP, and/or BHSS programs or services only.

Table Five: BHSA Components			
Total Housing Interventions Funding (1)			
	Year 1	**Year 2**	**Year 3**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 7,332,582.00	$ 8,371,940.00	$ 8,631,470.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ 935,153.00	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 8,267,735.00	$ 8,371,940.00	$ 8,631,470.00

Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
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	$ 6,539,529.00	$ 6,539,529.00	$ 6,539,529.00	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 914,623.00	$ 914,623.00	$ 914,623.00	$ -	$ -	$ -
% 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	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 781,451.00	$ 781,451.00	$ 781,451.00	$ -	$ -	$ -
% 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)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -

Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 8,235,603.00	$ 8,235,603.00	$ 8,235,603.00	$ -	$ -	$ -

Housing Interventions Transfer Information	Year 1	Year 2	Year 3
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	Year 1	Year 2	Year 3
Housing Interventions Component Admin Expenses	$ 32,132.00	$ 32,132.00	$ 32,132.00
Total Housing Interventions Expenditures (auto-populated)	$ 8,267,735.00	$ 8,267,735.00	$ 8,267,735.00
Housing Interventions Populations to be Served	Year 1	Year 2	Year 3
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 4,133,868.00	$ 4,185,970.00	$ 4,315,735.00
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 1	Year 2	Year 3
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	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%

<--- not sure why this is red, we are meeting the 50% requirement

Projected Individuals to be Served (Unduplicated)	Year 1	Year 2	Year 3
Eligible Children/TAY (25 years and younger)	5	5	5
Eligible Adults/Older Adults	260	260	260

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year 1	Year 2	Year 3
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.

3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.

4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.

5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).

6. W&I Code § 5892, subdivision (b)(2).

7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.

8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Table Six: BHSA Components			

Total Full Service Partnership (FSP) Funding

	Year 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 7,428,330.00	$ 7,694,131.00	$ 7,932,649.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 7,428,330.00	$ 7,694,131.00	$ 7,932,649.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FSP Intensive Case Management	$ 4,184,743.00	$ 4,184,743.00	$ 4,184,743.00	$ 3,034,331.00	$ 3,034,331.00	$ 3,034,331.00	$ -	$ -	$ -
High Fidelity Wraparound	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 167,656.00	$ 167,656.00	$ 167,656.00	$ 167,657.00	$ 167,657.00	$ 167,657.00	$ -	$ -	$ -
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	$ 2,882,290.00	$ 2,882,290.00	$ 2,882,290.00	$ 1,663,706.00	$ 1,663,706.00	$ 1,663,706.00	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ 97,126.00	$ 97,126.00	$ 97,126.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 7,331,815.00	$ 7,331,815.00	$ 7,331,815.00	$ 4,865,694.00	$ 4,865,694.00	$ 4,865,694.00	$ -	$ -	$ -

FSP Transfer Information	Year 1	Year 2	Year 3
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -

FSP Administrative Information	Year 1	Year 2	Year 3
FSP Component Admin Expenses	$ 96,515.00	$ 96,515.00	$ 96,515.00
Total Full Service Partnership Expenditures (auto-populated)	$ 7,428,330.00	$ 7,428,330.00	$ 7,428,330.00

Projected Individuals to be Served (Unduplicated)	Year 1	Year 2	Year 3
Eligible Children/TAY (25 years and younger)	20	30	40
Eligible Adults/Older Adults	50	55	60

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year 1	Year 2	Year 3
MHSA "Encumbered" INN	$ -	$ -	$ -

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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.

Total Behavioral Health Services and Supports (BHSS) Funding

	Year 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 9,681,027.00	$ 11,541,196.00	$ 11,898,974.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 1,952,826.00		
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 11,633,853.00	$ 11,541,196.00	$ 11,898,974.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 3,323,183.00	$ 3,323,183.00	$ 3,323,183.00	$ 2,265,103.00	$ 2,265,103.00	$ 2,265,103.00	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 200,000.00	$ 200,000.00	$ 200,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Early Intervention Expenditures	$ 5,958,343.00	$ 5,943,812.00	$ 6,242,154.00	$ 560,975.00	$ 560,975.00	$ 560,975.00	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 199,250.00	$ 199,250.00	$ 199,250.00	$ 163,022.00	$ 163,022.00	$ 163,022.00	$ -	$ -	$ -
All Other EI Expenditures	$ 5,759,093.00	$ 5,744,562.00	$ 6,042,904.00	$ 397,953.00	$ 397,953.00	$ 397,953.00	$ -	$ -	$ -
Outreach and Engagement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 2,048,881.00	$ 2,048,881.00	$ 2,048,881.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ 2,048,881.00	$ 2,048,881.00	$ 2,048,881.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 11,530,407.00	$ 11,515,876.00	$ 11,814,218.00	$ 2,826,078.00	$ 2,826,078.00	$ 2,826,078.00	$ -	$ -	$ -

BHSS Prudent Reserve Transfer Information	Year 1	Year 2	Year 3
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -

BHSS Administrative Information	Year 1	Year 2	Year 3
BHSS Component Admin Expenses	$ 64,383.00	$ 64,383.00	$ 64,383.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 11,594,790.00	$ 11,580,259.00	$ 11,878,601.00

Youth-Focused Early Intervention Expenditures	Year 1	Year 2	Year 3

Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 3,038,755.00	$ 3,293,755.00	$ 3,293,755.00

Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	Year 1	Year 2	Year 3
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	51.2%	51.5%	52.5%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.0%	55.4%	52.8%

Projected Individuals to be Served (Unduplicated)	Year 1	Year 2	Year 3
Eligible Children/TAY (25 years and younger)	2850	2950	3050
Eligible Adults/Older Adults	3500	3600	3700

Projected BHSS Funds transferred to WET or CF/TN	Year 1	Year 2	Year 3
BHSS transfer to WET	$ -	$ -	$ -
BHSS transfer to CF/TN	$ 2,048,881.00	$ 2,048,881.00	$ 2,048,881.00

Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	Year 1	Year 2	Year 3
Estimated MHSA WET Funds	$ -	$ -	$ -
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).

2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.

3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.

4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.

5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Table Eight: BHSA Plan Administration						
INTEGRATED PLAN ADMINISTRATION AND MONITORING	Year 1		Year 2		Year 3	
Total Projected Improvement and Monitoring Expenditures	$	295,229.00	$	295,229.00	$	295,229.00
Total Projected County Integrated Plan Annual Planning Expenditures	$	132,200.00	$	132,200.00	$	132,200.00
New and Ongoing Administrative Costs	$	-	$	-	$	-

Select County Population Size:	More than 200k

Administrative Information Validation						
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$	27,329,918.00	$	27,607,267.00	$	28,463,093.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)		1.1%		1.1%		1.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)		0.5%		0.5%		0.5%
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.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 2,997,357.00
Local Prudent Reserve Maximum (1)	$ 3,916,761.98
Excess Prudent Reserve Funds (auto-populated)	$ (919,404.98)
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).	

