DRAFT

FY 2026 - 2029 Behavioral Health Services Act (BHSA) Integrated Plan
Sonoma County
Submitted to DHCS on 3/30/26

We welcome and value stakeholder and community feedback to help inform the final plan. Please send feedback to:
BHSA@sonomacounty.gov

2026 - 2029 Integrated Plan
Sonoma 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**.

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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.

County, City, Joint Powers, or Joint Submission
County

Entity Name
Sonoma County

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COUNTY BEHAVIORAL HEALTH SYSTEM OVERVIEW

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Table 5. Number of Children and Youth Served

Criteria	Number of Children and Youth Under Age 21

Received Medi-Cal Specialty Mental Health Services (SMHS)	**1095**
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	**52**
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**64**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	**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	**16**
Were chronically homeless or experiencing homelessness or at risk of homelessness	**10**
Were in the juvenile justice system	**76**
Have reentered the community from a youth correctional facility	**59**
Were served by the Mental Health Plan and had an open child welfare case	**247**
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	**11**
Have received acute psychiatric care	**140**

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**.

Table 6. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	**560**
Received Medi-Cal SMHS	**2646**
Received DMC or DMC-ODS services	**1460**
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	**179**
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	**520**
Experienced unsheltered homelessness	**520**
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	**00**
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	**00**
Were in the justice system (on parole or probation and not currently incarcerated)	**624**
Were incarcerated (including state prison and jail)	**746**
Reentered the community from state prison or county jail	**624**

Received acute psychiatric services	**562**

Input the number of persons in designated and approved facilities who were Admitted or detained for 72-hour evaluation and treatment rate
4017

Admitted for 14-day and 30-day periods of intensive treatment
833

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
6

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

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
No

Please describe the local data used during the planning process
The data for 14-day and 30-day periods of intensive treatment provided by Santa Rosa Behavioral Health Hospital was erroneous. The County is working with the hospital to provide the Department of Health Care Services (DHCS) with accurate data.

Certain data elements requested cannot currently be reported by Sonoma County. For example, information related to homelessness cannot be fully addressed because the County's Electronic Health Record does not capture all of the specific classifications being requested, nor does it allow for reliable distinction among categories such as individuals experiencing unsheltered homelessness or transitions from unsheltered to sheltered settings. Sonoma County is actively

exploring options to improve how this information is collected within the electronic health record (EHR). In addition, available data related to individuals with involvement in the justice system is limited and not comprehensive.

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

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
Smartcare

County participates in a Qualified Health Information Organization (QHIO)?
No

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://urldefense.com/v3/__https:/fhir-calmhsa-provider.ehn-prod.net/fhir/swagger-ui/?page=Location__;!!IJLa0CrXIHAf!Q11UpAthQGbkdC5S1wRVm20QqqOqzm4X8bDZ_Qvxs0vHvDMQ3xX3UaaDWGV8LTnrXk_jCJLM8Qziyjg9CHwhJy-JSlHF5XG8DA$but

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

No

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

County Behavioral Health System Service Delivery Landscape

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

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

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

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

Community Mental Health Services Block Grant (MHBG)

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

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

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

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

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

Please select all set-asides that the county behavioral health system participates in under SUBG
Discretionary
Adolescent/Youth Set-Aside
Perinatal Set-Aside
Primary Prevention Set-Aside

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

Please describe these challenges or concerns:
Department of Health Care Services audit and monitoring requirements can slow program expansion by creating significant administrative burden. For example, if the County wanted to use discretionary funding to support multiple Sober Living Environments (SLEs), the County would be required to develop and maintain a separate monitoring plan for each SLE, even when individual contracts are small.

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

Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination,
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)
Training

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

Please describe these challenges or concerns
Current definitions are too restrictive in requiring an Opioid Use Disorder (OUD) diagnosis. With the exception of marijuana and alcohol, the opioid epidemic is impacting most illicit drug use, often through fentanyl contamination. As a result, the County is unable to use Opioid Settlement Funds (OSF) to place an individual whose primary substance use is amphetamines into an OSF-funded Sober Living Environment (SLE), even though many people who use methamphetamine have likely been exposed to fentanyl, often unintentionally and without their knowledge.

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?
CSC for FEP
FACT
ACT
Clubhouse Services
Enhanced CHW Services
IPS Supported Employment
Peer Support Services

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

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

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

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)

e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Enhanced Community Health Worker (CHW) Services
IPS Supported Employment
Peer Support Services

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

Please describe these challenges or concerns
Costs for ASAM Levels 3.7 are extremely high and our hospital partner we are in talks with is not even certified. Even if certified the reimbursement is far less than the cost of the service.

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?
No

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

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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.

Marked 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?
Gender
Race or Ethnicity

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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
Below

For children/youth
Below

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

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
Not Applicable

For children/youth
Not Applicable

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

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?
Below

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

In Sonoma County, FY2021 data on Specialty Mental Health Services (SMHS) penetration rates show clear disparities across racial and ethnic groups. Black residents had the highest penetration rate, exceeding 5%, more than double the overall county average of 2.4%. Individuals categorized under "Unknown Race/Ethnicity" also had relatively high rates, close to 5%. White residents fell just above the county average at around 3%, while "Other Race/Ethnicity" groups were slightly below at about 2.8%. In contrast, Alaskan Native or American Indian residents accessed services at lower rates, around 1.7%, and both Asian or Pacific Islander and Hispanic residents experienced the lowest penetration rates, each close to 1%. These patterns highlight significant inequities in access to specialty mental health care.

In Sonoma County, FY2022 data on Non-Specialty Mental Health Services (NSMHS) penetration rates by sex show notable differences in access. Adult females had a penetration rate of 19.3%, well above the county average of 16.2%. In contrast, adult males accessed services at a significantly lower rate of 12.4%, falling well below the county average. This gap suggests that men are underutilizing available mental health services compared to women, pointing to potential barriers such as stigma, cultural expectations, or service delivery models that may be less responsive to men's needs.

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

The County will strengthen access to care through targeted systems, programs, and partnership investments informed by SmartCare data, CHIP and CHA,

penetration rates, and disparity data. To address access measures below the statewide average, the County will improve timely assessment, referral, and engagement by strengthening coordination, standardizing intake and referral pathways, and improving linkage between access points and ongoing services. The County will support youth through the school-based CAPE (Crisis Assessment, Prevention, and Education) Team is in partnership with Sonoma County Office of Education.

Beginning July 1, 2026, the Latinx Clinic will expand culturally and linguistically responsive services for families involved in or at risk of child welfare involvement, with a focus on caregivers of infants and young children. Enhancements include strengthened referral pathways with Youth and Family Support Services FSP and Child Welfare Services, increased family education and advocacy supports, and coordination with Youth Access Teams, Mobile Support Teams, and Crisis Assessment, Prevention, and Education (CAPE) to divert families from crisis-driven removals.

With the implementation of DMC-ODS in December 2024, access to substance use disorder treatment is expanding across levels in the continuum of care,, including residential, withdrawal management, outpatient, and medication assisted treatment through providers such as Siyan SUD Outpatient Program, Pura Vida Outpatient Program, The Lakes Outpatient Program, Center Point DAAC Redwood Empire Addictions Program, Muir Wood, Buckelew Orenda, the Dr. Sushma D. Taylor Recovery Center, Santa Rosa Treatment Center, and additional outpatient programs countywide.

The County will also strengthen partnerships with peer and family support organizations, older adult collaboratives, justice involved programs, and youth prevention providers. Ongoing review through the Quality Improvement Committee will guide data driven improvements to access and equity.

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 Support (BHSS)
BHSA Full Services Partnership (FSP)
1991 Realignment
2011 Realignment
State General Fund

Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Community Mental Health Block Grant (MHBG)
Substance Use Block Grant
Other

Please describe other
Local tax: Measure O and Opioid Settlement Funds

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
Gender
Race or Ethnicity
Sex
Other

Please describe other
Gender/Sexuality

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

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

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

Homelessness: Supplemental Measures

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

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

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

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

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

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?
Gender
Race or Ethnicity

Homelessness: Disparities Analysis

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

In the County's 2024 Point-in-Time (PIT) Count, striking disparities emerge in rates of homelessness by race and ethnicity. American Indian or Alaska Native residents experience the highest rate by far, at 455 per 10,000, nearly nine times the overall county rate of 52 per 10,000. Black residents also face disproportionately high homelessness at 226 per 10,000, over four times the county average. Native Hawaiian or Other Pacific Islander residents experience homelessness at 142 per 10,000, while individuals identifying with multiple races report 89 per 10,000. In contrast, Hispanic/Latina/o (51 per 10,000), White (42 per 10,000), and Asian or Asian American (23 per 10,000) residents fall below or near the county average. These figures highlight severe racial inequities in housing stability, with Native and Black communities experiencing homelessness at alarmingly high rates compared to other groups.

In the Sonoma PIT Count, 66% of survey participants identified as male, 32% identified as female, and 2% identified as another gender. Among the female respondents, less than 1% indicated that they were currently pregnant. Over three-fifths of survey respondents were over the age of 41. The age group with the most respondents was 41-50 years old. Persons identifying as LGBTQ+ (lesbian, gay, bisexual, gender non-conforming, transgender, or queer) are overrepresented in the population experiencing homelessness when compared to the general population: as of 2018, 5.6% of the US population Identified as LGBT. According to the 2024 Sonoma Homeless Survey, eight percent (8%) of survey respondents identified as LGBTQ, down from 20% in 2023.

The data shows significant racial and ethnic disparities in people experiencing homelessness who accessed services from the CoC rate. American Indian/Alaska Native individuals have by far the highest service utilization rate at 381 per 10,000, followed by Black residents at 324 per 10,000 far above the overall county rate of 69. Native Hawaiian or Pacific Islanders also experience higher-than-average utilization at 176 per 10,000. In contrast, Hispanic/Latina/e/o residents (80 per 10,000) are close to the countywide rate, while White residents (68 per 10,000) fall slightly below it. Asian or Asian American residents have the lowest utilization rate, at just 13 per 10,000. These differences highlight that Native and Black communities in Sonoma County are disproportionately experiencing homelessness and accessing related services, while Asian communities appear significantly underrepresented in the system, raising questions about both inequitable risks of homelessness and potential barriers to accessing services. In Sonoma County, homeless service utilization in 2024 shows a gender disparity:

cisgender men access services at a higher rate (87 per 10,000) compared to cisgender women (68 per 10,000).

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)

Beginning July 1, 2026, Sonoma County will strengthen coordinated housing and behavioral health initiatives to reduce homelessness among individuals with severe mental illness and or severe substance use disorders. These efforts are informed by local data, including the Point in Time Count, SmartCare, the Community Health Improvement Plan, and the Community Health Assessment, align with the Behavioral Health Services Act, and address areas where outcomes lag behind statewide averages, including housing retention for individuals with high behavioral health acuity and persistent racial disparities.

By July 2026, the Homelessness Division will become a section within the Behavioral Health Division, enabling closer alignment of planning, funding, and service delivery to reduce fragmentation and improve coordination across outreach, treatment, and housing.

The County will continue to support No Place Like Home permanent supportive housing. The County will support targeted transitional housing, including Mickey Zane Place, Eliza's Village, Behavioral Health Bridge Housing at Arrowood with BHSA Houning Intervention funds. The Count will also support recovery oriented options such as Buckelew Hope Village Sober Living and Women's Recovery Services Transitional Housing.

To improve housing access and placement rates below statewide benchmarks, the County will invest $2 million annually beginning in FY 2026–29 in housing assistance for rental subsidies, deposits, utilities, eviction prevention, and

housing navigation. PIT and HMIS data show that upfront housing costs and limited navigation support are key barriers to housing exits.

The County will strengthen outreach through the Whole Person Care team, align pathways from outreach to housing, and continue coordination with Continuum of Care funding. Sonoma County will also provide match funding for Behavioral Health Continuum Infrastructure Program Round 2, including a psychiatric health facility and peer respite services to reduce cycles of crisis and homelessness.

Please identify the category or categories of funding that the county is using to address the homelessness goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
2011 Realignment
Other

Please describe other
Innovation Funds, Measure O, Federal/HUD CoC, State HHAP

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

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023
How does your county status compare to the statewide rate/average?

For adults/older adults

Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 – 2022
How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

180-day post-certification involuntary detention rates per 10,000
Not Applicable

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
Above

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

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023

Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

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

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Above

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?
No Disparities Data Available

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

Santa Rosa Behavioral Health Hospital (SRBHH), formerly SRBHH, has reported its 14-day and 30-day involuntary detention rates data, which was submitted prior to FY 2023–24. It appears that there has been a significant overcount of holds due to differences in the reporting methodology.

Before FY 2023–24, SRBHH submitted data that tracked daily totals for each hold type, which likely reflected the total number of patients on that hold type each day, rather than the number of new holds written. In FY 2023–24, SRBHH transitioned to a fillable PDF format form provided by DHCS, requiring the reporting of each individual hold type, resulting in more accurate counts.

The discrepancy is evident in FY 2023–24, where the data reports 3,287 14-day holds (5250s), while the PDF report shows only 458, a difference of nearly seven-fold.

This discrepancy appears to be a result of the earlier reporting methodology, and it is expected that this issue will resolve itself in future dashboard cycles, likely within the next 3–4 years as more accurate data from FY 2024–25 is incorporated into the rolling dashboards. In the meantime, the Department of Health Services, Behavioral Health Division (DHS-BHD) is working closely with SRBHH to submit corrected data for past periods.

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)

No additional data is available.

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)

To reduce the county's rate of institutionalization and address measures where our status is below the statewide average or median, Sonoma County is planning to strengthen and implement several key programs and initiatives beginning July 1, 2026. These efforts aim to provide more community-based care, enhance access to supportive services, and reduce reliance on institutional placements. The initiatives are designed to meet the specific needs of high-risk subpopulations identified through local data and to improve the overall behavioral health system's outcomes.

Behavioral Health Bridge Housing will continue to be a pivotal initiative. This program provides individuals experiencing homelessness and behavioral health challenges with temporary, stable housing paired with supportive services. Data indicating the high correlation between homelessness and higher rates of institutionalization informs this program. By offering bridge housing, the County aims to prevent unnecessary hospitalizations and other institutional placements, helping individuals stabilize in the community.

Crossroads to Hope, a community-based program, will also be strengthened. This initiative targets individuals who have historically faced barriers to accessing mental health care, such as those with co-occurring substance use disorders. Data showing higher institutionalization rates among this group has led to the expansion of services that offer immediate access to care and wraparound services, addressing both mental health and social determinants of health.

The Psychiatric Health Facility (PHF) will focus on enhancing diversionary programs to prevent unnecessary admissions. The county will also develop a Peer Respite facility, offering a non-clinical alternative to hospitalization for individuals in crisis. Peer respite data shows that individuals often have better outcomes when treated by peers in a less institutional environment, which directly supports efforts to reduce institutionalization rates.

The Mobile Support Team will be expanded to provide on-site, immediate behavioral health interventions in the community. This team, equipped with mental health professionals and peer support specialists, responds to crises in

real time, preventing individuals from being transported to emergency rooms or psychiatric facilities. Our data indicates that individuals who engage with mobile support services are less likely to require institutional care and show improved long-term stability.

The County will strengthen CAPE to reduce untreated conditions by ensuring that crises lead to engagement rather than missed opportunities. CAPE will emphasize rapid assessment, brief intervention, and direct linkage to ongoing treatment, including follow-up contacts after crisis encounters. This is particularly relevant to local needs given the high percentage of youth with no service visits despite need.

The Whole Person Care program will continue to integrate physical, behavioral, and social care for high-needs individuals. By focusing on comprehensive, coordinated care, this program targets gaps in the system where individuals often slip through, leading to higher institutionalization rates. Data has shown that people with multiple health conditions and no clear care coordination are more likely to end up in psychiatric or medical facilities.

FEP SOAR (Supportive Outreach and Access to Resources) will be a critical component in supporting First Episode Psychosis (FEP) individuals. This program uses a coordinated specialty care model that provides early, intensive intervention for individuals experiencing their first psychotic episode. Our data indicates that early intervention significantly reduces long-term institutionalization and improves outcomes, so the expansion of FEP SOAR services will be a priority, particularly for youth and young adults.

Care Court, in alignment with state initiatives, will work to divert individuals with severe mental health conditions away from the criminal justice system and institutional care, offering court-ordered treatment plans and services to reduce incarceration and hospitalization rates. Data suggests that individuals who receive coordinated, court-supervised treatment are less likely to experience repeated institutionalization.

Lastly, Transitional Recovery services will support individuals exiting institutional settings, such as psychiatric hospitals, by providing intensive wraparound services to help them reintegrate into the community. By offering housing, mental health services, and peer support, this program will address the data indicating

that individuals often cycle back into institutional care due to inadequate community reintegration supports.

These programs are all aligned with Sonoma County's efforts to reduce institutionalization by offering more robust community-based options for care. Through partnerships with local providers, peer specialists, and county health teams, we aim to create an integrated care system that supports individuals in their communities rather than relying on institutional settings. Additionally, data collected from current program participants, including discharge records, behavioral health assessments, and housing outcomes, informs ongoing program development and ensures that our strategies are targeted to the populations most at risk for institutionalization.

These collective efforts, designed to address gaps in care and support individuals throughout their treatment journey, will contribute to a significant reduction in institutionalization rates by providing individuals with the resources and services they need to thrive outside of institutional settings.

Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG
Other

Please describe other
MHSA Innovation, Measure O, BHBH Grant, Felony IST Growth Cap Penalty Fund

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?
Race or Ethnicity

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023

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

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

The 2024 Sonoma County arrest data shows stark inequities across race, ethnicity, sex, and age. Black residents are disproportionately impacted, with an arrest rate of 11,444 per 100,000, more than four times higher than Hispanic residents (3,408 per 100,000) and nearly five times higher than White residents (2,382 per 100,000). When broken down further by sex, the disparities become even more extreme: Black males face an arrest rate of 17,318 per 100,000, the highest among all groups, while Black females also face disproportionate rates at 4,789 per 100,000, far higher than white (1,290) and Hispanic women (1,134). Hispanic males (5,566 per 100,000) and white males (3,551 per 100,000) also show elevated rates compared to their female counterparts, though still far below the levels experienced by Black men.

Age patterns highlight additional disparities, with arrest rates peaking among adults ages 30–39 (6,305 per 100,000) and ages 20–29 (5,171 per 100,000). Rates then drop considerably among older adults, falling to 2,978 for those ages 40–69 and just 211 for those 70 and older. These findings reveal that Black residents, particularly Black men, and younger adults are disproportionately entangled in the criminal justice system in Sonoma County, pointing to deep racial and age-based inequities in arrests.

The adult recidivism conviction rate data show clear racial disparities. Black adults have the highest recidivism rate at 42.9 percent, followed by white adults at 34.5 percent, while Hispanic adults have the lowest rate at 30.2 percent. This pattern indicates that Black adults are disproportionately impacted by repeat convictions compared to other racial groups.

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)
Sonoma County is actively working to reduce the rate of institutionalization and address disparities in behavioral health through a variety of programs and

initiatives, many of which are designed to support individuals involved with the criminal justice system and those with complex behavioral health needs. These efforts are aligned with the Sonoma County Stepping Up Committee's goal to divert individuals from unnecessary incarceration or institutional care by improving access to behavioral health services and promoting alternative approaches.

Care Court is one of the key initiatives designed to connect individuals with severe mental health disorders to treatment instead of incarceration. This program focuses on those with untreated behavioral health issues and criminal justice involvement, ensuring they are connected with court-ordered behavioral health services, which research shows can reduce recidivism and institutionalization.

The Crossroads to Hope Innovation program is another crucial initiative addressing the needs of individuals with serious behavioral health disorders and have been diverted from the criminal justice system. By providing housing and wraparound services, Crossroads aims to reduce the risk of hospitalization or jail time, which often results from untreated behavioral health disorders.

To further address institutionalization, the Department of State Hospitals (DSH) plays a role in both short- and long-term care needs for individuals with severe mental health issues. Sonoma County works closely with DSH to ensure a smooth transition from institutional care back into the community with ongoing support, reducing the likelihood of readmission or involvement with the criminal justice system.

The Jail InReach Program is a critical initiative that connects individuals who are incarcerated with mental health services before they are released. By identifying behavioral health needs and connecting inmates with appropriate treatment, the program helps prevent re-entry into both the justice system and institutional care, ensuring individuals are stabilized in the community.

BH Bridge Housing is an essential component in preventing homelessness and its associated risks, including institutionalization. This program offers temporary housing for individuals transitioning from institutional care or incarceration, with behavioral health services that facilitate recovery and reintegration into society.

FACT (Forensic Assertive Community Treatment) FSP (Full Service Partnership) provides intensive case management and treatment services to individuals with serious mental illness, often those who are at risk of hospitalization or homelessness. This program aims to keep individuals out of institutional settings by providing holistic, person-centered care, including housing support, and community reintegration.

Mental Health Diversion programs, including Specialty Court Programs like the Mental Health Diversion Court and Behavioral Health Court, are designed to divert individuals with mental health conditions from incarceration and institutionalization by offering treatment alternatives. These courts provide individuals the opportunity to receive mental health treatment while avoiding the long-term consequences of incarceration and the risk of institutionalization.

The Justice Mental Health Collaboration Project (Pre-trial Mental Health Release) focuses on identifying individuals with behavioral health issues early in the judicial process. This project facilitates pre-trial release with mental health treatment instead of detention, particularly for individuals whose mental health issues contribute to their involvement in the criminal justice system.

AB 109, a program that facilitates the release of nonviolent offenders back into the community, includes intensive supervision and mental health support services. Sonoma County ensures that individuals who are released under AB 109 have access to behavioral health care, housing, and case management, which decreases the need for institutional care and incarceration.

Finally, New Hope For Youth provides services for young people involved with the justice system, focusing on behavioral health and trauma-informed care. This program works to divert youth from detention and ensure that they receive services in the community to prevent future institutionalization.

Sonoma County also utilizes the Sonoma County DUI Program to provide treatment services for individuals arrested for driving under the influence. The program focuses on addressing substance use disorders to reduce the likelihood of future arrests, hospitalization, or involvement with the justice system.

These programs, while designed to serve a broad range of individuals, also specifically aim to address disparities in mental health and behavioral health

outcomes, particularly among marginalized groups. For example, individuals from communities of color and homeless populations often face higher rates of incarceration and institutionalization. Crossroads to Hope and FACT FSP provide targeted services for these populations, ensuring they receive appropriate behavioral health care, housing, and social support.

Disparities in access to care are also addressed by programs like Care Court, which targets individuals who are at risk of becoming institutionalized due to untreated mental health disorders, ensuring they receive the necessary court-ordered treatment and support services, rather than facing incarceration or hospitalization.

Please identify the category or categories of funding that the county is using to address the justice-involvement goal

BHSA FSP
BHSA Housing Interventions
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SUBG
Other

Please describe other

AB 109 Community Correction Partnership, MHSA Innovation, Department of State Hospitals, Prop 47 Jail InReach Program, BH Bridge Housing Grant, Felony IST Growth Cap, Opioid Settlement Funds

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?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
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
In Sonoma County, the 2022- 2025 foster care data highlights significant age- and sex-based disparities. Infants under the age one are the most overrepresented, with a foster care placement rate of 614 per 100,000, far higher than the countywide average of 454. By contrast, placement rates decline for school-aged children, with rates of 385 per 100,000 for ages three to five, 334 for ages 11 to 15, 337 for ages 18 to 21, and the lowest rate of 269 for ages six to 10. These patterns show that the youngest children face the greatest vulnerability for removal into foster care, while middle childhood appears to carry somewhat lower risk.

When examined by sex at birth, disparities are also present. Female children have a foster care placement rate of 374 per 100,000, compared to 339 per 100,000 for males. Both groups fall below the countywide average of 454, suggesting that the

higher county rate is largely driven by the youngest age groups rather than differences by sex. Overall, Sonoma County's data underscores that infants are especially at risk of entering foster care, while sex differences, though present, are less pronounced than age-related disparities.

The 2021 Sonoma County data on open child welfare cases receiving specialty mental health services reveals sharp disparities across race, age, and sex. Hispanic children (21.8%) and those identified as "Other" (21.4%) accessed services at rates close to the countywide average of 23.4%, but Black and white children had suppressed rates of just 1%, suggesting very limited access to needed care or small population counts that mask inequities. Age differences are also pronounced: older youth ages 18–20 had the highest penetration rate at 32.4%, indicating greater service engagement as they transition to adulthood, while children ages 6–11 also accessed services at relatively higher levels (21.7%). By contrast, younger children were far less likely to receive services, with only 7.7% of children ages 3–5 and just 1% of infants (0–2) and adolescents ages 12–17 engaged in SMHS care.

Gender patterns show smaller differences, with females (24.5%) accessing services at slightly higher rates than males (22.3%). Overall, the data highlight that while older youth and some racial groups are connecting to services, Black and white children, very young children, and adolescents remain significantly underserved within Sonoma County's child welfare system.