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	30%	30%	40%	100%
Component Allocations	$ 7,332,582.00	$ 7,428,330.00	$ 9,681,027.00	$ 24,441,939.00
Year Two				
Allocation Percentage, with Transfers	30%	28%	42%	100%
Component Allocations	$ 8,371,940.00	$ 7,694,131.00	$ 11,541,196.00	$ 27,607,267.00
Year Three				
Allocation Percentage, with Transfers	30%	28%	42%	100%
Component Allocations	$ 8,631,470.00	$ 7,932,649.00	$ 11,898,974.00	$ 28,463,093.00
BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 7,332,582.00	$ 7,428,330.00	$ 9,681,027.00	$ 24,441,939.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ 935,153.00	$ -	$ 1,952,826.00	$ 2,887,979.00
Estimated Total Available Funding for Year One	$ 8,267,735.00	$ 7,428,330.00	$ 11,633,853.00	$ 27,329,918.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 8,267,735.00	$ 7,428,330.00	$ 11,594,790.00	$ 27,290,855.00
Year Two				
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 8,371,940.00	$ 7,694,131.00	$ 11,541,196.00	$ 27,607,267.00

Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ -	$ 39,063.00	$ 39,063.00
Estimated Total Available Funding for Year Two	$ 8,371,940.00	$ 7,694,131.00	$ 11,580,259.00	$ 27,646,330.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 8,267,735.00	$ 7,428,330.00	$ 11,580,259.00	$ 27,276,324.00
Year Three				
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 8,631,470.00	$ 7,932,649.00	$ 11,898,974.00	$ 28,463,093.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 104,205.00	$ 265,801.00	$ -	$ 370,006.00
Estimated Total Available Funding for Year Three	$ 8,735,675.00	$ 8,198,450.00	$ 11,898,974.00	$ 28,833,099.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 8,267,735.00	$ 7,428,330.00	$ 11,878,601.00	$ 27,574,666.00
BHSA Plan Admin Expenses				

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 295,229.00	$ 295,229.00	$ 295,229.00	$ 885,687.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 132,200.00	$ 132,200.00	$ 132,200.00	$ 396,600.00
Total Projected New and Ongoing Administrative Expenditures	$ -	$ -	$ -	$ -

Appendix 2
Community Program Planning Process Supporting Documentation

This section includes materials used to promote community engagement sessions, such as emails, social media posts, flyers, and informational documents. These resources helped share information, invite participation, and ensure the community could provide input during the planning process.

BEHAVIORAL HEALTH SERVICES ACT

What is BHSA?

The Behavioral Health Services Act (BHSA), also known as Proposition 1, is a California law that reforms the state's behavioral health system by modernizing funding, expanding services, and improving access to care, particularly for those with the most significant needs. It focuses on integrating mental health and substance use disorder treatment, increasing housing support, and strengthening the behavioral health workforce. BHSA is replacing the Mental Health Services Act (MHSA), passed in 2004.

What does BHSA mean for local BHS departments?

- **Community-Driven Planning:** Local departments must work closely with community members to decide how to use the funds. Community input will help shape programs and services.

- **Improved Services:** With BHSA support, BHS departments can create new programs, increase outreach, and provide better care tailored to community needs.

- **Accountability:** BHS departments regularly report on how BHSA funds are spent and the results they achieve, ensuring transparency.

- **Collaboration:** BHSA encourages BHS departments to work with other community organizations, providers, and stakeholders for stronger, coordinated care.

What does this mean for our programs and services?

BHSA expands services to include substance use treatment, shifts 30% of funds to housing for those with severe behavioral health needs, prioritizes high-need populations (e.g., SMI, SED, SUD, homeless, justice-involved), and adjusts funding allocations across traditional MHSA program categories.

This may cause shifts in current MHSA funded program services, requirements, and goals.

Key Points

- BHSA is diverting 30% of former MHSA funds to a new housing component.

- BHSA (formerly MHSA) tax revenue funds county mental health services.

- BHSA reforms should improve accountability and transparency, with a greater reporting burden on local staff.

- BHSA expands the scope of services to include substance use disorders, housing, and focusing on integrated care.

- Prevention efforts will be controlled and funded by the state.

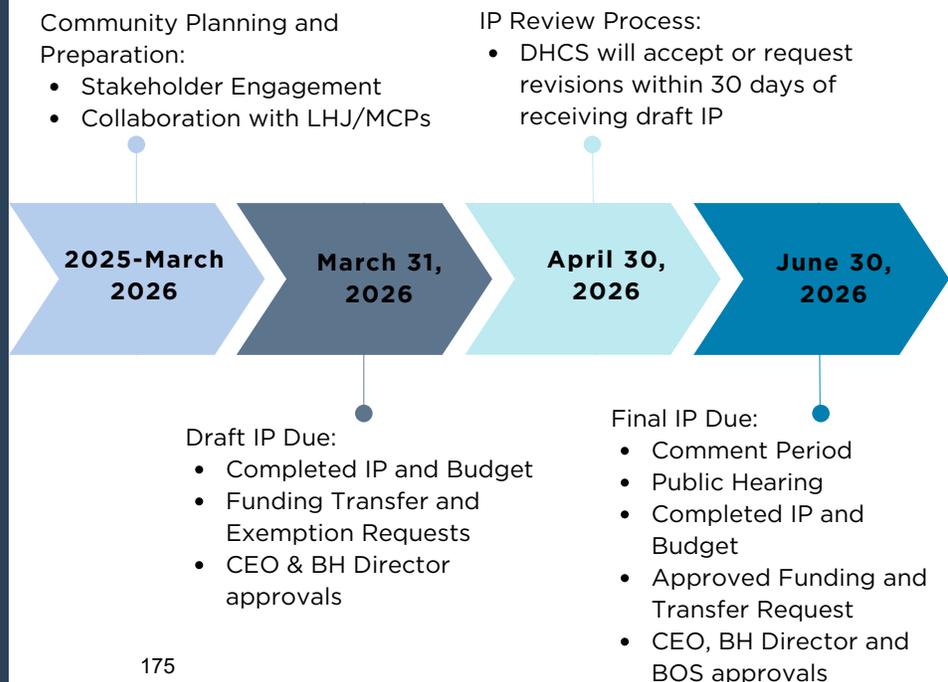## Integrated Plan (IP) and Community Planning Process (CPP)

Amy Rhoades, our new BHSA Coordinator, is working on the CPP, which will inform our integrated plan, reflecting goals and priorities for July 2026-June 2029. This process will gather feedback and needs from community members and partner organizations.

Amy will be reaching out to different program managers and supervisors to learn about your programs, and to identify best ways to gather feedback from your clients.

The first draft of this plan is due March 31, 2026.

Questions? Email Amy.Rhoades@santacruzcountyca.gov

Integrated Plan (IP) Submission Timeline

Community Planning and Preparation:
- Stakeholder Engagement
- Collaboration with LHJ/MCPs

IP Review Process:
- DHCS will accept or request revisions within 30 days of receiving draft IP

2025-March 2026 → **March 31, 2026** → **April 30, 2026** → **June 30, 2026**

Draft IP Due:
- Completed IP and Budget
- Funding Transfer and Exemption Requests
- CEO & BH Director approvals

Final IP Due:
- Comment Period
- Public Hearing
- Completed IP and Budget
- Approved Funding and Transfer Request
- CEO, BH Director and BOS approvals

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YOUR VOICE MATTERS! JOIN OUR

COMMUNITY FORUMS

Santa Cruz County Behavioral Health wants to hear from you as we create our first Behavioral Health Integrated Plan for July 2026 – June 2029.

Join other community members in identifying needed services for individuals, their families and loved ones affected by mental health and substance use challenges.

Your input will help shape the behavioral health services we provide.

Request Language Support/ Interpretation

Please register and make your request at least 72 hours in advance of the meeting.

📞 831-713-8285

✉️ MentalHealth.ServicesAct @santacruzcountyca.gov

Participants will receive a $25 gift card in appreciation of their time and input!

Central County
Monday, Nov. 17 | 4:00-6:00pm

Aptos Public Library
Betty Leonard Community Room
7695 Soquel Dr, Aptos, CA 95003

North County
Tuesday, Nov. 18 | 4:30pm-6:30pm

Santa Cruz County Behavioral Health
1400 Emeline Ave. Bldg. K. | Room 206 & 207
Santa Cruz, CA 95060

South County
Tuesday, Nov. 20 | 10:00am-12:00pm

NAMI Santa Cruz County
35 Penny Ln. Suite 2
Watsonville, CA 95076

REGISTRATION IS REQUIRED.

Scan the QR code to confirm you will attend!

Need help registering? Contact us with your questions.

📱 **REGISTER**

¡SU VOZ ES IMPORTANTE!
ACOMPÁÑENOS EN NUESTROS

FOROS COMUNITARIOS

La División de Salud Mental del Condado de Santa Cruz quiere escuchar de usted.

Ayúdenos a crear nuestro primer Plan Integrado de Salud Mental y Tratamiento del Uso de Sustancias para julio de 2026 –junio de 2029.

Junto con otros miembros de su comunidad, identifique los servicios necesarios para las personas que han sido afectadas por retos de salud mental y del uso de sustancias.

Su contribución ayudará a dar forma a nuestros servicios de salud conductual.

Apoyo lingüístico/ interpretación

Regístrese y haga su solicitud al menos 72 horas antes de la reunión. Por favor contáctenos con sus preguntas.

📞 **831-713-8285**
✉ **MentalHealth.ServicesAct @santacruzcountyca.gov**

Centro del Condado
Lunes, 17 de nov. | 4:00-6:00pm
Biblioteca Pública de Aptos
Sala Comunitaria Betty Leonard
7695 Soquel Dr, Aptos, CA 95003

Norte del Condado
Martes, 18 de nov. | 4:30pm-6:30pm
División de Salud Mental y Tratamiento del Uso de Sustancias del Condado de Santa Cruz
1400 Emeline Ave. Bldg. K. | Cuarto 206 & 207
Santa Cruz, CA 95060

Sur del Condado
Martes, 20 de nov. | 10:00am-12:00pm
NAMI Santa Cruz County
35 Penny Ln. Suite 2
Watsonville, CA 95076

Se requiere registración

Escanee con su teléfono para regístrarse.

¡Recibirá una tarjeta de regalo de $25 en agradecimiento por su tiempo y aportaciones!

REGÍSTRESE

santacruzhealth.org/MHSA

f 📷 **@CountyofSantaCruz**

Amy Rhoades

Hello and Happy Friday!

This is a friendly reminder to register for our BHSA Community Forums happening next week. Your feedback will help shape the County's first Behavioral Health Integrated Plan.

Upcoming Forums:
- **Central County:** Monday, Nov. 17, 2025 | 4–6 PM
- **North County:** Tuesday, Nov. 18, 2025 | 4:30–6:30 PM
- **South County:** Thursday, Nov. 20, 2025 | 10 AM–12 PM

More details and registration here: https://www.surveymonkey.com/r/5XV3RLS

Please help us spread the word to community members and partners.

Thanks,
Amy

Amy Rhoades, MPH
Health Services Manager | Behavioral Health Division
Santa Cruz County Health Services Agency
1400 Emeline Ave. Santa Cruz, CA 95060
Web: www.santacruzhealth.org

Dear Community Partner,

Santa Cruz County Behavioral Health Division invites you to participate in our Behavioral Health Services Act (BHSA) Community Program Planning process. We'll be hosting three regional community forums to hear from individuals, families, providers, and partners affected by mental health and substance use challenges.

Your feedback will help shape the County's first Behavioral Health Integrated Plan, launching July 1, 2026.

Upcoming Forums:
- **Central County:** Monday, Nov. 17, 2025 | 4–6 PM
- **North County:** Tuesday, Nov. 18, 2025 | 4:30–6:30 PM
- **South County:** Thursday, Nov. 20, 2025 | 10 AM–12 PM

Details:
- Registration is <u>required</u> at least 72 hours in advance of the meeting you plan to attend. Link to registration: https://www.surveymonkey.com/r/5XV3RLS
- Flyers available in English and Spanish (attached).
- Forums will be conducted in English; however, interpreters will be available upon request through the registration process.

Please share this invitation with your networks. Thank you for helping shape the future of behavioral health in Santa Cruz County.

If you have any questions, feel free to reach out to us at MentalHealth.ServicesAct@santacruzcountyca.gov.

Thanks,
Amy

Salud Mental y Tratamiento del Uso de Sustancias

Amy Rhoades, MPH
Health Services Manager | Behavioral Health Division
Santa Cruz County Health Services Agency
1400 Emeline Ave. Santa Cruz, CA 95060
Web: www.santacruzhealth.org

County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 Emeline Ave., SANTA CRUZ, CA 95061-0962

TELEPHONE: (831) 454-4000   FAX: (831) 454-4488   TDD: Call 711

Press Release

Join an Upcoming Community Forum to Transform Behavioral Health Services in Santa Cruz County

Santa Cruz County Behavioral Health Services invites community members to participate in upcoming Behavioral Health Services Act (BHSA) Community Forums to help transform the County's First Behavioral Health Integrated Plan for July 2026 – June 2029.

The BHSA provides funding to improve mental health and substance use services through community-driven planning and engagement. These forums offer residents, families, and community partners the opportunity to share ideas, identify needs, and help guide priorities for behavioral health programs across the county.

"The Behavioral Health Services Act Community Forums are an opportunity for every voice to be heard as we shape the future of local care. I invite everyone to join us, learn about upcoming changes to behavioral health services, and share your perspective to help guide how we serve our community and strengthen the foundation of wellness for all," said Dr. Marni R. Sandoval, Director of Santa Cruz County Behavioral Health.

"Behavioral health challenges touch every family, every neighborhood, and every generation. This is a moment to listen, learn, and lead—together," said Connie Moreno-Peraza, Health Services Agency Director. "Your experiences and ideas will help guide how we invest in mental health and substance use services that truly meet local needs."