The 2024 Sonoma County data on child maltreatment substantiation highlights important age- and race-based disparities. Infants under the age one are at dramatically higher risk, with a substantiation incidence rate of 9.9 per 1,000—more than three times the overall county rate of 3.0. Rates drop significantly among older children, with 3.3 per 1,000 for ages three to five, 3.1 for ages one to two, 2.7 for ages 16 to 17, 2.6 for ages six to ten, and the lowest rate of 2.2 for ages 11 to 15. This pattern underscores the heightened vulnerability of infants, who are far more likely than older children to be the subject of substantiated maltreatment reports.

When broken down by race and ethnicity, Latino children have the highest substantiation rate at 3.6 per 1,000, slightly above the county average, while white children are just below the average at 2.8 per 1,000. In contrast, Asian or Pacific Islander, Black, and Native American children all have suppressed rates of 0.1,

and children identified as multi-race are reported at 0.0. These suppressed rates may reflect small population sizes or underreporting, but they also raise questions about potential inequities in how maltreatment is identified, substantiated, or recorded across different racial and ethnic groups.

Overall, the data show that infants and Latino children are disproportionately impacted by substantiated maltreatment in Sonoma County, revealing critical age- and race-based inequities in child protection outcomes.

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.

Beginning July 1, 2026, the Latinx Clinic will expand culturally and linguistically responsive services for families involved in or at risk of child welfare involvement, with a focus on caregivers of infants and young children. Enhancements include strengthened referral pathways with Youth and Family Support Services FSP and Child Welfare Services, increased family education and advocacy supports, and coordination with Youth Access Teams, Mobile Support Teams, and Crisis Assessment, Prevention, and Education (CAPE) to divert families from crisis-driven removals.

To further reduce removals, Sonoma County will align these initiatives with a broader continuum of services beginning July 1, 2026, 0–5 early childhood programs, Adult FSP, Telecare, Integrated Recovery Teams, Collaborative Treatment and Recovery Teams (CTRT), family support services, peer wellness centers, and partnerships with Seneca Family Agencies for foster youth. Additional supports include Dependency Drug Court, Drug Free Babies, and a new Housing Assistance Program to address housing instability as a driver of child welfare involvement.

Sonoma County's planned July 1, 2026 enhancements directly respond to local data showing disproportionate foster care placement and maltreatment among infants and Latino children, as well as gaps in early access to specialty mental health services. By strengthening the FASST FSP, expanding the Latinx Clinic, and coordinating across behavioral health, child welfare, and community partners, the County aims to reduce unnecessary child removals, improve equity, and support safe family preservation.

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
BHSA Housing Interventions
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG
Other

Please describe other
Measure O

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
Below

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

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022
How does your county status compare to the statewide rate/average?

For the full population measured
Above

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
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.
In Sonoma County, more than half of adults (55.6%) who needed help for emotional or mental health problems or substance use had no visits for behavioral health care in 2023, reflecting widespread unmet need. When broken down by race, adults of two or more races had the highest rate of unmet need, with about two-thirds going without care. White adults followed at just under 50%, while Latino adults were slightly lower, and Asian adults had the lowest rate of unmet need at around 30%. Data for American Indian/Alaska Native, Black, and Native Hawaiian/Pacific Islander adults were suppressed, likely due to small sample sizes. These findings show that while unmet behavioral health needs affect all communities, adults of two or more races in Sonoma County are especially likely to go without care, highlighting deep inequities in access and service utilization.

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)

Beginning July 1, 2026, Sonoma County will strengthen and implement a coordinated set of access, outreach, crisis, and capacity initiatives intended to reduce the County's level of untreated behavioral health conditions. These actions are informed by local 2023 data showing that 55.6% of adults who needed help for emotional/mental health problems or substance use had no behavioral health visits, indicating substantial unmet need.

The County's outcomes are below statewide averages for timely access and treatment engagement Sonoma County's FY 2026–29 approach prioritizes: faster entry to care, crisis diversion and early intervention, and treatment capacity expansion so that individuals who are identified can be placed quickly into the right level of care.

Sonoma County will strengthen Youth and Adult Access Teams to reduce the "no visit" rate by improving the front door to services. The Access Teams will incorporate targeted engagement strategies for sub-populations highlighted by the 2023 data, particularly adults of two or more races, who have the highest unmet need by using culturally responsive communication, and navigation supports to reduce drop-off between identification and first appointment.

The County will strengthen CAPE to reduce untreated conditions by ensuring that crises lead to engagement rather than missed opportunities. CAPE will emphasize rapid assessment, brief intervention, and direct linkage to ongoing treatment, including follow-up contacts after crisis encounters. This is particularly relevant to local needs given the high percentage of youth with no service visits despite need.

Sonoma County will expand Whole Person Care strategies that address outreach to unhoused individuals with serious behavioral health challenges. This approach is intended to improve treatment initiation and continuity for individuals who are historically less likely to access care.

The County will strengthen Coordinated Specialty Care (CSC) with a specific focus on outreach and early identification, to reduce untreated early psychosis and related conditions. Enhancements will include community-based outreach, partnership referral pathways, and active follow-up to engage individuals who may otherwise not present for traditional outpatient care.

To address inequities in access and utilization, Sonoma County will implement and strengthen targeted initiatives including: Latinx Youth Outreach and Advocacy (RFP), to reduce cultural/linguistic barriers and increase early engagement for youth and families; LGBTQ+ Outreach (RFP), to address stigma, improve trust and safety in services, and increase linkage to affirming care; Best Practices for BIPOC Communities (RFP language), requiring culturally responsive service delivery, and community partnership strategies to improve engagement among underserved groups.

While the 2023 adult unmet-need measure highlights especially high unmet need among adults of two or more races, these targeted approaches reflect the County's broader equity strategy: improving access for communities that face structural and cultural barriers to initiating care, including populations where local data are suppressed but inequities are still a concern.

Sonoma County will implement Comprehensive Services for 0–5 to reduce untreated conditions by intervening earlier with young children and caregivers. Early childhood and family-centered interventions reduce escalation of behavioral health needs over time and support caregiver stability, both of which improve overall treatment engagement and reduce downstream crisis utilization.

The Peer Wellness Centers are an engagement point for residents who are not accessing traditional care, directly responsive to the high "no visit" rate. Peer services offer relationship-based support, coaching, and navigation that can move individuals from ambivalence or mistrust into active treatment and can be particularly effective for those who have repeatedly disengaged.

To reduce untreated conditions, Sonoma County will expand capacity where system constraints contribute to delays and disengagement by partnering with hospitals and residential treatment providers to coordinate care and enable more timely placements, supported by a 50% increase in residential treatment and withdrawal management beds.

This capacity expansion directly targets a common driver of untreated conditions: individuals are identified and motivated for care, but placement delays lead to relapse, crisis recurrence, or complete disengagement.

Where Sonoma County performs below statewide averages on access and engagement indicators, the County's July 1, 2026 approach is designed to close gaps through:

A strengthened front door (Access Teams) to reduce the share of residents with need who have no visit;

Low-barrier engagement (peer wellness and outreach programs) to reach those least likely to initiate care—especially adults of two or more races identified by local data as having the highest unmet need;

Crisis-to-care pathways (CAPE, hospital partnerships, follow-up protocols) so acute events translate into ongoing treatment rather than missed connections;

Capacity increases (inpatient and residential/withdrawal management beds) to reduce wait times and treatment delays that contribute to untreated conditions; and

Equity-focused outreach and culturally responsive service requirements (Latinx youth, LGBTQ+, and BIPOC best practices) to reduce disparities in utilization and engagement.

Together, these FY 2026-2029 program enhancements are specifically designed to reduce Sonoma County's high level of untreated behavioral health conditions, while using local disparity data to prioritize outreach and engagement strategies for populations experiencing the greatest barriers to care.

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

MHBG
Other

Please describe other
Measure O

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024
How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For children/youth
Below

Quality Domain Score (Treatment Perception Survey (TPS)), 2024
How does your county status compare to the statewide rate/average?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Engagement In School: Primary Measures
Twelfth Graders who Graduated High School on Time (Kids Count), 2022

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

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?
Below

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023
How does your county status compare to the statewide rate/average?
Below

Overdoses: Primary Measures

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

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

For the full population measured
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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
Below

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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)
Below

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
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

For related policy information, refer to **3.E.6 Statewide Behavioral Health Goals**. Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Suicides

Suicides

Please describe why this goal was selected
Sonoma County is prioritizing suicide prevention as a key goal because local rates are significantly higher than the statewide average. In 2022, Sonoma's suicide death rate was 16.0 per 100,000, compared to the California statewide rate of 11.0 and a statewide median of 12.1. These numbers place Sonoma well above many other counties, underscoring the urgent need for targeted prevention and mental health interventions. Suicide is a preventable outcome of mental health crises, and focusing on this goal reflects the county's commitment to reducing avoidable deaths, addressing gaps in crisis services, and ensuring that vulnerable populations receive the support they need. By focusing on suicide prevention, Sonoma County aims to save lives and strengthen 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

The 2022 Sonoma County suicide data reveals clear disparities by both age and sex. The overall county suicide death rate was 16.0 per 100,000, but some groups faced much higher risks. Adults ages 45 to 64 had the highest age-adjusted suicide rate at 23.8 per 100,000, followed by older adults ages 65 to 84 at 20.1 per 100,000. Adults ages 25 to 44 were closer to the county average, at 16.4 per 100,000. This pattern indicates that middle-aged and older adults are particularly vulnerable to suicide in Sonoma County.

Differences by sex are even more pronounced. Males had a suicide death rate of 25.4 per 100,000, four times higher than females, who had a rate of just 6.2 per 100,000. This stark gap mirrors national trends showing men are at far greater risk of suicide deaths, underscoring the importance of targeted prevention and intervention efforts. Overall, the data highlight that suicide disproportionately impacts men and middle-to-older age groups in Sonoma County.

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)

Sonoma County will strengthen and align a comprehensive set of suicide prevention, crisis response, and treatment initiatives to improve suicide-related outcomes across the lifespan, with particular focus on populations experiencing disproportionately high risk. These efforts are guided by local suicide mortality data, and system performance indicators that demonstrate the need for earlier identification, targeted prevention, faster access to care, and sustained engagement following crisis.

The 2022 Sonoma County suicide data reveal significant disparities by age and sex. While the overall county suicide death rate was 16.0 per 100,000, adults ages 45–64 experienced the highest rate at 23.8 per 100,000, followed by older adults ages 65–84 at 20.1 per 100,000, indicating elevated risk among middle-aged and older adults. Adults ages 25–44 were closer to the county average at 16.4 per 100,000.

Disparities by sex are even more pronounced. Males experienced a suicide death rate of 25.4 per 100,000, four times higher than females at 6.2 per 100,000. These patterns mirror national trends and underscore the need for targeted, gender-

responsive prevention strategies, as well as interventions that address social isolation, substance use, untreated mental illness, and life stressors that disproportionately affect men and older adults.

This data informed Sonoma County's decision to prioritize suicide prevention strategies that combine community-based prevention, crisis response, and long-term treatment and recovery supports, with particular attention to adults in midlife and older adulthood and to men who experience the highest mortality risk.

Sonoma County's suicide prevention efforts are anchored in the Sonoma County Suicide Prevention Strategic Plan and coordinated through the Life Worth Living Suicide Prevention Alliance, which convenes behavioral health, public health, education, justice partners, healthcare providers, community-based organizations, and individuals with lived experience. The County will strengthen this coordinated framework to ensure prevention, crisis response, and treatment services function as an integrated continuum.

Community-level prevention and early identification will continue through Suicide Prevention Training Program, Connection is Prevention events, and the Suicide Prevention Hotline. These efforts are designed to reduce stigma, increase recognition of warning signs—particularly among men and middle-aged adults—and expand pathways to help for individuals who may not otherwise engage in behavioral health services. Data showing that many individuals who die by suicide have limited recent contact with care which reinforces the importance of these broad, upstream strategies.

To improve outcomes for individuals experiencing acute suicide risk, Sonoma County will strengthen the full crisis continuum including enhanced coordination among the Mobile Support Team (MST), Access Team, Crisis Assessment, Prevention, and Education (CAPE), Crisis Stabilization Unit, Crisis Residential Units, and BH Bridge Housing.

These services provide timely assessment, crisis intervention, and safe alternatives to incarceration or unnecessary hospitalization. Strengthening these pathways is particularly important for middle-aged and older adults, who may present later in crisis and are at higher risk of lethal outcomes, and for men, who are more likely to die by suicide despite often having fewer prior treatment contacts.

Suicide prevention will be further embedded across all treatment teams, recognizing that suicide risk frequently co-occurs with serious mental illness, substance use disorders, chronic health conditions, and social stressors. This includes coordination across Community Mental Health Clinics, Collaborative Treatment and Recovery Teams, and Whole Person Care team that address behavioral health needs.

Full Service Partnership (FSP) programs—including FASST, Transition Age Youth FSP, Adult FSP, Integrated Recovery Team, and the Older Adult Intensive Team—are central to this strategy. These programs provide intensive, long-term, relationship-based services for individuals at highest suicide risk, including adults with repeated crises and older adults experiencing isolation or functional decline. Local data showing elevated suicide rates among adults ages 45–64 and 65–84 directly informed the emphasis on strengthening services for these age groups.

The Sonoma County DUI Program is also incorporated into the County's suicide prevention strategy, reflecting evidence that substance use and impaired judgment are strongly associated with suicide risk, particularly among adult males, who experience both higher DUI involvement and higher suicide mortality.

Sonoma County will continue to strengthen Peer Centers and family and client education and support services, which reduce isolation and promote sustained engagement following crisis. Peer and family supports are especially important for men and older adults who may be less likely to seek traditional services but benefit from relationship-based, non-clinical support.

Sonoma County will advance a coordinated, data-informed suicide prevention strategy that directly responds to local disparities showing disproportionately high suicide rates among men and middle-aged and older adults. Through strengthened community prevention, crisis response, treatment continuity, and recovery supports aligned under the Life Worth Living Suicide Prevention Alliance and the County's Suicide Prevention Strategic Plan, Sonoma County aims to reduce suicide deaths and ensure timely, equitable, and effective support for residents most at risk.

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

BHSA BHSS
BHSA FSP
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG
SUBG
Other

Please describe other

Sonoma County General Fund, Measure O, Client Fees

COMMUNITY PLANNING PROCESS

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

Stakeholder Engagement

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

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

County outreach through social media
County outreach through townhall meetings
Focus group discussions
Key informant interviews with subject matter experts
Meeting(s) with county
Provided data to county
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings
Other

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

Engaged with stakeholders via listserv that contains approximately 2,500 subscribers

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

Type of engagement	Engagement date
Survey participation	03/03/2025
Other	07/11/2025
Workgroups and committee meetings	01/15/2025
Meeting(s) with county	01/23/2025
Workgroups and committee meetings	02/05/2025
Workgroups and committee meetings	02/11/2025
Meeting(s) with county	02/25/2025

Workgroups and committee meetings	**03/19/2025**
Training, education, and outreach related to community planning	**04/04/2025**
Workgroups and committee meetings	**04/08/2025**
Training, education, and outreach related to community planning	**04/15/2025**
Workgroups and committee meetings	**04/16/2025**
Meeting(s) with county	**04/23/2025**
Workgroups and committee meetings	**05/13/2025**
Workgroups and committee meetings	**05/14/2025**
Workgroups and committee meetings	**05/25/2025**
Workgroups and committee meetings	**05/30/2025**
Workgroups and committee meetings	**06/02/2025**
Training, education, and outreach related to community planning	**06/03/2025**
Workgroups and committee meetings	**06/16/2025**
Training, education, and outreach related to community planning	**6/17/2025**
Workgroups and committee meetings	**06/18/2025**
Training, education, and outreach related to community planning	**06/18/2025**
Workgroups and committee meetings	**06/30/2025**
Workgroups and committee meetings	**07/01/2025**
Workgroups and committee meetings	**07/09/2025**
Workgroups and committee meetings	**07/16/2025**
Key informant interviews with subject matter experts	**07/16/2025**
Workgroups and committee meetings	**07/28/2025**
County outreach through townhall meetings	**07/22/2025**
County outreach through townhall meetings	**07/30/2025**
Workgroups and committee meetings	**08/12/2025**
Focus group discussions	**08/12/2025**
Workgroups and committee meetings	**08/13/2025**
Provided data to county	**09/10/2025**
Focus group discussions	**08/22/2025**
Workgroups and committee meetings	**10/08/2025**
Workgroups and committee meetings	**10/10/2025**

Workgroups and committee meetings	**10/21/2025**
Provided data to county	**10/29/2025**
Workgroups and committee meetings	**12/02/2025**
Workgroups and committee meetings	**12/09/2025**
Workgroups and committee meetings	**12/10/2025**
Key informant interviews with subject matter experts	**01/07/2026**
Workgroups and committee meetings	**01/28/2026**
Workgroups and committee meetings	**02/10/2026**
Workgroups and committee meetings	**02/11/2026**

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

Aldea
Behavioral Health Board
Buckelew
CalMHSA
CBHDA
Child Parent Institute
City of Healdsburg
City of Petaluma
City of Rohnert Park Housing and Homeless
City of Santa Rosa
City of Sebastopol
City of Windsor
Cloverdale Senior Center
Commission on the Status of Women
Community Baptist Collaborative
Community Support Network
COTS
Council on Aging
Counseling and Psychological Services at Sonoma State U
Early Learning Institute
Felton Institute
First 5 Sonoma County
Hanna Center
HomeFirst
Human Services Department, Foster

Kaiser Permanente
Latino Service Providers
Mother Care
NAMI
Partnership Health Plan
Petaluma Health Center
Petaluma Mayor's Office
Petaluma People Services Center
Positive Images
Providence
Raizes Collective
Santa Rosa Behavioral Health Hospital
Santa Rosa Community College
Siyan Clinical Research
Sonoma Connect
Sonoma County Behavioral Health Division
Sonoma County Board of Supervisors
Sonoma County Homeless Services Division
Sonoma County Human Services Adult and Aging
Sonoma County Human Services CPS
Sonoma County Office of Education
Sonoma County Probation
Sonoma County Public Defender
Sonoma County Public Heath Division
Sonoma County Sheriffs Department
Sonoma County Superior Court
The Living Room
Veterans Affairs
VOICES
West County Community Services

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 Rosa
2	Petaluma
3	Rohnert Park

4	**Windsor**
5	**Healdsburg**

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?
Disability insurers

Disability insurers
Attempted on 3/3/2026 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.
Sonoma County Behavioral Health (SCBH) incorporated diverse stakeholder viewpoints into the development of the FY 2026–2029 Behavioral Health Services Act (BHSA) Integrated Plan through a comprehensive and inclusive Community Program Planning (CPP) process. This process engaged a broad range of stakeholders, including the BHSA Steering Committee, the Community Program Planning (CPP) Workgroup, the Life Worth Living Suicide Prevention Alliance, the Behavioral Health Board, countywide Town Halls conducted in both English and Spanish, specialized housing focus groups, and community surveys. Meeting minutes, summaries, and survey results from these activities document how community-identified strengths, needs, and priorities directly informed each component of the Integrated Plan.

The BHSA Steering Committee provided foundational guidance during the transition from the Mental Health Services Act (MHSA) to BHSA. Members requested clear explanations of new funding categories, implementation timelines, and emerging state requirements. They raised concerns about funding volatility, the three-year reversion timeline, and restrictions on the use of BHSA housing funds. Steering Committee members emphasized community priorities related to housing stability, crisis stabilization, wraparound services, and sustained case management. Their input led SCBH to establish a dedicated

Housing Workgroup, enhance communication materials, and ensure outreach efforts reflected racial, cultural, geographic, and lived-experience diversity. The Committee also emphasized transparency in the use of data and encouraged expanded engagement with historically underserved communities.

The CPP Workgroup played a central role in shaping the design and implementation of Listening Sessions across Sonoma County. Members stressed the importance of culturally relevant, community-defined approaches, including deeper qualitative questioning, expanded outreach, and accessible materials for diverse racial, ethnic, linguistic, and geographic populations. They identified barriers such as cultural stigma, intergenerational trauma, and lack of clarity around existing data sources. Their feedback informed the tailoring of Town Halls and outreach strategies to better meet the needs of specific communities.

The Life Worth Living Suicide Prevention Alliance contributed critical expertise on suicide trends and prevention strategies. Members recommended strengthening real-time data-sharing systems, expanding hospital participation, and collecting more detailed demographic and occupational data to better identify risk patterns. They emphasized the need for follow-up supports for youth and families, trauma-informed approaches to address workforce burnout, and expanded access to evidence-based and community-based suicide prevention training. These recommendations directly informed the Integrated Plan's suicide prevention and early intervention strategies.

Countywide Town Halls provided direct community input on system strengths and gaps. Participants identified the need for stronger cross-system coordination among behavioral health, housing, transportation, and social services. They emphasized prioritizing services for Latinx and undocumented residents, LGBTQ+ communities (particularly transgender and nonbinary individuals), older adults, and individuals with functional or cognitive challenges. Community members highlighted the importance of culturally responsive, community-rooted practices, building trust in county systems, and increasing transparency in funding decisions and program requirements. Peer-to-peer models were consistently identified as effective strategies for improving access and strengthening trust.
At the recommendation of the Steering Committee, SCBH conducted Housing Focus Groups in August and September 2025 with individuals who had lived experience of homelessness and behavioral health challenges. Participants

identified safety concerns, lack of privacy in shelters, inconsistent rule enforcement, barriers to consistent case management, and insufficient supports for individuals with serious mental illness. They recommended trauma-informed housing environments, enhanced onsite clinical and peer services, expanded outreach teams, and practical supports such as dog kennels to support employment access. Participants also identified transportation, digital access, and documentation barriers, recommending monthly bus passes, free internet access at service sites, and assistance obtaining identification, Medi-Cal, and mobile phones. These insights directly shaped priorities for integrated housing and behavioral health service models, expanded case management, strengthened peer workforce roles, and improved transportation and digital access supports. SCBH is collaborating with the County's Homelessness Division to integrate these recommendations into BHSA-funded transitional housing programs at Eliza's Village and Micky Zane Place beginning July 2026.

Across all engagement activities, stakeholders consistently emphasized the value of culturally grounded and lived-experience perspectives. Community members called for strengthening the SCBH Latinx Clinic, expanding culturally rooted early intervention programs, investing in peer-led wellness centers, and hiring staff with lived experience. Stakeholders highlighted the importance of trauma-informed, disability-sensitive approaches and the need to evaluate both evidence-based and community-created practices. There was strong support for improving data systems, integrating quantitative and qualitative measures, and ensuring outcomes reflect community-defined success.

Through this extensive and collaborative planning process, the FY 2026–2029 BHSA Integrated Plan reflects the priorities identified by Sonoma County's diverse communities. These include expanding housing-linked behavioral health supports; strengthening crisis response and early intervention services; investing in culturally grounded and peer-led models; improving real-time data and response systems; and enhancing transparency and communication. Input gathered through meetings, focus groups, surveys, and listening sessions directly informed the Plan's strategies, and SCBH remains committed to continued stakeholder engagement throughout implementation.

Upload File (optional)

2026-5-14 BHSA Steering Com Minutes and PPT.pdf
10.21.25 BHB Minutes Zoom webinar.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.
Attended key CHA and CHIP meetings as requested; Served on CHA and CHIP governance structures and/or subcommittees as requested.

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

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as required
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
Institutionalization
Overdoses
Suicides
Other

Please describe
Findings from 2023 Mental Health Forum, FY 22-23 MHSA Listening Report, Behavioral Health Measure Section of FY 26-29 Draft BHSA IP

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
Suicides

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.
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
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.

Sonoma County considered the Local Health Jurisdiction's Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and broader Public Health strategic priorities throughout the development of this Integrated Plan. The CHA/CHIP identified behavioral health, suicide prevention, substance use, housing stability, and health equity as critical community need, each of which aligns closely with BHSA priorities. These findings informed our gap analysis, stakeholder engagement questions, priority-setting discussions, and development of BHSA-funded strategies. By grounding the Integrated Plan in the LHJ's data and community-validated priorities, Sonoma County ensures alignment across public health and behavioral health systems, reduces duplication of efforts, and strengthens coordinated, population-level approaches to improving health and wellbeing.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

Partnership Health Plan and Kaiser

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and

collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

The reinvestment plan is being developed by the MCPs with Public Health and Behavioral Health in bi-monthly collaboration meetings. This plan will be reviewed by stakeholders, and it is anticipated that the plan will be completed by June 2026.

COMMENT PERIOD AND PUBLIC HEARING

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

Comment Period and Public Hearing

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
4/16/2026

Date the stakeholder comment period closed
5/19/2026

Date of behavioral health board public hearing on draft IP
5/19/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
Link

Please provide the link to the public posting
https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/behavioral-health-services-act

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 (optional)
https://sonomacounty.gov/health-and-human-services/health-services/divisions/behavioral-health/behavioral-health-services-act

File Upload

Optional

Please select the process by which the draft plan was circulated to stakeholders
Public Posting
Email outreach
Other

Attach email
N/A

Please specify the other process the draft plan was circulated to stakeholders
Engaged with stakeholders via listserv that contains approximately 2,500 subscribers.