Forum Dates and Locations:

Central County: Monday, November 17 | 4–6 PM
Aptos Public Library
Betty Leonard Community Room
7695 Soquel Dr, Aptos, CA 95003

North County: Tuesday, November 18 | 4:30–6:30 PM
Santa Cruz County Behavioral Health
1400 Emeline Ave. Bldg. K. | Rooms 206 & 207
Santa Cruz, CA 95060

South County: Thursday, November 20 | 10 AM–12 PM
NAMI Santa Cruz County
35 Penny Ln. Suite 2
Watsonville, CA 95076

Registration is required. To register, visit https://www.surveymonkey.com/r/5XV3RLS
Interpretation services will be available upon request. Submit your request at least 72 hours prior to the event.

Participants will receive a $25 gift card in appreciation of their time and input. Visit **santacruzhealth.org/BHSA** for more information.

###

From:	Amy Rhoades
Sent:	Monday, December 1, 2025 1:58 PM
To:	Mental Health Services Act
Cc:	Marni Sandoval; Meg Yarnell
Subject:	Friendly Reminder: TOMORROW - BHSA Educational Session and Focus Group for County BH Contractors
Attachments:	For Contract Providers..pdf

Hello,

Friendly reminder to please join us **tomorrow in person** to discuss key changes from MHSA to BHSA, upcoming timelines and state requirements, and share your input to help shape our three-year Integrated Plan for the Behavioral Health Services Act (BHSA).

Event Details

📅 **December 2, 2025**

🕑 **2:00–5:00 PM**

📍 **1400 Emeline Ave., Rooms 206 & 207**

Feel free to reach out if you have any questions.

Thanks,
Amy

From: Amy Rhoades
Sent: Monday, November 24, 2025 12:44 PM
To: Mental Health Services Act <MentalHealth.ServicesAct@santacruzcountyca.gov>
Cc: Marni Sandoval <Marni.Sandoval@santacruzcountyca.gov>; Meg Yarnell <Meg.Yarnell@santacruzcountyca.gov>
Subject: BHSA Educational Session and Focus Group for County BH Contractors

Hello Behavioral Health Contractors,

You are invited to join us for an in-person BHSA Educational Session and Contractor Focus Group to learn about the new Behavioral Health Services Act (BHSA) and share your input to help shape our three-year Integrated Plan.

This is a major statewide transition, and we want all contractors to feel informed, aligned, and supported as we move forward together.

During this session, we will review:
- Key changes from MHSA to BHSA

- Upcoming timelines and state requirements
- Opportunities for contractor involvement, coordination, and feedback throughout the transition

Event Details
📅 **December 2, 2025**
🕐 **2:00–5:00 PM**
📍 **1400 Emeline Ave., Rooms 206 & 207**

Your participation and insights are essential as we plan for the next three years under BHSA. We hope to see you there!

Please feel free to reach out with any questions.

Thanks,
Amy

Salud Mental y
Tratamiento del Uso
de Sustancias

Amy Rhoades, MPH
Health Services Manager | Behavioral Health Division
Santa Cruz County Health Services Agency
1400 Emeline Ave. Santa Cruz, CA 95060
Web: www.santacruzhealth.org

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of intended recipient(s) and may contain confidential and protected information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Amy Rhoades

From:	Jane Batoon-Kurovski on behalf of Marni Sandoval
Sent:	Wednesday, December 10, 2025 2:14 PM
To:	HsaMhSubsAbuse
Subject:	BHSA Educational Session Follow Up
Attachments:	BHSA Educational Sessions virtual version.pdf; BHSA Educational Sessions_Virtual_FINAL_.pdf

Importance: High

Good afternoon Behavioral Health,

Thank you everyone for taking the time to attend one of our BHSA Educational Sessions for staff. In case you missed it, the powerpoint slides are attached and you can watch one of the recordings here:
 Educational Session BHSA.mp4

If you attended one of the sessions and have not completed the demographic survey, please do at the following link: https://www.surveymonkey.com/r/P79MBTL

We are holding two more sessions for anyone in Santa Cruz County next week. Feel free to register if you would like to listen to the session live. These are open to anyone so feel free to share with consumers or outside partners.
Registration link: https://www.surveymonkey.com/r/S52F7NQ

If you are unable to attend a live session but would still like to contribute to the BHSA Implementation Plan, please email your feedback to **MentalHealth.ServicesAct@santacruzcountyca.gov**. We will also be sharing out a Community Survey with the department very soon as a way to collect additional information to help identify priorities in our BHSA 3-year plan.

Please reach out to Amy Rhoades with any questions.

Sincerely,

Dr. Marni R. Sandoval
Behavioral Health Director
Santa Cruz County Health Services Agency
1400 Emeline Ave, Santa Cruz, CA 95060
Email: marni.sandoval@santacruzcountyca.gov
Phone: (831) 454-4767
Web: www.santacruzhealth.org/behavioralhealth/

Salud Mental y
Tratamiento del Uso
de Sustancias

Good afternoon Behavioral Health,

BHSA represents a major statewide transition that will impact nearly every part of our system of care. We want you to be informed.

You are invited to join one of our upcoming Behavioral Health Services Act (BHSA) educational sessions. With tight timelines from the state, it's essential that all staff feel informed, prepared, and supported as we move through this change together.

Your participation is very important. These sessions will equip you with the information you need and offer opportunities to contribute to this critical work.

Session Dates:
- **Option 1:** December 8, 2025 | 2:30 PM–4:30 PM
- **Option 2:** December 10, 2025 | 10:00 AM–12:00 PM

Please register using the link below and select the session that best fits your schedule:
Register here: https://www.surveymonkey.com/r/SHD7QZ3
You will receive the Zoom meeting link after registering.

If you have any questions, please contact our BHSA Coordinator, Amy Rhoades, at
Amy.Rhoades@santacruzcountyca.gov

Salud Mental y
Tratamiento del Uso
de Sustancias

Dr. Marni R. Sandoval
Behavioral Health Director
Santa Cruz County Health Services Agency
1400 Emeline Ave, Santa Cruz, CA 95060
Email: marni.sandoval@santacruzcountyca.gov
Phone: (831) 454-4767
Web: www.santacruzhealth.org/behavioralhealth/

From:	Amy Rhoades
Sent:	Monday, January 5, 2026 3:55 PM
To:	Mental Health Services Act
Subject:	Gentle Reminder - BHSA Community Survey - Input Needed!

Hello & Happy New Year!

Thank you to those who have already completed our BHSA Community Survey.
If you haven't already, please do by the end of this week. Your input is greatly appreciated and valued.

Link: https://www.surveymonkey.com/r/59GFPRW

Feel free to reach out with any questions.

Thanks,
Amy

From: Amy Rhoades
Sent: Thursday, December 18, 2025 1:01 PM
To: Mental Health Services Act <MentalHealth.ServicesAct@santacruzcountyca.gov>
Cc: Marni Sandoval <Marni.Sandoval@santacruzcountyca.gov>
Subject: BHSA Community Survey - Input Needed!

Hello,

We're inviting community members and partners to share their thoughts and experiences to help shape local behavioral health services. Your voice matters, and completing our BHSA community survey is a great way to provide input.