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table
Table 7. Stakeholder Input
The County has not started the public comment period. At this time the County has not received any substantive comments.

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
The County has not started the public comment period. At this time the County has not received any substantive comments.

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.

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

SFY 2025-26 QIP has been submitted instead of SFY 2026-27 QIP. SFY 26-27 QIP is not available, Sonoma County will upload SFY 2026-27 QIP once it becomes available.

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

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.)

Table 8. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	**20**
Substance Use Disorder (SUD) services only	**0**
Both MH and SUD services	**1**

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

Table 9. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of contracted BHSA provider locations
SMHS only	**8**
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? **41%**
Note: DHCS will provide each county with a list of their SMHS providers that also contract with MCPs. Counties will then calculate a final percentage after excluding SMHS providers that do not offer any services that may be covered as NSMHS.

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

a. Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening
b. Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
c. Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding

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

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

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

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

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

BEHAVIORAL HEALTH SERVICES ACT/FUND PROGRAMS

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

Behavioral Health Services and Supports (BHSS)

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

General

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

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

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP) Program #1

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

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided

Sonoma County Community Mental Health Centers (CMHCs) are regionally based service teams designed to improve access to specialty mental health services for underserved populations, consistent with the goals of the Behavioral Health Services Act (BHSA). CMHCs prioritize outreach, engagement, and treatment for

individuals who experience barriers to care, including racially and ethnically diverse communities, individuals requiring culturally and linguistically appropriate services, and people experiencing homelessness with mental illness.

CMHCs operate in four geographically distinct areas of Sonoma County: Guerneville, Cloverdale, Petaluma, and Sonoma, to ensure services are delivered close to where people live. While each CMHC is linked to the County's broader adult system of care, teams are community-focused and tailored to the unique needs of their local service areas.

Services are provided through strong collaborations with community-based organizations, law enforcement partners, and local Federally Qualified Health Centers (FQHCs). These partnerships support BHSA priorities by promoting coordinated, integrated, and equitable care; reducing disparities; and improving engagement and outcomes for individuals with serious mental health needs in smaller and historically underserved communities.

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

Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**295**
FY 2027 – 2028	**295**
FY 2028 – 2029	**295**

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Based on clients served from FY 23-24.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #2

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

related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Support services

Please describe the specific services provided

Siyan Clinical Research – Project RAIN (Resources, Assessment, Intensive Case Management, Navigation) is an Adult Therapy and Case Management program designed to address critical service gaps in access to quality psychiatric and behavioral health care for vulnerable and underserved populations in Sonoma County. The program provides outpatient therapy, mental health rehabilitation services, targeted case management, and crisis intervention to adults with significant mental health needs.

Project RAIN offers services in both English and Spanish and operates Monday through Friday from 8:30 a.m. to 5:00 p.m. The program employs a culturally competent, multidisciplinary approach to effectively engage individuals from diverse backgrounds, including Medi-Cal beneficiaries and those who face barriers to accessing care.

The program is grounded in an integrated Recovery and Medical Model that ensures services are personalized, timely, and coordinated to meet each client's unique needs. Through this approach, Project RAIN promotes recovery, improves overall functioning, and empowers clients to achieve personal wellness goals and greater stability in their lives.

Since its launch, Project RAIN has demonstrated strong performance outcomes, providing more than 1,000 services within its first year of operation. The program expanded staffing to meet growing demand for therapy and case management services among Sonoma County Medi-Cal clients and hired bilingual Spanish-speaking therapists and case managers to better serve Spanish-speaking-only individuals. Project RAIN has also achieved excellent client retention rates, supporting continuity of care and sustained engagement in services.

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

Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**161**
FY 2027 – 2028	**161**
FY 2028 – 2029	**161**

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

Based on clients served from FY 23 – 24

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #3

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

Please select the service types provided under Program

Supportive services

Please describe the specific services provided

Crisis Intervention Training (CIT) is a Behavioral Health Services Act (BHSA)–aligned training program for local law enforcement and first responders in Sonoma County. The program supports BHSA goals by strengthening cross-system collaboration, promoting early identification and intervention, and improving equitable responses to individuals experiencing mental health crises, including those with potentially severe and disabling mental illness.

CIT is conducted biannually and focuses on engaging and educating first responders in trauma-informed, recovery-oriented, and culturally responsive approaches to crisis response. The training equips law enforcement and emergency personnel with practical tools, knowledge, and access to behavioral health resources that enhance safe de-escalation, appropriate referral, and diversion from unnecessary emergency department visits or incarceration when clinically appropriate.

Through structured learning and direct engagement, participants build awareness of local behavioral health services and strengthen coordination with community-based providers. Site visits and tours of mental health and community-based organizations are incorporated to foster relationships, improve system navigation, and increase understanding of available behavioral health supports. This integrated approach advances BHSA priorities by improving continuity of care, reducing disparities, and promoting effective community-based crisis response across Sonoma County.

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

Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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 the Adult and Older Adult System of Care
Based on CIT's past participation data.

Early Intervention (EI) Programs #1

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
Alternative Family Services (AFS) Therapy Clinic

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

Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide.

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
Mobile Response and Stabilization Services (MRSS)
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Triple P – Positive Parenting Program (Triple P)

Please provide the name of the EBPs and the CDEPs that apply
Wisdom Pathways Reparative Parenting Approach
Core Practice Model (CPM)

Please describe intended outcomes of the program or service
Alternative Family Services (AFS) Therapy Clinic provides Specialty Mental Health Services to children and youth ages 0–20 in Sonoma County who meet medical necessity criteria. The program aligns with BHSA Early Intervention outcomes by reducing mental health symptoms, improving functioning, strengthening protective factors, and preventing escalation to higher levels of care.

AFS delivers trauma-informed, family-centered services that promote emotional regulation, resilience, and stability within family systems. Clients receiving services demonstrate measurable reductions in trauma-related and mental health symptoms, improved behavioral and emotional functioning, and increased success in school and community settings. Caregivers experience enhanced parenting skills, engagement, and capacity to support their child's mental health needs.

Core services include individual, family, and group therapy; rehabilitation; plan development; Intensive Home-Based Services (IHBS); and Targeted Case

Management, including Intensive Care Coordination (ICC). Services are delivered by a multidisciplinary team of licensed clinicians, associates, and paraprofessionals who collaborate with families, Child and Family Teams, schools, and community partners to ensure coordinated care.

Ongoing CANS/ANSA assessments guide treatment planning, monitor progress, and support timely transitions to lower levels of care. Through these coordinated, outcome-driven services, AFS promotes reduced mental health symptoms, improved functioning, strengthened family relationships, increased protective factors, and prevention of escalation to higher levels of care, enabling children, youth, and families to achieve long-term stability and resilience.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**30**
FY 2027 – 2028	**30**
FY 2028 – 2029	**30**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected Number of Individuals Served is based on FY 23-24 data (clients served).

Early Intervention (EI) Programs #2

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
Community-Defined Best Practices for BIPOC Populations Program (RFP)

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
Indicated prevention, early intervention, and strengths-based culturally responsive services using a Community-Defined Best Practices (CDBP) approach.

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
A.C.O.R.N Youth Wellness Program
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
Aunties and Uncles Program

Please provide the name of the EBPs and CDEPs that apply
This has not been determined yet. This program is currently in the request-for-proposal (RFP) process, so the specific EBPs and CDEPs have not yet been finalized, but they are expected to be defined by July 1, 2026.

Please describe intended outcomes of the program or service
Sonoma County's Community-Defined Best Practices (CDBP) program (currently in RFP) will provide culturally and linguistically responsive early intervention behavioral health services for Black, Indigenous, Latinx, and other communities of color. The program will serve children and youth from populations that experience behavioral health disparities and barriers to traditional care.

The program aligns with BHSA Early Intervention goals by aiming to: Reduce untreated behavioral health conditions: Youth will demonstrate improved emotional regulation, decreased trauma and stress-related symptoms, and enhanced overall behavioral health; Improve functioning: participants will show better social, school, and community engagement through peer-to-peer health promotion, culturally facilitated support groups, and strengths-based wellness activities; Strengthen protective factors: through traditional and culturally rooted practices, talking circles, and family engagement enhance resilience, coping skills, and family functioning; Prevent escalation to higher levels of care: Early, culturally responsive interventions aim to reduce crises, suicide risk, and the need for intensive or restrictive services.

Program activities may include: culturally affirming workshops, presentations, and community events highlighting cultural strengths; training on suicide prevention, behavioral health awareness, and access to culturally responsive services; and peer, family, and community engagement that fosters holistic wellness. Outreach and education efforts increase awareness, engagement, and utilization of behavioral health resources, with warm referrals to Sonoma County services.
Through these coordinated, culturally grounded services, the program seeks to reduce behavioral health disparities, prevent crises, and promote long-term stability, resilience, and wellness for BIPOC children, youth, families, and communities.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	126
FY 2027 – 2028	126
FY 2028 – 2029	126

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

Projected number of Individuals served through this Community-Defined Best Practices (CDBP) BIPOC program is based on similar programs/services from FY 23-24 data.

Early Intervention (EI) Programs #3

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

Mobile Support Team (MST)

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

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

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

Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
Mobile Response and Stabilization Services (MRSS)

Please provide the name of the EBPs and CDEPs that apply

Mobile Response and Stabilization Services (MRSS)

Please describe intended outcomes of the program or service

The Mobile Support Team (MST) is Sonoma County Behavioral Health's countywide, 24/7 behavioral health crisis response program and is a core

component of the County's Behavioral Health Services Act (BHSA) Early Intervention (EI) continuum. MST is designed to advance BHSA goals by promoting early access to services, timely intervention, and prevention of more serious mental health and substance use conditions, including the avoidance of unnecessary hospitalization, justice system involvement, and long-term impairment.

MST provides immediate, community-based crisis response through a centralized Crisis Call Center and multidisciplinary Mobile Crisis Response Teams. The Crisis Call Center offers real-time crisis screening, triage, and consultation, ensuring individuals and families receive the right level of care at the right time. When in-person support is needed, Mobile Crisis Response Teams, comprised of behavioral health clinicians, alcohol and other drug counselors, and senior client support specialists respond countywide to provide on-scene assessment, de-escalation, safety planning, and 5150 evaluations when appropriate. Services are available to individuals of all ages, regardless of insurance status, and are delivered in the least restrictive, most clinically appropriate setting. MST teams may respond independently or in coordination with law enforcement when safety concerns require a co-response.

Consistent with BHSA Early Intervention priorities, MST emphasizes prevention, early identification of emerging behavioral health needs, and rapid linkage to care. The program facilitates follow-up services, secure transportation, and warm handoffs to Crisis Stabilization Units, hospitals, outpatient behavioral health and substance use treatment, and other community-based supports. MST collaborates closely with local partners, including SAFE and inRESPONSE, to ensure a coordinated, equitable, and culturally responsive "no wrong door" crisis response system across Sonoma County.

The intended outcomes of the Mobile Support Team program align with BHSA goals and include: early identification and stabilization of behavioral health crises; reduced severity and duration of crises through timely intervention; prevention of escalation to higher levels of care; decreased reliance on emergency departments, inpatient hospitalization, and law enforcement; improved access to behavioral health services for underserved and uninsured populations; increased continuity of care through effective linkage and follow-up; and enhanced safety and well-being for individuals, families, and the broader community. Through these outcomes, MST supports BHSA's overarching goal of

promoting wellness, recovery, and resilience while reducing the long-term impact of untreated behavioral health conditions.

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

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

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**399**
FY 2027 – 2028	**399**
FY 2028 – 2029	**399**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected Number of Individuals Served is based on FY 23-24 data (clients served)

Early Intervention (EI) Programs #4
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
Collaborative Treatment and Recovery Team (CTRT)

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

Please specify “other” type of Treatment Services and Supports

CTRT offers recovery-oriented education, self-advocacy support, system navigation skills, and collaborative care planning to adults who are new to behavioral health services. Unlike programs that focus on crisis intervention or a specific diagnosis, such as first episode psychosis, CTRT emphasizes early engagement and individualized support to help participants effectively navigate the behavioral health system. These activities are best categorized under “Other” treatment services and supports, as they foster participant empowerment, active involvement in care, recovery, and continuity of services, all of which align closely with the core goals of BHSA Early Intervention: promoting wellness, preventing the escalation of behavioral health challenges, and supporting long-term recovery and resilience.

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 Collaborative Treatment and Recovery Team (CTRT) is a Sonoma County Behavioral Health Early Intervention (EI) program designed to support adults who are new to the behavioral health system by providing timely, coordinated, and recovery-oriented assistance. Consistent with the Behavioral Health Services Act (BHSA) Early Intervention goals, CTRT focuses on early engagement, reducing barriers to care, and preventing the escalation of behavioral health needs by helping individuals successfully access and navigate services at the beginning of their treatment journey.

CTRT provides individualized guidance, education, and practical support to help participants understand their behavioral health needs, available treatment options, and the structure of Sonoma County’s behavioral health system. Through a collaborative approach, the program promotes self-advocacy, shared decision-making, and the development of system navigation skills, empowering participants to actively engage in care planning and make informed choices about their recovery. Education about mental illness is provided to participants and their families to increase understanding of symptoms, treatment approaches, and strategies for managing mental health challenges.

Working in partnership with local community-based contractors, CTRT strengthens access and linkage to community-based resources and support networks, including outpatient behavioral health services, housing, social services, and peer supports. This collaborative model enhances continuity of care, reduces service fragmentation, and ensures warm handoffs to appropriate ongoing supports. Services are person-centered, culturally responsive, and tailored to the unique needs and goals of each participant.

The intended outcomes of CTRT align with BHSA EI priorities and include increased engagement and retention in behavioral health services; improved understanding of mental health and treatment options; enhanced self-advocacy and independent system navigation skills; reduced barriers to accessing care and community resources; and improved coordination across service providers. Through early intervention and supportive linkage, CTRT aims to prevent symptom escalation, reduce the need for crisis or higher levels of care, and promote recovery, independence, and meaningful community participation. Collectively, these outcomes support BHSA's overarching goal of promoting wellness, resilience, and recovery while reducing the long-term impact of untreated or emerging behavioral health conditions.

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

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

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**220**
FY 2027 – 2028	**220**
FY 2028 – 2029	**220**

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

Projected Number of Individuals Served is based on FY 23-24 data (clients served).

Early Intervention (EI) Programs #5

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

Program or service name

Crisis Assessment, Prevention, and Education (CAPE) Program

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

Access and Linkage: Assessments
Access and Linkage: Screenings
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

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

Mobile Response and Stabilization Services (MRSS)

Please provide the name of the EBPs and CDEPs that apply

Mobile Response and Stabilization Services (MRSS)

Please describe intended outcomes of the program or service

The Crisis Assessment, Prevention, and Education (CAPE) program is a Sonoma County Behavioral Health Early Intervention (EI) initiative that provides comprehensive behavioral health support directly within schools, colleges, and community partner sites. Operating on high school campuses across the county CAPE brings licensed, license eligible mental health clinicians and substance use disorder counselors to youth in their learning environments. The program offers

screening and assessment for at-risk youth, mobile crisis response, and peer- and family-based support, while also providing education and training to students, school staff, families, and community partners to recognize early warning signs of mental health challenges, suicide risk, and other behavioral health concerns. By collaborating closely with school counseling services, health centers, crisis intervention teams, and family support organizations, CAPE creates a coordinated, prevention-focused system of care that strengthens connections across Sonoma County's educational and community settings.

CAPE aligns with BHSA Early Intervention goals by emphasizing the early identification of emerging behavioral health needs, preventing the escalation of crises, increasing access to appropriate supports, and promoting resilience and wellness among youth. Through proactive screening, thorough assessment, crisis response, and educational outreach, the program works to reduce the long-term impact of untreated behavioral health conditions while fostering recovery-oriented, community-based care.

The intended outcomes of CAPE include the early identification and assessment of at-risk youth to enable timely intervention, the prevention of behavioral health crises and reduction of suicide risk, and increased awareness and knowledge among students, families, and school staff about mental health challenges and available resources. The program also seeks to improve engagement with appropriate behavioral health services and support networks, enhance coordination among schools, colleges, and community partners, and promote recovery, resilience, and well-being by fostering self-advocacy, coping skills, and supportive environments. Overall, CAPE advances BHSA EI goals by reducing barriers to care, facilitating early intervention, and strengthening community-based prevention and support systems for youth behavioral health.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**2405**
FY 2027 – 2028	**2405**
FY 2028 – 2029	**2405**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on clients served in FY 24-25.

Early Intervention (EI) Programs #6

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
Seneca WRAP Program

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

Please specify "other" type of Treatment Services and Supports
Seneca WRAP provides family-centered, strengths-based care coordination, advocacy, skill-building, and support, which are not diagnosis-specific or crisis-focused but aim to promote engagement, resilience, and stability. These individualized treatment and support activities fit under "Other" treatment services and supports.

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

A.C.O.R.N Youth Wellness Program

Please provide the name of the EBPs and CDEPs that apply

High-Fidelity Wraparound

Please describe intended outcomes of the program or service

The Seneca WRAP (Wraparound) program is a family-centered, strengths-based initiative designed to support children, youth, and families facing complex behavioral health, emotional, and social challenges that put them at risk of out-of-home placement or instability in their current placement. WRAP offers a highly individualized approach in which a dedicated team, including the child or youth, family members, behavioral health professionals, and community supports, collaboratively develops and implements a comprehensive care plan tailored to each family's unique needs, goals, and cultural strengths. Emphasizing family voice, empowerment, and shared decision-making, the program ensures services are relevant, culturally responsive, and grounded in the lived experiences of participants. Staff provide intensive care coordination, advocacy, and support to help families access behavioral health services, housing, educational resources, and community programs. By working within the family's natural home environment, school, and community, WRAP fosters skill-building, strengthens relationships, enhances resilience and self-sufficiency, and supports long-term stability, with the overarching aim of preventing unnecessary placement outside the home and reducing reliance on restrictive care.

The intended outcomes of the Seneca WRAP program focus on improving family functioning, stability, and overall well-being. WRAP seeks to increase engagement with behavioral health and community supports, enhance family and youth coping skills, and strengthen protective factors that support resilience and sustainable functioning. By facilitating access to appropriate services, advocating for family needs, and coordinating care across multiple systems, the program aims to reduce behavioral health symptoms, prevent placement disruptions, and promote positive social, educational, and behavioral outcomes for children and youth. Families participating in WRAP are expected to experience greater stability in home placements, improved communication and problem-solving within the family unit, and enhanced capacity to navigate systems of care independently over time.

The Seneca WRAP program aligns closely with key goals of the Behavioral Health Services Act (BHSA) Early Intervention (EI) framework. BHSA EI prioritizes early engagement, prevention of condition escalation, increased access to services, and support for recovery and wellness goals that WRAP advances by identifying and intervening with youth and families at critical moments of need. WRAP's individualized, strengths-based approach supports early linkage to behavioral health services and community resources before challenges escalate into crises that require higher-level care. The program's emphasis on family empowerment, skill-building, and culturally responsive planning promotes sustained engagement in care and contributes to long-term recovery, resilience, and self-advocacy. By reducing barriers to care, enhancing coordination across systems, and fostering supportive, stable home environments, WRAP embodies BHSA EI priorities to mitigate the long-term impacts of untreated behavioral health challenges and promote wellness across the lifespan.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**110**
FY 2027 – 2028	**110**
FY 2028 – 2029	**110**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected Number of Individuals Served is based on FY 24-25 data (clients served).

Early Intervention (EI) Programs #7

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
Department of Health Services, Behavioral Health Division (DHS-BHD) Youth Access Program

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

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
Screening, Brief Intervention, Referral to Treatment (SBIRT)

Please provide the name of the EBPs and CDEPs that apply
Referral to Treatment (SBIRT)

Please describe intended outcomes of the program or service
The Youth Access program is Sonoma County Behavioral Health's first point of contact for youth and families seeking mental health services. Serving individuals up to age 20, the program offers screening, assessment, and referral services to ensure that youth are connected to the appropriate level of care, whether through Specialty Mental Health Services (SMHS) or Federally Qualified Health Centers (FQHCs). Referrals to Youth Access come from psychiatric hospitals, managed care providers, FQHCs, or directly from families via the Main Access Line. Using structured tools such as the California CANS 50, clinicians assess behavioral health needs, determine the appropriate setting for treatment, and develop service plans that reflect youth and family preferences, including language and

provider gender. Youth Access also provides case management, supports connection to community-based services, and coordinates care until discharge for those qualifying for ongoing SMHS.

The intended outcomes of the Youth Access program focus on ensuring timely and appropriate access to behavioral health services. These outcomes include early identification of youth behavioral health needs, accurate assessment and triage to the right level of care, and effective linkage to services that support treatment and recovery. By facilitating smooth referrals and care coordination, the program aims to reduce delays in service, enhance family and youth engagement, and improve overall behavioral health outcomes.

The Youth Access program aligns closely with BHSA Early Intervention (EI) goals by promoting early identification and assessment of emerging behavioral health needs, facilitating access to appropriate services, and supporting recovery-oriented engagement before challenges escalate. By providing a structured intake, screening, and referral process, Youth Access reduces barriers to care, ensures youth and families are connected to timely and culturally responsive services, and strengthens continuity of care within the behavioral health system. Through these efforts, the program embodies BHSA EI priorities of preventing the progression of behavioral health conditions, enhancing access to recovery-oriented services, and supporting youth and families in achieving improved well-being and resilience.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

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

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

Projected number of individuals served is based on FY 24-25 data (clients served).

Early Intervention (EI) Programs #8

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

Sonoma County Behavioral Health Division Adult Access Program

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

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

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 Sonoma County Behavioral Health Division Adult Access Team serves as the initial point of contact for individuals seeking mental health services through Sonoma County's Behavioral Health Division. Individuals may self-refer by calling or visiting the Access offices at 2225 Challenger Way, as outlined on the Division's website. The Access Team is available 24 hours a day, 7 days a week to answer questions and initiate the intake process.

Individuals may also be referred to the Access Team as a step-up in care from one of the County's Federally Qualified Health Centers (FQHCs) or following discharge from a psychiatric hospital. The Department of Health Services,

Behavioral Health Division (DHS-BHD) monitors all Sonoma County residents admitted to psychiatric hospitals and ensures they receive an Access assessment within seven business days of discharge.

An Access Team Screener evaluates each individual's level of mental health need, schedules an assessment appointment, and connects clients to appropriate community resources. The Access assessment includes a structured set of questions designed to evaluate functioning across multiple life domains and determine how mental health symptoms impact daily functioning. The Adult Access Team uses the Adult Needs and Strengths Assessment (ANSA) to determine the appropriate level of care and assignment to a treatment team.

While individuals await placement with a long-term treatment team and case manager, the Access Team provides short-term, limited case management focused on crisis response and urgent needs. This may include crisis intervention services or assistance with immediate housing concerns.

A warm handoff between the Access clinician and the assigned long-term clinician occurs within seven days of team placement. Once ongoing services begin, care is provided by the long-term case manager, allowing the Access Team to maintain timely access, assessments, and intake services for new clients.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**713**
FY 2027 – 2028	**713**
FY 2028 – 2029	**713**

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

Projected number of individuals served is based on FY 24-25 data (clients served).

Early Intervention (EI) Programs #9

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 Service name

After-Hours Behavioral Health Phone Coverage Services (currently contracted through Optum – MOU

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

Access and Linkage: Referrals
Access and Linkage: Other
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

After-Hours Information and Resource Navigation Support: This includes providing callers with behavioral health information, answering questions about available services, and guiding individuals to appropriate county resources outside of regular business hours. It does not include formal referrals, assessments, or direct clinical care, but ensures timely access to the system and supports connection to services.

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 Optum After-Hours Phone Coverage service provides centralized telephone support for residents and Medi-Cal beneficiaries seeking behavioral health information outside of regular business hours. Operating evenings, nights, weekends, and designated holidays, Optum staff answer incoming calls to provide general guidance on behavioral health resources, information about available services, and contacts for urgent or emergency situations. While the service does not authorize treatment, provide formal referrals, or deliver clinical care, it ensures that caller information is forwarded to the appropriate county behavioral health call center for follow-up during regular business hours. The program functions as a critical bridge, connecting individuals to the behavioral health system when standard access points are closed.

The intended outcomes of this service focus on ensuring timely access to behavioral health information, reducing delays in connecting individuals to services, and supporting individuals in navigating the behavioral health system. By providing immediate guidance and resource information, Optum aims to prevent unnecessary escalation of mental health concerns, ensure individuals know where and how to seek help, and promote continuity of care through warm handoffs to county providers.