Please take a few minutes to complete the survey here by January 9, 2026:
https://www.surveymonkey.com/r/59GFPRW

We'd also appreciate your help sharing the survey link with other community members and partners.

Thank you for helping us improve behavioral health services in our community!

Thanks,

County of Santa Cruz
November 10, 2025

✅ YOUR VOICE MATTERS!... **See more**

YOUR VOICE MATTERS

Share your input at an upcoming Community Forum to help shape the future of Santa Cruz County Behavioral Health services

Upcoming Community Forums:

Mon., November 17 | 4pm-6pm
7695 Soquel Dr, Aptos, CA 95003
Betty Leonard Community Room

Tues., November 18 | 4:30-6:30pm
1400 Emeline Ave. Building K.
Santa Cruz, CA 95060
Room 205 & 207

Thurs., November 20 | 10am-12pm
35 Penny Ln Suite 2,
Watsonville, CA 95076

Participants will receive a
$25 gift card
in appreciation of their time and feedback!

Registration is required.
Sign up today!

santacruzhealth.org/BHSA

SU VOZ IMPORTA

Comparta su opinión en uno de los próximos Foros Comunitarios para definir el futuro de los servicios de la División de Salud Mental y Tratamiento del Uso de Sustancias del Condado de Santa Cruz

Próximos Foros Comunitarios:

Lunes, 17 de nov. | 4pm-6pm
7695 Soquel Dr, Aptos, CA 95003
Sala Comunitaria Betty Leonard

Martes, 18 de nov. | 4:30-6:30pm
1400 Emeline Ave. Edificio K.
Santa Cruz, CA 95060
Cuarto 205 y 207

Jueves, 20 de nov. | 10am-12pm
35 Penny Ln Suite 2,
Watsonville, CA 95076

Recibirá una tarjeta
de regalo de $25
en agradecimiento por su tiempo y aportaciones

Es necesario registrarse.
¡Anótese hoy!

santacruzhealth.org/BHSA

👍 1

👍 Like   💬 Comment   ↪ Share

Write a comment...

187

County of Santa Cruz
9,600 followers
1mo

We're excited to kick off our first BHSA Community Forum! 💚
Together with community members, we're beginning to shape our next Integrated Plan—ensuring local voices guide Behavioral Health priorities and the services we invest in for the years ahead.

Join us at one of our next two forums:
📍 North County
Tuesday, November 18 | 4:30–6:30 PM
Santa Cruz County Behavioral Health Services Division
1400 Emeline Ave, Building K, Santa Cruz, CA 95060
Room 206 & 207

📍 South County
Thursday, November 20 | 10 AM–12 PM
NAMI Santa Cruz County
35 Penny Ln, Suite 2, Watsonville, CA 95076

Spanish interpretation services will be available.
See you there!

County of Santa Cruz
December 12, 2025 at 9:18 AM · 🌐

BHSA EDUCATION

OPEN TO ALL COMMUNITY MEMBERS

OPTION 1:
DECEMBER 16, 2025
10:00AM-12:00PM

OPTION 2:
DECEMBER 18, 2025
3:30PM-5:30PM

Register here:
surveymonkey.com/r/S52F7NQ

Questions
📞 831-713-8285
✉ MentalHealth.ServicesAct
@santacruzcountyca.gov

santacruzhealth.org/BHSA

EDUCACIÓN BHSA

ABIERTO A TODOS LOS MIEMBROS DE LA COMUNIDAD

OPCIÓN 1:
16 DE DICIEMBRE DEL 2025
10:00-12:00

OPCIÓN 2:
18 DE DICIEMBRE DEL 2025
15:30-17:30

Regístrate aquí:
surveymonkey.com/r/S52F7NQ

Preguntas
📞 831-713-8285
✉ MentalHealth.ServicesAct
@santacruzcountyca.gov

santacruzhealth.org/BHSA

Public Health Department of Santa Cruz County
December 8, 2025 at 3:55 PM · 🌐

Big changes are coming to behavioral health across the state. Join us to learn about the transition to the Behavioral Health Services Act (BHSA), what it means for loca... **See more**

See translation

👍 Like   💬 Comment   ➤ Share

Write a comment...

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Community Program Planning Findings (2026)

Between November 2025 and January 2026, the Santa Cruz County Behavioral Health Division conducted a wide community engagement process to better understand local behavioral health needs, strengths, and priorities. This effort gathered input to guide future behavioral health services across the county.

A total of 273 community members participated through community forums, educational sessions, focus groups, interviews, and a countywide survey. Participants included individuals with lived experience, family members, service providers, community-based organizations, and other key partners. Their voices are helping shape how services are delivered and where new investments are needed.

This outreach was part of the County's Community Program Planning (CPP) Process, a required component of Behavioral Health Services Act (BHSA) planning that ensures community members have meaningful opportunities to provide input on behavioral health priorities. Feedback collected through the CPP has been carefully reviewed and analyzed alongside local service data, outcome trends, and state requirements. Community input directly helps to inform funding decisions, program design, and service priorities included in the County's BHSA Plan. This process helps ensure that behavioral health services reflect the real needs of Santa Cruz County residents and that resources are invested where they can have the greatest impact.

This report summarizes the community engagement activities and highlights key themes, priority needs, and emerging opportunities identified by participants. It is intended to provide a clear overview of what we heard from the community and how that input is shaping BHSA planning and future behavioral health investments.

Activities

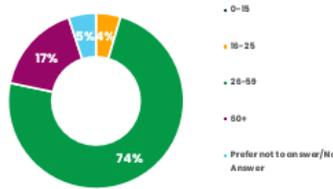| CPP Activity	# Meetings	When	Populations/Partners Attended
BHSA Education Sessions	5	12/2/25	Contract providers
		12/8/25	County BH staff
		12/10/25	General public in SCC
		12/16/25	Consumers of BH services
		12/18/25	Other required partners
Community Forums	3	11/17/25 11/18/25 11/20/25	Open to the whole county. Hosted events in Watsonville (South County), Aptos (Central County), and N. Santa Cruz (North County)
Focus Groups with priority populations and key partner groups	8	11/18/25	County BH Providers
		11/19/25	BHAB Members
		11/19/25	Justice Involved
		12/1/25	SMI #1
		12/2/25	SUDS Program Consumers
		12/2/25	Contract Providers
		12/3/25	SMI #2
		12/17/25	Spanish speaking youth consumers
Key Informant Interviews	3	11/4/25	CBO president and patient advocate
		11/13/25	Peer support specialist with history of SMI
		12/15/25	TAY consumer of services
Educational sessions during standing meetings with other partners (as requested by partners)	4	8/11/25	Youth Lived Expertise Board (YLEAB)
		8/21/25	Behavioral Health Advisory Board 1
		10/16/25	Behavioral Health Advisory Board 2
		12/18/25	Presentation to PATH Collaborative group
Community Survey	1	12/25 – 01/26	County wide survey stayed open for 4 weeks

Who Participated

Region of County Respondents Live
- **44%** North
- **20%** Central
- **18%** South
- **12%** Live out of County
- **6%** No Answer