The service aligns with BHSA Early Intervention (EI) goals by facilitating early access to the behavioral health system and supporting timely linkage to appropriate care. Although it does not deliver clinical treatment or EBPs/CDEPs directly, Optum After-Hours promotes the BHSA EI priorities of reducing barriers to care, providing timely information, and supporting crisis prevention and early engagement. By connecting callers to the right resources and ensuring follow-up by county providers, the program helps mitigate the impacts of emerging behavioral health challenges and contributes to overall system responsiveness and continuity of care.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1220**
FY 2027 – 2028	**1220**
FY 2028 – 2029	**1220**

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

Projected number of individuals served is based on FY 24-25 data (clients served).

Early Intervention (EI) Programs #10

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

Comprehensive Early Childhood Development & Behavioral Support Services for 0–5-year-olds (RFP)

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

Access and Linkage: Screenings
Access and Linkage: Assessments
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

The Comprehensive Early Childhood Development & Behavioral Support Services for 0–5-year-olds program offers family-centered, trauma-informed interventions such as in-home parent education, individual and group counseling for children and caregivers, and resource navigation with closed-loop referrals. These services focus on strengthening caregiver capacity, promoting healthy parent-child relationships, enhancing social-emotional and behavioral functioning in young children, and preventing the escalation of mental health challenges.

Because these interventions are not crisis-focused or diagnosis-specific, but rather aim to build protective factors, support early development, and prevent functional impairment or out-of-home placement, they fit best under "Other" treatment services and supports. This category captures services that are proactive, holistic, and recovery-oriented, supporting early intervention goals by addressing mental health and developmental needs before they progress to more severe conditions requiring specialized treatment.

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
Infant and Early Childhood Mental Health Consultation
Parent Child Interaction Therapy (PCIT)
Screening, Brief Intervention, Referral to Treatment (SBIRT)

Please provide the name of the EBPs and CDEPs that apply
Infant and Early Childhood Mental Health Consultation

Please describe intended outcomes
The Comprehensive Early Childhood Development & Behavioral Support Services for 0–5-year-olds Program is currently in the Request for Proposals (RFP) process and will begin implementation in FY 26–27. This program is designed to provide early identification, intervention, and support for young children and their caregivers who may be at risk for social-emotional, developmental, or behavioral challenges but do not yet qualify for Specialty Mental Health Services. The program will offer comprehensive screenings and assessments for children, mental health assessments for caregivers, in-home parent education, individual and group counseling, and resource navigation with closed-loop referrals to ensure families are connected to appropriate behavioral health and community services. Additionally, the program will conduct community outreach and education to increase awareness of available services and strengthen protective factors that support family stability and child well-being.

The intended outcomes of the program include improved social-emotional and behavioral functioning in children, strengthened caregiver capacity and resilience, enhanced parent-child relationships, and reduced likelihood of crises

or out-of-home placements. By addressing behavioral health and developmental concerns early, the program aims to prevent functional impairment, support long-term well-being, and promote sustained engagement in services.

The program aligns closely with BHSA Early Intervention (EI) goals, emphasizing early identification, timely access to supportive services, prevention of condition escalation, and family-centered, culturally responsive care. Through evidence-based and trauma-informed interventions, the program seeks to increase protective factors, build resilience, and support recovery-oriented outcomes, consistent with BHSA EI priorities to reduce the long-term impacts of untreated behavioral health challenges and promote wellness across the lifespan.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1522**
FY 2027 – 2028	**1522**
FY 2028 – 2029	**1522**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected number of individuals served is based on FY 23-24 data (clients served) from similar programs.

Early Intervention (EI) Programs #11

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
Latinx Youth Wellness & Advocacy Program

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: Other

Please specify “other” type of Access and Linkage
By providing mentorship, peer education, and wellness promotion activities, the program facilitates engagement with behavioral health resources, supports participation in prevention and early intervention, and helps youth navigate systemic barriers, even though it does not provide formal clinical assessments or referrals.

Please specify “other” type of Treatment Services and Supports
The program delivers culturally and linguistically responsive skill-building, resilience workshops, advocacy opportunities, and empowerment-focused group activities, which support behavioral health promotion, prevention, and early intervention without being diagnosis-specific, crisis-focused, or targeting FEP/co-occurring disorders.

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
Cultura y Bienestar Program

Please provide the name of the EBPs and CDEPs that apply
Cultura y Bienestar Program

Please describe intended outcomes of the program or service

Sonoma County Behavioral Health is seeking a qualified contractor through an RFP to implement the Latinx Youth Wellness & Advocacy Program, an early intervention initiative designed to provide culturally and linguistically responsive behavioral health support for Latinx youth. The program addresses behavioral health disparities, systemic barriers, and inequities in access to care while promoting wellness, empowerment, and leadership development.

The program will provide mentorship, peer education, and advocacy opportunities, both individually and in group settings, enabling Latinx youth to engage in local and county-level initiatives, such as awareness events, campaigns, presentations, and community projects. Staff will conduct community outreach and engagement to increase awareness of behavioral health services and support participation in prevention and early intervention efforts. Wellness promotion activities—including workshops, skill-building sessions, and group events—will focus on fostering resilience, self-advocacy, and empowerment while addressing BIPOC disparities in behavioral health outcomes.

Aligned with BHSA Early Intervention goals, the program targets Latinx youth and communities experiencing behavioral health disparities, aiming to prevent the onset of behavioral health conditions, reduce inequities, and address factors contributing to juvenile and adult justice system involvement. Services will be delivered in partnership with local organizations serving Latinx youth to maximize reach, engagement, and sustainable community impact.

This RFP seeks a contractor capable of delivering these services with cultural competence, adherence to BHSA regulations, and a commitment to measurable outcomes that advance early intervention and equity in behavioral health.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**260**
FY 2027 – 2028	**260**
FY 2028 – 2029	**260**

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

Projected number of individuals served is based on FY 23-24 data (clients served) from similar programs.

Early Intervention (EI) Programs #12

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

Sonoma County Behavioral Health LatinX Clinic

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

Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

The Sonoma County Behavioral Health LatinX Clinic provides comprehensive Early Intervention treatment services and supports that extend beyond screening and referral activities. These services are designed to address emerging mental health concerns at an early stage and to strengthen individual, family, and community protective factors among Latinx children, youth, and families.

The clinic offers evidence-based individual therapy for children and caregivers to address social-emotional and behavioral concerns, build coping skills, and reduce the impact of stress and trauma. Family therapy is provided to strengthen

caregiver–child relationships, improve communication, and support healthy family functioning within a culturally responsive and trauma-informed framework. These services emphasize early intervention to prevent the escalation of mental health challenges and reduce the need for more intensive or crisis-based services.

In addition, the clinic facilitates parent support groups that provide psychoeducation, peer support, and skill-building opportunities. These groups enhance caregiver knowledge of child development and mental health, reduce isolation, and promote resilience by reinforcing family and community protective factors. The clinic also delivers psychiatric rehabilitation and education services, focusing on building functional skills, emotional regulation, and self-advocacy, as well as increasing understanding of mental health and available supports.

All treatment services are delivered in Spanish and English and are grounded in the cultural values, traditions, and lived experiences of the Latinx community. By providing culturally and linguistically responsive early intervention treatment services, the LatinX Clinic improves access to timely behavioral health supports, enhances family resilience, and promotes positive mental health outcomes for Latinx children, youth, and families in Sonoma County.

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
Family Centered Treatment

Please provide the name of the EBPs and CDEPs that apply
Trauma-Informed Care (TIC); Cognitive Behavioral Therapy–Informed Interventions (CBT); Culturally Responsive, Family-Centered; Culturally Adapted Parent Support Groups (CDEP); Care (CDEP);
Please describe intended outcomes of the program or service
The Sonoma County Behavioral Health LatinX Clinic is a welcoming, community-based program created to support the emotional well-being of Latinx children, youth, and families through BHSA Early Intervention services. The clinic focuses on identifying concerns early, strengthening family and community supports, and reducing barriers that often prevent Latinx families from accessing behavioral

health care. Services are provided in both Spanish and English and are rooted in respect for the cultural values, traditions, and lived experiences of the Latinx community.

The LatinX Clinic works in partnership with families to promote wellness and prevent mental health challenges from becoming more serious. Through community outreach and education, the program helps reduce stigma around mental health, increases awareness of available resources, and encourages families to seek support early. Children and caregivers can receive screenings and assessments for social-emotional, behavioral, and developmental concerns, along with guidance and education that supports healthy growth and emotional development.

Families are offered individual and family therapy, parent support groups, and psychiatric rehabilitation and education services that are trauma-informed and family-centered. These services are designed to build coping skills, strengthen relationships, and support caregivers in their role as the primary source of stability and resilience for their children. The clinic also helps families navigate systems of care by connecting them to behavioral health and community resources and providing follow-up support to ensure services are accessed and maintained.

By offering culturally responsive Early Intervention services in a trusted and supportive setting, the LatinX Clinic aims to improve emotional well-being for children and youth, increase caregiver confidence and resilience, and strengthen family and community protective factors. The program seeks to ensure that Latinx families receive timely, relevant, and respectful support that helps prevent the escalation of mental health concerns, reduces the need for crisis services, and supports long-term wellness and stability for families in Sonoma County.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**383**
FY 2027 – 2028	**400**
FY 2028 – 2029	**450**

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

The projected number of individuals served is based on FY 24–25 client data. Because the Latinx Clinic opened in August 2025, we have also included July 2025 data. We anticipate annual increases in clients served as the program becomes better known within the community.

Early Intervention (EI) Programs #13

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

Older Adult Collaborative (OAC)

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

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

Acceptance and Commitment Therapy (ACT)

A.C.O.R.N Youth Wellness Program
Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC)
AFFIRM Youth
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
Assertive Continuing Care (ACC)
Attachment and Biobehavioral Catch-Up (ABC)
Aunties and Uncles Program
Blues Program
Bounce Back
Brief Alcohol Screening and Intervention of College Students (BASICS)
Brief Risk Reduction Interview and Intervention Model (BRRIIM)
Brief Strategic Family Therapy (BSFT)
Caregiver Guide: Healthy Youth: Early Intervention Services for Youth At Risk of Substance Use Behaviors
CBT for PTSD
Celebrating Families (CF)
Child and Family Traumatic Stress Intervention (CFTSI)
Child Parent Psychotherapy (CPP)
Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Late Life Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Collaboration Leading to Addition Treatment and Recovery from Other Stresses Manua (CLARO)
Collaborative Care Model
Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT)
Community Reinforcement and Family Training (CRAFT)
The Community Wellness Program
Contingency Management (CM)
Convivencia
Creating Lasting Family Connection (CLFC)
Crossover Youth Practice Model
Cultura y Bienestar Program
Culture as Treatment

Culturally Informed and Flexible Family Treatment for Adolescents (CIFFTA)
Homebuilders
Curriculum-Based Support Group (CBSG) Program
Depression Treatment Quality Improvement (DTQI)
Dialectical Behavior Therapy
Drug counseling (individual and group)
Drum-Assisted Recovery Therapy for Native Americans (DARTNA)
Early Psychosis Prevention and Intervention Center (EPPIC)
Early Risers "Skills for Success" Risk PreventionProgram
Early Start Wellness Initiative
Effective Black Parenting Program
Eye Movement Desensitization and Reprocessing (EMDR)
Family Acceptance Project
Family Centered Treatment
Family Check-up
Family Connections (FC)
Family Spirit
Familywell: A Prevention and Early Intervention Initiative
Felton Institute (re) MIND Central
Foothill Family's Healthy Futures Program
Functional Family Therapy (FFT)
Gathering of Native Americans (GONA)
Gender Health Center
Hazelden Co-occurring Disorders Program
Honoring Children, Mending the Circle (HC-MC)
Incredible Years
Infant and Early Childhood Mental Health Consultation
Integrated Co-Occurring Treatment (ICT)
Interpersonal Therapy (IPT)
Living With Love
Marijuana Brief Intervention
The Matrix Model
Mending Broken Hearts
Mental Health SkillBuilding and Mood Intervention
Mentalization Based Therapy (MBT)
Menta Sana, Vida Sana Project
Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan

Mobil Response and Stabilization Services (MRSS)
Mom Power
The Mothers and Babies Course "Mamás y Bebés"
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Multidimensional Treatment Foster Care (MTFC)
Multidimensional Family Therapy (MDFT)
Multisystemic Therapy (MST)
Native Talking Circles
Nurturing Parenting Program (NP)
OCAPICA Project HOPE
Parent Child Assistance Program (PCAP)
Parent Child Interaction Therapy (PCIT)
Parenting Wisely
Parent as Teachers (PAT)
Pediatric Primary Care Behavioral Health (Pediatric PCBH)
Portland Identification early Referral Model (PIER)
Positive Indian Parenting
Prevention of Suicide in Primary Care Elderly (PROSPECT)
Problem Solving Therapy (PST)
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders
Reconnecting Youth Program (RY)
Reflective Parenting Program (RPP)
Residential Student Assistance Program (RSAP)
SafeCare
Safe Passages Law and Social Justice Life Coaching Project
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
The Strengthening Families Programs (SFP)
Strong Beginnings
Structed Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP-ART)
Teen Intervene
Traditional Healer Services and Natural Helper Services
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Trauma Recovery and Empowerment (TREM)
T.R.I.B.E (Turning Resilience Into Brilliance for Eternity)
Triple P – Positive Parenting Program (Triple P)

Twelve-Step Facilitation Therapy (TSF)
UCLA Training, Intervention, Education, Services (TIES) Transition Model
Written Exposure Therapy (WET)
The Zoosiab Program

Please provide the name of the EBPs and CDEPs that apply

Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors)

Please describe intended outcomes of the program or service

The Older Adult Collaborative (OAC) is a partnership between the Sonoma County Human Services Department (Adult & Aging Division) and sub-contracted community agencies that advance the Behavioral Health Services Act (BHSA) Early Intervention goals for older adults. The OAC integrates depression screening, education, and early intervention into existing older adult services, including case management and community-based supports. The program utilizes the evidence-based Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors) model, which combines screening, psychoeducation, behavioral activation, and linkage to services. Clients who screen positive for depression are offered early intervention supports and, when clinically appropriate, are referred to mental health services for additional care. The collaborative also emphasizes strong cross-agency coordination and peer support among staff to ensure consistent, high-quality service delivery.

The intended outcomes of the Older Adult Collaborative are to improve the emotional well-being and mental health of older adults through early identification, timely intervention, and coordinated support, consistent with BHSA Early Intervention priorities. The program aims to increase early detection of depression and emotional distress among older adults who may not otherwise access behavioral health services, allowing concerns to be addressed before symptoms worsen or become disabling. Through evidence-based intervention and linkage to appropriate services, the OAC seeks to reduce the severity and progression of depressive symptoms, improve functioning and quality of life, and increase engagement in mental health and community-based supports. Additionally, the program is intended to reduce disparities in access to care, strengthen system collaboration, and build sustainable early intervention capacity, ultimately reducing the need for more intensive behavioral health services over time.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**2500**
FY 2027 – 2028	**2500**
FY 2028 – 2029	**2500**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected number of individuals served is based on FY 24-25 data (clients served).

Early Intervention (EI) Programs #14

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
Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) Wellness & Support Program

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: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

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 LGBTQ+ Wellness & Support Program is designed to provide culturally responsive behavioral health support, advocacy, education, and therapeutic services to Sonoma County's LGBTQIA+ population, with a focus on early identification and intervention consistent with BHSA's Early Intervention (EI) goals. The program serves LGBTQ+ clients, including children, youth, and other populations at risk for developing mental health disorders or experiencing disparities in behavioral health outcomes. In alignment with BHSA EI priorities, the program seeks to prevent the onset or worsening of mental health conditions, reduce suicide and self-harm, and promote recovery, resilience, and well-being.

The program provides peer-led behavioral health support groups in safe, inclusive, and affirming environments to foster social connection and early engagement with mental health resources. Trauma-informed therapy is available to address the unique experiences of trauma, discrimination, and minority stress within LGBTQ+ communities, delivered using culturally responsive and evidence-based approaches. The program also includes LGBTQIA+ cultural competency training for staff and community providers to strengthen organizational capacity, increase knowledge and skills, and ensure that services are delivered in accessible, inclusive, and affirming ways. Participants have access to a welcoming and supportive space for advocacy, resources, and referrals, reducing societal and self-stigma and facilitating timely access to care. Leadership development, training, and ongoing support for LGBTQ+ individuals are provided to foster empowerment, skill-building, and engagement in the broader community. Through community outreach and engagement, the program delivers recovery-focused messaging to encourage early help-seeking and timely access to behavioral health services.

The intended outcomes of the program are aligned with BHSA Early Intervention goals and include increased recognition of emerging mental health concerns among LGBTQ+ clients, enhanced connection to culturally responsive behavioral health care and community resources, reduction in suicide, self-harm, and progression of mental health conditions, increased social support and resilience,

strengthened staff knowledge and organizational capacity to serve LGBTQ+ populations effectively, and reduction of disparities in access and outcomes for historically underserved or marginalized groups. This program is currently undergoing a Request for Proposal (RFP), and the program design and intended outcomes may be refined slightly as a result of the contracting process.

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)

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**311**
FY 2027 – 2028	**311**
FY 2028 – 2029	**311**

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projected number of individuals served is based on FY 23-24 data (clients served) from similar program(s).

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
First Episode Psychosis (FEP) Program

CSC program description
The First Episode Psychosis (FEP) program is a specialized, recovery-oriented initiative designed to provide early identification, intervention, and

comprehensive support for individuals experiencing their first episode of psychosis, between the ages of 15 and 30. Early intervention is critical to improving long-term outcomes, and the program will focus on minimizing the impact of psychosis on education, employment, relationships, and overall quality of life.

FEP services are delivered by a multidisciplinary team including psychiatrists, therapists, case managers, peer specialists, and family support coordinators. Core services include psychiatric assessment and medication management, individual and group therapy, family education and support, skills development, and coordination with community resources. The program emphasizes care navigation, helping participants access housing, employment, educational opportunities, and social supports to foster recovery and functional independence.

A cornerstone of the FEP program is its family and youth-centered approach, recognizing that engaging and educating family members or caregivers significantly enhances recovery outcomes. The program incorporates culturally and linguistically responsive practices to ensure services are accessible and effective for BIPOC populations.

By intervening early, the FEP program aims to reduce hospitalizations, prevent long-term disability, and support participants in achieving personal, educational, and vocational goals. Services are coordinated across the behavioral health system to ensure a seamless continuum of care, reflecting BHSA's commitment to early intervention, improved behavioral health outcomes, and reducing disparities in access and treatment for individuals experiencing psychosis.

This program is part of an RFP for Sonoma County, seeking a qualified contractor to implement and operate the FEP program in alignment with BHSA goals and evidence-based practices for FEP.

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.

Table 13. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Population

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**58**
Number of Uninsured Individuals	**6**

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**8.5**
Number of Teams Needed to Serve Total Eligible Population	**2**

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for 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.

Table 14. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**8**	**8**	**8**
Total Number of Teams	**2**	**2**	**2**

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

Please list the other funding source(s)
Separate funding sources by comma
Mental Health Block Grant; Medi-Cal (FFP)

Outreach and Engagement (O&E) Program #1

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement.

Program or activity name
Sonoma County's Whole Person Care (WPC) Program

Please describe the program or activity
Sonoma County's Whole Person Care (WPC) Program provides outreach and engagement, short-term recuperative care, and intensive case management services to individuals with complex medical, behavioral health, housing, and social service needs. The program focuses on identifying and engaging eligible participants, building trust, obtaining informed consent and data-sharing authorizations, and completing comprehensive assessments and screenings to determine needs and eligibility for intensive care management.

Place-based outreach and engagement teams are strategically deployed throughout Sonoma County, including high-density urban areas and geographically remote, historically underserved communities, to identify and enroll participants in the field. WPC staff actively partner with and accept referrals from community providers and systems that frequently interact with the program's target population, including hospitals, emergency departments, community health centers, law enforcement, jails and probation, community-based organizations, shelters, supportive and low-income housing, medical respite programs, and through self-referral.

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

Table 15. Estimated Number of Individuals Served in O&E Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served

FY 2026 – 2027	**77**
FY 2027 – 2028	**77**
FY 2028 – 2029	**77**

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

Based on FY 23-24 data, clients served in FY 23-24 by WPC.

County Workforce, Education, and Training (WET) Program #1

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).

For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name

Behavioral Health Peer Training Program

Please select which of the following categories the activity falls under

Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9 (optional)

The Behavioral Health Peer Training Program is currently undergoing a Request for Proposals (RFP) to identify a provider to deliver workforce development opportunities grounded in lived behavioral health experience. The program supports system transformation and advances a recovery-oriented, consumer-driven, and holistic behavioral health system.

The program collaborates with individuals, community organizations, behavioral health providers, and system partners to expand awareness of peer roles and leadership opportunities. Targeted outreach—particularly in underserved and outlying areas—promotes equitable access to training and career pathways, addressing disparities in workforce representation.

The selected provider will recruit, train, supervise, and support individuals with lived behavioral health experience as volunteers, interns, and employees. Core components include a Medi-Cal–certified Peer Support Specialist Training Program, preparation for certification, and guidance to graduates in securing internships that enhance professional development.

The program prioritizes reducing workforce disparities by actively recruiting individuals from underrepresented communities, including communities of color, bilingual/bicultural individuals, and those with lived behavioral health experience. Ongoing mentorship, peer support groups, and education support retention, career advancement, and leadership development.

Outreach and training for community-based organizations and behavioral health providers promote peer integration, recovery-oriented practices, and workforce development strategies. By combining education, professional pathways, and sustained support, the program strengthens a diverse, skilled, and recovery-focused behavioral health workforce while advancing peer-led system transformation across the county.

County Workforce, Education, and Training (WET) Program #2

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).

For each program or activity that is part of the county's overall WET program, provide the following information.

Program or activity name: **Sonoma County's Workforce, Education, and Training (WET) activities**

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Sonoma County's Workforce, Education, and Training (WET) activities support a skilled, resilient, and culturally responsive behavioral health workforce. The goal is to make Sonoma County Behavioral Health an attractive place to work while promoting wellness, professional growth, and meaningful, client-centered care.

WET trainings strengthen clinical excellence, evidence-based practices, and trauma-informed, culturally responsive frameworks for staff at all levels, including clinical, peer, and support roles. Trainings cover staff development and practices such as Strengths Model Care Management, Family Systems, EMDR, CBT for Psychosis and Depression, Cognitive Behavioral Social Skills Training, DBT, Trauma-Focused CBT, Assertive Community Treatment, Harm Reduction, Seeking Safety, Motivational Interviewing, and Psychopharmacology for non-medical staff.

Culturally responsive practices are integrated throughout, emphasizing collaboration with peers in the workforce, cultural humility, LGBTQIA+ client considerations, and adapting evidence-based systems to community needs ("fidelity vs. fit"). Peer-based and lived-experience approaches, including WRAP and Transformative Mutual Aid, further strengthen a workforce reflective of the communities served.

To address workforce disparities, WET promotes recruitment, retention, and advancement of staff from underrepresented communities, integrates equity and implicit bias training, and supports mentorship and professional development. By investing in education, skill-building, cultural responsiveness, equity, and wellness, BHSA WET advances BHSA goals of workforce development, reducing disparities, and delivering high-quality, community-based behavioral health services.

County Workforce, Education, and Training (WET) Program #3

Program or activity name: **Crisis Intervention Training (CIT)**

Please select which of the following categories the activity falls under:
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Crisis Intervention Training (CIT) is a Behavioral Health Services Act (BHSA)–aligned training program for local law enforcement and first responders in Sonoma County. The program supports BHSA goals by strengthening cross-system collaboration, promoting early identification and intervention, and improving equitable responses to individuals experiencing mental health crises, including those with potentially severe and disabling mental illness.

CIT is conducted biannually and focuses on engaging and educating first responders in trauma-informed, recovery-oriented, and culturally responsive approaches to crisis response. The training equips law enforcement and emergency personnel with practical tools, knowledge, and access to behavioral health resources that enhance safe de-escalation, appropriate referral, and diversion from unnecessary emergency department visits or incarceration when clinically appropriate.

Through structured learning and direct engagement, participants build awareness of local behavioral health services and strengthen coordination with community-based providers. Site visits and tours of mental health and community-based organizations are incorporated to foster relationships, improve system navigation, and increase understanding of available behavioral health supports. This integrated approach advances BHSA priorities by improving continuity of care, reducing disparities, and promoting effective community-based crisis response across Sonoma County.

Capital Facilities and Technological Needs (CFTN) Program #1

Project name: **Avatar by Netsmart Technologies**
Please select the type of project: **Technological needs project**
If Technological Needs Project, please select the focus area(s) of the project **Electronic health record system**
Please describe the project: **In Sonoma County Behavioral Health, Avatar, provided by Netsmart Technologies, has historically served as the primary Electronic Health Record (EHR) system for documenting and managing mental health and substance use disorder services within the Department of Health Services. Avatar is a comprehensive behavioral health EHR used for client demographics, clinical documentation, treatment planning, scheduling, billing, reporting, and case management, supporting coordinated care and regulatory compliance.**

Sonoma County Behavioral Health has begun transitioning to Netsmart's SmartCare as its new primary EHR system. SmartCare is a modern, cloud-based platform designed to enhance usability, interoperability, data reporting, and care coordination across behavioral health programs. As part of this phased implementation, Avatar will remain in use for a limited period of time to support continuity of care, historical data access, and program operations during the transition.