Region of County Respondents Work
- **54%** North
- **20%** South
- **8%** Central
- **7%** Live out of County
- **11%** No Answer

Ages (Years)
- 0-15
- 16-25
- 26-59
- 60+
- Prefer not to answer/No Answer

17% | 5% | 4% | 74%

Gender Identity
- **67%** Female
- **23%** Male
- **3%** Nonbinary/Genderqueer
- **1%** Transgender
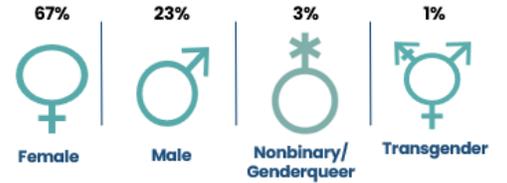
Race/Ethnicity
- **54%** White/Caucasian
- **26%** Hispanic/Latino/Latinx
- **5%** More than one race
- **3%** African American/Black
- **2%** Asian/Asian American
- **2%** Other Race/Ethnicity
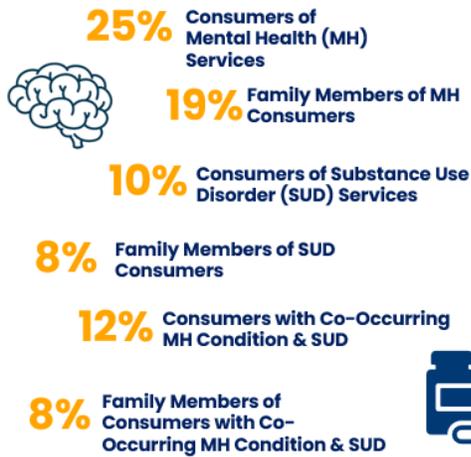- **1%** American Indian/Alaskan Native
- **7%** Prefer Not to Answer/No Answer

Primary Language
- **83%** English
- **13%** Spanish
- **1%** American Sign Language
- **1%** Other
- **2%** Prefer Not to Answer/No Answer

Sexual Orientation
- **77%** Heterosexual
- **7%** Bisexual
- **5%** Queer
- **3%** Lesbian
- **1%** Other
- **7%** Prefer Not to Answer/No Answer

Consumers & Family Members
- **25%** Consumers of Mental Health (MH) Services
- **19%** Family Members of MH Consumers
- **10%** Consumers of Substance Use Disorder (SUD) Services
- **8%** Family Members of SUD Consumers
- **12%** Consumers with Co-Occurring MH Condition & SUD
- **8%** Family Members of Consumers with Co-Occurring MH Condition & SUD

- **1%** Military Service
- **44%** Military Family Member
- **7%** Representatives from LGBTQIA+ Communities
- **13%** Lived Experience with Homelessness
- **3%** Youth Including from Marginalized Communities
- **9%** Domestic Violence/Sexual Abuse Representatives

*Each participant can select more than one stakeholder category.

5

Key Findings

Barriers to Getting Behavioral Health Care

Survey respondents described several challenges that make it difficult to access or stay engaged in care.

Top barriers included:

- Difficulty finding providers who are accepting new clients
- Poor coordination between providers and services
- Not enough in-person care options
- Transportation challenges
- Confusion about where to go for help
- Feeling unheard or disrespected while receiving services
- These barriers show that many residents struggle not just with finding services, but with navigating a complex and fragmented system.

System Strengths

Community members also highlighted important strengths in the county's behavioral health system.

Top strengths included:

- Quality mental health services and supports
- A dedicated and compassionate workforce
- Stronger care coordination in some programs
- Growing community education and awareness
- Expanding access to care

Participants praised providers who go above and beyond to support clients and noted the value of local nonprofit organizations that help residents find services.

These strengths provide a strong foundation to build upon as the county works to improve its system.

Major Gaps and Unmet Needs

While strengths exist, community members emphasized several urgent needs.

Most frequently identified gaps:

- Not enough treatment beds, including mental health and substance use residential programs

- Limited availability of mental health services
- Insufficient housing, especially for people leaving facilities or experiencing homelessness
- Care coordination gaps
- Continued need for better public education and awareness
- Residents reported that people often experience long waits for services or must leave the county to receive appropriate care.
- Housing was repeatedly identified as critical to recovery for:
  - People exiting jail or treatment facilities
  - Individuals experiencing homelessness
  - Families needing stable supportive housing

Community-Recommended Solutions

General Mental Health & Access Focused	General Substance Use Disorder Focused	General Housing & Support for Unhoused Focused
• Enhance Community Education • Wellness Centers and Drop-in Centers, use of Club House model • More Peer Delivered Services • Safe Spaces • Expand County FIT Team with Sheriff • Navigation Hub Center • Diversify Providers to Ensure Bandwidth if Agency/Program Closes • Work with AARP and Older Adults	• Supervised Use Centers & Syringe Exchange • More Incentive Programs	• Develop a Universal Housing Referral Form/Process • Bring MHCAN Back • Need a Sobering Center • More Sober Living Environments • Housing for Families • Repurpose Unused Sites to Support the Unhoused

How This Input Will Shape Future Services

Planned investments include:

- Expanded Full Service Partnership Programs
- Intensive programs will continue supporting children, youth, adults, and older adults with the highest behavioral health needs through evidence-based and field-based care models.
- Major Housing Investments, including:
  - Rental subsidies
  - Permanent supportive housing
  - Shared housing
  - Interim housing options
  - Housing navigation services
- Crisis & Early Intervention Services
- New Youth crisis residential and stabilization programs
- Early psychosis treatment programs
- School-based behavioral health services

Moving Forward

This community-driven process ensures that Santa Cruz County's behavioral health system evolves to better meet local needs.

Residents emphasized the importance of:

✓ Easier access to care
✓ More treatment capacity
✓ Stronger coordination
✓ More stable housing
✓ Services that are respectful and culturally responsive

Appendix 3
Quality Improvement Work Plan Fiscal Year 2025–2026

Required submission by Department of Health Care Services (DHCS)

Quality Improvement Work Plan
Santa Cruz County Behavioral Health Division, Quality Improvement Branch

FY 2025–2026

Santa Cruz County Behavioral Health Mental Health Plan (MHP) & Drug Medi-Cal Organized Delivery System (DMC-ODS)

EXECUTIVE SUMMARY

The Santa Cruz County Behavioral Health Division (BHD) operates under an integrated service delivery model that prioritizes operational excellence and sustainable, high-quality care. The Behavioral Health Quality Management (QM) Program is responsible for evaluating the effectiveness of BHD services and supporting all aspects of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) operations through comprehensive performance monitoring and improvement activities.

In alignment with Federal and State regulations—including 42 CFR, Title 9 of the California Code of Regulations, and the California Welfare and Institutions Code—as well as the contractual obligations and performance expectations set by the Department of Health Care Services (DHCS), the Quality Management (QM) Program partners closely with both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS). Together, they ensure regulatory compliance and drive continuous quality improvement efforts that support equitable, person-centered behavioral health care across the system.