Maintaining both systems temporarily allows the County to ensure a smooth and stable migration of data, workflows, and users while minimizing service disruptions. This transition reflects Sonoma County Behavioral Health's commitment to improving

technology infrastructure, supporting clinical and administrative efficiency, and strengthening data-driven decision-making and quality improvement efforts.

Full Service Partnership Program

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

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

Table 16. Estimated Number of Individuals Eligible for Full Service Partnership Services

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**973**
Number of Uninsured Individuals	**128**
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**383**

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

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

Table 17. Estimated Number of Individuals Eligible for ACT

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**137**
Number of Uninsured Individuals	**18**

Table 18. Estimated Number of Individuals Eligible for FACT

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	**68**
Number of Uninsured Individuals	**9**

Table 19. Estimated Number of Teams Needed to Serve Total Eligible Population

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**30**
Number of Teams Needed to Serve Total Eligible Population	**3**

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.

Table 20. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**12**	**20**	**20**
Total Number of Teams	**2**	**3**	**3**

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

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

Table 21. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams Needed to Serve Total Eligible Population

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	768
Number of Uninsured Individuals	101

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	35
Number of Teams Needed to Serve Total Eligible Population	7

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.

Table 22. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	19	25	25
Total Number of Teams	4	5	5

High Fidelity Wraparound (HFW) Eligible Population

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

Note: HFW guidance is forthcoming; DHCS will provide these estimates in accordance with HFW guidance.

Table 23. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**175**
Number of Uninsured Individuals	**34**

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**66**
Number of Teams Needed to Serve Total Eligible Population	**3**

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.

Table 24. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**26**	**30**	**30**
Total Number of Teams	**10**	**12**	**12**

Individual Placement and Support (IPS) Eligible Population

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

Table 25. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population	Estimates

Number of Medi-Cal Enrolled Individuals	**1445**
Number of Uninsured Individuals	**190**

IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**102.5**
Number of Teams Needed to Serve Total Eligible Population	**41**

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.

Table 26. Total Number of IPS Practitioners and Teams

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	**4**	**20**	**20**
Total Number of Teams	**2**	**8**	**8**

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

Sonoma County is actively working on training efforts to ensure practitioners are equipped to deliver more than one evidence-based practice (EBP). This includes cross-training staff in multiple EBPs, such as Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), to ensure sufficient capacity and flexibility to respond to changing service needs and demands within Full Service Partnership (FSP) programs.

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

Sonoma County employs a whole-person, trauma-informed approach by investing in workforce development, equity initiatives, and leadership practices that strengthen partnerships with families and individuals' natural supports. Staff receive ongoing training in trauma-informed care, peer-led services, and evidence-based modalities to address behavioral health, physical health, and social needs in a coordinated, person-centered way. Collaboration with families, caregivers, and other natural supports is central to recovery and wellness.

To support staff amid challenges like budget uncertainty and staffing pressures, Sonoma County prioritizes trauma-informed leadership. The Principles into Practice series provides reflective spaces for staff to explore trauma-informed principles at personal, team, and system levels to foster mutual support, trauma-informed supervision, and staff retention.

The County has also launched a department-wide Equity Circle, opened a Latinx Clinic, and trained staff on equity foundations, while continuing to identify ways to integrate trauma-informed and equity-centered practices across DHS-BHD programs and services.

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

Sonoma County is dedicated to reducing disparities among Full-Service Partnership (FSP) participants through targeted outreach, culturally responsive services, and equity-focused program design. The County actively monitors participation and outcomes across demographic groups to identify and address gaps in access, engagement, and service delivery.

Community Mental Health Centers (CMHCs) provide outreach, engagement, and outpatient specialty mental health services to adults across four regionally based areas of the County. In addition to serving geographically isolated adults with serious mental illness, CMHCs support individuals who are homeless, those with co-occurring substance use disorders, and racially and ethnically diverse communities that have historically been underserved. Sonoma County has also implemented initiatives to hire more bilingual and culturally responsive staff and opened a dedicated Latinx Clinic to better serve the Latinx community.

FSP participants are encouraged to utilize FSP-funded Peer Wellness Center(s) (currently under RFP) for peer support and advocacy services and have access to the Client & Family Support Program, which provides behavioral health navigation, education, outreach, and support to strengthen caregiving and improve access to services. For Transition Age Youth (TAY), the TAY Full-Service Partnership Program (TAY-FSP) (currently under RFP) offers wraparound services, including engagement, independent living supports, linkage to care, and access to education, career, mentoring, and housing resources. Families are connected to the Family & Client Education Support Program (currently under RFP), providing education, advocacy, and peer support through workshops, peer-to-peer support, and outreach to strengthen resilience and system navigation.

Workforce development, including trauma-informed care, cultural humility, and peer-led approaches, further supports equitable engagement and care. Together, these strategies aim to remove barriers, enhance access, and ensure all FSP participants, and their families have equitable opportunities for recovery, wellness, and meaningful community integration.

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
Care experience
Engagement in school
Engagement in work
Overdoses
Prevention of co-occurring physical health conditions
Quality of life
Social connection
Suicides

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

Sonoma County Behavioral Health provides ongoing engagement to individuals receiving Full-Service Partnership (FSP) Intensive Case Management (ICM) through personalized, flexible, and culturally responsive strategies. Case managers and FSP teams maintain frequent, proactive contact with participants through in-person visits, phone check-ins, and digital communication to promote continuity of care, trust, and sustained engagement. Sonoma County is actively working to hire additional staff in order to maintain low staff-to-client ratios, which supports individualized, intensive, and relationship-based care.

FSP participants are encouraged to access FSP-funded Peer Wellness Center(s) (currently under RFP), which offer peer support, advocacy, and opportunities for social connection. The Client & Family Support Program provides ongoing behavioral health navigation, education, outreach, and support to participants and their families, strengthening caregiving and improving access to services. Transition Age Youth (TAY) participants receive enhanced engagement through the TAY Full-Service Partnership Program (TAY-FSP) (currently under RFP), which delivers wraparound services including independent living supports, linkage to care, and access to education, career, mentoring, and housing resources.

Engagement efforts are further strengthened through trauma-informed and culturally responsive practices, including initiatives to hire bilingual staff, support practitioners with lived experience, and provide peer-led services. These strategies ensure that FSP ICM participants remain actively connected to services, supported in their recovery, and engaged in meaningful community integration.

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.)

Sonoma County is assessing current Full-Service Partnership (FSP) Intensive Case Management (ICM) teams to determine readiness for transition to Assertive Community Treatment (ACT) where clinically appropriate. This assessment includes evaluation of caseload size, staffing ratios, service intensity, and participant acuity. Where feasible, the County will transition existing FSP ICM teams to ACT models to ensure individuals with the highest needs receive the appropriate level of multidisciplinary, field-based care.

Program expansion and restructuring will be guided by data on service utilization, outcomes, and equity considerations to ensure access to the required level of care across Sonoma County. While the County remains committed to expanding services and reducing caseloads, funding limitations and challenges in hiring and retaining qualified staff continue to affect the pace and scale of implementation.

To support compliance with FSP requirements, Sonoma County will prioritize workforce development, including training in ACT fidelity, trauma-informed care, cultural responsiveness, and team-based service delivery. Ongoing quality improvement and fidelity monitoring will ensure programs meet required FSP levels of care while balancing fiscal realities and workforce capacity and maintaining person-centered, recovery-oriented services that promote housing stability, wellness, and community integration.

Please indicate whether the county FSP program will include any of the following optional and allowable services
No

Primary substance use disorder (SUD) FSPs
No

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

Other recovery-oriented services
No

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

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

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

To ensure that Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of eligible children and youth who are in, or at risk of being in, the juvenile justice system, Sonoma County's Behavioral Health Division engaged in a comprehensive, multi-faceted planning and development process. This included review of local and state-level data on juvenile justice involvement, behavioral health needs, and service utilization, as well as analysis of disparities related to race, ethnicity, and geography.

The County engaged a broad range of stakeholders including juvenile justice partners, the Sonoma County Office of Education, Child Welfare Services, community-based organizations such as VOICES (a youth-led, peer-driven program for transition-age youth with severe mental health challenges), and Behavioral Health providers from the TAY FSP team to better understand system gaps, barriers to engagement, and opportunities for early intervention. Input was gathered through stakeholder meetings, BHSA Steering Committee and stakeholder forums, and cross-system collaborations such as Sonoma County's Stepping Up Committee. These activities highlighted the complex and intersecting needs of justice-involved and at-risk youth, including trauma exposure, family disruption, housing instability, and unmet behavioral health needs.

Insights from this planning process informed the development of FSP services that emphasize intensive, wraparound, and youth-centered approaches. Programs are designed to be trauma-informed, culturally responsive, and developmentally appropriate, with a strong focus on engagement, family involvement, and coordination with education and child-serving systems. Ongoing stakeholder engagement, data review, and quality improvement processes continue to guide implementation, ensuring FSP services remain responsive to the evolving needs of justice-involved children and youth while promoting diversion, stability, recovery, and long-term positive outcomes.

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

To ensure that Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of eligible children and youth who identify as Lesbian, Gay, Bisexual, Transgender, Queer, and Plus (LGBTQ+), the Department of Health Services – Behavioral Health Division (DHS-BHD) engaged in a

comprehensive, multi-faceted planning and development process. The County reviewed available behavioral health, utilization, and disparities data related to LGBTQ+ children and youth, and incorporated findings from stakeholder surveys, community discussions, and system planning efforts to identify service gaps, barriers to engagement, and areas for improvement.

The County engaged a broad range of stakeholders to ensure LGBTQ+ perspectives were meaningfully represented in FSP program design. This included collaboration with Positive Images, an LGBTQIA+ community center providing mental health support, advocacy, and education, which participated in BHSA Steering Committee meetings, the Suicide Prevention Alliance, and other stakeholder forums. Input was also gathered through BHSA stakeholder meetings and cross-system discussions to better understand the behavioral health needs, trauma experiences, and service access challenges faced by LGBTQ+ children and youth.

Insights from this engagement informed the development of FSP services that are trauma-informed, culturally responsive, and youth-centered, with an emphasis on affirming care, family engagement when appropriate, and coordination with community-based supports. Ongoing stakeholder engagement, data review, and quality improvement activities continue to guide implementation, ensuring that FSP services remain responsive to the evolving needs of LGBTQ+ children and youth and support equity, safety, and positive behavioral health outcomes.

In the child welfare system

To ensure that Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of eligible children and youth who are in, or at risk of being in, the child welfare system, the DHS-BHD engaged in a comprehensive, multi-faceted planning and development process. The County reviewed behavioral health and child welfare data, distributed stakeholder surveys, and engaged in cross-system planning through stakeholder meetings and workgroups to better understand service gaps, barriers to engagement, and the complex needs of children and youth involved in child welfare. Key informant interviews were conducted with subject matter experts from Child Protective Services, Behavioral Health, and other child-serving systems to inform program design.

Input was also gathered through Sonoma County's BHSA Steering Committee and BHSA stakeholder meetings, as well as community forums, to ensure diverse perspectives were represented. These activities provided critical insights into the behavioral health needs, trauma exposure, and service coordination challenges faced by children and youth in the child welfare system. Findings from this process guided the development of FSP services that are trauma-informed, culturally responsive, and youth-centered, with a strong emphasis on family engagement, care coordination, and collaboration with child welfare partners.

This approach ensures that FSP services integrate intensive behavioral health supports with education, social services, and other natural supports, aligning with BHSA Early Intervention goals to prevent the onset or escalation of mental health conditions, reduce self-harm and suicide risk, and promote resilience, stability, and long-term recovery for children and youth involved in the child welfare system.

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

To ensure that Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of eligible older adults, the County engaged in a comprehensive planning process that included review of behavioral health utilization data, demographic trends, and service outcomes. DHS-BHD worked closely with Sonoma County's Older Adult Intensive Team (OAIT) to gather data and input on BHSA services, service gaps, and the behavioral health needs of older adults.

Stakeholder input was gathered through surveys, workgroups, and BHSA Steering Committee and stakeholder meetings, along with key informant interviews with Human Services Department and aging services partners. To ensure older adult perspectives were represented, the County partnered with the Council on Aging and included their participation on the BHSA Steering Committee.

These efforts informed the development of trauma-informed, age-appropriate FSP services that integrate behavioral health supports with care coordination, social

connection, and community-based resources. This approach aligns with BHSA Early Intervention goals to reduce isolation, prevent escalation of mental health conditions, and promote recovery, resilience, and quality of life for older adults.

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

To ensure Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of LGBTQ+ adults, DHS-BHD conducted a multi-faceted planning process, reviewing behavioral health utilization and disparities data and gathering input through surveys, community discussions, and system planning.

Stakeholders, including Positive Images, a local LGBTQIA+ community center participated in BHSA Steering Committee meetings, the Suicide Prevention Alliance, and other forums to provide expertise on mental health needs, trauma, and access barriers. Additional input was collected through BHSA stakeholder meetings and cross-system discussions.

These insights informed the development of trauma-informed, culturally responsive, and adult-centered FSP services emphasizing affirming care, participant choice, and coordination with community supports. Ongoing stakeholder engagement, data review, and quality improvement continue to ensure FSP services remain responsive to the evolving needs of LGBTQ+ adults and promote equity, safety, and positive behavioral health outcomes.

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

To ensure that Sonoma County's Full-Service Partnership (FSP) program addressed the unique needs of eligible adults who are in, or at risk of being in, the justice system, Sonoma County's Behavioral Health Division engaged in a comprehensive, multi-faceted planning and development process. This included review of local and state-level data on justice system involvement, behavioral health needs, and service utilization among adults, as well as analysis of disparities related to race, ethnicity, and geography.

The County engaged a broad range of stakeholders including staff from the County's Forensic Assertive Community Treatment (FACT) team, Adult FSP's Teams, Wellness Center staff, Substance Use Disorder (SUD) Team, community-based organizations like West County Community Centers, NAMI, Latino Service Providers, Buckelew, Sherrif's Office, and other stakeholders to better understand system gaps, barriers to engagement, and opportunities for intervention. Input

was gathered through stakeholder meetings, BHSA Steering Committee and stakeholder forums, focus group discussions held at the Wellness Centers, and cross-system collaborations such as Sonoma County's Stepping Up Committee. These activities highlighted the complex and intersecting needs of justice-involved and at-risk adults, including trauma exposure, housing instability, co-occurring substance use, and unmet behavioral health needs.

Insights from this planning process informed the development of FSP services that emphasize intensive, wraparound, and adult-centered approaches. Programs are designed to be trauma-informed, culturally responsive, and person-centered, with a strong focus on engagement, care coordination, and integration with community and justice system supports. Ongoing stakeholder engagement, data review, and quality improvement processes continue to guide implementation, ensuring FSP services remain responsive to the evolving needs of justice-involved adults while promoting diversion, stability, recovery, and long-term positive outcomes.

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

Drug Abuse Alternatives Center (DAAC) – Opioid Settlement Funds Grant Contract, and DMC-ODS contract

West County Community Health Center (WCHC) – FQHC grant contracts and DMC
Santa Rosa Community Health Center (SRCH) – FQHC grant contract
-ODS contract
Santa Rosa Treatment Program (SRTP) OTP / NTP

Program descriptions

DAAC:

Mobile Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP) Vehicle: The provider is in the process of securing a U.S. Drug Enforcement Administration (DEA) inspection for its mobile Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP) vehicle, which will be affiliated with its existing brick-and-mortar clinic. Approval and implementation are projected by the end of May 2026. The mobile unit will serve key locations that support individuals experiencing homelessness, including The Living Room, Mary Isaak Center, and Catholic Charities shelter sites, and will also provide services at local residential treatment facilities to expand access to Medication-Assisted Treatment (MAT). The mobile unit will not dispense methadone, but it will offer other U.S. Food and Drug Administration (FDA)-approved MAT medications and will prescribe and administer medication in the field, return to sites weekly, and support linkage to the brick-and-mortar DAAC REAP NTP/OTP facility.

Outreach Van ("WOW Van"): The outreach van will provide data-driven outreach in the community to advance racial equity, regional equity, and other priorities identified through public health data analysis. The van is currently operating in the community, and additional grant funding prior to July 1, 2026 will support procurement of a new vehicle and the addition of a dedicated outreach manager to expand services. The WOW Van serves encampments and other areas with high rates of substance use disorder and provides syringe exchange services, safer use supplies (including pipes), naloxone, and fentanyl test strips. It will also expand services to more geographically distant areas such as Cloverdale and Healdsburg, improving regional access to MAT and harm reduction services.

WCHC:

Partnering contracts with WCHC. These contracts leverage public health data for overdose and ED visits identifying West County, in particular the Russian River area as an area of focus. This area is the highest geographic need in terms of regional equity for overdose support. WCHC is enhancing SUD treatment

infrastructure and rapid access to MAT by developing a peer workforce pipeline, developing new rapid referral processes for MAT to establish same day treatment and access, funding a portion of addiction medicine fellowship doctors, and engaging in targeted outreach. Extensive outreach in rural areas with members that are unable to make it to the clinic sites and meet persons where they are in the community is part of the effort.

SRCH:

A partnering contract with SRCH and Sonoma County Department of Health Services (DHS) funding a special populations SUD case manager and providing some funding for addiction medicine fellowship doctor. In addition to street medicine team and addiction fellowship work that is funded also includes outreach to other hospitals, jails, unsheltered, recently, post incarceration discharges, and youth populations as an area of focus for SUD. The funded case manager deploys alongside street medicine and all sites in the community and works to coordinate complex referrals for buprenorphine inductions, enrollment, retention, and also supports harm reduction services. Harm reduction services include prescribing clean syringes, accepting disposal, fentanyl test strips, dispensing Naloxone. Mobile clinics at shelters also provide STI testing, wound care, and other medical services. This contract leverages public health data for overdose deaths and ED visits being among the highest in region in terms of volume and in terms of identified regional equity needs.

Street Medicine Team (Both SRCH and WCHC programs partnership and County funding):

Mobile clinics and street medicine clinics in rotation at key areas including:

- **Sam Jones Hall (Homeless Shelter): 2x / week**
- **Eliza's Village (Homeless Shelter): 1x / week**
- **Mickey Zane (Homeless Shelter): 2x / Month**
- **Sage Commons (Permanent Supportive Housing) 2x / month**
- **Saint Vincent De Paul Commons (Permanent Supportive Housing) 2x / month**
- **Catholic Charities Drop-in Center (Homeless Services Center) Parking Lot: 1x / week**
- **Street medicine clinic pilot: rotating locations typically 1x / week**

Prescribers will go out in the community at areas unsheltered persons gathered in cities, encampments, and even meeting individual persons whenever appointment slots are not being utilized. Providers can do same day prescription of MAT medications and case managers can assist to access a prescription that day when clinically indicated. They will titrate and monitor doses appropriately and provide services at these sites or in the community and work toward getting members in stabile settings and transferring to services a brick and mortar location either at the FQHC or an OTP / NTP program.

Addiction Medicine Fellowship Addiction Spots (Both SRCH and WCHC programs partnership and County funding) (Addiction Medicine Fellowship)

- **Sutter Santa Rosa Regional Hospital (Inpatient Medicine Attending/Addiction Medicine Consultation Service)**
- **Santa Rosa Community Health - Vista Campus (New Beginnings, Precepting)**
- **Santa Rosa Community Health - Caritas Campus (Primary Care, homeless outreach and MAT clinics)**
- **Santa Rosa Community Health - Lombardi Campus (MAT clinic)**
- **West County Health Center - Third Street House (Healthcare for the Homeless)**
- **West County Health Center - Russian River Health Center (Psychiatry)**
- **Drug Abuse Alternative Center - DAAC REAP (Community-based MAT/methadone treatment)**

A hospital liaison case manager meets monthly with substance use navigators and local SUD providers and addiction medicine fellows. In many cases addiction medicine fellow start medications in the hospital / ED setting and then see them in local sites in the community in their normal site rotation. This promotes better continuity of services for members needing care.

Current funding source

Measure O funding: a Sonoma County tax to fund behavioral health services for WCHC & SRCH programs
Opioid Settlement Funds: DAAC and WCHC programs
DMC Funding: DAAC REAP and SRTP (NTP / OTP sites)

BHSA changes to existing programs to meet BHSA requirements

At this time, the Sonoma County Department of Health Services (DHS) cannot provide or guarantee same-day access to medication for opioid use disorder with methadone through a Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP). DHS will work to leverage and strengthen partnerships with contracted NTP/OTP providers, including the Drug Abuse Alternatives Center, Recovery and Prevention (DAAC REAP) program and Santa Rosa Treatment Program (SRTP), to move toward meeting these requirements. DHS plans to engage providers through quarterly contract meetings for the remainder of the fiscal year and conduct additional planning discussions to support implementation prior to the June 30, 2029 deadline.

In addition, current grant-funded work with Federally Qualified Health Centers (FQHCs) includes developing improved referral processes and case management supports that will help expedite access to methadone through local NTP/OTP programs. While specific intake or structural changes within the NTP/OTP programs have not yet been finalized, DHS will continue working with providers to implement necessary system improvements and achieve compliance by the 2029 deadline.

Expected timeline of operation

The County anticipates meeting all program requirements no later than June 30, 2029. The mobile Narcotic Treatment Program (NTP) operated through the Drug Abuse Alternatives Center (DAAC) Recovery, Engagement, and Access Program (REAP) has a projected launch date of May 2026, expanding field-based access to treatment services. Enhancements to DAAC's mobile outreach van will be implemented during the current fiscal year, with continued process refinements planned for Fiscal Year 2026–27 to optimize service delivery and outreach effectiveness.

All grant-funded initiatives include sustainability plans designed to support ongoing operations, with the goal of achieving full program sustainability prior to June 30, 2029.

Mobile-field based programs

Existing programs

Drug Abuse Alternatives Center (DAAC) – Opioid Settlement Funds Grant Contract, and DMC-ODS contract

Program descriptions

The DAAC Outreach Van, known as the "WOW Van," provides data-driven, community-based outreach designed to advance racial equity, regional equity, and public health priorities identified through local data analysis. The WOW Van is currently operating in the community and delivers low-barrier harm reduction and substance use disorder (SUD) prevention services in areas with the highest demonstrated need.

The van primarily serves people experiencing homelessness and individuals in high-risk SUD impact zones, offering syringe exchange services, safer-use supplies (including pipes), naloxone distribution, and fentanyl test strips to reduce overdose risk and prevent the spread of infectious disease. Services are provided using a harm reduction framework that prioritizes dignity, safety, and trust.

Grant funding beginning prior to July 1, 2026, will support the purchase of a new outreach van and the addition of a dedicated Outreach Manager, expanding capacity and strengthening program coordination, data tracking, and community engagement. With these enhancements, the WOW Van will extend services to more geographically distant and underserved areas, including Cloverdale and Healdsburg, improving regional equity and access to medications for addiction treatment (MAT) and harm reduction resources.

Through strategic deployment, culturally responsive engagement, and data-informed service delivery, the WOW Van increases access to life-saving interventions, reduces overdose risk, and connects marginalized community members to treatment and support services across the county.

Current funding source

Measure O funding: a Sonoma County tax to fund behavioral health services for WCHC & SRCH programs
Opioid Settlement Funds: WCHC programs

BHSA changes to existing programs to meet BHSA requirements

Primary BHSA changes being implemented to meet program requirements include leveraging Public Health data analysis to expand services into more

geographically distal areas, advancing regional equity, and increasing targeted outreach to priority populations to promote racial equity. These efforts align with BHSA expectations for data-driven service planning and outreach.

While the outreach van is already operational, a revised deployment schedule and new grant performance metrics will be implemented prior to June 30, 2026, with full implementation occurring during Fiscal Year 2026–27 to ensure alignment with data-driven requirements.

Expected timeline of operation

The deployment schedule and new grant performance metrics will be implemented prior to June 30, 2026, with full implementation occurring during Fiscal Year 2026–27 to ensure alignment with data-driven requirements.

Open-access clinics

Existing programs

Drug Abuse Alternatives Center (DAAC) – Opioid Settlement Funds Grant Contract, and DMC-ODS contract
Santa Rosa Community Health Center (SRCH) – FQHC grant contract
West County Community Health Center (WCHC) – FQHC grant contracts and DMC-ODS contract

Program descriptions

Drug Abuse Alternatives Center (DAAC) Recovery, Engagement, and Access Program (REAP): provides comprehensive medications for addiction treatment (MAT), including methadone and other FDA-approved medications, to support individuals with opioid use disorder. REAP is designed as a low-barrier entry point into care, meeting participants where they are and prioritizing engagement, safety, and continuity of treatment. In addition to MAT services, the program offers on-site harm reduction services that reduce overdose risk, prevent the transmission of infectious diseases, and build trust with individuals who may not yet be ready to engage in formal treatment. By integrating treatment and harm reduction in a single setting, REAP supports sustained engagement and improved health outcomes.

Key services include:

- **Medications for addiction treatment, including methadone and other FDA-approved options**
- **On-site syringe exchange and safer-use supplies**
- **Low-barrier, harm reduction–focused engagement**

Santa Rosa Community Health's Caritas Campus: provides integrated primary care, homeless outreach, and medications for addiction treatment in a setting designed to be accessible and responsive to individuals with complex health and social needs. Services are available through both drop-in access and scheduled appointments, allowing flexibility for individuals who face barriers to consistent care. The Caritas Campus offers full-scope primary care alongside MAT, ensuring that patients can address acute and chronic medical conditions while also receiving treatment for substance use disorders. This integrated approach supports continuity of care, improves health stability, and reduces reliance on emergency services.

Services provided include:

- **First-come, first-served drop-in services and scheduled appointments**
- **Full-scope primary care**
- **Medications for addiction treatment**
- **Homeless-focused outreach and engagement**

Santa Rosa Community Health's Lombardi Campus: functions as a specialized MAT clinic while also providing comprehensive primary care services. The Lombardi Campus offers both drop-in and scheduled appointments to ensure access for individuals at varying stages of readiness and stability. By combining MAT with primary care, the clinic supports a holistic approach to recovery that addresses both physical health and substance use needs.

Services include:

- **Drop-in and scheduled MAT services**
- **FDA-approved medications for addiction treatment**
- **Full-scope primary care services**

The West County Health Center's Third Street House: is part of the Healthcare for the Homeless program, delivers low-barrier healthcare services for individuals experiencing homelessness in West County. Services are provided on a drop-in basis, reducing barriers for individuals who may not be able to maintain

scheduled appointments. Third Street House integrates primary care, behavioral health services, and medications for addiction treatment, supporting stabilization and improved access to care for a highly vulnerable population.

Key services include:

- **First-come, first-served drop-in healthcare**
- **Primary care and behavioral health services**
- **Medications for addiction treatment offered multiple days per week**

Current funding source

Measure O funding: a Sonoma County tax to fund behavioral health services for WCHC & SRCH programs
Opioid Settlement Funds: WCHC programs

BHSA changes to existing programs to meet BHSA requirements

Sonoma County will continue to leverage existing funding and contractual relationships to ensure compliance with Behavioral Health Services Act (BHSA) requirements while strengthening access to addiction medicine services across the continuum of care. The County currently supports addiction medicine services at both brick-and-mortar Federally Qualified Health Centers (FQHCs), including Santa Rosa Community Health (SRCH) and West County Health Center (WCHC), as well as through rotating clinics embedded in community settings such as shelters and supportive housing sites. This approach ensures low-barrier, geographically distributed access to care for individuals with substance use disorders.

While Sonoma County meets current BHSA requirements, planned program enhancements will focus on expanding access points and reducing wait times for treatment, particularly within Narcotic Treatment Program (NTP) and Opioid Treatment Program (OTP) settings. The County will work with existing contracted providers, including Drug Abuse Alternatives Center (DAAC) and Santa Rosa Treatment Program (SRTP), Sonoma County's second OTP/NTP site, to increase service capacity, improve intake efficiency, and shorten time to initiation of care. These changes are intended to strengthen system responsiveness, improve treatment engagement, and ensure timely access to evidence-based addiction medicine services in alignment with BHSA priorities.

Expected timeline of operation

The Department of Health Services (DHS) will meet all program requirements no later than June 30, 2029. The mobile Narcotic Treatment Program (NTP) operated through the Drug Abuse Alternatives Center (DAAC) Recovery, Engagement, and Access Program (REAP) is projected to launch in May 2026, expanding field-based treatment capacity. Enhancements to DAAC's mobile outreach van will be implemented during the current fiscal year, with additional process refinements planned for Fiscal Year 2026–27 to optimize service delivery and performance.

All grant-funded initiatives include sustainability plans designed to support ongoing operations, with the objective of achieving full program sustainability prior to June 30, 2029.

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

New programs

The Drug Abuse Alternatives Center (DAAC) outreach van ("WOW Van") expansion represents an enhancement to an existing program, while the mobile Narcotic Treatment Program / Opioid Treatment Program (NTP/OTP) services are new program additions.

Program descriptions

DAAC Outreach Van ("WOW Van"):

The DAAC Outreach Van ("WOW Van") provides data-driven community outreach to advance racial equity, regional equity, and access to substance use disorder (SUD) services, as identified through public health data analysis. While the outreach van is currently operating in the community, grant funding beginning prior to July 1, 2026 will support the acquisition of a new vehicle and the hiring of a dedicated Outreach Manager to expand and strengthen program capacity.
The WOW Van serves homeless encampments and areas with high SUD prevalence, delivering harm reduction and overdose prevention services, including syringe exchange, safer-use supplies (e.g., pipes), naloxone distribution, and fentanyl test strips. In addition, the van will expand services to outlying and underserved communities, such as Cloverdale and Healdsburg, improving regional equity and access to medications for addiction treatment (MAT) and harm reduction services across Sonoma County.

DAAC Mobile NTP / OTP Vehicle:

DAAC is in the process of launching a Mobile Narcotic Treatment Program / Opioid Treatment Program (NTP/OTP) vehicle affiliated with its existing brick-and-mortar DAAC REAP NTP/OTP facility. The mobile unit is currently undergoing DEA inspection, with projected approval and implementation by May 2026. Once operational, the mobile NTP/OTP unit will deliver field-based MAT services at key community locations that serve individuals experiencing homelessness, including The Living Room, Mary Isaak Center, and Catholic Charities shelter sites, as well as selected residential treatment facilities to further expand access to care. The unit will prescribe and administer FDA-approved MAT medications (excluding methadone), provide weekly site visits, and serve as a direct linkage to ongoing care at the DAAC REAP NTP/OTP brick-and-mortar program.

Planned funding

Measure O funding: a Sonoma County tax to fund behavioral health services for WCHC & SRCH programs
Opioid Settlement Funds: DAAC and WCHC programs
DMC Funding: DAAC REAP and SRTP (NTP / OTP sites)

Planned operations

Sonoma County's new Assertive Field-Based SUD Treatment Services will be implemented through a combination of expanded outreach operations and new mobile treatment services operated by the Drug Abuse Alternatives Center (DAAC). Together, these efforts will provide targeted, field-based engagement and treatment access for individuals experiencing homelessness and others with high substance use disorder (SUD) needs, particularly in underserved and geographically isolated areas.

The DAAC Outreach Van ("WOW Van") represents an expansion of an existing program. Operations will continue to be guided by public health data to prioritize locations with high SUD prevalence and unmet need, with a focus on advancing racial equity and regional equity. Beginning prior to July 1, 2026, grant funding will support the purchase of a new outreach vehicle and the addition of a dedicated Outreach Manager to enhance operational capacity, coordination, and reach.

The WOW Van will conduct regular, targeted outreach at homeless encampments and other high-need community locations, delivering harm reduction and overdose prevention services, including syringe exchange, safer-use supplies, naloxone, and fentanyl test strips. Expanded operations will allow the van to reach outlying communities such as Cloverdale and Healdsburg, improving access to harm reduction services and medications for addiction treatment (MAT) for residents who face geographic and transportation barriers to care.
In addition, DAAC will implement new Mobile Narcotic Treatment Program / Opioid Treatment Program (NTP/OTP) services as a program addition. The mobile NTP/OTP unit, affiliated with DAAC's existing REAP NTP/OTP brick-and-mortar facility, is currently undergoing DEA inspection, with anticipated approval and launch by May 2026. Once operational, the mobile unit will deliver assertive, field-based MAT services directly to individuals who are unlikely to access traditional clinic-based care.

Planned operations include weekly site visits to key community locations that serve individuals experiencing homelessness, such as The Living Room, Mary Isaak Center, and Catholic Charities shelter sites, as well as selected residential treatment facilities. The mobile unit will prescribe and administer FDA-approved MAT medications (excluding methadone) in the field and provide direct linkage and continuity of care with DAAC's brick-and-mortar NTP/OTP program.
Together, the expanded WOW Van outreach and the new mobile NTP/OTP services will function as a coordinated, assertive field-based model that engages high-need populations, reduces barriers to treatment, and improves access to timely, evidence-based SUD care across Sonoma County.

Expected timeline of implementation

- **FY 2025–26: The DAAC Outreach Van ("WOW Van") will continue current operations while preparatory activities take place, including public health–informed site planning, procurement of a new outreach vehicle, and recruitment of a dedicated Outreach Manager to support program expansion.**

- **FY 2026–27: Expanded WOW Van operations will launch with the new vehicle and Outreach Manager in place, increasing outreach coverage to high-need areas and extending services to outlying communities such as Cloverdale and Healdsburg. DAAC's Mobile NTP/OTP vehicle is expected to receive DEA approval and complete final inspections.**

- **By May 2026: Mobile NTP/OTP services will be implemented, initiating weekly field-based MAT service delivery at identified homeless service sites and selected residential treatment facilities.**

- **FY 2027–29: Program maturation, ongoing evaluation, coordination with community partners, and adjustments based on service utilization and community need.**

Mobile-field based programs

New Programs:

The DAAC Outreach Van ("WOW Van") expansion represents an enhancement to an existing program, while the mobile NTP/OTP services are new program additions.

Program descriptions:

Sonoma County Department of Health Services plans to expand mobile-field based services to increase access to addiction treatment and harm reduction for populations facing geographic, transportation, and structural barriers to care. These efforts include the expansion of the Drug Abuse Alternatives Center (DAAC) Outreach Van, known as the "WOW Van," and the implementation of new mobile Narcotic Treatment Program (NTP) and Opioid Treatment Program (OTP) services. Together, these initiatives represent a strategic shift toward a more flexible, responsive, and equity-focused service delivery model.

The WOW Van expansion builds on an existing, successful mobile harm reduction program that provides low-barrier, community-based services in areas identified through public health and equity data. The expanded program will increase service capacity, geographic reach, and staffing to better serve people experiencing homelessness and individuals in areas with high substance use–related harm. Services provided through the WOW Van include syringe exchange, safer-use supplies, naloxone distribution, fentanyl test strips, and engagement for referral to treatment and supportive services. This expansion is designed to strengthen racial and regional equity by extending services to underserved and rural areas and reducing barriers for individuals who may not access traditional clinic-based settings.

In addition, Sonoma County will implement new mobile NTP/OTP services to complement existing brick-and-mortar treatment sites. DAAC is currently completing federal inspection of its mobile NTP/OTP unit with the Drug Enforcement Administration, with projected approval and implementation by May 2026. The mobile unit, affiliated with DAAC's licensed brick-and-mortar Recovery, Engagement, and Access Program (REAP) NTP/OTP facility, will expand field-based access to FDA-approved medications for addiction treatment (excluding methadone). The mobile NTP/OTP will provide initiation and administration of medications in community settings, weekly site-based follow-up, services at homeless service locations including The Living Room, Mary Isaak Center, and Catholic Charities shelters, and support for residential treatment facilities to improve continuity of care. Participants will also be linked to ongoing treatment at the DAAC REAP site, ensuring smooth transitions from outreach to structured services.

Both the WOW Van expansion and mobile NTP/OTP services are planned for implementation prior to June 30, 2026, strengthening Sonoma County's ability to meet BHSA priorities by improving access, reducing disparities, and delivering timely, evidence-based addiction treatment and harm reduction services directly in the community.

Planned funding

Program operations will be supported through a blended funding strategy including:

- **Measure O funding to support behavioral health service expansion**
- **Opioid Settlement Funds to enhance outreach and treatment infrastructure**
- **Drug Medi-Cal (DMC) reimbursement supporting DAAC REAP and Sonoma Treatment and Recovery Programs (SRTP) NTP/OTP services**

Planned operations

Sonoma County's mobile, field-based services are designed to expand access to addiction treatment and harm reduction for individuals facing geographic, transportation, or structural barriers. The initiatives include the expansion of the DAAC Outreach Van ("WOW Van") and the implementation of mobile Narcotic Treatment Program (NTP) / Opioid Treatment Program (OTP) services.

The WOW Van will provide low-barrier, community-based services informed by public health and equity data. Services include syringe exchange, safer-use

supplies, naloxone distribution, fentanyl test strips, and engagement for referral to treatment and supportive services. By extending coverage to underserved and rural areas, including Cloverdale and Healdsburg, the program strengthens regional and racial equity in harm reduction and SUD services.
The mobile NTP/OTP vehicle, affiliated with DAAC's licensed REAP NTP/OTP facility, will deliver field-based FDA-approved medications for addiction treatment (excluding methadone), initiate treatment in community settings, provide weekly follow-up, serve homeless service locations and residential treatment facilities, and link participants to ongoing care at the DAAC REAP site. These programs are coordinated with existing brick-and-mortar treatment sites to ensure continuity of care, regulatory compliance, and rapid access to treatment.

Both programs will include ongoing evaluation, community coordination, and adjustments based on service utilization, community needs, and equity considerations.

Expected timeline of implementation

- **FY 2025–26: The WOW Van will continue current operations while preparatory activities are completed, including site planning, procurement of a new vehicle, and recruitment of a dedicated Outreach Manager. DAAC's Mobile NTP/OTP vehicle is projected to receive DEA approval and complete final inspections in May 2026.**
- **By July 1, 2026: Expanded WOW Van operations will launch with the new vehicle and Outreach Manager, increasing coverage in high-need areas and extending services to outlying communities.**
- **FY 2026–29: Both mobile programs will operate continuously, with regular evaluation and program adjustments to optimize access, engagement, and equity across the county.**

Open-access clinics

New programs

No additional programs or clinic sites are planned at this time; however, Sonoma County will continue to collaborate with West County Health Centers (WCHC), Santa Rosa Community Health (SRCH), and Drug Abuse Alternatives Center (DAAC) and may develop additional sites or program expansions in the future based on demonstrated community need and funding availability.

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

Sonoma County is working to strengthen partnerships with its contracted Federally Qualified Health Center (FQHC) providers, Santa Rosa Community Health (SRCH) and West County Health Centers (WCHC).

Sonoma County's approach to meeting same-day Medication-Assisted Treatment (MAT) access requirements includes targeted investments in addiction medicine fellowship positions, street medicine teams, and community-based outreach services delivered in partnership with SRCH, Drug Abuse Alternatives Center (DAAC), and WCHC, as described in prior sections. Through these combined efforts, the County is currently able to support prescribing and same-day access to MAT medications across multiple regions and service locations.

A known system gap remains in the rapidity of access to methadone treatment through Narcotic Treatment Program / Opioid Treatment Program (NTP/OTP) services. Same-day methadone initiation continues to be challenging, and this limitation will persist even with the implementation of the planned mobile NTP/OTP unit, as the mobile service will not dispense methadone.

Sonoma County will continue to monitor and assess gaps in same-day MAT access through ongoing coordination with FQHC partners SRCH and WCHC, and with contracted NTP/OTP providers DAAC and Santa Rosa Treatment Program (SRTP). The County will track timeliness of care using data from the electronic health record system, specifically measuring the time between an initial request

for services and treatment initiation, with a target average access time of one day or less.

During quarterly meetings with contracted partners, Sonoma County will review outreach effectiveness, referral pathways, and field-based service delivery to:

- **Improve timeliness of methadone access where feasible**
- **Strengthen consistency of same-day MAT initiation**
- **Expand successful same-day connections for non-methadone MAT medications**

The County will also monitor program capacity and census levels for NTP/OTP providers through electronic health record data and required reporting from contracted FQHC partners.

If monitoring identifies ongoing gaps—particularly related to methadone access—Sonoma County will evaluate opportunities to leverage Opioid Settlement Funds to strengthen delivery systems and address unmet need. Additional funding may be deployed during Fiscal Year 2028–29 if access requirements are not fully met prior to that period.

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

- **Contract directly with MAT providers in the County**
- **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)**
- **Contract with MAT providers in other counties**

Please provide the names of other counties the contracted MAT providers are located in: **Mendocino County**

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

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
Large Gap

Housing in mobile home communities
Medium Gap

(Permanent) Single room occupancy units
Large Gap

(Interim) Single room occupancy units
Medium Gap

Accessory dwelling units, including junior accessory dwelling units
Large Gap

(Permanent) Tiny homes
Large Gap

Shared housing
Large Gap

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

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

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

License-exempt room and board
Large Gap

Hotel and Motel stays
Large 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
Large 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?

To expand housing supply and increase access to housing for BHSA-eligible individuals, Sonoma County plans to leverage a combination of local, state, and federal funding sources, as well as cross-system partnerships. Locally, the County will utilize Measure O funding to support housing stability initiatives and increase access to housing for individuals with behavioral health needs. At the state and federal levels, Sonoma County will braid funding sources to strengthen housing capacity and improve long-term housing outcomes.

The County will leverage Medi-Cal Managed Care Plans (MCPs) to provide transitional rent and housing-related supports that help individuals exit homelessness and stabilize in housing. CalAIM funding will be used to expand access to housing and support services, with a focus on increasing housing retention and reducing returns to homelessness for individuals with significant behavioral health needs. In addition, Sonoma County will utilize the Behavioral Health Bridge Housing (BHBH) Program to expand the supply of transitional housing, rental subsidies, and Sober Living Environment (SLE) subsidies, supporting individuals as they transition to permanent housing.

Through the strategic alignment of these non-BHSA funding sources, partnerships, and programs, Sonoma County will strengthen its housing

continuum and improve access, stability, and long-term housing outcomes for BHSA-eligible individuals.

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 be strategically aligned with existing local, state, and federal housing resources to strengthen and expand Sonoma County's continuum of housing supports for BHSA-eligible individuals. BHSA funding will be used to fill critical gaps that emerge when time-limited housing resources end, including the conclusion of the six-month transitional rent subsidies provided through Medi-Cal Managed Care Plans and the planned sunset of the Behavioral Health Bridge Housing (BHBH). By sustaining and scaling housing supports that have demonstrated effectiveness, BHSA will help ensure continuity of care and prevent housing instability for individuals with behavioral health needs.

BHSA funds will be leveraged to provide flexible housing assistance, including rental subsidies, security deposits, and other housing-related costs that often create barriers to housing stability or lead to returns to homelessness. These interventions will complement existing housing and homelessness response systems by supporting individuals as they transition from interim or bridge housing into permanent housing and by stabilizing those at risk of losing housing due to financial or behavioral health challenges.

Through this coordinated approach, BHSA Housing Interventions will strengthen the overall housing continuum by bridging short-term and long-term resources, increasing housing retention, and ensuring that BHSA-eligible individuals remain connected to behavioral health services and supports. This alignment will promote long-term housing stability, reduce homelessness, and support recovery and wellness across Sonoma County's behavioral health system.

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

Sonoma County's behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions is grounded in a Housing First, person-centered, and recovery-oriented approach that integrates housing with behavioral health services and supportive resources. The County prioritizes rapid access to

permanent housing while minimizing barriers to entry and ensuring individuals remain connected to ongoing mental health and substance use supports.

To strengthen system coordination and improve housing outcomes, Sonoma County is aligning the Homelessness Division more closely with Behavioral Health, creating a more integrated and cohesive approach to housing and behavioral health service delivery. This alignment supports shared planning, coordinated funding strategies, and streamlined service pathways for individuals with complex behavioral health and housing needs. The behavioral health system also works in close partnership with Managed Care Plans, housing providers, and community-based organizations to align BHSA Housing Interventions with the broader homelessness response system.

In addition, Sonoma County has released a Request for Proposals (RFP) for a Housing Interventions Administrator, which will be contracted to support implementation of BHSA Housing Interventions. This administrator will assist with coordinating housing interventions, supporting clients and housing providers, managing landlord engagement, and ensuring effective delivery of housing-related supports. The role is intended to strengthen system capacity, improve coordination across programs, and enhance housing placement and retention outcomes for BHSA-eligible individuals.

Individuals receiving BHSA Housing Interventions are supported through housing navigation, care coordination, and tenancy-sustaining services that address both behavioral health needs and practical barriers to housing stability. Flexible financial supports, including rental assistance, security deposits, and move-in costs, are used to facilitate timely placement into permanent housing and prevent housing loss.

To promote long-term retention, Sonoma County emphasizes ongoing engagement in behavioral health treatment, trauma-informed and culturally responsive services, and coordination across systems, including primary care, substance use services, and social supports. Data sharing, continuous monitoring, and cross-system collaboration are used to track housing outcomes, identify risks to housing stability, and intervene early when challenges arise. Through this integrated strategy, Sonoma County aims to increase permanent housing placements, reduce returns to homelessness, and support sustained recovery, stability, and wellness for BHSA-eligible individuals.

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)?

Sonoma County's behavioral health system promotes permanent housing placement and retention for individuals receiving BHSA Housing Interventions through a Housing First, person-centered, and recovery-oriented approach that integrates housing with behavioral health and supportive services. The County prioritizes rapid access to permanent housing while minimizing barriers and ensuring ongoing connection to mental health and substance use supports. To strengthen coordination and outcomes, Sonoma County is aligning the Homelessness Division more closely with Behavioral Health, creating a more cohesive and integrated housing and behavioral health system. The County also partners with Managed Care Plans, housing providers, and community-based organizations to align BHSA Housing Interventions with the broader homelessness response system.

In addition, Sonoma County has released an RFP for a Housing Interventions Administrator to support implementation of BHSA Housing Interventions. The contracted administrator will assist clients and housing providers, coordinate housing supports, strengthen landlord engagement, and enhance housing placement and retention outcomes for BHSA-eligible individuals. BHSA Housing Interventions include housing navigation, care coordination, tenancy-sustaining services, and flexible financial assistance such as rental support, security deposits, and move-in costs to prevent housing loss.

BHSA funds help support a range of county-run and contracted housing programs. Eliza's Village, a county-operated interim housing and support site, provides shelter, services, and pathways toward permanent housing for people with serious behavioral health conditions transitioning out of unsanctioned encampments through the Coordinated Entry process, ensuring BHSA-eligible clients can access tenant-based vouchers. Similarly, Mickey Zane Place in Santa Rosa serves medically vulnerable or high-needs individuals experiencing homelessness, providing wrap-around services including case management, health support, and assistance accessing benefits. Behavioral Health Bridge Housing at Arrowood provides interim housing coupled with behavioral health

treatment for individuals experiencing homelessness and serious behavioral health challenges, supporting stabilization and transition to permanent housing. Opportunity House, operated by Community Support Network, is a short-term residential program offering up to 60 days of housing and behavioral health support for homeless or at-risk BHSA clients.

Independent and Supported Living Services are available to BHSA clients through programs like Sonoma County Independent Living (SCIL), which assists adults with complex behavioral health needs in gaining and maintaining independent housing through case management. Intensive Case Management programs support individuals transitioning from hospital or institutional settings into community living with supportive services. The county also partners with the Felton Institute to operate Crossroads to Hope, a transitional housing program in Santa Rosa serving individuals with justice involvement and significant mental health needs.

Through this network of housing options, rental and operating supports, and integrated behavioral health services, Sonoma County aims to increase permanent housing placements, reduce returns to homelessness, and promote long-term stability, recovery, and wellness for BHSA-eligible individuals.

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

Sonoma County's behavioral health system ensures that all Housing Interventions settings provide access to clinical and supportive behavioral health care through an integrated, person-centered approach. BHSA-funded programs, including interim, transitional, and permanent supportive housing—are linked with Behavioral Health teams and community providers to deliver on-site or easily accessible mental health and substance use services.

Care is coordinated through Housing Navigation, Case Management, and Intensive Case Management programs, connecting residents to therapy, peer support, tenancy-sustaining services, and other behavioral health supports. All housing programs are integrated into the Coordinated Entry system, which prioritizes individuals with the greatest needs, ensures equitable access, and links housing placements with appropriate behavioral health services.

To maintain quality and consistency, Sonoma County is working on standardized protocols, trauma-informed and culturally responsive practices, and cross-system communication. Training and technical assistance are provided to housing staff to support recovery-oriented care.

Eligible Populations

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

Sonoma County's behavioral health system identifies BHSA-eligible individuals through Behavioral Health programs, homelessness outreach, shelters, hospitals, Coordinated Entry, and community partners. Once identified, individuals are screened using a standardized tool to assess housing stability, behavioral health needs, and risk factors for homelessness, with screenings available in multiple languages and accessible formats. Eligible individuals are then referred to appropriate BHSA Housing Interventions, including Bridge Housing, permanent supportive housing, or Independent and Supported Living programs, with case managers providing housing navigation, clinical support, and tenancy-sustaining services. Referrals and placements are coordinated across behavioral health, homelessness services, and community-based providers, and outcomes are monitored to ensure equitable access, timely placement, and long-term housing stability.