The Santa Cruz County Behavioral Health Quality Improvement (QI) Work Plan goals for FY 2025–2026 are organized around five key themes: access, timeliness and network adequacy, coordination of care, beneficiary rights and satisfaction, documentation standards compliance and utilization management, quality improvement, and cultural and linguistic competence. The goals within these themes are designed to advance service delivery, optimize outcomes, and ensure the system meets evolving regulatory and community expectations.

Enhancing access to care, ensuring network adequacy, and promoting timely service delivery are top priorities of the Quality Improvement (QI) program. The County aims to offer 80 percent of routine MHP and DMC-ODS appointments within 10 business days and accurately document 80 percent of service requests in the SRDL, with timely issuance of NOABDs when this is not achieved. Additional access efforts include monitoring the accuracy of 24/7 access line responses and ensuring bi-directional closed loop referrals between the Managed Care Plan (MCP) and Mental Health Plan (MHP) are achieved

Enhancing care coordination is a component of CalAIM policy changes. The new emphasis on HEDIS measures from DHCS require system enhancements related to care coordination. In our FY 25–26 Work Plan, 50 percent of referrals between

Managed Care Plans (MCPs) and the Mental Health Plan (MHP) are expected to include documented outreach and referral status. Additionally, half of all internal MHP and DMC-ODS referrals will be processed through CareConnect—a closed-loop referral system within the Behavioral Health Division's electronic health record that supports interoperability with organizations outside of Avatar. For individuals discharged from acute psychiatric facilities, the County targets a 50 percent follow-up rate within seven days and 73 percent within thirty days. Both MHP and DMC-ODS network colleagues are working to improve linkage to Behavioral Health (BH) services for beneficiaries within 30 days of an Emergency Department visit for MH and SUD diagnoses. Efforts toward exceeding the Minimum Performance Levels (MPL) for these HEDIS measures (FUM 30 day and FUA 30 day) include HIPAA and 42CFR Part 2-compliant data exchange across care settings. Lastly, QI will work collaboratively with Plan Administration as needed to develop a Quality & Health Equity Workplan to address BH Accountability Measures that fall below the MPL.

Under the quality assurance umbrella, the County emphasizes strict procedural compliance with beneficiary rights protocols, delivery of culturally competent services and service improvement. This includes timely resolution of grievances, appeals and state hearings and enhancements to review processes for sentinel events in instances of client death related to suicide and overdose. Quality will also be measured through client outcomes on an annual basis, with over 65 percent of clients demonstrating a reduction in their actional scores on 3 or more CANS/ ANSA items that have an original score of 2 or 3. Another goal is to achieve 75 percent accuracy in documenting test calls—both during business hours and after hours—including caller details and call disposition. Additionally, 90 percent of test callers are expected to receive accurate MHP & DMC-ODS access and beneficiary rights information through the 24/7 access line. Finally, within the monthly MHP Utilization Review Committee meetings, the County aims for 80 percent compliance of monthly samples of reviewed charts within the following clinical chart components: (1) Problem List Updated; (2) TCM Care Plan Present; (3) CalAIM Assessment Up to Date; (4) ANSA/CANS Timely Completion; (5) Progress Notes Timely.

Workforce development is a cornerstone of quality improvement, ensuring staff have the skills, support, and expectations needed to provide high-quality care. Meeting direct service provision standards is one part of this effort, with an expected improvement in direct service provision of 5% per provider group for County-employed direct care staff to maximize access and strengthen the Division's financial stability. At the same time, Santa Cruz County is investing in equity-focused training to build a culturally responsive and inclusive workforce. By June 30, 2026, 68 percent of County BH Division staff will complete the mandated seven-hour CLAS training, and 100 percent of direct service staff will complete gender inclusive training. Together, these initiatives advance both access and equity, building a workforce capable of sustaining long-term quality improvements across the system.

WORK PLAN GOAL CATEGORIES

1. Access to 24/7 Services
2. Coordination of Care
3. Beneficiary Rights & Satisfaction
4. Documentation Standards Compliance & Utilization Management
5. Quality Improvement
6. Cultural & Linguistic Competence

GOALS

To be achieved by the end of the 2025-26 fiscal year, June 30, 2026.

Category #1: Access to 24/7 Services
(Timeliness, Authorization, Network Adequacy)

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
1.1	MHP	Access Adult and Access CBH	75% of referrals between **MCP** and **MHP** (bi-directional) will include documented client outreach and indicate referral status as accepted, appointment made, or in progress.	Shared bidirectional referral tracking workflow; BH Access leadership and QI leadership collaborating with the Alliance to ensure both MHP to MCP have complete documentation of referrals
1.2a	DMC-ODS	DMC-ODS	80% of **DMC-ODS** requests for services will be entered accurately in SRDL. If Timely Access standards are not met, appropriate staff will issue a Timely Access NOABD and follow NOABD workflow 90% of the time.	QI monthly monitoring of SRDL reports and NOABDs; contractor submission of SRDL Timeliness Report; NOABD workflow: alignment with non-clinical PIP efforts/interventions
1.2b	MHP & DMC-ODS	Adult Access and Access CBH / DMC-ODS	80% of **MHP** and **DMC-ODS** first offered routine appointments will be within 10 business days.	QI monthly monitoring; contractor submission of SRDL Timeliness Report; NOABD workflow; investigation of workflows from other Counties; alignment with non-clinical PIP efforts/interventions

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
1.3a	MHP & DMC-ODS	Administration / Quality Improvement	90% of test callers will receive accurate BH access and beneficiary rights information via the 24/7 access line.	Test calls through Community Connections. Regular QI monitoring and reviews of call performance through test calls and QA reports. Sharing feedback with BHD and AnswerNet (after-hour operators) to guide improvements. Meetings and trainings as needed to ensure consistent call quality and staff development.
1.3b	MHP & DMC-ODS	Administration / Quality Improvement	80% of after-hours and business test calls will be documented correctly and will include name, date, and disposition.	Documentation review. Regular QI monitoring and reviews of call performance through test calls and QA reports. Sharing feedback with BHD and AnswerNet (after-hour operators) to guide improvements. Meetings and trainings as needed to ensure consistent call quality and staff development.