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

Yes

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

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

To ensure that Sonoma County's Housing Interventions addressed the unique needs of children and youth who were in, or at risk of being in, the juvenile justice system, the Behavioral Health system undertook a comprehensive, multi-faceted planning process. This included conducting a countywide housing gap analysis, distributing stakeholder surveys, hosting a Housing Workgroup Committee,

facilitating several housing-focused group discussions, and conducting key informant interviews with subject matter experts from the Human Services Department and Child Protective Services. In addition, two townhall meetings were held, and input was gathered through the BHSA Steering Committee, BHSA stakeholder meetings, and participation in Sonoma County's Stepping Up Committee. These activities provided a rich understanding of the housing needs, barriers, and service gaps faced by justice-involved youth, as well as strategies to enhance equity, cultural competence, and accessibility.

Behavioral Health used these insights to guide the design of Housing Interventions that linked stable housing with behavioral health, substance use, education, and social supports, ensuring services were trauma-informed, culturally responsive, and youth-centered. This approach aligned with BHSA Early Intervention goals to prevent the onset or escalation of mental health conditions, reduce suicide and self-harm, and promote resilience and recovery. Continuous engagement, feedback, and quality improvement processes were implemented to ensure that interventions remained effective, responsive, and aligned with the evolving needs of justice-involved children and youth.

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

To ensure that Sonoma County's Housing Interventions addressed the unique needs of eligible children and youth who identify as Lesbian, Gay, Bisexual, Transgender, Queer, and Plus (LGBTQ+), DHS-BHD engaged in a comprehensive, multi-faceted planning process. The county conducted a housing gap analysis, distributed stakeholder surveys, hosted a Housing Workgroup Committee, and facilitated several housing-focused group discussions. Key informant interviews were conducted with subject matter experts from the Homelessness Division and Child Protective Services to better understand systemic barriers and service gaps. The county also held two townhall meetings and gathered input through the BHSA Steering Committee and BHSA stakeholder meetings.

To ensure LGBTQ+ perspectives were represented, the county invited Positive Images, an LGBTQIA+ community center established to provide mental health support, advocacy, and education to participate in the BHSA Steering Committee, Suicide Prevention Alliance, and Housing Workgroup. These meetings provided rich insights into the housing and behavioral health needs of LGBTQ+ youth, informed strategies to enhance equity, cultural responsiveness, and accessibility,

and supported the integration of trauma-informed and youth-centered approaches into Housing Interventions.

In the child welfare system

To ensure that Sonoma County's Housing Interventions addressed the unique needs of eligible children and youth who are in, or at risk of being in, the child welfare system, the Behavioral Health system engaged in a comprehensive, multi-faceted planning process. The county conducted a housing gap analysis, distributed stakeholder surveys, hosted a Housing Workgroup Committee, and facilitated several housing-focused group discussions. Key informant interviews were conducted with subject matter experts from the Homelessness Division and Child Protective Services to better understand systemic barriers, service gaps, and the unique needs of youth involved in child welfare. The county also held two townhall meetings and gathered input through the BHSA Steering Committee and BHSA stakeholder meetings.

These activities provided rich insights into the housing and behavioral health needs of children and youth involved in the child welfare system and informed strategies to enhance equity, cultural responsiveness, and accessibility. The findings guided the integration of trauma-informed, youth-centered approaches into Housing Interventions, ensuring that services linked housing stability with behavioral health, education, and social supports in ways that align with BHSA Early Intervention goals to prevent the onset or worsening of mental health conditions, reduce self-harm and suicide risk, and promote resilience and recovery.

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

To ensure that Sonoma County's Housing Interventions addressed the unique needs of older adults, the County engaged in a comprehensive, multi-faceted planning process. The DHS-BHD conducted a housing gap analysis, distributed stakeholder surveys with support from DHS-BHD's Older Adult Intensive Team to help promote and increase participation, hosted a Housing Workgroup Committee, and facilitated several housing-focused group discussions.

Additionally, staff conducted site visits and contracted consultants to facilitate focus groups at local homeless shelters and temporary housing sites to better understand the lived experiences and needs of older adults experiencing housing instability. Key informant interviews were conducted with subject matter experts from the Human Services Department to identify systemic barriers, service gaps, and the specific housing and behavioral health needs of older adults. The county also held two townhall meetings and gathered input through the BHSA Steering Committee and BHSA stakeholder meetings.

To ensure the perspectives of older adults were fully represented, the county invited the Council on Aging, a local non-profit organization providing services to seniors aged 60 and older in Sonoma County to participate in the BHSA Steering Committee. Council on Aging brings expertise in senior housing, behavioral health, and community support, serving a county population that includes over 137,000 older adults, many of whom will rely on supportive services as the population ages.

These activities provided valuable insights into the housing and behavioral health needs of older adults and informed strategies to enhance equity, accessibility, and cultural responsiveness. The findings guided the integration of trauma-informed and age-appropriate approaches into Housing Interventions, ensuring services link housing stability with behavioral health supports, social engagement, and other essential resources. This approach aligns with BHSA Early Intervention goals to prevent the onset or escalation of mental health conditions, reduce isolation and risk of harm, and promote resilience, recovery, and quality of life for older adults.

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

To ensure that Sonoma County's Housing Interventions addressed the unique needs of adults who were in, or at risk of being in, the justice system, the Sonoma County's DHS-BHD undertook a comprehensive, multi-faceted planning process. This included conducting a countywide housing gap analysis, distributing stakeholder surveys, hosting a Housing Workgroup Committee, facilitating several housing-focused group discussions, and hiring consultants to conduct focus groups at local homeless shelters to better understand the lived experiences and needs of justice-involved adults. Key informant interviews were conducted with subject matter experts from the Human Services Department to identify systemic barriers, service gaps, and housing challenges. In addition, two

townhall meetings were held, and input was gathered through the BHSA Steering Committee and BHSA stakeholder meetings, as well as participation in Sonoma County's Stepping Up Committee. These activities provided a rich understanding of the housing and behavioral health needs, barriers, and gaps faced by justice-involved adults, and informed strategies to enhance equity, cultural competence, and accessibility.

DHS-BHD used these insights to guide the design of Housing Interventions that linked stable housing with behavioral health, substance use, social supports, and other essential services, ensuring programs were trauma-informed, culturally responsive, and adult-centered. This approach aligns with BHSA goals to prevent the onset or escalation of mental health conditions, reduce suicide and self-harm, and promote resilience and recovery. Continuous engagement, feedback, and quality improvement processes were implemented to ensure that interventions remained effective, responsive, and aligned with the evolving needs of justice-involved adults.

In underserved communities

To ensure that Sonoma County's Housing Interventions addressed the unique needs of eligible adults from underserved communities, DHS-BHD engaged in a comprehensive, equity-focused planning process. The county conducted a countywide housing gap analysis and reviewed available and disaggregated data to identify disparities impacting adults from underserved populations, including individuals experiencing homelessness, communities of color, LGBTQ+ individuals, older adults, individuals with serious mental illness, and those with co-occurring substance use conditions. Stakeholder surveys were distributed to gather input from service providers and community partners serving underserved adult populations, and a Housing Workgroup Committee was convened to identify systemic barriers, service gaps, and equity challenges in housing access.

To elevate lived experience and community voice, the county facilitated multiple housing-focused group discussions and hired consultants to conduct focus groups at local homeless shelters, prioritizing engagement with adults from underserved communities. Key informant interviews were conducted with subject matter experts from the Human Services Department and the Homelessness Division to better understand cross-system challenges related to housing instability, behavioral health access, and service coordination. The county also held two townhall meetings delivered in both English and Spanish to ensure

meaningful participation from linguistically diverse communities. Additional input was gathered through the BHSA Steering Committee and BHSA stakeholder meetings.

These activities provided critical insight into the housing and behavioral health needs, barriers, and disparities experienced by adults from underserved communities. Behavioral Health used these findings to inform the development of Housing Interventions that integrate stable housing with behavioral health care, substance use services, and supportive services in culturally responsive, trauma-informed, and accessible ways. This approach aligned with BHSA goals to prevent the onset or escalation of mental health conditions, reduce suicide and self-harm, address inequities in access and outcomes, and promote recovery, stability, and long-term wellness for adults from historically underserved communities.

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?

Sonoma County's Homeless Coalition, led by the County Department of Health Services, coordinates regional planning, policy, and housing funding for homelessness. Behavioral Health actively engages in CoC planning, data sharing, and partnerships like HomeFirst to prioritize vulnerable populations for permanent supportive, rapid rehousing, and interim housing. Through strategic planning and shared HMIS data, Behavioral Health and the CoC work together to improve coordinated entry, expand support services, and align healthcare with homelessness solutions.

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

Sonoma County's Homeless Coalition, led by the County Department of Health Services, coordinates regional planning, policy, and housing funding for homelessness. Behavioral Health actively engages in CoC planning, data sharing,

and partnerships like Home First to prioritize vulnerable populations for permanent supportive, rapid rehousing, and interim housing. Through strategic planning and shared HMIS data, Behavioral Health and the CoC work together to improve coordinated entry, expand support services, and align healthcare with homelessness solutions.

Public Housing Agency

Sonoma County collaborates closely with local Public Housing Agencies, including the Sonoma County Housing Authority, to integrate housing subsidies and vouchers with behavioral health support services. Through Coordinated Entry and cross system planning, individuals with behavioral health needs are connected to appropriate PHA resources. Joint planning ensures that affordable housing programs align with behavioral health priorities, helping those with the highest needs access housing, while ongoing coordination across human services, housing authorities, and CoC governance supports this alignment.

MCPs

The Sonoma County Behavioral Health system collaborates closely with Partnership HealthPlan of California and Kaiser Permanente, the Medi-Cal managed care plans serving county residents, to coordinate health, behavioral health, and housing supports. The County meets regularly with both MCPs to strengthen partnerships and align with a current focus on enhancing collaboration around transitional rent supports. These efforts include improving referral tracking processes, increasing effective utilization of MCP benefits, and jointly monitoring housing stability and health outcomes. This coordinated approach ensures the effective integration of Medi-Cal, behavioral health, and housing systems to better serve individuals experiencing or at risk of homelessness in Sonoma County.

ECM and Community Supports Providers

Sonoma County's Behavioral Health system collaborates closely with Enhanced Care Management (ECM) and Community Supports providers to ensure coordinated, person-centered care for individuals with complex behavioral health, medical, and housing needs. Through regular cross-system meetings, we're working towards an enhanced referral system to align treatment plans with housing stabilization goals. Community Supports providers deliver housing transition, tenancy sustaining services, and short-term housing assistance that complement behavioral health treatment and recovery supports. The County

emphasizes shared care planning, clear communication, and data-informed coordination to improve referral tracking, maximize use of Medi-Cal benefits, and monitor housing stability and health outcomes, ensuring seamless integration of Medi-Cal, behavioral health, and housing services in Sonoma County.

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

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?
Sonoma County Behavioral Health works closely with Homekey+ and other supportive housing sites to provide coordinated services, funding, and referrals that support and house BHSA-eligible individuals. Sonoma County's Behavioral Health Division will continue partner with housing operators at Homekey-funded sites like Elderberry Commons to prioritize individuals with significant behavioral health needs for housing stability. Through Coordinated Entry's referral pathway, Behavioral Health programs, and Medi-Cal partners ensure timely access to housing and services. Funding will be braided across Behavioral Health resources, Medi-Cal benefits, and housing funds to support ongoing case management, tenancy-sustaining services, and care coordination. The County will collaborate with site operators, Enhanced Care Management, and Community Supports providers to track referrals, coordinate services, and monitor housing stability and health outcomes, ensuring that Homekey+ and supportive housing sites effectively serve BHSA-eligible individuals and support long-term housing stability.

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

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?
Sonoma County will coordinate the use of HHAP dollars to support the housing needs of BHSA-eligible individuals through a braided funding approach that aligns homelessness and behavioral health resources. HHAP funds will primarily support housing-focused case management and tenancy support services, while

BHSA funding will be leveraged to cover complementary housing-related costs such as security, property management, building maintenance, food supports, and other operational needs that help stabilize placements. In addition, available capital and operating funds will be used to make targeted building improvements, increasing habitability and occupancy for BHSA-eligible residents.

To strengthen system coordination and improve housing outcomes, Sonoma County is aligning the Homelessness Division more closely with Behavioral Health, creating a more integrated and cohesive approach to housing and behavioral health service delivery. This alignment supports shared planning, coordinated funding strategies, and streamlined service pathways for individuals with complex behavioral health and housing needs. The behavioral health system also works in close partnership with Managed Care Plans, housing providers, and community-based organizations to ensure BHSA Housing Interventions are fully aligned with the broader homelessness response system, maximizing resources and improving access to stable, supportive housing.

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?
The County Behavioral Health system expects to serve at 70-150 individuals annually with rental subsidies under BHSA Housing Interventions. In the first year, a smaller number is anticipated as program implementation and operational

processes are established. As the program matures, the County plans to expand capacity to serve additional individuals, ensuring participants achieve stable housing, sustained engagement in behavioral health services, and improved health and wellness outcomes. The county is planning to provide rental subsidies for 32 individuals, security deposits for 50 individuals, eviction prevention for 30 individuals, and transitional rent for 40 individuals.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
70

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
40

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?
BHSA rental subsidies are a newer resource, Sonoma County anticipates serving a smaller number of individuals in the initial year, with capacity increasing over time as programs and referral pathways are fully implemented. The County's methodology for estimating total rental subsidies and the total number of individuals served on an annual basis is based on projected transitions and utilization across existing behavioral health and housing programs.

Estimates incorporate individuals transitioning from Peer Respite and Behavioral Health Bridge Housing programs into interim or permanent housing; participants in permanent housing settings supported through the expanded Flex Pool; and individuals completing their initial six months of Managed Care Plan–funded housing supports who may continue to receive rental assistance through BHSA. Projections are informed by historical program throughput, expected lengths of stay, unit availability, and anticipated transitions to longer-term housing stability. As implementation progresses, Sonoma County will refine estimates using actual utilization data and ongoing system performance monitoring.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments Non-Time-Limited Permanent Settings: Single and multi-family homes

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

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Sonoma County's BHSA Housing Interventions are designed to promote housing stability, recovery, and wellness for individuals with behavioral health needs. BHSA funds will be used for rental subsidies and short-term or transitional housing supports, tenancy-sustaining services such as eviction prevention and housing navigation, and placement in supportive housing, including permanent supportive housing and rapid rehousing. Additionally, the County will fund a contractor to administer, monitor, and track housing vouchers, subsidies, and

housing supports, ensuring effective implementation, oversight, and outcomes for participants.

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
Sonoma County's behavioral health system will identify a portfolio of available units for BHSA-eligible individuals through close collaboration with the Continuum of Care (CoC), Permanent Supportive Housing providers, and other homelessness system partners. Behavioral Health staff will participate in CoC meetings, coordinated entry, and case conferencing to track unit availability and align placements with system priorities.

As applicable, the County will also leverage Flex Pool strategies, including master leasing, to expand housing options and reduce barriers to placement. These efforts are supported by partnerships with housing providers, community-based organizations, housing authorities, and Managed Care Plans to ensure timely access to appropriate interim and permanent housing for individuals with complex behavioral health needs.

Total number of units funded with BHSA Housing Interventions per year
70

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 (optional)
N/A

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
200

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
In Sonoma County, BHSA Housing Operating Subsidies are used to support the ongoing operational costs of housing programs serving individuals with behavioral health needs. These funds help cover expenses such as staff salaries for on-site supportive services, utilities, maintenance, insurance, security, and other costs necessary to operate housing programs safely and effectively. Operating subsidies are applied to permanent supportive housing, transitional housing, and interim housing programs, ensuring that residents not only have stable housing but also access to integrated behavioral health services. By providing reliable operational funding, these subsidies support program sustainability, housing stability, and positive recovery and wellness outcomes for Sonoma County residents.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive Housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: License-exempt room and board
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit
Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) [134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
70
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 (optional)
N/A

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
100

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

Sonoma County plans to use BHSA Housing Interventions funding to support landlord outreach and mitigation activities that expand housing options for BHSA-eligible individuals. These funds will be used to secure permanent supported for individuals with serious behavioral health conditions including those individuals staying in Eliza's Village, Mickey Zane Place and Behavioral Health Bridge Housing at Arrowood. We anticipate using these funds for rental subsidies, transitional rent, outreach to engage and recruit landlords, provide education about available supports, and reduce perceived risks associated with renting to tenants with complex behavioral health needs.

Sonoma County plans to allocate funds to cover costs such as unit damage, unpaid rent, vacancy loss, and other tenant-related expenses not covered by security deposits. In addition, incentives and holding fees will also be part of mitigation costs to increase landlord participation, improve unit availability, and support housing stability.

Total number of units funded with BHSA Housing Interventions per year
70

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
300

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
In Sonoma County, BHSA Participant Assistance Funds provide short-term, flexible support to help individuals with behavioral health needs achieve and maintain housing stability while engaging in services. Funds may be used for security deposits, first month's rent, moving expenses, transportation, or essential household items. These funds will be administered by a contractor in coordination with our DHS-BHD teams to ensure long-term housing retention, stability, and improved behavioral health outcomes.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

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

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
130

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Sonoma County will use BHSA Housing Interventions funding to provide Housing Transition Navigation Services and Housing Tenancy Sustaining Services for BHSA-eligible individuals, including those not eligible through Medi-Cal Managed Care Plans. Services will align with allowable Community Supports activities while operating outside Medi-Cal eligibility and provider requirements when funded by BHSA.

Housing Transition Navigation Services will support individuals in locating, securing, and moving into housing, while Housing Tenancy Sustaining Services will focus on maintaining housing stability through tenant education, lease compliance support, coordination with property managers, and early intervention to prevent housing loss. To implement these services, Sonoma County has released a Request for Proposals (RFP) to contract with a provider experienced in delivering housing navigation and tenancy sustaining services, ensuring capacity and alignment with the County's behavioral health and homelessness systems.

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

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
The County is prioritizing the BHSS funding for outreach and engagement, the 7% allowed is not sufficient.

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

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
No

Please explain why the county is not providing this intervention
The County was going to use Capital Development Funds as the match dollars for a BHCIP II Grant; however the County was not awarded the BHCIP II Grant.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention (optional)
N/A

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

Anticipated number of individuals served per year (optional)
0

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Sonoma County plans to use BHSA Housing Interventions funding to support the continuation of Behavioral Health Bridge Housing (BHBH), which is scheduled to conclude in 2027. BHSA funding will help sustain housing and supportive

services for individuals with significant behavioral health needs as these time-limited programs wind down, to the extent resources are available. This approach is intended to minimize service disruptions, promote housing stability, and ensure continuity of care for Medi-Cal–eligible clients during and after the transition from expiring BHBH programs.

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

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

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

Housing Transition Navigation Services
Housing Deposits
Housing Tenancy and Sustaining Services
Short-Term Post-Hospitalization Housing
Transitional Rent

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

Housing Transition Navigation Services

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

7/1/2026

Housing Deposits

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

7/1/2026

Housing Tenancy and Sustaining Services

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2026

Short-Term Post-Hospitalization Housing
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2026

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
7/1/2026

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)?
Sonoma County Behavioral Health will coordinate closely with Medi-Cal Managed Care Plans (Kaiser Permanente and Partnership HealthPlan of California) to ensure eligible Medi-Cal members are identified and referred to housing-related Community Supports, including Transitional Rent. MCPs will be responsible for identifying members with housing needs and initiating referrals to Sonoma County's housing programs.

The County is currently developing a warm, coordinated, and efficient referral policy and procedure that aligns with CalAIM-required referral and care coordination processes. This policy and procedure will emphasize timely

communication, confirmation of Medi-Cal eligibility, and seamless handoffs between MCPs and County programs to ensure members receive appropriate housing supports without disruption to care.

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

Sonoma County Behavioral Health maintains ongoing coordination with Medi-Cal Managed Care Plans (MCPs), including Kaiser Permanente and Partnership HealthPlan of California, to ensure the County's contracted provider network for Housing Interventions is known, current, and accessible. The County shares updated provider network information through regular interagency meetings, operational workgroups, and written communications, including provider lists and referral guidance.

Ongoing processes include routine updates to MCP contacts when contracts are added or modified, collaborative review of referral workflows, and coordination on eligibility criteria and service capacity. Sonoma County Behavioral Health also engages MCPs in continuous quality improvement efforts to address referral volume, access, and service alignment. Regular communication with MCP care teams will ensure that they have the necessary information to make timely and appropriate referrals for BHSA 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)?

No

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?

Sonoma County Behavioral Health has processes in place to promote continuity of care for Medi-Cal members with significant behavioral health conditions when MCP-provided housing services are exhausted, to the extent resources are available. Through the use of Interdisciplinary Multidisciplinary Team (IMDT) meetings, the County collaborates with MCPs, housing providers, and behavioral

health providers to proactively plan for transitions, identify ongoing needs, and coordinate next steps prior to the conclusion of MCP housing services.

The County works closely with its contracted behavioral health and housing providers to align service planning, explore available housing and supportive service options, and ensure warm handoffs occur whenever possible. Additionally, Sonoma County Behavioral Health is developing a formal policy and procedures that outline roles, responsibilities, and coordination processes to support continuity of services, including escalation pathways and communication protocols, to minimize service gaps and support sustained recovery and housing stability.

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)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Funder
Housing Supportive Services Provider

What organization is serving as the Operator?

Sonoma County has released a Request for Proposals (RFP) to identify an organization to serve as the Operator of the Flexible Housing Subsidy Pools. The operator will be determined through the RFP process in accordance with County procurement requirements.

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

Rental Subsidies
Landlord Outreach and Mitigation Funds
Participant Assistance Funds
Housing Transition Navigation Services and Tenancy Sustaining Services

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

In addition to the roles and functions described above, Sonoma County Behavioral Health will support the launch and scaling of the Flexible Housing Subsidy Pool by leading planning, coordination, and oversight activities. The County will release a Request for Proposals (RFP) to identify an operator for the Flex Pool and will provide contract management and performance monitoring once an operator is selected.

Sonoma County Behavioral Health will help facilitate coordination with Medi-Cal Managed Care Plans, behavioral health providers, and housing partners; support alignment with CalAIM requirements; and assist with the development of policies, procedures, and referral workflows to ensure effective implementation and ongoing operations of the Flex Pool.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

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

WORKFORCE STRATEGY

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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

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

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

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

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

Yes

Does the county intend to adopt this recommended approach for 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**

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
Enter a Percent value
9%

For county behavioral health (including county-operated providers), please select the **five positions** with the greatest vacancy rates
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
Psychiatrist
Substance Use Disorder Counselor

Please describe any other key workforce gaps in the county
While our nursing Full-Time Equivalent (FTE) allocations are less impacted, the leanness of the allocations for Registered Nurses (RNs) often affects our Crisis Stabilization Unit's ability to remain open, especially overnight, due to vacations, illness, or other absences.

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)?

Sonoma County anticipates that workforce needs will evolve over the next three fiscal years, requiring both increased staffing capacity and greater specialization to meet new and emerging requirements under Behavioral Health Transformation, BH-CONNECT, and the Behavioral Health Services Act (BHSA). Implementation of new evidence-based practices (EBPs), enhanced care coordination, and expanded community-based services will require staff with expertise in integrated care, data reporting, and culturally responsive service delivery.

To support this transition, the County will prioritize a phased approach that includes strategic hiring and targeted workforce development. Existing and newly hired staff will receive training on new EBPs, including initial certification where applicable, ongoing coaching to support fidelity, and training related to new data collection and reporting requirements such as Individual Service Level (ISL) reporting. The County will also leverage training and technical assistance opportunities provided by DHCS, CalMHSA, Centers of Excellence, and other partners. In addition, training expectations and implementation requirements will be incorporated into provider contracts to promote consistency and alignment across the behavioral health system.

Currently, Sonoma County BHD section managers are participating in webinar trainings offered by the Centers of Excellence on EBPs including ACT/FACT, Individual Placement and Support (IPS), and Clubhouse services to prepare for implementation with fidelity and support future participation in bundled rate opportunities. Sonoma County BHD Adult Services is also planning to contract with community providers to incorporate IPS and Clubhouse models into their programs. Within County-operated programs, staffing expansion may be challenging due to current fiscal constraints and workforce shortages; however, the County intends to strengthen and expand ACT and FACT team capacity over time to support implementation and meet opt-in requirements.
While these efforts will strengthen system readiness and support BHSA implementation, ongoing workforce shortages, high caseloads, and fiscal limitations may affect the pace of workforce expansion and participation in some optional EBP opportunities without additional funding and resources

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?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sonoma County BH plans to participate in HCAI's Medi-Cal Scholarship Program (MBH-SP) in 2027. Having missed the March 16, 2026, deadline to enroll and support workforce seeking these scholarships, Sonoma BH will plan to prepare to participate in the next round in 2027.

Sonoma County BH will support applicants pursuing education in one of the following eligible professions: Alcohol and Other Drug (AOD) Counselor, Certified Peer Support Specialist, Community Health Worker, Licensed Clinical Social Worker, and Licensed Marriage and Family Therapist.

Sonoma County BH will offer the following eligible practice sites to grantees needing to complete their obligation to provide direct client care: Community Mental Health Center (CMHC), Crisis Stabilization Unit (CSU), Psychiatric Health Facility (PHF), Substance Use Disorder Treatment Program (outpatient certified by DHCS), and Short-Term Residential Therapeutic Programs/ Children's Crisis Residential Programs.

Sonoma County BH will monitor grantees in their completion of their service obligation. This includes oversight of maintaining required service hours and absences and changes in schedules. Sonoma County BH will work with Sonoma County HR to determine appropriate monitoring of these grantee staff. As these "grantee staff" will be staff employed by Sonoma County, this will require negotiation with HR, Fiscal, and CAO office due to current fiscal strains preventing expansion of the workforce. This is in the planning stage. This monitoring will require coordination with Sonoma County Department of Health Services Human Resources department.

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

The County of Sonoma has actively promoted California Health Care Access and Information (HCAI) workforce programs, and the HCAI repayment program particularly, among its behavioral health workforce via emails to the Behavioral Health Division and our contracted CBOs. Lisa Nosal, our Cultural Responsiveness, Inclusion, and Training Coordinator, is on the HCAI mailing list, has been following news about the programs, and serves as our division's contact person to help answer and direct questions from staff. The Division is also looking forward to leveraging HCAI's recruitment and retention program, especially for retaining staff due to our limited ability to hire right now.

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

Yes

Please explain any actions or activities the county is engaging in to leverage the program

The County of Sonoma has actively promoted California Health Care Access and Information (HCAI) workforce programs, and the HCAI repayment program particularly, among its behavioral health workforce via emails to the Behavioral Health Division and our contracted CBOs. Lisa Nosal, our Cultural Responsiveness, Inclusion, and Training Coordinator, is on the HCAI mailing list, has been following news about the programs, and serves as our division's contact person to help answer and direct questions from staff. The Division is also looking forward to leveraging HCAI's recruitment and retention program, especially for retaining staff due to our limited ability to hire right now.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
The County is engaging with California Health Care Access and Information organization to learn about the statewide workforce programs. This program is designed to build the workforce of SUD counselors, CWHs, and peer support specialist.

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

Please explain any actions or activities the county is engaging in to leverage the program:
The County is engaging with California Health Care Access and Information organization to learn about the statewide workforce programs. The County is very interested in applying, and the BHD Medical Director is investing the application.

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:
The Behavioral Health Division (BHD) addresses workforce gaps through a mix of intentional approaches. 1) In the past 24 months, BHD has collaborated with Human Resources to reduce the BHD vacancy rate from 28% to a low of 8% circa December 2025. 2) BHD is supporting staff growth and mobility by encouraging and supporting staff returning to school to earn bachelor's and master's degrees, certificates, licenses, and continuing education credits. And 3) a mix of Affinity groups are in place to provide spaces for staff to meet with peers. These groups allow for discussions on career growth, peer-to-peer support, retention, and help create a sense of belonging.

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

Sonoma_Integrated Plan Budget Template Version 3_FINAL_DRAFT.xlsx

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

Behavioral Health Services and Supports (BHSS)

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit.

Full Service Partnership (FSP)

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit.

Housing Interventions

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's

maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit.

Enter date of last prudent reserve assessment

3/30/2026

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

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit. Sonoma County will not be transferring any funds from the prudent reserve to other BHSA components.

FSP

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit. Sonoma County will not be transferring any funds from the prudent reserve to other BHSA components.

Housing Intervention

Sonoma County's prudent reserve balance is below the maximum allowable threshold established by the Department of Health Care Services (DHCS) which is 20% of the average MHSA revenues from FY 2020–2025. Sonoma County's maximum prudent reserve level is $6,864,014. The County currently maintains a prudent reserve balance of $944,980.88, which is well below the allowable limit. Sonoma County will not be transferring any funds from the prudent reserve to other BHSA components.

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

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Behavioral health director certification

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

Complete

County administrator or designee certification

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

Completed

Board of supervisor certification

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

Due with the Final Plan by June 30, 2026

Table One: Behavioral Health Care Continuum Projected Expenditures									
	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services	**Yes/No**								
Primary Prevention Services	Yes	$ 430,570.00	$ 430,570.00	$ 430,570.00	$ 493,603.00	$ 493,603.00	$ 493,603.00	1817.00	2083.00
Early Intervention Services	Yes	$ 374,865.00	$ 374,865.00	$ 374,865.00	$ 124,955.00	$ 124,955.00	$ 124,955.00	900	300.00
Outpatient Services	Yes	$ 10,964,550.00	$ 10,964,550.00	$ 10,964,550.00	$ 1,167,352.00	$ 1,167,352.00	$ 1,167,352.00	1794	191.00
Intensive Outpatient Services	Yes	$ 1,382,305.00	$ 1,382,305.00	$ 1,382,305.00	$ 31,416.00	$ 31,416.00	$ 31,416.00	440	10.00
Crisis and Field-Based Services	Yes	$ 1,578,167.00	$ 1,578,167.00	$ 1,578,167.00	$ 262,048.00	$ 262,048.00	$ 262,048.00	2415	401.00
Residential Treatment Services	Yes	$ 14,955,590.00	$ 14,955,590.00	$ 14,955,590.00	$ 853,575.00	$ 853,575.00	$ 853,575.00	1244	71.00
Inpatient Services	No	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	0	0
Mental Health (MH) Services									
Primary Prevention Services	Yes	$ 46,781.00	$ 46,781.00	$ 46,781.00	$ 649,487.00	$ 649,487.00	$ 649,487.00	86	1194
Early Intervention Services	Yes	$ 11,223,022.00	$ 11,223,022.00	$ 11,223,022.00	$ 3,432,776.00	$ 3,432,776.00	$ 3,432,776.00	1772	542
Outpatient and Intensive Outpatient Services	Yes	$ 37,005,989.00	$ 37,005,989.00	$ 37,005,989.00	$ 28,002,800.00	$ 28,002,800.00	$ 28,002,800.00	2310	1748
Crisis Services	Yes	$ 21,734,686.00	$ 21,734,686.00	$ 21,734,686.00	$ 6,332,487.00	$ 6,332,487.00	$ 6,332,487.00	3065	893
Residential Treatment Services	Yes	$ 3,600,040.00	$ 3,600,040.00	$ 3,600,040.00	$ 593,821.00	$ 593,821.00	$ 593,821.00	97	16
Hospital and Acute Services	Yes	$ 16,124,619.00	$ 16,124,619.00	$ 16,124,619.00	$ 3,408,315.00	$ 3,408,315.00	$ 3,408,315.00	932	197

Table One: Behavioral Health Care Continuum Projected Expenditures (cont'd)									
	Services Are Provided in County	**Total Projected Expenditures On Adults and Older Adults (Year One)**	**Total Projected Expenditures On Adults and Older Adults (Year Two)**	**Total Projected Expenditures On Adults and Older Adults (Year Three)**	**Total Projected Expenditures on Children/Youth (under 21) (Year One)**	**Total Projected Expenditures on Children/Youth (under 21) (Year Two)**	**Total Projected Expenditures on Children/Youth (under 21) (Year Three)**	**Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults**	**Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)**
Subacute and Long-Term Care Services	Yes	$ 12,440,380.00	$ 12,440,380.00	$ 12,440,380.00	$ 0	$ 0	$ 0	147	0
Housing Services (MH + SUD)									
Housing Services	Yes	$ 37,010,393.00	$ 37,010,393.00	$ 37,010,393.00	$ 629,696.00	$ 629,696.00	$ 629,696.00	2351	40
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 168,871,957.00	$ 168,871,957.00	$ 168,871,957.00	$ 45,982,331.00	$ 45,982,331.00	$ 45,982,331.00	19370	7686

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 20,996,980.00	$ 35,000,000.00	$ 26,000,000.00
Workforce Investment Activities	$ 960,759.00	$ 960,758.00	$ 698,078.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 18,563,743.00	$ 18,563,743.00	$ 18,563,743.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 6,096,752.00	$ 6,096,752.00	$ 6,096,752.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 46,618,234.00	$ 60,621,253.00	$ 51,358,573.00

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

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

Table 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	$52,425,526.00	$50,425,526.00	$50,425,526.00
1991 Realignment (Bronzan-McCorquodale Act)	$16,613,095.00	$16,613,095.00	$16,613,095.00
2011 Realignment (Public Safety Realignment)	$23,057,513.00	$23,057,513.00	$23,057,513.00
State General Fund	$1,618,513.00	$1,618,513.00	$1,618,513.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$65,262,109.00	$65,262,109.00	$65,262,109.00
Projects for Assistance in Transition from Homelessness (PATH)	$0	$0	$0
Community Mental Health Block Grant (MHBG)	$704,778.00	$704,778.00	$704,778.00
Substance Use Block Grant (SUBG)	$2,696,789.00	$2,696,789.00	$2,696,789.00
Commercial Insurance	$25,284.00	$25,284.00	$25,284.00
County General Fund	$1,588,709.00	$539,440.00	$539,440.00
Opioid Settlement Funds	$4,654,433.00	$4,515,394.00	$4,515,394.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal funding	$99,006.00	$99,006.00	$99,006.00
Other state funding (including DSH funding)	$29,935,867.00	$39,343,923.00	$30,243,923.00
Other county mental health or SUD funding	$2,000,000.00	$2,000,000.00	$2,000,000.00
Other foundation funding	$60,790,900.00	$68,574,171.00	$68,411,491.00
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)	$261,472,522.00	$275,475,541.00	$266,212,861.00
Total Projected Expenditure Variance	$0	$0	$0

Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$214,854,288.00	$214,854,288.00	$214,854,288.00
Auto-validation: Table 2: Other County Expenditures	$46,618,234.00	$60,621,253.00	$51,358,573.00

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

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

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Year Two Component Allocation (dollars)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Year Three Component Allocation (dollars)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Unspent Mental Health Services Act (MHSA) to BHSA	$8,000,000.00	$8,000,000.00	$41,110,776.00	$57,110,776.00
Excess Prudent Reserve (PR) to BHSA	$0	$0	$0	$0
BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**
Rows 38-40: input your county's base BHSA funding allocation by component and year.
Rows 43-54: this section will be auto-populated from the sections below it.
Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.
Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Funding Transfer Request Allocations		
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**
Base Percentage and Funding	30%	$11,518,902.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New Housing Interventions Base Percentage (auto-populated)	30%	$11,518,902.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New FSP Base Percentage (auto-populated)	35%	$13,438,719.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New BHSS Base Percentage (auto-populated)	35%	$ 13,438,719.00

Funding Transfers (Year One)				
	Housing Intervention (Year One) (1)	**Full-Service Partnership (Year One)**	**Behavioral Health Services and Support (Year One)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	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%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)		
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**
Base Percentage and Funding	30%	$ 11,518,902.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New Housing Interventions Base Percentage (auto-populated)	30%	$ 11,518,902.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New FSP Base Percentage (auto-populated)	35%	$ 13,438,719.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New BHSS Base Percentage (auto-populated)	35%	$13,438,719.00

Funding Transfers (Year Two)				
	Housing Intervention (Year Two) (1)	**Full-Service Partnership (Year Two)**	**Behavioral Health Services and Support (Year Two)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	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%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$11,518,902.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New Housing Interventions Base Percentage (auto-populated)	30%	$11,518,902.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New FSP Base Percentage (auto-populated)	35%	$ 13,438,719.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**
Base Percentage and Funding	35%	$13,438,719.00
Percentage Reduced	0%	$0
Percentage Added	0%	$0
New BHSS Base Percentage (auto-populated)	35%	$13,438,719.00

Funding Transfers (Year Three)				
	Housing Intervention (Year Three) (1)	**Full-Service Partnership (Year Three)**	**Behavioral Health Services and Support (Year Three)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	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%	35%	35%	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	$31,927,005.00	$8,000,000.00	$8,000,000.00	$17,565,027.00
PEI	$14,288,767.00	$0	$0	$14,288,767.00
Encumbered INN	$2,187,211.00	$0	$0	$2,187,211.00
Unencumbered INN	$1,830,581.00	$0	$0	$1,830,581.00
WET	$2,619,595.00			$2,619,595.00
CFTN	$2,619,595.00			$2,619,595.00
Total (auto-populated)	$55,472,754.00	$8,000,000.00	$8,000,000.00	$41,110,776.00

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	$944,980.88
Local Prudent Reserve Maximum (2)	$8,607,473.00
Excess Prudent Reserve Funding that must be transferred	**$ (7,662,492.12)**
Housing Intervention (3)	$0
FSP	$0
BHSS (4)	$0
Total Transferred Excess Prudent Reserve (auto-populated)	$0

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.
Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.
Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.
Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value.
It will automatically display as a negative value in the cell.
Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions.
Enter this percentage as a positive value.
Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.
Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.
Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.
Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.
Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."
Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."
Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."
Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75)
must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.
Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."
Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN
funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.
Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.
Row 133: enter the dollar amount of prior year prudent reserve ending balance
Row 134: enter the prudent reserve maximum for your county.
Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**
Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.
Row 139: the total transferred excess prudent reserve is auto-populated.

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

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.

Table Five: BHSA Components			
	Total Housing Interventions Funding (Year One)	**Total Housing Interventions Funding (Year Two)**	**Total Housing Interventions Funding (Year Three)**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$11,518,902.00	$11,518,902.00	$11,518,902.00
Transfers into Housing Intervention component from Local Prudent Reserve	$0	$0	$0
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$3,000,000.00	$2,500,000.00	$2,500,000.00
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$14,518,902.00	$14,018,902.00	$14,018,902.00

Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**

Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$200,000.00	$200,000.00	$200,000.00	$0	$0	$0
Operating Subsidies	$0	$0	$0	$0	$0	$0
Bundled Rental and Operating Subsidies	$500,000.00	$500,000.00	$500,000.00	$0	$0	$0
% of Rental and Operating Subsidies Administered through Flex Pools	100%	100%	100%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$1,500,000.00	$1,500,000.00	$1,500,000.00	$0	$0	$0
Operating Subsidies	$0	$0	$0	$0	$0	$0
Bundled Rental and Operating Subsidies	$6,949,980.00	$6,143,902.00	$6,143,902.00	$1,643,987.00	$1,643,987.00	$1,643,987.00

% of Rental and Operating Subsidies Administered through Flex Pools	100%	100%	100%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$100,000.00	$100,000.00	$100,000.00	$0	$0	$0
Other Housing Supports: Participant Assistant Funds (2)	$200,000.00	$200,000.00	$200,000.00	$0	$0	$0
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$1,900,000.00	$1,900,000.00	$1,900,000.00	$0	$0	$0
Other Housing Supports: Outreach and Engagement (2)	$0	$0	$0	$0	$0	$0
Capital Development Projects	$0	$0	$0	$0	$0	$0
Housing Flex Pool Expenditures (start-up expenditures)	$0	$0	$0	$0	$0	$0
BHSA Innovative Housing Intervention Pilots and Projects	$0	$0	$0	$0	$0	$0
MHSA INN Projects	$0	$0	$0	$0	$0	$0

Subtotal (auto-populated)	$11,349,980.00	$10,543,902.00	$10,543,902.00	$1,643,987.00	$1,643,987.00	$1,643,987.00

Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$0	$0	$0
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$1,322,816.00	$2,000,000.00	$ 2,000,000.00
Total Housing Interventions Expenditures (auto-populated)	$12,672,796.00	$12,543,902.00	$12,543,902.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$7,643,902.00	$7,643,902.00	$7,643,902.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$150,000.00	$150,000.00	$150,000.00
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**

Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0%	0%	0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	52.6%	54.5%	54.5%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	0.0%	0.0%	0.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	24	24	24
Eligible Adults/Older Adults	827	827	827
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$0	$0	$0

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab.
Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.
Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be
transferring excess PR funds to Housing Interventions please report them here.
Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.
Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent
through their Medi-Cal MCP.
Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.
Row 63: input expenditures for BHSA-funded innovation pilots or projects.
Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.
Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.
Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.
Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.
Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.
Row 75: the proportion of funds dedicated to capital development will be auto-populated**.**
Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.
Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.
Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including
requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA
funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

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 One)	**Total Full Service Partnership (FSP) Funding (Year Two)**	**Total Full Service Partnership (FSP) Funding (Year Three)**
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$13,438,719.00	$13,438,719.00	$13,438,719.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$0	$0	$0
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$3,000,000.00	$2,500,000.00	$2,500,000.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$16,438,719.00	$15,938,719.00	$15,938,719.00

Full Service Partnership Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$504,742.00	$504,742.00	$504,742.00	$1,174,238.00	$1,174,238.00	$1,174,238.00	$21,350.00	$21,350.00	$21,350.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$1,304,778.00	$1,367,170.00	$1,367,170.00	$905,874.00	$905,874.00	$905,874.00	$96,996.00	$96,996.00	$96,996.00
FSP Intensive Case Management	$9,971,284.00	$9,471,284.00	$9,471,284.00	$2,419,322.00	$2,419,322.00	$2,419,322.00	$760,532.00	$760,532.00	$760,532.00
High Fidelity Wraparound	$1,317,393.00	$1,376,043.00	$1,376,043.00	$611,998.00	$611,998.00	$611,998.00	$ 88,683.00	$ 88,683.00	$ 88,683.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$160,000.00	$160,000.00	$160,000.00	$160,000.00	$160,000.00	$160,000.00	$320,000.00	$320,000.00	$320,000.00
Assertive Field-Based Initiation for SUD Treatment Services	$1,840,215.00	$1,642,837.00	$173,710.00	$971,247.00	$971,247.00	$0	$868,968.00	$671,590	$173,710.00

Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$0	$0	$0	$0	$0	$0	$0	$0	$0
BHSA Innovative FSP Pilots and Projects	$0	$0	$0	$0	$0	$0	$0	$0	$0
MHSA INN Projects	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal (auto-populated)	$15,098,412.00	$14,522,076.00	$13,052,94900	$6,242,679.00	$6,242,679.00	$5,271,432.00	$2,156,529.00	$1,959,151.00	$1,461,271.00

FSP Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$2,654,953.00	$2,899,480.00	$2,899,480.00
Total Full Service Partnership Expenditures (auto-populated)	$17,753,365.00	$17,421,556.00	$15,952,429.00
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	508	508	508
Eligible Adults/Older Adults	2523	2523	2523
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$0	$0	$0

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.
Rows 31-40: input the projected expenditures for each FSP service category or program for each year.
Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36.
Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.
Row 39: input expenditures for BHSA-funded innovation pilots or projects.
Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.
Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.
Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.
Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.
Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County
Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill
appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

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.

Table Seven: BHSA Components			
	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)**	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$13,438,719.00	$13,438,719.00	$13,438,719.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$0	$0	$0
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$7,565,027.00	$5,000,000.00	$5,000,000.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$21,003,746.00	$18,438,719.00	$18,438,719.00

Behavioral Health Services and Supports Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$1,879,957.00	$1,879,957.00	$1,879,957.00	$2,809,745.00	$2,809,745.00	$2,809,745.00	$152,193.00	$152,193.00	$200,743.00
Early Intervention Expenditures	$13,293,486.00	$12,293,486.00	$12,293,486.00	$8,094,879.00	$8,094,879.00	$8,094,879.00	$777,014.00	$777,014.00	$777,014.00
Coordinated Specialty Care for First Episode Psychosis	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$100,000.00	$519,881.00	$265,092.00	$265,092.00
All Other EI Expenditures	$13,293,486.00	$12,293,486.00	$12,293,486.00	$8,094,879.00	$8,094,879.00	$8,094,879.00	$777,014.00	$777,014.00	$777,014.00
Outreach and Engagement	$1,552,900.00	$1,552,900.00	$1,552,900.00	$644,039.00	$644,039.00	$644,039.00	$48,550.00	$48,550.00	$48,550.00

Workforce Education and Training (WET)	$960,759.00	$960,758.00	$698,078.00	$0	$0	$0	$0	$0	$0
Dedicated BHSA WET funds	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dedicated MHSA WET funds	$960,759.00	$960,758.00	$698,078.00	$0	$0	$0	$0	$0	$0
Capital Facilities and Technological Needs (CFTN)	$811,826.00	$1,465,277.00	$695,102.00	$0	$0	$0	$0	$0	$0
Dedicated BHSA CF/TN funds	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dedicated MHSA CF/TN funds	$811,826.00	$1,465,277.00	$695,102.00	$0	$0	$0	$0	$0	$0
BHSA Innovative BHSS Pilots and Projects	$0	$0	$0	$0	$0	$0	$0	$0	$0
MHSA INN Projects	$1,559,904.00	$627,307.00	$0	$0	$0	$0	$0	$0	$0
Subtotal (auto-populated)	$20,158,832.00	$18,879,685.00	$17,219,523.00	$11,648,663.00	$11,648,663.00	$11,648,663.00	$1,497,638.00	$1,242,849.00	$1,291,399.00

BHSS Prudent Reserve Transfer Information+B48:E67	**Year One**	**Year Two**	**Year Three**

Transfers out of BHSS component into Local Prudent Reserve	$0	$0	$0
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 2,896,915.00	$ 2,000,000.00	$ 2,000,000.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 23,055,747.00	$ 20,879,685.00	$ 19,219,523.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 7,173,368.00	$ 6,382,948.00	$ 6,382,948.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	98.6%	86.4%	0%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	53.6%	51.5%	51.5%

Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	4486	4486	4486
Eligible Adults/Older Adults	5980	5980	5980
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$0	$0	$0
BHSS transfer to CF/TN	$0	$0	$352,610.00
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$2,619,595.00	$1,658,836.00	$698,078.00
Estimated MHSA CF/TN Funds	$2,619,595.00	$1,807,769.00	$342,492.00
MHSA "Encumbered" INN	$2,187,211.00	$627,307.00	$0

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.

Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.

Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.

Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.

Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.

Row 45: input expenditures for BHSA-funded innovation pilots or projects.

Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations,
and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

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 One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 886,983.00	$886,983.00	$886,983.00
Total Projected County Integrated Plan Annual Planning Expenditures	$1,138,559.00	$1,138,559.00	$1,138,559.00
New and Ongoing Administrative Costs	$886,982.00	$886,982.00	$886,982.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$51,961,367.00	$48,396,340.00	$48,396,340.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.7%	1.8%	1.8%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	2.2%	2.4%	2.4%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$0	$0	$0
Planning	$0	$0	$0
Total	**$0**	**$0**	**$0**

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants

by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

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	$944,980.88
Local Prudent Reserve Maximum (1)	$8,607,473.00
Excess Prudent Reserve Funds (auto-populated)	$(7,662,492.12)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$0
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$0
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$0
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$0
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$0
Total Distributions From the Local Prudent Reserve (auto-populated)	$0

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.
Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.
Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.
Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

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%	35%	35%	100%
Component Allocations	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	**Full Service Partnerships (Year One)**	**Behavioral Health Services and Supports (Year One)**	**Year One Totals**
Estimated Year One Component Allocations *(BHSA Funding Only)*	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00
Transfers From PR Into Component	$0	$0	$0	$0
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$3,000,000.00	$3,000,000.00	$7,565,027.00	$13,565,027.00

Estimated Total Available Funding for Year One	$14,518,902.00	$16,438,719.00	$21,003,746.00	$51,961,367.00
Transfers from Component Into PR	$0	$0	$0	$0
Estimated Total Year One Expenditures	$12,672,796.00	$17,753,365.00	$23,055,747.00	$53,481,908.00
BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	**Full Service Partnerships (Year Two)**	**Behavioral Health Services and Supports (Year Two)**	**Year Two Totals**
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$11,518,902.00	$13,438,719.00	$13,438,719.00	$ 38,396,340.00
Transfers From PR Into Component	$0	$0	$0	$0
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 4,346,106.00	$1,185,354.00	$2,947,999.00	$8,479,459.00
Estimated Total Available Funding for Year Two	$15,865,008.00	$14,624,073.00	$16,386,718.00	$46,875,799.00
Transfers from Component Into PR	$0	$0	$0	$0
Estimated Total Year Two Expenditures	$12,543,902.00	$17,421,556.00	$20,879,685.00	$50,845,143.00
BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	**Full Service Partnerships (Year Three)**	**Behavioral Health Services and Supports (Year Three)**	**Year Three Totals**
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$11,518,902.00	$13,438,719.00	$13,438,719.00	$38,396,340.00

Transfers From PR Into Component	$0	$0	$0	$0
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$5,821,106.00	$(297,483.00)	$507,033.00	$6,030,656.00
Estimated Total Available Funding for Year Three	$17,340,008.00	$13,141,236.00	$13,945,752.00	$ 44,426,996.00
Transfers from Component Into PR	$0	$0	$0	$0
Estimated Total Year Three Expenditures	$12,543,902.00	$15,952,429.00	$19,219,523.00	$47,715,854.00
BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$886,983.00	$ 886,983.00	$886,983.00	$2,660,949.00
Total Projected County Integrated Plan Annual Planning Expenditures	$1,138,559.00	$1,138,559.00	$138,559.00	$3,415,677.00
Total Projected New and Ongoing Administrative Expenditures	$886,982.00	$886,982.00	$886,982.00	$2,660,946.00

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.
Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.
Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.
Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.