Category #2: Coordination of Care

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
2.1	MHP & DMC-ODS	Access Adult and Access CBH, Adult MH Outpatient, CBH, DMC-ODS	BH will launch Care Connect internally, with inclusion of documented workflows. BH will test the use of "MedAllies" access within Care Connect for DMC agency(ies) who operate outside of Avatar. Once launched, 50% of internal referrals within **MHP** and **DMC-ODS** will be initiated and closed through CareConnect.	Care Connect implementation & training for internal MHP teams and DMC-ODS network programs
2.2	MHP	Adult MH Outpatient, CBH	65% of clients will show improvement by reducing actionable scores (from an original score of 2 or 3) on at least three CANS/ANSA items. Goal will be measured for all MHP programs at the County and contracted agencies.	Stakeholders Workgroup; Outcome tracking via dashboard

*Note for DMC-ODS Coordination of Care Goals see Goal 1.2a & 5.2

Category #3: Beneficiary Rights & Satisfaction

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
3.1	MHP & DMC-ODS	Quality Improvement	The Plan will resolve 100% of beneficiary requests to change treatment providers, grievances, appeals and fair hearings in accordance with the required resolution time frame requirements.	QI to review all beneficiary rights items, both MHP and DMC-ODS every quarter to identify trends and ensure timely resolution (30 days). If delays to resolutions are found, QI staff work with management to find and fix the issues causing them. QI also works with program staff to help resolve client concerns and reports the number of grievances and appeals to DHCS quarterly and annually.
3.2	MHP & DMC-ODS	Quality Improvement	Medical Directors will complete a chart review for 90% of Sentinel Event reports of client deaths within two weeks of receipt of death notification. Subsequently, if Medical Directors and QI deem a Sentinel Event Review is indicated, QI will convene a formal Sentinel Event review process.	Refinement of Standard Operating Procedure+ escalation matrix document to guide chart review processes

Category #4: Documentation Standards Compliance & Utilization Management

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
4.1	MHP & DMC-ODS	MHP & DMC-ODS	BH providers will improve their direct service provision by a minimum of 5% per provider group to meet direct service standards set in BH policy.	Dashboards + team coaching
4.2	MHP	MHP Adult and CBH	80% of the charts reviewed in the monthly samples at MHP UR Committee meetings will be compliant in the following 5 clinical documentation categories: (1) Problem List Updated; (2) TCM Care Plan Present; (3) CalAIM Assessment Up to Date; (4) ANSA/CANS Timely Completion; (5) Progress Notes Timely.	Embed automated alerts in the EHR for overdue CalAIM assessments / MSE / DX and ANSA/CANS cycles. Update TCM Care Plan template to ensure case management-specific goals are distinguishable from mental health goals. Develop/train staff on a problem list protocol based on Social Determinants of Health (Z55-65 codes) to ensure alignment with CalAIM and future outcome measures.

Category #5: Quality Improvement

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
5.1	MHP	Quality Improvement, Adult Access and CBH Access	MHP will exceed 56% follow up within 30 calendar days after ED visits for MH / self-harm Diagnoses [FUM30].	Access teams continue to use Process Measure of ED Tracker to inform changes to workflows to enhance follow up rates.
5.2	DMC-ODS	Quality Improvement, Adult Access and CBH Access, DMC-ODS	DMC-ODS will exceed 36% follow up within 30 calendar days after ED visits for SUD Diagnoses [FUA30].	Access teams continue to use Process Measure of ED Tracker to inform changes to workflows to enhance follow up rates.
5.3	MHP	Adult MH, CBH, Medication Support	**73%** of Medi-Cal members who have an inpatient psychiatric admission will receive a BH service within 30 calendar days of discharge [FUH30]	Improve communication between in-patient and outpatient teams; add discharge tracker
5.4	DMC-ODS	Quality Improvement and DMC-ODS	DMC-ODS Admin & QI will work collaboratively to develop a Quality & Health Equity Workplan to address DMC-ODS HEDIS measures below the MPL. A work plan will be developed for 100% of DMC-ODS HEDIS measures that failed to meet MPL.	QI and DMC-ODS admin to investigate pain points in care transitions for IET and POD or other salient HEDIS measures with DMC-ODS.

Category #6: Cultural & Linguistic Competence

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
6.1	MHP & DMC-ODS	All BH branches	68% of BH Division County staff will complete 7-hour CLAS training	Learning management System reminders; onboarding alerts

Goal ID	Plan	BH Division Sponsor(s)	Goal Statement	Recommendation for Interventions
6.2	MHP & DMC-ODS	All Staff (County, Contractor)	a. 95% of BH County and contract agency staff who have direct contact with beneficiaries and support people will complete required training in gender- inclusive care b. Any staff member named in a substantiated grievance related to non-inclusive gender-related care will complete or re-take the required training prior to resuming direct client contact 100% of the time.	a. Announcements, Deployment of on-demand recorded training that meets requirements, Goal Reminders b. Add a dedicated data field in the behavioral health electronic database to track grievances related to transgender, gender-diverse, and intersex (TGI) individuals. Assign a designated Subject Matter Expert (SME) Utilization Review Specialist to handle all TGI-related grievances.

Appendix 4
How to Submit Public Comment

Share your feedback to help inform the final integrated plan submission.

Public Comment Period: March 18, 2026 – April 16, 2026

Public Comment Submission for Behavioral Health Services Act (BHSA) Integrated Plan (IP)

In Person
At Behavioral Health Advisory Meeting
April 16, 2026 | 1400 Emeline Ave. Room 206
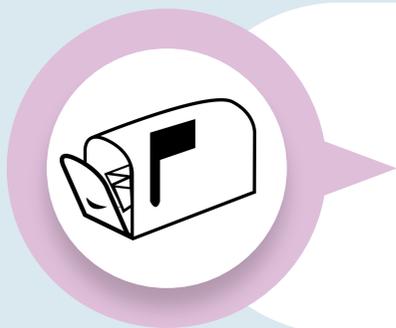
By Phone
Leave a voicemail at 831-713-8285

Email
Email your feedback to
MentalHealth.ServicesAct@santacruzcountyca.gov

Online
Visit santacruzhealth.org/BHSA

Mail Feedback to:
Santa Cruz County Behavioral Health
Attention: Amy Rhoades
1400 Emeline Ave. Santa Cruz CA 95060

santacruzhealth.org/BHSA

BEHAVIORAL HEALTH
HEALTH SERVICES AGENCY

SANTA CRUZ COUNTY
BEHAVIORAL HEALTH

Behavioral Health Services Act Integrated Plan

Public Comment Form

Thank you for taking the time to review and provide feedback on the County's Behavioral Health Services Act (BHSA) Integrated Plan (IP). Your input will help ensure the plan reflects community needs and priorities.

The public comment period for this IP is March 18, 2026 to April 16, 2026. All feedback submitted during the public comment period will be reviewed and considered prior to final submission.

1. **Please identify which community partner group you represent. Select all that apply.**

   ☐ Providers

   ☐ Community Organizations

   ☐ Person with Lived Experience

   ☐ Community Member

   ☐ Veterans or active military service

   ☐ County Public Health Representative

   ☐ County Behavioral Health Representative

   ☐ Health Care Organizations

   ☐ Consumer of behavioral health services in Santa Cruz County

   ☐ Law Enforcement

   ☐ Continuum of Care representatives

   ☐ Representatives from LGBTQIA+ communities

   ☐ Managed Care Plan

   ☐ Local education agencies

   ☐ Child Welfare Agencies

   ☐ Other (please specify):

2. **Overall, do you feel the BHSA Integrated Plan addresses the most pressing behavioral health needs in our community?**

   ☐ Yes

   ☐ Somewhat

   ☐ No

   ☐ Unsure

   1a. Please explain:

_____

_____

3. **What strengths do you see in the proposed plan?**

_____

_____

_____

4. **Are there gaps, concerns, or areas for improvement that you would like to share?**

_____

_____

_____

5. **Any additional comments or recommendations?**

_____

_____

_____

Thank you for helping shape the future of behavioral health services in our community.